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1.1.1 Virtual psychiatric care fast-tracked: reflections inspired by the COVID-19 pandemic

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Abstract

For many patients and healthcare providers, the move to virtual psychiatric care has been fast-tracked by the COVID-19 pandemic. In this article, we consider a patient perspective and a provider perspective on the transition to virtual psychiatric care and its strengths and limitations, as well as a call for much-needed future research.

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The COVID-19 pandemic has rapidly transformed service delivery, including the delivery of medical care, around the world. As jurisdictions worldwide enacted measures to slow the spread of the SARS-CoV-2 virus, service providers quickly adapted. What was previously a slow expansion of telemedicine and virtual care over the past two decades, with the primary goal of overcoming geographical barriers,¹ became suddenly fast-tracked in a matter of weeks. A rapid transition to virtual psychiatric care, care provided by telephone or video, is one such transformation resulting from the COVID-19 pandemic and the measures implemented to contain it.

Leaders and advocates in the field of telepsychiatry are expecting, and in fact encouraging, these changes to persist post-pandemic.²⁻⁴ The aim of this article is to reflect on the transition to virtual psychiatric care through three lenses:

a patient perspective, a provider perspective and a scholarly perspective, including a call for future research. The patient and provider perspectives obtained for this article reflect individual experiences with the transition to virtual psychiatric care and are not intended to capture the diversity of perspectives and experiences that may exist. The patient and providers have experienced both models of care pre- and post-pandemic onset.

A patient perspective, by Ms Sandra Lubert

“I am a mental health patient with a diagnosis of depression, PTSD and chronic sleep disruption. I have been either ill or in remission for many years and have experienced extensive clinical intervention both before and during the COVID-19 pandemic; that is, both actual, in-person care and virtual, online care. Clearly, a physical meeting between patient and practitioner in a clinical environment is often warranted. Face-to-actual-face is sometimes best, and I am not advocating the replacement of such visits with online care. Further, some of our most vulnerable populations lack access to telehealth and/or virtual technology and for these individuals, it is imperative that we either provide them with the tools required to access proposed alternative care or continue to provide traditional, in-person interventions. Barriers to online care can be significant, salient features and these need to be considered. When a physical appointment is required or even simply preferred, this must be accommodated. I believe that an ideal system of mental health care features a robust, multi-faceted approach which meets the needs of all patients and practitioners. My own mental illness includes severe insomnia and related suicidality. Six weeks ago – right around the onset of the pandemic – I had a psychiatric crisis requiring an ER visit and overnight hospitalization. This urgent, on-site care was life-saving. But I believe that my follow-up care, which has been entirely virtual, has been just as critical. This recent experience leads me to believe that the rapid changes necessitated by COVID-19 have a great deal to teach us about psychiatric care delivery. For me, as a recipient, ‘pandemic-period psychiatry’ (via eVisits) has not only been adequate and helpful, it has in many ways been far more effective than its in-person counterpart. There are three main aspects of online care that have enhanced the overall experience for me: reduced cost, ease of access, and increased flexibility/comfort. From a very practical standpoint, I can state that eVisits have saved me money. I have not had to pay for gas to get to and from appointments, and I have not had to pay for parking. Many patients travel a significant distance in order to see clinicians, and this can be very expensive. Some rely on caregivers, taxis, or public transit. Again, while this may seem insignificant, the cost of transportation can be a major deterrent in seeking treatment, particularly for those on a limited income. Ease of access around virtual care is a huge factor. My mental illness is often incapacitating; when I am in crisis, it is difficult for me to get out of bed, let alone leave my house. Things like getting dressed, planning for travel time, being presentable may seem trivial, but for those struggling with severe mental illness, these obstacles can be insurmountable. The anxiety induced by having to leave the house and get to one’s doctor is sometimes crippling and prevents us from seeking care. When I am in distress, the idea of sitting in a waiting room (often in tears, usually in psychic pain) is intolerable. For those dealing with a physical disability in addition to mental illness, barriers are even more debilitating. When access is restricted, the situation with mental health can become dire. Indeed, it can even become deadly. eVisits have saved me; I have been better able to access consistent, necessary psychiatric care because I can do so virtually from my home. Increased flexibility is perhaps the most beneficial aspect of virtual care. Since the variables of transportation and location are removed, both patient and practitioner are better able to schedule meetings. Modifying appointments has also been far easier to accomplish online, with recipient and caregiver both having immediate access to electronic calendars and other tools. Involving my partner in an eVisit is merely a matter of inviting her to sit next to me at my computer. Both my doctor and I have information at our fingertips if needed. Finally, I feel more comfortable with eVisits. Meeting with my practitioner from my own environment puts me more at ease. Ultimately, this has to do with a levelling effect – it makes me feel like I am more of an equal in the patient–practitioner exchange. Traditional appointments take place in the doctor’s realm – their office, clinic, the hospital... in some ways, this gives them the ‘home field advantage’, as it were. I am in their space. They know where everything is, who everyone is, but it is largely unfamiliar to me. I am a guest. I don’t have my own mug, for tea.”

A provider perspective, by Dr Tea Rosic, psychiatry resident, and Dr Zainab Samaan, staff psychiatrist

“Suddenly, going to the clinic to see patients is a health risk to both my patients and me. I am faced with a precarious balancing act as I find ways to provide adequate psychiatric care to patients who face increasing anxiety, depression, social isolation, and changes in mental status during the pandemic. The novelty of COVID-19, the ever-dynamic guidelines, processes, and instructions, issues of shortage and conservation of PPE, and new risk–benefit equilibria as we consider each clinical decision are all present in ways we have not encountered before. Virtual care has alleviated the risk carried by face-to-face contact but has raised many new challenges. Do I have a printer, fax machine, dedicated telephone line, secure email, and contact information for community pharmacies? Do I know how to schedule appointments without administrative staff support? New medicolegal challenges arise: what if a patient has an urgent psychiatric need, should I be available online 24 h/day? Can we send patients to hospital or are we contributing to risk of transmission and placing patients at greater risk? Not unlike before the pandemic, my patients in greatest need of care often face the greatest barriers in accessing it: limited mobile phone minutes, barriers in access to internet and virtual technologies, lack of privacy. Nevertheless, virtual care has been transformative. Being able to provide much needed care despite the pandemic restrictions is satisfying. Seeing patients through telemedicine modalities has opened the door to better assessments of their environment and allows for easier involvement of other family members when invited. I see patients’ pets and other important aspects of their lives. How often does it occur, in the clinic, that we have no access to updated medication lists, and how much time is spent trying to gain this information before making further treatment recommendations? With virtual visits and medications accessible to the patient in their home, this problem is averted. Virtual care during this pandemic has so quickly transformed how (and from where) we do our jobs. I have greater control over my schedule, working hours are more flexible and I am more available outside of structured clinical time. How these changes will evolve following the pandemic is unknown, but there is much to be learned and gained from this experience.”

A scholarly perspective: the evidence base

Virtual psychiatric care has an established evidence base and has shown effectiveness in a variety of areas, including within different patient populations and in different clinical settings.⁵ Previous research suggests that building therapeutic rapport is just as effective virtually as it is in person.⁵ For clinicians thrust into providing virtual psychiatric care, the strengths and limitations of this model of service delivery are becoming clearer. Recognising and reflecting on these is just as important now as it will be post-pandemic, when organisations and providers decide on the models of care they will offer. In the post-pandemic era, in-person healthcare may indeed become ‘option B’ for many patients.⁶ We are working through the technical issues, concerns about confidentiality and provider payment obstacles that each slowed the advance of virtual care in the past. For many patients, as described above, virtual care provides the easier access, flexibility and comfort that is lacking from in-person, hospital- or clinic-based care. Some patients may be greatly benefited by ongoing virtual appointments.

For all of the potential benefits of virtual psychiatric care, there are shortcomings that must be considered. Physical examination cannot be conducted as usual and there may be challenges in comprehensively assessing physical appearance and functioning in virtual psychiatric assessments. Virtual care may impose additional barriers to assessment for patients presenting with certain symptoms, such as paranoid ideation,^{7,8} although a recent study on the use of telepsychiatry for first-episode psychosis suggests that 50% of patients reported telepsychiatry as a favourable modality for follow-up.^{9,10} Patients experience differential access to virtual platforms and technology, based on socioeconomic and other factors.¹¹ In particular, patients with severe and persistent mental illness may face even greater barriers to accessing care virtually than the general patient population.⁸ Individuals living in close quarters with multiple family members may have insufficient space to talk while maintaining privacy and confidentiality.^{11,12} Older adults and individuals with disabilities may face challenges with access to technology, visual impairment or hearing impairment, creating barriers and gaps in care. Cultural factors in virtual care must be carefully considered and addressed. Patients who require language interpreters may be disadvantaged by virtual psychiatric care.¹³ With the expansion of virtual psychiatric care, we must be particularly mindful of the risk of widening the gap in access to care for patients who are marginalised or otherwise vulnerable. The broader issue of global healthcare access inequities in telepsychiatry is being raised.¹⁴

Research and practice implications

In this article, we aimed to provide both patient and provider perspectives on the rapid and monumental shift to virtual psychiatric care that occurred, seemingly overnight, in many jurisdictions. However, the perspectives shared may be limited in their generalisability for settings outside of a well-funded public healthcare system or in places with limited existing capacity for the provision of telemedicine. We stress that the experiences of unique patients and unique providers, working in diverse clinical settings, managing different clinical presentations and operating in distinct healthcare systems worldwide might be critically different. The global healthcare community will benefit from hearing and learning from diverse experiences and perspectives.

As we rapidly usher in this new era of virtual psychiatric care, concerted efforts must be made to study and learn from our experiences. Research must be undertaken to examine the impact of these changes in psychiatric service delivery for different patient groups and different providers. Ensuring identification of individuals and groups whose needs are not met will be critical. Qualitative research that can capture the depth and detail of our human experiences with virtual psychiatric care will be necessary. Economic analyses of the costs and savings of this model will also be integral. There is some pre-pandemic evidence to suggest great potential cost savings with widespread use of telemedicine – including savings accrued from shorter time spent travelling and waiting, for both patients and providers.^{15,16}

Clinical and research groups worldwide have begun to publish and share their experiences in implementing telepsychiatry during the COVID-19 pandemic for patient populations in various settings, including child and adolescent psychiatry,¹⁷ general out-patient psychiatry^{11,13} and in-patient psychiatry.¹⁸ Surveys of psychiatrists using telepsychiatry during the pandemic indicate benefits such as convenience and flexibility, as well as challenges in relation to the use of technology, impact on confidence in diagnosis and impact on therapeutic alliance.¹³ Authors are giving consideration to the experience of trainees and educators using telepsychiatry.¹⁹

The COVID-19 pandemic propelled us into a new era of virtual psychiatric care, and opened the door to a re-evaluation of how, and why, we provide mental healthcare in the ways we do. This door will remain open, post-pandemic, allowing us to rigorously evaluate, shape and refine our models of care to meet the needs of our patients as best as possible.

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All three authors are responsible for the article concept and design. T.R. conducted the literature search. All three authors contributed to writing the first draft of the manuscript and critically revising the final manuscript; all three reviewed and approved the final manuscript.

Declaration of interest

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Supplementary material

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1.1.2 The contagiousness of memes: containing the spread of COVID-19 conspiracy theories in a forensic psychiatric hospital

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Abstract

COVID-19 has transformed healthcare service provision. In addition to the spread of a virus, there has been an equally concerning emergence and spread of conspiracy theories. Such theories can threaten societal cohesion and adherence to the necessary public health guidance. In a forensic in-patient setting, such difficulties can be amplified. In this paper, we outline the key theory in relation to the development and spread of conspiracy theory memes. We propose primary, secondary and tertiary level responses to tackle the possible generation and spread of harmful conspiracies in the forensic in-patient setting. We consider this to be important, as there is a risk that such beliefs could affect patients' mental health and, in extremis, undermine physical health efforts to reduce the spread of COVID-19.

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Forty-four cases of pneumonia of unknown microbial origin were reported to the World Health Organization (WHO) on 31 December 2019.¹ Investigations revealed that the culprit organism was a novel coronavirus, dubbed COVID-19. COVID-19 has spread quicker than experts anticipated; the WHO declared an international state of emergency – a

true pandemic – in early March 2020, as the virus spread rapidly between continents. The human cost has been, and continues to be, vast.

The public health response

The global response to COVID-19 has emphasised the necessity for reduced close contact; hence, the intervention termed ‘social distancing’. To achieve this aim, many governments implemented ‘lockdown’ strategies to limit the free movement of the public, although the precise restrictions and severity of the measures have differed from country to country. The UK government urged people to ‘Stay Home, Save Lives, Protect the NHS’, with only essential travel permitted, restricted mixing of households and citizens at one point limited to a single exercise outing per day. There was a national drive to ‘flatten the curve’, with the stated intention to avoid overwhelming the National Health Service (NHS). A further patriotic message resonated with the public; that is, to protect the most vulnerable in society. Ultimately, the effectiveness of government and society’s efforts to maintain this unconventional and rather antisocial injunction will be measured by the number of casualties.

A forensic mental health hospital facing the pandemic

We are based in a psychiatric medium secure unit (MSU) in the West Midlands, UK. The MSU has capacity for 90 male patients across multiple wards and provides care to men who present with complex risk behaviours and experience psychopathology that warrants treatment under the Mental Health Act 1983 (amended 2007). The reality of COVID-19 within the MSU community parallels the changes seen in wider society. Initially, the virus was an abstract threat. However, measures were quickly implemented to increase hand-washing, social distancing and isolation of symptomatic patients.

At the time of writing, there have been 24 COVID-19 cases confirmed by positive swab in our MSU. Many patients experienced mild to moderate symptoms. However, three individuals required transfer to an intensive care unit for intubation and ventilation. Fortunately, they made a good recovery and returned to the MSU. Those with milder symptoms have been encouraged to self-isolate in their bedrooms. In anticipation of an increase in infections, one ward was designated to be the ‘COVID ward’, to contain the infection within a specific area and minimise further spread.

Clinical practice has changed significantly and it is hoped that, by mimicking national restrictions, the spread of COVID-19 will be contained. However, it is acknowledged that true ‘lockdown’ cannot be instated owing to the necessary travel between wards to maintain essential care.

The Trojan horse: a split between staff and patients?

Patients in the MSU have been required to adjust to novel protocols (use of personal protective equipment (PPE), social distancing, etc.) while also processing the increased limitations on their movements at all times. Such dramatic changes, in the context of access to 24 h news coverage, have understandably heightened anxiety, fear and uncertainty. Of course, this is in addition to the usual physical and relational security provisions, such as air locks, keys and high fences that can be a source of angst for patients.

In these unprecedented conditions, we consider that there is a risk of an ‘us versus them’ dynamic developing, particularly as situational threat is high.² On closed wards, it is plausible that staff are the vehicles of virus transmission, transporting the contagion onto the ward asymptotically, given the incubation period of COVID-19. It is possible that some patients may view the movement of staff as contamination. The usual psychological containment that high staffing levels can provide may now be perceived as hostile, dangerous and unpredictable – when the danger cannot be seen, who is infected and imposing threat to the community? As the staff group fulfil the role of caregivers, a complicated role reversal ensues, as the caregiver is viewed as the source of danger: the Trojan horse entering the fortress.

The emergence of conspiracy theories

We have noticed that conspiracy theories have emerged in tandem with the COVID-19 spread. Conspiracy theories have been defined as ‘attempts to explain the ultimate causes of significant social and political events and circumstances with claims of secret plots by two or more powerful actors’.³ Notably, conspiracy theories are similar to, though distinct from, misinformation and/or ‘conspiracy hypotheses’. Misinformation – false or inaccurate information, often intended to deceive (e.g. ‘fake news’) – can underpin conspiracy theories as it undermines mainstream narratives; conspiracy hypotheses are legitimate counter-narratives that can occur when there is uncertainty about the official story. Again, these can increase uncertainty and trust in a centralised message. The relationship between these phenomena is likely to be fluid.

Research has shown that conspiracy beliefs are common. For example, 60% of Americans believe that the CIA killed JFK⁴ and 46% of leave voters in the EU referendum believed that the vote would be rigged.⁵ There are many other types of theory that gather large follower groups.³ COVID-19 conspiracy theories have included fear of 5G broadband networks and persistent notions that the virus is man-made.⁶

Interestingly, individuals who hold one conspiracy theory are more likely to believe others,⁷ thus suggesting a possible underlying tendency to seek counter-narrative explanations and prefer them to information presented by institutions. Individuals who hold conspiracy beliefs are predominantly male, unmarried and of lower socioeconomic status. They are more likely to have weak social networks and belong to ethnic minority groups. Notably, they are likely to have had adverse childhoods and experience psychiatric problems as adults.⁸ Such demographics are highly consistent with a typical in-patient forensic population.^{9,10}

Particular environmental conditions and psychological processes have been mooted to underpin such beliefs. In a review, Douglas et al¹¹ identified three psychological motivations that led to a preference for conspiracy explanations: epistemic, existential and social. Each has particular relevance to the patient group in an MSU.

The epistemic motivation relates to an individual’s or group’s understanding and knowledge of a phenomenon; conspiracy theories can allow individuals to preserve a sense of understanding in the face of uncertainty and contradiction. These beliefs are noted to become stronger when events are widespread and/or significant,¹² and when simplistic, mundane explanations are perceived as unsatisfactory.¹³ Conspiracy beliefs can foster a sense of cognitive closure when the situation lacks a clear, consistent and understandable official message.¹⁴

When individuals feel anxious, threatened and powerless in the face of danger, they may gravitate towards conspiracy theories to achieve a sense of comfort.^{11,15,16} These are viewed as existential motivations.¹¹ Such powerlessness can be exaggerated by a perception of alienation from decision makers and a breakdown in containment and social order.^{7,15}

Douglas et al¹¹ note that social motivations also contribute to the formation of conspiracy beliefs. Groups that have experienced persecution, for example victims of police harassment¹⁷ or racial discrimination,¹⁸ are more likely to perceive dominant groups as conspiring against them. Research has shown that members of low-status groups are more likely to endorse conspiracy theories than those of higher status.^{15,19} In-group attachments can strengthen in the face of group threat, and ‘collective narcissism’ (an emotional investment in an unrealistic belief about the in-group’s greatness)²⁰ can develop, particularly when underprivileged, undervalued and under threat.¹⁹ This may function to protect the in-group by forming a shared ‘us versus them’ narrative.²¹ Similarly, individual narcissism is understood to emerge as a defence in response to perceived powerlessness; a conspiracy theory is powerful as it ascribes ‘special knowledge’ to the believer, imbuing a safe sense of superiority.²²

Such motivations and psychosocial characteristics are relevant and, in some circumstances, exaggerated in the MSU population. For example, research has linked subclinical delusional thinking²³ and schizotypy^{24,25} to conspiracy thinking. Individuals diagnosed with paranoid personality disorder demonstrate similar conspiratorial thinking.^{26,27} Cognitive/affective mechanisms at play in such samples are also relevant to those at the distressing/impairing end of the psychosis continuum, i.e. those diagnosed with schizophrenia.²⁸ For example, the omission of true cognitive information²⁹ could precipitate a jumping to conclusions (JTC) bias that is associated with the rapid appraisal of ambiguous or anomalous stimuli to form a conclusion without a sound evaluation of evidence.³⁰ Such a bias is evident in subclinical³¹ and clinical populations.³² Moulding et al³³ have identified that holders of conspiracy beliefs are more likely to view the world as threatening. Such schematic views of the world as dangerous³⁴ can underpin the process whereby delusional beliefs – in an attempt to secure cognitive closure – form from misappraisals of anomalous stimuli.³⁰ Of note, a high

proportion of our in-patient population hold – or have held – delusional beliefs.

Disproportionately, MSU in-patients have been exposed to early life danger³⁵ and hold negative schematic beliefs about self, others and the world.³⁶ Psychotic delusions, conspiracy theory beliefs and self-protective distortions have a propensity to surface when conditions are dangerous and uncertain.^{15,16}

The impact of the pandemic within the clinic

Meme theory can help to explain how such ideas spread, particularly in contained environments. Dawkins³⁷ considered memes to be cultural phenomena that pass from one mind to another, and survive (or die) through a process analogous to genetic selection. Goertzel³⁸ noted ‘conspiracy theorizing [*sic*] is a rhetorical meme that transforms scientific controversies into human dramas with villains who can be exposed’.

In the general population, COVID-19 conspiracy theory memes (e.g. 5G phone masts, man-made virus) have gone viral, with some harmful and persistent consequences. More broadly, memes that run as counter-narratives to the government’s explanations and advice affect some people, who may then spread their ideas to others. This may lead to a failure to act according to government guidelines and in the best interest of public health.⁶

We have observed conspiracy theory memes to develop in two distinct ways within the MSU. First, ‘organic memes’ have developed on one ward. These have taken the form of a belief that the pandemic is orchestrated by the hospital staff to restrict leave and delay discharge. Such a belief is likely to have formed with no outside influence and is perhaps good evidence that humans will seek conspiracy theory explanations in isolation to allay epistemic, existential and social concerns.^{11,19} It is our view that, despite several men endorsing this meme to a greater or lesser degree, it will likely wither and fail to spread owing to its fallibility in the face of simple counter-evidence and the physical health restrictions that prohibit mixing of wards (this meme is unlikely to be shared by staff members).

The type of second conspiracy meme is more problematic and harder to contain. These are externally generated conspiracy theories. Such memes may find traction among the internal population by direct or indirect conversations, through telephone contact, media consumption and where there are exchanges of perspectives. It is not possible – or ethical – to stop the introduction of conspiracy theory memes via telephone contact with relatives. However, staff members may be prone to conspiracy beliefs because of their own sense of powerlessness, threat and existential anxiety. As staff members move around the MSU, there is a risk of them spreading conspiracy beliefs to others. Additionally, misinformation might be introduced into the hospital. This new discrepant information may destabilise an already vulnerable in-patient population and prime conspiratorial thinking.

The impact of a COVID-19 conspiracy theory meme outbreak

Healthy secure wards are able to maintain a negotiated homeostasis, whereby clear boundaries and good clinical practice maintain order, safety and containment, while also promoting mental health rehabilitation. Conspiracy theory memes present a threat to this architecture. A possible consequence is a breakdown in trust and cohesion, which would undermine physical and psychological safety, and challenge measures to contain the virus.⁶

Uncertainty and unpredictable danger can be precipitants of anxious threat states. Changes in routine or the introduction of new conditions can trigger a loss of perceived environmental control and subsequent attempts to regain safety. As such, periods of stress and threat require the use of automatic self-protective behaviours and implicit information processing strategies.²⁹ Harmful conspiracy theories or hypotheses can increase uncertainty and decrease trust in authority figures. For many men in forensic in-patient settings, violence or self-harming behaviour has been – or is – an adaptive part of their self-protective behavioural repertoire. When in conditions of threat, such behavioural expressions might manifest to gain control, discharge arousal, communicate distress or elicit care.

Similarly, splitting is a possibility, with competing memes generating an ‘us versus them’ dynamic. As described previously, this is an evidenced component of conspiracy theory motivation, and staff members can become targeted if inequality is perceived (e.g. locked down versus transient, exposed versus PPE). Systemically, these processes can heighten the sense of danger for other residents and group anxiety can escalate. Of course, staff members are not immune to such effects and negative consequences are possible (e.g. burnout, increased punitiveness).

The response

Memes are hypothesised to spread in a manner analogous to a virus.^{37,38} Hence, we propose that a fast, stringent and proactive strategy is required to curb the sharing of unhelpful and false memes. We suggest that the response to ‘prevent’ and ‘treat’ conspiracy theories can be pitched according to the public health approach to diseases: primary, secondary and tertiary prevention.

Importantly, some degree of uncertainty is unavoidable owing to a global lack of clarity regarding COVID-19. It has to be acknowledged that there are few unambiguously *true* known facts about the virus. We do not advocate the suppression of questioning or critical challenge of official narratives. A host of different memes, differing in strength, transmissibility and potential harmfulness, will spread among staff and patients. We recommend that professionals demonstrate clinical judgement to determine if and when intervention is required and listen to alternative perspectives, discussing them in context.

Primary prevention

Primary prevention aims to prevent disease or injury before it occurs. To prevent the development of conspiracy theories within an MSU, we recommend addressing the conditions that lead to such thinking.

We consider the first line of response to be education. Conspiracy theory memes are hypothesised to breed from indecision and uncertainty; gaps in knowledge allow room for a counter-narrative to develop to fulfil a need for cognitive closure¹⁴ and a perception of control.^{11,15,16} We view the regular and consistent dissemination of clear and transparent information about the pandemic, the ‘outer world’ situation and MSU policy to be essential to maximise patients’ knowledge. Information can be adapted to account for complex communication needs, and care plans developed accordingly. Ideally, patients who are vulnerable to being affected by conspiracy beliefs should be identified and bespoke assessments and management plans completed.

The staff group are not immune from conspiratorial thinking. Helping staff members to feel informed requires the consistent dissemination of information in a manner that is accessible to all. Changes in practice should be quickly communicated. Information should be transparent, with an open forum approach to address queries and signpost to relevant resources. In addition, an honest acknowledgement of challenges that individuals and teams will face is necessary to ensure preparedness. To prevent splitting and/or ‘suffering in silence’, regular reflective practice, peer group supervision and *ad hoc* ‘check ins’ can give space for the processing of anxiety and an opportunity to work through uncertainties and questions. Greater use of virtual connectivity has allowed sick or shielded colleagues to sustain communication with core teams, thus maintaining a collective ‘togetherness’.

Research has suggested that it is important that education provided for staff and patients is presented in an ‘even-handed’ manner (i.e. do not dismiss counter-narratives offhand) to prevent the perception of indoctrination or bullying.^{39,40} Failure to do this successfully could lead to the educator being absorbed into the conspiracy belief.⁴¹ Information sharing might take the form of standardised and accessible information boards, regular ward ‘community meetings’ and individual conversations with patients and staff to ensure that they feel informed about events.

In our NHS trust, daily staff briefings have been provided by the chief executive officer. There are daily meetings held by senior management within the MSU to strategise, coordinate a unified response and ensure that information is shared – and then cascaded – evenly throughout the site. In addition, members of different clinical disciplines have adapted their roles. For example, individual psychologists have ‘cohorted’ to provide intensive support for single wards, occupational therapists have provided opportunities for activity and release from the claustrophobic ward spaces and the psychiatric team have employed a ‘shadow rota’ to ensure that sickness does not reduce the provision of emergency care. Collectively, these additions and adaptations to practice can be understood as ‘inoculation’ of the community.⁴² Many of these organisational strategies are likely to be in place to serve other, important needs. However, it is our view that such good practice is also relevant to the aims of this paper.

Secondary prevention

The aim of secondary prevention is to reduce the impact of a disease or injury that has already occurred. We recommend that conspiracy theories already in circulation should be identified at the earliest possible point and the conveyance slowed. The ultimate aim is to challenge unhelpful or disruptive memes that threaten to break down cohesion in the MSU community. Strategies need to prevent re-emergence and reconnect those affected to a less detached position. However, if this is not possible, the focus shifts to containment and reduction of the spread to others.

The infection control response to COVID-19 (i.e. ‘lockdown’ of wards) will inadvertently prevent the cross-contamination of conspiracy theory memes across the MSU site. However, conspiracy theories can infiltrate the community via telephone calls, media and/or staff acting as vectors. It is clearly counterintuitive, unethical and disproportionate to restrict or monitor private phone calls. Secondary prevention should therefore be targeted at the management of memes that are conspiratorial in nature or undermining of national or local COVID-19 policies.

We recommend that changes in anxiety, mood and behaviour associated with conspiracy thinking – or exposure to such ideas – should be observed as part of the usual monitoring of mental state. In the MSU, all patients are regularly reviewed by the nursing staff and forensic psychiatrists, who examine their mental states and the extent of psychopathology. Patients can be given space to explore their thoughts and feelings about such theories; the clinician can then establish whether intervention is required. A ‘COVID-19 formulation-led’ approach to addressing concerns as they arise is recommended.

When discussing conspiracy theories – or related memes – information should be presented in a consistent, clear and accessible manner so that further doubt, ambiguity or reinforcement of the conspiracy does not result.⁴¹ The patient will require adequate knowledge to close the ‘uncertainty gap’. This work may also be achieved through group or individual therapy sessions. In our MSU, we have found that acceptance and commitment therapy (ACT) principles have been beneficial, particularly as these can address issues relating to control and uncertainty.⁴³ In addition, mindfulness practice can help to calm heightened arousal states, release troubling thoughts and teach self-awareness.⁴⁴ As uncertainty is largely inescapable, such therapeutic approaches are preferable to the suppression of all but the most harmful memes. Cognitive remediation strategies can improve reasoning ability⁴⁵ and various non-verbal therapies can help to up- or down-regulate arousal.

Considering the ward as a whole, the maintenance of a ‘safe’ and ‘cohesive’ environment is vital to prevent the harmful effects of conspiracy theory memes. The basis for this is already provided via the implementation of the ‘Safewards’ approach⁴⁶ and positive behavioural support planning.⁴⁷ Indeed, an approach not dissimilar to trauma-informed care could be adopted: ‘pandemic-informed care’ would incorporate the necessary physical health precautions, while also proactively identifying and addressing the emergence of conspiracy theory memes and promoting a clinical awareness of the vulnerabilities of patients who are prone to engage in conspiracy thinking. Pandemic-informed care would also include the provision of staff support and reflective practice.

Some patients who have been exposed to conspiracy theories may become paranoid, anxious or distressed in response to this exposure. If there is a resultant significant decline in symptoms and functioning in which the expression of delusional ideas and other psychotic features is identified, there are a range of pharmacological, psychological and risk-management techniques that may need to be considered.

Tertiary prevention

Tertiary prevention is a strategy to reduce the impact of an ongoing illness or injury that has lasting effects. By definition, many individuals who are resident in an MSU experience complex psychopathology and are vulnerable to anxiety, paranoia and conspiratorial beliefs. Clinicians involved in their care are well advised to consider the impact of ‘lockdown’, uncertainty and competing narratives, and the destabilising effect that each might have.

A multidisciplinary approach is required to incorporate such formulations into care planning and intervention, as has been undertaken across our MSU. In acutely psychotic patients – and those susceptible to relapse – there is a risk that COVID-19-related fears could become enmeshed with pre-existing delusional belief systems. In a patient who becomes absolutely engrossed by conspiracy beliefs to the point that it manifests as a delusion and/or other features of a psychosis and significantly affects their function, an individual, tailored approach must be adopted. The priority

would be the containment of severe pathological symptoms, with consideration given to pharmacological and risk management interventions. In addition, the reinforcement of a consistent and safe environment is necessary to allow the individual to feel secure and grounded. Access to regular, trusted and familiar nursing staff is likely to be important. Arousal-regulating therapy might also be considered. Deterioration in mental state may prompt a review of the patient's current setting. A decision may need to be taken as to whether an acute ward may be more appropriate or higher levels of observations needed. In each case, the acute symptomatology needs to be addressed and, in time, once stable, measures taken to challenge the conspiracy thinking via psychological intervention.

As regards measures introduced to support staff, it is recommended that these are maintained beyond the acute phase of the response. Conspiracy theory memes might retract while the various levels of intervention are in place. However, if support is withdrawn too quickly, a breakdown in communication, increased isolation and potential feelings of abandonment (that accompany burnout) might prompt disharmony and a failure to adhere to the previously outlined necessary actions. This may lead to a second wave of conspiracy beliefs emerging.

Conclusions

These are extraordinary times in society and clinical practice; there is a heavy emphasis on how to identify and manage the physical health manifestations of COVID-19 among the general population, existing patients and the workforce. However, COVID-19-associated conspiracy theory memes also present a societal challenge, which is perhaps exaggerated in a forensic in-patient setting. There is nuance as to what memes should be challenged and the degree to which challenge is made. This is a clinical decision on a case-by-case basis. However, a failure to intervene in an appropriate, effective and ethical manner when memes are potentially harmful could precipitate a breakdown in therapeutic relationships, ward cohesion and the successful implementation of physical health procedures. The consequences of such breakdown relate to mental health deterioration, increased risk behaviours and the failure to curtail the spread of COVID-19. Below, we make suggestions that are consistent with the conspiracy theory literature, which may be helpful to manage the development and spread of conspiracy theory memes (we also consider this guidance to be applicable to other custodial settings, such as prisons): provide clear, consistent and up-to-date information to patients and staff; clearly explain the rationale for change (e.g. new practices/restrictions); empower staff and patients to make informed decisions in relation to care; develop bespoke multidisciplinary COVID-19 formulations for each patient; regularly review patients with reference to their experience of COVID-19; ensure that all clinical environments are 'safe spaces' and that interactions are therapeutically informed (pandemic-informed wards); provide psychological intervention to address uncertainty, change and anxiety, and consider the use of cognitive remediation strategies to enhance reasoning; be prepared to utilise short- and long-term pharmacological and risk-management strategies as required if mental state deteriorates significantly; maintain team cohesion through regular reflective practice, peer supervision and *ad hoc* individual 'check ins'; provide appropriate challenge to conspiracy theory memes, with an awareness of the theory outlined in this paper.

We thank Stephanie Wilson, Sarah Shanahan and Fiona Hynes for reading – and commenting on – draft versions of this paper. Their contributions have improved our work significantly.

Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2020.120>.

[click here to view supplementary material](#)

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R.P. and A.J. contributed equally to the conceptualisation and writing of this paper.

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pmc Psychiatry P.R.N. is edited by four psychiatrists who are involved in direct clinical care, and it shows in the way the book is configured to focus on practical, pragmatic learning. The use of multicoloured formatting, illustrations, text boxes and bullet points makes for easy reading and quick assimilation. Its small format also allows for easy portability in a handbag or backpack, to serve as a quick reference.

Though positioned as an undergraduate textbook for medical students, it will prove to be equally valuable to trainee psychiatrists, nurses, social workers and occupational therapists. Multiple choice question (MCQ) and objective and structured clinical examination (OSCE) skills are covered, case studies are aplenty and each chapter has salient points highlighted. At the end of each chapter, there is information available in the form of films, plays, novels, papers and useful resources. This second edition builds on the well-regarded first edition (2009), which was highly recommended in the BMA book awards (2010). The 2020 edition adds a chapter on forensic psychiatry. Chapters have been updated to incorporate new research and facts. Accessibility seems to have been a focus, with emphasis on diagrams, pictures and artwork.

The book is divided into two parts. Part 1 offers an overview of psychiatry, including psychiatric assessment, interview skills and psychiatry as a career choice. Part 2 focuses on ‘theory’, with an emphasis on imparting key information on major psychiatric conditions in a lucid, concise manner. Chapters are well laid out, with a uniform template that proffers developmental, neurobiological and sociological perspectives. Cross-cultural aspects of psychiatric illness are included in all the chapters.

I would have liked to see author credits for each chapter individually, but that is a minor quibble.

Strunk’s *The Elements of Style*, first published a century ago, emphasised the rules of writing and language composition. *Psychiatry P.R.N.* reflects advancements in modern publishing, wherein the written word is intertwined with audio-visual and interactive media to enhance learning. I would suggest *Psychiatry P.R.N.* as recommended reading for all psychiatry training grades, as well as consultants who are interested in teaching and training.

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1.1.3 Brice Pitt, MD, FRCPsych

Claire Hilton

date

2021-12

Contents

- *Brice Pitt, MD, FRCPsych*

pmc Formerly Emeritus Professor of Psychiatry of Old Age, Imperial College, London, UK

Brice Pitt, who died aged 89 on 16 January 2021, was a highly significant pioneer of old age psychiatry, as well as a colourful personality. In 1971, he was a founder member of the informal ‘coffee house’ group of psychogeriatricians, which preceded the RCPsych’s Special Interest Group (now a Faculty) for Old Age Psychiatry. He was the group’s first secretary (1973–1978). As the chair of the subsequent Section (1986–1990), he led old age psychiatry through turbulent debate to achieve government recognition as a distinct medical specialty in 1989. He also chaired the College’s Public Education Committee and, associated with this role, wrote *Down with Gloom! or How to Defeat Depression* (illustrated by Mel Calman). In it, as elsewhere in his writing, he was open about his personal experience of depression.

Brice’s passion for his subject was evident in *Psychogeriatrics: An Introduction to Psychiatry of Old Age* (1974). About this book, he said: ‘I wrote down everything I knew off the top of my head. It was a doddle’. His turn of phrase was often vivid and insightful: psychogeriatricians were ‘a happy band of pilgrims’ who needed ‘occasional militancy [...] to gain a fair share of scant resources, to put them to best use, to make do with too little while wheeling, dealing, and fighting for more’. *Psychogeriatrics* was followed by other books, including *Feelings about Childbirth* (1978), which was based on his MD thesis on post-partum depression (a life-long interest: he was President of the Association for Postnatal Illness at the time of his death) and *Mid-Life Crisis: Its Cause and How to Overcome It* (1980), and they all received international acclaim. These volumes were variously translated into Japanese, Spanish, Polish, Finnish, French, Croatian, Afrikaans and other languages.

Brice was born on 19 December 1931, the son of Norman Pitt, a surgeon, and Emily (née Crawford), a nurse. Brought up in Surrey, he attended Epsom College. In the immediate post-war years, children perhaps conformed more to parental direction than they do today. Brice wanted to be an actor, but his father told him he would have to study medicine. He was unsure how to reconcile this direction with his wishes, but when watching Alfred Hitchcock’s psychiatric melodrama *Spellbound* (1945), he decided that if medicine was to be his destiny, he would be a psychiatrist.

Like his father, Brice went to Guy’s Hospital Medical School in London. David Stafford-Clark, psychiatrist, television personality and author of books on psychiatry for a lay readership, was his teacher. After house jobs came National Service in the Army, first at The Royal Victoria Military Hospital at Netley, then Singapore and Hong Kong. In 1960, Major Brice Pitt moved back into civilian medicine. He opted for psychiatry training at Springfield Hospital in south-west London. There, he treated his ‘first proper old person’. He was ‘perplexed by the richness of the symptomatology’ and perturbed by the attitude that the hospital was ‘like a castle, a good registrar would fend off the elderly, as those who got in were bound to stay [...] dumped by their family’. He objected to excluding people on account of age. Perhaps a childhood memory haunted him: ‘My sainted grandmother had a stroke and threw a knife at me in a tantrum: this affected me profoundly and left me wondering why’.

As a senior registrar, Brice worked with Ford Robinson, who had a ward and day hospital for functionally ill older people at St Clements Hospital, Mile End, London. It was rare in those days to have any dedicated psychogeriatric training. Brice also trained at Claybury, a large psychiatric hospital also in London. It had a ‘tremendous atmosphere emanating from the therapeutic community approach’ nurtured by the ‘superb’ physician superintendent Denis Martin. Brice called Claybury ‘Camelot’, after the mythical fellowship of King Arthur, with all participants equal at the Round Table.

Appointed consultant psychogeriatrician at Claybury in 1966, Brice inherited 400 occupied beds, a catchment area of about 65 000 over-65s, a social worker, a senior house officer and some general practitioner sessions. Local geriatrician Malcolm Hodgkinson said to him: ‘You don’t want a waiting list, you never admit for continuing care, and you don’t want to run a sleepy service’, and he thought: ‘My God, the one thing I do not want ever to be accused of by Malcolm is running a sleepy service’. And he never did. He started by establishing a mixed-sex ward at Claybury, risqué in a gender-segregated hospital. He also introduced routine home assessments for older people, a practice that became widespread. Camelot fell when Martin died. New-style district general hospital psychiatry beckoned, and a prize post at the brand-new Princess Alexandra Hospital, Harlow, lured Brice back to general psychiatry. But in 1971 he returned to psychogeriatrics in Tower Hamlets, where innovation included a collaborative psychiatric–geriatric unit with geriatrician Chris Silver.

In the early 1980s, Brice moved to Barts (City and Hackney), to join psychogeriatrician Alan Gardner, ‘a very obsessive serious fellow, while there is something a bit flighty about me some of the time’, he said. In 1986, he moved again, to St Mary’s Hospital, Paddington, as the UK’s fourth professor of old age psychiatry. While there, he established the Hammersmith Hospital memory clinic, one of the first in the country. This led to him being dubbed ‘Memory Man’ in a local newspaper, for his pioneering work.

Brice also fulfilled his dream to be an actor. With the Tower Theatre Company, he played royalty, noblemen, judges, bishops and Badger in *The Wind in the Willows*. He directed plays and wrote some, including *Anatomy of Melancholy* and *The Memory Clinic*. In 2005, under the pseudonym Beric Norman, he wrote a novel, *Mordred’s Version*, rooted in the original Camelot.

Chaucer would have appreciated his words and humour at the RCPsych’s Old Age Faculty meeting in 2013, when he was presented with its lifetime achievement award: In March, when Spring is nigh, but strong winds blow
The Faculty of Old Age Shrinken blithely go On Pilgrimage, to venues academic
And each and every one a well trained medic To discourse on derangements of the mind
Of older persons, troubled with all kind States of confusion, madness, melancholy –
Yet to my mind the meeting was full jolly [...] His presence at the gathering, to receive meant
His peers’ award for his Lifetime Achievement! [...] Brice was delighted to be offered this award
Which he never knew existed: Thank you, Lord!¹

Brice had a large family. Married three times, he was father of Gareth, Caroline, Tristram and Rosalind, grandfather of Shem, Fiona, Helen and Joshua, and stepfather to children from the marriage of his third wife, Judy. They all survive him.

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1.1.4 Brian M. Davies, MD, DPM, FRCP, FRCPsych, FRANZCP

Roger Glass

date

2021-12

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- *Brian M. Davies, MD, DPM, FRCP, FRCPsych, FRANZCP*

pmc Formerly Cato Professor of Psychiatry, University of Melbourne, Victoria, Australia

Professor Brian Davies, Victoria's first Professor of Psychiatry, died on 15 November 2020 at the age of 92. As a pioneer of academic psychiatry, he was regarded as a trail-blazer for Australian academic psychiatry who facilitated the training and career development of many successful colleagues. He was appointed to the foundation chair of the University of Melbourne's first academic Department of Psychiatry, taking up the Cato Chair in 1964. He rapidly established the department in the forefront of the specialty. The department that he led quickly gained an enviable reputation for wide-ranging quality research, excellent teaching, and state of the art treatment and caring for patients. To the end of his tenure 26 years later, he steadfastly focused his energies in three main areas: teaching students and postgraduates, service provision and facilitating quality research.

In his typically modest way, Brian attributed the fact that he was able to attract excellent people to accept positions in his department to 'good fortune' rather than the fast-developing reputation of his department as a centre of excellence. The Cato Chair became, arguably, the most prestigious Chair of Psychiatry in Australia, with staff receiving many Australian and New Zealand Commonwealth honours. Many leading psychiatrists, including George Szmukler, Edmond Chiu, David Ames, Graham Mellsop, Sidney Bloch and Graham Burrows, either received their early training or worked as psychiatrists and researchers in his department. His quiet, diffident and, at times, enigmatic nature resulted in a leadership style that enabled department staff to feel free to pursue their research passions while also being gently guided and supported yet nudged when necessary. He led not by acting as a loud front man, forever talking up the achievements of his 'empire', but more as an avuncular encourager and facilitator, open to good ideas but willing to guide and advise when required. The postgraduate psychiatry trainees in Brian's unit learned much from observing him assess patients, quickly and efficiently focusing in on the most salient aspects of their presentation and demonstrating his renowned clinical acumen. To many he became a mentor as well as a teacher. He expected much but also returned loyalty and support.

Brian played a leading role in the group of psychiatrists and business entrepreneurs who conceived the idea of building a modern private psychiatric hospital in Melbourne in 1975. He characteristically played down his pivotal role in setting up and conducting meetings that culminated in the opening of The Melbourne Clinic in 1978. The clinic became Australia's largest private psychiatric hospital. After retiring from the Cato Chair of Psychiatry in 1990, Brian continued to work in private practice, both at The Melbourne Clinic and elsewhere, finally retiring in 2009, aged 81.

Born on 8 June 1928 in Llanelli, South Wales, the son of a miner, Tom Davies, and Lilian (née Drake), a primary school teacher who was passionate about English literature, Brian followed his 6-years-older brother to Cardiff University Medical School. He graduated in 1950, his medical training having included just one lecture in psychiatry. He said: 'I wasn't interested – in those days psychiatry was the last chapter in the medical textbooks – I just wanted to be a physician like my brother'. Having completed training as a physician, Brian asked senior colleagues for advice regarding what should be his next career step. 'Do psychiatry training – psychiatry will be big in 4 years' was the advice. He was able to secure a training position at the Maudsley Hospital in London, where he worked in the unit of Professor Sir Aubrey Lewis, an Australian psychiatrist who had become a towering figure in UK psychiatry. From 1956 to 1964 at the Maudsley and Bethlem Royal Hospital, Brian immersed himself in the newly emerging and exciting field of research into antidepressants. He published world-leading research on tricyclic and monoamine oxidase inhibitor antidepressants.¹

Looking beyond the possibilities of a psychiatric career in Britain, he decided to apply instead for a more interesting academic post, just then advertised – that of Cato Professor of Psychiatry at the University of Melbourne. He, his wife and two children arrived in Melbourne in April 1964, after a 4-week sea journey. His outstanding ability was rapidly

recognised and in 1968 he delivered the Beattie-Smith lecture, the highest honour that Melbourne psychiatry bestows on its leaders. His topic was: ‘Recent Studies of Severe Mental Depressive Illnesses’. He authored a classic student textbook, *An Introduction to Clinical Psychiatry*, which went through four editions from 1966 and remains well-known to a generation of Australian medical students and psychiatrists.

Brian had a quiet manner. He had very little ‘small talk’ and colleagues could sometimes feel that he kept them at a distance. This was more to do with his shy nature than any personal dislike. Persistence in pursuing issues with Brian was often rewarded with knowledgeable and helpful suggestions, advice and encouragement. In recent years he had delighted in reconnecting, at regular lunches, with many former work colleagues from his time as Cato Professor. He remained modest, continuing to be somewhat uncomfortable when publicly praised and never seeking special recognition or honours for himself.

Reading was a lifelong passion for Brian, his taste extending over many genres. He had a love for, and a deep knowledge of, Shakespeare. He also developed an enduring love of golf. He became a skilled and well-known player at Royal Melbourne Golf Club, actively participating until his last year.

In 1951, Brian married Rona (née Waters), a nurse, the start of over 67 years of loving marriage, sadly ended in 2019 with Rona’s death. They had a daughter, Debra, and son, Gareth, together with three admiring grandchildren.

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1.1.5 Individual placement and support: cross-sectional study of equality of access and outcome for Black, Asian and minority ethnic communities

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2022-02

Abstract**Aims and method**

To explore whether people from Black, Asian and minority ethnic (BAME) communities experience equality of access and outcome in individual placement and support (IPS) employment services. Cross-sectional data were analysed of all people with severe mental health problems who accessed two mature high-fidelity IPS services in London in 2019 ($n = 779$ people).

Results

There were no significant differences between the proportions of people who gained employment. The data strongly suggest that people from BAME communities are not differentially disadvantaged in relation to either access to or outcomes of IPS employment services.

Clinical implications

The challenge for mental health professionals is not to decide who can and who cannot work but, how to support people on their case-loads to access IPS and move forward with life beyond their illness.

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- *Individual placement and support: cross-sectional study of equality of access and outcome for Black, Asian and minority ethnic communities*
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 - * *Equality of outcome*
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pmc It is recognised that people from Black, Asian and minority ethnic (BAME) communities both perceive¹ and experience inequality in access,² experience and outcomes³ within mental health services in England. The NHS Long Term Plan makes a renewed commitment to improve and widen access for adults needing mental health support partly through a new community-based offer. This includes access to employment support for people with severe mental health problems through the expansion of the evidence-based individual placement and support (IPS) approach.⁴

IPS involves a direct, individualised search for competitive employment that avoids lengthy pre-employment preparation or training and does not screen people for work ‘readiness’. It does not exclude people on the basis of diagnosis, symptoms or substance misuse. IPS is a ‘place and train’ approach, rather than a traditional ‘train and place’ approach, to vocational rehabilitation. There are now 27 randomised controlled trials supporting the efficacy of IPS compared with traditional vocational rehabilitation.⁵ National Institute for Health and Care Excellence (NICE) guidance recommends IPS for people with severe mental health problems who wish to gain and retain employment.^{6,7}

Within this context, consideration needs to be given to ensuring that people from BAME communities have fair access to employment support and equal opportunities to gain employment. There has been considerable concern that there is no parity between BAME communities and the White majority in access, experience and outcomes of mental healthcare⁸ and so it is right that we ask questions about the effectiveness of IPS for BAME groups.

Method

This was a service evaluation of two IPS services in London. Formal ethical approval was therefore not required.

The IPS services

To explore whether people from BAME communities experience equality of access and outcome in IPS, two IPS services together serving five London boroughs were selected: Central and North West London NHS Foundation Trust (CNWL) IPS service, serving people using secondary adult community mental health services in the boroughs of Westminster, Kensington & Chelsea, Harrow and Hillingdon (CNWL also provides IPS services in Milton Keynes but data from this service were not included in the current study because this was a relatively new service and our focus was on mature London services); Working Well Trust (WWT) IPS service, which works in partnership with East London NHS Foundation Trust (ELFT) serving people using secondary adult community mental health services in the borough of Tower Hamlets.

These services were selected because they are both mature, high-fidelity IPS services recognised as centres of excellence by the Centre for Mental Health.⁹ Both serve areas of London where there are large BAME communities and they represent the two main models of providing IPS in English secondary mental healthcare services. The CNWL IPS service is provided by the trust and all employment specialists are trust employees and members of multidisciplinary adult community mental health teams. The WWT IPS service is a voluntary sector organisation whose employment specialists are employed by the WWT but integrated into ELFT Tower Hamlets adult community mental health teams.

Data

The two IPS services provided anonymised cross-sectional data on all people with severe mental health problems who accessed their service between 1 January and 31 December 2019. For each person, the following anonymised data were supplied: ethnicity (White, Asian/Asian British, Black/Black British, Mixed, Other) age gender date of accessing the IPS service job outcome (whether the person gained at least one day of open paid employment by 31 December 2019). More detailed data on duration of employment were not available but anecdotal evidence suggests that in practice the majority were employed for a longer period.

Data were also provided by the respective mental health trusts on the ethnicity and gender breakdown of everyone served by their adult community mental health teams for the same time period.

Results

Table 1 shows that $n = 779$ people accessed the two IPS services between 1 January 2019 and 31 December 2019: $n = 412$ accessed the CNWL IPS service and $n = 367$ accessed the WWT IPS service. Ethnicity data were available for $n = 714$ (92%) of these people. Table 1

Number of people accessing the individual placement and support (IPS) services between 1 January and 31 December 2019, by ethnicity, gender and age			
	CNWL IPS service	WWT IPS service	Total
People accessing IPS 1 Jan to 31 Dec 2019, n	412	367	779
Ethnicity, n (%)			
White	134 (36.7)	114 (41.3)	278 (38.9)
Asian/Asian British	77 (21.1)	114 (32.7)	191 (26.8)
Black/Black British	64 (17.5)	63 (18.1)	127 (17.8)
Mixed	38 (10.4)	21 (6.0)	59 (8.3)
Other	52 (14.2)	7 (2.0)	59 (8.3)
Missing (not known/prefer not to say), n	47	186	5
Gender, n (%)			
Male	207 (50.2)	180 (49.2)	387 (49.7)
Female	205 (49.8)	186 (50.8)	391 (50.3)
Missing (not known/prefer not to say), n	11	1	1
Age, years: mean (s.d.), range	37.73 (12.02), 17–65	34.39 (10.74), 18–69	36.16 (11.55), 17–69 ¹

¹ CNWL, Central and North West London NHS Foundation Trust; WWT, Working Well Trust.

Equality of access

To explore equality of access to IPS services for those from BAME communities, for each service the number of people of different ethnic communities accessing the service was compared with the ethnic breakdown of those using secondary adult community mental health services in the boroughs served, using a χ^2 -test statistic for goodness of fit. The ethnic breakdown of those using secondary adult community mental health services was selected rather than general population data for the boroughs served because it is people using secondary adult community mental health services who constitute the population eligible to access the IPS service. The results of these analyses can be seen in *Table 2*. *Table 2* Proportion of people from different BAME communities accessing individual placement and support (IPS) services in 2019 in comparison with their proportions in the population using adult community mental health services

People accessing IPS service, n (%)	People using adult community mental health services, n (%)	People from BAME communities accessing IPS services, %
CNWL IPS service	White 134 (36.7) 2774 (39.6) $\chi^2 = 22.05, P < 0.01$	Asian/Asian British 77 (21.1) 1158 (16.5) 6.6
Black/Black British 64 (17.5) 810 (11.5) 7.9	Mixed 38 (10.4) 936 (13.3) 4.1	Other 52 (14.2) 1335 (19.0) 3.9
Not known/stated 47 (11.4) 1350 (16.1) 3.5	WWT IPS service	White 144 (41.3) 900 (41.1) $\chi^2 = 34.22, P < 0.01$
Asian/Asian British 114 (32.7) 805 (36.7) 14.2	Black/Black British 63 (18.0) 259 (11.8) 24.3	Mixed 21 (6.0) 61 (2.3) 34.4
Other 7 (2.0) 167 (7.6) 4.2	Not known/stated 18 (4.9) 90 (3.9) 20.0 ²	

Table 2 shows that there were significant differences in the proportions of people of different ethnicities accessing the IPS service compared with the respective secondary adult mental health service populations (CNWL IPS service: $\chi^2 = 22.05, P < 0.01$; WW IPS Service $\chi^2 = 34.22, P < 0.01$).

In both services, the proportions of White and Asian/Asian British clients accessing IPS were similar to those in the population of people using secondary adult community mental health community services. However, in both services, the proportion of Black/Black British clients accessing IPS was 52% greater than in the population using secondary adult community mental health services: respectively 17.5% compared with 11.5% in the CNWL IPS service and 18.0% compared with 11.8% in the WWT service.

The proportions of men and women accessing the IPS service did not differ significantly from the proportions using adult community mental health services (CNWL: $\chi^2 = 2.61, P = 0.11$; Working Well Trust: $\chi^2 = 0.14, P = 0.71$).

Equality of outcome

To explore equality of employment outcome of IPS services for those from BAME communities, job outcomes for people of different ethnicities were compared using χ^2 -test statistics. Two separate analyses were performed. The first considered everyone accessing the IPS services between 1 January and 31 December 2019 and whether or not they had gained employment by 31 December 2019. However, some of these people – those accessing the service later in the year – would only have had the opportunity for a very short period of support before 31 December 2019. Therefore, a separate analysis was conducted considering only those who had accessed the service in the first half of the year (between 1 January and 30 June 2019) and had therefore had the opportunity of at least 6 months' support. The results of these analyses can be seen in *Table 3*. *Table 3* Job outcomes by 31 December 2019 by ethnic group

People who gained employment by 31 Dec 2019, n (%)	CNWL IPS service	WWT IPS service	Total	All who accessed IPS 1 Jan to 31 Dec 2019
141 (38.6)	141 (38.6)	107 (30.7)	248 (34.7)	714
(412 people, ethnicity data available for 365)	107 (30.7)	248 (34.7)	355 (49.8)	714
(367 people, ethnicity data available for 349)	248 (34.7)	355 (49.8)	603 (84.5)	714
(779 people, ethnicity data available for 714)	Ethnicity White 47 (35.1) 46 (31.9) 93 (33.5)	Asian/Asian British 35 (45.5) 37 (32.5) 72 (37.7)	Black/Black British 23 (35.9) 18 (28.6) 41 (32.3)	Mixed 15 (39.5) 5 (23.8) 20 (33.9)
Other 21 (40.4) 1 (14.3) 22 (37.3) ² = 2.50, $P = 0.64$ ² = 1.76, $P = 0.78$ ² = 1.46, $P = 0.84$	People who had opportunity for at least 6 months' support by 31 Dec 2019	55 (43.3)	127 (54 (42.2))	128
(139 people, ethnicity data available for 127)	54 (42.2)	109 (42.7)	163 (62.5)	128
(135 people, ethnicity data available for 128)	109 (42.7)	163 (62.5)	272 (84.4)	128

² BAME, Black, Asian and minority ethnic; CNWL, Central and North West London NHS Foundation Trust; WWT, Working Well Trust.

(274 people, ethnicity data available for 255) Ethnicity White 18 (39.1) 29 (46.0) 47 (43.1) Asian/Asian British 8 (40.0) 13 (39.4) 21 (39.6) Black/Black British 6 (30.0) 10 (45.5) 16 (38.1) Mixed 10 (66.7) 2 (22.2) 12 (50.0) Other 13 (50.0) 0 (0) 13 (48.1) $\chi^2 = 5.66, P = 0.22$; $\chi^2 = 2.78, P = 0.59$; $\chi^2 = 1.43, P = 0.84$ ^{3,4}

Table 3 shows that, when considering everyone accessing the service between 1 January and 31 December 2019, 34.7% had gained employment by 31 December 2019: 38.6% in the CNWL IPS service and 30.7% in the WW IPS Service. Considering only those who had the opportunity of at least 6 months' IPS support (those who had accessed the service between 1 January and 30 June 2019), by 31 December, 42.7% had gained employment: 43.3% in the CNWL IPS service and 42.2% in the WW IPS service.

There was no significant difference in the employment outcomes by 31 December 2019 for people from different ethnic backgrounds (for everyone accessing IPS between 1 January and 31 December 2019: $\chi^2 = 1.46, P = 0.84$; for those who had the opportunity for at least 6 months' input: $\chi^2 = 1.43, P = 0.84$). Neither was there any significant difference between the outcomes for people of different ethnicities in either of the services when considered separately.

This equality of employment outcome was found when men and women from different ethnic backgrounds were considered separately. For those accessing IPS between 1 January and 31 December 2019 there was no significant difference in job outcomes between those from different ethnic groups for men ($\chi^2 = 7.62, P = 0.11$) or for women ($\chi^2 = 2.84, P = 0.59$). Similarly, equality of employment outcome was found for people from different ethnic backgrounds in different age groups (up to 25 years of age: $\chi^2 = 1.62, P = 0.81$; 26–40 years: $\chi^2 = 4.38, P = 0.38$; 41–55 years: $\chi^2 = 0.50, P = 0.97$; over 55 years: $\chi^2 = 2.93, P = 0.60$).

Discussion

The data collected from these two mature high-fidelity London IPS services strongly suggest that IPS is equally effective in securing employment for people of different ethnic backgrounds using secondary mental health services. For men and women, young and old there were no significant differences between the proportions who gained employment by the end of the year in which they accessed IPS services. It is not known whether similar results would be obtained in less well-established services – it takes time to implement an effective IPS service. With the NHS England national roll-out of IPS it is essential that routine service monitoring includes access and outcome data broken down by ethnicity to demonstrate the key IPS principle of 'zero exclusion' that ensures services are equally effective across different communities.

Although the proportions of men and women accessing these IPS services did not differ, there were significant differences in the proportions of people of different ethnicities accessing them. These differences do not suggest differential disadvantage for people from BAME communities. Quite the reverse, the proportions of Black/Black British people accessing each IPS services were higher than their proportions in the populations of people using secondary adult community mental health services in the areas (CNWL: 17.5 v. 11.5%; WWT: 18.0 v. 11.8%). However, there are marked differences between the two services: in CNWL the proportion of people from different ethnic communities accessing IPS did not differ markedly, but at WWT there were substantial differences. The reasons for this cannot be ascertained from the data. For example, it may reflect a positive bias in referrals to IPS or a greater interest in work opportunities by the different ethnic communities (perhaps itself reflecting greater deprivation/different employment rates). The data considered here are for those who engaged with the services: it is not known how many were referred

³ CNWL, Central and North West London NHS Foundation Trust; IPS, individual placement and support; WWT, Working Well Trust.

⁴ i.e. accessed IPS between 1 January and 30 June 2019.

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but did not engage with the service offered. It should also be noted that the ‘not known/stated’ ethnicity category was higher in CNWL than in WWT/Tower Hamlets adult mental health services.

It has sometimes been suggested that South Asian communities may be protective of people with psychosis and consider employment as a risk. Our study would suggest that this is not the case. It showed no differences in access or outcome for Asian/Asian British people. Similarly, previous research has demonstrated that Asian/Asian British people using IPS services were more likely to be in employment than their White counterparts.¹⁰ However, in our study it should also be noted that, although in CNWL the proportion of Asian/Asian British people was substantially higher among those accessing IPS services than among the adult community mental health services population (21.1 v. 16.5%), in WWT it was lower (32.7 v. 36.7%). It is possible that this difference results from different composition of the Asian/Asian British population (WWT: 80.5% Bangladeshi, 4.9% Indian, 4.1% Pakistani; CNWL: 4.8% Bangladeshi, 41.7% Indian, 13.6% Pakistani). Clearly this area requires greater understanding and a more detailed breakdown of ethnicity than was possible here.

Literature relating to BAME communities and mental health services is replete with examples of disparities in access, experience and outcome of services and, in particular, high levels of compulsion.¹¹ In England, people with mental health problems from BAME communities have been less likely to use employment support services and as a consequence have been less likely to succeed in gaining employment than their White British peers.^{12,13} Morgan et al¹⁴ have suggested that addressing the social needs of BAME patients is likely to lead to improved clinical outcomes and engagement with services. Perhaps increasing the availability of IPS is one good way of doing this?

How IPS works

IPS services are entirely voluntary. In line with the fidelity standards for IPS,¹⁵ an employment specialist is integrated into a clinical team. People using secondary mental health services can access IPS services if they themselves want to work – there is no selection on the basis of diagnosis or supposed ‘readiness’ for work. IPS is personalised and based on the individual’s preferences and choices – very different from typical mainstream employment support programmes. Through shared decision-making, IPS rebalances power and encourages a collaborative dialogue between the employment specialist and the individual. Shared decision-making relies on two sources of expertise: the employment specialist as an expert on supporting individuals with mental health problems to gain and retain employment, and the individual as an expert on themselves, their social circumstances, attitudes to work, and health, values and preferences. Both must be willing to share information and accept responsibility for joint decision-making. The employment specialist needs to provide information about the most effective ways to gain and retain employment. The individual needs to tell the employment specialist about their preferences. As IPS is integrated into the clinical team, the challenge for mental health professionals is not to decide who can and who cannot work but how to support people on their case-loads to access IPS and move forward with life beyond their illness.¹⁶ Two interesting findings arise from this study: a disproportionate number of Black/Black British people were attracted to the IPS services – gaining employment was of importance to them – and there were no significant differences in outcomes for people from different ethnic backgrounds.

Limitations and implications

Clearly, further research is necessary. The naturalistic design of this study is a limitation yet provides a real-world understanding of access to and outcomes from IPS services achieved for BAME communities using secondary mental health services. The data collected here considered only outcomes at the end of the year studied. It is possible that others would have gone on to gain employment had longer-term follow-up been possible. Data on type of employment and job tenure were not collected, neither could people’s experience of using the services be ascertained, and a more detailed breakdown of ethnicity than was possible here would clearly be desirable. However, it is interesting to note that, of the three randomised controlled trials of IPS in England, none has reported outcomes by ethnicity,^{17–19} whereas some of the naturalistic studies have.^{20,21} Although there is a clear need for better quantitative data, the collection of qualitative data relating to people’s experience of using IPS services is necessary to understand some of the differences found and ensure equality of access and outcome for all.

Everyone has the right to be treated with dignity and respect, without discrimination, and to be able to access appropriate mental healthcare when it is needed. Identifying and reducing health inequalities in access, experience and outcomes is essential to the delivery of high-quality mental healthcare. Mental health services have a duty to use data and existing resources to identify inequalities. The present study strongly suggests that people from BAME communities are not differentially disadvantaged in relation to either access to or outcomes of IPS employment support services.

Rachel Perkins is a clinical psychologist and senior consultant at Implementing Recovery through Organisational Change (ImROC), based in London, UK. **Rash Patel** is Head of Employment and Volunteering at Central and North West London NHS Foundation Trust, London, UK. **Amelia Willett** is Operations Director at the Working Well Trust, London, UK. **Laura Chisholm** is Employment Services Manager at the Working Well Trust, London, UK. **Miles Rinaldi** is Head of Strategic Development at South West London and St George's Mental Health NHS Trust, London, UK.

Data availability

Data are available from the corresponding author.

R.Pe. is the lead author. R.Pe. and M.R. designed the study, completed the statistical analysis and wrote the first draft of the paper. R.Pa., A.W. and L.C. collected the data, provided interpretation and commented on drafts of the manuscript. All authors were involved in production of the final version of the paper and meet ICMJE criteria for authorship.

This work was conducted as part of the work of IPS Grow, a partnership programme led by Social Finance and funded by NHS England to support the expansion of IPS services across England in response to the NHS Long Term Plan.

Declaration of interest

None.

1.1.6 Obituary: Vivienne Cohen, MRCS, LRCP, FRCPsych – ERRATUM

Kate Lockwood Jefford

date
2022-02

Contents

- *Obituary: Vivienne Cohen, MRCS, LRCP, FRCPsych – ERRATUM*

pmc The Publisher would like to correct the following errors in this published Obituary: In the sixth paragraph: *Levenhulme Teaching Fellowship* should instead be *Leverhulme Teaching Fellowship*. In the eighth paragraph: *Sam Cohen, a liaison psychiatrist and former professor of psychiatry at the Royal London Hospital* should instead be *Sam Cohen, a liaison psychiatrist who became professor of psychiatry at the Royal London Hospital*. In the eleventh paragraph: *five grandchildren and many great-grandchildren* should instead be *twelve grandchildren and twenty-nine great-grandchildren*.

The Publisher apologises for these errors.

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1.1.7 Magical thinking and moral injury: exclusion culture in psychiatry

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2022-02

Abstract

This is an article about exclusion. We might not like to admit it – even fail to realise it – but National Health Service (NHS) mental health service structures have become increasingly focused on how to deny people care instead of help them to access it. Clinicians learn the art of self-delusion, convincing ourselves we are not letting patients down but, instead, doing the clinically appropriate thing. Well-meant initiatives become misappropriated to justify neglect. Are we trying to protect ourselves against the knowledge that we’re failing our patients, or is collusion simply the easiest option? Problematic language endemic in psychiatry reveals a deeper issue: a culture of fear and falsehood, leading to iatrogenic harm. An excessively risk-averse and under-resourced system may drain its clinicians of compassion, losing sight of the human being behind each ‘protected’ bed and rejected referral.

Contents

- *Magical thinking and moral injury: exclusion culture in psychiatry*
 - *The language of exclusion*
 - *Systems designed to exclude*
 - *A convenient pandemic*
 - *Rehumanising psychiatry*
 - *Data availability*
 - *Declaration of interest*

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The language of exclusion

Choice of words in clinical work and documentation can betray troubling attitudes, personal values and fears. Given that psychoanalytic theory remains a core component of psychiatric training, we could do better at recognising our own defences. We have developed an entire lexicon of weasel words and magical thinking that we pass between generations and disciplines. It would be hard to come up with an exhaustive list of lies we tell ourselves in psychiatric practice; this does not claim to be one. Neither is this the first time anyone has pointed out the problematic language used in psychiatry.¹ Patients are, of course, acutely aware of the absurdity.^{2,3} There are many which should be easily recognisable to anyone working in National Health Service (NHS) mental health services in 2021 and whose origins demand scrutiny. Perhaps the most widespread example is the language of suicide risk.

Despite all evidence against checklists and risk stratification,⁴ we continue to behave as if risk is both predictable and quantifiable, persuading ourselves that certain stock phrases convey a protective coating. ‘Fleeting thoughts of suicide’, for example, sometimes seen as the precursor to an ‘impulsive’ suicide attempt or act of self-harm. Although it is not without value to record these things in the course of trying to understand someone’s state of mind, it is important to question the attached meaning. In writing ‘no plans or intent’ we make ourselves feel better about the unpredictable nature of suicide, hanging false hope on thoughts that come and go. Rather than admit that someone might end their life but we don’t know when or how, we purport to know it is unlikely to occur. This inevitably leads us to seek reassurance from patients, framing questions about suicide for a negative answer.⁵ Rarely is this more clear than when documenting that someone can (or cannot) ‘guarantee their safety’. It should not be for patients to ‘guarantee’ anything to clinicians – it is our responsibility to hold hope, not for them to promise us a future in which we are not standing before a coroner. It can be painfully obvious when a clinician has alighted on their ‘aha’ moment, the thing that (they believe) proves low risk. Any suggestion that a person has ambivalence towards suicide or actually wants to live (such as voluntarily seeking medical help) risks this interpretation. It is almost as if we take the worst-case scenario and work backwards from there, starting at ‘this person might kill themselves’, followed by ‘how can I prove it wasn’t my fault?’ Our starting point should be the simple recognition of distress and a desire to help. It is that connection on a human level which so often makes the difference to people in crisis. Nobody ever says they were saved by a thorough risk assessment, and certainly not one treated as a stand-alone list of questions delivered without empathy. One wonders if there is another medical specialty in which there is such dogged devotion to a non-evidence-based practice. We seem to pay heed to neither scientific evidence nor personal testimony, available in abundance: ‘When the focus is purely on risk, professionals are often left with the frustration and anxiety of holding the risk, service users are left invalidated and abandoned’.⁶ Bad experiences reinforce learning; inquests and internal investigations can feel adversarial and sometimes ask the wrong questions. Clinicians may feel pressured to say (with the benefit of hindsight) that they would have done things differently; perhaps the only acceptable excuse for having ‘got it wrong’, so to speak, is because we thought the risk was not there. Miles argues that many such problems have their basis in shame, which means that doctors (and other health professionals) ‘become morally neutral, unquestioning automatons, at the mercy of organisational edicts, and fail to advocate for the needs of their patients’.⁷

Further speculation seeks not only to see the future but to determine a person’s motivation. Someone who frequently harms themselves in a way that may or may not have suicidal intentions may be pronounced at risk of ‘death by misadventure’. The implication here is that the patient may die without really meaning to. It is impossible to forecast the drivers and intentions behind a theoretical final act; attempting to do so is designed to alleviate our anxiety about the opacity of the future and introduce a seed of blame on the part of the patient. Similarly, patients may find themselves told they ‘have capacity’ to end their lives, in a perverse justification of medical inaction.⁸ Mental capacity – a concept enshrined in legislation intended to enhance the autonomy and decision-making of vulnerable people – is used to legitimise neglect.⁹ The tendency to stray from objectivity into value judgement is an unfortunate but familiar feature of psychiatric notes, from the truly offensive ‘manipulative’ to the frankly bizarre ‘behavioural’, used to infer that a patient is doing something in a conscious and deliberate manner rather than because they can’t help it. Such terminology does not stand up to scrutiny: not only does it arrogantly assume the ability to precisely determine patients’ motivations and intentions, but it is also nonsensical. All behaviour is ‘behavioural’; one might as well describe breathing as respiratory.

Moral judgement and focus on self-preservation are both ways in which we make the case for denying people care. We do a further massive disservice to patients by assuming they do not see through us, perpetuating the sense of alienation which characterises too many encounters with mental health services.^{2,10}

Systems designed to exclude

We cannot blame individuals for mindless practice without acknowledging the system that has created them. Ours is a culture of senseless fragmentation: separation of addiction and illness, of mental and physical, of mind and brain, of deserving and undeserving. At their very worst, modern mental health services seem to operate on two polarised (but related) values: coercion and exclusion. The former is probably most familiar as a critique of psychiatry as per the recent government White Paper.¹⁰ Time will tell whether statutory reform will lead to the desired aim of reduced coercion. Less talked about, perhaps, than the coercive aspect of psychiatry is the troubling drive to exclude people from services. We exclude based on postcode, diagnosis, complexity, comorbidity. Too much need, not enough need. Risk, lack of motivation, readiness for change, any possible reason to keep people out. We have apparently accepted, without question, the term ‘gatekeeping’ to refer to admission to psychiatric beds, a process that generally involves the agreement of a crisis resolution and home treatment team. While accepting the almost perpetual state of bed crisis in NHS psychiatric services, we should consider what this terminology says about the systemic attitude towards our patients. Our services are fortresses; patients are intruders to be prevented from breaching our defences. There is a rot in a system that views beds as needing protection from patients. Mental health services have developed an ethos of exclusion at an organisational level which naturally drives and perpetuates poor practice at an individual level.

One form of exclusion from care arises out of the false distinction between mind and body. Referrals to secondary care mental health services may be refused if there is a perception that the problem is ‘organic’ unless it fits neatly into a memory clinic remit. René Descartes died in 1650 yet still we subscribe to the dualistic fantasy that mental and physical can be clearly delineated, with health services persistently commissioned in a way that keeps them separated. This has resulted in baseless and ill-defined concepts which dominate practice: take ‘medical clearance’, for example – a requirement that any patient attending an emergency department be reliably pronounced to have no medical condition before having a psychiatric assessment.¹¹ Although nobody would argue that an acute medical condition should not be promptly identified and treated, problems arise when we refuse to assess and manage in parallel. As is now recognised, this leads to inadequate patient care and should not be routine practice¹² (though its grip is tenacious). We ask medical colleagues to ‘exclude organic causes’ of a disturbed mental state, as if it is always possible to do this acutely or to precisely isolate which symptom arises from which condition; as if conditions cannot coexist. In their detailed analysis of the incoherent distinction between ‘organic’ and ‘functional’, Bell et al¹³ conclude that ‘the functional–organic distinction often seems like a tool that helps determine treatment priority dressed up in the language of causation’. Neurologists and other specialists may be as guilty of this as psychiatrists,¹⁴ but we should surely have a greater interest in challenging what is essentially another form of stigma. As long as we rely on outdated pseudo-medical concepts, mental health workers will view ‘physical health’ as a kind of unpredictable bogeyman to be feared and avoided.

A convenient pandemic

Stigma towards people with mental illness in medical settings is well-documented and tackling it a slow process; it was only in January 2020 that the Side by Side consensus statement was published¹³ but the COVID-19 pandemic that hit us just a month later jeopardises its intentions. Driven by the pandemic, there is a vogue for developing acute psychiatric assessment sites away from emergency departments.¹⁵ Across the UK are hastily created diversions for people in mental health crises and it remains to be seen whether these will prove either safe or cost-effective. While acknowledging a genuine need for infection control, the more cynical among us may see certain organisations leaping on the opportunity to do what they have been wanting to for years, which is to exclude psychiatric patients from emergency departments. The party line is that this is a compassionate move: an emergency department isn’t the place for someone in mental health crisis.¹⁶ Arguably, it’s not the most relaxing place for someone with sepsis or a fractured neck of femur either but it’s where most of us would want to be in that situation. When Samuel Shem, in his cult novel about North American internal medicine,¹⁷ coined the term ‘GOMER’ (Get Out of My Emergency Room) he was describing a group of elderly patients with dementia, perceived to use time and resources but never improve or die. ‘GOMER’ refers to the doctors’ reaction when these unfortunate people arrive in their department. However, it seems as if this attitude is even more applicable to people with mental illness, certainly in the 21st-century NHS. Treating psychiatric patients as ‘GOMERS’ is systemically endorsed. A separation of mental and physical emergency locations reinforces the dangerous notion that we can reliably ascertain (even pre-hospital) whether someone needs ‘physical’ care or not.

The pandemic has also focused attention on the concept of moral injury – ‘perpetrating, failing to prevent, or bearing

witness to acts that transgress deeply held moral beliefs and expectations'¹⁸ – in medicine.¹⁹ There is a psychological toll that comes with having to ration resources, transfer patients out of area owing to bed pressures, suspend vital services and see waiting lists grow longer. These have been headline news over the past year,²⁰ yet all are challenges that have faced psychiatry for far longer. Perhaps we have already grown used to excusing exclusion and senseless divisions in order to avoid the reality that services have been systematically cut and we cannot give patients what they need.²¹ The mental health profession has had its compassion eroded by moral injury for longer than we can remember, rationing care for so long that we have come to believe that exclusion is clinically indicated. We claim to be encouraging personal responsibility and autonomy, preventing dependence, avoiding institutionalisation, reducing unnecessary referrals, all of which allows systemic failings to continue. Some of our processes seem almost designed to harm; the ways in which institutional factors have an impact on specific aspects of people's illnesses Kafkaesque. For example, people with eating disorders, among whom the belief that one is 'not sick enough' is common, are literally denied help until they are 'sick enough'.²² People with personality disorder diagnoses who have experienced trauma, rejection and interpersonal discord throughout their lives are rejected by professionals within a system that tells them they should not have time and resources wasted on them.²³ These are not cognitive distortions but grim reality. This culture of exclusion, coupled with the expectation that patients take responsibility to quell clinician anxiety, is a toxic mix.

Rehumanising psychiatry

One consultant psychiatrist pontificating about culture in a journal is not going to drive the kind of genuine change that needs to filter through every layer of our system. Decades of damage requires time to repair, not to mention the buy-in of all parties. Training has a role, from undergraduate level upwards across all professional groups, but organisations must have the guts to implement culture shift rather than a series of slightly altered tick boxes. The more clinicians work side by side with the people who use mental health services (and those who have been excluded from them), the more effective the message. Meaningful training and service development should be truly co-produced; a fundamental problem is the focus on beds and breaches and targets instead of the human story behind each number. Arguably, senior managers who would willingly allow an unwell patient to wait in an emergency department for more than 24 h for the purposes of 'gatekeeping' might take a different view if it were them or a loved one, so should not be permitted to distance themselves from clinical realities. This is not to say that all those working on the front line are faultless patient advocates. Lack of compassionate care for people in mental health crisis pervades emergency services and, although burnout and 'compassion-fatigue' play a role, there are deep-seated negative attitudes towards certain patients. Although co-production is vital, the responsibility for recognising and calling out harmful culture and practices should not fall entirely on the shoulders of those who have suffered it. In short, our profession must open its eyes. Regulatory bodies such as the General Medical Council tell us to 'make the care of the patient your first concern'²⁴ yet we stray from this to prioritise the needs of clinicians and organisations. In a culture of self-protection, exclusion will inevitably become a central aim because, of course, the best way to prevent ourselves from harm is to prevent the 'danger' from getting near us. How have we so comprehensively forgotten to put patients first?

Realism and honesty should be embedded in training, rather than teaching perfect medicine in an imperfect world. Our patients will have more trust in us if we are open about scarcity of resources and restrictions on referrals; if we acknowledge that we cannot provide all we would like to. Instead of pretending that exclusion is clinically appropriate we must name it. However, clinical staff can only safely preach honesty if senior leaders support this endeavour. Although the Royal College of Psychiatrists has produced some welcome position statements and guidelines, this must translate to institutional and organisational change. Senior consultants, managers and academics who do not recognise anything in this article may need to reacquaint themselves with the front line; it will surely resonate with junior doctors, nurses, allied health professionals, students and – most importantly – patients and carers: 'Educating the next generations of clinicians and social workers is vital, but they won't survive immersion in toxic cultures. We need honesty from organisations where poor care and neglect have become systemic and endemic'.²⁵

Patients and carers have been speaking out about exclusion and iatrogenic harm for too long; psychiatrists complaining about blame culture similarly. It is time this was translated into action by those with most power to effect change. Consider this a call to arms: if the content resonates then ensure you do more than shout into your echo chamber.

With thanks to Dr David Foreman for inviting this contribution and for his editorial advice.

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trust lead for suicide prevention for East London NHS Foundation Trust and an honorary clinical senior lecturer at Queen Mary, University of London, UK.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in its writing.

This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Declaration of interest

None.

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1.1.8 Review of antipsychotic prescribing at HMP/YOI Low Newton

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date

2022-02

Abstract

Aims and Method

The purpose of this review was to establish whether the prescription of antipsychotic medication in HMP Low Newton was safe, rational and consistent with current best practice. A search of the electronic healthcare records was performed on 14 March 2018 to identify all the women in the prison who were prescribed antipsychotic medication, and then data were collected from the records.

Results

A total of 46 out of 336 prisoners (13.7%) had been prescribed antipsychotic medications; 29 of the 46 patients (84.8%) were also prescribed other psychotropic medications at the same time. Quetiapine was the most frequently prescribed antipsychotic and was also the most likely to be prescribed for off-label indications. Less than one-third of all antipsychotic prescriptions were for psychotic disorders.

Clinical implications

The rationale for prescribing all antipsychotic medication, especially for off-label indications, should be clearly documented and reviewed regularly within the prison by the mental health team and psychiatrist.

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- *Review of antipsychotic prescribing at HMP/YOI Low Newton*
 - *Introduction*
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 - *Results*
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Introduction

HMP Low Newton is one of 13 women's prisons in England, and houses approximately 350 inmates aged 18 years and above. It manages a mixed population of remand and short-term sentenced prisoners and those serving longer sentences, including a significant number serving life or indeterminate sentences. The turnover is high (approximately 70 receptions per week) and psychiatric morbidity is common.

Women in prison are five times more likely to have a mental health problem than women in the general population, with 78% exhibiting some kind of psychological disturbance on reception according to the 12-item General Health Questionnaire.¹ A study of remanded prisoners found 11% to be acutely psychotic on reception.²

At any one time, the mental health team in HMP Low Newton provides support to about a third of the population, about a quarter of whom have complex mental health needs.³ The team conducts triage assessments for approximately 20 new patients each week. There are three sessions of clinical input from a psychiatrist, which, given the constraints on access to prisoners, amounts to approximately 6–8 h direct clinical contact per week. There are no other prescribers within the team. Primary care services are provided by an independent organisation, G4S Healthcare.

Antipsychotics are potent drugs, primarily licensed for the management of schizophrenia, mania and other severe psychotic disorders. They have the potential to cause a wide range of acute and long-term side-effects, some of which can be serious, including parkinsonism, neuroleptic malignant syndrome, obesity, diabetes, cardiotoxicity, sudden death, hormonal changes, electrolyte imbalances, convulsions and blood dyscrasias.

Although they can also be prescribed in both psychiatric and general practice for the relief of stress, anxiety and psychological distress, those licensed for this purpose, which include chlorpromazine, olanzapine and haloperidol, should only be used in the short term. There is no evidence that antipsychotics have any demonstrable long-term benefit in the management of personality disorders.⁴ Despite this, off-label prescribing is increasingly common and has been identified as a cause for concern.⁵

There is a growing body of literature highlighting the misuse potential of some antipsychotic medications, particularly quetiapine.^{6,7} There is also increasing awareness of the risks of harm from misuse and diversion of prescribed medicines in prison. These extend beyond the effects of the drugs themselves to include bullying, threats and coercion, and debt.^{8,9} Deaths from the misuse of prescribed drugs, including antipsychotics, are rising. The numbers of deaths caused by antipsychotics in 2017 saw an increase of just over 5% from 2016, which equates to a rate of 2.1 per 1 million population.¹⁰

Aims/objectives

The purpose of this review was to ascertain whether the prescription of antipsychotic medication in HMP Low Newton was safe, rational and consistent with current best practice. We considered best practice guidance from the National Institute for Health and Care Excellence and adopted the following principles. Antipsychotic medication should only be prescribed if there is a clearly documented, evidence-based rationale, consistent with the drug's licence and/or best practice guidelines. Patients receiving antipsychotic drugs should be regularly reviewed by specialist mental health services. No patient should be prescribed more than one antipsychotic or equivalent doses above *British National Formulary* (BNF) limits.

Method

This review was registered with and approved by Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust clinical audit department.

All medical records within the prison are held on an electronic system, and all prescribing is done electronically. A search of the electronic healthcare records was performed on 14 March 2018 to identify all the women in the prison who were being prescribed antipsychotic medication on that day. Their healthcare records were then reviewed by the authors to identify: patient's age date of reception into HMP Low Newton antipsychotic prescribed and dose prescriber's professional status date of prescription diagnosis or indication for prescription (where recorded) other psychotropic medication past or future contact with mental health services.

Within TEWV NHS Foundation Trust, 'off label' is defined as the use of a medicine that has a marketing authorisation for an indication (condition), at a dose, via a route or for a patient category (e.g. age) that is not listed in the Summary of Product Characteristics for that medicine. Therefore, any antipsychotic prescription that met this criterion was defined as 'off label'.

Results

The prison roll for that day was 336. Forty-six women (13.7% of the total population) were identified as having a current prescription for antipsychotic medication.

Age distribution

The ages of the women taking antipsychotic medication ranged from 22 to 55 years, with a mean and median of 35 years (*Fig. 1* and *Table 1*) This was consistent with the age profile of the population as a whole within the prison.³ *Fig. 1* Age in years of the women prescribed antipsychotic medication *Table 1* Age distribution Age, years Patients, N <21 021–30 1631–40 1741–50 11 >50 2

Length of time in prison

The number of days each patient had been in HMP Low Newton on the date of the audit ranged from 4 to 2430, with an average of 363 days. The distribution suggested distinct groups, with the majority having spent less than 180 days in the prison and a second significant group having been in for more than a year, reflecting the fact that the prison houses both a transient population of remand and short-sentenced prisoners and a more stable population serving longer-term sentences (*Table 2*). *Table 2* Length of time in prison in days Time in prison, days No. of prisoners <91 1191–180 11181–270 4271–360 6 >361 14 Range 4–2430 days Average 363 days

Reception

The majority of patients (26, 56.5%) had been admitted directly from the community; 19 (41.3%) had come from other prisons and one (2.2%) had been discharged from a psychiatric hospital.

Antipsychotics prescribed

The antipsychotics prescribed are shown in *Table 3*. By far the most popular antipsychotics were quetiapine (20 patients) and olanzapine (16 patients). Other antipsychotics prescribed were risperidone (three patients), flupenthixol (two patients), aripiprazole (two patients), sulpride (one patient), chlorpromazine (one patient) and zuclopenthixol (one patient) (*Table 3*). *Table 3* Antipsychotics prescribed Antipsychotic No. of patients Quetiapine (inc. modified release) 20 (43.5%) Olanzapine 16 (34.8%) Risperidone 3 (6.5%) Sulpride 1 (2.20%) Flupenthixol 2 (4.30%) Aripiprazole 2 (4.30%) Chlorpromazine 1 (2.20%) Zuclopenthixol 1 (2.20%)

No patients were prescribed doses above BNF limits. One patient was prescribed two antipsychotics, zuclopenthixol and aripiprazole, after it was recommended that aripiprazole be started for hyperprolactinaemia secondary to zuclopenthixol.

Prescriber

Thirty (65.20%) of the prescriptions for antipsychotics were started by a psychiatrist. These included 12 (26.10%) started in HMP Low Newton during the current period of imprisonment; three (6.50%) had been started in another prison but during the current period of imprisonment, and 15 (32.5%) had been started in the community or during a previous period of imprisonment. Sixteen (34.80%) prescriptions were prescribed by a general practitioner (GP) or primary care services.

Polypharmacy

One patient was prescribed aripiprazole for hyperprolactinaemia in addition to zuclopenthixol. Only seven patients (15.2%) were not prescribed any additional psychotropic medications.

The amounts and types of other psychotropic medications prescribed are summarised below (Tables 4 and 5).
 Table 4: Number of additional psychotropics prescribed
 Additional psychotropics: No. of patients: 07127210324050
 Table 5: Type of additional psychotropics prescribed
 Type of drug: No. of patients: No. of scripts
 Specific agent: Scripts for agent
 Antidepressant: 2932
 Mirtazapine: 13
 Sertraline: 7
 Trazadone: 4
 Fluoxetine: 3
 Venlafaxine: 2
 Amitriptyline: 1
 Duloxetine: 1
 Paroxetine: 1
 Opiates: 1414
 Methadone: 1
 stabilisers/anticonvulsants: 33
 Depakote: 1
 Lamotrigine: 2
 Stimulants: 22
 Atomoxetine: 1
 Dexamphetamine: 1

One patient was prescribed a total of five psychotropic medications, comprising zuclopenthixol depot injection, aripiprazole, atomoxetine, sertraline and clonazepam. This patient had been returned to prison from a medium secure unit and had a diagnosis of emotionally unstable personality disorder (EUPD) and attention-deficit hyperactivity disorder.

One patient was prescribed three psychotropic medications (duloxetine, lamotrigine and buprenorphine) in addition to quetiapine. Medication had been started in HMP New Hall, and the diagnosis recorded was depression and EUPD.

Indication and diagnosis

The BNF licensed indications for each of the prescribed antipsychotics prescribed are summarised in Table 6.
 Table 6: BNF licence indication for each antipsychotic prescribed
 BNF licence indication: Aripiprazole, Chlorpromazine, Flupenthixol, Olanzapine, Quetiapine (inc modified release), Risperidone, Sulpride, Zuclopenthixol
 Schizophrenia/psychosisxxxxxxx, Maniaxxxxx, Short-term management of agitation/excitement/anxietyxx, Depressionxx, Bipolar prophylaxisx, Nausea/vomiting/tics/hiccup, Short-term use for aggression in patients with Alzheimer'sx

Patient notes were reviewed to identify recorded diagnoses or indications for each patient who had been prescribed an antipsychotic. The reasons recorded in the notes are summarised in Tables 7 and 8.
 Table 7: Documented indication for each antipsychotic medication in the notes
 Quetiapine: Olanzapine, Risperidone, Sulpride, Flupenthixol, Aripiprazole, Chlorpromazine, Zuclopenthixol
 Total: EUPD 104211120, EUPD + PTSD 213, EUPD + depression 112, EUPD + psychosis 22
Psychosis/schizophrenia 23117, Drug-induced psychosis 33, Bipolar 213, Mood stabilisation 213, Depression 0, Psychotic depression 11, Anxiety/paranoia 112, Number 201631221146
 Table 8: Licenced versus off-label indications documented in the notes for each antipsychotic prescription
 Antipsychotic (N): Licensed indication (N), Off-label indication (N)
 Quetiapine (20): Depression (1), Anxiety/paranoia (1), Psychosis/schizophrenia (2), EUPD (10), Bipolar (2), EUPD + PTSD (2), Mood stabilisation (2), Olanzapine (16): Psychosis/schizophrenia (5), EUPD (4), Drug-induced psychosis (3), EUPD + PTSD (1), Anxiety/paranoia (1), Bipolar (1), Depression (1), Risperidone (3): EUPD (2), Psychotic depression (1), Sulpride (2): EUPD (1), Anxiety/paranoia (1), Flupenthixol (2): Psychosis/schizophrenia (1), EUPD (1), Aripiprazole (1): Psychosis (1) (hyperprolactinaemia), Chlorpromazine (1): EUPD (1), Zuclopenthixol depot (1): EUPD (1)

Less than a third (13/46 = 28.3%) of the prescriptions for antipsychotics were for psychosis (including affective psychoses), and three were for bipolar affective disorder. The remainder were for non-psychotic conditions.

Sixteen of the 46 prescriptions were within the licensed indications. Of the 30 (65.2%) that were prescribed for off-label indications, half (15/30 = 50%) were quetiapine (Table 9). Fisher's exact test was used to determine the significance of this and gave a *P*-value of 0.3496, which is below the typical cut-off for statistical significance (*P* < 0.05).
 Table 9: Number of off label prescriptions for quetiapine in comparison to other antipsychotics
 Licensed indication: Quetiapine 515, Other drugs 1115

Two-thirds of the prescriptions where non-licensed indications were recorded in relation to quetiapine were for EUPD (10/15 = 66.6%), plus additional two for EUPD and post-traumatic stress disorder (12/15 = 80%).

Contact with mental health team

The average length of time between arrival in HMP Low Newton and review by the mental health team was 30.2 days (range 0–310 days). This is summarised further in *Fig. 2*. The average number of days between arrival and review for the seven patients who were seen more than 31 days after coming to HMP Low Newton was 166 days, which suggests that these patients tended to have longer sentences and did not present with symptoms until later in their sentences. Of the 46 patients, 36 had been reviewed by a psychiatrist, five were on the waiting list to be seen, one had declined input as they felt mentally stable and four had no follow-up planned. The average time between review by the mental health team and review by a psychiatrist was 87.97 days. This is broken down further in *Fig. 3*. *Fig. 2* Length of time between arrival in HMP Low Newton and review by the mental health team *Fig. 3* Length of time between review with the mental health team and review with a psychiatrist

Of the five patients on the waiting list for the psychiatrist, four had been seen by the mental health team for the first time in the 10 days prior to the sample collection date (14 March 2018). One patient had been on the waiting list since January 2018 and had been waiting 8 weeks so far for an appointment. Of the four patients that had not been seen by the psychiatrist and were also not on the waiting list to be seen, 50% (2/4) continued to be followed up by the mental health team. All four of these patients were prescribed quetiapine which had been commenced prior to coming to prison. The characteristics of these four patients are outlined in more detail in *Table 10*. *Table 10* The characteristics of the 4 patients prescribed antipsychotic medications but not under psychiatrist review

Patient 1	Patient 2	Patient 3	Patient 4
Age (years)	36	35	49
Time in HMP Low Newton (days)	120	141	163
Received from HMP New Hall	Community	Community	Community
Antipsychotic	Quetiapine	Quetiapine	Quetiapine
Other psychotropics	Mirtazapine	Methadone	nil
Antipsychotics commenced	Prior to reception	Prior to reception	Prior to reception
Diagnosis	EUPD	Psychotic episode	EUPD
Follow-up by mental health team	No	No	Yes

Summary of findings

On the day of the survey, 46/336 prisoners (13.7%) were prescribed antipsychotic medications. No patients were prescribed high-dose antipsychotics. Only one patient was prescribed more than one antipsychotic, and the rationale for this was clearly stated. Twenty-nine of the 46 patients (84.8%) were prescribed other psychotropic medications, most commonly an antidepressant and/or an opiate. Two patients (4.34%) were prescribed four or more psychotropic medications. Both of these had diagnoses of EUPD. Approximately a third of prescriptions were initiated by primary care/GP. Of the 65.2% of prescriptions initiated by psychiatrists, approximately half were started during the current period of imprisonment. Quetiapine was the most frequently prescribed antipsychotic and was also the most likely to be prescribed for off-label indications. Less than a third of all antipsychotic prescriptions were prescribed to treat psychotic disorders. The most common non-licensed indication for antipsychotics being prescribed was EUPD, which accounted for approximately half of all the prescriptions. The average length of time between arrival in HMP Low Newton and review by the mental health team was 30 days, with the majority being seen in less than 7 days. Forty-one of the 46 patients (89.1%) had prior or planned appointments with the psychiatrist.

Discussion

This review identified a number of positive findings: no patient was prescribed high-dose antipsychotic therapy; only one patient was prescribed combination antipsychotic therapy, and in this case the second agent was commenced for a side-effect of the first and had been initiated by a psychiatrist who remained involved in the patient's care. The majority of patients were reviewed by the mental health team with 7 days of reception and had prior or planned appointments with the psychiatrist to review their medication.

The review highlighted a high rate of off-label prescriptions for antipsychotic medication within the prison. The study confirmed that this was particularly the case with quetiapine, which, given the high rates of misuse of this drug within the prison, is of concern. Although there was no clear reason for this, one can speculate that, owing to the high number of female prisoners reporting difficulties with 'mood' and 'voices', quetiapine is chosen because of its reported benefits

in relation to ‘mood stabilisation’, as well as its antipsychotic effects. There is also, however, a likelihood that this medication is often requested by the prisoners for its ‘tradeable’ status and potential for misuse.¹¹

There is a high rate of polypharmacy in relation to psychotropic medication, which can increase the risk of side-effects and physical health complications. All but two of the patients were prescribed no more than three psychotropic agents. Again, this is likely to be due in part to a high rate of comorbid substance misuse within the prison population. Furthermore, there is a tendency for patients to prefer medication over alternative treatments such as psychological intervention.

Psychological therapies are identified as the primary treatment for patients with personality disorder.⁴ At HMP Low Newton, a variety of psychological services are available. These include the 12-bedded Primrose Unit, for women with severe personality disorder, which forms part of the Offender Personality Disorder Pathway, and a Psychologically Informed Planned Environment wing. The prison forensic psychology services offer a range of assessments and treatments, and the scope of this work is driven by consultancy with offender management units and offender managers within the community. Finally, there is the prison mental health team, who work in line with trauma-informed care principles and can offer a range of individual and group therapies. However, there is often a waiting list for such services, and potentially suitable prisoners often do not remain within the prison long enough to start and complete identified treatments before release or transfer.

Although a large proportion of the prescriptions were issued by a psychiatrist, it is noted that approximately half were commenced in either in the community or during a different prison sentence. Therefore, it is possible that some patients are reissued prescriptions without a thorough review of need, current mental state and other prescribed treatments. Also, the records indicate that often little consideration is given to whether the patient has adhered to medication in the community and so, often, this is simply re-prescribed if it is on the GP summary. The guidelines in relation to use of antipsychotic medications for minor symptoms, such as anxiety, stress or agitation, are clear that it should be a short-term measure only. However, such prescriptions are often continued for prolonged periods without a critical review. This tendency may be exacerbated in the prison population by transfers to other establishments, early release, failures to engage with the mental health team, and a relative lack of attention paid to the initial timing and indications for prescribing.

Recommendations

The patient’s diagnosis and/or the indication for each prescription should be clearly recorded at the point of prescription in the running case record and in the medication section of the electronic notes system. In order to reduce the rate of off-label prescribing, all patients arriving at the prison who are prescribed antipsychotic medication on or shortly after reception should be brought to the attention of the psychiatrist and the mental health team manager. All of these patients should be allocated to a secondary care worker and given an appointment to see the team psychiatrist. The secondary care nurse should obtain all relevant past records. The psychiatrist should conduct an initial case review note and advise on either withdrawing or continuing antipsychotic medication prior to the review. Particular attention should be given to patients who have a primary diagnosis of EUPD, particularly those for whom antipsychotics have been prescribed for the relief of minor symptoms, such as stress, anxiety and insomnia. The presumption should be that medications for these reasons should only be prescribed in the short term, and this should be clearly explained to the patient. Care should also be taken with patients who have a history of substance misuse, or of secreting and hoarding medication, as this often indicates involvement in trading. If patients have not adhered to antipsychotic medication in the community, then it should not be automatically re-prescribed on reception without review by the mental health team or psychiatrist. Prescriptions for quetiapine should be kept under regular review and withdrawn unless there are clear reasons for continuing to prescribe. This review should be repeated after a year to assess the effects of these measures on off-label prescribing.

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L.C. had a substantial role in the design of the study, acquisition and analysis of the data, and drafting and revising the work. S.B. had a substantial role in the design of the study, in addition to drafting and revising the work.

Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <http://doi.org/10.1192/bjb.2020.80>.

[click here to view supplementary material](#)

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1.1.9 Interview with Dr Jan Wise

Abdi Sanati

date

2022-02

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pmc Dr Wise is a consultant in general adult psychiatry working in inner city London. I first met Dr Jan Wise around 15 years ago through another colleague. At that time, Dr Wise was already active in the British Medical Association (BMA). I found his knowledge of medicolegal and contractual issues vast and unparalleled. I have always admired his wisdom and his structured approach in solving problems. He remains active in the BMA and is currently the chair of BMA Medicolegal Committee. What made him stand out for me was his work on physician burnout, something I faced a few years ago. Dr Wise is also active at international level. He is elected to the Board of European Psychiatric Association. In addition to that he is also an Honorary Member of the World Psychiatric Association and Distinguished International Fellow of the American Psychiatric Association. I caught up with him to discuss issues such as pressure on psychiatrists and his international work.

Thank you very much for agreeing to this interview Dr Wise. You mentioned in your article that going an extra mile endangers staff and patients. Could you elaborate on that statement please?

We are a finite resource. We are human. We are limited and we are fallible. So, even under normal circumstances, there's a limit to how long we can stay on the board, clerking a patient, how long we can sit in casualty comforting the truly distressed psychotic patient who is ripping their hands to shreds, trying to escape the manacles the police have put them in. And this is a never-ending tide. There is always a need to care, there is no end to the misery that is out there, that we want to address. And if we do not place limits on ourselves, we will wear ourselves out. Even before COVID-19, we wore out faster than we were replaced. If I'm going to say that more succinctly, 'We will never run out of patients, we will run out of you'. So staff have got to look after themselves, to avoid burnout, the moral distress that we're seeing at the moment. We hear from the BMA and in surveys that there are unprecedented numbers of doctors in general – not just psychiatrists – who want to leave, who want to reduce their hours, who don't want to do this.

Thank you, another thing that comes up is the danger of being at risk of clinical negligence charges.

Yes. People go into medicine because they want to help others, and that urge to help often clouds our judgement. Things are much better now than they were 25 years ago when some of us started. With exception reporting and reduced hours, we are less often in the scenario of people being so tired that they fall asleep at the nursing station. But what we forget is that the General Medical Council is going to hold you to the standards of the reasonable doctor with your experience. So if you're underperforming because you're excessively tired, whether that's from a long shift, having young children, or sick relatives that you are caring for, if you make a mistake, being tired is unlikely to be a defence. So, when people stay beyond their shift, or they have covered a night because the trainee was sick and there was no one to come in, we need to protect ourselves by letting the system know we are not fit to deliver care, because making an error by staying behind really puts your registration at risk, let alone the very unpleasant process of a relative or a patient deciding to sue you, because you made a mistake.

Thank you. Reading your work on this topic is very interesting. It seems that going the extra mile has been celebrated as something of value, you're expected to say it in interviews that you are willing to go the extra mile. It is expected from us now.

And that's the problem. If someone said they would never go the extra mile that would be a disaster for the profession and for the person. The Royal Army Medical Corps has as its motto *In Arduis Fidelis*, faithful in adversity. And in unusual circumstances, I would hope we would pull together for something like the Clapham rail disaster, Grenfell Tower or Piper Alpha, and we would all be there. But when it is not unusual, when it's not even every month, but it's every week, then it's wholly inappropriate to go even the extra 10 metres, because it just allows the government to underfund the service. And eventually people won't be able to go the extra distance and all patients will suffer, because we didn't say enough is enough.

You have written about it in the context of the whole of profession of medicine. How do you specifically see it in psychiatry?

Well the good news is, we have excellent training in boundaries, so it's relatively easy working in a profession where people aren't going to die if you don't do it, to have less porous boundaries than someone working in emergency medicine or oncology. I think the trainees are beginning to see from some consultants how to have an appropriate work-life balance. If they go the extra distance on Monday, they go short on Tuesday, Wednesday or Thursday, but on one day that week, they leave early to make up for the extra delivery. I think that is becoming easier. But what I hear, from colleagues and from other services like child and adolescent mental health services, are phrases like we need to get better at saying we are not commissioned to do that. Doing something that we are not commissioned to do, is to deliver it for free. Which means we are not delivering what we were commissioned to do unless we are delivering more hours than we should be. In a very concrete way, restricting yourself to what is commissioned in the time that is commissioned, and making it clear why you are doing that, helps managers argue for the funds they need. It is very simple for management to say it takes 12 man hours a day to deliver that and you have only commissioned 8 man hours, and many consultants are making it clear that they have used to give you 12 but they do not feel appreciated, so they are now only doing what you pay for.

One thing I liked about your writing is emphasis on contracts, because we are contracted to deliver something, but many of us go beyond our contracts and feel it is a moral duty to do so.

There are many different types of expectations. Everyone has an internal model of what they would like to be, different from what they are. One of the goals of therapy is to get people to marry those models because it leads to more happiness. The reason I mention that is, I would really hope that just as we say to an adolescent that peer pressure is not a good reason to give up your virtue prematurely or to take drugs, I don't see why peer pressure is a good reason to overdeliver, to stay late or start early. Now, as you've mentioned, there are other pressures, we have expectations on ourselves. If you're a perfectionist and everything has to be just so, it is a real struggle to make it perfect with the resources we have now. It was a real struggle 10 years ago, and we do not have now what we had 10 years ago.

I was thinking that if the service is well-functioning, does it need people to work beyond their contract?

It very much depends upon how one defines well-functioning. Deming, an economist, said that every system is perfectly designed to get that to give the results it gets. If the staff are working to their contracts then they are not overdelivering. If that delivers what was commissioned then that is 'well-functioning' – but it may not be a 'good service'. But I am not sure we will ever have an average service that achieves that because, on average, consultants across the UK are working 4–6 hours a week beyond what they're contracted to do.

Another issue is physician burnout, as you mentioned doctors are burning out. And one thing that I fear is that in the post-pandemic National Health Service (NHS), we will have even more and more burnout. I do not think giving more money would fix it.

In the short term, the pandemic has been absolutely horrendous. It's been horrendous for its acute devastation, but also because it has eroded rest and recreation. People cannot travel, and rest and recreation is more than just not being at work. It is seeing our loved ones, seeing friends and family, going and doing those interesting things that feed the soul and spirit. There are also positives from the pandemic. We have learned that we don't need endless meetings, or to be in the same room for procedural issues. It kills creativity.

You can't do research development across Zoom. Unless you already have a really strong relationship with your peers, it's very difficult for those ideas to zing around the room to snowball and become something truly exhilarating and exciting. So we do need in-person meetings, but we are no longer losing hours to get to a room that we feel obliged to sit in to listen to something for 45 min when we really need to only hear 10 min. That actually is great for democracy like medical staff committees or local negotiating committees, because it means that you can do them more often. So the time before a response has been given is dramatically cut. You can have your consultant body complaining about the on-call rota or raising issues about trainees safety or highlighting that there's a personality conflict with a clinical director much faster than ever before. So I agree that it is exhausting, that everybody is tired, but it has given some real opportunities for change, including the realisation that there's got to be more to life than work.

That is very true. Staying on the issue of burnout, I remember that in a conference some leading scholars put the responsibility of burnout on the individual. If the individual walks away they wouldn't burn out. What about the role of the system?

I think you are referring to the sense that resilience in a way, blames the person for not being able to cope. And it is very difficult to build resilience in a disaster. The NHS does not have enough resources, if there were more staff, more time, less demand, we wouldn't be burning out like this. If you think about burnout as the consequence of friction between personal aspiration and what can be delivered, we know that the NHS is like a supertanker, it takes years to change its directions. It takes over a decade to train a new consultant. So, if we want to keep on doing things the way we're doing them, people are going to burn out, we will fail. We should be creative, for instance using nurse prescribers, or physician assistants, changing our view about handling risk. There are tasks that can be dropped or allocated to rapidly trainable members of staff that would change their day-to-day jobs. None of us do the mundane activities we did 20 years ago, or even 10 years ago. They've been devolved to other staff. I'm concerned that when we take back some of those administrative duties such as booking or changing appointments, even with an app, it is inefficient. So it's helping people to think about why does it feel useless, what is the frustration and how does one fit within that? That, I think, is the key to maintaining longevity in the service, which is critical in a way it wasn't previously; people are now going to be in psychiatry till 67 years of age, probably 69 for those who are starting now, because the state pension age will go up, rather than leaving at 55 with mental health officer status.

Do you think the mental health officer status should be reinstated?

Yes, from a pragmatic perspective. However, if they do not change the pension rules, then when people hit 50 years old or thereabouts, they will need to go part time, which is a good thing. We have a paucity of child and adolescent services in north-west London. There are charities interested in growing the independent sector provision, and they were very, very concerned that this would harm the NHS. A couple of us spoke with them, pointed out the waiting lists and the barriers to providing more. And it helped them understand that were they to point out to relatively new consultants that they can work in the independent sector for part of the time, in a multidisciplinary team, they will actually grow capacity to treat an underserved proportion of the population. There are also those who've retired with mental health officer status who are available, and there will be those who need to reduce their provision to the NHS because of breaches of the annual allowance, who are also available. So independent provision is not necessarily at the detriment of NHS provision, it can be positive for patients and positive for staff.

It's interesting because NHS and the private sector are presented as the polar opposites, and private is seen as kind of the dark side. I think a healthy private service could help the NHS.

Absolutely. If people have a reasonable alternate source of income they're not beholden to a single master, they're able to point out inappropriate working conditions, lack of respect or the shameful physical environment. Why should patients and staff have to put up with substandard facilities? There is no reason why we shouldn't support independent

provision, which is not in direct conflict with the NHS, e.g. the independent sector can't really provide adequately for psychosis. Although I do hear a growing view that the NHS can't provide adequate care in metropolitan areas.

One thing I have witnessed is the constant reorganisation of the services, and what do you think is the effect is on psychiatrists?

Well one of the effects is understanding it's a life cycle event. The first time it happens, you're full of enthusiasm, it's going to solve these problems. The second time, well, maybe they just didn't do it right the first time. The fifth time, your main concern becomes, how am I going to get a solo office. Will I still have a secretary? One's enthusiasm for the delivery of clinical care can erode with time, I exaggerate for dramatic purposes. In the last reorganisation we had, I delivered a piece of work pointing out that the manpower calculations for the metrics that were planned meant that staff would have no breaks in a week. This was nursing staff, so that was inappropriate. The revised metrics still meant that they only got half an hour's break in the week! So, consultants still have an important role in reorganisation. But we need to bear in mind that the primary purpose is often not what we're told this is for. It is politically driven, it hides budget or manpower cuts. Consultation must be meaningful; to paraphrase, no change to me, without me!

And how do you see the increase in bureaucracy in psychiatry? That is one of my pet hates, I have to admit.

It goes hand in hand with an increasing conviction that if you measure everything, you can prevent the things you want to prevent. One of the biggest drawbacks I found of electronic records is the loss of the narrative. I am fully aware that this may be harking back to an inglorious past that was never present. But when I look at case files for medicolegal reports, I see the old discharge summaries, and someone's life is explained in glorious detail. It's very difficult to piece that together nowadays from an electronic patient record. There are advantages, one can cut and paste the highlights quite easily. But it then appears to be that all one is reading is cut and paste, for the large part.

One thing that I always ask about is clustering, and the way patients are reduced to clusters.

Yes. Some people have gone as far as identifying clusters with diagnosis. And how is that going to help them when we start using ICD-11!

It's interesting you mentioned narrative. One thing, as psychiatrists, we used to be trained in, was psychopathology, which emphasises narrative. And it's kind of being pushed out of the curriculum. And that is, I think, to the detriment of psychiatry. What do you think?

It is sometimes surprising the lack of scepticism that I see in trainees. Why is this patient presenting in this way at this time? It's relatively easy to say why in this way, but there's not enough attention to why at this time. We underrecognise the degree of secondary gain that can be present. Whether it's problems with neighbours, benefits or family. Often, that is the secret to understanding why there's a deterioration now.

You are very involved with European psychiatry. Reading some articles from mainland Europe, I think there is a gap between UK and European psychiatry, and we need to actually get more together.

Definitely. One of the things that's very odd about looking at other systems is, it's really easy to idolise them or denigrate them. So for years, I was going to the American Psychiatric Association for clinical excellence and the European Psychiatric Association for connections, networking and friendship. As time went on I realised that the USA does have truly outstanding Centres of Excellence. But the average UK psychiatrist, in my view, was better than the average USA psychiatrist. Looking at Europe, what came across was the importance of cultural differences and local circumstances. You do need unique solutions for different places. In Iceland in the middle of winter, when you can barely travel to the next building because of the snow and the wind and the ice, meant they were world leaders in telepsychiatry 30 years ago. And then you compare that with Denmark, who had a huge influx of refugees during the Yugoslav War, but a tremendous shortage of translators, they started using telepsychiatry for interpreters for psychological treatments for post-traumatic stress disorder. There are different approaches to hospitalisations, so Italy has a very low rate of compulsory hospital admissions compared with the UK. It's being exposed to these that leads you to see important clinical differences that arise from legal and political differences. It also highlights what can go horribly wrong if you don't pay attention to the politics.

I think politics also manifests itself in defensive practice. The fear of going to Coroner's Court. It's something that worries me that we will be more defensive, and it doesn't serve patients well.

It is an attempt to protect oneself against an unknowable risk. As Professor Wasserman has stated, one can reduce suicide at a population level, but not at an individual level. If you very thoroughly treat every single patient, the same number are probably still going to die, but for most people, that is so horrible that they can't run with it. One of the things I've noticed is by accepting that there is a risk that cannot be eliminated, and once one's done what one can do, and been clear about therapeutic risk, there are usually fewer adverse outcomes. Partly because you've put the risk on the table and said we've done what we can do, that there is a chance it will go horribly wrong, but if we don't take this risk it will never get better, or by being clear the risk is not one that psychiatry can solve, or is commissioned to solve.

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1.1.10 In Memoriam BJPsych Bulletin In Memoriam List 2022

date

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1.1.11 Transference-focused psychotherapy as an aid to learning psychodynamic psychotherapy: qualitative analysis of UK psychiatry trainees' views

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date

2022-02

Abstract

Aims & method

Learning psychotherapy can be difficult and stressful. We explore core trainees' ($n = 5$) views on undertaking a psychodynamic psychotherapy training case using transference-focused psychotherapy (TFP), in an East London NHS Foundation Trust supervision group. We used framework analysis of focus group interviews to examine trainees' concerns, their views about this experience and its impact on general psychiatric practice.

Results

Trainees described various concerns on starting: providing an effective intervention, insufficient experience and training-related pressures. However, they found that TFP addressed some of them and was helpful for learning psychodynamic psychotherapy. Difficulties around the countertransference remained at end-point. Trainees suggested that introductory teaching and learning through observation might be worthwhile.

Clinical implications

Trainees' experience suggests that an evidence-based operationalised approach such as TFP can be integrated into the core psychiatry curriculum as a psychodynamic psychotherapy learning method. Trainees report benefits extending to other areas of their practice.

Contents

- *Transference-focused psychotherapy as an aid to learning psychodynamic psychotherapy: qualitative analysis of UK psychiatry trainees' views*
 - *Background*
 - *Aims*
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 - * *Trainees' concerns about starting a psychotherapy long case and their recommendations*
 - * *Trainees views on learning psychodynamic psychotherapy using TFP and its impact on psychiatric practice*
 - *Discussion*

- * *Strengths and limitations*
- * *Recommendations*
- *Data availability*
- *Declaration of interest*
- * *Supplementary material*

Transference-focused psychotherapy (TFP) is an evidence-based, manualised¹ treatment for borderline personality disorder,^{2–4} with modifications for narcissistic personality disorder.^{5,6} Developed from Otto Kernberg's contributions on borderline personality organisation,^{7,8} it offers a structured approach to the treatment of severe personality disorders.

TFP offers operationalised technical guidance based on modified psychoanalytic principles that are helpful for the general psychiatrist.⁹ We hypothesised that there are specific TFP characteristics (*Box 1*) that may be facilitators for a meaningful training experience in the UK, especially in the context of training in the National Health Service (NHS) and the drive for developing suitable skills for a patient population with severe personality pathology. TFP has been used in psychiatric residency training in Australia and the USA with positive learning outcomes for residents.^{10–12} It has recently been introduced in the UK as a modality for the supervised experience of trainees and this is the first reported study describing trainees' views. *Box 1* About transference-focused psychotherapy

Transference-focused psychotherapy (TFP) is a psychodynamic treatment grounded in contemporary object relations theory and supported by randomised controlled trials. Its main premise is the central importance of transference analysis, as manifested in the 'here and now' of the therapeutic relationship, in relation to the integration of fragmented psychological structures (borderline personality organisation). The treatment is operationalised in a treatment 'manual'¹ that provides the technical framework (strategies, tactics and techniques) to be used by the therapist. Key modifications from traditional psychoanalysis include an emphasis on a diagnostic 'structural assessment', lesser frequency (1–2 sessions/week), more active participation by the therapist, and focus on the treatment frame and treatment objectives as negotiated in the treatment contract (with limit setting when self-destructive behaviours occur). In line with its psychoanalytic origin, TFP examines various communications at different levels (verbal, non-verbal, countertransference) and aims to help the patient understand and resolve unconscious conflicts and work towards greater personality integration.

Background

The role of psychodynamics in medical education and psychiatric training curricula dates from the beginning of psychoanalysis.¹³ Tensions between the medical model in psychiatry and the psychoanalytic paradigm remain.¹⁴ The Royal College of Psychiatrists (RCPsych) places importance on psychotherapy learning in core and higher psychiatry training in the UK.¹⁵ Core trainees need to meet psychotherapy-specific curriculum competencies: participation in Balint-type or case-based discussion groups and supervised psychotherapy experience. Completion of core training and examinations lead to RCPsych membership and eligibility for progression to higher specialty training. The aim is not for all trainees to progress to medical psychotherapy specialism, but for psychiatrists to be psychotherapeutically informed.¹⁶

Trainees' views on case-based discussion groups¹⁷ and cognitive-behavioural therapy (CBT)¹⁸ indicate that these are valued as part of their training development. Psychodynamic psychotherapy has been used for learning psychodynamic principles and for the long-case requirement.¹⁹ Reports indicate that starting out in psychodynamic psychotherapy is daunting²⁰ and related ideas are challenging but valuable.^{21,22} The General Medical Council's Medical Psychotherapy Report (2013) has triggered further research on psychotherapy training needs. There is accumulating evidence about specific specialist approaches and their usefulness for the trainee psychiatrist.^{23,24}

Aims

This study was set up to identify the baseline and end-of-therapy views of core trainee psychiatrists in East London NHS Foundation Trust (ELFT) regarding a TFP approach to their psychodynamic long case. We investigated (a) concerns about starting out, (b) recommendations regarding training needs, (c) the perceived advantages and disadvantages of using TFP and (d) its impact on current and future psychiatric practice.

Method

Five core trainees in the same supervision group were identified and invited to participate in the study. They were informed that participation was voluntary, that the interviewer of the focus group discussions would be independent from their supervisory structure and that transcripts would be anonymised before analysis.

We conducted two focus group interviews with the participants, one at the start and one at the end-point of their training case. We employed a framework approach^{25–27} owing to its suitability for analysis of textual data, particularly semi-structured interview transcripts. The focus group interviews were facilitated by a clinical psychologist with no background in TFP. The interviewer asked five questions designed to investigate the study's initial aims. Two were asked a baseline: What are your main concerns about starting a psychodynamic long case? What would you find most helpful in starting a psychodynamic long case? and the remaining three at end-point: What are the advantages of using TFP for your first psychodynamic long case? What are the disadvantages of using TFP for your first psychodynamic long case? How has the experience of having used TFP on a psychodynamic long case affected your current and ongoing psychiatric practice? Open, non-suggestive prompts repeating the question and inviting further elaboration or participant dialogue, and a prompt at end-point inviting trainees to think back to their baseline concerns, were permitted. Discussions were audio recorded, lasting 75 and 60 min each. We transcribed recordings verbatim and anonymised transcripts ahead of independent familiarisation with the data by the interviewer and the lead author. Line-by-line open coding was conducted independently by the two, who subsequently compared labels, resolved differences through discussion, homogenised themes and jointly produced the resulting indexes and charts. Additional deductive review of the transcripts, mapping of themes, analysis and interpretation were completed jointly in a final stage by two of the authors and the interviewer.

All participants (in year 2 and year 3 of training at baseline), two males and three females, provided consent to the study. All had already completed the academic and basic clinical part of their training for their level (psychotherapy lectures, case-based discussion groups) and all but one had completed their CBT short case. None had formal psychodynamic psychotherapy experience or had worked in a personality disorder service and all were expected to undertake preparation for the training method (*Table 1*). All joined the baseline focus group interview and one did not take part in the end-point interview. All met their training expectations, and all except one (the patient discontinued psychotherapy early) completed their case after 1 year. *Table 1* Characteristics of the transference-focused psychotherapy (TFP) training method

Characteristics	Details
Format of clinical experience	Individual TFP once a week
Duration	1 year
Allocated patients' characteristics	Personality disorder diagnosis: borderline personality disorder or narcissistic personality disorder (as assessed on SCID-II DSM-IV). ²⁸
	Moderate to severe pathology.

Moderate to severe pathology.

Informed consent for session audio-recording of all sessions for training purposes. Patient preparation requirements Assessment, preliminary contract setting²⁹ and goal setting completed by the specialist service.

Trainee-led contract finalisation takes place in a preliminary meeting after allocation. Trainee preparation requirements Familiarisation with the TFP 'manual'.¹

Orientation to the supervision process and regular preliminary attendance of the group. Supervision characteristics Facilitated by a consultant psychiatrist in medical psychotherapy and accredited TFP teacher.

Format: group. Frequency: once weekly.

Duration: 1 h.

1:1 preparation and progress review meetings with the supervisor at start, midpoint and end of case.

Review and supervision of audio-recorded sessions.

Review of end-of-case formulation report

Cases related to this study were assessed prior to allocation and consideration was given to reducing the risk of patient drop-out. Patients allocated had borderline personality disorder or narcissistic personality disorder diagnoses and scored in the lower range of the Global Assessment of Functioning (GAF) (scores of 51–10), indicating serious impairment.

The study was registered as a service development project and was granted approval by the East London NHS Foundation Trust Ethics Committee.

Results

Major themes from our analysis matched the questions asked. The subthemes derived from the data, and we present findings in two sections, each following analysis of the respective interviews. The first section (Trainees' concerns) addresses the first two aims of our study using baseline data (*Table 2*) and the second (Trainees' views) the last two, with end-point data (*Table 3*). *Table 2* Thematic analysis: focus group (5 participants) views at baseline Themes Subthemes (1) Concerns about taking on a long case Providing an effective intervention Insufficient experience and training Training-related and other pressures (2) Recommendations about taking on a long case Practical training skills Improvement in supervision Introductory teaching Common scenarios and basic tips Access to personal psychotherapy *Table 3* Thematic analysis: focus group (4 participants) views at end-point Themes Subthemes (1) Advantages of using TFP Clarity about the nature of psychotherapy Improved ability to manage the therapeutic encounter Facilitates long-case supervision Facilitates long-case preparation Facilitates learning psychodynamics (2) Disadvantages of using TFP General/unspecified limitations Limitations related to countertransference management Difference from the psychiatric model (3) Impact on initial concerns about taking on a long case Reduces anxiety about doing it wrong Reduces anxiety about doing it right Reduces anxiety about the patient discontinuing psychotherapy early Reduces anxiety about making interventions Facilitates formulating/planning treatment No effect on concern about lack of effectiveness Positive effect on concern about lack of effectiveness No effect on concern about training commitments (4) Effects on psychiatric practice Positive effect on the clinical encounter Positive effect on understanding of personality disorder Positive effect on working in team Positive effect on education and training skills¹

Trainees' concerns about starting a psychotherapy long case and their recommendations

“I have never even seen any kind of talking therapy happen [...] normally in medicine you sort of at least see something, like someone put in a cannula or someone take a history’ (participant 1).” “[...] that’s probably quite difficult for us to swallow, being medical, ’cause I think you always think there needs to be some sort of result, whereas maybe there isn’t always some big result that you want, but in our heads we probably think that every time there should be, so this puts more pressure on you’ (participant 3).” Trainees expressed concerns at baseline about treatment effectiveness and lack of competency: ‘the intervention I am doing, how therapeutic is it?’ (participant 5); ‘is it a waste of time?’ (participant 1). They said they had no previous training and experience, no direct observation of treatment delivery, a limited theoretical and conceptual map and limited familiarity with the field: ‘you don’t even know how you are supposed to sit’ (participant 1); ‘I don’t have that deep knowledge of psychoanalysis to really understand what I’m doing’ (participant 2). This left them with uncertainty, a sense of lack of purpose, inadequacy and unpreparedness. They were concerned about the quality of care they delivered, potential errors in treatment delivery, negative treatment effects and causing harm to the patient: ‘I am a bit worried about saying the wrong thing and sort of causing damage,

1

TFP, transference-focused psychotherapy.

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I guess people who have actually trained in therapy would be less likely to' (participant 3); 'the feel of failure is quite strong: is it gonna be your fault?' (participant 5).

Additional pressures originated from their wish to complete their long case in a timely manner for training progression: 'one of the big concerns is about the [patient] dropping out before doing enough work to complete the case' (participant 2). They discussed the emotional and personal commitments to the patient and the task in hand, and reported pressures relating to the continuity and intensity of contact and a sense of isolation. Some trainees mentioned having had no personal psychotherapy as an added concern.

Given perceived limitations in the current format for preparation for the long case and the limited duration of supervision sessions, trainees recommended introductory teaching (theory and technique) and suggested focusing on practical skills and observational learning (audio, video, simulation and expert demonstration methods): 'seeing someone having psychodynamic work in practice' (participant 2); 'a few key [tips]: tell me in three sentences what am I supposed to be doing when I start' (participant 1). They also noted that anxiety management skills would be useful.

Trainees views on learning psychodynamic psychotherapy using TFP and its impact on psychiatric practice

"I think I was really worried that I was going to do it [psychotherapy] wrong or not be able to do it or not know what I was doing [...] I think the more you do it you realise there isn't really a right and wrong [...] I think you have a lot more anxiety about it before you start' (participant 3)." "at the beginning [I didn't] see the point of a trainee doing a long case if you have no interest in going into doing psychotherapy training as an SpR [specialist registrar], but I think it has changed my clinical practice [...] I would hope it's not something I would forget or lose as I go through the career' (participant 4)." "you get a sort of more rounded view of how they [patients with personality disorder] feel, I think that they suffer more [...] and I understand what it's like for them a bit more' (participant 1)." At the point of completion of the long case, trainees discussed the positives and negatives of using TFP, its impact on their initial concerns and day-to-day psychiatric practice.

They reported an overall positive effect on their initial concerns: TFP reduced anxiety about competence, harming the patient, the patient discontinuing psychotherapy early and making therapeutic interventions. They remained worried about the effectiveness of psychotherapy. There was no impact on their concerns about competing training pressures.

Trainees said that TFP provided clarity about the nature and purpose of psychotherapy and it made the theory more accessible and less obscure. They also spoke about TFP enabling a focus on the patient–therapist relationship 'in the here and now', and their increased ability to focus on affect, challenge engagement on a cognitive level, address recurrent transference and countertransference patterns and manage the negative transference: 'I think it is clearer what you are supposed to be doing with TFP' (participant 4); 'It helps you mentalise yourself a bit more in the session' (participant 3); 'with TFP alone I guess you are quite protected in some way, because however [the patients] respond even if it is quite negative, this could be a positive thing, 'cause there was a lot of affect in the room, there is a lot of material' (participant 3).

They reported that the treatment contract and frame provided a shared sense of purpose for themselves and the patient, reduced their anxiety about interventions and activity in the session, and enabled them to manage risk, address acting out and better understand the patient's expectations: 'I think the TFP frame was useful in [...] thinking about why that happened without it feeling really personal' (participant 2); 'in TFP you are more allowed to bring up breaks to the contract – with my patient I felt much more comfortable to do this' (participant 4).

Finally, they shared a view that TFP enables preparation at baseline and ahead of each session, allowing them to recall sessions and report them in supervision in a structured way. They said it facilitated the use of supervision within time constraints by offering a shared language and reference framework, which allowed them to track affectively important material, understand and feedback in supervision the challenges to the frame and the patient–therapist relationship: '[TFP] framed how I would relate the session back to the group' (participant 2).

In terms of the shortcomings of TFP, they felt that its focus on the transference neglected other important relationships in the patient's life and limited the variety of potential directions for the therapy. They reported that the expectation of therapist activity and the manualised model produced performance and adherence anxiety: 'I was quite anxious

at least for the first 10 sessions to make sure I was on model' (participant 2). Some trainees said that TFP theory and practice was difficult to link and that the marked difference from the psychiatric model, in combination with their limited exposure to psychoanalytic theory, was a limitation for using the model. They said that the challenges in managing countertransference-related difficulties were not fully overcome by using TFP. They described negative therapist feelings produced by the focus on the transference, and difficulties with maintaining therapeutic neutrality. They also mentioned experiencing uncertainty in the face of patients developing positive feelings, attachment to the therapist, genuine affective contact and psychological progress: 'I feel like my patient has made progress and that he is being genuine and the more he is like that, the more difficult it is for me to know what to do' (participant 3).

Trainees noted that TFP experience improved their daily psychiatric practice and working with patients in various general adult psychiatric settings: 'I find it easier to be clear about the point of us meeting and to maintain the boundaries around that, whereas before when I first started I always found it hard to keep my clinic sessions down to the right length [and to] be clear with them and myself about why we are meeting' (participant 2). They felt it improved awareness and management of transference/countertransference 'in the room' in such settings, made interactions with patients (especially those with a personality disorder) less stressful and improved their ability to manage boundaries, set therapeutic goals and contracts, promote openness, instil hope, manage time, risk and acting-out, and liaise with specialist services. They felt that TFP improved their understanding of the nature of personality disorder and the patients' subjective experience: 'It gives you a better hope' (participant 1); 'I think you just have [...] more understanding of it [personality disorder]' (participant 3); 'I think I am more confident [...] managing assessments or interactions [...] being boundaried and also commenting on things that I might not know how to comment on before and being quite open with the patient in a professional way' (participant 3).

They said that working in teams was positively affected through an improved ability to supervise teams, and to recognise and address colleagues' and teams' strong affective reactions to interactions with patients with personality disorders: 'you are able to have that discussion [about frustration and acting out] with your colleagues, like PLNs [psychiatric liaison nurses]' (participant 2); 'using the TFP sort of structure [to think] about actually why is this anxiety being raised, why is the team acting in such a way' (participant 4). They reported that their experience provided transferable skills for tutoring and education and improved their understanding of the role of psychotherapy in the curriculum.

Two participants said this experience motivated them to seek further experience in psychotherapy.

Discussion

Trainees with no previous experience in psychodynamic psychotherapy expressed intense anxieties related to the prospect of providing this intervention for the first time. They described ambivalence about the value of psychodynamic psychotherapy at baseline, professional self-doubt and training-related pressures. The interview after completion of their long cases indicated that some of these anxieties are alleviated and that TFP has overall positive effects for trainees, extending into their general psychiatric practice, though with some limitations.

Describing therapist difficulties is a core area of the psychotherapy literature but there are few publications specifically identifying what psychiatry trainees find difficult.^{20,30,31} Our study group's anxieties partly match the available taxonomy for psychotherapists' (both novice and seasoned) struggles.³² This pattern of self-doubt, recognised for the novice therapist,³³ is to be expected also for the trainee psychiatrist in the early stages of development but may improve with professional progression.³⁴ This trajectory of change is supported by our findings of some improved anxieties at end-point. Trainees report increased confidence about doing psychotherapy and working with patients with personality disorders in the general psychiatric setting.

Manualisation in psychodynamic psychotherapy is an emerging trend.³⁵ Trainees hold contrasting views about this aspect of TFP. On the one hand, they reported that the specific treatment framework promoted learning psychodynamic principles in a structured manner and facilitated supervision. On the other hand, they said it produced performance anxieties. Importantly though, trainees reported that it helped with management of risk and acting out. There are limitations relating to persistent scepticism about the effectiveness of psychotherapy, ongoing difficulties in managing the countertransference, TFP's psychoanalytic origin, which trainees feel unfamiliar with and consider at odds with the established medical model, and training-related pressures. It is noteworthy that trainees felt helped in managing their countertransferential feelings in psychiatric settings rather than in their psychotherapy work. This both indicates the

complexity of use of the countertransference in psychotherapy and suggests the potential contribution of a psychoanalytically informed training such as TFP for psychiatrists in their daily work.

Evidence indicates a high rate of early dropout in patients receiving psychotherapy.³⁶ This is less prevalent in psychiatric training³⁷ but important to consider, given the impact on training progression. TFP was reported to affect concerns about doing psychotherapy, but it did not affect the experience of training-related pressures.

Given the increasing complexity of the population seen in secondary care, finding suitable training cases may be difficult. Cases treated in this study had moderate to severe personality disorder. TFP may facilitate a pragmatic approach to training within the current NHS service limitations. Four of the five trainees were able to complete their cases and described making good use of the intervention. Supervisors may wish to consider trainees' competence when allocating cases³⁸ and be aware of the difficulties relating to the focus on the transference, trainees' performance anxieties, pressures about 'being on model' and the lack of access to personal therapy.^{39,40} Trainees reported that using a TFP approach partially reduced levels of anxiety about doing psychotherapy with a subgroup of patients with complex problems.

Supplementing supervision with other modes of preparation and learning, with a focus on direct observation, audio-visual material^{41,42} and simulated learning should be considered for incorporation into standard supervision groups.

Strengths and limitations

This is the first study in the UK to examine the views of core trainees about doing a long psychotherapy case using TFP as the modality of choice. TFP has been recently introduced in the country and its use for training purposes in the NHS only recently started. We provide an early description of trainees' views about this evidence-based treatment, linking it with training-specific needs.

Limitations in this study are inherent to the study design and the small number of participants, typical of the size of supervision groups in core training. Theoretical saturation in the analysis may be suboptimal because of the small sample size,⁴³ but limited use of TFP in the UK for training purposes did not allow the inclusion of further focus groups at this time. We studied the views of trainees in a single supervision group, in one locality within one NHS trust. The preparation and supervision were specific to this locality and the generalisability of findings is limited by this. We anticipate that as use of the model grows in the UK, opportunities will arise for further studies of trainees' views that may in addition explore patients' experience of TFP.

We safeguarded against positive bias by explicitly separating the training evaluation process from participation in the study from the outset. Participation in the study was optional. The long-case supervisor did not facilitate the focus group discussions, and the transcripts were anonymised to limit the supervisor's ability to identify a specific trainee's comments and views and to limit self-censorship and selective reporting. The participants were explicitly invited to report their views about the negatives of using TFP to further mitigate this risk and they indeed shared a range of opinions. The risk that the focus group responses may have been biased by the participants' perceived expectations of their supervisor is nevertheless present. Attrition at end-point (one trainee did not participate in the end-point focus group) also reinforces the risk of positive bias in the results presented.

Recommendations

Findings from our study of trainees' views about using TFP support the use of this model for core training purposes. Learning psychodynamic psychotherapy can be difficult and stressful, and this model of training delivery addresses some of the concerns of the starting trainees. We recommend that the use of TFP can help improve their confidence about the effectiveness of psychodynamic psychotherapy and their capacity to treat patients and manage clinical encounters, and can facilitate their use of supervision. There are additional reported collateral benefits for the developing psychiatrist, in terms of working with patients with personality disorders, understanding of psychodynamic aspects in psychiatry, working in teams, and improving education and training skills.

Learning psychodynamic psychotherapy remains a fundamentally challenging endeavour that requires working with and tolerating uncertainty. The problem of some trainees experiencing a dissonance between established psychiatric

training and the psychoanalytic principles used by TFP remains, and further integration between disciplines is still required.⁴⁴ TFP does not offer a magic bullet for the intrinsically complex nature of learning psychodynamic psychotherapy. However, our study suggests that it addresses some of the trainees' anxieties about taking this task on.

On the basis of these findings, we recommend that the RCPsych considers using TFP in its core training curriculum for meeting the psychotherapy long-case requirement. Our findings are in keeping with evidence from the international paradigm about the usefulness of TFP for psychiatry training purposes.

We thank the five participant trainees, Dr Patrick Grove for his contribution to the study, and Drs Matthew Roughley and Iain McDougall for their helpful comments on the final manuscript.

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Data availability

The data that support the findings of this study are not available to share due to ethical considerations about the privacy of the participants.

T.L. conceptualised and designed the study. O.K.B., G.N. and T.L. contributed equally to drafting the manuscript.

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Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <http://doi.org/10.1192/bjb.2020.129>.

[click here to view supplementary material](#)

1.1.12 No wrong door: addressing injustices and achieving better mental health-care provision for under-18s in acute physical healthcare settings

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Abstract

The distressing reality that mental healthcare for children and young people in acute trust settings in the UK is woefully underprovided is not news. But with acute trust debts being written off, hospital trusts and commissioners of services have a timely opportunity to address this age- and condition-based discrimination.

Delivering a just service for under-18s depends on attitude, resources and adequate knowledge of the tasks involved. This article aims to describe the current landscape, summarise the arguments for better integrating mental healthcare into physical healthcare settings, articulate the tasks involved and the challenges for commissioning and providing, and finally share examples of current service models across the country.

Ultimately, commissioning and provider choices will be constrained by resource pressures, but this article aims to underscore why commissioning and providing a portmanteau ‘no wrong door’ hospital service for children, young people and families is worth the headache of thinking outside old commissioning and provider boxes.

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pmc In 2019, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report into the mental healthcare of young people in the UK¹ concluded that: mental healthcare was not given the same level of importance as physical healthcare in general hospitals. General hospital staff were not receiving enough support from mental health professionals in the general hospital setting, particularly with regard to risk management.

Despite these damning findings, the report did not advise commissioners how they could use their purchasing power to exact a more equitable provision of mental healthcare for young people in hospital settings. Unhelpfully, in terms of systems change, many of NCEPOD’s recommendations can be implemented at a ‘tick box’ level, through superficial changes to job definitions and training plans.

And, having stated in 2015 that ‘What is particularly worrying is that children with physical, learning or mental health

needs are telling us they have poorer experiences [in hospitals]’,² Ted Baker, the Care Quality Commission’s chief inspector of hospitals, noted in the 2020 Assessment of Mental Health Services in Acute Trusts (AMSAT) report³ that: “Physical and mental health care have traditionally been delivered separately. While investment and improvements in mental health services are welcome, physical and mental health services will only truly be equal when we stop viewing physical and mental health as distinct. Services need to be built around all of people’s needs and not determined by professional or interest groups.”

He continues: “Many of the people attending acute hospital emergency departments with physical health needs may also have mental health needs. These people are in a vulnerable position and need to be treated with compassion and dignity. This must be in a way that makes them feel safe and upholds their human rights. In our report, we raise concerns that people with mental health needs are not always receiving this level of care. How well they are treated in an emergency department, or elsewhere in an acute hospital, is often linked to the importance that mental healthcare is given by the trust board. Acute trusts must do more, but they also need support from mental health trusts to develop better and more integrated approaches to care.”

AMSAT makes some welcome recommendations for integrated care systems and acute trusts; however, with no absolute commissioning directives regarding ‘whole person’ hospital care, most trusts will choose to overlook this central aspect of patients’ – and especially children’s – care.

The tendency for adult and physical health priorities to set the agenda within acute trusts means that children and young people with mental health needs seem always to be last in the queue. This is despite the well-known rates of comorbidity between long-term physical and mental health conditions in children (*Fig. 1*)⁴⁻⁷ and the immediate, let alone long-term, resource implications of failing to address these psychiatric comorbidities.⁸ Fig. 1 Prevalence of mental disorders in children with specific physical complaints. From Meltzer et al, p. 74.⁴ © Crown copyright 2000, see <http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/>.

The levers of integration

As AMSAT points out, if integrated treatment of mind and body is to be achieved, it must be underpinned by effective service-level agreements between stakeholders. The principles that guide such contracts were well articulated in *Side by Side*,⁹ published in February 2020. This UK-wide consensus statement, agreed by the Royal Colleges of Psychiatrists, Nursing, Emergency Medicine and Physicians, calls on all parties to work together to better care for patients with mental health needs in acute hospitals.

‘Best care’ is characterised by: reciprocal competencies in each staff group, physical and mental joint ownership of the care of children and young people while in the hospital co-location of physical and mental health staff.

Addressing the second and third aspects, reciprocal competencies and joint ownership of care, can be relatively easy, but as Ted Baker observed in AMSAT: ‘Where high-quality leadership for better mental health in acute trusts was lacking, we saw how there was more likely also to be a lack of appropriate training to support staff and poor working relationships between acute and mental health trusts.’³

Reciprocal competencies

Exchange programmes for junior doctors and nurses are already in place in some areas. Likewise, many health practitioner training programmes now contain modules offering reciprocal competency qualification, and frameworks such as the UCL competency framework¹⁰ allow staff to register as having reached various competencies in relation to mental health training. This model could be used to determine levels of mental health competency and capacity within the acute trust workforce. Those aiming to improve capacity in this area should be aware that the ‘We Can Talk’ training¹¹ used by many trusts to help staff to feel better equipped to talk about mental health problems with children and young people, detect safeguarding issues and provide signposting is not a child and adolescent mental health services (CAMHS) competency framework. Consequently, adoption of this training across a trust should not be used to distract from inadequate mental health staffing. Both are needed: upskilling of physical health staff, as well as direct employment of specialist mental health staff.

Joint ownership

Joint ownership of patient care can be interrogated by examining a trust's pathways and protocols. These agreements can usefully confirm which team will take lead responsibility for a young person's care. Children and young people who have used hospital emergency departments during mental health crisis describe how the experience of feeling unwanted at a time of particular vulnerability puts them off returning.¹² Given increasing rates of self-harm and suicide in young people,^{13,14} this is not a desirable outcome.

Co-location of staff

The biggest challenge to achieving genuine side-by-side working is co-location of physical and mental health staff. This is not simply a problem of estate management and a lack of space – it is because co-location of mental and physical healthcare provision presents a challenge to the very notion of what an acute hospital is about. Acute trust functioning and the commissioning of services within hospitals remains mired in an outdated notion of physical healthcare. Within this conceptualisation, physical health is divorced from the unconscious and from emotional and irrational reactions to physical ill health and disease, let alone family psychological factors, and care packages are linear processes.

Key considerations in commissioning integrated care for children and young people

Four main areas need to be considered when negotiating contracts for integrated acute trust care for under-18s: the range and complexity of mental health tasks to be addressed; commissioning discontinuities and fragmentation between adult and child, mental and physical, local and regional/national/international services; funding sources for non-patient-facing activities, including staff support and professional development; ensuring a single 'front door' for children and young people and their families.

Tasks to be addressed

Broadly speaking, three mental health tasks need to be managed in the acute trust setting: crisis/emergency mental health presentations; non-urgent psychiatric or psychological problems; systems issues regarding complex cases. *Box 1* gives more detail. *Box 1* Mental health tasks relating to under-18s to be managed in the acute trust setting

Crisis/emergency mental health presentations. These presentations involve under-18s in the emergency department or on the ward who need urgent joint assessment, alongside physical monitoring with or without treatment. Some individuals may need an emergency place of safety within the hospital. They might include children and young people with self-harm and attempted suicide, psychosis, acute confusional states (delirium), eating disorders and sudden deterioration in behaviour in the context of autism spectrum disorders or intellectual disability. A significant proportion will have safeguarding needs. Some children and young people will have psychiatric needs related to physical health medicines (e.g. intensive care medicines) or their physical condition (e.g. brain injury).

Non-urgent psychiatric or psychological problems in in-patients, day patients or out-patients. This group might include children and young people with medically unexplained physical symptoms such as pain or paralysis, those experiencing major emotional reactions following a newly diagnosed long-term condition, for example non-adherence with medication in asthma or insulin-dependent diabetes mellitus, those with a psychiatric condition in the context of a long-term physical condition, such as attention-deficit hyperactivity disorder in the context of epilepsy, and those subject to medical child abuse/fabricated and induced illness.

Systems issues regarding complex cases. Physical health staff dealing with cases involving complicated systems dynamics or complex child or parent psychopathology need access to support, training and consultation from expert mental health colleagues to effectively manage the staff effects that can ensue. These can include conflict within teams (splitting), accidental medical harm of children and young people, inadvertent collusion with abusive parents and staff burnout. Mental health staff embedded with their physical health colleagues can run reflective groups, facilitating psychological processing and providing in-context staff support. Such reflective groups have been shown to reduce staff sickness and burnout in physical healthcare staff.^{12,13}

Commissioning discontinuities and fragmentation

Commissioning discontinuities and fragmentation are rife for under-18s in hospital, with 16- and 17-year-olds most disadvantaged despite having the highest rates of psychological morbidity (*Fig. 2*).¹⁵ *Fig. 2* Under-18s requiring emergency mental health assessment in the emergency department of one London teaching hospital over the period 2013–2019.

The age discontinuity between paediatric commissioning and CAMHS commissioning, especially given the former's non-alignment with educational transition points, is surely an area for urgent attention by integrated care systems (ICSs) (*Box 2*). ICSs are tasked with breaking down barriers to care as part of delivering the National Health Service's long-term plan,¹⁶ but with the COVID-19 pandemic having changed the commissioning landscape, how will the new block contracts affect this? *Box 2* Ensuring that 16- and 17-year-olds are not forgotten Paediatric commissioning finishes at 16, but CAMHS commissioning finishes at 18. The physical arrangement of acute trusts, with most paediatric emergency departments and wards having an age cut-off of the 16th birthday, means that the over-16s end up in environments that are far from young-person friendly. Having no in-house under-18s mental health staff to visit them in these 'inappropriate' settings doubly disadvantages the under-18s; their adult equivalents are far more likely to have access to in-house liaison psychiatry teams, since commissioning for adult mental healthcare in hospitals is more advanced than that for under-18s.

How does the commissioning arrangement work when a hospital functions not only as a local 'district general', but also as a regional, national and possibly international specialist referral centre? Most acute trusts have arrangements in place for costing physical healthcare packages involving national and international patients, but these rarely take into account potential mental health needs. Greater recognition needs to be given to this side of the 'business' and financial packages developed accordingly.

Funding for non-patient-facing activities

Funding sources for non-patient-facing activities, including staff support, are vital for the sustainability of any integrated service. Significant amounts of non-patient-facing activity are involved in the first two tasks listed in (*Box 1*): dealing with crisis/emergency mental health presentations and non-urgent psychiatric or psychological problems. A 75-min crisis consultation will often require as much time again, often more, liaising not only with other hospital and primary care staff, but also other agencies, especially social care and education, as well as adult mental health if parental mental illness is a factor. Emergency tariffs rarely cover the hours of work involved or the numbers of mental health staff who may need to be involved. Tariffs need to contain adequate funding for staff with sufficient knowledge of child and adolescent mental health to complete this important liaison work, and payment by results has often meant that provider trusts end up running these services at a loss.

Mental health staff are also important for delivering staff support, something that has become very obvious during the current COVID-19 pandemic. Plenty of evidence exists for the benefits on staff well-being of reflective practice,^{17,18} but this is rarely factored into commissioning agreements between acute providers and commissioners.

Ensuring a single 'front door'

Finally, how does the commissioning arrangement ensure that children and young people and their families are not having to visit multiple 'front doors' and tell their story multiple times? Having on-site, integrated mental health staff ensures not only that under-18s and their families have an experience of one extended team caring for them, meaning that any mental health professional coming to see them has a good sense of their physical context and is already well-briefed on their possible mental health difficulties, but, perhaps more importantly, that they can access mental healthcare even if they come from a family or culture where attending CAMHS or having mental health problems is difficult to accept or act upon, and where a separate visit to a mental health clinic simply will not happen.¹⁹ Equally, if the young person's family of origin is chaotic and/or their emotional and behavioural presentations stem from neglect or abuse, the hospital provides a one-stop shop. This offer is unlikely to be the case if commissioning relies on in-reach from local CAMHS.

Developing a just and best-fit model

Having reflected on how a local hospital service might deliver or not on good care as articulated above, commissioners and providers planning to establish or enhance integrated hospital care for under-18s within the next commissioning cycle might want to consider the following. Is/will the team be multidisciplinary (more common in paediatric liaison/children's psychological medicine teams) or unidisciplinary (as in crisis teams or paediatric psychology services)? Are/will the team members be employed by the acute trust or by the mental health trust, with honorary contracts with the acute trust? There are pros and cons to each. Does/will the funding come via block contracts or activity-based, condition-specific funding streams? The mental health needs of children and young people are often inchoate and less amenable to being fitted into diagnostic boxes or care bundles. Embedded staff, able to respond to the queries of paediatric staff or the sudden call for help with a child's behaviour or family's emotional response, are invariably more useful than staff tied to specific conditions or workstreams. Who does/will do the commissioning? Local children's mental health commissioners are responsible for ensuring adequate 24/7 emergency provision, but who will take on responsibility for in-patient, day-patient and out-patient provision? Will this be agreed on a cost-per-case basis with local children's mental health commissioners or will the acute trust agree tariffs with local, regional and national commissioners that include mental health activity? The latter is certainly more sustainable in terms of paediatric mental health service financial viability. Does/will the mental health service involve one team or a multitude of different units within the hospital? In some hospitals, the paediatric psychology service functions separately from the paediatric mental health team (which may be called a paediatric liaison team or children's psychological medicine team), and in some hospitals, the paediatric psychologists are not joined in one service, but are simply members of their condition-specific paediatric teams.

Examples of some current models for under-18s mental health provision

With these considerations in mind, commissioners and providers can examine which of the following models is best for their acute trust/s. Services at these example trusts are further outlined in the Appendix. An acute trust-employed under-18s mental health service covering the emergency department, wards and out-patients. The team delivers in-house training, staff support and reflective practice. This model is followed at the Whittington Hospital, London. A mental health trust-employed emergency department psychiatric service (adult practitioners) and CAMHS crisis team which sees under-18s emergency department presentations and those admitted for less than 24 h. An acute trust-employed paediatric (i.e. under-16s) mental health team sees all other cases, including crisis admissions of more than 24 h. A paediatric mental health team delivers in-house training, staff support and reflective practice. This is the model at the John Radcliffe Hospital, Oxford. A mental health trust-employed emergency department service, with an on-site under-18s mental health team during normal working hours. An on-site mental health team sees certain groups of in-patients and out-patients as part of acute trust-funded, condition-specific service level agreements (e.g. for Tourette syndrome), as well as 'generic' in-patients and out-patients if funding is agreed on a cost-per-case basis by local commissioners. There is a large acute trust-employed, condition-specific paediatric psychology service, separate from the mental health team. A paediatric psychology service delivers in-house training, staff support and reflective practice. This model is followed at the Evelina Children's Hospital and St Thomas' Hospital, London. An acute trust-employed under-25s out-of-hours mental health emergency team as well as CAMHS in-reach during normal working hours. An acute trust-employed community counselling service providing in-reach or outpatient services for children on wards or out-patients, as well as paediatric staff support. This model is followed at the Blackpool Victoria Hospital, Blackpool.

A binary choice?

In effect, commissioners and providers working within integrated care systems have two broad choices when they consider mental health provision for children, young people and families in acute trust settings: an embedded, multi-disciplinary children's psychological medicine team, staffed by practitioners such as paediatric psychologists, child and adolescent psychiatrists, child mental health nurses, child psychotherapists, physical therapists and social workers, all directly employed by the acute trust and working across all settings; two separate mental health teams, one employed by the mental health trust and seeing crisis/emergencies (uni- or multidisciplinary, with nurses usually providing the unidisciplinary input) and one employed by the acute trust seeing all other patients (uni- or multidisciplinary, with psychologists usually providing the unidisciplinary input).

In an ideal world, where team boundaries are minimised, the first model is preferable. Such embedded services allow children, young people and families access to timely mental healthcare, when and where they need it, with staff versed in their physical health needs and without the long waits that currently plague access to CAMHS. Clinical scenarios involving acute behavioural disturbance on paediatric wards or the need for urgent and ongoing psychiatric care for children and young people in intensive/high-dependency care cannot wait around for funding requests that take weeks to agree. Equally, children and young people with disabling unexplained physical symptoms may not appear to mental health commissioners to be 'mental' and legitimate recipients for funding (not fitting usual CAMHS eligibility criteria), so then fall between posts.

It is hoped that this article gives commissioners and providers the questions and framework to query current arrangements and to ask themselves: Can children, young people and families in my integrated care system expect a unified care offer when they walk through the front door of our local acute trust/s? Will acute trust care costs be contained by having timely mental, as well as physical, healthcare available to the large cohort of under-18 in-patients and out-patients with long-term conditions for whom we are responsible? Will under-18s under our care genuinely find that there is no wrong door when they find themselves requiring hospital care?

I thank both my reviewers for their helpful comments, as well as all those who commented informally in the production of this document, in particular Dr Peter Hindley, who prompted me to get on and write about this area, and Dr Sebastian Kraemer for support with the early drafts.

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Declaration of interest

None.

Detailed service descriptions

Blackpool Victoria Hospital, Blackpool

The Child & Adolescent Support & Help Enhanced Response (CASHER) service offers emergency assessment to young people under 25 from 5 pm–10 pm on weekdays and from 10 am–10 pm on weekends and bank holidays. CASHER provides support for young people 365 days a year. CASHER also provide an on-call night time service via their dedicated number (07810 696565) and will come into the hospital to see young people outside of their usual working hours. Each shift is staffed by two mental health staff, one CAMHS-trained and one not. Staff from local CAMHS opt into the staffing rota, which is run by the hospital bank. This avoids any issues with rota absence due to annual leave or sickness. CASHER also offer weekend clinics and drop in sessions for those in crisis. Over 16s are admitted to the adolescent unit or adult medical wards whenever necessary.

CASHER also run an 'Intensive Home Support' service (CASHER RAIS) which provides immediate support to young people who may have presented at accident and emergency or are currently on waiting lists for other services. CASHER

RAIS ensures that young people are not left unsupported at any stage during their care. CASHER has also adapted their face to face REACH-OUT Groups that are held in the more deprived areas of Blackpool, Fylde & Wyre by supporting online sessions via Zoom with colleagues from Lancashire Children's Services as well as Attend Anywhere for Blackpool Teaching Hospitals online sessions.

CASHER close links to local services including CAMHS and YoutherapY, which are both run by the acute trust. YoutherapY, to which in- and outpatients can be referred or can self-refer, has counsellors working with paediatric staff and children, young people and families in the hospital, as well as working in community sites.

Evelina Children's Hospital and St Thomas' Hospital, London

South London and Maudsley NHS Foundation Trust's National and Specialist Paediatric Liaison Service is a multi-disciplinary team focusing on young patients with comorbid medical and psychological conditions (<https://www.slam.nhs.uk/national-services/child-and-adolescent-services/paediatric-liaison/>).

The team receives referrals from across the UK and internationally for certain conditions and also provides assessment and treatment of in-patients at the Evelina Children's Hospital and St Thomas' Hospital. The service comprises four consultant psychiatrists, a clinical nurse specialist, a family therapist, a counselling psychologist and specialist training doctors.

Staff are employed by the local mental health trust, with funding coming from a mixture of sources, including portions of the local CAMHS block contract, cost-per-case funding for in- and out-patient work from mental health commissioners and acute hospital funding via service level agreements related to particular conditions, such as tics and Tourette syndrome.

Oxford University Hospitals Children's Psychological Medicine (CPM) service

Oxford University Hospitals Children's Psychological Medicine (CPM) service is primarily staffed by paediatric psychologists, with 2.2 whole-time equivalent child and adolescent psychiatrists. All staff are employed by Oxford University Hospitals NHS Foundation Trust (OUH). OUH has a large adult psychological medicine service, and the child and adolescent psychiatrists are managed within this larger group of adult psychiatrists. OUH's John Radcliffe Hospital is a trauma centre and it receives children who have sustained complex trauma following suicide attempts.

All CAMHS emergencies presenting to the emergency department are seen by the emergency department psychiatry service, which is provided by the local mental health trust. Any children needing in-patient care beyond 24 h, e.g. for medical treatment of an overdose, are then managed by CPM. The adult psychological medicine consultants provide out-of-hours Responsible Clinician cover for all children and young people detained at OUH. The child and adolescent psychiatrists do not undertake any out-of-hours work.

CPM and psychological medicine are funded by out-patient and in-patient tariffs. Some work is funded using best practice tariffs, some by service level agreements with specific teams and some is paid for by monies coming in for medical student teaching. Oxford's Children's Hospital also purchases generic CPM child and adolescent psychiatrist input using money from their overall budget, charged by OUH to commissioners. Any new service development has a small amount immediately factored into the costings to cover CPM or psychological medicine costs.

Whittington Hospital, London

Whittington Health NHS Trust's paediatric mental health team (PMHT) at the Whittington Hospital, London, is staffed by psychiatry, nursing, family therapy and psychotherapy (see <https://www.whittington.nhs.uk/default.asp?c=25315>).

The service offers liaison input to the paediatric team, in-patients and out-patients, and crisis assessments and management in Whittington Hospital's emergency department and the paediatric ward. The service also supports staff on neonatal intensive care.

The PMHT is part of acute paediatrics. The latter is commissioned within the context of the national contract for acute hospital services. Since the PMHT is not a commissioned service, it has to be funded out of the paediatric budget. Whittington paediatrics have been commissioned under Payment by Results for a number of years, with income generated from attendances / admissions. However, this has changed as part of the Covid finance / contracting arrangements and services are now paid for as a block contract. The contract amount is fixed and based on historic expenditure and demand trends.

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1.1.13 Improving attitudes toward electroconvulsive therapy

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Abstract**Aims and method**

Electroconvulsive therapy (ECT) often causes fear in the general public because of media representation and negative reported side-effects. This study evaluates a new video focusing on experiences of ECT and how this can aid communicating medical information to the public. Knowledge and attitudes toward ECT after watching the video were compared with a group that received no information and a group that read the current NHS leaflet on ECT. The role of empathy was also considered as a covariate.

Results

The video was the only condition found to positively affect knowledge and attitudes toward ECT. The video was especially beneficial to those that possessed low perspective-taking trait empathy.

Clinical implications

These findings demonstrate the video improved knowledge and attitudes toward ECT compared with current material or no information. We suggest that the addition of personal experiences to public information adds perspective, improving overall attitudes toward health treatments.

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Electroconvulsive therapy (ECT) is a mental health treatment involving the use of electric currents to induce a seizure,¹ and is used to treat life-threatening depression, catatonia and severe, long-lasting mania that is resistant to medication.^{1,2} However, ECT raises fear among the general public,^{3–5} largely because of its dramatization in the mainstream media.^{2,5–8} Concerns are, however, not entirely based on fiction, as some patients have reported adverse psychological side-effects as a result of ECT treatment, implying possible signs of trauma response.⁹ The National Health Service (NHS) information for patients undergoing ECT consists of a science-based leaflet from the National Institute for Health and Care Excellence (NICE),¹ despite research suggesting that healthcare education may be better received alongside contextual and emotive evidence.^{9,10} Gold Coast Health in Australia implemented these principles, focusing on adding contextual evidence for the benefits of ECT,¹¹ but there is no empirical evidence as to whether this approach improved perceptions of ECT.

From a psychological perspective, trait empathy is one factor which may affect someone's ability to relate to the per-

sonal accounts of those receiving ECT. Both cognitive and affective empathy have a positive relationship with the ability to perceive emotional content.¹² Specifically, cognitive empathy can facilitate ‘perspective-taking’ capabilities.¹³ Following the use of the video produced by Gold Coast Health,¹¹ the Southern Health NHS Foundation Trust developed a similar tool to foster more accurate perceptions of ECT. This study is the first to empirically test whether the use of the emotion-based information improves perception of ECT compared with the current leaflet. We aimed to test whether the new video fulfils its purpose to promote a more positive attitude and better knowledge of ECT in the UK public, and whether trait empathy plays a role in any effects.

Method

Ethics

Ethical approval was given by the University of Portsmouth Undergraduate and Taught Postgraduate Psychology Department Research Ethics Board (clearance number 2019-036).

Design

The experiment used an independent groups design. Participants were randomly allocated to one of three conditions based on type of ECT information (no information, science-based leaflet or emotional video). The dependent variables were mean scores on the ECT knowledge and attitude questionnaire. Two subscales of the Interpersonal Relativity Index (IRI), perspective-taking and empathic concern, were used to control for differing levels of trait empathy in the participant sample.

Participants

Participants were recruited by volunteer sampling. Posters were advertised around the University of Portsmouth, asking for volunteers to complete an online survey about ECT; these were not aimed at psychology students, but they were not excluded from taking part. Participants that were not students were recruited by sending a request for participation to local community facilities. The survey link was further sent by the non-student participants to their own colleagues, to increase the number of non-student participants. Participant ages ranged from 18 to 67 years ($N = 146$, mean age 31.94 years, s.d. 13.49). The sample comprised 51 men and 95 women, and both students ($n = 39$) and non-students ($n = 107$). *Table 1* shows the mean age and gender and student ratios for each condition. *Table 1* Participant demographic information

Condition	Mean age in years (s.d.)	Female:male participants	Students:non-students
No information	34.40 (14.37)	29:23	10:42
NHS leaflet	30.98 (12.74)	36:24	17:34
New video	29.98 (13.24)	29:13	11:31

Participants were asked to disclose any experience with ECT, and any mental illness that might qualify an individual for ECT. Some participants disclosed previous experience with ECT ($n = 64$), with a significant proportion ($n = 21$) receiving their knowledge from film or television. Some participants disclosed previous experience of mental health problems ($n = 84$), with the majority ($n = 63$) having experience with severe clinical depression.

Materials

The survey consisted of a revised version of the IRI,¹⁴ an ECT attitude and knowledge questionnaire¹⁵ and two types of information on ECT use as treatment for mental illness.

IRI

Two subscales from the revised version of the Basic Empathy Scale¹⁴ were used to measure trait empathy: empathetic concern and perspective-taking. The scales were rated using five-point Likert scales, with a high score representing higher trait empathy scores.

ECT attitude and knowledge questionnaire

The ECT scale consisted of both an attitude and knowledge subscale. Each statement was scored on a six-point scale, with high scores indicating a more positive attitude or correct knowledge of ECT.

Information on ECT use in mental health treatment

A public information leaflet was taken from the NICE guidance for the prescription and administration of ECT in depression, mania and catatonia.¹ This leaflet contains mainly scientific evidence of the efficacy and use of ECT. For this study, the sections ‘What is NICE?’ and ‘What are depressive illness, mania, schizophrenia and catatonia?’ were omitted. A video intervention was developed by the lead author and Southern Health NHS Foundation Trust based on a successful educational video created by Gold Coast Health, Australia.¹¹ The video focuses on the experiences of patients, nurses and caregivers with ECT. The video is available to the public at: <https://vimeo.com/369525494>.

Procedure

All participants completed the survey online and provided written informed consent before taking part. Participants were first asked about any experience with ECT and any mental health conditions, and then completed the IRI. They were then randomly allocated to one of three information conditions: no information, the current NHS leaflet or the newly developed video. Participants in the leaflet and video condition were presented with the educational material and asked to watch/read carefully before completing the knowledge and attitudes to ECT questionnaire. Participants in the no information condition only completed the knowledge and attitudes to ECT questionnaire.

Results

Descriptive statistics

Figures 1 and 2 show the distribution of the knowledge and attitude scores in each of the three information conditions. The median scores indicate participants in the video condition had more correct knowledge and a more positive attitude. Importantly, in the attitudes to ECT factor only the video condition showed a median score above the mid-point, indicating a positive attitude. Receiving no intervention or the ECT leaflet had distributions that sat mostly below the mid-point for both knowledge and attitudes, thus meaning the video condition was the only form of intervention likely to encourage accurate knowledge and facilitate a more positive attitude toward ECT when compared with receiving no information or the current leaflet. These findings suggest that video information is the most positive tool of the three studied. *Fig. 1* Distribution of electroconvulsive therapy knowledge scores across each information condition (points represent individual participant ratings). *Fig. 2* Distribution of electroconvulsive therapy attitude scores across each information condition (points represent individual participant ratings).

The role of empathy in the success of the ECT educational material

To analyse the data further, a one-way multivariate analysis of covariance (MANCOVA) was conducted on ECT attitude and knowledge data comparing data from each information condition. Empathetic concern and empathic perspective-taking used as covariates. A significant multivariate effect of information type was found (Wilks' $\lambda = 0.84$, $F(4, 280) = 6.36$, $P < 0.001$), with a small effect size. Empathic perspective-taking was a significant covariate in the multivariate model (Wilks' $\lambda = 0.95$, $F(2, 140) = 3.44$, $P = 0.035$), with a small effect size. No significant effect of empathetic concern was found on perception of ECT.

The significant omnibus MANCOVA justified separate univariate ANOVA on the dependent variables. There was a significant effect of information type on knowledge scores ($F(2, 141) = 11.68$, $P < 0.001$), with a small effect size. *Post hoc* pairwise comparisons with a Bonferroni adjustment revealed that knowledge scores were significantly higher in the video condition compared with the leaflet condition ($P = 0.01$) and receiving no intervention ($P < 0.001$). There was also a significant effect of information type on attitudes to ECT scores ($F(2, 141) = 11.45$, $P < 0.001$), with a small effect size. *Post hoc* pairwise comparisons with a Bonferroni adjustment showed attitude scores to be highest in the video condition when compared with the leaflet condition ($P = 0.003$) and receiving no intervention ($P < 0.001$). There was no significant difference observed between the leaflet and receiving no information for either knowledge or attitudes to ECT.

Perspective-taking was found to be a significant covariate for attitudes to ECT only ($F(1, 141) = 5.06$, $P = 0.026$), with a small effect size. This suggests the increase in positive attitude to ECT after watching the video exists after controlling for the underlying trait empathy. It also suggests empathic perspective-taking accounts for a very small but significant portion of the variance in attitudes to ECT. *Figure 3* shows the relationship between emotional perspective-taking on ECT attitudes in each of the three conditions. Although the regression line for the video was similar across the range of perspective-taking scores ($\beta = 0.06$, s.e. 0.25), there was a small positive relationship for the NHS leaflet group ($\beta = 0.29$, s.e. 0.16) and the no information group ($\beta = 0.30$, s.e. 0.21). When perspective trait empathy was high, attitudes toward ECT in the three information conditions were similar; when perspective trait empathy was low, attitudes toward ECT scores in the new video condition were higher than the NHS leaflet and no information conditions. From this, we can infer that the style of intervention had little effect on those already high in trait empathy; however, for those with low trait empathy, the video proved beneficial for improving perceptions of ECT. *Fig. 3* Relationship between perspective-taking and attitudes toward electroconvulsive therapy in each of the information conditions.

The role of gender and student status on the effect of ECT educational material

To check the data for potential biases arising from gender and student status, an independent group MANCOVA was conducted on ECT attitude and knowledge scores comparing data from each information condition. Gender (male/female) and student status (student/non-student) were used as covariates. A significant multivariate effect of information type was found (Wilks' $\lambda = 0.87$, $F(4, 280) = 5.10$, $P = 0.001$), with a small effect size. Gender was a significant covariate (Wilks' $\lambda = 0.92$, $F(2, 140) = 6.19$, $P = 0.003$), with a small effect size. No significant effect of student status was found on perceptions of ECT. The significant omnibus MANCOVA justified separate univariate analysis of variance on the dependent variables. There was a significant effect of information type on knowledge scores ($F(2, 141) = 2.88$, $P < 0.001$), with a small effect size. *Post hoc* pairwise comparisons with a Bonferroni adjustment revealed that knowledge scores were significantly higher in the video condition compared with the leaflet condition ($P = 0.01$) and receiving no intervention ($P < 0.001$). There was also significant effect of information type on attitudes to ECT scores ($F(2, 141) = 8.87$, $P < 0.001$), with a small effect size. *Post hoc* pairwise comparisons with a Bonferroni adjustment showed attitude scores to be highest in the video condition when compared with the leaflet condition ($P = 0.005$) and receiving no intervention ($P < 0.001$). There was no significant difference observed between the leaflet and receiving no information for either knowledge or attitudes to ECT. Gender was found to be a significant covariate for knowledge of ECT ($F(1, 141) = 12.38$, $P = 0.001$), with a small effect size, and attitudes to ECT ($F(1, 141) = 6.35$, $P = 0.013$). This suggests that the increase in knowledge and a more positive attitude to ECT after watching the video exists after controlling for gender. It also suggests gender accounts for a small but significant portion of the variance in knowledge and attitudes toward ECT.

Discussion

ECT knowledge and attitudes

Our findings suggest that both knowledge and attitudes to ECT can be significantly improved using contextual and emotive information. Only the video condition improved knowledge and attitudes to ECT, whereas the leaflet currently used by the NHS did not improve either knowledge or attitudes compared with no information. For both the no intervention condition and the leaflet condition, participants sat below the mid-point for attitudes and on or below the mid-point for knowledge, suggesting that they were still inclined to perceive ECT negatively. These findings suggest that, compared with other styles of intervention, the video would work best to educate patients and carers on the use of ECT to treat mental health illnesses. These results support current literature which suggests that interventions focusing on more emotional, real-life experience may be more effective for perception improvement than using factual information alone.^{13,15,16} It should be noted that all the main and covariate effects were small, and the distributions in all three experimental conditions had participants that perceived ECT both positively and negatively. This suggests that although the video may help to improve perceptions of ECT, it is not a 'silver bullet', and might best used alongside other informational material. Future research should assess whether combining the leaflet and the video improved the perceptions above and beyond the video alone.

An alternate explanation for our results may be the modal differences between video and written information; the introduction of a dynamic stimulus may have been enough to demand more attention from participants than reading a leaflet. Some research has suggested showing patients a video can reduce anxiety around healthcare treatments more than written information.¹⁷ To address this, it would be important to examine whether a similar improvement in knowledge and attitudes is found irrespective of how the content was delivered. It should also be noted that although the efficacy of ECT is outside of the scope of this research, there is still large debate as to whether there are any noticeable and long-lasting benefits to undergoing ECT.^{2,3,7,18} Additionally, meta-analyses report high relapse rates among many patients.¹⁹ There are some ethical considerations on whether improving attitudes toward ECT is acceptable if the benefit of the treatment is, in some cases, limited and relapse is likely.

The role of trait empathy

We hypothesised that trait empathy would offer some explanation as to why emotional content was more effective compared with scientific information. We found that perspective-taking influenced attitudes to ECT, but this was only the case for participants who received no information or the NHS leaflet; those with higher perspective-taking trait empathy had a more positive attitude to ECT. Perspective-taking had no effect on attitudes to ECT in the video condition. Therefore, participants with high perspective-taking scores had similar attitudes to ECT in all three conditions, whereas participants with lower perspective-taking empathy had a more negative perception of ECT in the leaflet and no information groups compared with the video group. The video, therefore, seemed to directly improve the attitude of participants who had lower perspective-taking abilities. The proposed reason for this is that the video directly adds context to ECT as a treatment. This allowed participants with lower perspective-taking empathy to relate to the treatment or participants in a similar way to those participants with high perspective-taking empathy.

This explanation seems to be consistent with evidence from neuroimaging studies, which has demonstrated a link between perspective-taking ability and the ventromedial prefrontal cortex,²⁰ a brain area that is also critical for perception and reaction to the suffering of others.¹⁹ Thus, scoring higher in perspective-taking may make an individual more likely to be able to imagine the suffering of those experiencing severe mental health problems, which explains why they may react more positively to ECT even with limited information around the treatment. Furthermore, adding context in the form of another person's account can elicit a more empathetic response from participants when making decisions,²¹ and that the empathy elicited is generally more appropriate when context is present;²² this suggests that the context in the video may have encouraged a more empathetic response to the content, even for those who do not naturally empathise with another's situation

Alongside the significant covariate effect of trait empathy, gender was found to be a separate significant covariate for both knowledge and attitudes. We suspect that the known gender variation in empathy²³ can partly explain why gender was a significant covariate. This information provides grounds to suggest further research is conducted into the effect

of an emotional, video-based stimulus, and whether any specific gender effects exist in relation to the efficacy of these training materials.

Clinical implications

These findings provide a deeper insight into the use of education to improve perception of ECT, with emotional stimuli proving to be the best method for information delivery, especially for people with low perspective-taking empathy. Overall, better knowledge of people's experiences with ECT may ultimately mean less fear and apprehension among the public.²⁴ The results of our findings can be used as a recommendation for both the NHS and the wider health sector on how to structure and deliver their informational material. A critical point seems to be that personal accounts and context are important in the effective delivery of health information.

Limitations and suggestions for future research

This study focuses on ECT, which carries a large amount of stigma.^{6,8} Going forward, it could be interesting to explore whether the effect exists with other health treatments with potential negative public perceptions. Some alternative treatments still have stigma attached,⁴ and contextual evidence may be the key to improving perceptions of these treatments for mental health illnesses. The results provide grounds to recommend that more emotive content should be introduced when educating the public about mental health. Suffering from a mental health disorder can still affect your ability to find work and maintain relationships.²⁵ Further, certain disorders, such as schizophrenia and psychosis, are still hugely feared by the general public.²⁶ Introducing a context and personal experiences to these illnesses helps to distinguish between mental health in the real world and the overdramatization of disorders fed to the public by the media.²⁷ Making the distinction between individual and symptom could help integration in society, improve quality of life and aid recovery for those with a mental illness.

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Data availability

This study was preregistered on 6 November 2019 on the Open Science Framework. Data and details of the preregistration are available at the following link: <https://doi.org/10.17605/OSF.IO/SY6AP>.

O.C. was responsible for initial conceptualisation of the study and its hypotheses, direction of the ECT video and oversight of its production, designing and conducting the study, analysis of results and end write-up of the study. M.B. provided general guidance through all experimental processes and edited the final manuscript. P.T. provided a critical clinical perspective and comments.

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Declaration of interest

None.

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1.1.14 Response to: Does COVID-19 pose a challenge to the diagnoses of anxiety and depression? A psychologist's view

Allan House

date

2022-02

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- *Response to: Does COVID-19 pose a challenge to the diagnoses of anxiety and depression? A psychologist's view*
 - *What is the problem?*
 - *Who is responsible?*
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 - *Collective trauma and a collective response*
 - *A conclusion*

pmc In her recent article, Johnstone (Bulletin, September 2021) writes critically about how we have responded professionally to the effects of the COVID-19 pandemic. While it is easy to agree with some of what she has to say, much of her argument consists of a series of assertions that are neither entirely accurate nor logically connected to each other or to her main contention.

What is the problem?

Johnstone's central claim is that by using psychiatric diagnosis we label things as abnormal that are in fact normal. The opening example of handwashing and cleaning is unfortunate because it is unconvincing – hardly anybody spends 'most of the day' doing it and there is more to the diagnosis of OCD than cleaning: resistance, ritualising, other compulsions and so on. Certainly, the use of florid metaphors about tsunamis and pandemics of mental disorder is unhelpful, and research does show that much unhappiness and anxiety during the pandemic has proved to be transient. But then many illnesses, including those caused by the COVID-19 virus, can be transient and non-disabling – it doesn't mean they aren't illnesses. Every doctor, including every psychiatrist, knows the value of watchful waiting: the question is how we respond when symptoms are not transient or non-disabling. When Johnstone talks about 'people with a psychiatric history', I take it to mean people who most psychiatrists would regard as having a long-term mental disorder. We can agree that 'It is untrue and even patronising to assume that everyone in this group will fail to cope', but does any psychiatrist actually assume that? More fundamentally, Johnstone is opposed to the idea of psychiatric diagnosis (and

not just of anxiety and depression) because it rests upon defining mental illness in relation to social norms while (as she and her colleagues have argued elsewhere) masquerading as being analogous to the more legitimate processes of medical diagnosis. It is an error to assume that medical diagnosis is radically different in all respects: it does for example recognise social causes (cigarette smoking, hazardous drinking, unhealthy eating, physical inactivity) and defines some of its most prevalent disorders such as hypertension, hyperlipidaemia and diabetes mellitus according to deviation from norms. More important is the question of whether the states so diagnosed are harmful and, if so, whether intervening is beneficial.

Who is responsible?

I found it difficult to suppress a smile at Johnstone's jibe about the self-serving nature of articles promoting the importance of research in the areas of expertise of the authors. But it is too narrow to name only academics and Public Health England as the actors in a debate about the nature of public mental health – professional bodies, the pharmaceutical industry, politicians and journalists are among others who set the agenda and the tone. The emergence of the phrase 'mental health' is an interesting topic in its own right, and one way to view its effects is to see it as a vehicle for medicalisation of distress. It might, however, be as useful to think of it as effect rather than cause of the individualisation of societal problems – a phenomenon that has deep cultural roots and consequences that go beyond psychiatry into penal policy, welfare provision and education.

What are the alternatives?

It is a category error to propose formulation as an alternative to diagnosis – the latter is a descriptive statement, whereas the former provides an explanatory framework, a point illustrated by the training requirement that psychiatrists are expected to be able to make a biopsychosocial formulation and management plan as well as coming to a diagnosis. It is not news that the onset of many mental disorders is preceded by adverse life events and difficulties – research in this area goes back half a century – or that the content of some people's illnesses reflects these experiences. However, bundling together all mental disorders as 'various forms of distress... that are understandable responses to adversities' does not do justice to the issues. Not everybody reports life adversities before onset; the nature of adversity may be reflected in the content of some but not all conditions; life adversity does not explain the differences in form of the various mental disorders; there is a strong genetic risk for some disorders. It is difficult to know what it means to say that mental disorder is 'what we do' in response to threats, but in my reading it is hard to see it as other than dismissive of the reality of mental illness.

Collective trauma and a collective response

There is a disconcerting *volte face* at the end of Johnstone's piece. Having presented the argument that what we are seeing in the pandemic is essentially normal, part of a meaningful response to stress and not to be pathologised, we are finally offered the idea of collective trauma – defined as an experience that overwhelms our usual ways of coping. If states like anxiety and depression are to be thought of as arising because of this overwhelming of usual ways of coping, how is that different from the way that psychiatrists think about what they are likely to call mental disorders? Only, it seems, in the reluctance to use a descriptive vocabulary that distinguishes between different conditions – as if it is a trivial matter whether somebody is hearing voices, embarked upon life-threatening self-starvation or unable to touch a newspaper for fear it will give them a fatal infection. How are we supposed to use this way of thinking to help people now, while they and we wait for a fairer society? Local peer networks may indeed help some, but they won't suffice for the severity and diversity of problems we face. One of the central tensions of healthcare is that we can recognise that health and illness have social determinants, but as clinicians it is individuals that we see. Isn't a question of picking one or the other – both are important, and I think most psychiatrists understand that.

A conclusion

Surely we can all agree about some things: it is important not to medicalise distress that does not merit such an approach; social adversities are important risks to our mental well-being, and government policies in recent years have both exacerbated these risks and done much damage to society's ability to help those most in need as a result of them; professionals in healthcare have a responsibility to speak out both for individuals in need and also about the social conditions that contribute to their difficulties. These simple and powerful messages are obscured by wrapping them, as here, in a muddled polemic animated as much as anything else by anti-psychiatry sentiment.

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1.1.15 Transforming MRCPsych theory examinations: digitisation and very short answer questions (VSAQs)

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Abstract

Many examinations are now delivered online using digital formats, the migration to which has been accelerated by the COVID-19 pandemic. The MRCPsych theory examinations have been delivered in this way since Autumn 2020. The multiple choice question formats currently in use are highly reliable, but other formats enabled by the digital platform, such as very short answer questions (VSAQs), may promote deeper learning. Trainees often ask for a focus on core knowledge, and the absence of cueing with VSAQs could help achieve this. This paper describes the background and evidence base for VSAQs, and how they might be introduced. Any new question formats would be thoroughly piloted before appearing in the examinations and are likely to have a phased introduction alongside existing formats.

Contents

- *Transforming MRCPsych theory examinations: digitisation and very short answer questions (VSAQs)*
 - *Choosing examination formats for the MRCPsych*
 - *Digitisation of examinations*
 - *Very short answer questions*
 - *Trainees' views on digitisation and VSAQs*
 - *Conclusions and future directions*
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pmc Examinations are now being delivered on online platforms in many undergraduate and postgraduate contexts. The COVID-19 pandemic has accelerated this, as digital platforms have the potential to enable examination delivery during lockdowns, or if trainees are isolating or in quarantine, without social distancing concerns. Education is also becoming increasingly international, and the MRCPsych examination is both sought after and has been delivered in international centres for many years. However, travel to examination centres for both staff and candidates is expensive, and significantly increases its overall carbon footprint.

The Royal College of Psychiatrists has therefore decided to deliver its theory examinations via digital platforms as from Autumn 2020, using a combination of artificial intelligence and in-person online proctoring (equivalent to traditional invigilators) to ensure that high standards of probity are maintained. The examinations will initially be delivered using the two existing question formats, multiple choice questions (MCQs) and extended matching questions (EMQs). However, digital platforms enable the use of new question formats that may allow more comprehensive coverage of the syllabus (the syllabus can be found at: <https://www.rcpsych.ac.uk/training/exams/preparing-for-exams>). We know that assessment has a powerful effect in driving learning,¹ and multiple choice question formats may encourage rote learning from question banks. We will thoroughly evaluate any new question formats before we introduce them into the MRCPsych examination, but we would hope that they would encourage deeper and more holistic learning strategies that would better equip our future psychiatrists to have the biggest impact on the mental health of their patients.

Choosing examination formats for the MRCPsych

When setting an examination, some of the key factors² that need to be considered when assessing its utility are shown in *Table 1*. Each of these factors have to be weighed up against each other, with differing weightings according to the purpose and type of assessment. Table 1 Key factors to be considered when assessing the utility of an assessment (adapted with permission from reference²)

Factor	Questions asked	Validity	Does the examination test what we want it to test?
Reliability	Are the results repeatable and accurate?	Are external sources of error other than candidate ability accounted for and reduced?	Educational impact
What is the impact of the examination upon trainees' learning?	Does it lead to deeper learning and long-term retention?	Acceptability	Is the examination acceptable to those sitting it and other stakeholders?
Cost	Are costs reasonable?		

MCQs are a format that lends itself to reliability through standardisation of answers and ease of evaluation of large numbers of candidates via machine marking. Although MCQs have been used since the inception of the MRCPsych in 1972, historically, short answer questions (SAQs) and essays were also utilised; these were phased out as individual marking of SAQs with increasing numbers of candidates was taxing, and there were questions about the reliability of essay marking.³ The format of MCQs evolved from initial true/false answers to the single best answer or 'best of five' in use today, as well as the use of the EMQs, in which there is a theme, several stems and a greater number of options, more easily assessing the application of knowledge.⁴ The MRCPsych is a high-stakes examination, with important consequences for candidates, our patients and society in general. In common with all high-stakes postgraduate medical assessments based in the UK, it is regulated closely by the General Medical Council, and all changes to format and structure must undergo prospective approval by them.

Given these concerns, the reliability of the MRCPsych must be extremely high, so that no trainee passes without the requisite ability. Fortunately, the written papers have excellent reliability (with Cronbach's alpha, a measure of reliability, consistently >0.85), but some have questioned whether this has happened at the expense of validity.^{5,6} Has the depth of clinical context and its application been lost? Perhaps we fail to reward those trainees who undertake in-depth study of complex issues, such as aetiology, ethics and the history of psychiatry.⁵ The main criticism of MCQs is a 'cueing' effect, whereby candidates are cued by the correct answer, rather than actively recalling it.⁷ There is evidence that requiring candidates to *construct* an answer, such as in SAQs, produces better memory than tests that require recognition.⁸ Additional issues with MCQs may include various 'test-taking' behaviours, such as eliminating wrong answers to arrive at the correct one, guessing from the options available and seeking clues from the language used to deduce the correct answer independently from the knowledge required.⁹

MCQs end up testing recognition memory, and recall is significantly affected by this cueing effect. Creating a good MCQ with valid and meaningful distractors (incorrect options) can be extremely hard. Poor-quality distractors can make guessing more rewarding. There are a number of areas of the syllabus where it is impossible to write valid

distractors, and as a consequence, clinically meaningful knowledge may not be examined and more obscure areas, where MCQs may be easier to write, are more likely to be tested.

As mentioned above, it is intuitive and commonly recognised that the assessment drives learning.¹ Areas of the syllabus that are more commonly examined are therefore more likely to be studied by trainees. Assessment factors contribute to strategies used to study,¹⁰ which could influence the trainees' overall learning and the extent of knowledge achieved. Developments in technology have allowed easy access to online MCQ 'question banks'. Many trainees therefore focus their effort on practicing these questions, rather than focusing on core learning and developing deeper understanding.

The costs of taking the MRCPsych for candidates are high¹¹ because of the high cost of the infrastructure behind the examination, e.g. the professional examinations team, detailed psychometric analysis, and supporting the psychiatrists who volunteer their time freely to create and quality-assure questions, and analyse the results. For several years now, the examination is budgeted not to make excessive surpluses, but if this inadvertently happens, the surplus is directed to the trainees' fund, which has previously funded the creation of the Trainees Online learning resource, among other projects. Moving to digital platforms may reduce costs to trainees as they no longer need travel or accommodation, and potentially could reduce overall costs as no physical venues are required; however, this is uncertain, and the costs of commercial contracts for software, training and ongoing IT support may counteract this.

Digitisation of examinations

The COVID-19 pandemic led to a rapid and unpredicted introduction of online examinations for the MRCPsych, although the College had plans to begin moving toward digitisation before the pandemic. Although there is a relative paucity of literature on online examinations,¹² one small study, in which a direct comparison of online examinations versus paper examinations was made, showed equivalent reliability and validity.¹³ In terms of candidate performance in online versus paper examinations, the few studies directly testing this have shown no significant differences.^{13,14} Candidates' perception of online examinations are often favourable, and one study found reduced anxiety when taking online compared with traditional paper-based examinations.¹⁴ Possibly, the fact that candidates are not able to see their peers might account for this. However, it is clear that the rapid introduction of digitisation for the MRCPsych caused considerable anxiety in trainees; the same study¹⁴ recognised that the first sitting of online examinations can cause anxiety, which later subsides with familiarity upon repeated testing.

Very short answer questions

Very short answer questions (VSAQs) are a novel format of written questions.^{15–19} A VSAQ consists of a short question for which an answer is required to be manually entered on computer screen from free recall, as open text. There are no options provided to choose from as in MCQs/EMQs. Generally, the answer would be only a few words. *Box 1* shows some examples of how VSAQs may look. Any correct response will attract one mark and any incorrect response will attract zero marks. Examination software would be programmed to recognise multiple versions of correct answers, using smart algorithms. These would allow different versions of a correct response to be recognised. For example, the first question in *Box 1* provides an example of several possible correct answers for that question; all of these answers would attract a full mark, and centre around the idea of a reduction or suppression of the default mode network. The software would additionally be programmed to highlight any answer that is a non-exact match (approximate) to any possible correct answers, and these will be manually reviewed by a designated and trained examiner to ascertain whether that represents a correct response. This will ensure that any unforeseen versions of correct responses will not go unrecognised and unrewarded. That response will then be saved in the list of correct answers for that question for any future examinations. Examiners will also review all other marking done by the computer, to ensure accuracy. Minor spelling errors or typos (e.g. 'inhibited' rather than 'inhibited') will not be penalised and will be picked up during the review process. VSAQs also allow for two entirely different but correct answers, as illustrated in the second example in *Box 1*. In this example, again, either of the responses will attract a full mark. *Box 1* Very short answer question examples. Example 1: A very short answer question with different versions of the correct answer: How does the 'default mode network' react in a healthy brain when one performs a goal-directed task? Correct answers may include, but are not limited to: Decreased activity Reduced activity Inhibited Suppressed Switched off Example 2: A very short answer question with different correct answers: Name the neurotransmitter mechanism thought to be responsible for clozapine-

induced hypersalivation. Correct answers would include: Alpha 2 receptor antagonism, Muscarinic M4 agonism. Again, differing versions of these correct answers would be accepted, e.g. α_2 adrenergic antagonism.

The free recall tested by the VSAQs can be more easily focused on clinically relevant topics, and allow freedom to assess a wider spectrum of the syllabus where MCQs may be impossible to write. This should encourage trainees to refocus on core learning through textbooks and primary papers, and make their knowledge base more clinically relevant in the long term.

In the studies to date, VSAQs have been shown to have higher reliability than MCQs, and reduce the cueing effect.^{15–17} They may improve validity by testing nascent knowledge and clinical skills, rather than the ability to pass examinations.¹⁵ In one study of 300 medical students,¹⁵ 69% of students undertaking VSAQs felt that they were more representative of how they would be expected to answer questions in actual clinical practice, and about half felt that they would change their learning strategies in response. However, these studies were conducted on undergraduate medical students and may not be generalisable to postgraduate psychiatry trainees. Additionally, as far as we are aware, there has not been any published data that uses VSAQs from a high-stakes examination such as the MRCPsych, although at least one other College are considering their introduction for UK medical trainees.²⁰ Finally, as VSAQs require recall rather than recognition, candidates appear to universally score lower in them when compared with MCQs;^{15–19} this must be carefully accounted for in the standard setting process that sets the pass mark, so that standard setting judges are aware of likely lower scores in comparison with MCQs, particularly in first iterations of the test when they are lacking comparative past data. To account for this, there would be pilot questions tested and a full analysis undertaken to inform future standard setting.

Trainees' views on digitisation and VSAQs

The opinion of psychiatry trainees was obtained via a presentation by the Chief Examiner, Dr Ian Hall, to the Psychiatric Trainees' Committee. The Examinations Sub-Committee's Trainee Representative also sought feedback on the Psychiatric Trainees' Committee collaborative platform, 'Workplace'. The questions submitted to the College's webinar, 'MRCPsych Exam – Changes to exam delivery this Autumn', attended by over a thousand psychiatry trainees and supervisors, were also reviewed in summarising concerns with regards to the digitisation of the theory examinations.

Psychiatry trainees raised several concerns with regards to the digitisation of the theory examinations (*Table 2*). In the context of sitting the examinations from home, a common theme was how technical issues, such as insufficient internet connectivity, would be resolved, what support would be available to assist with this, and how the College would ensure candidates were not disadvantaged as a result of technical issues. Trainees also expressed concerns as to how cheating would be identified, particularly the potential to 'trick' proctoring technology, to prevent inflated examination marks disadvantaging other trainees. Similarly, they expressed concerns that trainees may be falsely accused of cheating if they write notes or look away from the screen. The concerns regarding cheating are in keeping with the published literature of both candidates' and examination setters' perceptions of online examinations.¹² Trainees also noted that some trainees' home environments may be unsuitable for sitting examinations, because of caring commitments or house-sharing arrangements. Trainees were also keen to understand how candidates with dyslexia and other specific learning needs would be accommodated. Furthermore, trainees expressed an expectation that examination fees would be reduced in the context of digital examinations. *Table 2* Common themes of trainees' concerns and responses

Concern	Responses
Technical issues, e.g. internet connectivity	The College partners with third-party software providers who have both expertise and a track record in high-stakes online examination delivery. Trainees are encouraged to test the resilience of their internet and device in advance, using provided software. Software developers design software to account for brief interruptions, and protocols exist for more significant technical issues.
Cheating, proctoring and false accusations	All alerts from the artificial intelligence software proctoring are reviewed by a live proctor. Final decisions about cheating are made following rigorous review by the Examinations Sub-committee, and subject to the normal appeals process.
Unsuitable home environment	Candidates can choose any suitable workstation with reliable internet to take the examination, e.g. a family member's or friend's house, a work or university computer.
Examination should not be reduced to a 'spelling test' in very short answer questions	Variations in answers and spelling mistakes will be accounted for, and examiners would review incorrect answers, including typos and spelling errors.

Despite the concerns raised, trainees generally appeared to agree with the prospect of the digitisation of the theory examinations, even outside the current context of COVID-19. However, many expressed a strong preference for these

to be conducted in test centres to prevent technical issues or cheating, and to ensure candidates with home settings unsuitable for sitting examinations were not disadvantaged.

With regards to the introduction of VSAQs, the trainee response was generally positive. Trainees felt it addressed their request for a greater emphasis on the testing of core knowledge and that VSAQs were better at testing the application of knowledge than the current format. However strong concerns were raised with regards to the examinations not becoming a 'spelling test', and particularly that this may disadvantage candidates with dyslexia, other specific learning needs and international medical graduates. They noted that not all spelling errors are of equal clinical significance and where it is clear that a candidate's intended meaning is correct, that this should be accepted as a correct answer.

Conclusions and future directions

The digitisation of examinations is inevitable, and the pace of change has been rapid as a result of the COVID-19 pandemic. For the MRCPsych theory papers, this could bring several improvements in terms of examination delivery, such as improved convenience and access to the examination, and faster processing of results. However, it also brings opportunities for improving assessment. We hope that a careful, phased introduction of alternative question formats such as VSAQs will enable a more comprehensive sampling of the examination syllabus, a greater focus on core knowledge and promote deeper, more holistic and integrated learning strategies. We know that these issues are of importance to trainees and clinical educators alike.

Any change like this requires comprehensive evaluation and testing, and because this is a high-stakes postgraduate medical qualification, the UK General Medical Council will need to prospectively approve any changes.²¹ As mentioned above, before any partial introduction, we plan to pilot questions on trainees and conduct an extensive psychometric analysis of the results. This would include an equality analysis to assess the impact on differential attainment in protected groups. The successful delivery of such a change requires comprehensive stakeholder engagement, and none are more important than the doctors training in psychiatry who take the examination; we plan ongoing consultation with trainees. We must also ensure that our training programmes prepare candidates thoroughly, with supervisors and tutors being up to date with new assessment methodologies and the reasons for their introduction. There would be the potential for online learning platforms to assist trainees with the new style questions. Stakeholder feedback has been largely positive on the face validity of VSAQs, in promoting the acquisition of knowledge that will be useful in clinical practice, and so help deliver better healthcare for people with mental health problems.

We thank the trainees who contributed their views to this paper, both from the Psychiatric Trainees' Committee and those who attended the webinar.

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We confirm that all authors meet all four ICMJE criteria for authorship. K.S., N.A. and I.H. conceived the article, K.S., N.A., S.E. and I.H. all contributed to the draft and final versions. K.S. reviewed and revised the article.

Declaration of interest

All authors are members of the Examinations Sub-Committee at the Royal College of Psychiatrists, which sets the MRCPsych theory papers. This article represents their views rather than the view of the committee as a whole.

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1.1.16 Lack of respect and balance

Margaret White

date

2022-02

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- *Lack of respect and balance*

pmc This editorial and current issue of BJPsych Bulletin do nothing to be ‘respectful and balanced’ about issues of trans health. Reprinting the article which caused the controversy in the first place means that it is exposed to a wider audience, and instead of having a counterbalancing view in another article, it has the article by Griffin et al which contains a number of anti-trans talking points. Anything which is supportive of trans people or current best practice standards for trans health is relegated to the letter pages. None of the authors of the two articles are gender identity specialists; they have instead mobilised their credentials in other areas to claim expertise in an area where they have none. The voices of trans people are either absent or denigrated as some kind of online-based groupthink.

Trans health is its own research field, and there are plenty of researchers that the *Bulletin* could have reached out to for a counterbalancing view. Instead, they have amplified anti-trans voices once more, with a sop that those with opposing views could write a letter or propose an article.

I am not seeking to silence debate, and acknowledge that this is a controversial area. However, issues around trans health are treated particularly poorly in the *Bulletin*. Would the *Bulletin* accept having two papers on women’s mental health written solely by men who had no expertise in women’s mental health, or two papers on ethnic minority mental health written solely by white people who had no expertise in ethnic minority mental health? If not, why is it acceptable for this to happen for trans people?

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1.1.17 Vivienne Cohen, MRCS, LRCP, FRCPsych

Kate Lockwood Jefford

date

2022-02

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- *Vivienne Cohen, MRCS, LRCP, FRCPsych*

pmc Formerly Senior Lecturer and Consultant Medical Psychotherapist, St Bartholomew's Hospital and Medical College, London, UK

Vivienne Cohen, who has died at the age of 94, was a visionary, award-winning psychiatrist at the forefront of the developing fields of National Health Service (NHS) psychotherapy and group analytic treatments. A talented protégé of the pioneering psychoanalyst and military psychiatrist S.H. Foulkes, and the first female doctor to train in group therapy, she was a founder member of the Institute of Group Analysis (IGA) and developed one of the earliest out-patient psychotherapy departments, establishing creative links between the NHS and IGA that remain today. Her passion for training doctors and allied professionals earned her an international reputation as a teacher and supervisor.

Born Vivienne Wolfson on 1 November 1926 in London, she attended the first Jewish primary school in north-west London – co-founded by her father in 1932 – but, as war forced the family to move between London and grandparents in Hove and Ayrshire, her secondary education was fragmented across eight different schools. Vivienne studied determinedly to catch up, alongside looking after her younger sister and baby brother, early evidence of her indefatigable commitment to education and caring for others.

Her parents – and the entrenched patriarchy of the time – expected her to leave school at 14 and train as a secretary, but Vivienne had other ideas: she wanted to be a doctor. She recruited her strong-minded paternal grandmother, who argued that Vivienne was ‘too clever’ to leave school. Her parents listened.

In 1945, Vivienne won a state scholarship to University College – one of three London medical schools that accepted women – entering a pre-clinical year where one in five students were female, and completed clinical training at West London Hospital Medical School, founded to prioritise access to women. A fellow student described her as ‘principled, steady with purpose, full of ideals, brilliant and insightful, but always with a spirit of fun and humour’. In 1950 she won the Rudolf Konstan prize for medicine and she qualified in 1951.

Entering the Maudsley Hospital in 1957 as a trainee, Vivienne met Foulkes, renowned for developing innovative group treatments at the Military Neurosis Centre at Northfield. ‘Michael’, as he was known to family and close friends, became her lifelong supervisor, mentor and friend. In 1962, after working for Professor Linford Rees – a ‘marvellous’ experience where she taught and supervised psychiatric social workers – she was appointed chief assistant psychotherapist to Foulkes in his service at St Bartholomew's Hospital. After Foulkes retired in 1963 she led the service single-handedly at consultant level, expanding and improving provision to growing numbers of referrals by providing treatment both directly and from medical students and trainee psychiatrists and non-medical psychotherapists under her supervision.

In 1978 Vivienne was formally appointed consultant medical psychotherapist and senior lecturer – a rare academic post in psychotherapy – at St Bartholomew's Hospital and Medical College, and continued to build and organise the service to become one of the most reputable in the UK. In 1983 she won a national award – the first prize of this kind for psychotherapy – for her ‘imaginative’ audio-visual study of group therapy technique and practice for training purposes. In 1985 she received a Levenhulme Teaching Fellowship to support her programme of supervised clinical placements for non-medical IGA trainees. These ‘internships’ were highly competitive, as they provided a wealth of clinical experience and expert supervision, as well as enhancing the service's group treatment capacity alongside individual, couple and family therapies. In 1987 this model won her a Barnett Prize for efficient use of NHS resources.

Vivienne was a senior member of staff at the IGA and served on many local, national and international committees with an emphasis on service provision and training. She was invited frequently to teach abroad, including Denmark, Italy and Australia, and ran an intensive group therapy course in Israel. She published extensively on groups in major

journals¹ and textbooks^{2,3}, covering many aspects, including supervision, training, NHS provision, cultural factors, large groups and organisational dynamics. Her vision and commercial and organisational skills played a key part in securing the building in Daleham Gardens, NW3 that is still home to the internationally renowned IGA today.

In 1955 Vivienne married Sam Cohen, a liaison psychiatrist and former professor of psychiatry at the Royal London Hospital. It was a supportive relationship with mutual regard for their respective specialties: Sam's ward milieu drew on therapeutic community principles and Vivienne published on psychological aspects of medical conditions. Sam died in London in 2004.

Vivienne eschewed private practice, preferring to work in the NHS providing what people needed, not what they could afford. Following retirement she set up a charitable foundation to fund a group psychotherapist post in the City & Hackney Psychotherapy service. When the service relocated to premises near Homerton Hospital, staff wanted a new, distinct name and, in August 2014, Vivienne Cohen House was opened at an event she attended with family, describing herself as 'bowled over'. The chair of East London NHS Foundation Trust thanked Vivienne for her contribution to psychotherapy for residents of the City of London and Hackney over half a century, nurturing the service from its origins, sharing her skills and knowledge with patients, colleagues and trainees. Many of her trainees working today will remember their first experiences of psychotherapy supervision for her astute recall of clinical detail and her tactful creation of both personal and clinical insights in the warm ambience of her office.

Charming, vivacious and sharp, Vivienne Cohen was an independent thinker and courageous doer, a dedicated clinician and inspiring teacher. Always direct and honest, she saw herself not as a pioneer or 'anything special',⁴ but as someone who did what needed to be done.

Loved and admired by her children Michael and Elisheva, five grandchildren and many great-grandchildren, Vivienne was excited by the next generation, encouraging them to pursue their dreams and celebrating their achievements.

Since retirement, she divided her time between Israel and London and enjoyed opera, museums and ballet.

In January 2021, Dr Vivienne Cohen passed away at home in Israel with her family around her.

With thanks to Dr Cohen's family, Mark Salter, John Schlapobersky and Gyles Glover.

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1.1.18 Author's reply

Norman Poole

date

2022-02

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- *Author's reply*

pmc I thank Dr Margaret White for the letter in response to my recent editorial 'Publishing controversy'. It raised important challenges. Why have the trans health papers been published online and in print even though written by non-specialists in gender identity, and should opposing views be relegated to the Correspondence section? First, all papers published online also appear in the paper journal eventually. To do otherwise would have marked these papers out as

somehow different. Dr White does not wish to silence debate, but not publishing in print form as usual would be a form of censure even if not censor. Although this is a controversial and contested area, the papers did not express extreme views. In fact, Marci Bowers, president-elect of the World Professional Association for Transgender Health, recently raised concerns similar to those expressed in the *Bulletin* papers. However, we remain keen to present all opinions so have commissioned papers from gender identity experts, which are making their way through the editorial process. When the papers by Griffin et al and Evans were published on First View, they quickly attracted several complaints with demands for their retraction, which as explained in the editorial was not appropriate. Those authors were invited to write opposing articles but unfortunately, for their own reasons, none took up the offer. Hence our decision to publish all the available letters alongside the original papers so readers can evaluate the arguments for themselves. I hope this and the forthcoming papers assures Dr White that no one's voice is relegated to the correspondence section in the *BJPsych Bulletin*, but letters, such as Dr White's, are also an invaluable element of discourse.

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1.1.19 Self-harm and suicide in adults: will safety plans keep people safe after self-harm?

Allan House

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2022-02

Abstract

Safety planning is recommended as a part of the response to everybody who presents after self-harm, although there is surprisingly little evidence for its effectiveness. There is potential for such plans to be experienced as unhelpful if patients are not genuinely involved in their production and if the plan does not include information about meaningful sources of support. Staff training is needed to ensure that plans are delivered in a collaborative way and self-harm services need to be improved nationally if such plans are to be effective.

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- *Self-harm and suicide in adults: will safety plans keep people safe after self-harm?*
 - *What is safety planning?*
 - *How effective is safety planning after self-harm?*
 - *Could safety planning have detrimental effects?*
 - *Can we mitigate the potential harms of poorly managed safety planning?*
 - *Declaration of interest*

pmc It has been known for a long time that the risk of suicide is greatly increased after hospital presentation due to self-harm.¹ England's National Suicide Prevention Strategy recognises this risk and its 2017 report 'expanded the scope of the National Strategy to include self-harm as a new key area for action'.² This welcome policy change brings with it a dilemma – how to respond to self-harm as a suicide risk while at the same time responding to its many other meanings. Suicide is perhaps the worst outcome in psychiatry and inevitably captures our attention – can we develop our services to respond to the risk without at the same time allowing the 'risk-reduction' aspect of service provision to overshadow the rest of the process of care? The recent Royal College of Psychiatrists (RCPsych) report *Self-harm and Suicide in Adults* (CR229)³ can be read as an attempt to answer this question.

What is safety planning?

The RCPsych's report is forthright in stating that there is more to assessment after self-harm than judging suicide risk and that management should involve a 'holistic psychosocial approach' at the core of which, at least in the short term, is making a safety plan. According to the report, such a plan comprises: individual strategies or activities to instil hope; calming or distracting activities; restriction of access to common means of suicide; and contacts for social and crisis support.³ It has to be said that some of the illustrative activities seem a bit weak for the work they have to do – looking at a photo of a great view or doing Sudoku for example – but if the plan is genuinely co-produced then its elements might be expected to make sense to the person to whom it applies.

There are a number of similar approaches to that proposed by the RCPsych, and something very similar forms a part of the risk management plan endorsed by the National Institute for Health and Care Excellence (NICE) as an essential component of the response to self-harm.⁴ On the face of it, it seems like an uncontroversial recommendation that everybody should indeed have something like a safety plan: does that initial impression hold up to closer scrutiny, especially in relation to the dilemma under discussion here?

How effective is safety planning after self-harm?

The first thing to say is that, given how roundly they are endorsed by the RCPsych, there is surprisingly little evidence to support the use of safety plans as a means of reducing repetition of self-harm. In fact, CR229 cites only one supportive study,⁵ a retrospective case-note review of 48 cases from the USA. Elsewhere, a small randomised controlled trial ($n = 97$) of active-duty US Army soldiers⁶ reported, in a comparison of a crisis response plan versus a 'contract for safety', an effect on self-reported attempted suicide at 6 months (3/64 v. 5/33 participants). A recent review of suicide prevention interventions⁷ reported a positive effect on subsequent self-harm rates but the positive outcome for that part of the review is accounted for by only two studies: one⁸ is a study of men in active military service which used multiple outcomes and reported a reduction in self-reported attempted suicide but not in emergency department attendances for self-harm. The other⁹ is a non-randomised comparison of Veterans Affairs hospitals; 90% of participants were men with 'suicide-related concerns' and the primary outcome (a composite measure of 'suicidal behaviour') was found in 3–5% at 6 months. The results of these studies are not only unconvincing but they are not generalisable to the UK self-harm population.

Of closer relevance to the position of UK clinicians seeing people after an episode of self-harm is the non-randomised Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE) study,¹⁰ which reported self-reported suicide attempts but not all self-harm episodes, citing a 12-month difference of 20.9% (treatment as usual) v. 18.3% (intervention) – a result that is by no means definitive given the study design. The only UK randomised controlled trial of a comparable intervention¹¹ – called a volitional help sheet, with many of the features of a suicide prevention plan – found no difference in 6-month self-harm repetition rates between usual care and the new intervention.

Could safety planning have detrimental effects?

Does the lack of evidence of effectiveness matter? Isn't such a common-sense action worth implementing regardless of limited evidence of its effectiveness? The reason to be cautious is that there are non-trivial possibilities of unwanted outcomes from a misapplication of the approach – misapplication, that is, in the way the plan is introduced, how it is negotiated and what are its specific components. If adverse consequences are to be avoided then they need to be considered by the service during the planning and delivery of suicide prevention plans after self-harm.

One possible problem arises from the degree to which the implementation of the suicide prevention plan is left to the person who has self-harmed. The first four of the six suggestions under the heading 'sources of support' in the RCPsych report relate to marshalling social or informal supports,³ yet we know that people who self-harm find it difficult to confide in others^{12,13} and may be struggling with mood disorder and difficulties with problem-solving – problems that can exacerbate difficulties in calling on the assistance of others. The social network can be a positive resource or, on the other hand, a source of the adversity underlying self-harm, and it is not easy to get a clear picture during a single brief encounter: the result is that it can be neglected or misunderstood, especially during an assessment oriented towards the identification of individual pathology. Personal accounts, especially given by those with a history of repeated self-harm, indicate that conversations with staff can emphasise strongly this assumption of individual responsibility, for example by referring pointedly to the person's mental capacity.

The second substantial problem arises from the organisational context within which planning usually takes place. In truth, service provision for many people after self-harm is poor. Typically, self-harm, despite its associated suicide risk, is not seen as falling within the remit of community mental health teams or Improving Access to Psychological Therapies (IAPT) services and yet there are very few specialist clinics. Again, from accounts of people with personal experience, this general lack of provision is exacerbated by the prevalence of the unhelpful concept of non-suicidal self-injury¹⁴ – a diagnosis that suggests (misleadingly) that the individual is at low risk of suicide and that can therefore make accessing services difficult because the problem is not seen as sufficiently severe.

The worst case, then, is that a clumsily negotiated or unilaterally developed safety plan, coupled with inaccessible professional aftercare, leads to a sense of being left alone in managing the impulse to self-harm and its attendant dangers. We do not know the frequency with which these negative outcomes occur, because the relevant research has not been undertaken.

Can we mitigate the potential harms of poorly managed safety planning?

One of the recurring complaints about self-harm services is that risk assessment is so often delivered as a thoughtless box-ticking exercise. To avoid safety planning going the same way it has to be delivered as a genuinely collaborative effort. A pre-printed form with little space for personalisation will not convey the right message or serve the purpose. Staff who are going to be undertaking safety planning should therefore be trained in techniques for joint planning – which may be drawn from those with expertise in techniques such as shared decision-making.¹⁵

Quality improvement projects should be aimed not just at monitoring comprehensiveness of coverage; they could usefully explore the experience of safety planning from the perspective of people who have attended hospital after self-harm – including their level of personal involvement in the content and their sense of the usefulness of the plans. A starter might be the measure developed by NICE.¹⁶

Making safety planning meaningful depends on the accuracy and usefulness of nominated sources of support, and yet informal sources can be difficult to identify and engage in a single session after an episode of self-harm, while professional sources (such as specialist services) are not available in most places, even at the level of telephone follow-up. If we are to be serious about making self-harm 'a key area for action' then we must press for proper professional services for those seen after self-harm – to allow immediate follow-up for help responding to current circumstances and in the longer-term to offer therapeutic support for change. It is these services that will allow resolution of the dilemma of care – making risk reduction meaningful without allowing risk management to define the healthcare response to self-harm.

Research is needed to determine the effectiveness and safety of safety planning, as an adjunct or alternative to standard assessments and follow-up planning. Research in other areas has usefully shown that an important moderator of out-

comes is the degree to which there is genuine collaborative engagement of patients with planning,¹⁷ and such process evaluation would be an important component of any future evaluation.

Allan House is Emeritus Professor of Liaison Psychiatry in the Leeds Institute of Health Sciences, School of Medicine, University of Leeds, UK. His research interests include the overlap between physical and mental disorder, medically unexplained symptoms, suicide and self-harm.

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Declaration of interest

None.

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1.1.20 Effects of decision aids for depression treatment in adults: systematic review

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Abstract

Aim and Method

To determine the effect on decisional-related and clinical outcomes of decision aids for depression treatment in adults in randomised clinical trials. In January 2019, a systematic search was conducted in five databases. Study selection and data extraction were performed in duplicate. Meta-analyses were performed, and standardised and weighted mean differences were calculated, with corresponding 95% confidence intervals. The certainty of the evidence was evaluated with GRADE methodology.

Results

Six randomised clinical trials were included. The pooled estimates showed that decision aids for depression treatment had a beneficial effect on patients' decisional conflict, patient knowledge and information exchange between patient and health professional. However, no statistically significant effect was found for doctor facilitation, treatment adherence or depressive symptoms. The certainty of the evidence was very low for all outcomes.

Clinical implications

Using decision aids to choose treatment in patients with depression may have a beneficial effect on decisional-related outcomes, but it may not translate into an improvement in clinical outcomes.

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Depression and decision-making

Depression is the most frequent psychiatric disorder and the third most frequent cause of disability-adjusted life-years.^{1,2} The majority of patients with depression are eligible to receive treatment, which includes different psychological and pharmacological interventions^{3,4} that seem to have similar efficacy.^{5,6} However, patients with depression frequently have low access⁷ and adherence to depression treatment.⁸

Patients with depression want to receive more information about their disorder, and participate in their health-related decisions.^{9,10} In this sense, shared decision-making is an approach for patient-centred care that seeks to actively involve patients in the decision-making process of choosing between two or more medically acceptable and evidence-based treatment options.¹¹ It is hypothesised that active patient involvement empowers the patient and could improve treatment adherence and satisfaction rates, which may result in better treatment effectiveness.^{12–14}

Decision aids in depression

Decision aids are the main tools used to facilitate shared decision-making and support patients in making informed choices.¹⁵ These materials are developed in different formats (paper, video, web-based tools, etc.), and describe the condition and the benefits and harms of each treatment option, and encourage patients to identify which outcomes are the most important for them when making a choice.^{16,17} Usually, these interventions have to be adapted according to specific population needs, considering the context of their application.¹⁸ The decision aids mainly seek to improve patient knowledge, decisional conflict and patient–clinician communication.¹⁹ Additionally, they have also been studied to explore their clinical effects, such as treatment adherence²⁰ or reduction of symptoms.²¹

Although the use of decision aids may cause benefits such as higher treatment adherence and, therefore, higher clinical improvement, it may also cause harm, such as an increased level of patient stress.²² In addition, people with major depressive disorder could have abnormal decision-making behaviour in a social interaction context because of an altered sensitivity for reward and punishment, reduce experiences of regret and poor decision performance.²³ This situation could also affect the use of decision aids in patients with depression.

Regarding decision aids for depression treatment, there is still concern about the benefit–harm balance, although some studies have assessed their effects. Therefore, this systematic review aimed to search for randomised clinical trials (RCTs) to assess the effects of decision aids on the shared decision process and clinical outcomes in adults with depression.

Method

The protocol for this systematic review has been registered with the International Prospective Register of Systematic Reviews (PROSPERO; identifier CRD42019121878). This study was approved by the Institutional Review Board of the Human Medicine Faculty of Ricardo Palma University (CE-8-2019).

Literature search and study selection

For this systematic review, we included all RCTs that included adults with any type of depression. These RCTs must have compared a group that received a decision aid that aimed to help patients decide about their treatment for any kind of depression treatment (as a stand-alone intervention, or as the main element within a complex intervention) with a group that did not, and directly assessed any beneficial or adverse effects in adults with depression. We excluded RCTs that had as population only pregnant women because they have different risks that should be considered when deciding whether to use antidepressants.²⁴ Also, we excluded conference papers. There were no restrictions on language or publication date.

Decision aids were defined as tools or technologies used to help patients make informed decisions by offering information about treatment options, and help them to construct, clarify and communicate their values and preferences.²⁵ However, sometimes it is difficult to differentiate from other information-based interventions.²⁶ To define if the proposed intervention was a decision aid, we used the six-item qualifying criteria for decision aids developed by the

International Patient Decision Aid Standards Collaboration, as it provides the definition standards for decision aids: (a) describes the health condition or problem for which the index decision is required, (b) states the decision that needs to be considered, (c) describes the options available for the index decision, (d) describes the positive features of each option, (e) describes the negative features of each option and (f) describes what it is like to experience the consequences of the options.²⁷

The decision aid assessed by the RCTs needed to meet all six criteria to be included in our systematic review.

A literature search was performed in two steps: a systematic review of five databases, and a review of all documents cited by any of the studies included in the first step. For the first step, we performed a literature search in five databases: Medline, EMBASE, Scopus, Web of Science and ClinicalTrials.gov. We used terms related to decision support, decision aid, decision-making, depression and clinical trials. The complete search strategies for each database are available in Supplementary File 1 available at <https://doi.org/10.1192/bjb.2020.130>. The last update of this database search was performed on 5 January 2019. Duplicated records were removed with EndNote version X8 for Windows (Clarivate Analytics, Thomson Reuters, New York; see <https://endnote.com/>). After that, titles and abstracts were independently screened by two pairs of independent reviewers (C.A.A.-R. with M.E.D.-B., and N.B.-C. with C.J.T.-H.) to identify potentially relevant articles for inclusion. This was performed with the online software Rayyan version 01 for Windows (Qatar Computing Research Institute, Qatar Foundation, Qatar; see <https://rayyan.qcri.org>).²⁸ Disagreements were resolved through a discussion with a third reviewer (J.H.Z.-T.). Then, the full text of potentially relevant articles were assessed to evaluate their eligibility. This process was also independently performed by two researchers. The complete list of excluded articles at this full-text stage is available in Supplementary File 2.

For the second step, two independent reviewers (M.E.D.-B. and N.B.-C.) assessed all documents listed in the references section of the studies selected in the first step, and collected all articles that fulfilled the inclusion and exclusion criteria.

Data extraction

Two independent researchers (C.A.A.-R. and M.E.D.-B.) extracted the following information from each of the included studies into a sheet of Microsoft Excel version 2018 for Windows: author, year of publication, title, population (inclusion and exclusion criteria), setting, intervention (name, type, the methodology of application and length of use), comparator (name, type, the methodology of application and length of use), time of follow-up and effects of decision aid in all included outcomes.

Intervention information was collected with the Template for Intervention Description and Replication (TIDieR) checklist.²⁹ The checklist originally was designed for pharmacological interventions; thus, we included only the following items, adapted for more complex interventions: name of intervention, rationale, location of delivery, materials, procedures, who provided, modes of delivery (grouped or individual), frequency (sessions) and possible options to choose within the decision aid. In case of disagreement, the full-text article was reviewed again by the researchers, to reach a consensus.

Study quality and certainty of the evidence

Two independent researchers (C.A.A.-R. and N.B.-C.) used the Cochrane Risk of Bias Tool for RCTs to assess systematic errors (or bias) in the design, conduct, analysis and reporting of the RCT that could potentially underestimate or overestimate the results.³⁰ We followed the instructions stated in the Cochrane Handbook for Systematic Reviews of Interventions and evaluated selection bias, performance bias, detection bias, attrition bias and reporting bias to assess each of the six domains of the tool as low, high or unclear risk of bias, by each RCT included in the systematic review.³¹

To assess the certainty of the evidence, we used the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology,³² which classifies it in a very low, low, moderate or high certainty of the evidence each outcome in the systematic review. This classification is based on the following criteria: risk of bias (evaluated through the Cochrane Risk of Bias Tool), inconsistency (heterogeneity between the RCT results and in terms of population, intervention, comparator and outcome; additionally assessed by the I^2 test), indirectness (how different are the included RCTs to the question of interest) and imprecision (width of the confidence interval). The certainty of the evidence

was assessed for all meta-analysed outcomes and non-meta-analysed outcomes that were important for decision-making. Additionally, when two or more RCTs assessed the same outcome, but a meta-analysis was not performed, we summarised the individual data of each RCT narratively, and then assessed the certainty of the evidence following the recommendations proposed by Murad et al.³³

Statistical analyses

We performed meta-analyses to summarise the results of the RCTs that evaluated the same outcomes. When outcomes were measured with different scales across studies, we calculated standardised mean differences (SMD) to compare and meta-analyse these studies; otherwise, we calculated weighted mean differences (WMD). For outcomes that had been measured more than once, we only considered the final measurement to perform the meta-analyses, as suggested in the Cochrane Handbook.³¹ We assessed heterogeneity with the I^2 statistic, and we considered that heterogeneity might not be significant when $I^2 < 40\%$.³¹ We considered it appropriate to use random-effects models in all the meta-analysis because of the overall heterogeneity in terms of population, intervention and comparators.³⁴ We executed a sensitivity analysis, taking into account contradictory results within studies. We did not consider to exclude studies with high risk for bias for sensitivity analysis, because all the included RCTs had at least one domain of the Cochrane Risk of Bias Tool with a high risk of bias. Also, we did not execute a subgroup analysis because of the low number of studies by each meta-analysis. Publication bias was not statistically assessed because the number of studies pooled for each meta-analysis was less than ten.³⁵ The data were processed with Stata version 15.0 for Windows.

Results

Studies characteristics

We found a total of 3309 titles. We removed 804 duplicates and screened a total of 2505 titles, of which 41 were evaluated in full text. Of these, 35 were excluded (reasons for exclusion are detailed in Supplementary File 2) and six were included.^{17,36–40} Additionally, we evaluated 255 documents cited by any of the six included studies, from which no additional study was included (*Fig. 1*). *Fig. 1* Flow diagram (study selection). RCT, randomised controlled trial.

Patient characteristics

In the included RCTs, the number of participants ranged from 147 to 1137. Regarding the study setting, three studies were performed in primary care centres,^{17,38,39} one in out-patient clinics³⁷ and two were performed remotely (one intervention was sent by mail to the participants³⁶ and one was an online intervention⁴⁰). With regards to depression diagnosis for inclusion criteria, two studies used the Patient Health Questionnaire-9,^{38,39} one study used the DSM-IV,³⁷ one study used the DSM-IV and the ICD-10,¹⁷ one used self-report criteria⁴⁰ and another did not specify the diagnosis criteria.³⁶ Also, only one study specified the severity of depression according to the inclusion criteria.³⁸ Characteristics of each included study are available in Supplementary File 3.

Interventions and comparators

Interventions were heterogeneous across studies; four studies used visual decision aid (leaflets, booklet, cards or DVD),^{36–39} and two studies used a computer-based decision aid (webpage or artificial intelligence).^{17,40} Regarding the decision aid application: in two studies, physicians applied the decision aids,^{38,39} in two studies the decision aids were self-applied,^{17,36} in one study the decision aids were applied by a pharmacist³⁷ and in one study decision aids were applied by artificial intelligence.⁴⁰ All decision aids presented possible options regarding the patient's depression treatment. Specifically, four decision aids presented options for the use of antidepressant drugs, psychotherapy/psychological treatment or watchful waiting.^{17,37,39,40} Furthermore, two decision aids presented options for start, stop, increase or switch antidepressant treatment.^{36,38} Intervention's characteristics are detailed in Supplementary File

4, using the TIDieR checklist. Regarding the control group, in five studies, participants received either usual care or no intervention, and in the remaining study, the decision aid was compared with an informative intervention.⁴⁰

Outcomes

Included RCTs assessed a wide variety of outcomes, including decision-making process outcomes, such as decisional conflict, information exchange, patient knowledge, patients involvement in decision-making, decision regret, etc. Decisional conflict is known as the degree of patient insecurity about possible consequences that occur after deciding their health,⁴¹ and information exchange assess the communication between doctor and patient about their illness and its management when there is a need to decide on patient's health.⁴² Additionally, there are also clinical outcomes (such as depressive symptoms, adverse effects, treatment adherence and health-related quality of life). All the measured outcomes and definitions, by each RCT, are presented in *Table 1*. Table 1 Outcomes evaluated in the included studies Aljumah et al, 2015³⁷ LeBlanc et al, 2015³⁸ Loh et al, 2007³⁹ Simon et al, 2012⁴⁰ Perestelo-Perez et al, 2017¹⁷ Sepucha et al, 2012³⁶ Adherence: Morisky Medication Adherence Scale (0–8 points) Adherence: Patient self-report and pharmacy records to categorise patients' adherence (Yes or no adherence) Adherence: single question: 'How steadily did you follow the treatment plan?' (1–5 points, Likert scale) Adherence: single question (0–100 standardised points) Decisional control preferences: Control Preference Scale Adverse effects: mortality Health-related quality of life: EuroQol-5D in Arabic version (0–100 points) Decisional conflict: Decisional Conflict Scale (0–100 points) Consultation time: documented in minutes by the physicians, following each consultation (minutes) Decisional conflict: Decisional Conflict Scale (0–100 points) Decisional conflict: Decisional Conflict Scale (0–100 points) Patient involvement in the decision-making process: Observing Patient Involvement in Decision-Making scale (0–100 points) ^a Knowledge: self-developed questionnaire (0–100 points) Patient involvement in the decision-making process: Man-Son-Hing-instrument (patient perspective) Knowledge: self-developed questionnaire (0–100 points) Knowledge: self-developed scale of knowledge of treatment options (0–8 points) Knowledge: self-developed questionnaire about depression and methods for managing depression symptoms (0–100% correct answers) Depressive symptoms: Montgomery–Åsberg Depression Rating Scale (0–60 points) Depressive symptoms: PHQ-9 Depressive symptoms: Brief PHQ-D Decision regret: Decision Regret Scale (0–100 points) Treatment intention: question: 'If you had to choose a treatment right now, what treatment would you choose?' Patient's beliefs about medicine: Patients' Beliefs about Medicine Questionnaire (specific and general) (5–25 point each) Patient involvement in the decision-making process: Observing Patient Involvement in Decision-Making scale (0–100 points) (Evaluator perspective) Doctor facilitation: assess for the facilitation of patient involvement, given by the physician, during the consultation, using the Perceived Involvement in Care Scale (0–100 points) Doctor facilitation: assess for the facilitation of patient involvement, given by the physician, during the consultation, using the Perceived Involvement in Care Scale (0–100 points) Satisfaction of treatment: Treatment Satisfaction Questionnaire for Medication: (0–100 points) Satisfaction of decision aid: questionnaire on acceptability and satisfaction of the decision aid Satisfaction with clinical care: CSQ-8 questionnaire ^a Preparation for decision-making: Preparation for decision-making scale (0–100 points) Information exchange: assess the information exchanged between doctor and patient during the consultation, using the Perceived Involvement in Care Scale (0–100 points) Information exchange: assess the information exchanged between doctor and patient during the consultation, using the Perceived Involvement in Care Scale (0–100 points)¹²

¹ EuroQol-5D, European Quality of Life-5 Dimensions; PHQ-9, Patient Health Questionnaire 9; PHQ-D, Der Gesundheitsfragebogen für Patienten (Patient Health Questionnaire in German version); CSQ-8, Client Satisfaction Questionnaire-8.

² Results not presented in the paper.

Risk of bias

Regarding the risk of bias, mostly all RCTs detailed random sequence and allocation concealment. Two RCTs presented a high risk of attrition bias because they some participants were lost to follow-up. Furthermore, three RCTs had an unclear risk of bias for selective reporting. All six RCTs failed to blind the outcome assessment, and five RCTs failed to blind personnel and participants (*Fig. 2*). *Fig. 2* Risk of bias in the selected studies.

Effects on decision-making process outcomes

When pooling the RCTs, we found that decision aids had a beneficial effect on information exchange (two RCTs; WMD 2.02; 95% CI 1.11–2.93), patient knowledge (four RCTs; SMD 0.65; 95% CI 0.14–1.15) and decisional conflict, which refers to patient insecurity about the possible consequences that occur after deciding their health (three RCTs; WMD 5.93; 95% CI 11.24 to 0.61). Additionally, we found no statistically significant effect on doctor facilitation (two RCTs; WMD 1.40; 95% CI 4.37 to 7.18).

Regarding the outcome of patient involvement in the decision-making process, two RCTs present their results for this outcome, but each of them used a different instrument and perspective of assessment. Loh et al³⁹ used the Man-Son-Hing scale (patient perspective) and found a statistical difference between study groups (mean difference 2.5; 95% CI 1.6–3.4). Alternatively, LeBlanc et al³⁸ used the Observing Patient Involvement in Decision-Making scale (evaluator perspective), and also found a statistical difference between study groups (mean difference 15.8; 95% CI 6.5–25.9).

The remaining decision-making process outcomes were assessed only by one RCT, and we did not find differences between the study groups in terms of length of consultation,³⁹ decisional control preference (between passive, active or shared)¹⁷ and decision regret.⁴⁰ However, we found a beneficial effect to be sure of the intention to choose a treatment (sure or not sure),¹⁷ in the treatment satisfaction,³⁷ in the decision aid satisfaction³⁸ and the preparation of patients for decision-making.⁴⁰

Effects on clinical outcomes

We did not find beneficial effect on treatment adherence (three RCTs; SMD 0.20; 95% CI 0.31 to 0.71), and depressive symptoms (three RCTs; SMD 0.06; 95% CI 0.22 to 0.09) (*Fig. 3*). Also, one RCT evaluated one adverse effect, mortality, and reported no adverse effects in both intervention and control arms,³⁶ and another one found no differences between study groups for health-related quality of life.³⁷ *Fig. 3*(a) Forest plot of decision aid for decisional conflict, higher is worse. (b) Forest plot of decision aid for patient knowledge, higher is better. (c) Forest plot of decision aid for depression symptoms, higher is worse. (d) Forest plot of decision aid for treatment adherence, higher is better. (e) Forest plot of decision aid for doctor facilitation, higher is better. (f) Forest plot of decision aid for information exchange, higher is better. SMD, standardized mean differences; WMD, weighted mean differences.

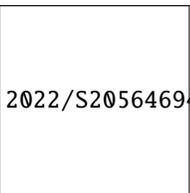
Sensitivity analysis

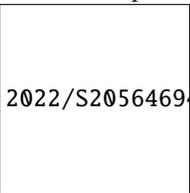
Three of the performed meta-analyses had important heterogeneity ($I^2 > 40$). Of these, only the meta-analysis performed for treatment adherence (three RCTs; SMD 0.20; 95% CI 0.31 to 0.71) included studies with contradictory results. Thus, we executed a sensitivity analysis for this outcome, excluding the RCT by Simon et al,⁴⁰ because its results contradicted the other results of the two RCTs by Loh et al and Aljumah et al.^{37,39} The global effect of this sensitivity analysis, with only two RCTs, was an SMD of 0.50 (95% CI 0.29–0.70).

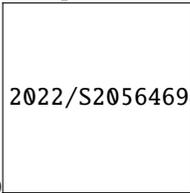
Certainty of evidence

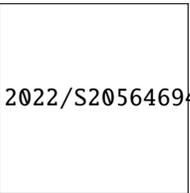
We created a Summary of Findings table, using the GRADE methodology to assess the certainty of evidence. For this, we included those outcomes that were considered important for the patient and/or their practitioner. We found that the evidence for all these outcomes was of very low certainty, mainly because of high risk of bias, inconsistency and imprecision of RCTs (Table 2). Table 2 Summary of findings to evaluate the certainty of the evidence, using the GRADE methodology

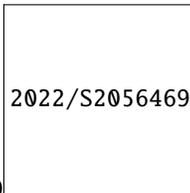
Outcomes Anticipated absolute effects (95% CI) Number of participants and studies Certainty of the evidence (GRADE) Risk with decision aids Information exchange between patient and doctor *a* 2.02 points of
 Perceived Involvement in Care Scale higher (1.11 higher to 2.93 higher) 239 (2 RCTs)  2022/S2056469420001308_inline1.jpg

Very low *bcd* Patient knowledge *a* 0.65 s.d. higher (0.14 higher to 1.15 higher) 982 (4 RCTs)  2022/S2056469420001308_inline2.jpg

Very low *bcef* Doctor facilitation of patient involvement during the consultation *a* 1.40 points of Perceived
 Involvement in Care Scale higher (4.37 lower to 7.18 higher) 239 (2 RCTs)  2022/S2056469420001308_inline3.jpg

Very low *bcd* Patient involvement in the decision-making process, using two scales with different perspectives (patient and evaluator) Both studies showed statistical improvement of patient involvement in the decision-making
 process from both patient and physician perspective 290 (2 RCTs)  2022/S2056469420001308_inline4.jpg

Very low *bcd* Decisional conflict *a* 5.93 points of Decisional Conflict Score lower (11.24 lower to 0.61 lower) 558 (3
 RCTs)  2022/S2056469420001308_inline5.jpg

Very low *bce* Consultation time *a* 2.5 minutes higher (0.9 lower to 5.9 higher) 194 (1 RCT)  2022/S2056469420001308_inline6.jpg

Very low *bcd* Adherence to treatment 0.20 s.d. higher (0.31 lower to 0.71 higher) 459 (3 RCTs)

2022/S2056469420001308_inline7

Very low *bcef* Depression symptoms 0.06 s.d. lower (0.22 lower to 0.09 higher) 667 (3 RCTs)

2022/S2056469420001308_inline

Very low *bcd* Health-related quality of life 0.02 points in EuroQol-5D higher (0.8 lower to 0.12 higher) 220 (1 RCT)

Very low *bcd*³⁴⁵⁶⁷⁸⁹¹⁰

Discussion

We included six RCTs that evaluated the effects of decision aid in adults with depression. These studies were heterogeneous, had small sample sizes and presented with a high risk of bias. When pooling the RCTs, we found benefits in some outcomes such as decisional conflict, patient knowledge and information exchange, but not in clinical outcomes such as depression symptoms or treatment adherence. All of the outcomes included in the Summary of Findings table had very low certainty of evidence.

The interventions used in the six included RCTs fulfilled all the qualifying items from the International Patient Decision Aid Standards Collaboration criteria.²⁷ However, there was heterogeneity regarding the type of decision aids used (including leaflets, booklets, cards, DVD, a webpage or artificial intelligence), treatment options in the decision aids and by whom they were administered (physicians, pharmacists, researchers or the patient themselves). This heterogeneity is expected because the use of the decision aids largely depends on context, and has to be adapted according to population needs.¹⁸ However, the fact that there were not even two studies that used the same decision aid affects the capability of synthesis and interpretation of the pooled results.⁴³

Regarding the quality of the included RCTs, participants were not blinded because of the intervention's intrinsic nature. This represents an important source of bias as the perception of subjective outcomes could have been influenced.⁴⁴ Additionally, most RCTs used a no-intervention group as the control without placebo. However, using an information-based intervention about treatment options for depression without a decision-making process as a control group in the RCTs would have helped to prevent the complex intervention effects, and ensure that the effects of the decision aid are not explained only by higher attention from a health professional.⁴⁵

Regarding the effects of decision aid, our pooled estimates suggest no effect in clinical outcomes, as described by a previous review that assessed decision aid in patients with mood disorders and found no effect with depressive symptoms,⁴⁶ and by another systematic review that assessed decision aid for screening tests and found no effect in treatment adherence.⁴⁷ These results could be explained by a linear and logical sequence that we propose. First, the decision aid gives the information to the patient about depression and its treatment options, which explains the 'knowledge' improvement. Then, the patients are more capable of discussing the disease and their treatment options with

³ EuroQol-5D, European Quality of Life-5 Dimensions; GRADE, Grading of Recommendations Assessment, Development and Evaluation; RCT, randomised controlled trial; s.d., standard deviations.

⁴ Higher points are better.

⁵ Blinding of allocation, personnel and/or outcome assessment was not detailed in the publication. Incomplete data are reported.

⁶ Sample sizes were small (<400).

⁷ Selective reporting was not evaluated as the protocol was not available.

⁸ $I^2 > 40\%$.

⁹ 95% confidence intervals include 0.5 value.

¹⁰ Higher points are worse.

the health professional, which explains the ‘information exchange’ improvement. Later, the patient feels capable of making a choice, which explains the decrease in ‘decisional conflict’. After making a choice, the patients receive their treatment and feel satisfied with their decision, which improves the ‘sure of the intention to choose a treatment’, the ‘treatment satisfaction’ and the ‘decision aid satisfaction’. Lastly, it would be expected that all of these achievements are translated into clinical outcomes: a higher treatment adherence and subsequent reduction of depressive symptoms.

However, regarding this last point, other factors could influence clinical outcomes. Adherence could be affected by accessibility to the treatment, the way the patients perceive the effectiveness of the treatment, severity of the disease, etc.⁴⁸ Additionally, depressive symptoms could be affected by the treatment adherence itself, the adequacy of the chosen treatment for the clinical characteristics of the patient and other psychosocial factors.⁴⁹ In addition, some methodological issues could explain the results. None of the studies included in the meta-analysis of depressive symptoms, and only one of the three studies included in the meta-analysis of treatment adherence were designed to assess those outcomes, so there could have been a lack of power to find a difference between study groups.

The pooled analysis found no effect of decision aids on treatment adherence (SMD 0.31 to 0.71). This meta-analysis included three RCTs.^{37,39,40} One of them⁴⁰ contradicted the results of the other two, in addition to having the smallest sample size and the highest risk of bias (as a result of attrition bias and small sample size). Thus, a sensitivity analysis removing that RCT found a beneficial effect of decision aids for treatment adherence (SMD 0.50; 95% CI 0.29–0.70). Thus, we cannot exclude a possible positive effect of decision aids on treatment adherence, which has to be assessed in future studies.

On the other hand, we did find beneficial effects in decision-making process outcomes, such as decisional conflict, information exchange and patient knowledge, similar to a previous review.⁴⁶ These three outcomes are expected for a decision aid designed to facilitate the shared decision-making process. Five^{17,36–38,40} out of six RCTs assessed decision aids developed to enhance patients’ involvement in the decision-making process, support their choices, empower them and improve their knowledge about their therapeutic options. Consequently, the decision aid’s main objective may determine the outcomes (decision process or clinical outcomes) it will affect. Future studies assessing decision aid clinical outcomes must assess a decision aid specially designed to improve clinical outcomes, such as treatment adherence, depressive symptoms and quality of life.

Altogether, our results suggest that the use of a decision aid in patients with depression may have an effect on knowledge, information and decision-related outcomes. However, its effect on adherence is doubtful, and there seems to be no effect on depressive symptoms. Although we found a very low certainty of the evidence, stakeholders are needed to decide in this regard. Healthcare institutions must consider the costs, acceptability and applicability of this intervention in their context. Additionally, healthcare professionals must consider the balance between desirable and undesirable consequences of the decision aid’s application, and acknowledge the patient information and involvement as decisive components for the shared decision-making process,^{50,51} to make a decision applicable to each particular patient.

Limitations and strengths

Our study included a small number of heterogeneous studies. However, we decided to conduct a meta-analysis to test the hypothesis about the overall effect of decision aid in patients with depression, for a better decision-making process.⁴³ The certainty of the evidence was very low for all the prioritised outcomes, which demonstrates the need for more well-designed and adequately reported RCTs with higher sample sizes.

On the other hand, this systematic review has important strengths: it followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement and was inscribed in the PROSPERO database. Also, we performed a comprehensive search strategy across multiple databases, without language restriction, and across articles that cited each of the found studies, which allowed us to find all studies reported in previous systematic reviews^{46,47} and other studies that were not found in these reviews. Lastly, we evaluated the certainty of evidence with the GRADE methodology.

In conclusion, we found six RCTs that evaluated the effects of decision aid in adults with depression. Evidence of very low certainty suggests that decision aids may have benefits in decisional conflict, patient knowledge and information exchange, but not in clinical outcomes (treatment adherence and depression symptoms). More RCTs are needed to adequately assess the effects of decision aids in patients with depression.

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Supplementary material

For supplementary material accompanying this paper visit <http://doi.org/10.1192/bjb.2020.130>.

[click here to view supplementary material](#)

Data availability

The data that support the findings of this study are available from the corresponding author, C.A.A.-R., upon reasonable request.

C.A.A.-R. and J.H.Z.-T. formulated the research question. C.A.A.-R., J.H.Z.-T. and A.T.-R. designed the study. C.A.A.-R. and J.P.-M. developed the research strategy. C.A.A.-R., J.H.Z.-T., M.E.D.-B., N.B.-C. and C.J.T.-H. did the screening and data extraction. C.A.A.-R. and A.T.-P. did the statistical analysis. C.A.A.-R., J.H.Z.-T., A.T.-R. and J.A.D.-V. interpreted the data for the work. C.A.A.-R. drafted the first manuscript. All authors critically reviewed and approved the final manuscript.

Declaration of interest

None.

ICMJE forms are in the supplementary material, available online at <https://doi.org/10.1192/bjb.2020.130>.

1.1.21 Author's reply

Lucy Johnstone

date

2022-02

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- *Author's reply*
 - *Declaration of interest*

pmc I do indeed agree with the statements in Professor House's final paragraph and with several of his other points, for example, that there are many vested interests in the debate about public mental health, and that we can see the term 'mental health' itself as both effect and cause of the individualisation of societal problems. Indeed, it is that individualisation – not, as he seems to assume, the psychiatric profession itself – that my critique is aimed at. I have always argued that all professions, including my own, need to be aware of the limitations and potential harms of their

theories and practices. That is why I raised concerns not just about over prescribing, but about ‘formal psychological interventions [which may be] unnecessary for most and can actually be harmful if implemented too early.’

I find Professor House’s final phrase ‘...a muddled polemic animated as much as anything else by anti-psychiatry sentiment’ the most worrying part of his response. This kind of language suggests that he has moved beyond rational and evidence-based argument, into *ad hominem* dismissal. It invites a fight rather than a debate, and since I do not identify as ‘anti-psychiatry’ (whatever that means) I have no desire to take up such a challenge. I will simply observe that the areas in which I take a different position from him are fundamental, legitimate and increasingly common. For example, clinical psychologists’ professional guidelines on formulation state that it is ‘not premised on a functional psychiatric diagnosis’.¹ Professor House is free to use the term differently but not to simply rule other definitions out of court. Yes, we need to offer immediate help to individuals as well as addressing adversities, but that help does not have to be based on unproven medical assumptions about the nature and origins of their distress. Yes, there are social causal factors and unclear boundaries in some physical health conditions, but no one is arguing that diabetes is a mental health problem; common sense tells us that this analogy doesn’t work, despite the claims of anti-stigma campaigns and some professionals. And so on.

In 2017, a United Nations report noted ‘The urgent need to... target social determinants and abandon the predominant medical model that seeks to cure individuals by targeting “disorders” and recommended that ‘Mental health policies should address the “power imbalance” rather than “chemical imbalance”’.² Rather than allowing ourselves to be distracted by attempts to defend a failed paradigm, we all urgently need to work towards this future.

Declaration of interest

L.J. is an independent trainer and offers training in formulation and the Power Threat Meaning Framework (PTMF). She has published books and articles on formulation and is one of the lead authors of the PTMF.

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1.1.22 Undergraduate psychiatric education: current situation and way forward

Gaia Sampogna Hussien Elkholy Franziska Baessler Bulent Coskun Mariana Pinto da Costa Rodrigo Ramalho Florian Riese Andrea Fiorillo¹

date

2022-05

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The original version of this article was published with an error in an author’s affiliation. A notice detailing this has been published and the error rectified in the online PDF and HTML copies.

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Abstract

Undergraduate psychiatric education is essential for the training of medical students and for their recruitment into psychiatry. A significant shortage of graduates choosing a career in psychiatry has been recently documented, and this trend might have many causes. When medical students have positive experiences of teaching, elective placements and exposure to psychiatric patients, their attitudes towards psychiatry are significantly better. Therefore, there is a need to improve the quality of undergraduate training courses in psychiatry. Innovative teaching strategies are suggested, including the use of movies, virtual reality, simulated patients and multiprofessional training wards.

Contents

- *Undergraduate psychiatric education: current situation and way forward*
 - *Characteristics of undergraduate training in psychiatry*
 - *Unmet needs and the way forward for undergraduate training in psychiatry*
 - *Conclusions*
 - *Data availability*
 - *Declaration of interest*

pmc Undergraduate education in mental health is an essential part of the training of medical students. Given the high prevalence of mental health problems in the general population, all practitioners should have the basic skills to identify and manage mental disorders.¹ According to the World Psychiatric Association (WPA), undergraduate psychiatric education aims to improve the quality of mental health education and, consequently, the quality of care provided to people with mental disorders.

Furthermore, high-quality undergraduate education in psychiatry is crucial for the future recruitment of medical students into psychiatry as a specialty. In the past 10–15 years the percentage of graduates choosing a career in psychiatry has been significantly reduced.² Possible explanations for this negative trend include the low quality of teaching, stigma towards people with mental disorders and negative attitudes of medical doctors towards psychiatry.³ In particular, it could be that some aspects of the psychiatric discipline, such as the use of compulsory treatment and the presence of negative stereotypes attached to psychiatrists, may have an adverse effect on both recruitment and retention of medical students in psychiatry.^{3–5} In some European countries, students may consider a placement in psychiatry as ‘low priority’.⁶

However, students’ attitudes towards the discipline change if they have positive teaching experiences, elective placements and direct contact with patients with mental disorders. Several strategies have been proposed for improving the attitudes of medical students towards psychiatry. These include direct contact with patients (particularly those who get better after treatment), an emphasis on the evidence-based treatments and approaches used in psychiatry, and a close relationship with consultants and senior trainees during their education. Therefore, to overcome stigma and the negative image of the discipline, in 2009, the Royal College of Psychiatrists in the UK suggested organising periodic meetings between medical students and licensed psychiatrists throughout medical school and the development of an *ad hoc* mentoring programme.⁷

Furthermore, receiving an adequate undergraduate psychiatric education may be useful not only for students interested in psychiatry, but it could also help those who want to pursue a different medical career. In particular, undergraduate psychiatric education may teach them the communication skills, and explain concepts and thought processes necessary to understand patients and their disorders from biological, psychological and sociocultural viewpoints.

Improving the quality of undergraduate education can support the process of de-stigmatisation of psychiatry, since medical students can develop correct and unbiased opinions regarding the discipline, which in turn can play a significant role in ameliorating the healthcare services provided to patients with mental health problems (or related physical complaints) in other medical settings.

Taking a worldwide perspective, this paper aims to: (a) describe the characteristics of undergraduate training in psychi-

atry; (b) discuss the most relevant unmet needs of undergraduate training in psychiatry in medical schools; (c) outline some innovative strategies to improve undergraduate psychiatric education.

Characteristics of undergraduate training in psychiatry

Undergraduate psychiatric training greatly varies across different countries and university sites. Some medical schools include psychiatry programmes as optional, and others have only 2 weeks of mandatory formal training in psychiatry.⁸ A recent survey promoted by the International Federation of Medical Students' Associations (IFMSA) in collaboration with the WPA noted that psychiatry education is mandatory in 81 out of the 83 surveyed countries, and is an elective course only in two countries (Ethiopia and Nigeria).⁹ Furthermore, the duration of classes on theory significantly varies across countries (e.g. from just 1 day to more than 30 days); Nigeria and Burkina Faso do not have any practical classes at all. Even in Western countries, some medical schools offer only 4 weeks of training in psychiatry.⁹ Undergraduate psychiatric training in the USA is longer than it is in Asian and Pacific regions. Methods for evaluating students' knowledge and competencies also vary among countries, although the most common way of assessing it is multiple choice questions. The format of teaching does not significantly vary, with most medical schools offering a combination of lectures, bedside teaching and computer-based learning.⁸ Overall, the survey conducted by IFMSA shows that undergraduate psychiatric education is not given enough prominence in undergraduate medical curricula.

Unmet needs and the way forward for undergraduate training in psychiatry

A number of unmet needs in undergraduate psychiatric education have recently been highlighted in the literature. In particular, the limited availability of tutors, highly trained faculty members and clinicians at several sites is adversely affecting the quality of provided and perceived undergraduate training.¹⁰

Second, in some contexts, limited resources are a significant obstacle to good-quality training, especially in relation to access to adequate facilities and evidence-based educational materials.

Many traditional educational methods are not easily applied in undergraduate psychiatric education (e.g. some patients may be reluctant to disclose their mental problems to students because of delusional thoughts; others may feel that the presence of a third person breaks the therapeutic alliance with their psychotherapist). Furthermore, in many sites, students have limited access to psychiatric patients at the bedside, and thus gain little practical knowledge of many psychiatric disorders.¹¹

Therefore, novel methods to teach psychiatry should be put in place and trialled. It is beyond the scope of this paper to systematically review all the innovative teaching models used in psychiatry, so we have selected some of the most promising approaches to outline here.

Simulation techniques offer one innovative solution. Techniques such as student role-play and simulated patients have been found to improve the communication skills and empathy of undergraduate medical students and seem to be very well accepted.¹² These techniques are used to teach history taking and formulating a management plan and can depict challenging clinical situations (e.g. acutely agitated patients) or rare syndromes, which would otherwise be neglected during training.¹³

Another innovative solution is the use of movies as an educational tool. Watching movies and videos with students may allow them to discuss misconceptions about mental disorders in a relaxed setting (i.e. not in the patient's presence) and whether the clinical descriptions are accurate or not. Using videos to teach particular topics to medical students has been shown to result in improved recall of those situations.¹⁴

The Psychiatry Early Experience Programme (PEEP) was proposed in 2015 in the UK. Medical students are paired with specialists in psychiatry, to shadow them while on-call and for one regular day shift during each of their jobs.¹⁵ By joining the programme, students are exposed to a wide range of mental health problems and develop insight into psychiatric trainees' work. The students can also attend lectures given by psychiatric experts and clinical sessions with patients. The programme looks very promising, as confirmed by the fact that many students who joined it developed more positive attitudes towards psychiatry and seemed less reluctant to choose psychiatry as a speciality.¹⁵

In 2019, the American Psychiatric Association launched the Psychiatry Student Interest Group Network (PsychSIGN), a networking initiative that includes students interested in psychiatry. It provides resources and mentoring opportunities for students to help them to deepen their interest in the field.^{9,16}

Interprofessional training wards offer another innovative teaching opportunity. These enable students and trainees from different health professions to work in collaboration to manage the medical treatment and rehabilitation of real-life patients, taking a multidisciplinary perspective.

Finally, another aspect to be improved is related to providing feedback to medical students at the end of their rotation in psychiatry. A recent study carried out in Sweden using a structured feedback tool found that medical students were more satisfied at the end of the rotation period if they had received structured feedback on their internship.¹⁷

Conclusions

Undergraduate training in psychiatry is essential for psychiatric education and practice. Providing good-quality undergraduate training increases students' interest in mental health, reduces stigma towards people with mental illness and increases students' confidence in working with people with mental health problems.^{1-3,18}

Initiatives aiming at improving psychiatric education during the early years of medical school have been well received and have been found to be effective in changing the attitudes of medical students towards the discipline. Novel techniques using virtual reality, movies and simulation can help increasing the psychiatric knowledge and practical skills of undergraduate medical students, without affecting patient confidentiality and the therapeutic alliance.

This work has been conceived within the activities of the WPA Section on Education in Psychiatry, whose members are acknowledged for their ongoing commitment and support in improving the quality of undergraduate education in psychiatry.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

G.S., H.E. and A.F. wrote the first draft of the paper. All authors revised the paper and approved the final version.

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Declaration of interest

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1.1.23 Malik Hussain Mubbashar, MB BS, FRCP (London), FRCP (Edinburgh), MRCP (Glasgow), FCPS (Pakistan), FRCPSych

David P. Goldberg Fareed A. Minhas

date

2021-06

Contents

- *Malik Hussain Mubbashar, MB BS, FRCP (London), FRCP (Edinburgh), MRCP (Glasgow), FCPS (Pakistan), FRCPSych*

pmc Formerly Professor and Head of the Institute of Psychiatry, Rawalpindi, Principal, Rawalpindi Medical College and Vice-Chancellor, University of Health Sciences, Lahore, Pakistan

Malik Hussain Mubbashar, the leader of psychiatry in Pakistan for a generation and a pioneer in the development of community mental health services and psychiatric research, died on 10 August 2020, at the age of 75 years. His work in the establishment of community mental health services served as a model for such services in low-income countries throughout the world. Initially, local men were recruited and trained to provide services to those identified in need. This was soon followed by school programmes, which enlisted head teachers, persuading them to include information about mental disorders in their curricula. Professor Mubashar was remarkably innovative in his approach, for example, recruiting children to identify people in their village who might benefit from seeing a doctor and arranging travel for them. His research activities were always both scientifically rigorous and highly relevant to the needs of people with mental health problems in areas where specialist services were thin on the ground or non-existent. He carried out a community survey of stress and psychiatric disorder in rural Punjab, a prevalence study of psychiatric morbidity among the attendees of a native healer in Rawalpindi, as well as a unique randomised trial of the impact of a school mental health programme in rural Rawalpindi, Pakistan. He had a highly productive publication record, authoring or co-authoring many peer-reviewed papers as well as 28 books.

He was highly effective as a teacher. At the Rawalpindi Medical College (RMC), where he was Principal for some years, he reorganised undergraduate education, introducing problem-based learning. As Vice-Chancellor of the University of Health Sciences, Lahore, he made the study of behavioural sciences mandatory in undergraduate medical education. He was responsible for the postgraduate psychiatric training of large numbers of junior doctors, for many of whom he arranged further training in the UK, especially with Professor David Goldberg in the Department of Psychiatry at the University of Manchester, with whom he developed a special link. When they achieved consultant status, many of his former trainees would put up a photograph of Professor Mubashar in a prominent position in their departments. He was also active in obtaining legal rights for people with mental illness in Pakistan. After years of incessant effort, he was instrumental in the passage of the Mental Health Ordinance 2001. His interest in promoting public policy in favour of the mentally ill more generally motivated him to make links with whoever was President of Pakistan at the time.

His influence in psychiatry extended well beyond national boundaries. His Institute of Psychiatry in Rawalpindi was recognised as a World Health Organization (WHO) Collaborating Centre for Mental Health Research and Training, of which he was the Director. Among many other international positions, he was chair of the Global Mental Health Network, Global Forum for Health Research at WHO, Geneva. The WHO Community Mental Health Programme was his brainchild, and he had a particularly influential link with the development of such programmes in the WHO Eastern Mediterranean region.

Malik Hussain Mubbashar was born in Lahore on 1 August 1945, the son of Miraj-ud-din Malik and Shahzadi Anwar. His father was a government employee in the irrigation department. After completing his medical training at King Edward Medical College, Lahore, in 1968 with honours, he underwent further medical and then psychiatric training in London at Guy's Hospital with David Stafford-Clark. While in England he passed the membership examinations of three UK medical colleges. He was strongly motivated by having seen in childhood the ill-treatment of the mentally ill.

On return to Pakistan in 1972, he was appointed to the Central Government Hospital, Rawalpindi. However, to his disappointment, the administration of the hospital made it abundantly clear that he was not welcome as a psychiatrist and refused him any clinic space to see psychiatric patients. Manifesting his inevitable grit, as he did throughout his career, he set up his table and chair under the shade of a tree in a neglected, remote corner of the hospital. Within 8 years, his department had grown into an Institute and then into a WHO Collaborating Centre.

His administrative talents and leadership qualities were rapidly recognised. Professor Mubbashar was closely involved with the College of Physicians and Surgeons Pakistan (CPSP), becoming Dean of the newly formed Faculty of Psychiatry. He was elected President of the Pakistan Psychiatric Society. He served as Principal of the Rawalpindi Medical College before going on to become the Vice-Chancellor of the University of Health Sciences, Lahore.

During his lifetime he was accorded many honours. Two of the highest civilian awards of the Pakistani government, Hilal-e-Imtiaz and Sitara-e-Imtiaz, were conferred on him. The CPSP's gold medal for psychiatry, the most prestigious medal in the field, is named the Malik Hussain Mubbashar Gold Medal.

In his spare time, he enjoyed visiting rural areas and trekking.

Professor Mubasshar is survived by his wife Dr Yasmin Mubbashar, whom he married in 1973, children Sabooh, Aamna, Zainab, Saima, Fatima, Maryam and Imtiaz (five of whom are psychiatrists) and 15 grandchildren.

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pmc Ruth Paddon has written a short biography. It is devoid of self-pity and rancour; it has a simple, pellucid style that I found very moving.

She describes coming through childhood abuse, anxiety and parental illness to reach an early adulthood that appeared promising. She then developed depression and psychosis (and anorexia) and had several hospital admissions. Her initial life plans and expectations were not fulfilled but she made use of other options that became available, including moving to Italy. Adverse experiences are clear but not harrowing, there is no bitterness despite the pain, and she thanks those who have supported her. The personal descriptions are complemented by family photos which locate her and her family as ordinary human beings.

As a psychiatrist, I often reflect on how little time I spend with each patient: maybe 15 minutes a week for an in-patient and 30 minutes every 3 months for an out-patient. Meanwhile, they are hearing voices or experiencing negative thoughts most of the time every day. Paddon gives a very balanced view: it is clear that most of her time is without professionals but she is positive about all the staff she mentions; she values the specific role they have to play (particularly when performed with warmth and friendliness). She is clear about the more extensive (and different) help she has had from her family (particularly siblings).

I knew Ruth Paddon in a professional capacity many years ago. I found it personally educational to see how I figured (briefly) in her life and compare it with my experience of being her psychiatrist.

This book is very readable and it is relatively short (34 pages of text and 10 of photos). I would recommend it to psychiatric staff, patients and relatives equally. It is a balanced, genuine and accessible account of a life that has been intermittently diverted or temporarily held up (the 'stillness' of the title) by depression and psychosis.

It is currently available only to order from the publisher (email: info@tempoallibro.it).

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1.1.24 Mamoon Rana, MA, MBBS

Affia Qazi

date

2021-06

Contents

- *Mamoon Rana, MA, MBBS*

pmc Psychiatric trainee, North East London NHS Foundation Trust, UK

Dr Mamoon Rana, a much loved, highly regarded, enormously valued and committed junior psychiatrist, died at the age of 48 years of COVID-19 on 16 April 2020 after a short illness.

Mamoon was born in Punjab, Pakistan, the youngest of four children. She graduated from Lahore Medical College, worked in her native country for some years, after which she and her husband emigrated to the UK. She secured a training post in psychiatry in 2018 and embraced the discipline with huge enthusiasm. She had a lovely bed-side manner and great listening skills. At an early stage in her career she showed a keen interest in teaching and was often to be found with medical students on the wards instilling them with her newly acquired knowledge of psychiatry. Her eagerness for learning was infectious. She had enormous potential and there is no doubt she would have contributed enormously to the field of psychiatry.

Mamoon was a calm, caring and loving person, who was intelligent, witty and full of life. Her husband, Dr Azeem Qureshi, an anaesthetist at Newham University Hospital, describes her as a remarkable woman who gave hope and joy to those around her. She was also a very good cook and a devoted mother.

Mamoon was buried in East London, her family in Pakistan being unable to attend her funeral owing to the coronavirus travel restrictions. She is survived by her husband Azeem, and their 8-year-old daughter Narmin.

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1.1.25 Lynn Sinclair Gillis, MB ChB, MD, FRCPsych

Joan Raphael-Leff

date

2021-06

Contents

- *Lynn Sinclair Gillis, MB ChB, MD, FRCPsych*

pmc Formerly Head of the Department of Psychiatry, University of Cape Town, and consultant psychiatrist, Groote Schuur Hospital, Cape Town, South Africa

Lynn Gillis, who died recently at the age of 96 years, was, over a long period, one of the leaders of academic psychiatry in South Africa. In the 1960s and 1970s, he was a pioneer of community psychiatry and set up numerous community psychiatry services, mostly led by nurses. Under his guidance, a day hospital was established in 1963 in Cape Town, allied to a community service and psychiatric social club, which promoted continuity of care for patients in the community. This linked outreach provisions with psychiatric advocacy, aiming to destigmatise mental illness. Out-patient clinics were established at most hospitals and peripheral clinics in many parts of the country, which catered mostly for patients who had been discharged from hospital. Later legislation in 1976 made formal provision for a community service in country areas associated with particular psychiatric hospitals. Over time, an active Division of Child and Adolescent Psychiatry was established in Cape Town's Red Cross War Memorial Children's Hospital.

Courageously defying apartheid segregation, Lynn integrated staff across wards. In 1968, he carried out a significant research project into the rate of mental illness and alcoholism in the multiracial groups of people in the Cape Peninsula. Later, he organised a community service for alcoholism, and a specialised geriatric service, the first in South Africa. In 1980, he was appointed to head the newly established Social Psychiatry Medical Research Council Unit, which focused on research in community-based mental health. In collaboration with Professor Julian Leff of the UK Medical Research Council, he carried out a number of studies of the social precipitants of relapse in schizophrenia. Their studies revealed massive discrepancies in the lived experience of the different racial groups.

Lynn's clinical teaching and research laid the foundations for the existing Department of Psychiatry at the University of Cape Town, now a leader of psychiatric research on the African continent. Professor Dan Stein, the current Head of the Department, recalls that 'the clinical, teaching, research, and social responsiveness strengths of the existing Department are in no small measure due to his pioneering work'. As well as clinical work and carrying out research, Lynn wrote several books dealing with different aspects of clinical practice in psychiatry and psychiatric education. Towards the end of his life he published a series of reflections on his rich and varied experience.

Lynn was born on 1 February 1924 to Jewish parents who had migrated from Kretinga in Lithuania. His father, Julius Gillis, was a dentist who grew competition roses as a hobby. His mother, Annie Gillis (née Lynn), was a concert pianist who gave music lessons locally. He was first brought up in the small South African town of Kroonstad in the Orange Free State. As a result, he spoke vernacular Afrikaans (a language he deemed second only to Yiddish in its rich array of metaphors and flamboyant curses) with fluency. At the age of 9 years, a year after the family had moved to Johannesburg, he contracted scarlet fever. His experience in the Children's Fever Hospital may have influenced his later ideas about hospitals as institutions.

He entered Witwatersrand medical school in 1941. He interrupted his medical studies to enlist as a medical assistant in the South African Medical Corps, serving in makeshift hospitals in North Africa and Italy. Returning to South Africa in 1945, he completed his medical studies, qualifying as a doctor in 1948. After qualification, he worked until 1962 at Tara Hospital, Johannesburg, a pioneering mental health facility where he was influenced by the indomitable Dr Mary Gordon, a migrant from Russia. In the 1950s, Lynn took a break from Tara to hold positions at both the Maudsley Hospital in London and St Francis Hospital, Haywards Heath in Sussex. In 1962, he was recruited to fill the position of founding Head of the Department of Psychiatry and Mental Health at the University of Cape Town and first consultant at Groote Schuur Hospital (posts he held for 27 years).

During his career, Lynn won numerous awards, among them the Salus Medal (silver) for Meritorious Service to Medicine (1989) and the Merit Award for Outstanding Services, Medical Association of South Africa (1990). He also held many positions of responsibility, including President of the South African National Council for Mental Health (1969–1970, 1976–1978, 1981–1983) and President of the College of Psychiatrists of South Africa (1969–1971). He was an elected member of the International Brain Research Organization (1977–1989), President of the South African Geriatrics Society (1978–1980), President of the South African Gerontological Association (1982–1993) and Chairman of the National Research Programme on Ageing of the South African Population, Human Sciences Research Council (1987–1991). He was a founding member and later Fellow of the Royal College of Psychiatrists (1971).

Although a reserved man, Lynn's warmth, compassion and mischievous humour influenced several generations of psychiatrists, psychologists and allied practitioners as much as his professional capacities as inspirational teacher, mentor and author of many publications. He had a long-lasting effect on his trainees, many of whom rose to eminence in South Africa, the USA and the UK. Today, they still acknowledge the lasting legacy of his singularly trusting style of leadership, which fostered personal initiative. Ever curious, his awareness of the many contradictions and unconscious processes of the human mind drew Lynn to psychoanalysis, and he pursued a lifelong interest in Buddhism. He always

had a subtle appreciation of beauty, art and music. In retirement he studied sculpture and became a prolific creator of many austere carvings in marble and rare woods. An enthusiastic mountaineer, he remained remarkably healthy and agile until his last years. He was lucid and fiercely independent to the end of his full and fulfilled professional and artistic life. He died on 24 May 2020.

His wife Shirley (née Lurie) died in 2015 after they had been married for 64 years. One daughter, Susan, died in 2012. He leaves a daughter Jennifer, four grandchildren and three great grandchildren.

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The ‘*Cognitive Sports Therapy Manual*’ is a 120-page book centred on holistic, fundamental concepts, such as ‘mind, body, breath’, for supporting mental health. It is based on 12-week practical courses and support groups (available at www.cognitivesportstherapy.com), designed by a founding Multi Disciplinary Team composed of psychiatric, general practice, yoga and exercise professionals. It includes the use of non-medical jargon and practical tools, such as a gratitude journaling, screening tools, care planning, worksheets and calendar logs, for tracking personal progress related to ‘mind, body and breath’ exercises.

This type of manual is timely, particularly given the emerging robust evidence base for the therapeutic role of ‘lifestyle psychiatry’ (e.g. exercise, nutrition, sleep, stress management and adverse health behaviours) within severe mental illness. The back of the manual makes reference to some of these key papers and texts.

Within front-line psychiatry work, the use of some of these proposed, alternative therapeutic methods is well aligned with the preventative direction of the NHS Long Term Plan. This may prompt traditional Multi Disciplinary Teams to include professionals who can optimise such lifestyle factors (e.g. physiotherapists), particularly when patients with severe mental illness cite lack of staff support as a major barrier to physical activity engagement.

Despite idealism toward holistic interventions, we also have evidence from pragmatic trials led by [Gaughran et al](#) (<https://doi.org/10.1186/s12888-017-1571-0>), demonstrating the challenges of embedding positive lifestyle factors for severe mental illness. Therefore, this type of manualised approach may be more suited as a well-being strategy for those with higher levels of motivation. Further, I believe that the book should have included a screening function or content related to the risks of over-reliance on exercise as a coping mechanism, as we know this can result in exercise addiction and associated dysfunctional eating behaviours.

In summary, I enjoyed reading this manual and knowing that there are professional initiatives exploring holistic, lifestyle factor optimisation that can benefit individuals across the mental health spectrum.

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1.1.26 Veganism and eating disorders: assessment and management considerations

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Correspondence

Sarah Fuller (sarah.fuller@nhs.net)

date

2022-04

Abstract

The number of people following a vegan diet in the UK is increasing. Eating disorder clinicians are anecdotally reporting that more of their patients with anorexia nervosa are wanting to follow a vegan diet. The relationship between veganism and eating disorders is unclear. A fictitious scenario is used to explore these issues. An approach is described that clinicians may follow to help patients to understand the potential relationship between their eating disorder and veganism. The human rights issues this involves are also explored. It is hoped that this article will make readers more aware of this complex issue and the impact it can have on engagement with services and on treatment options.

Contents

- *Veganism and eating disorders: assessment and management considerations*
 - *Clinical scenario*
 - *Discussion*
 - * *The complex relationship between veganism and restrictive eating disorders*
 - * *Approach to assessing vegan diets in people with eating disorders*
 - * *What are the patient's legal rights regarding dietary choice within SEDUs?*
 - * *What nutritional considerations need to be taken into account in vegan diets?*
 - * *What are the implications for refeeding patients who are vegan?*
 - *Reflections and considerations on the clinical scenario*
 - * *Practical management*
 - * *The real people involved*
 - *Conclusions*
 - *Data availability*
 - *Declaration of interest*

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Clinical scenario

You are a trainee in a tier 4 specialist eating disorders unit (SEDU) and a 22-year-old female has been admitted under section 3 of the Mental Health Act 1983 (MHA) with a body mass index (BMI) of 12.7 kg/m², having lost 7 kg in 5 weeks. She has had amenorrhoea for 2 years. She was diagnosed with anorexia nervosa at age 17, requiring a 6-month admission, also under section 3 of the MHA, to a general tier 4 child and adolescent mental health unit. Since age 18, she has followed a strict vegan diet, whereas her family do not. She says her reasons for adopting this are ethical: a concern for the environment and animal welfare. Her family have questioned this, citing the timing of her illness and some lifestyle choices that conflict with veganism, such as using cosmetics containing animal products.

The SEDU has been unable to provide a full vegan diet. As a result, she is refusing to eat. For the past 72 h she has retired to bed and is only drinking water. At present, her physical health observations are stable. In the morning handover, the nursing staff request a professionals' meeting following the unit's policy regarding refusal to eat.

Questions to consider: What is the relationship between veganism and eating disorders? How can clinicians assess this? What are the patient's rights with regard to dietary choice on the in-patient unit? What are the nutritional considerations of a vegan diet? What are the implications for refeeding patients who are vegan?

Discussion

The complex relationship between veganism and restrictive eating disorders

The Vegan Society defines veganism as: "A philosophy and way of living which seeks to exclude – as far as is possible and practicable – all forms of exploitation of, and cruelty to, animals for food, clothing or any other purpose; and by extension, promotes the development and use of animal-free alternatives for the benefit of animals, humans and the environment. In dietary terms it denotes the practice of dispensing with all products derived wholly or partly from animals."¹ Compared with vegetarianism, veganism requires extensive dietary and lifestyle restrictions to avoid any product derived from animals.

Clinicians who support patients with restrictive eating disorders such as anorexia nervosa will be aware of the number of ways that patients can restrict their diet, ranging from total caloric restriction and self-diagnosed dietary allergies/intolerances to socially acceptable dietary restrictions such as vegetarianism or veganism. The link between vegetarianism and the development of eating disorders is well established in the literature.²⁻⁶ These researchers suggest that some individuals with restrictive eating disorders adopt a vegetarian diet to limit the available dietary choices or to justify a choice that is lower in calories. However, this apparent link may be due to methodological problems encountered in some of these studies. For example, eating disorder screening tools would not be able to differentiate between dietary restraint from being vegetarian or restraint driven by an eating disorder.^{7,8}

For decades, diets have claimed to assist weight loss by advocating different forms of restriction. It is known that following diets can be the trigger to developing eating disorders in vulnerable individuals.⁹ A recent example of a popular diet is the 'clean eating movement', which advocates eating freshly prepared, unprocessed foods and recommends eating more plant-based foods. This movement is highly active on social media, with prominent influencers advocating diets, often with no qualifications to do so. If taken to an extreme, this can lead to 'orthorexia'. Orthorexia describes a presentation in which the person becomes pathologically obsessed with eating healthy food.^{10,11} The term, coined by American physician Steven Bratman, does not appear in any of the classifications used in psychiatry but is used in practice to describe this presentation. For some patients, the overlap between healthy eating, dieting, clean eating, orthorexia and veganism is blurred.¹²

In the past 10 years, the number of people following a vegan diet in the UK has increased and veganism is particularly common in younger age groups,¹³ females¹⁴ and those living in urban areas.¹⁵ It is estimated that ~1% of the UK population now follow a vegan diet.¹⁶ Clinicians may be worried that veganism shares aspects in common with restrictive eating disorders, controlled dietary exclusion and checking of food labels. Some researchers have suggested that the theoretical link between dietary restriction seen in eating disorders is mirrored in veganism.^{17,18} Furthermore, the individuals who are more likely to adopt a vegan diet have demographic overlap with those at risk of developing an eating disorder.

At present there is a lack of research into veganism in individuals who have restrictive eating disorders. Some studies have shown that those following a vegan diet are at lower risk of developing pathological eating disorders,¹⁹ whereas others have highlighted that former adolescent vegans may be at increased risk of extreme ‘unhealthful’ weight-control behaviours.²⁰ However, adolescence is a period in which an individual starts to become independent of their family, become more socially conscious and develop their self-identity. Many young people adopt dietary patterns that are different from their families’ and therefore clinicians need to be aware of the distinction between healthy curiosity or lifestyle choices and eating-disordered behaviours.

We conducted a flash survey, via SurveyMonkey, on 1 March 2018 to identify how many patients receiving either specialist eating disorder unit (SEDU) treatment or day hospital treatment identified as vegan on admission. In total, 65 specialist services responded, representing 1008 patients with eating disorders. Within adult services, rates of veganism were reported as 46/419 (11%) in the SEDUs and 11/173 (6.4%) in the day hospitals. In child and adolescent services, the rates were 37/230 (16%) in the SEDUs and 15/186 (8.1%) in the day hospitals. These rates are higher than the national reported prevalence¹⁶ of 1% and this initial finding suggests that more research is needed to identify the actual prevalence within SEDUs.

Approach to assessing vegan diets in people with eating disorders

Clinicians should be mindful of two key questions when trying to distinguish whether an individual is following a vegan diet for ethical reasons or not. First, are ethical choices seen in non-food aspects of life, such as clothes, toiletries and use of free time? Second, is there a pattern of increasing dietary restriction, such as starting off with healthy eating, then vegetarianism and finally veganism, or were ethical concerns present before the dietary restriction began?

What are the patient’s legal rights regarding dietary choice within SEDUs?

When balancing medical decision-making with human and equality rights, clinicians should be aware that veganism is classed as a non-religious belief protected under Article 9 of the European Convention on Human Rights (the right to freedom of thought, conscience and religion).²¹ Case law and guidance^{22,23} indicates that for a belief to engage Article 9 it must: be sincerely held be a belief and not an opinion/viewpoint concern a weighty and substantial aspect of human life and behaviour attain a certain level of cogency, seriousness, cohesion and importance be worthy of respect in a democracy, compatible with human dignity and must not conflict with the rights of others. These criteria can be referred to when trying to understand whether a patient’s vegan beliefs are distinct from their eating disorder. It is worth noting that the beliefs of an individual cannot be decided or overridden by others, and only a court can decide whether the belief complies with the criteria.

The Human Rights Act 1998 (section 6) stipulates that a public body must not act in a way that is incompatible with a Convention right. In practice this means that patients have a right to their beliefs being respected by the organisation providing care. Providing vegan food for patients who request it would therefore ensure compliance with this obligation. However, there are defences to allegations under section 6, including, for example, vegan food not being in the best interests of the patient and whether the patient is deemed to lack capacity to make important healthcare decisions.

There are two forms of discrimination, direct and indirect. Direct discrimination occurs where, contrary to section 13 of the Equality Act 2010, certain groups/people are treated differently because they hold a particular philosophical belief. Indirect discrimination can take place where, contrary to section 19 of the Act, there is an apparently neutral policy that applies to all but has the effect of disadvantaging certain groups/people (e.g. those expressing their philosophical belief in veganism). This means that if a SEDU has an inflexible catering regimen that does not allow for veganism, it leaves the unit open to legal action stating indirect discrimination. In claims arising, an objective justification for the inflexible regime will be required. Clinicians do have a potential defence to individual claims of indirect discrimination if life-saving treatments are required, for example nasogastric tube feeding, given that there is no appropriate vegan enteral feed available at present.

What nutritional considerations need to be taken into account in vegan diets?

With appropriate expertise and planning, there is no reason why a vegan diet should not be well balanced and sufficient to meet the nutritional needs of any individual. Vegans need to ensure that they eat a wide variety of foods and find suitable plant-based alternatives for meat and dairy products. However, research suggests that there are specific nutritional vulnerabilities within a vegan diet that require particular attention or supplementation.²⁴ This has led some European countries to suggest that vegans have blood tests every 3 months to monitor their nutritional status.²⁵ Current guidance in the UK (<https://www.nhs.uk/live-well/eat-well/vegetarian-and-vegan-diets-q-and-a/>) is for vegans to take an appropriate vitamin and mineral supplement to ensure that their nutritional needs are met.

The key nutrients of concern are vitamin B₁₂, vitamin D, iodine, selenium and omega-3 fats.²⁴ People who have a restrictive eating disorder may not be able to eat a sufficient quantity and variety of foods and consequently they may become deficient in these and other nutrients. Close monitoring of patients' biochemistry is therefore advised to identify whether they are deficient in any nutrients.

What are the implications for refeeding patients who are vegan?

It is possible to refeed a patient on a vegan diet. Following a vegan diet is not an identified risk factor for the development of refeeding syndrome. However, it is important to be aware that, in some cases, like-for-like adaptations to catering menus may result in a vegan patient having to eat a larger volume of food. This may result in psychological distress as they compare their portions with those of their non-vegan peers. It may also be problematic for patients experiencing delayed gastric emptying that results in uncomfortable bloating and pain.^{26,27}

Clinicians should also be aware that, if treatment is required for micronutrient deficiency (such as calcium, phosphate or magnesium) due to refeeding syndrome, some vegan alternatives may not have the equivalent nutritional value or bioavailability.^{28,29} It is well worth having discussions with the local pharmacy to ensure that supplies of such micronutrients are available and their characteristics are summarised for use in out-of-hours and other urgent situations. However, in life-threatening emergencies, treatment should be given.³⁰

There is currently only one prescribable supplement drink registered as vegan friendly in the UK (AYMES ActaSolve Smoothie®), but this is not nutritionally complete and it is also not suitable for enteral feeding.³¹ However, if nasogastric tube feeding is required, given the absence of any vegan enteral feeds, clinicians should be aware that many vegans will often accept foods that contain minimal amounts of animal products, for example a soya-based enteral feed in which the only ingredient that is not vegan may be a vitamin such as vitamin D. In cases where a person refuses to accept this option, and they are deemed not to have the capacity to make such a decision, legal advice should be sought for clarification and support.

Reflections and considerations on the clinical scenario

In the clinical scenario introducing this article the patient is at high risk of refeeding syndrome and is likely to be cognitively impaired owing to starvation. There is still an option to work with her to re-establish regular eating on a fully vegan diet, which would be the least restrictive option under the MHA. Irrespective of whether the veganism is independent of her eating disorder or not, facilitating a vegan diet in line with her beliefs will result in her feeling understood and will allow the therapeutic relationship to be repaired. Any discussions about the relationship between veganism and her eating disorder can take place when she is no longer at medical risk and is able to engage cognitively.

This scenario does pose the question: do patients with eating disorders have the right to follow a vegan diet while admitted to a SEDU? Indeed, our flash survey highlighted that not all units are able to provide a vegan diet – 15/21 adult SEDUs (71.4%) and 10/13 child and adolescent SEDUs (76.9%) that responded could not – i.e. the option of following a vegan diet while receiving tier 4 treatment is not yet universal. However, the survey did not enquire into the difference between vegan diets being available versus vegan diets being offered in practice.

Veganism is becoming much more common and it is defined as a protected characteristic under the Equality Act 2010. Therefore, SEDUs need to find ways to adapt to meeting vegan beliefs just as religious beliefs are accommodated. It is

unlikely that a SEDU would expect a person of Jewish faith to eat pork, for example. Provision of a complete vegan diet plan incorporating all the nutrients required to avoid refeeding syndrome and promote healthy weight restoration is possible but requires the input of a specialist dietitian.

The British Dietetic Association's Mental Health Specialist Group has endorsed an internal document to help dietitians understand whether the decision to follow a vegan diet is likely to be linked to an eating disorder or is a genuine lifestyle choice that pre-existed someone's illness (this document is not yet available outside of the BDA). In some instances, veganism can help a person recovering from an eating disorder, allowing them to discover new foods and ways of cooking, change the way they perceive food and embrace the vegan subculture. For others it may be an opportunity to restrict their diet and maintain their eating disorder.

Practical management

In the short and medium term, i.e. during this patient's admission, her veganism can be respected but also challenged in a therapeutic way, as it is not clear that her decision to follow a vegan diet is not linked to her illness. It is important to remember that being malnourished is associated with poor cognitive flexibility, so it might be more appropriate to address this once appropriate and regular nutrition is well established. At that stage, working with the unit's dietitian, it can be challenged with modifications to her meal plan and social tasks involving eating outside of the unit with family and friends. The aim would be to expand the variety of her diet while maintaining a weight at which her body is functioning and no longer experiencing any symptoms of poor nutrition and to challenge aspects of her veganism that may have been hijacked by her anorexia nervosa. In the long term, her community eating disorder team can continue to work with her and her dietary choices as is usual practice.

Treating someone with anorexia nervosa requires that the person's religion or belief is respected while at the same time ensuring that the person is not discriminated against in terms of the quality of treatment they receive. This can produce a quandary owing to the lack of vegan sip feeds and enteral feeds, which may be required under certain circumstances. In life-saving situations some patients may be prepared to accept non-vegan treatment options. In the meantime, pharmaceutical companies are being encouraged to produce vegan alternatives.

Certain situations, such as treatment under the MHA, which could include compulsory nasogastric feeding or treatment with non-vegan medication, produce ethical dilemmas. On the one hand, the therapeutic relationship with the patient is already under strain; on the other hand, treatment could be life-saving. At present, and in the absence of equivalent vegan enteral feeds and medicines, the best that can be done is to treat the patient as you would any other, while being as collaborative as possible and minimising the use of non-vegan options.

In March 2019, a consensus statement was published outlining guidance for practitioners in the UK treating vegan patients with eating disorders.³⁰ This will help services to provide appropriate treatment for these individuals.

The real people involved

The fictitious case scenario is based on the reflections of a real patient and a carer. We obtained informed consent from both to create the scenario and to publish their anonymised reflections here.

A patient's reflection

“My veganism has always been respected in 20 years of [NHS and private] treatment, and even when tube feeding/supplements were required I had a product that was soya based and only had one element that was derived from animals. Wherever possible, my medication also was free from animal ingredients. My diet was limited and often “safer”, but I wanted the opportunity to challenge myself with foods I could enjoy socially within the restrictions of my illness. After 5 years in the community, I had an admission where I felt that I was detained in part due to the unit's anti-vegan policy. I gave up. Not being listened to led to a standstill in my treatment – it was “them versus me”. Veganism was the only thing stronger than my illness: I would drink a litre of oil over a teaspoon of cow's milk. I needed

tube feeding and the idea of a cow's milk-based feed was difficult to accept. My body felt like a graveyard. My mental health, identity and soul were damaged and instead of fighting anorexia I was fighting the system.”

A carer's reflection

“I am 100% convinced that my daughter's request to follow a vegan diet was driven by her illness. Through her whole life I had ensured that the family had a healthy and balanced diet which included treats and party food. In our house, no food was a “bad” food. Prior to being diagnosed with anorexia, she first announced that she wanted to cut out meat, then fish, then eggs. Within three months she wanted to become vegan. We embraced family treatment and had many tantrums along the way regarding her veganism. We are now in a good place and she has admitted, guiltily, that she never wanted to be vegan and her illness drove her to pursue this as a way of restricting.”

We would like to thank both the patient and the carer, who are not related, for their contribution to this paper. Both have asked to remain anonymous.

Conclusions

We have highlighted the increasing incidence of veganism at a national level and the flash survey has suggested increased incidence within the eating disorders population. Concerns about animal welfare, environmental considerations and health impacts appear to be driving this change. There has been little research into veganism and eating disorders and more research is needed. A fictitious case has been used to explore the approach clinicians can take to support a vegan patient with an eating disorder. This included considerations on the relationship between the eating disorder and veganism, refeeding on a vegan diet and the legal implications for patients on a SEDU. The anonymous perspective of a patient and a carer highlight the multifaceted issues inherent in recovery from an eating disorder and the nuanced role veganism can play. Wherever possible, treatments for people with eating disorders should be person centred and therefore this is an opportunity to adapt meal plans, offer appropriate supplements and engage vegan patients in their treatment.

Sarah J. Fuller is an advanced specialist eating disorders dietitian with East London NHS Foundation Trust, UK. **Andrea Brown** is a consultant psychiatrist and psychotherapist in eating disorders with Schoen Clinic York, UK. **Jeanette Rowley** is a legal advisor and Chair of the Vegan Society's International Rights Network, Birmingham, UK. **Jade Elliott-Archer** is a solicitor in the Medical Negligence team of Irwin Mitchell LLP, Birmingham, UK.

Data availability

The data that support the findings of this study are available from the corresponding author, S.J.F., upon reasonable request.

S.J.F. and A.B. undertook the reviews of the literature, drafted the paper and analysed the data. J.R. and J.E.-A. provided the legal contributions.

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Declaration of interest

None.

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1.1.27 Author's reply

Emmeline Lagunes-Cordoba

date

2022-04

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pmc We agree with the comment regarding how ethnic minority is an independent effect with respect to differential attainment; however, this paper tried to focus on the subgroup showing the largest effect size, IMGs.

The comment regarding IMGs of White ethnicity is an illustration of the above (ethnicity: moderate effect on differential attainment; 'IMG-ness': large effect on differential attainment), so we are grateful you have helped us to make this point more explicit. However, we think the central point of our paper remains – that IMGs need special focus as, unlike ethnicity, to be an IMG is not a protected characteristic, so interventions to support IMG might not be deemed to be a priority or even a need. Overall, we consider that this is complex and delicate, with many further layers of intersectionality, including gender, sexual orientation and social background, but it is promising that more and more work, including yours, is beginning to address the many issues affecting IMGs working in the UK.

Declaration of interest

None

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1.1.28 Risk, demand, capacity and outcomes in adult specialist eating disorder services in South-East of England before and since COVID-19

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date

2022-04

Abstract

Aims and method

This is a longitudinal cohort study describing the demand, capacity and outcomes of adult specialist eating disorder in-patient services covering a population of 3.5 million in a South-East England provider collaborative before and since the COVID-19 pandemic, between July 2018 and March 2021.

Results

There were 351 referrals for admission; 97% were female, 95% had a diagnosis of anorexia nervosa and 19% had a body mass index (BMI) <13. Referrals have increased by 21% since the start of pandemic, coinciding with reduced capacity. Waiting times have increased from 33 to 46 days. There were significant differences in outcomes between providers. A novel, integrated enhanced cognitive behaviour therapy treatment model showed a 25% reduction in length of stay and improved BMI on discharge (50% v. 16% BMI >19), compared with traditional eclectic in-patient treatment.

Clinical implications

Integrated enhanced cognitive behaviour therapy reduced length of stay and improved outcomes, and can offer more effective use of healthcare resources.

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National background

In the 2019 Health Survey for England, 16% of adults aged 16 years (19% of women and 13% of men) screened positive for a possible eating disorder. This included 4% (5% of women and 3% of men) who reported that their feelings about food had interfered with their ability to work, meet personal responsibilities or enjoy a social life.¹ This is almost a threefold increase since 2007.² These findings may be surprising, but are consistent with international epidemiological data.³

In parallel, hospital admissions in England of people with eating disorders have increased from 4849 in 2007–2008 to 19 116 in 2018–2019.⁴ This shows an almost fourfold increase in demand, and there has been no investment in specialist eating disorder in-patient services during this time. Approximately 70% of people needing hospital admission are adults with anorexia nervosa.

On 6 November 2020, after the inquest into five avoidable deaths, the coroner for Cambridgeshire and Peterborough, concluded that National Health Service (NHS) treatment for patients with anorexia nervosa is ‘not a safe system’ and risks ‘future deaths’.⁵ These statements mirror the 2017 Parliamentary Health Service Ombudsman (PHSO) report.⁶ Three years ago, the PHSO made several helpful recommendations, including reviewing medical education, improving the workforce, ensuring the parity of funding of services across the age range and strengthening coordination of care. There has been limited progress since.⁷

Child and adolescent eating disorder services have received substantial investment since 2015,⁷ and progress toward meeting the referral to treatment waiting time standard has been monitored (<https://www.england.nhs.uk/statistics/statistical-work-areas/cyped-waiting-times/>). These standards require child and adolescent eating disorder services to begin out-patient treatment within 1 week for urgent cases and 4 weeks for non-urgent cases. However, neither the standards nor monitoring are in place for adults, and the much-awaited funding into community eating disorder services has not yet reached the front line. Adult in-patient eating disorder services are part of specialist services and have been commissioned by NHS England. Over the past few years, NHS England has initiated a shift of commissioning to regional NHS collaborations, with the intention of transformation of care pathways focusing on the health of local populations, with the aim of improving outcomes and cost-savings.

Aims and objectives

In this paper, we describe demand and capacity for hospital treatment of patients with severe eating disorders in the Healthy Outcomes for People with Eating Disorders (HOPE) provider collaborative in South-East England since July 2018, and examine the effects of the COVID-19 pandemic. In addition, we compare the outcomes between different in-patient services, using the traditional eclectic treatment model with a new integrated enhanced cognitive behaviour therapy (I-CBT-E) treatment across the care pathway.

Method

This is a longitudinal cohort study, involving all patients with eating disorders referred for admission from a total population of 3.5 million in South-East England. The study has been approved by the Oxford Health NHS Foundation Trust Audit Department. Patient consent was not needed for the study.

The HOPE provider collaborative

The HOPE network was one of the first pilot sites of adult eating disorders selected by NHS England. It was established in shadow commissioning form in July 2018. The main goal of the network was to bring together in-patient and community services from several organisations providing in-patient and out-patient services for adults with eating disorders. Initially, the network included a total population of 5.2 million.

The footprint was reduced in September 2019, and the following partners have remained in the provider collaborative: Oxford Health NHS Foundation Trust (Oxfordshire, Buckinghamshire, Swindon, Wiltshire), Berkshire Healthcare NHS Foundation Trust, Gloucestershire Health and Care NHS Foundation Trust and the Priory Group (in-patient provision in Bristol).

The total population of the geographical footprint is 3.5 million. Oxford Health NHS Foundation Trust provides 14 beds in Oxford, and 6 beds in Marlborough. In addition, Oxford has six day patients and Marlborough has four. Berkshire and Gloucestershire have day services for 8 and 12 patients, respectively. The Bristol Priory is an independent partner in the provider collaborative providing specialist eating disorder beds; however, as it has a national contract with NHS England, their beds are not aligned with the HOPE provider collaborative.

This provider collaborative has developed a more collaborative and joined-up approach to admissions and discharge planning, with the aim of improving access closer to home and joint working between in-patient and out-patient teams. A weekly joint clinical activity panel consisting of senior clinicians from each organisation and a single point of access for all referrals has been established, to ensure that decisions about admissions are made by highly experienced clinicians. Referrals and outcomes have been systematically monitored since July 2018, for the whole geographical area.

There was also an agreement to monitor outcomes, and compare the NHS England standard eclectic model of care⁸ with a new, integrated stepped-care model using I-CBT-E in Oxford, building on the pioneering work of Dalle Grave et al.⁹ I-CBT-E offers a single evidence-based psychological model delivered by a multidisciplinary team, starting before admission and continuing across the treatment pathway (40 sessions in total). A detailed I-CBT-E formulation ensures continuity, consistency and a personalised treatment plan.

The COVID-19 pandemic has significantly affected capacity as a result of infection control measures across the care pathway. In-patient and out-patient services needed to reduce the number of people in poorly ventilated and crowded buildings. Day services had to be closed because of environmental and staffing challenges. Furthermore, remote working may have caused delays in recognition of deterioration of non-cooperating patients (both in primary and secondary care).

Demographic and clinical data

This paper analyses data from the partners who have been part of the provider collaborative since the beginning (Oxfordshire, Buckinghamshire, Wiltshire, Gloucestershire and Berkshire) for the period from July 2018 to 1 April 2021. The data collected concerns referrals, including demographic and clinical information, such as diagnoses and severity of physical risk related to malnutrition, and outcome of referrals, including length of admission and travelling distance. Body mass index (BMI) was recorded on referral, admission and discharge for those admitted. No additional outcome data was recorded for patients not admitted.

Statistical analysis

Descriptive statistics were conducted to describe the demographic and clinical characteristics of the referred patients. Categorical variables were compared by χ^2 -test, and continuous variables by independent t -test and ANOVA, using SPSS for Windows version 22.

Results

Between July 2018 and 1 April 2021 there were 351 referrals for admission; 97% were female and mean age was 29.6 ± 11 years. According to DSM-5 severity ratings, 56.3% had extreme anorexia nervosa, 20.8% had severe anorexia nervosa, 17.9% had mild-to moderate anorexia nervosa, 1.8% had severe or extreme bulimia nervosa and 3.2% had other specified feeding or eating disorder. Approximately 65% of referrals were urgent or emergencies since the establishment of the provider collaborative. Urgency of referral was determined by the risk to the patient's health and safety, including level of malnutrition and risk to self; 19% of referrals had a BMI < 13 , which is an indicator of potentially life-threatening malnutrition, and a further 37% had extreme malnutrition. This pattern of referrals remained unchanged after the COVID-19 pandemic, but the absolute numbers increased by 21%.

There were no significant differences in mean age (29.20 ± 10.5 years v. 30.1 ± 11.9 years), gender (97% v. 99% female), diagnosis (95% v. 96% anorexia nervosa) or need for compulsory admissions (84.6% v. 83.4% informal), before or since the COVID-19 pandemic.

The impact of the COVID-19 pandemic on the outcome of referrals

Before the COVID-19 pandemic, 63.6% of patients were admitted, which has increased to 65% since the COVID-19 pandemic (Table 1). The number of patients waiting has increased by 20%. However, this is likely to increase further with time, as the in-patient capacity for admission is insufficient, not just within the footprint, but also nationally. The reason for no admission was usually because of the patient refusal and/or ongoing out-patient treatment. Approximately half of these patients were admitted following a second referral. Table 1 Outcome of referrals before and since COVID-19 (number of patients and percentages)

	Before COVID-19	Since COVID-19	Total
Not admitted	65 (38%)	55 (35%)	120 (36%)
In-patient unit in the HOPE provider collaborative area			
Cotswold House Oxford	50 (29%)	50 (32%)	100 (30%)
Cotswold House Marlborough	15 (9%)	22 (14%)	37 (11%)
Bristol Priory	9 (5%)	12 (8%)	21 (6%)
Out of area			
Priory OOA	15 (9%)	14 (9%)	29 (9%)
NHS OOA	14 (8%)	3 (2%)	17 (5%)
Cygnet	4 (2%)	2 (1%)	6 (2%) ¹

Before the COVID-19 pandemic, 43% of referrals could be admitted within the network, which has increased to 54% since the COVID-19 pandemic. The Priory Group provided 5% of admissions within the geographical area and a further 9% out of area.

Waiting times and travelling distance

The distance from home to hospital increased during the COVID-19 pandemic (from 41.4 ± 60 miles to 56 ± 78 miles). Eight patients were admitted to Priory Glasgow because of a lack of bed availability in England. Waiting times increased from 33 ± 44 days to 46 ± 43 days (t -test = 0.03)

Even pre-COVID-19, the HOPE network already had a large demand/supply mismatch, with insufficient specialist beds within the network and lengthy waiting times even for patients with extreme or life-threatening malnutrition. This causes a vicious cycle of delayed and high-risk referrals requiring urgent admissions. Figure 1 demonstrates the variation in waiting times before and since the COVID-19 pandemic. It shows huge variations, even for the most high-risk patients, reflecting the reduced capacity in the system. One of the additional challenges is the lack of striated beds, which makes it difficult to meet the needs of patients who present with a high level of behavioural disturbance resulting from comorbidities such as autism spectrum disorders or personality disorders. Fig. 1 Waiting times for admission depending on severity of malnutrition.

¹ HOPE: Healthy Outcomes for People with Eating Disorders; OOA: Out of area placement; NHS, National Health Service Providers.

The reduced specialist in-patient and day treatment capacity has had a significant impact on community teams in the footprint. Because of the lack of prompt access to specialist eating disorder units, approximately 19% of patients have required acute admission to general hospitals for emergency medical treatment. This represents a 20% increase during the COVID-19 pandemic, when acute hospital capacity is also reduced.

Differences between in-patient providers

Before the COVID-19 pandemic, there were significant differences between individual in-patient services in terms of length of stay (Supplementary Table 1 available at <https://doi.org/10.1192/bjb.2021.73>).

As part of the establishment of the provider collaborative, Cotswold House Oxford has been pioneering the implementation of an integrated stepped-care treatment, based on an intensive CBT-E model developed between Professor Fairburn in Oxford and Dr Dalle Grave in Italy.¹⁰ The model advocates integration of NICE-approved psychological treatment across the care pathway, with clear goal-oriented, time-limited admissions, followed by day and out-patient treatment. Given the differences between the Italian healthcare system and the NHS, we adapted the model by including a crisis admission pathway for those patients who refused full weight restoration but agreed to informal treatment. The details of the treatment will be discussed in a separate paper.

Here, we summarise the comparison between the outcomes of patients who were admitted to the Oxford unit and other specialist units that use the current standard eclectic treatment approach promoted by NHS England. Previous internal service evaluation of the Oxford pilot programme before the COVID-19 pandemic showed improved outcomes, reduction of restrictive practices (such as needing to use nasogastric feeding under restraints), improved patient outcomes and reduced length of stay. Despite the challenges, this has been maintained through the COVID-19 pandemic (Table 2): 50.5% patients reached a BMI >19 compared with 16% in all other providers ($\chi^2 = 0.000$). Table 2 Comparison of the traditional eclectic in-patient treatment with the Oxford pilot programme (integrated CBT-E)

In-patient treatment model	n	Means	d	Significance (two-tailed)
Referral BMI	Integrated CBT-E	9014.72	0.050	0.377
	Eclectic model	9214.51	0.96	
Discharge BMI	Integrated CBT-E	8818.22	0.0001	
	Eclectic model	8417.01	0.89	
Length of admission (days)	Integrated CBT-E	8885.154	0.01	
	Eclectic model	92107.268	0.8	
Home mileage to in-patient unit	Integrated CBT-E	7620.62	0.000	
	Eclectic model	7967.180	0.5	
Age (years)	Integrated CBT-E	9032.213	0.005	
	Eclectic model	9427.558	0.80	
Waiting time for admission (days)	Integrated CBT-E	8933.48	0.95	
	Eclectic model	9233.14	0.3 ²	

Discussion

To our knowledge, this is the first paper providing a systematic analysis of referral patterns, access, waiting times and outcomes for adults with eating disorders requiring specialist in-patient treatment in England. The main strength of the study is the systematic data collection for 2.5 years, across a large geographical area with a population of 3.5 million. As the joint data collection had been established in July 2018, we have also been able to analyse the impact of the COVID-19 pandemic on this patient population and corresponding services. Although regional, our data derive from a large geographical area, representing 6% of the population of England, so we believe that our findings are representative of most adult eating disorder services elsewhere in the country.

Referrals have increased by 20% since the COVID-19 pandemic, and this has resulted in increasing number of patients needing admission to acute hospitals and further away from home. Waiting times for admission were long even before

2

CBT-E, enhanced cognitive behaviour therapy; BMI, body mass index.

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the COVID-19 pandemic, and <50% of patients could be admitted close to home. Of those admitted, approximately a third were placed out of area. Out-of-area placements are well-known to cause distress to patients and families, and have been shown to have longer length of stay and poorer outcomes.¹¹ Most worryingly, even before the COVID-19 pandemic, patients with life-threatening malnutrition had to wait several weeks for admission, and this timescale has increased further since the pandemic, placing patients, staff and provider organisations at risk.

Although current national-level data by NHS Benchmarking on bed occupancy in hospitals suggest that demand is not dangerously high, this is not an appropriate indicator of how pressured specialist eating disorder services are across the care pathway. Infection control requirements and workforce impact of COVID-19 mean that the majority of NHS services are running at reduced capacity. Many services are struggling with reduced staffing levels resulting from the COVID-19 pandemic. Furthermore, in specialist eating disorder services, monitoring risks and ensuring patient flow between in-patient, day and out-patient services has become much more challenging in an already pressurised system.

The physical environment is important to ensure patient and staff safety. The Royal College of Psychiatrists has been campaigning for improving mental health estates and facilities.¹² This has become even more pressing since the COVID-19 pandemic: improving services to meet increasing demand requires capital investment into NHS mental health services

Following the high-profile reports into avoidable deaths, there has been an acknowledgement that adult community eating disorder services need to be funded to reach parity across the age range,^{6,13} and this is reflected in the new NHS England commissioning guidance for adult eating disorder services. However, this is still aspirational, and many adult patients struggle to access care or face long waiting times. This may explain the high number of patients in our network referred to hospital with a BMI of <13, in a life-threatening emergency, which has increased by 20% during the COVID-19 pandemic. This is a concern, as although the Royal College of Psychiatrists published the ‘Management of Really Sick Patients with Anorexia Nervosa’ (MARSIPAN) guidelines to improve patient safety in emergencies,^{14,15} their implementation has been inconsistent in acute hospitals, as shown by the recently reported tragedies. This is partly because of the limited training of eating disorders for doctors and allied health professionals, an area of concern that was identified by the PHSO.¹⁶

Although it is possible that the much needed investment into adult community eating disorder services in the next few years will reduce the need for in-patient treatment in the future, this is going to take several years. In-patient provision needs to be increased to meet current demand, which has quadrupled since 2007–2008 in England.⁴ Furthermore, recent national epidemiological data¹ indicate increasing prevalence across the lifespan, and this is consistent with increasing referrals to the community teams and the increasing rates of hospital admissions. NHS-led provider collaboratives will only succeed if funding meets the need in the population served.

However, it is important to consider the significant variations in length of stay and short-term outcomes between providers. Our findings are consistent with previous research. In 2013, a UK-wide cohort study of adult specialist eating disorder units reported an average length of stay of 182 days and an average discharge BMI of 17.3,¹⁷ with only 22% reaching a BMI of 19 by discharge. In our study, only 16% of patients admitted to a unit offering standard eclectic treatment reached a discharge BMI >19, as opposed to 50% in the I-CBT-E pilot programme (within a 25% shorter length of stay), Discharge BMI is an important predictor of medium- and long-term outcomes.^{18,19} Although this was not a randomised controlled trial, the treatment model is based on a previous randomised controlled trial, and published manuals.^{9,10,20,21}

The findings of the Oxford pilot programme (I-CBT-E) utilising an evidence-based and integrated stepped-care approach suggests that, with service transformation, reduced length of stay, improved patient outcomes and reduced restrictive practices are achievable. This can ensure use of existing limited in-patient capacity more effectively, and suggests a significant opportunity for cost-savings. This is particularly important, as a large proportion of patients in the cohort had an illness duration of >10 years. Our findings replicate previous studies from Italy,^{22,23} and suggest that the model is generalisable to the NHS. However, adaptation would require the redesigning of care pathways, staffing levels and skill mix. CBT-E training is freely available online (<https://www.cbte.co/for-professionals/training-in-cbt-e/>) and has been tested in previous research.²⁴

The main limitations of our study are that we only had BMI as a consistent indicator of outcome at discharge, and that the comparison between in-patient providers was not based on randomisation. However, randomisation would not have been practically possible, given the limited capacity and the dispersal of beds in a wide geographical area in England

and Scotland. Further work with our partners will explore more details of the longer-term psychosocial and health economic outcomes.

A multicentre, randomised controlled trial would be desirable, but it is important to note that the current NHS England standard contract is based on expert opinion rather than trial evidence, or robust outcome monitoring.

Clinical implications

It has been frequently stated that anorexia nervosa has the highest mortality of any mental disorder affecting young people and adults.^{25,26} We should not accept this: people should not die of anorexia nervosa or any eating disorder, as they are treatable mental disorders.²⁷ Severe complications, such as malnutrition, are safely reversible, even in the most extreme cases.

The I-CBT-E model is based on a cohesive, integrated stepped-care approach for people with severe eating disorders, and wider implementation in the NHS has the potential to both improve short-term and long-term outcomes, with the added benefit of cost-savings. A national audit of demand, capacity and treatment outcomes would help to establish the need for specialist eating disorder beds, as well as explore the differences between various treatment models. There is an urgent need for capital investment into NHS mental health facilities to ensure a safe environment for patients and staff in the light of the COVID-19 pandemic.

We are very grateful to all of our partners for submitting the data, Beris Cummings and Este Botha for data collection and Dr Andrew Ayton for proofreading.

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Supplementary material

For supplementary material accompanying this paper visit <http://doi.org/10.1192/bjb.2021.73>.

[click here to view supplementary material](#)

Data availability

The data that support the findings of this study are available from the corresponding author, A.A., upon reasonable request.

A.A. and A.I. developed the initial idea. D.V., S.R. and D.F. helped with the design and data collection. A.A. wrote the first draft and all authors contributed to the final draft and the revised version.

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Declaration of interest

None.

1.1.29 David Walter Millard, FRCPsych, MD, MA (Mus)

Rupert McShane

date

2022-04

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- *David Walter Millard, FRCPsych, MD, MA (Mus)*

pmc Formerly Consultant Psychiatrist, Oxfordshire Mental Healthcare Trust, and Lecturer in Applied Social Studies, University of Oxford, UK

David Millard, who died on 13 January 2021 aged 89, had a varied career as a practitioner, teacher, academic and historian. The idea that a patient's social context could be altered in such a way that it enhances recovery from mental illness was at the heart of his work. The practical manifestation of this idea was the therapeutic community movement. David's interest in what makes groups and institutions tick resulted in a career that was framed by psychiatry, but which, in the middle period, took what was, at the time, an unconventional multidisciplinary path.

David was born on 9 February 1931 in Gloucestershire to Walter, a biology teacher, and Gladys Jarvis, a nurse (and a descendent of Thomas Hardy). One of David's school reports berated him for spending so much time on music, but his parents' occupations were influential in his choice of medicine. Following qualification from the University of Birmingham Medical School, he had intended to pursue a career in surgery, but Harold Macmillan and Suez intervened and a short service commission as a doctor in the Royal Army Medical Corps followed. On return, his career changed direction and he embarked on psychiatric training at Rubery Hill Hospital in Birmingham. There he experienced the therapeutic community run by John Yerburch, which shaped his future interests and career choices. He moved to Sir William Trethowan's professorial unit at the Queen Elizabeth Hospital in Birmingham, where he established a therapeutic community on Ward North 5A. Returning to Rubery as a young consultant, he was instrumental with others in building a third therapeutic community. However, after just 4 years, in 1970, his enthusiasm for the workings of multidisciplinary teams, growing academic interests and enjoyment of teaching led him to take the unusual step of relinquishing his consultant post in Birmingham to become Lecturer in the Department of Applied Social Studies at the University of Oxford. This reflected his interest in bringing psychiatry and social work together. The students were trainee social workers and probation officers. A devout Christian, he also taught Psychology of Religion for the Faculty of Theology and was for 20 years a Council Member and chair of the Institute of Religion and Medicine.

Through his continuing interest in the new and evolving Association of Therapeutic Communities (founded in 1972), David became the inaugural convener of its research group, followed by 8 years as joint editor of the *International Journal of Therapeutic Communities*. A prolific contributor to this and related fields, his MD thesis *Collected Writings on the Therapeutic Community* (1995) included an important contribution on the life and work of Maxwell Jones. This was reprinted in *150 Years of British Psychiatry 1841–1991: The Aftermath* (1996), edited by Hugh Freeman and German Berrios.

In 1979, under Sir Richard Doll's wardenship, David was invited to be one of the 18 Founding Fellows of Green College Oxford. He held posts as Senior Tutor and later Dean of Degrees. His devotion to the College was to last for the rest of his life. On retirement he was made an Emeritus Fellow of the College.

During his years teaching in the Department of Applied Social Studies, David maintained his clinical interests as an honorary consultant in Michael Gelder's newly formed professorial unit at the Warneford Hospital in Oxford, where he provided a psychodynamically informed out-patient service, including teaching medical students in the clinic. Gelder's

style of rigorous structured exploration of psychiatric diagnosis and the ambitiousness of academic medicine was not really to David's taste – but he enjoyed seeing patients too much to give up clinical work.

He retired from academic work in 1991 but continued his connection with NHS psychiatry, taking on a substantive post as consultant in old age psychiatry in 1994, which was to last for 6 years.

In Oxford his wide interest in social processes within institutional contexts led to his involvement in the governance of local organisations concerned with the elderly and with delivering often innovative services to psychologically vulnerable people in the community. Always interested in the most disadvantaged, David nurtured organisations that looked for restorative pathways, such as those for the homeless and people involved with the criminal justice system.

David was a careful, thoughtful listener. His wise advice – 'If it's not clear, get more information' – lies at the antithesis of decisive medical action in the absence of certainty, but was a constant reminder to go the extra mile for the patient. He led, but did not drive his teams to make better, broader, decisions. His espousal of flat hierarchy, drawn from the same humility that drew him to therapeutic communities, endeared him to staff of all disciplines.

An able cellist, pianist and musician with a keen interest in historical instruments, including constructing his own clavichord, David obtained an MA in Music following retirement. His dissertation, on musical feminine endings – in which an additional unexpected step is added and the penultimate chord is the strongest – betrayed his deep interest in the psychology of resolution.

He married Heather, by whom he had two children (Julian and Hilary). They divorced in 1976. He then married Sheila, a psychiatric social worker and group analyst, whose attention he attracted by his performance in role-play as an elderly grandmother at a conference.

In his later years he suffered from vascular dementia. It was fitting that, in his final illness, his wife was supported in his care by doctors, nurses and institutions whose development David had influenced: he reaped as he had sowed.

He is survived by Sheila, his two children, his two step-children (Peter and Laura) and his sister Ann.

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1.1.30 Response to: Lagunes-Cordoba et al 'International medical graduates: how can UK psychiatry do better?'

Paul Tiffin Lewis Paton

date

2022-04

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- *Response to: Lagunes-Cordoba et al 'International medical graduates: how can UK psychiatry do better?'*

pmc The paper by Lagunes-Cordoba et al¹ makes important points in relation to differential attainment in psychiatry. However, we note the statement: 'we note that technically the term "IMG" applies to a White British citizen who studies abroad and returns to work in the UK, yet such an individual is less likely to face attainment gaps'. This may not be entirely true, depending on what one means by 'attainment' in this context. We previously published a study

using data drawn from the UK Medical Education Database (UKMED), which investigated educational performance and success at recruitment into specialty training for UK International Medical Graduates (IMGs). These are doctors who are UK citizens but have obtained their primary medical qualification outside the UK. We showed that, on average, ratings at the Annual Review of Competence Progression were poorer for UK IMGs than non-UK IMGs. Nevertheless, UK IMGs were more likely to be successful, compared with IMGs, when applying for a specialty training post.² This finding obviously raises issues of fairness, and effectiveness, in postgraduate medical selection. We would also wish to draw attention to our own recently published study of differential attainment in the MRCPsych examination, which was not cited in the paper, though highly relevant.³ This demonstrated that differential pass rates at the Clinical Assessment of Skills and Competencies existed for candidates (both UK graduates and IMGs) who identified as being from minority ethnic groups, even after controlling for the influence of performance on knowledge-based components of the examination. Similar findings were previously reported by Esmail, for the Clinical Skills Assessment component of the MRCGP.⁴ At the time we suggested that these differential pass rates were likely to have complex underlying causes but urgently required investigating and addressing. Understanding and addressing differential attainment is clearly a matter of social justice but is also essential to the well-being of the National Health Service, its patients and the overseas-qualified staff it has traditionally relied on. Therefore, we felt it was important to draw attention to our own findings, which we believe have contributed to understanding this important but sensitive area of workforce research.

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1.1.31 Recognition and management of depression in early psychosis

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date

2022-04

Abstract**Aims and method**

Depression in first-episode psychosis (FEP) is highly prevalent and associated with poor outcomes; it has become increasingly recognised and adopted in national and international guidelines for psychosis. Using a 26-item questionnaire, this study aimed to explore if this shift has led to greater recognition among UK psychiatrists, and more effective management of depression in FEP.

Results

Of the 297 respondents, 54.4% observed depression occurring in chronic psychosis, with the least number of respondents (17.7%) identifying depression occurring frequently during FEP. Although there was reasonable agreement in the use of antidepressants as a first-line treatment for depression (70% prescribing antidepressants), there was uncertainty around assessing depression and delineating from psychosis symptoms, and particularly negative symptoms.

Clinical implications

Evidence-based treatments for comorbid depression in psychosis will lead to clearer national guidelines, allowing for optimal management of depression in early psychosis, potentially leading to improved outcomes for these individuals.

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pmc Depression is prevalent in first-episode psychosis (FEP), with rates of up to 70% at illness onset.¹ It is associated with a higher risk of relapse,² poorer functional outcomes^{3,4} and suicide.⁵ Although the National Institute for Health and Care Excellence (NICE) recommends monitoring for depression within psychosis, specific guidance on the treatment of comorbid depression has been limited, until recently.^{6,7} The lack of large-scale controlled trials investigating the effectiveness of adjunctive antidepressants⁸ has perhaps resulted in considerable variation in prescribing practices.^{6,9} A study of 80 000 international psychiatrists showed little consensus on the best management strategy for treating depression in schizophrenia; a third of clinicians reported that they rarely or never prescribe antidepressants in combination with antipsychotics.^{9,10} Since this publication in 2001,⁹ depression as a common occurrence in psychosis has become more widely recognised.^{11,12} Monitoring for depression in psychosis is featured more commonly in national and international guidelines,⁷ and the recent British Association for Psychopharmacology updated consensus statement is the

first UK guide to include specific pharmacological treatment recommendations.¹³

We aim to understand whether there has been an improvement in clinician awareness of depression in psychosis; this may have an impact on effective management, particularly in the early stages of psychosis, where treatment is likely to be more effective.¹⁴ Using a survey which was distributed to UK psychiatrists, this study aimed to explore the level of recognition and management of depression through the course of FEP.

Method

Participants

Participants were members of the Royal College of Psychiatrists, which is a professional organisation of psychiatrists based in the UK. The sample therefore comprised psychiatrists of various ages and career stage, from those in training to consultant level. Although there are around 8700 psychiatrists registered at the Royal College of Psychiatry, the survey was targeted at, and only distributed to, the general adult faculty. Participants were given the opportunity to enter into a prize draw to win £200 worth of Amazon vouchers.

Measures

Management of Depression in Psychosis questionnaire

The Management of Depression in Psychosis questionnaire is a shortened version of Siris et al's original questionnaire.⁹ It was felt to be the most suitable as it was designed to evaluate clinician awareness and management approach. It also allows for comparison of trends of psychiatric practices in assessing and managing depression in psychosis over time. The questionnaire has been adapted to focus on the identification of depression and prescribing in the early course of psychosis. For the purpose of this study, recognition of depression is defined as assessing for the three cardinal symptoms of depression, namely low mood, anhedonia and anergia. The questionnaire was built into Survey Monkey for ease, practicality and anonymous online administration. The questionnaire was completed anonymously and comprised 23 questions relating to the following: demographic characteristics of the respondents (e.g. gender, years since graduation, specialty/subspecialty and region of practice); recognition of symptoms relevant to the diagnosis of depression; depression time course in psychosis; factors and symptoms that prompt the prescription of antidepressants; evaluation measures; and treatment selection and practice (e.g. medication dose and duration).

Procedure

The questionnaires were completed over a period of 2 months after being granted ethical approval and agreed sponsorship by University of Birmingham (REC Reference: ERN_18-1658). Participants were provided with information about the study, informed of the voluntary nature of their participation, and reminded that responses were anonymous with the option to opt in for the prize draw. Written informed consent was obtained from all participants.

Data analysis

Data were downloaded from Survey Monkey (see http://www.surveymonkey.co.uk/r/Depression_in_psychosis_survey) and inspected using a Microsoft Excel (365 for Windows) worksheet. Descriptive statistics were explored using SPSS version 24 for Windows.

Results

In total, there were 297 respondents; although on average, it was observed that a third of the participants who completed the survey also skipped at least one question in the questionnaire. A total of 52% were male, and on average, the sample had 21 years (s.d. 11.5) of practice since graduating from medical school. Responses by geographical regions were as follows: London (13.4%), South-East (12.4%), West Midlands (11.9%), South-West (11.9%) and Scotland (11.9%). We had the least responses from Wales (2.6%), Northern Ireland (2.6) and East Midlands (3.6%), and 26.8% of participants did not give a response. The majority of the respondents were clinicians that practiced within community settings (67.7%).

Observed prevalence and time course of depression in psychosis

A total of 41.2% of participants had a case-load of which patients with psychosis comprised >50%; 46.6% had between 5–50% and 1.3% had <5%. The majority of respondents reported observing depression occurring concurrently with chronic stable psychosis (54.4%), and 23% reported depression occurring concurrently with acute relapse. With regards to depression emerging in the initial phase of illness, 19.1% observed depression within the prodromal phase to the acute psychotic phase; 32.4% reported depression emerging as the first acute episode of psychosis resolves, and 17.7% of respondents reported observing depression during the first episode of psychosis.

Assessment and diagnosis of depression in psychosis

Respondents were asked to select the first five most relevant symptoms they consider in diagnosing depression in psychosis: 93.2% identified low mood, 68.3% identified anhedonia, 57.1% identified suicidal thoughts, 53.2% identified poor motivation and 48.3% identified interest in life as a symptom. Please see *Fig. 1* for the full breakdown of symptoms reported by respondents. *Fig. 1* Breakdown of main symptoms identified by respondents to diagnose depression in psychosis.

The majority of participants reported not utilising a specific interview system to inform a diagnosis of depression in psychosis (96.6%). In terms of employing depression evaluation measures, 35.1% of respondents reported using none, 39.1% used the Beck Depression Inventory, 28.5% used the Hamilton Rating Scale for Depression, 17.2% used the Brief Psychiatric Scale and 9.3% used the Calgary Depression Scale for Schizophrenia (CDSS).

Recognition and management of depression in psychosis

Participants were asked about which clinical guidelines they used to aid the recognition and management of depression in psychosis: 61.5% of respondents used NICE guidelines, 50.0% used the Maudsley Prescribing Guidelines, 27.6% used British Association for Psychopharmacology guidelines and 12.0% used *BJPsych Advances* (previously known as *Advances in Psychiatric Treatment*) articles; the remainder mainly used clinical experience.

Treatment approaches

Antidepressant therapy

The majority of respondents reported that antidepressant medication would be their first line of treatment for psychosis with comorbid depression (69.5%), 32.5% indicated cognitive-behavioural therapy, 12.3% reported a 'watch and wait approach' and 7.4% would reduce the dose of the prescribed antipsychotic medication.

In terms of factors that would prompt prescribing of an antidepressant, 84.2% reported a family history of depression, 40.4% reported poor interpersonal and social skills, 39.2% reported 'living alone' and 29.8% reported a 'recent loss or rejection'. Key symptoms prompting a prescription of an antidepressant medication included hopelessness (80.1%), low mood (76.5%) and suicidal ideation (75.5%).

With regards to antidepressants prescribed in early psychosis with comorbid depression, selective serotonin reuptake inhibitors were generally preferred; the majority of respondents opted for sertraline (85.4%), followed by mirtazapine (49.8%), fluoxetine (45.4%) and venlafaxine (33.7%). Interestingly, 28.8% of participants opted for citalopram and 15.1% opted for escitalopram. Please see *Fig. 2* for the proportions of antidepressants prescribed. *Fig. 2* Proportions of antidepressants reported to be prescribed as first-line treatments for depression in early psychosis

Antipsychotic therapy

Participants were asked about antipsychotics they routinely prescribe for young people with early psychosis. Atypical antipsychotic agents were the most commonly prescribed: 66.0% of respondents opted for aripiprazole, 54.2% opted for olanzapine, 52.2% opted for risperidone and 44.3% opted for quetiapine. Clozapine was selected by 9.9% of respondents. Please see *Fig. 3* for the proportion of antipsychotics prescribed. *Fig. 3* Proportions of antipsychotics prescribed by respondents.

Drug combinations and treatment duration

In terms of conjunctive antidepressant and dopamine antagonist prescribing, 55.7% reported they would not frequently prescribe this combination, 35.8% reported often prescribing and 8.5% affirmed that they very often prescribe this combination.

A total of 13.5% of respondents stated that they would completely avoid mirtazapine and olanzapine in combination, with a handful citing reasons such as weight gain and oversedation; 14.4% stated they would actively avoid citalopram and antipsychotics in combination, with some citing reasons such as increased risk of corrected QT interval prolongation; and 42.3% reported that there were no combinations that they would actively avoid.

With regards to duration of therapy, 47.8% of respondents estimated expecting clinical benefits within 2–4 weeks of adding antidepressant to dopamine antagonist therapy, 43.3% thought it would likely take 4–6 weeks and 7.5% predicted improvement in 6–12 weeks. The majority of participants (77.5%) felt that antidepressant therapy should continue for 6–12 months once the individual showed a satisfactory response, 15.7% felt that therapy should continue for >12 months and 8.3% felt that therapy should continue for 3–6 months. In terms of physical health monitoring when coprescribing, 77.9% monitored heart rhythm via electrocardiogram, monitored blood chemistry (prolactin, glucose and lipid profile), 73.4% monitored bloods (prolactin, glucose and lipid profile) and 42.9% undertook a physical examination. However, 18.2% reported that no physical health interventions were carried out.

Non-pharmacological treatment approaches

On average, most respondents prescribed non-pharmacological therapies for depression in FEP, with 82.1% opting for psychoeducation and cognitive-behavioural therapy, 67.2% opting for psychosocial interventions and 42.3% opting for family interventions. A further 10.5% of participants reported prescribing electroconvulsive therapy, and a handful opted for lifestyle interventions and supportive psychotherapy.

Reflections from respondents

Overall, about a third of the participants highlighted difficulty in delineating negative symptoms of psychosis from depression during a period of psychosis. Others described the complex interactions of positive and cognitive symptoms that are hard to disentangle, as well as the possibility of an affective illness occurring as the primary driver for psychosis. Many respondents expressed keenness in offering psychology or psychotherapy, but cited problems with availability at the time of need.

Discussion

This study aimed to gauge the level of recognition and management approaches used by UK psychiatrists to manage and treat depression in psychosis. With depression in psychosis now being adopted in national and international clinical guidelines,⁷ we wanted to explore whether any change in recognition has led to more effective management of depression in those with psychosis, particularly in the early stages of illness.

Overall, the majority of respondents (69.5%) indicated the use of antidepressant medication as a first line of treatment for young people with psychosis and comorbid depression. There was reasonable agreement among clinicians on the contextual factors and key symptoms that would prompt a prescription of antidepressant medication. For example, the majority of respondents reported low mood and anhedonia as the major symptoms for diagnosing depression (93% and 68%, respectively), with 45% also identifying anergia as a core symptom. Over 80% of participants reported that they would routinely prescribe a selective serotonin reuptake inhibitor (sertraline in particular). This indicates a reasonable agreement between clinicians on the best strategy for managing comorbid depression with psychosis. These findings demonstrate a possible shift in the management strategy since Siris et al's⁹ earlier publication, where a third of clinicians reported that they would rarely prescribe antidepressants in adjunct to antipsychotic medication.

Although previous studies have reported 70% prevalence rates of depression at illness onset,¹ our study showed fewer respondents (19%) identified depression as occurring frequently in FEP; instead, 54% reported observing depression occurring with stable psychosis. This might suggest that depression in the early phases of psychosis is still underrecognised; this is concerning, given that young people in particular are at heightened risk of suicide within the first 12 months following the initial episode of psychosis.^{15,16} However, it must also be acknowledged that the findings from our survey are reliant on the memory of clinicians, with a potential for recall bias, and so the accuracy of these findings may be challenged.

Despite a consensus on treatment strategies for depression, what became apparent from the survey was the uncertainty around assessing depression and delineating from psychosis symptoms, and particularly negative symptoms. Interestingly, a large proportion do not employ structured interview schedules to inform their assessment, which could aid this delineation. In particular, the CDSS was only used by 9% of respondents. The CDSS is a short and easily used instrument, designed specifically for the assessment of depression in psychosis, as it distinguishes between negative and positive symptoms.¹⁷ Better promotion of these evaluation measures may be warranted.

There were also reports of challenges faced by clinicians in determining if the symptoms were part of an affective component of the psychotic episode, potentially highlighting the need for a better understanding of the diagnostic uncertainty and course of depression in early psychosis.¹⁸

Over the past two decades, there appears to have been a shift in prescribing of antipsychotic medications – particularly from the first generation (typical) to second generation (atypical) agents.¹⁹ This is also reflected in our survey, where the majority were prescribing atypical agents such as aripiprazole, olanzapine, risperidone and quetiapine, compared with 4.9% and 3.9% of respondents prescribing haloperidol and zuclopenthixol. Thus, there appears to be a particular preference toward the antipsychotics believed to have the least side-effects, but not with recognition that some antipsychotics may have more antidepressant properties,²⁰ or possibly promote depression, such as haloperidol.¹³

In regards to coprescribing in the present study, most respondents reported that there were no combinations of antidepressants and antipsychotics that they would actively avoid; however, some did express actively avoiding citalopram and antipsychotic in combination, with some citing risk of prolongation of the corrected QT interval. A similar percentage reported they would actively avoid a combination of mirtazapine and olanzapine because of increased risk of weight gain and sedation. In line with this, the majority of respondents (>70%) stated that they provided routine physical health monitoring when coprescribing. These findings indicate that clinicians are perhaps more cognisant of the potential physical health problems caused by antipsychotic medications, and may suggest proactiveness in mitigating such risks. Although this finding is encouraging, recent data shows that only 32.3% of individuals with severe mental illness in England receive a full physical health check.^{21,22} Given the lowered life expectancy of individuals with schizophrenia, the current NICE recommendations advocate for annual physical health checks for all individuals with severe mental health problems.²³ Improving physical health monitoring should remain a top priority.²²

Implications for clinical practice

Our results may indicate further training and embedding of routine assessment tools into clinical practice is needed to further increase the recognition and management of depression, which, if achieved, could improve outcomes. Indeed, this finding is in keeping with the wider literature on the difficulty of promoting the use of instruments, such as the CDSS, into routine practice.²⁴ A suggestion may be to embed these instruments into electronic patient records, and include monitoring of comorbidities as part of quality improvement programmes, and national audits such as the National Clinical Audit of Psychosis.²⁵

Study strengths and limitations

This study was the first to explore clinician recognition and management of depression in young people with FEP. Although the survey was completed by 297 clinicians, responses were underrepresented in certain parts of the country (particularly Wales, Northern Ireland and East Midlands), and overall response rate was low. On average, a third of the participants who completed the survey also returned incomplete questionnaires, affecting the overall representativeness of the information provided.

This study relied on the clinician reflecting on their previous practice, awareness and general approach, and they were provided with multiple options for each question. As such, there is a potential for recall bias. Furthermore, some questions were focused on depression within psychosis more generally, meaning that responses were less specific to depression in FEP. It is also very likely that clinicians within the Early Intervention Service and those with more interest in this field may have been more involved in the survey. An Amazon voucher was also offered as an incentive for participation, again, further introducing a respondent bias.

Another limitation was in disseminating the survey. Because of regulations governing the Royal College of Psychiatry, emails were only distributed to members registered under the General Adult Psychiatry faculty. The questionnaire was not disseminated to other psychiatric disciplines that may have been relevant, such as Child and Adolescent Mental Health Service, and Forensic or Learning Disability subspecialties. Finally, the survey was UK-based, with a low response rate. Further research is required to understand whether these practices are uniform in a larger sample of participants, and across different countries, particularly in the USA and Europe.

In conclusion, although there is now more consensus on recognising depression in early psychosis strategies, there continues to be variations in the approach toward its assessment and management (e.g. in the use of specific interview schedules or evaluation measures to assess depression in those with psychosis). Although our findings are tentative, given the low response rate, the survey indicates that adjunctive treatment is being administered by most clinicians; however, some expressed difficulties in differentiating between depression occurring in relation to psychosis and negative symptoms of psychosis, and there was little consensus on treatment duration and time of expectation of response. Embedding of structured assessment tools into routine practice, in addition to devising clearer national guidelines based on large definitive trials, would be instrumental in improving future practice in early psychosis, potentially leading to improved outcomes.

We thank the Royal College of Psychiatrists for supporting our research by distributing our study information to its members. We also thank the clinicians who took time to participate in this study.

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Data availability

The corresponding and senior authors had full access to study data and had final responsibility for the decision to submit for publication. The data that support the findings of this study are available on request from the corresponding author, S.L.G. The data are not publicly available due to privacy or ethical restrictions.

R.U. was the chief investigator and funds recipient. S.L.G. and Z.B. designed the study protocol and survey. The data were analysed by Z.B. and S.L.G. Z.B. and S.L.G. drafted the manuscript, with further input from R.U. All authors provided comments on the manuscripts and approved the final version.

Declaration of interest

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Supplementary material

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1.1.32 Finding order within the disorder: a case study exploring the meaningfulness of delusions

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Abstract

Can delusions, in the context of psychosis, enhance a person's sense of meaningfulness? The case described here suggests that, in some circumstances, they can. This prompts further questions into the complexities of delusion as a *lived* phenomenon, with important implications for the clinical encounter. While assumptions of meaninglessness are often associated with concepts of 'disorder', 'harm' and 'dysfunction', we suggest that meaning can nonetheless be found within what is commonly taken to be incomprehensible or even meaningless. A phenomenological and value-based approach appears indispensable for clinicians facing the seemingly paradoxical coexistence of harmfulness and meaningfulness.

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pmc The prevailing clinical view of delusions in the context of psychosis, as reflected in the cognitive literature, supports the central proposition that delusions are the result of disturbances of reasoning and that they represent maladaptive appraisals about the world one inhabits. Such inferences are often taken to be grossly outside of the realm of psychological comprehension and, for the most part, inherently dysfunctional. In some cases, this can lead to prejudiced attributions of bizarreness, irrationality and meaninglessness. Very few empirical studies have investigated the relationship between delusions and meaningfulness. In addition, since the so-called ‘operational revolution’ in psychiatry, a tendency to focus on notions of disorder, disability and distress has often led to a reduced attention to issues of subjectivity, personhood and meaningfulness within the experience of illness. Through presenting this case study, we wish to bring these issues back to the fore.

The case of Harry, the ‘happiest man in the world’

Mr Harry is a 33-year-old gentleman who has been complaining of being the target of a worldwide conspiracy for the past 5 years. He explains that one day, he was in his room and he was picking his nose. The cameras in his room recorded it and this was uploaded to the internet; now everyone in the world, especially those in the USA, are talking about it. People in the streets make signs like scratching their nose or straightening their hair, as an indication to him that they have seen his videos and know about him. He believes that there is a hierarchy of people who are taunting him, and this hierarchy goes up to the Illuminati and the Queen. He thinks that there are lizard people in charge of the Earth that have made people believe that the Earth is round, when in fact it is flat and ends at the Arctic and Antarctic (where there are ice cliffs beyond which we are not allowed to go). He believes that people are being told lies since the day they are born, and two- and three-dimensional imagery are used by the National Aeronautics and Space Administration to fool people into believing what they see is real, just like in the film ‘The Truman Show’. Harry thinks that scientists are trying to fool humanity by leading us away from religion. Satan is taking over the world and the Earth is moving at 6660 miles per hour.

During a consultation with one of the authors (R.R.), Harry explained how he knows all this: ‘My senses have shown me that nothing is real, there is nothing outside this world, just infinite space’. These experiences are unique to him and he feels very special as a result, as nobody else has access to the truth. He reported watching YouTube videos that have proven all his theories, and now fully understands what the world is really like. He is the happiest man in the world and states that every day is filled with novelty and excitement. Harry finds it surprising that people are blind to all this, and have nothing better to do in their lives than following him around, listening to his thoughts and controlling him. However, he has now learnt that he can reply back and influence their thoughts positively, which has made him feel more powerful than he has ever felt. Harry denies ever feeling threatened or anxious when he found out about the conspiracies, although he has not been able to work because of this outside interference. When asked further about the challenges of conducting a life under the control of others, Harry replied: “‘If I went out one day and I realised that

people weren't expecting me to be there, it would be a real shock again ... I would be ... I don't know ...?! I got so used to people expecting me to be there and lash out with them ... I would feel alone again, which is what everyone else feels, like alone. So people are like a family for me, it's like a safety blanket, they make me feel so comfortable now ... If I found out that they are not watching me and reading my mind, I would feel alone and crazy like everyone else. To feel like I have everyone following me around, whether it's negative or positive, that alone is a force of power ... knowing that you can influence people's minds in the right way, I feel like Jesus (of course I'm not) but why not believe?"

Clinical encounter

Harry was referred to Early Intervention in Psychosis services via his general practitioner, after revealing the unusual situation in which he found himself. He was prompted to seek help by his family, who were concerned about his mental health, although he did not believe he needed help. Rather, he thought that everyone else was deluded for not realising what was really happening. At the time of the first interview with the psychiatrist, Harry was described as a very pleasant, cooperative gentleman, and caring father. Upon examination, his content of thought was characterised by ever-increasing systems of conspiratorial views of the world and described as bizarre – including, for example, the idea that the Queen is a lizard in disguise. This was associated with a mild degree of formal thought disorder and decline in social and occupational functioning. There was no evidence of marked changes in mood, hyperactivity or other signs of elation. Harry described 'voices' talking to him and about him, although when asked the direct question of whether he was 'hearing' voices, he denied this. Risk to others was considered to be low, whereas a potential vulnerability to others was highlighted.

Given the presence of clear positive psychotic features and impairment in functioning, suggesting first-episode psychosis, Harry was informed about treatment options and antipsychotic medication was prescribed. At the following appointment, Harry reported non-adherence with his medication. He said that he had realised there was a microchip inside him that was being used by others to monitor him and read his mind. People were making signs at him, following him around, thus he needed to 'deal with them'. He insisted that he was 'completely in control' and that those who were persecuting him were the ones needing help. While discussing medication, he became irritable and started accusing staff of considering him 'crazy'. He was not amenable to persuasion or reasoning. To avoid escalation, the clinician had no option but to let him leave for his home.

Management options were discussed, and clinicians were divided between those who felt that Harry's symptoms should not be necessarily considered pathological, and those who felt that his presentation would fulfil the criteria for compulsory admission to hospital. This latter understanding was motivated by the clear evidence of mental disorder, a detected risk of him acting out on his beliefs that others were persecuting him, potential risk (but no evidence of this) to his children and failed attempts to treat him in the community. Initial diagnostic considerations made by the treating clinician were in keeping with a diagnosis of schizophrenia. However, this diagnosis was challenged by others, who suggested that his delusions were better explained by a delusional disorder or, more simply, were in keeping with the influence of cultural factors and were not pathological at all. Harry remained convinced throughout that his experiences were real, that he was the happiest man in the world and that clinicians had no good reason to 'label' him as mentally ill or recommend a compulsory admission. Unfortunately, the disagreement led to significant subjective distress reported by Harry, a breakdown in the therapeutic relationship, disengagement from the team and other adverse social consequences, including denial of access to his children for a period of time.

Questions concerning current conceptions of delusions

This case is illustrative of more general, unresolved issues concerning current conceptions of delusions, which have a knock-on effect on the clinical encounter with deluded patients (irrespective of their diagnosis, but potentially more relevant in the case of schizophrenia). In particular: What exactly is pathological about delusions? This is briefly discussed in *Delusional complexities*. Are delusions the source of the problem or a response to the problem? This is addressed in *The phenomenological approach to delusion formation*. Can delusions have and give meaning? An overview of the small body of relevant literature is offered in the corresponding section. Our inquiry into meaning in this context takes a subjectivist naturalist perspective on the conception of 'meaning'. Meaning refers here to the extent to which one's life is subjectively experienced as making sense, and as being motivated and directed by valued goals.

We temporarily leave diagnostic challenges aside and explore possibilities for a cross-disciplinary dialogue between philosophy and psychiatry concerning the nature and meaning of delusions, with direct relevance for clinical practice. Implications for the clinical encounter are discussed in the final section.

Ethical considerations

The reported patient agreed to the publication of the case study and provided written consent. All steps were conducted in accordance with the regulations of Coventry and Warwickshire Partnership NHS Trust and the Declaration of Helsinki. Written approval for the publication of the report was obtained from the Research & Innovation Department, Coventry and Warwickshire Partnership NHS Trust.

Delusional complexities

Delusions are core psychopathological features of severe mental illness. They are present in the vast majority of patients at first presentation to early intervention services across affective and non-affective diagnoses within the psychosis spectrum.¹ They are often associated with great distress, depression and harm, representing a significant therapeutic challenge for clinicians.^{2,3} Despite extensive literature on the potential psychological, neurocognitive and phenomenological underpinnings of delusion formation,⁴⁻⁶ there is no consensus as to what causes delusions or why they are maintained despite their harmful consequences. Furthermore, cross-disciplinary attempts to define their puzzling nature remain inconclusive – perpetuating the philosophical debate between doxasticists (who regard delusions as beliefs) and non-doxasticists (who regard delusions as other than beliefs).

In psychiatric practice, given the absence of clear biological markers, the distinction between delusional and non-delusional ideas is not straightforward. Although meta-analyses of the available data corroborate a connection between reasoning biases and the occurrence of delusional ideas,⁷ they do not provide an explanation as to why delusions have the specific thematic content that they have, nor do they establish clear evidence for a causal relationship. Given the difficulties in defining what kind of phenomena delusions are, and in identifying the aetiological factors involved in their formation and maintenance, the clinical examination and study of delusions continue to focus on their (apparently more reliable) doxastic features. Such features predominantly consist of negative epistemic attributes such as falsehood/incorrectness, fixity/resistance to counterargument and counterevidence, and implausibility of content.⁸ For example, the DSM-5 defines delusion as: “‘A false belief based on incorrect inference about external reality that is firmly held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not ordinarily accepted by other members of the person’s culture or subculture (i.e. it is not an article of religious faith). When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. Delusional conviction can sometimes be inferred from an overvalued idea (in which case the individual has an unreasonable belief or idea but does not hold it as firmly as is the case with a delusion)’ (p. 819).⁹”

However, as philosophers have already made clear, overreliance on these criteria is often not a successful strategy when trying to distinguish pathological beliefs from everyday irrational beliefs.¹⁰ For instance, prejudiced, superstitious or self-enhancing beliefs are all often ill-grounded and impervious to counterargument, yet they do not warrant a psychiatric diagnosis or compulsory treatment. In the case of Harry, these criteria evidently fell short and clinicians immediately noticed how similar Harry’s belief were to those held by ‘flat earthers’ and other fringe communities with heavy influence across social media. What then makes such beliefs different from those of patients affected by schizophrenia? When do beliefs become a symptom of mental disorder?

Focusing on the psychological and sociological features (such as distress, harm and dysfunction) associated with certain unusual convictions might be a better way forward for clinicians. However, this pragmatic approach, relying on criteria of clinical utility, hides other significant and ethically loaded challenges.¹¹ For instance, how do we equitably decide on the threshold of harm or potential harm that deserves a psychiatric diagnosis and/or warrants treatment against someone’s will? Such a decision will necessarily involve a value judgement on the part of the clinician not only about what might be harmful to another person in relation to their behaviour, but also in relation to their own feelings (e.g. levels of distress), sociocultural background, previous life circumstances and future goals. Disregarding the value-laden context that shapes the lived experience of delusional phenomena might increase patients’ vulnerability to suffering

epistemic injustice.¹² Harry for example, appeared to be adequately fulfilling his parental role and repeatedly denied feeling distressed, anxious, worried or depressed. A battery of psychological tests showed no clinically relevant anxiety or depression; rather, they revealed surprisingly high levels of meaning in life (see discussion below). On the other hand, his level of social and occupational functioning is moderately low. Harry is unable to maintain a stable occupation and what seems to be giving a special significance to his experience (i.e. the fact that he has special access to the truth) is effectively making him an outcast from society.

Clinicians therefore seem to be faced with a case of meaningful dysfunction. The person's beliefs seem to impose a limitation on their objective ability to keep consistent employment (social dysfunction). Concurrently, they also seem to enhance the person's sense of agency and belonging, and no distress is reported with regards to either the beliefs or the ensuing impairment. Does such a condition deserve clinical attention? Does it require pharmacological treatment? Despite being grounded within a delusional experience, could such feelings play a protective role against depression and anxiety?

It is clear that, although the concept of delusions as 'false beliefs' is commonly taken for granted within mainstream psychiatry, their complex nature remains difficult to grasp. As a result, the threshold for pathology or dysfunction continues to be set on pragmatic grounds relying on criteria of severity and degree of distress/functional impairment. However, in certain cases, it seems that the clinical utility of pragmatic criteria is limited by a clash with the framework of values of the individual patient. This begs the key question of what constitutes a meaningful or functional life, and leads us further into the relationship between facts and values in psychiatry.¹¹

Although many of these questions remain open and in need of further philosophical investigation, an important response in the past 20 years has been the renewed interest in phenomenological approaches to psychopathology. This has been accompanied by a revival of the legacy of Karl Jaspers and other classical authors, such as Minkowski, Bleuler, Conrad, Blankenburg, Mayer-Gross and J.S. Strauss, among others.^{13–17} The phenomenological approach argues that, particularly in the case of schizophrenia, there is a qualitative difference between 'true' delusions and delusion-like ideas, and that a more precise and in-depth characterisation of changes in the experience of self and lived world is needed if we aim to distinguish non-disordered analogues from clinically relevant forms of psychopathology.

The phenomenological approach to delusion formation

Various phenomenologically informed authors have challenged the view that delusions are beliefs (see *Table 1* for some excerpts from the contemporary phenomenological literature). In contrast with the doxastic (i.e. belief-based) position, phenomenologists have understood delusions to be either something of a completely different nature from beliefs (this is the 'non-doxastic' view), or they have suggested that this discussion is beside the point as it is failing to engage with what is most fundamental to delusion.¹⁸ Jaspers himself wrote: 'To say simply that a delusion is a mistaken idea which is firmly held by the patient and which cannot be corrected gives only a superficial and incorrect answer to the problem. Definition will not dispose of the matter' (p. 93).¹⁹ Table 1 Conceptions of delusions from a phenomenological perspective 'For the phenomenologist, delusion is typically understood not as an individual belief [...] but as a mutation of the ontological framework of experience itself.' (p. 633)²⁰ 'It follows that delusions, at least in this scenario, are not simply anomalous beliefs or perceptions. [...] They have a type of intentionality that differs from mundane experiences of believing, remembering, imagining or perceiving.' (p. 153)²¹ 'One might indeed argue that the so-called 'delusional beliefs' are not beliefs in the epistemic sense at all, for they lack the basis of a shared intentional relation to the world.' (p. 25)²² 'Schizophrenic delusions typically reflect a fundamentally altered existential-ontological structure of subjectivity.' (p. 173)²³ 'When a subject enters into a delusional state, he or she is entering into an alternative reality. [...] one can enter into a delusional reality just as one can enter into a dream reality, or a fictional reality, or a virtual reality.' (pp. 255–6)²⁴

Following Jaspers, much phenomenological research has drawn attention to the subtle and all-enveloping changes that are often described by patients with delusions during the 'prodromal' or 'pre-delusional' stages. Jaspers refers to this experience as 'delusional mood' or 'delusional atmosphere', and describes it as follows: "'Patients feel uncanny and that there is something suspicious afoot. Everything gets a new meaning. The environment is somehow different—not to a gross degree—perception is unaltered in itself but there is some change which envelops everything with a subtle, pervasive and strangely uncertain light. A living-room which formerly was felt as neutral or friendly now becomes dominated by some indefinable atmosphere. Something seems in the air which the patient cannot account for, a distrustful,

uncomfortable, uncanny tension invades him' (p. 98).¹⁹

In Jasper's view, the subsequent emergence of a specific belief content can only be understood in the context of a 'transformation in our total awareness of reality'.¹⁹ Such fundamental transformation can, in some cases, give rise to what he calls 'delusion proper' or 'primary delusions' to distinguish them from 'delusion-like ideas'. Although the latter kind of delusional beliefs can be understood as an excess or lack of certain known emotional states or responses (such as fear, melancholy, suspiciousness, anxiety and wonder), the former kind of delusions remain largely incomprehensible in the face of empathic or common-sense attempts to grasp their meanings.

Just as Harry mentioned the film 'The Truman Show' to aptly communicate his puzzling experience of infinite space, many patients talk about living in a 'real simulation' or a 'fake reality' to convey the sense of unreality that surrounds them. In these moments, they often describe changes in their subjective experience of the lived world, including the dimensions of time, space, objects, atmospheres and other persons.²⁵ For example, time or movements might be experienced as accelerated or slowed down, objects may appear two-dimensional as if they were artificially projected on the backdrop of a theatrical scenery, and other people may look like mannikins, puppets or robots wearing a mask.²⁶ This is similar to what Renee describes as an all-embracing atmosphere of unreality in her memoir: "Objects are stage trappings, placed here and there, geometric cubes without meaning. People turn weirdly about, they make gestures, movements without sense; [...]. And I - I am lost in it, isolated, cold, stripped purposeless under the light. A wall of brass separates me from everybody and everything. In the midst of desolation, in indescribable distress, in absolute solitude, I am terrifyingly alone; no one comes to help me. This was it; this was madness [...] Madness was finding oneself permanently in an all embracing Unreality' (p. 33, abridged).²⁷

Although this can be perceived in some cases as an exciting and illuminating experience (such as in Harry's case), most often the delusional atmosphere is fraught with dread, anxiety and a sense of uncertainty. Patients often describe an increasing tension coupled with an unbearable sense of impending doom.

In his seminal work, the German psychiatrist Klaus Conrad calls this initial phase 'trema' (stage fright) – emphasising the suspenseful and expectational character of the experience.²⁸ Even Harry reported that it all came as a shock for him, calling into questions everything he knew about the world since the day he was born. This state of perplexity seems to trigger an urgent quest for meaning, as highlighted in many first-person reports and clinical accounts.²⁹ The delusion then provides the long-sought meaning that dissipates anxiety, perplexity and confusion. In this moment, which Conrad calls the 'apophany' or 'aha experience', the person promptly makes sense of what was previously only alluded to. This new (delusional) meaning alleviates the unbearable sense of dread previously felt. The soothing effect provided by the experience of finding 'a fixed point' to cling on is described well by Jaspers: "This general delusional atmosphere with its vagueness of content must be unbearable. Patients obviously suffer terribly under it and to reach some definite idea at last is like being relieved from some enormous burden [...] the achievement of this brings strength and comfort, and it is brought about only by forming an idea, as happens with health people in analogous circumstances' (p. 98, abridged).¹⁹

Framed in this way, the newly developed delusional framework can be understood as establishing a new 'order' within the 'disorder', one which can alleviate negative feelings of anxiety or induce intense feelings of wonder. This allows the person to re-establish a pragmatic connection with the world, although this can come at great expense because of the difficult integration between the shared sociocultural world and the delusional reality. Rather than being the source of the problem, the emerging delusional narrative (i.e. what we currently identify as belief) may be better interpreted as a secondary response to anomalous experiences which call into question our most fundamental assumptions about ourselves, the world and the meaning of life.

Can delusions have and give meaning?

After a period of disengagement with services, Harry agreed to continue working with the team, although he refused to interact with staff initially involved in his care. Because of the research interests of one of the clinicians (R.R.), Harry was invited to talk about his experiences, and he happily completed a small battery of self-administered psychological tests that measure depression (Calgary Depression Scale for Schizophrenia),³⁰ anxiety (Generalized Anxiety Disorder seven-item scale)³¹ and meaning in life (the Purpose-in-Life Test (PILT), the Life Regard Index (LRI) and the Multidimensional Existential Meaning Scale).^{32–34} These assessments revealed high scores across three measures of meaning in life (indicative of a strong sense of coherence (SOC), purpose and significance), and low scores on the depression and anxiety scales, suggestive of absent levels of depressive or anxious features (see *Table 2*). Table 2 Self-administered measures of depression, anxiety and meaning in life conducted in the case study Measure Total score - Details of measures Calgary Depression Scale for Schizophrenia 36 is commonly used to identify clinically significant depressive symptoms Generalized Anxiety Disorder seven-item scale 0 Scores of 5, 10 and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively Purpose-in-Life Test 96 Range 20 (low purpose) to 100 (high purpose) Life Regard Index 68 Range 14 (low life regard) to 70 (high life regard) Multidimensional Existential Meaning Scale 99 Range 15 (low existential meaning) to 105 (high existential meaning)

There is no doubt that Harry's experiences have brought about a significant change in the way in which Harry sees himself and the world around him, albeit one that others cannot recognise. As we can gather from his account, it all came as a shock, a powerful revelation of what life is really like. Whether this change is one that can be understood by others as 'having meaning' (i.e. making sense) and 'giving meaning' (i.e. contributing to a sense of purpose and significance) is a far more complex issue, but one worthy of further investigation and one that carries significant implications for the clinical encounter. From Harry's perspective, this new order seems to provide a coherent explanation for his experiences, while also enhancing his sense of direction in life and enthusiasm regarding the future.³⁵ There is, however, a remarkably small amount of empirical research that has examined such issues, which we briefly review below.

In a study by Roberts,³⁶ a group of patients with chronic schizophrenia displaying elaborated delusional systems was administered the PILT and the LRI. The author compared the scores obtained by actively delusional patients with chronic schizophrenia with a matched sample of other chronic patients, who were previously deluded but were now in remission. Psychiatric rehabilitation nurses and Anglican ordinands were also included as non-clinical comparison groups. Results showed that patients with elaborated delusions had a very high level of perceived purpose and meaning in life (and low level of depression and suicidal ideation), and PILT/LRI scores were significantly higher than those found in patients with chronic schizophrenia in remission. The group in remission felt both more depressed and found their lives less meaningful than those with active delusions. Scores in the actively deluded group were also similar to those found in the Anglican ordinands comparison group and higher than those found in the nursing group. Another study³⁷ investigated the relationship between the SOC and delusional experiences in individuals with schizophrenia, using self-report scales for delusions, SOC, depression and expressed emotion. SOC among participants experiencing acute delusion was found to be similar to the average scores found in the general population, but a reduction in SOC was found in the remission period, suggesting decreased well-being among those with reduced delusional intensity. These findings led Bergstein et al³⁷ to speculate about the subjective meaning-enhancing effect of delusional systems, and the potential negative consequences associated with the undermining of the acquired (delusional) background of meaning.

More recently, Isham et al² conducted a qualitative analysis of the narratives of 15 patients with past or present experiences of grandiose delusions. Although suggesting that serious harm (including social, physical, sexual, emotional and occupational) was occurring to people as a result of the delusions, the narratives examined contained first-person descriptions of the grandiose beliefs as highly meaningful: a meaning-making theme was generated through the analysis, where the delusion seemed to 'provide a sense of purpose, belonging, or self-identity, or to help make sense of unusual or difficult events.' A highly prevalent theme was related to social meanings (i.e. being useful to and a significant part of society), whereby participants felt 'part of a team', respected by others or involved in intimate relationships. Similarly, in their qualitative in-depth analysis of four cases, Gunn and Larkin³⁸ describe the development of delusions as an 'inevitable consequence of a radical alteration in lived experience'. Focusing on what was important to the participants and grounding their interpretation in the data by using interpretative phenomenological analysis, they highlight how all their participants had experienced some perceptual, affective and emotional anomalies demanding explanatory and

sense-making attempts. Although these attempts turn out to be delusional, they nonetheless seem to provide a fitting explanation for the anomalous experiences, as well as potential psychological benefits in terms of enhanced self-efficacy and meaningfulness.

Implications for the clinical encounter

Harry's case highlights the complexities intrinsic to the concept and nature of delusions, which are commonly taken for granted within mainstream psychiatry practice. By appealing exclusively to surface epistemic features, Harry's delusions might appear outwardly almost indistinguishable from fringe conspiracy beliefs. In both cases, they are ill-grounded and we have reasonable contradictory evidence regarding their veracity. Harry (just like many conspiracy theory believers) is not amenable to changing his mind about the fact that he is constantly monitored, that the Queen is a reptile in disguise and that the Earth is flat, among other more systematised convictions. His beliefs are certainly fixed and impervious to counterargument. Do these features make them pathological? By appealing to a pragmatic criterion of harmful dysfunction, we could agree on the fact that Harry's social and occupational functioning is impaired and therefore adequate interventions should be sought – aiming to ameliorate such undesirable state. However, Harry is telling us that he is the happiest man in the world. He reports finding a highly significant meaning for leading his life, something that gives him coherence and purpose. Value judgements necessarily come into play at this point, raising broader and more challenging questions about what makes a good life and where the threshold should be set for something meaningful to become harmful. Although we may not have a clear answer to these questions, we should at least attempt to investigate what the world feels like for Harry. Such phenomenological endeavour might not only open up a space for dialogue, but can also advance our understanding of the nature and constitution of delusional phenomena. Just like the three blind men who came to different conclusions as to the nature of an elephant, looking only at the 'belief' side of delusions might limit our understanding of what makes the delusional experience possible in the first place. This may further aid our attempts to define what makes delusions pathological or when they should be considered part of a disorder.

Taking into account the subjective changes to the sense of self and world often affecting people with delusions can improve our empathic understanding of delusional phenomena; that is, as arising in the context of a more global transformation of the sense of reality and familiarity. Within the clinical encounter, delusions can be at the same time harmful (e.g. causing a dysfunction of some kind) and meaningful. They can have meaning (i.e. make sense) in relation to uncanny changes in the lived world, and they can give meaning (i.e. purpose/significance) in the context of the person's unique life story and framework of values. When a clash of realities creates an impasse within the clinical encounter, clinicians should investigate the presence of anomalous and potentially distressing changes in the subjective experience of the lived world. Clinicians should also acknowledge the relentless sense of perplexity often arising from these experiences, which might trigger a search for explanations and a quest into the meaning of existence. Although empirical research into these issues is at its infancy, the potential role of feelings of meaningfulness in the maintenance of delusions (and their potential subsiding after remission) should be considered throughout the engagement and recovery processes. Further interdisciplinary research is needed to address the question of what constitutes meaningfulness and to explore its relationship with mental illness.

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Declaration of interest

None.

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1.1.33 Gwen Douglas, MB ChB, FRCPsych

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date

2022-04

Contents

- *Gwen Douglas, MB ChB, FRCPsych*

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Gwen (Gwen) Jean Elizabeth Douglas, child psychiatrist and psychoanalyst, who died aged 100 on 22 June 2021, was a pioneer in the treatment of puerperal psychosis. Tom Main, with whom Gwen trained at the Cassel Hospital in London, had previously shown that it was possible to admit seriously ill non-psychotic mothers with their babies to an in-patient unit. Gwen, however, was the first to describe such an approach with psychotic women who, after childbirth, were suffering from schizophrenia or affective disorders. In 1956, having qualified as a psychoanalyst, she published a short but highly influential paper in *The Lancet* on giving psychotherapy to six mothers with puerperal psychosis who had been admitted with their babies to the Neurosis Unit at the West Middlesex Hospital. She concluded that such mothers could be safely looked after with their babies and successfully treated with psychotherapy either alone, or combined with or following physical interventions.¹ She was supported by Main, who wrote of 'the twin dangers of separating mother and child, first and more obvious, to the child and second and as fateful to the mother's confidence in her future capacity as a mother.'² Over subsequent years, treatment on a mother and baby unit gradually came to be accepted as the most effective way to manage post-natal psychotic disorders.

Gwen was born on 4 October 1920 in Papatoetoe (Papatoitoe) on the North Island of New Zealand, the daughter of William (Bill), later Sir William, Jordan, a senior Labour politician and later New Zealand High Commissioner to the UK, and Winifred (née Bycroft). She came with her family to England at 15 and did her medical training at St Andrews University, qualifying in 1944. After qualification she served with the Medical Branch of the Royal New Zealand Air Force. Following the war she married Bill Douglas, a meteorologist, and they moved to Malta, returning to England in 1949 when Gwen trained in psychiatry. She and Bill had a son, Martin.

In 1963 Gwen was appointed to a consultant child psychiatrist post at Sutton Child Guidance Clinic, where she remained till 1986. She later worked as a psychiatrist (together with Betty Tylden and Egle Laufer) in the Obstetric Department of University College Hospital with Professors Nixon and Brandt, investigating the causes of emotional disorders of the puerperium and patients with psychosomatic disorders.

Before retiring as a child psychiatrist, she joined the University College Hospital Psychotherapy Department, and supervised medical students on the student psychotherapy scheme as well as trainee psychiatrists. She retired from

the National Health Service in 1991 and continued to practise privately as a psychoanalyst until the age of 86. She was much loved by colleagues, students and patients, who appreciated her warm, undogmatic and imaginative approach to psychoanalysis, which was influenced by her teachers Charles Rycroft and Donald Winnicott. She spoke with a gentle and confident voice without any trace of her New Zealand origins.

In retirement Gwen was a keen flower painter and gardener, who enjoyed receiving friends in her beautiful garden in Banstead. She was an avid reader and loved going to all the latest art exhibitions in London. After 2007 she spent her final years comfortably and happily at the Mary Feilding Guild in Highgate and more recently at Henford House in Warminster. She was predeceased by her husband, who died in 1987, and her son.

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1.1.34 Specialist teams as constituted are unsatisfactory for treating people with personality disorders

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date

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Abstract

It is now becoming standard practice in most advanced economies to provide specialist services for those with personality disorder. Such services, almost exclusively, provide complex well-structured psychological interventions lasting many months for a small number of those with borderline personality disorder pathology. The evidence suggests that these treatments are effective but they can only be provided for a small number of people. However, in every area the numbers of patients with significant personality disorder far exceeds those that are treated, and most of these have other personality disorders. It is argued that the current service system is not working efficiently and should be replaced by one that provides resources and expertise within community teams with some external advice from specialists but no transfer of responsibility to a designated team.

Contents

- *Specialist teams as constituted are unsatisfactory for treating people with personality disorders*
 - *Problems with current practice*
 - * *Readiness for referral*
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 - *Specialist services for EUPD*
 - * *Community mental health teams: a service for all with personality disorders*
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– Declaration of interest

In 2003 the now well-referenced and praised Department of Health booklet *Personality Disorder: No Longer a Diagnosis of Exclusion* made a number of statements about the development of new services that were being set up across the country at that time. This included: ““Good practice indicates that service provision for personality disorder can most appropriately be provided by means of: the development of a specialist multidisciplinary personality disorder team to target those with significant distress or difficulty who present with complex problems the development of specialist day services in areas with high concentrations of morbidity.’”¹

This advice has been followed for the subsequent 18 years and reinforced by National Institute for Health and Care Excellence (NICE) guidelines in 2009.² We believe it to be false, despite it being made in good faith, and a re-evaluation is needed.

Problems with current practice

Most parts of England now have a service devoted, if not dedicated, to the care of people with personality disorders.³ Although this is probably unique in providing the only national service for personality disorders in the world, it is not working too well. The notion behind these specialist services seems logical. Community mental health teams (CMHTs), at least initially, provide care for the main service-seeking group, those with emotionally unstable personality disorder (EUPD). But they are neither sufficiently skilled nor properly resourced for this task, so the obvious response is to refer them on to a specialist service. Unfortunately, this referral is not always successful, either because the appropriate specialist service is not available (very few offer comprehensive treatments) or it is judged that patients lack the psychological maturity to benefit from such an intervention. Rejections are frequent and this undermines the notion of ‘no longer a diagnosis of exclusion’. There can also be long delays and many bureaucratic hurdles to overcome before patients start treatment even if they are deemed suitable for one of the specialist treatments, mainly mentalisation-based treatment, dialectical behaviour therapy (DBT) or cognitive approaches. The experiences of patients in trying to access these services has promoted anger and also stigma, as many who feel rejected by these services for any reason blame the label of personality disorder and its incompetent adherents for their lack of care.⁴

Readiness for referral

An intervention to anticipate the delay has been suggested in this journal based on a transtheoretical model of change so as to ‘guide how to increase readiness for referral and when to refer’.⁵ This is complicated, including psycho-education about EUPD, personal formulation, crisis planning, motivational interviewing and several other things. But many will fail to negotiate this particular steeplechase of fences. At that point it is frankly ridiculous to expect the CMHT to provide further informed care. This inevitably leads to disenchantment on both sides; patients feel dissatisfied and are increasingly looking for interventions outside the standard systems to satisfy their needs⁴ and CMHTs feel disempowered while at the same time being ‘stuck’ with patients who are reluctant to engage.

The alternative view

A good service for those with personality disorder should be able to provide continuity of care and be able to engage with all those who have personality disorder. Currently, mental health professionals have a fixation with emotionally unstable personality disorder (EUPD) or its DSM equivalent, borderline personality disorder (BPD). This is understandable; it accounts for virtually all published guidelines⁶ and completely neglects the 84% of people with other personality disorders identified in national studies.⁷ There is another reason for paying more attention to the other personality disorders: their long-term outcome is currently less good than that for borderline personality disorder.^{8,9}

Specialist services for EUPD

So why does EUPD get all the attention? It is because it is the quintessential ‘treatment-seeking’ personality disorder (i.e. a type S personality disorder), in contrast to the majority of type R personality disorders, which are treatment rejecting.¹⁰ But treatment seeking should not be the only consideration. When services were being reconfigured to provide for those with personality disorder, a reliance on specialist services was unsurprising as these appeared to be underpinned by research evidence. But evidence is now changing. None of the systematic reviews of psychological treatments for personality disorder show compelling evidence of superiority of one psychological therapy over another or, indeed, when the specialist therapy was compared against good-quality clinical care.

Community mental health teams: a service for all with personality disorders

A good CMHT has: (a) a range of skills that can deal with a wide range of psychopathology, including managing many with comorbid mental illnesses; (b) stability, so that the team will provide continuity of care despite the loss of key individuals; (c) capacity to engage and contain individuals who are treatment resistant – given their experience in providing for those with severe mental illness; and (d) a closer link to general practice than specialist services.

Despite these advantages, nobody can be unaware of the pressures on CMHTs and so any additional service provision requires more training and resources if it is to be successful. In this context, services should be aware that significant funding is coming to community mental health services in the next 2 years (Tim Kendall of NHS England has pointed out that this funding includes a ring-fenced sum of £1.3 million for each 50 000 population group for community mental health and crisis-related services (T. Kendall, personal communication with permission, 2 June 2021)). This is genuinely new money and all should be prepared for this bonanza and ready and able to spend it wisely. This extra funding should enable a CMHT to include training in a simple assessment procedure that will allow it to separate those with significant personality disorder from those with lesser personality difficulties. Fortunately, the simple classification by severity in the new ICD-11 classification¹¹ is suitable for this task and straightforward scales are available to help with diagnosis.^{12,13} Patients with personality disorder who are not treatment seeking currently account for a disproportionate proportion of total costs¹⁴ and to fail to address their extra needs is negligent.

The procedure adopted by each trust could be along the following lines: one or more members of the CMHT are trained in the principles of identification and management of personality disorder on entry to the team each patient has their personality function assessed the trained CMHT members will take over the care-coordinating role for the patients with the more severe disorders when needed, a separate team with expertise in psychological treatments can be called in for advice and guidance, adding elements of the specialist interventions such as DBT but not involving taking over care from the CMHT the specialist team has an oversight role for patients with personality disorder in any part of care; this may often be particularly important when in-patient care is needed relevant information and care plans from the CMHT services will be shared more closely with primary care and crisis resolution teams, and day services when necessary, so that discontinuity in care can be reduced as much as possible greater use is made of primary care services and additional resources such as social prescribing, which has great potential in this group of patients but has been insufficiently embraced in mental health.¹⁵

The advantage of this arrangement is that all personality disorders are recognised, including the Galenic syndromes¹⁶ (closely intertwined mental state and personality disorders, named after Galen, who first postulated the link between personality and disease) such as substance misuse, impulsive disorders and anxiety and avoidant disorders (the general neurotic syndrome). Continuity of care and informed feedback are also more likely when patients are transferred to different parts of the services, and there is also much better transition from secondary to primary care.

This is the way forward, not the further accumulation of specialist teams.

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Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

C.D. wrote the first draft of this article; this was added to by P.T.. Both authors approved the final manuscript.

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Declaration of interest

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1.1.35 The challenges and necessity of situating ‘illness narratives’ in recovery and mental health treatment

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Abstract

In mental health services, recovery constitutes a guiding principle that is endorsed in professional medical guidelines and has become central to mental health policies across the world. However, for many clinicians, it can be a challenge to effectively embed recovery concepts into professionally directed treatment of disease without distortion, and ostensibly away from what matters to those who use the services. We discuss the evolving and multifaceted concept of ‘recovery’, including illness narratives to frame our discussion. We demonstrate how integration between a person-directed management of illness and a professionally directed treatment of disease can converge, resulting in positive outcomes for people with mental illness.

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- *The challenges and necessity of situating ‘illness narratives’ in recovery and mental health treatment*
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 - *Moving to recovery-orientated services*

- * *An anthropological model*
- * *Illness narratives and professionals' treatment*
- * *The UK and co-production: the Care Programme Approach as an exemplar*
- * *Contact with clinicians and patient engagement*
- * *The socialisation of the practitioner*
- * *Patient perspectives of 'corporate' recovery/criticism*
- *Moving forward: making it work*
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pmc Increasingly, patient-led research has been challenging traditional professional perceptions on the trajectory and outcomes of mental illness. (Of note, 'patient' is the stylistic word choice for this journal; the authors had submitted 'service user' in the draft. We recognise this is an area of discussion and debate). Many people may not fully recover from mental health problems, but can discover how to cope with their condition. Evidence has also highlighted that recovery, and many of the processes involved in it, can happen across a period – in many cases, outside of formal medical environments. In this editorial, we summarise and discuss contemporary aspects of recovery, including the co-concept of 'illness narratives'. We argue that although recovery can be a contested topic with differing views, it is also ubiquitous, and its meanings are not always fully incorporated into truly co-produced models. Models that put patients' narratives at the core could perform as a connecting mechanism that provides a process to take account of 'personalisation', which is likely to create a better fit with individual context, structure and the complex diverse realities of recovery-oriented practice and routinely provided interventions.

Definitions and debate

People outside of the formal health settings understand recovery in terms of their individual, specific and personal perceptions. Accordingly Anthony has shown that illness can hinder a person's perception of a productive life and undermine their process of recovery.¹ Anthony's work remains highly influential (and cited) to definitions of recovery, stressing that 'recovery is what people with disabilities do, recovery is a truly unifying human experience'.¹ He also asserts that recovery, is 'multi-dimensional, defying simplistic measurement'.¹ Other perspectives on recovery have been explored: Slade has divided these into two forms, with clinical recovery being defined as symptom changes viewed by the clinician,² and 'personal recovery' being defined as what the individual narrates and understands in a meaningful way.²

What is strikingly obvious here is that recovery is being presented in a distinct and separated pattern. This separation appears to be divided by the focus and the lens through which it is viewed. It is questionable whether this separation is helpful both clinically and furthering the discourse on recovery itself. The separation pushes apart the idea that 'professionally directed' treatment and 'person-directed' treatment can converge; indeed, the spirit of recovery would challenge the language of this – 'directed' inferring 'being done to a person' and would call for it to be more fitfully replaced by 'perspective'. McWade also reinforces our view that this concept of recovery can be defined in such a way that allows freedom to converge medical expertise and affords patients the autonomy in their individual journey to recovery.³ Patient movements have dominated the concept of recovery since the mid-1970s,⁴ and currently there has been criticism of professionals that look to be trying to 'mainstream' recovery concepts to their advantage.^{5,6}

Research on recovery

There has been a significant amount of research and published work attempting to support each of the individual recovery concepts, but little has been done on the positive outcomes of converging the constructs. Recovery research ranges from personal accounts⁷ to attempts to define, standardise or measure the conceptual framework,^{8,9} alongside histories¹⁰ and empirical studies.^{11,12} Recovery-orientated practice guidelines exist for service provision,^{13–18} including an emerging critique¹⁹ resting on personal recovery,^{9,20–22} recovery-oriented services,^{6,23–29} in addition to provider competencies.^{25,30–36} Despite the accumulation of research produced to support or isolate contested elements of recovery, disagreement and criticism remains over the definitions of recovery and on whether recovery has to be survivor-led or a policy directive.³⁷

Narrative and systematic forms of syntheses and reviews have tested tools^{20,22} to incorporate accepted components of recovery.^{34,38} This, however, has only led to further compound the idea of mainstreaming of recovery.³⁷ Amid this accumulation of criticisms, Braslow has shown that ‘recovery is everywhere’ despite including an array of perspectives.⁵ Since the 1990s, the concept of recovery in mental health domain has affected both the person experiencing mental health difficulties and the clinicians.³⁷ A conceptual framework that acknowledges recovery^{33,36} has been produced by Leamy et al, highlighting five main approaches in their CHIME framework: Connectedness, Hope – optimism, Identity, Meaning – purpose, and Empowerment.³⁸ However, CHIME has not been without its critics. Bird et al carried out a validation study applying thematic analysis of data from CHIME, using focus groups with those with diagnosed schizophrenia, bipolar disorder and depression.³⁶ They demonstrated that the CHIME framework was both valid and appropriate for use, but highlighted areas that were not included, such as ‘a desire for practical support, issues around diagnosis and medication, and scepticism about the concept of recovery’.³⁹ As noted, evaluating recovery is an inherently complex concept,⁴⁰ challenging the essence of creating ‘reliable measures of individual recovery’³⁹ and the construct validity of this. Andresen et al suggest that if the said concept of recovery is entirely individual,⁴¹ contrary to ‘what can it be normed and as might be expected for a concept in which symptom reduction is not paramount’, then ‘correlations with customary clinical outcome measures may possibly be poor and convergent validity low’.⁴²

Embracing diversity

Given all of this diversity of recovery principles, it is perhaps not surprising to find professionals misunderstanding and confused^{40,43} in the operational aspects, emphasised in popular guidelines, discourse, policies and research. Pilgrim aptly suggested that recovery is a polyvalent concept.⁴³ However, this does not translate easily to those who may wish to activate the recovery construct for better patient outcomes and improved service delivery. Quiet so, Braslow has argued that recovery remains an ‘unquestioned overarching principle and popularly known to include a melange of beliefs, values that materialized because of the intellectual and social movements’.⁵

Moving to recovery-orientated services

An anthropological model

To further link back to the discussion on the concept of converging the person-directed management of illness and professionally directed treatment, we recognise, similar to Davidson and Roe, that an anthropological model – one situated upon ‘principles of reciprocity’ that concerns itself more with the integration of healthcare⁴⁰ – could complement and augment professional knowledge.⁴⁴ However, this requires a substantial shift in the clinical lens, incorporating ‘lay types of knowledge’, such as a person’s own understandings of dealing with illness, including social functioning.⁴⁴ Suitably, Davidson and Roe conceptualise that meaningful illness narratives are a gift exchange, providing meaning, emotive steadiness, narration and collective experience.⁴⁰

Illness narratives and professionals' treatment

Biological aspects have often been viewed by patients as both coercive and impersonal,⁴⁵ although we may be seeing some welcomed change with this, and COVID-19 may offer an interesting corollary, with the emphasis of 'long-COVID' care moving toward wellness and self-management of long-term chronic difficulties. Pilgrim has pointed out that the root basis of patients' adverse perceptions can be based on pathology, making clinicians appear as 'chemotherapists with a prescription pad'.⁴⁵

The UK and co-production: the Care Programme Approach as an exemplar

In the UK, the National Institute for Health and Care Excellence explicitly calls for care plans to be jointly drawn up between individuals and their clinician, with shared decision-making and agreed dates to review its progress.⁴⁶ The Care Programme Approach (CPA) necessitates that health and social needs are comprehensively assessed and reviewed with individuals with serious mental illness, with a 'philosophy of recovery and to foster personalised care'.⁴⁷⁻⁴⁹

Despite their imbedding in contemporary British mental healthcare,⁵⁰ there remains a general lack of data exploring actual practice in the community, and even less that is focused on in-patient care.⁵¹ The Healthcare Commission in the UK assessed in-patient performance across 554 wards in 69 National Health Service (NHS) Trusts. About 40% were rated as 'weak' when it came to including patients and carers; astonishingly, half of care plans had no evidence of recording patients' views, and about a third made no mention as to whether there was a carer involved. A further third had input from the patients' community care coordinators only some or none of the time.⁵²

Work by Simpson et al examined the views and experiences of stakeholders involved in community mental healthcare, investigating factors related to the provision of personalised, collaborative, recovery-focused care.⁵³ They found substantial variations among sites for results on therapeutic relationships and participant groups in their study, related to the experiences of care planning and understandings of recovery and personalisation.⁵³ Consequently, carers expressed varying levels of input, and despite risk assessments being part of central clinical concerns, they were rarely discussed with patients.⁵⁴

Patients valued therapeutic relationships with care coordinators and others, and saw these as central to recovery. However, in another study by the same team, the staff, patient and carer interviews revealed gaps between shared aspirations and realities,⁵⁵ and staff accounts of routine collaboration contrasted with patient accounts and care plan reviews. They also found that personalisation was not a common phrase, but care was often delivered in an individualised way.⁵⁵ McWade has argued that this endorses that perspective of failure of co-opting or mainstreaming the 'thing' that is recovery.³

Contact with clinicians and patient engagement

'Illness management' can be understood as an approach to support patients with a diagnosis to engage with clinicians, to reduce patient susceptibility to the disease.⁵⁶ Conversely, 'illness problems' are the principal difficulties that symptoms and disability create in lives, and 'illness behaviour' then consists of initiating treatment (for example, changing diet and activities, resting, engaging in exercise, taking over-the-counter or prescribed medications and deciding when to seek care from professionals).⁵⁷ There is an overdue lack of understanding placed on the notion that there is a pre-existing underlying relationship between the person and their illness. Albeit in separation of formal treatment environments, this occurs in the way individuals perceive their difficulties, the type of help they envisage, and the approach they are willing to engage with for formal treatments; it includes making contact with clinicians and entering into a contract with services for future treatment.

The socialisation of the practitioner

For the purpose of this editorial, a critical discussion cannot be complete without including a focus on clinicians' understandings. Hitherto, psychiatric models have perhaps viewed the concepts of recovery from mental illness in a similar style to how clinicians have viewed physical illnesses.⁵⁸ We propose that Kleinman's illness narratives model has proved influential in this regard, remarking how the practitioner has also been socialised into a distinct collective experience of sickness. It is true that clinicians are trained to capture the essence of illness by using concepts that delineate disease. For instance the use of expressions such as relapse, recurrence, remission and recovery.⁵⁹ In this way, the symptom profile is used to transform the patient's illness (in a form of recasting of illness in accordance with the theories of disorder) into a disease formation.⁵⁷ The absence of an ongoing intervention other than that relationship can be perceived by care managers as a need for premature discharge from services, for fear of creating dependency. However, some who use services desire an ongoing relationship, which commonly matters more than interventions, and this aspect can be missing in some recovery narratives. The construct of so-called 'palliative psychiatric care' is informative in this regard.⁶⁰ Further, moral experience is central to Kleinman's model of illness narratives, incorporating constructs of ideal virtues of the practitioner⁶¹ and so opening up 'illness narratives' to create patient 'storylines', which brings to life inanimate parts of practices, policies and discourses.^{62,63} Hajer suggests that storylines are 'narratives on social reality', which combine elements from many different domains and 'provide actors with a set of symbolic references that suggest a common understanding'.⁶⁴ Albeit critically, Kleinman also envisaged that partnership is vital and is susceptible to change over time, with caregiving perceived as a construct focused more on 'doing good for others in their world' and projecting that 'as earnest and naïve as it sounds, it is what medicine is really about'.⁶⁵

Patient perspectives of 'corporate' recovery/criticism

Despite the common understandings, it should be noted that some patients remain suspicious of the recovery concept because it is potentially intolerant of those who do not change, and so it may remain, in their eyes, a source of oppression used against them.⁶⁶ There is a recurring critique of recovery presented as the 'next best thing',⁶⁷ and a mere form of symbolism, undermining 'authentic alliances'⁶⁸ donning recovery in a sense to reduce effective support.⁶⁹ Service cuts have been associated with the manner in which services and health systems manage future demand for mental healthcare, allied to the economic cutbacks planned for financial savings.^{70,71} Consequently, recovery concepts used in this method risk being used, or at least perceived, as indicative of justification to reduce services or their ability to provide timely input.

Moving forward: making it work

In the majority of English-speaking countries⁴⁰ the importance clinical recovery² and personal recovery are touted in guidelines for key clinicians.⁷²⁻⁷⁶ The significance of tackling personal recovery, in conjunction with more standard concepts of clinical recovery,² is currently endorsed in guidance for all key professions.⁷²⁻⁷⁶ Whether it as a model or framework, a movement or a guiding ethos, recovery is now 'the hegemonic guiding principle of public mental health policy'.⁵ The social sciences have already reworked treating disease as a process of medical micro-encounters,⁷⁷ and to the idea that 'disease problems' can occur within an individual's circumstances of everyday life.⁷⁶ It is evident that researchers, clinicians and services alike may require a more complex approach to personal narratives and construction of meaning if individual recovery is to be more clearly understood.⁷⁸

Psychiatric treatment historically conceptualised primarily based on a disease model could have the potential to impede the long-term treatment and assessment of those with chronic difficulties and illness. Linked to this assertion, Voronka has indicated that narratives can be utilised and shaped as a 'gap-mending' strategy,⁷⁹ not merely because they interfere with professional knowledge, but because they have the power to strengthen the capabilities of individuals to bring forth personal goals and generate a sense of identity,¹⁷ a fusion, a convergence to create a mechanism of acceptability, of both person-directed management of illness and professionally directed treatment of disease, or, in essence, shared understandings of recovery and shared decision-making toward that outcome. Roberts and Hollins have also encouraged that medicine ought to discern that 'disease understandings' are embedded in patients' experiences and their daily lives, and are considerably tied to a person's social history.⁷¹ This necessitates clinicians to move from a tradition

of ‘paternalistic attitudes’ of helping or being the expert, to create meaningful alliances.⁸⁰ Likewise, Lawton et al described an approach to illness experiences that recognises a dynamic interplay between ‘survivor’ and the healthcare system, whereby one affects the other,^{71,77} suggesting that medical encounters merely comprise a relatively insignificant portion of most patients’ lives (although symbolically they may represent more). Accordingly, the medical support to patients’ ‘sense-making’ tends, in reality, to be exhausted by the conditions and encounters met in the extra-medical social world.⁸¹

Recognising and embracing recovery concepts enhances care and the therapeutic experience for professionals and patients. The possible ‘recursivity’ between services and perceptions is relevant to understanding the way in which those with mental health problems might engage with care services.^{73,81} Peer support is increasingly recognised and implemented within NHS services, with roles in the UK typically at band 4/5; indeed, the Health Education England publication ‘Stepping Forward to 2021: The Mental Health Workforce Plan in England’ advocates even greater expansion of this.⁸² Nevertheless, there has equally been a call and need to deliver care in ways that have just not been possible in traditional teams. A potentially very fruitful and positive development in this regard has been the growth of recovery colleges, driven by strong patient engagement and roles, often at odds with, or at blurred boundaries to mainstream NHS services. Accordingly, central to improving outcomes for individuals, services should involve providing services that are ‘person-centred, strengths-based and recovery-focused’.⁷⁴ To enable the interpretation of the recovery approach into practice, there is a necessity to involving illness narratives as a mechanism to personalise treatment and care so that it can be operated and assessed within medical and research environments.^{20,25}

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Data availability

Data sharing not applicable – no new data generated.

N.K. conceived the idea, wrote the first draft and led the writing. N.K. and D.K.T. participated equally in the development and editing of the writing.

Supplementary material

For supplementary material accompanying this paper visit <http://doi.org/10.1192/bjb.2021.4>.

[click here to view supplementary material](#)

Declaration of interest

None.

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1.1.36 Views on psychotherapy research among members of the Medical Psychotherapy Faculty of the Royal College of Psychiatrists

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Abstract

Aims and method

Research drives innovation and improved practice in psychotherapy. We describe views of members of the Faculty of Medical Psychotherapy of the Royal College of Psychiatrists (RCPsych) regarding their knowledge, experience and perspectives on psychotherapy research. We sent questionnaires to the Faculty membership emailing list.

Results

In total, 172 psychiatrists from all levels of training returned fully complete responses. Respondents considered knowledge of psychotherapy research to be important to clinical work. Many have qualifications and experience in research but lack current opportunities for research involvement and would welcome the Faculty doing more to promote psychotherapy research. Perceived obstacles to research involvement included lack of competence, competing demands and wider organisational factors.

Clinical implications

The lack of research opportunities for medical psychotherapists may lead to their underrepresentation in psychotherapy research and a less medically informed research agenda. Providing support at academic, RCPsych and National Health Service organisational levels will allow more clinically relevant research not only in psychotherapy but in other psychiatric disciplines as well.

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pmc Research is a cornerstone of psychiatry in all its areas of knowledge, understanding and practice. As a branch of psychiatry, psychotherapy needs research. Although cognitive–behavioural therapy has been considerably researched, the relationship of psychoanalytic psychotherapy to research is complicated. Within psychiatry and among the public, there are common perceptions of psychoanalytic psychotherapy as unscientific and psychotherapists as uninterested in research.

Let us begin by outlining the issue: what is the problem regarding research in psychotherapy? There is evidence that psychoanalytic psychotherapy services within the public sector in the UK have been disproportionately reduced compared with other mental health services.¹ This may be due to a lack of a robust evidence base in psychoanalytically oriented psychotherapy compared with other modalities, such as cognitive–behavioural therapy. However, high-quality research in psychoanalytic psychotherapy can substantially advance our knowledge of the efficacy of treatment of different mental disorders.² Within the psychoanalytic community a lack of understanding and interest in research persists;^{3,4} this is reinforced by a (real and perceived) split in the community between academics, who do research, and clinicians, who see patients. Many of the trials in psychodynamic psychotherapy have lacked sufficient methodological rigour and do not necessarily reflect real-life practice.⁵

Among psychoanalytic psychotherapists, resistance to research is driven by several factors. Research methods (such as manualisation of treatments, randomisation of patients, recording of sessions, administering outcome measures) are often seen as interfering with clinical technique and practice. Practising therapists may have a poor understanding of the research currency of statistics and numbers and end up finding research activity mindless and meaningless. Moreover, research is treated with suspicion, as it may challenge established and cherished theories.⁵

Nevertheless, there are strong reasons for psychotherapists to engage in research. We need first to investigate the efficacy and outcomes of psychotherapy, to ascertain whether change does occur with treatment, and second to investigate the process of therapy, to understand what happens in therapy and how change occurs. We also need to ensure the safety and quality of treatment and to explore patients' experiences of psychotherapy. As for commissioners, patients and the public, their expectation of research engagement and the evidence base for psychotherapy needs to be satisfied. Finally, research is an effective means of interrogating new and existing theories and of communicating with colleagues.

One should bear in mind that psychiatric practice involves at its heart the use of a therapeutic relationship, and research into aspects of this relationship can reap useful and highly applicable rewards.^{6–8} The relative sparsity of research in this area reflects the current dominance of the biomedical paradigm within psychiatry. The predominance of cognitive–behavioural therapy, alongside the biomedical paradigm, has played a part in the neglect of psychotherapy research among psychiatrists.

The Faculty of Medical Psychotherapy of the Royal College of Psychiatrists has a membership consisting of psychiatrists who practise psychotherapy as their main therapy or use its principles in their work, as well as psychiatrists who may not be practising psychotherapy but have an interest in the subject. Among those practising psychotherapy, different modalities of therapy may be used; however, psychoanalytic psychotherapy is the main modality in which the majority of medical psychotherapists have been trained. The Faculty is interested in research and is exploring ways of promoting

psychotherapy research.

In this study, we surveyed our membership, with the aim of describing psychiatrists' views on research in psychotherapy and their experiences in engaging with research.

Method

Design

A web-based survey was designed by the two joint Research Leads (M.F. and T.L.) of the Faculty of Medical Psychotherapy. The Chair and Vice-Chair of the Faculty were consulted in the design of questions and response options. The College Registrar gave approval to the final version of the survey before its distribution to Faculty members. Survey responses were anonymous.

The survey consisted of 26 questions and covered the following areas: general respondent characteristics (member group, current post, work location) views on the importance of psychotherapy research ways of learning about psychotherapy research satisfaction with their own knowledge of psychotherapy research and interest in gaining knowledge research experience opportunities for, and obstacles to involvement in, psychotherapy research views on the Faculty's interest and involvement in research suggestions to the Faculty regarding promoting psychotherapy research suggestions to support trainees in psychotherapy research.

The format of the questions varied (Appendix) and some questions asked for additional free-text responses. The survey was written and hosted on SurveyHero and was sent out via email to the entire Faculty membership (3842 UK members and 827 overseas members). The email contained a brief message introducing the survey and the reason for doing it, and a direct link to the survey webpage. The email was sent in August 2019 by the College Faculty and Committee Manager. A reminder email was sent before closure at the end of September 2019.

Participants

All Faculty members, including psychiatrists at all levels of training and experience, were emailed about the survey.

Analysis

Only fully completed survey responses were included in the analysis. Data were examined numerically and we also identified key themes in the free-text responses.

Results

We emailed 4669 Faculty members about the survey; 501 persons viewed the survey, and 246 responses were received before the closure date, of which 172 were fully completed responses (i.e. all survey questions answered). The participation rate (number responded out of number viewed) was 49.1% and completion rate (number completed out of number participated) was 69.9%. The response rate (number of responses out of number who were emailed about the survey) was 5.2%. The characteristics of the 'completed' respondents are shown in *Table 1*. *Table 1* Characteristics and responses for the 'completed' respondents Total ($n = 172$) Consultant with CCT in medical psychotherapy ($n = 42$) Consultant in other specialty ($n = 60$) Higher trainee in medical psychotherapy or dual training incl. medical psychotherapy ($n = 14$) Core trainee or higher trainee in other specialty ($n = 25$) SAS^a or other ($n = 31$) Medical psychotherapy sessions form part of current post Yes 96 (56%) 34 (81%) 24 (40%) 12 (86%) 15 (60%) 11 (35%) No 76 (44%) 8 (19%) 36 (60%) 2 (14%) 10 (40%) 20 (65%) Work base UK 154 (90%) 41 (50%) 150 (83%) 13 (24%) 26 (84%) Outside UK 18 (10%) 11 (17%) 11 (16%) Do you agree that knowledge of psychotherapy research is important for your work? Strongly agree 109 (63%) 29 (69%) 36 (60%) 10 (71%) 13 (52%) 21 (68%) Agree 59 (34%) 12 (29%) 22 (37%) 4 (29%) 11 (44%) 10 (32%) Neither agree nor disagree 2 (1%) 0 (0%) 2 (3%) 0 (0%) 0 (0%) Disagree 2 (1%) 1 (2%) 0 (0%) 1 (4%) 0 (0%) Strongly disagree 0 (0%) 0 (0%) 0 (0%) 0 (0%) 0 (0%) Satisfaction with

own level of knowledge of psychotherapy research
 Very satisfied 9 (5%) 4 (10%) 1 (2%) 004 (13%) Somewhat satisfied 57 (33%) 17 (40%) 21 (35%) 4 (29%) 4 (16%) 11 (35%) Neither satisfied nor dissatisfied 48 (28%) 12 (29%) 20 (33%) 2 (14%) 4 (16%) 10 (32%) Somewhat dissatisfied 46 (27%) 8 (19%) 15 (25%) 6 (43%) 13 (52%) 4 (13%) Very dissatisfied 12 (7%) 1 (2%) 3 (5%) 2 (14%) 4 (16%) 2 (6%) Formal qualifications in research
 None 90 (52%) 18 (43%) 28 (47%) 9 (64%) 15 (60%) 20 (65%) BSc 22 (13%) 5 (12%) 9 (15%) 1 (7%) 6 (24%) 1 (3%) Masters level 13 (18%) 12 (29%) 10 (17%) 4 (29%) 2 (8%) 3 (10%) Doctorate (PhD/MD) 29 (17%) 7 (17%) 14 (23%) 03 (12%) 5 (16%) Other 13 (8%) 3 (7%) 4 (7%) 01 (4%) 5 (16%) Has ever held paid research post
 Yes 55 (32%) 14 (33%) 23 (38%) 3 (21%) 4 (16%) 11 (35%) No 117 (68%) 28 (67%) 37 (62%) 11 (79%) 21 (84%) 20 (65%) Has published non-psychotherapy research
 Yes 97 (56%) 27 (64%) 34 (57%) 3 (21%) 13 (52%) 20 (65%) No 75 (44%) 15 (36%) 26 (43%) 11 (79%) 12 (48%) 11 (35%) Has published psychotherapy research
 Yes 50 (29%) 19 (45%) 17 (28%) 01 (4%) 13 (42%) No 122 (71%) 23 (55%) 43 (72%) 14 (100%) 24 (96%) 18 (58%) Has current opportunities for involvement in psychotherapy research
 Yes 39 (23%) 12 (29%) 12 (20%) 6 (43%) 4 (16%) 5 (16%) No 131 (76%) 29 (69%) 48 (80%) 8 (57%) 21 (84%) 25 (81%) Blank 2 (0%) 1 (2%) 01 (3%) Satisfaction with current opportunities for involvement in psychotherapy research
 Very satisfied 15 (9%) 4 (10%) 4 (7%) 007 (23%) Somewhat satisfied 16 (9%) 10 (24%) 1 (2%) 1 (7%) 2 (8%) 2 (6%) Neither satisfied nor dissatisfied 71 (41%) 15 (36%) 29 (48%) 4 (29%) 9 (36%) 14 (45%) Somewhat dissatisfied 45 (26%) 10 (24%) 15 (25%) 7 (50%) 8 (32%) 5 (16%) Very dissatisfied 25 (15%) 3 (7%) 11 (18%) 2 (14%) 6 (24%) 3 (10%) Perceives obstacles to getting more involved in psychotherapy research
 No 37 (22%) 12 (29%) 9 (15%) 4 (29%) 4 (16%) 8 (26%) Yes 135 (78%) 30 (71%) 51 (85%) 10 (71%) 21 (84%) 23 (74%) In your opinion, is the Faculty of Medical Psychotherapy adequately interested and involved in research?
 No 37 (22%) 24 (57%) 12 (20%) 9 (64%) 20 (80%) 2 (6%) Yes 15 (9%) 3 (7%) 6 (10%) 0 (0) 2 (3%) 4 (13%) Unsure 120 (70%) 15 (36%) 42 (70%) 5 (36%) 3 (12%) 25 (81%) Would you like the Faculty of Medical Psychotherapy to do more to promote psychotherapy research?
 No 2 (1%) 1 (2%) 1 (2%) 0 (0) 0 (0) 0 (0) Yes 137 (80%) 34 (81%) 47 (78%) 11 (79%) 20 (80%) 25 (81%) Unsure 33 (19%) 7 (17%) 12 (20%) 3 (21%) 5 (20%) 6 (19%)¹

Respondent characteristics

Of the 172 respondents, 18 (10%) were from outside the UK and the rest were from within the UK; 42 (24%) were consultant psychiatrists with a Certificate of Completion of Training (CCT) in Medical Psychotherapy; 60 (35%) were consultant psychiatrists of other specialties; 14 (8%) were higher trainees in medical psychotherapy (including those in dual training); 25 (15%) were core or higher trainees in other specialties; and 31 (18%) were 'SAS (Specialist and Associate Specialist) or other' psychiatrists. Ninety-six respondents (56%) had medical psychotherapy sessions as part of their current post. In terms of research backgrounds, 82 of the respondents (48%) had some research qualification (i.e. BSc, Masters or Doctorate level degree, or other, or a combination of these); 97 (56%) had published non-psychotherapy research; 50 (29%) had published psychotherapy research; and 44 (26%) had published both types of research.

1

CCT, Certificate of Completion of Training; SAS: Specialist and Associate Specialist doctor; incl., including.

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Views and knowledge of psychotherapy research

When asked ‘Do you agree that knowledge of research is important for your work?’, 168 respondents (97%) answered in the affirmative (‘agree’ or ‘strongly agree’). Respondents were asked to rate their satisfaction with their own level of knowledge in psychotherapy research. Those who had the highest level of satisfaction were consultants in medical psychotherapy (50% were ‘somewhat’ or ‘very satisfied’), followed by SAS or other psychiatrists (48%), consultants in other specialties (37%) and higher trainees in medical psychotherapy (29%). Core and higher trainees in other specialties had the lowest satisfaction rate (16%). Rates of dissatisfaction (i.e. responses ‘somewhat’ or ‘very dissatisfied’) ranked almost in the reverse – highest among core and higher trainees in other specialties (68%), followed by higher trainees in medical psychotherapy (57%), consultants in other specialties (27%), consultants in medical psychotherapy (21%) and SAS or other psychiatrists (19%).

Respondents were asked to report which method(s) they used (from five given options and an option ‘other’) to gain knowledge in psychotherapy research. The most common methods were attending conferences (79% of respondents) and reading journals (78%), followed by discussion with colleagues (69%) and using electronic resources (such as saved Google scholar searches) (53%); 20% endorsed ‘involvement in psychotherapy research activity’ as a way of gaining knowledge; 11% reported ‘other’.

Research experience

Regarding experience in specific research activities, the most common activities were literature review, data collection, and data cleaning or analysis (each reported by 75% of respondents). Also fairly common were writing papers (67%), study design or protocol writing (60%) and recruiting research participants (53%). In total, 38% of respondents had been involved in peer reviewing and 33% in delivering interventions in a trial. Only 3% reported no involvement in any of these research activities.

Opportunities for psychotherapy research

Thirty-nine respondents (23%) reported having current opportunities for involvement in psychotherapy research – these respondents came from all five member groups (12 consultants in other specialties; 12 consultants in medical psychotherapy; 4 core and higher trainees in other specialties; 6 higher trainees in medical psychotherapy; 5 other psychiatrists).

On rating their current opportunities for involvement in psychotherapy research, 71 respondents (41%) were neutral (neither satisfied nor dissatisfied), 45 (26%) were somewhat dissatisfied and 25 (15%) were very dissatisfied. Fewer respondents were somewhat satisfied ($n = 16$; 9%) or very satisfied ($n = 15$; 9%). Trainees reported higher levels of dissatisfaction (i.e. either somewhat or very dissatisfied: 14 (56%) core and higher trainees in other specialties and 9 (64%) higher trainees in medical psychotherapy) than did non-trainee groups (26 (43%) consultants in other specialties, 13 (31%) consultants in medical psychotherapy, 8 (26%) other psychiatrists).

Obstacles to involvement in psychotherapy research

The majority of respondents perceived obstacles to becoming involved in psychotherapy research ($n = 135$; 78%). Additional free-text responses to this question were coded and assessed to identify specific themes. The themes identified are shown in *Table 2* and the following selection of free-text responses. *Table 2* Perceived obstacles to getting more involved in psychotherapy research
Age/retirement
Clinical workload
Lack of contacts or potential collaborators
Lack of funding/infrastructure/research administrative support
Lack of knowledge/competence/confidence
Lack of opportunities
Lack of personal interest
Lack of senior colleague support/mentoring
Lack of time/competing interests or commitments
Not in research post or no allocated time in job plan
Wider organisational factors
Other

Lack of time, competing demands: “‘Dedicated research time has been removed from my job plan. Clinical and managerial pressures now make research very difficult.’ ‘Mainly lack of dedicated time and links with established psy-

chotherapy researchers.”Lack of support and contacts: ““Too little time; no admin support for the scout work; no team or group to support applications; hostile competition from psychology and psychiatry; hopeless stereotypes about medical psychotherapy.’“Support and time. It requires membership of a group. I have not been able to develop these in spite of trying to collaborate with research psychologists.”Lack of opportunities, wider organisational factors: ““Don’t know who to contact/not aware of any current psychotherapy research projects being undertaken within my trust/its associated academic institute.’“There simply is no psychotherapy research as far as I know.’“Not seen as a priority by academics, therefore not encouraged/supported.’“No good research going on – multicentre – in my area of interest that is psychodynamic.’“There just isn’t a lot going on and when I do find some to be involved in it’s hard to get my name on the paper if and when it gets published.”Lack of potential collaborators, lack of senior colleague support: ““The lack of psychotherapy research that I would be interested in in close enough proximity to where I work.’“Limited interest in research among colleagues and trainers.’“The high-flying research department I work in regularly shunned psychotherapy research related proposals I made for seven years.””

Faculty role and activities to promote psychotherapy research

The majority of respondents ($n = 120$, 70%) were unsure whether the Faculty of Medical Psychotherapy was adequately interested and involved in research, 22% ($n = 37$) felt that it was not and 9% ($n = 15$) felt that it was. However, most respondents ($n = 137$, 80%) said they would like the Faculty to do more to promote psychotherapy research. Many ($n = 125$, 73%) said they would be interested in participating in Faculty activities to do with psychotherapy research. Respondents were asked what they would like the Faculty to do; they were offered six options, from which they could select as many as they wished (Table 3). The most popular option was ‘Facilitate networking among members who are interested or involved in research’. Additional free text responses gave further ideas: ““Ask the College to help make links with academics and possible sources of funding.’“Identify research experts.’“Link with other established research bodies.’“Network with other faculties, their newsletters, identify gaps and encourage joint working in projects.’“Networking could extend to mentoring.’“Pair trainees with research-orientated psychotherapists to inculcate a culture of research in next generation of psychotherapists.’“The Faculty could argue for the return of one day per week for research and the completion of the equivalent of an MSc in research.”” Table 3 Interventions the Faculty should deliver to promote psychotherapy research ($n = 172$; multiple selections allowed)

Facilitate networking among members who are interested or involved in research	132 (77%)
Feature articles related to research in the Faculty newsletter or other communication	119 (69%)
Offer conferences on psychotherapy research	118 (69%)
Organise skills workshops or webinars on research methodology	116 (67%)
Compile practical tips and guidance for setting up research projects	115 (67%)
Make psychotherapy research journals more accessible to members (e.g. via RCPsych library services)	104 (60%)
Other	12 (7%)

Trainees and psychotherapy research

When asked what the Faculty could do to specifically support trainees to get involved in psychotherapy research, the most popular response (of the four options offered), among both trainees and non-trainees, was ‘Help link up psychotherapy research supervisors to trainees’ (voted by $n = 148$ (86%) respondents). ‘Offer small grants, or a trainee award or prize for psychotherapy research’ and ‘Place more emphasis on research within the psychotherapy curriculum’ were voted by $n = 108$ (63%) and $n = 90$ (52%) respondents respectively. Again, free-text responses gave further elaborations and ideas, such as the following.

Placing research on the training agenda: ““There should be a better balance of what is asked of us within the curriculum. The more we get space and time to work with research that interests us during our core training, the more we will be able to continue to do it in the future and make an actual difference in research.’“It needs to be valued as a pursuit and encouraged as a part of the career path rather than a defeatist and sometimes elitist attitude precluding most from pursuing it.””Action from trainers and organisations: ““Encourage HEE [Health Education England] to develop more research-oriented training posts.’“Have psychotherapy consultants promoting a research-oriented practice.””Senior-level development opportunities: ““Develop consultants as well as trainees.’“It would be good to establish senior academic positions in medical psychotherapy.””Promoting psychotherapy research: ““Identify a list of research questions that psychotherapy research would be able to answer and publish it and regularly update it so that trainees can be inspired and

if they would like to do research, may consider choosing a topic.’ ‘More emphasis on psychotherapy research across all the curricula not just the psychotherapy curriculum.’” Other comments: “‘Not sure. Depends on the amount of time the trainee has. Pursuing the research agenda may be important but it is not as important as obtaining a thorough and secure grounding in clinical psychotherapy.’”

Discussion

Main findings

In this first ever survey of the membership of the Faculty of Medical Psychotherapy on research, psychiatrists across all levels of training and experience, working within and outside of medical psychotherapy as a specialty, strongly endorsed the importance of knowledge of psychotherapy research in their work. There was a high level of research experience or qualification among the survey respondents – almost half held a research degree, one-third had held a paid research post and 97% had engaged in some kind of research activity.

Given the low response rate to the survey, these findings cannot be taken as representative of the membership of the Faculty in general. Nevertheless, the survey highlights the existence of a group of members within the Faculty who are interested and engaged in research, and gives an indication of how the Faculty can play a part in this area. Despite the high prevalence of research qualifications and experience, only a minority of respondents had current opportunities for involvement in research, and the majority perceived obstacles to engaging in psychotherapy research. This points to an untapped potential and resource for psychotherapy research and begs the question of what one can or should do with it.

Strengths and limitations

Our survey is the first of its kind for the Faculty and addresses an important issue for training and development in medical psychotherapy. The questions were designed to extract relevant background data, views and experiences that can inform the Faculty’s strategy. The entire Faculty membership was surveyed and the low response rate means that the findings cannot be regarded as representative of the Faculty membership at large. The Faculty has a large number of quiescent members and this is also a factor in the low response rate. To put this in context, there were only 269 doctors with medical psychotherapy (or psychotherapy) as their specialty listed on the General Medical Council specialist register in 2019.⁹ This indicates that we had 42/269 (16%) of specialty-listed medical psychotherapists responding in this survey. Many of these doctors may not be working in designated psychotherapy posts or be practising psychotherapy. The number of doctors in postgraduate training in medical psychotherapy in the UK in the same year was 37. This indicates we had 14/37 (38%) of medical psychotherapy trainees responding.

One expects that members who are more research-inclined were more likely to take time to respond to the survey, thus biasing the results towards a more pro-research direction (i.e. viewing research as more important and having greater experience and interest in research) than would be found across the membership in general. Likewise, the views on research opportunities or lack thereof, and desire for more Faculty engagement with research, cannot be generalised across the entire membership of the Faculty. The responses may be subject to some degree of bias due to social desirability, although the free-text responses suggested considerable frankness of expressed views. The choice of interventions that the Faculty could deliver to promote research and support trainees in research were based on a pre-determined list of options and may not have covered all possibilities.

Nevertheless, the survey highlights the presence of a group of research-inclined members in the Faculty and points to ways that these members can be helped to participate more actively in research. Members are keen for the Faculty to facilitate networking. This may mitigate against the sense of isolation and disconnection that individuals may face among local colleagues or within organisations with little interest in psychotherapy research. Networking can take a number of forms – for example connecting experts and supervisors with trainees, linking with other faculties (such as the Faculty of Academic Psychiatry), links with established research and funding bodies. Other ideas for the Faculty to implement include featuring articles on research more prominently in newsletters, organising academic activities (e.g. conferences, skills workshops) on research, offering practical guidance on setting up projects, and better access to psychotherapy research journals (*Box 1* lists useful resources on research). *Box 1* Useful resources related to research Publications

Davis WE, Giner-Sorolla R, Lindsay DS, Loughheed JP, Makel MC, Meier ME, et al. Peer-review guidelines promoting replicability and transparency in psychological science. *Adv Meth Pract Psychol Sci* 2018; **1**: 556–73. Rhodes M. How to undertake a research project and write a scientific paper. *Ann R Coll Surg Engl* 2012; **94**, 297–9. Online guidelines Planning a good research project (Postgrad.com): https://www.postgrad.com/uk_research_planning/Basic_steps_in_the_research_process (North Hennepin Community College): <https://www.nhcc.edu/student-resources/library/doinglibraryresearch/basic-steps-in-the-research-process> Policies and guidance for researchers (UK Research and Innovation): <https://mrc.ukri.org/research/policies-and-guidance-for-researchers/#policies> Guidelines for completing a research protocol for observational studies (University College London Hospitals): http://www.sld.cu/galerias/pdf/sitios/revsalud/guidelines_for_observational_studies.pdf

Structural and organisational issues were also highlighted in the survey responses. The real and perceived disinterest and even hostility of academic institutions towards psychotherapy research, sometimes combined with negative preconceptions about medical psychotherapy, especially psychoanalytically oriented psychotherapy, create a culture that does not consider it possible for medical psychotherapists to engage in research. To an extent, this is reflected in certain deficits in research academic development opportunities for medical psychotherapy. In England, the National Institute for Health Research (NIHR) Integrated Academic Training Programme provides academic opportunities for doctors and dentists in specialty training, through the funding of Academic Clinical Fellowship (ACF) and Clinical Lectureship (CL) posts that support trainees to spend 25% (in the case of ACF) or 50% (CL) of their time in research training over 3 or 4 years. In more than a decade of this programme, no single trainee has been awarded such a post within the specialty of medical psychotherapy.

There are top-down as well as bottom-up problems to be addressed. The historical lack of research-active senior medical psychotherapists and the absence of medical psychotherapists within academic institutions means that medical psychotherapy has become a non-existent entity in many research circles. Some argue that research should be more embedded in training in medical psychotherapy, in which the prevailing emphasis is on acquiring clinical psychotherapeutic skill; they believe that knowledge of psychotherapy research, routine use of clinical outcomes, and experience in designing and conducting research should all form part of the curriculum for trainees. Among medical psychotherapy trainees, designated time that is meant for research or special interest (such sessions exist for psychiatry trainees of all specialties) is often used instead for further clinical experience or for personal psychotherapy.

Senior and consultant-level medical psychotherapists in the public sector have faced increasing cuts to sessions and their job plans focus exclusively on clinical service delivery; this approach is short-sighted and deprives medical psychotherapy of possibilities for development. A more beneficial strategy would be to encourage those medical psychotherapists with research experience and interests to pursue projects as part of their job plan, and to provide support where needed to facilitate this. Where a National Health Service (NHS) organisation already has an established partnership with an academic institution, links for psychotherapy research can be set up and formally endorsed by both organisations. Previous research has indicated that, to be willing to participate in research, psychotherapists expected high-quality designs, financial compensation and personal gains.¹⁰ This indicates the importance of support to therapists at both research and career-progression levels to encourage more participation in research.

Conclusions

From the survey, we conclude that there exists a group of members within the Faculty of Medical Psychotherapy who value research and are keen to engage in research activity, and are a resource that ought to be harnessed. Noting the greater level of dissatisfaction with their research involvement among trainees than among consultants, this is a particularly important group to focus resources on. A number of actions recommended by survey respondents are feasible and already being planned, for example establishing research networks, linking trainees with supervisors, conferences and workshops on research, and campaigning for more equitable academic opportunities nationally. Given the role of medical psychotherapists in combining a medical, psychiatric and psychotherapeutic perspective,¹¹ it is critically important that this unique perspective is brought to bear on the psychotherapy research agenda.

We thank Steve Pearce (Chair of the Faculty of Medical Psychotherapy) for advising on the survey design and Adrian James (Registrar of the Royal College of Psychiatrists) for approving the survey.

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Data availability

The data that support the findings of this study are available from the corresponding author, M.F., upon reasonable request.

M.F. led on study conception, survey design, data analysis and interpretation, and preparation and revision of the manuscript. T.L. was involved in study conception, survey design, data analysis and interpretation, and preparation of manuscript. J.Y. was involved in survey design, data interpretation and preparation of the manuscript. All authors have given final approval of the version to be published. All authors meet the ICMJE criteria for authorship.

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Declaration of interest

None.

Survey questions Are you a member of the Medical Psychotherapy Faculty of the RCPsych? If not, this survey is not for you. Are you a: Consultant with CCT in Medical Psychotherapy; Higher Trainee in Medical Psychotherapy (or dual training including medical psychotherapy); Consultant in other specialty (please specify); Core Trainee or Higher Trainee in other specialty (please specify); Other (please specify) Is your work base in the UK? UK; outside of UK. Please specify the geographical region or area What is your current post? Please enter (e.g. consultant in eating disorders) In your current post, do you have any sessions in medical psychotherapy? Please give details if you wish Do you agree that knowledge of psychotherapy research is important for your work? Strongly agree; Agree; Neither agree nor disagree; Disagree; Strongly disagree In which aspect of your work would you most like more knowledge of existent psychotherapy research? How do you gain knowledge of psychotherapy research? (tick all that apply) Reading journals; Using electronic resources (e.g. email alerts, saved scholar searches); Discussion with colleagues; Attending conferences; Involvement in psychotherapy research activity (please specify); Other (please specify) Are you satisfied with your current level of knowledge in psychotherapy research? Very satisfied; Somewhat satisfied; Neither satisfied nor dissatisfied; Somewhat dissatisfied; Very dissatisfied Have you any formal qualifications in research? (please tick all that apply) None; BSc, MSc, PhD or MD equivalent; Other (please specify) Have you ever held a paid research post? Please specify Have you ever been involved in the following kinds of research (not necessarily psychotherapy related)? Qualitative, Quantitative, Neither; Observational, Experimental, Neither; Epidemiological, Outcome, Neither What research activities have you ever been involved in? (please tick all that apply) Literature review; Study design or protocol writing; Recruiting research participants; Delivering intervention in a trial; Data collection, cleaning and/or analysis; Paper writing; Peer reviewing; Other (please specify); None Have you ever published non-psychotherapy research in a peer-reviewed journal? Have you ever published psychotherapy research in a peer-reviewed journal? Currently, do you have any opportunities for involvement in psychotherapy research? Please specify Are you satisfied with your current opportunities for involvement in psychotherapy research? Very satisfied; Somewhat satisfied; Neither satisfied nor dissatisfied; Somewhat dissatisfied; Very dissatisfied Do you perceive obstacles to getting more involved in psychotherapy research? If yes, please specify In your opinion, is the Medical Psychotherapy Faculty adequately interested and involved in research? Yes; No; Unsure. Please give reason for your answer Would you like the Medical Psychotherapy Faculty to do more to promote psychotherapy research? Yes; No; Unsure. Please give reason for your answer. What kinds of things should the Faculty do to promote psychotherapy research? (please tick all that apply) [The list of options appears in *Table 3* of this paper] What can the Faculty do to specifically support trainees to get involved in psychotherapy research? (please tick all that apply) Place more emphasis on research within the psychotherapy curriculum; Link up

psychotherapy research project supervisors to trainees; Offer small grants, or a trainee award or prize for psychotherapy research; Other (please specify)Are you interested in participating in Faculty activities to do with psychotherapy research? Extremely interested; Very interested; Somewhat interested; Not so interested; Not at all interested. Please leave your name and email and say something about your specific interestPlease leave any further comments you have on this subject here

1.1.37 Attitudes toward veganism in eating disorder professionals

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date

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Abstract

Aims and method

Veganism has increased in popularity in the past decade and, despite being a characteristic protected by law, is often viewed negatively by the general population. Little is known about the attitudes of healthcare professionals despite the potential influence on practice and eating disorder patient care. This is one of the first studies to investigate attitudes toward veganism within specialist eating disorder, general mental health and other professionals.

Results

A one-way ANOVA indicated all professionals held positive views toward veganism. General mental health professionals held statistically more positive veganism attitudes than specialist eating disorder and other professionals.

Clinical implications

As one of the first studies to suggest eating disorder professionals are not biased against veganism, it has important clinical practice implications, particularly when exploring motivations for adopting a vegan diet (health, weight loss, environmental or animal welfare concerns) in patients with eating disorders. Implications for further research are provided.

Contents

- *Attitudes toward veganism in eating disorder professionals*
 - *Method*
 - * *Design*
 - * *Pilot study*
 - * *Measures*
 - * *Participants and recruitment*
 - * *Procedure*

- * *Analysis*
- *Results*
 - * *Profession*
 - * *Gender*
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- *Discussion*
 - * *Implications for practice*
 - * *Limitations*
 - * *Future research and conclusions*
- *About the authors*
- *Data availability*
- *Declaration of interest*

pmc Eating disorders are serious psychiatric conditions characterised by abnormal eating patterns, either through strict or a lack of control of eating, and are driven by the over-evaluation of weight and shape concerns.¹ Research identifies several eating disorder development risk factors,² including, but not limited to, genetics,^{3,4} environmental,³ female adolescence,⁴ biopsychosocial influences⁵ and urbanisation.⁶

Veganism is a philosophy seeking to exclude using animals and animal products in all aspects of life, not just diet.⁷ It is estimated that around 1% of the UK population follow a vegan diet,⁸ reflecting a fourfold increase from 2014 to 2019. In the Western world, the demographics of veganism are predominantly young,⁹ female^{10,11} and living in urban areas.^{10,11} Importantly, veganism is protected by law as a non-religious philosophical belief.¹²

Veganism does not cause eating disorders, but there are similarities between known eating disorder risk factors and the prevalence data for veganism. Research suggests the general population are biased against veganism,^{13,14} but it remains unknown if specialist eating disorder (SED) professionals share these views. SED clinicians may be concerned about the potentially restrictive nature of vegan diets, and therefore may potentially be biased against veganism. Given the legal protection that veganism carries, when exploring the veganism of a patient with an eating disorder, clinicians must act with professionalism, respect, curiosity and a lack of personal bias. This is the first paper to investigate the attitudes of SED, general mental health (GMH) and other professionals toward veganism

Method

Design

This self-reported questionnaire study included the following independent variables: profession (SED, GMH and other professionals), age (18–29, 30–41, 42–54 and 55–67 years) and gender (male, female and other). The dependent variable was attitude toward veganism.

Pilot study

A pilot study involving three participants from SED, GMH and other professional groups indicated no adjustments to study measures.

Measures

Participants completed the General Eating Habits Questionnaire,¹⁵ scored on a 1 (vegan) to 7 (omnivore) Likert scale, and the 20-question Attitudes Towards Veganism Survey (ATvegan),¹⁰ scored on a 1 (negative attitudes) to 7 (positive attitudes) Likert scale, on Qualtrics (version for Windows; www.qualtrics.com). Cronbach's alpha ($\alpha = 0.86$) indicated a good level of internal reliability.¹¹

Participants and recruitment

A power analysis (G*Power for Windows, version 3.1.9.7; <https://www.psychologie.hhu.de/arbeitsgruppen/allgemeine-psychologie-und-arbeitspsychologie/gpower.html>) identified $n = 75$ for each professional group, giving a minimum sample size of 225. Participants were recruited through purposive sampling via professional networks and social media. A total of 430 responses were received and data were cleaned to exclude non-UK residents ($n = 15$), those under 18 or older than 68 years, those not identifying their professional group ($n = 3$) and vegan participants ($n = 20$), as research suggested this could bias responses as vegans have a strong sense of self-identity, which can affect their attitudes on topics ranging from animal welfare to political affiliation, and this could affect any findings of the research.^{13,16} *Table 1* provides key characteristics of the total sample ($n = 392$). *Table 1* Participant demographics Gender, n Profession Age group, year Male Female-Did not say Specialist eating disorder, $n = 11618-29214-30-41733-42-541525-55-68515$ -General mental health, $n = 9018-29418-30-41731142-54515155-6862$ -Other, $n = 18618-29832-30-412655-42-541428-55-68815$ -

Procedure

Full ethical approval was obtained and, following written informed consent, data was collected for 2 weeks during March 2020. Following completion, participants were debriefed, thanked and provided with researcher contact details for further questions. Ethical approval was granted by the University of Northampton's Psychology Ethics Committee (ethics approval donated by student number: 19432991). All adult participants provided written informed consent to participate in this study.

Analysis

Data was analysed using SPSS version 26 for Windows.

Results

An alpha level of 0.05 was used for all statistical tests.

Profession

Total attitude toward veganism scores were calculated indicating generally high mean scores and positive attitudes for all professional groups. This included the GMH ($n = 90$, mean 106.65, s.d. 17.96, range 54–137), SED ($n = 116$, mean 101.49, s.d. 16.13, range 61–136) and other professionals groups ($n = 186$, mean 101.08, s.d. 18.64, range 43–140).

All parametric assumptions were met. A one-way ANOVA was statistically significant, indicating a moderate effect size and a positive main effect of professional group ($F(2, 376) = 3.33$, $P = 0.04$, $p^2 = 0.02$).

Post hoc Bonferroni adjustments¹⁴ indicated mean GMH professionals group scores (mean 106.65 ± 5.72 , s.d. 17.96, $P = 0.04$) were significantly higher and more positive compared with the other professionals group. No significant difference was evident between the SED and GMH or other professionals groups.

Gender

Women ($n = 290$, mean 103.36, s.d. 19.24, range 59–140) had slightly higher mean veganism attitude scores than men ($n = 100$, mean 99.95, s.d. 17.33, range 43–134), but a Mann–Whitney *U*-test conducted on non-parametric data indicated no significant difference between women (median = 104, $n = 279$) and men (median = 101.5, $n = 98$) and attitude toward veganism scores ($U = 14\,777.00$, $z = 1.19$, $P = 0.23$).

Age

Younger participants aged 18–29 years had higher mean and more positive attitudes toward vegan scores ($n = 78$, mean 104.48, s.d. 16.74, range 66–138), compared with ages 30–41 years ($n = 163$, mean 102.17, s.d. 18.56, range 43–137), 42–54 years ($n = 103$, mean 102.81, s.d. 16.30, range 69–140) and 55–68 years ($n = 48$, mean 99.44, s.d. 20.40, range 54–135). However, a one-way ANOVA indicated no significant difference between participants' age and their attitude toward veganism score ($P = 0.50$).

Discussion

This study is one of the first to investigate veganism attitudes within SED, GMH and other professional groups. The aim was to identify whether the potential bias toward veganism found within the general population is prevalent within SED professionals. Findings suggested all three professional groups held positive veganism attitudes, with GMH professionals holding significantly more positive attitudes than SED and other professionals. Despite age and gender influencing veganism attitudes in the general population, no statistically significant age or gender differences were found within these professional groups.

Research has highlighted a level of bias against veganism within Western populations,^{13,17,18} leading to it being viewed as a minority group similar to ethnicity or sexual orientation.¹⁸ Not only are vegans often depicted as going against the status quo of normal dietary culture, but these attitudes are influenced by gender and age, with more prominent negative attitudes often found in older, male generations. As well as investigating whether these biases exist within SED professional populations, it was hypothesised that SED professionals would have a more negative view on veganism than other professionals. This is because SED professionals are aware of how dietary restrictions can negatively affect an individual's physical health and mental health. These general attitudes could be reflected in SED professionals' own veganism attitudes, and SED professionals should be aware of any such biases, as they could affect clinical practice and patient treatment. In 2019, a joint consensus statement from the Royal College of Psychiatrists, the British Dietetic Association and 'BEAT', the national eating disorder charity, was released regarding the importance of working collaboratively with vegan patients with eating disorders.¹⁹ This sought to address concerns raised by some vegan patients that their beliefs were ignored in treatment and that staff could be biased against veganism. In contrast, the current study appears to indicate that SED professionals are not biased toward veganism.

These findings are particularly important because SED professionals may be concerned when patients presenting with eating disorders make any significant dietary change before seeking treatment. Self-imposed dietary restrictions are

common in patients with restrictive eating disorders. These restrictions can be total caloric restriction, but can also involve excluding entire food groups such as carbohydrates or fats, or excluding ingredients in foods such as lactose or gluten. It is not uncommon to see numerous, escalating self-imposed dietary restrictions as a patient's eating disorder progresses. For example, someone who previously ate a diet that included meat could become pescatarian, then vegetarian and finally vegan – with each dietary change becoming more restrictive. There is evidence that there are increased rates of vegetarianism in patients with restrictive eating disorders, such as anorexia nervosa.^{20,21} As veganism requires more dietary restrictions than vegetarianism, researchers suggest that a similar link could be associated with veganism,²² which could raise concerns for SED professionals. Furthermore, SED professionals will be aware of the overlap in the demographics of veganism and factors that make an individual more susceptible to an eating disorder.

To adopt a vegan diet, an individual must avoid all animal products, ingredients or derivatives. Therefore, this requires them to check dietary labels and will result in the exclusion of foods they previously ate. These two behaviours, checking labels and food exclusion based on ingredients, are often seen in patients with restrictive eating disorders regardless of their overall dietary choice. These firm dietary rules veganism provides can be very attractive to patients who are anxious regarding what to eat. Based on the findings of the current study above, SED professionals do not show a bias against veganism. However, as research suggests that the general population perceive multiple barriers to switching to a vegan diet,²³ SED clinicians may therefore be suspicious of the apparent coincidence of such a dietary change during the onset of the eating disorder.

Implications for practice

Findings from this research suggest that SED professionals do not have more negative views on veganism compared with GMH and other professionals. Instead, all groups held positive attitudes toward veganism, with GMH professionals statistically holding the most positive views. This finding may be partly mediated by participant demographics, as GMH professional participants tended to be younger women compared with SED and other professionals. Knowing that SED professionals did not have a negative attitude toward veganism is important because when exploring a patient's veganism, the patient may feel vulnerable having a clinician challenge behaviour that may or may not be associated with their eating disorder. SED professionals can use this research to reassure patients that it is their eating disorder that is being questioned and not their veganism. Taking this dynamic further, it is important for these professionals to be aware of their 'social GRACES'.²⁴ This acronym was developed for clinicians to be aware of the many areas in life where we may have conscious or unconscious bias in clinical work. Using this acronym, there is more than one topic within each 'letter' and the full acronym is 'GRRRAACCEEESSS', encompassing gender, geography, race, religion, age, ability, appearance, class, culture, ethnicity, education, employment, sexuality, sexual orientation and spirituality.²⁴ Clinicians have both an ethical and legal responsibility to their patients not to bring any bias into the treatments they offer, if they themselves have different dietary choices from their patients,^{18,24,25} so there could be a D added to the 'social GRACES' – that of diet and dietary choice.

This research also has a much broader impact as it also reflects that SED professionals are practicing within relevant legal frameworks. As veganism is a protected characteristic within the law, these finds are important.^{12,26} If the main hypothesis of this study had been supported, it would have raised concerns that these professionals' opinions were significantly different. Going forward, our findings highlight the need for all SED clinicians to have an awareness of the nuanced issues veganism can bring for a patient with an eating disorder, as well as an awareness of the legal protection this characteristic holds. Navigating this difficult dynamic may be helped by this research, as it is one of the first studies to consider these issues.

These findings can be generalised to the wider UK SED profession, and will inform daily clinical practice, particularly as veganism is becoming more popular nationally.²⁷ The good response rate and high completion rates suggest that veganism is a topic of interest for professionals. Further international research could help generalise these findings in the wider Western world and globally.

Limitations

Bias was minimised by using reversed questions, valid instruments and measures, but future research in this area should recognise possibilities for bias. Because of the self-reported nature of this research, participants may have shown demand characteristics (participants changing reported behaviours in line with their interpretation of the study) that may have influenced the findings, particularly given the potential implications for SED and GMH professionals. Consequently, participants may have provided what they perceived as the professionally correct answers,^{27,28} or ‘socially desirable’ responses, rather than declaring any strong personal views to the contrary.²⁹

Future research and conclusions

Exploring the sensitive dynamic of veganism and eating disorders would benefit from further research. This includes investigating the extent that vegan clinicians feel that veganism can be used to facilitate dietary restriction in patients with eating disorders. Research targeting vegan SED professionals will provide an unbiased understanding of how veganism may be used to facilitate dietary restriction in patients with eating disorders. Although ethically sensitive, future research could focus on the extent that patients who have recovered from an eating disorder feel that veganism can be used to facilitate dietary restriction in eating disorders. Including SED professionals and patients who have recovered from an eating disorder from a range of demographics, including age, gender and ethnicity, would allow a more culturally diverse interpretation of this topic area.

The current research study was targeted at clinicians who work either in adult, child or adolescent mental health services. These clinicians may have different attitudes toward veganism when they are working with a child or an adult, and future research should consider potential differences here. For example, a 12-year-old girl who is presenting with a restrictive eating disorder and asking to become vegan for animal welfare reasons may evoke concerns from clinicians regarding the authenticity of this dietary change, especially when the nutritional adequacy of the vegan diet can be hard to achieve in this age group because of the nutritional demands of growth and puberty.³⁰ In contrast, an adult patient following a vegan diet because of a family history of heart disease may seem less concerning to SED professionals, and this research did not differentiate between the different motivations a patient may have. Therefore, future research should differentiate within the SED group by their area of speciality – children and young people or adult. Theoretically, an age-informed professional consensus could be developed, potentially demonstrating greater concern for younger patients or those who are following an increasing pattern of dietary restrictions leading to veganism.

In conclusion, veganism is an increasing and legally protected characteristic, but the general population hold negative attitudes toward veganism. Research identifies important similarities between vegan demographics and those at risk of developing an eating disorder. As a patient’s veganism may be challenged as part of their eating disorder treatment, it is important to identify if SED professionals hold the same biases, as this could have important implications for patient care and practice. This is the first study to highlight that SED professionals do not appear to be biased; in contrast, they hold positive views toward veganism, as do GMH and other professionals. Not only does this research suggest that SED professionals are practicing within the law, but it also indicates that they are aware of their social GRACES, and perhaps a ‘D’ for ‘diet’ could be added to this acronym. Further in-depth and more diverse research into professional’s attitudes toward veganism is encouraged.

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Data availability

The data that support the findings of this study are available from the corresponding author, S.J.F., upon reasonable request.

The project team included both authors. S.J.F. was the project investigator, and K.M.H. was the research supervisor.

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Declaration of interest

None.

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1.1.38 Local Health Systems Resilience in Managing the COVID-19 Pandemic: Lessons from Mexico

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Abstract

The concept of *resilience* was applied to the public health field to investigate the way health systems are impacted by health crises, what conditions allow them to mitigate the blow, and how they reorganize once the crisis is over. In 2020, the COVID-19 pandemic caused by the SARS-CoV-2 virus represented a global challenge demanding immediate response to an unprecedented health crisis. Various voices drew attention to the intensity of the crisis in countries with greater inequalities, where the pandemic converged with other social emergencies. We documented the experiences of health personnel who faced the pandemic at the primary care level while simultaneously maintaining the functioning of other areas of medical care. Our results derived from a qualitative study comprising 103 participants from five states of Mexico. We aimed to show through inferential analysis their perspective on what we call “the resilience of local health systems.” We observed three stages of experience during the crisis: (a) Preparation (official guidelines received to organize care, training, and planning of epidemiological surveillance); (b) Adaptation (performance of community-based prevention activities, infrastructure modifications, telehealth); (c) Learning (participatory governance with city councils, business sector, and organized population). The study suggests that the local health systems analyzed benefited from the initiatives of health personnel that in some cases positively exceeded their duties. In terms of the resilience analysis, they were able to handle the impact of the crisis and cope with it. Their transformative capacity came from the strategies implemented to adapt health services by managing institutional resources. Their experience represents a lesson on the strengthening of the essential functions of health systems and shows a way to address successfully the increasingly complex health challenges of the present and future times.

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- *Local Health Systems Resilience in Managing the COVID-19 Pandemic: Lessons from Mexico*

pmc Supplementary Material =====

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1.1.39 Psychiatric leadership development in postgraduate medical education and training

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2022-06

Abstract

The value of strong, compassionate medical leadership in the delivery of high-quality care to patients within mental health services is clear. Leadership development, however, is far less well explored. This article is for psychiatric trainees, trainers and mental health organisations. It provides an introduction to the importance of leadership development within postgraduate medical training, the theory that should underpin its delivery, and the opportunities for both informal and formal leadership development within psychiatric training.

Contents

- *Psychiatric leadership development in postgraduate medical education and training*
 - *Leadership development theory*
 - *Informal leadership development*
 - *Formal leadership development*
 - *Discussion*
 - *Conclusions*
 - *Declaration of interest*

pmc Doctors are frequently the head of healthcare teams,¹ with leadership an emergent theme within the skills, knowledge and behaviours required of our future doctors.² Leadership is the most influential factor in shaping organisational culture.³ It must be compassionate to stimulate improvement and innovation,⁴ and is the hallmark of high-quality care.⁵

¹ See pp. XX–XX, this issue.

Leadership can be conceptualised as ‘a process that occurs in a group context, involving the influence of others towards the attainment of a common goal’.⁶ Yet leadership is better conceptualised as a ‘triad’, whereby leadership, management and followership are distinct, but inextricably linked skills, and hereafter are considered as one.^{7,8}

Leadership has been formally recognised as a responsibility for all doctors since 2012,⁹ and is gradually being integrated into both undergraduate¹⁰ and postgraduate medical curricula.¹¹ To help guide trainees’ development within these domains, the Faculty of Medical Leadership and Management (FMLM) have produced standards for medical professionals¹² that clearly outline four key domains for doctors: A doctor’s ability to know and understand themselves and their impact on others. A doctor’s ability to know when to lead and follow, and how to establish and lead teams. A doctor’s ability to understand and positively contribute to the strategic direction and operational delivery of their organisation. A doctor’s ability to understand and positively contribute to the healthcare system.

Despite this initiative, the relevance and importance of leadership development is yet to be fully embraced by the medical profession. It is often still perceived as an ‘optional extra’ within medical training,¹³ and an unpopular, unrewarding and risky ‘add-on’.¹⁴ This lack of external validation, and outdated traditional view of medical professionalism, compromises the development of so-called ‘willing hybrids’, and the integration of leadership and managerialism as a legitimate and essential aspect of medical professionalism.^{15,16}

The argument for strong medical leadership within healthcare organisations is well defined.^{17,18} Mental health services face unprecedented challenges on an almost daily basis. Doctors must be engaged in leadership¹⁹ and with their organisations as a whole.²⁰ They must be capable of understanding and overcoming the volatile, uncertain, complex and ambiguous²¹ nature of providing not only health, but also social care, within an increasingly integrated systems-based approach.

Leadership development, therefore, is crucial, yet far less well explored. There is little robust evidence for the effectiveness of specific leadership development programmes, with a proliferation of diverse interventions throughout medical training and healthcare as a whole.³

It is clear, however, that the systematic integration of basic leadership development for all doctors needs to be embedded throughout postgraduate medical training, supplemented by enhanced and advanced opportunities for aspiring medical leaders, and that trainees themselves need to realise and accept leadership responsibility.

This article is for psychiatric trainees, trainers and mental health organisations. It builds on the already established position highlighting the positive impact of psychiatrists on leadership and management.²² It provides an introduction to the importance of leadership development within postgraduate medical training, the theory that should underpin its delivery, and the opportunities for both informal and formal leadership development available to psychiatric trainees within postgraduate medical training throughout the UK.

Leadership development theory

Healthcare, like many other industries, often falls victim to the ‘great training robbery’.²³ Organisations frequently support and encourage individuals to undertake externally provided leadership development programmes, and yet often fail to provide appropriate conditions on their return for them to contextualise and apply their learning within their clinical environment. Although this can be successful in developing their knowledge, skills and competencies, it effectively sets them up to fail, and leads to the continuation of entrenched and established ways of working.²⁴

If exclusively developed within the ‘classroom’, development will largely remain ‘horizontal’,²⁵ and leaders will fail to learn how to change and adapt to ever-changing circumstances.²³ Alternatively, an ‘*in vivo*’ approach, with the right conditions coordinated throughout a programme, can harness ‘vertical’ leadership development through the delivery of ‘heat experiences’, ‘colliding perspectives’ and ‘elevated sense-making’.²⁶

Heat experiences involve organisations taking calculated risks, and exposing leaders, who themselves must take a risk, to complex uncomfortable first-time challenges. Here, they are forced to grow, not just because they want to, but because there is a chance of failure, people are watching, and results matter. They are ‘the what’ that compels leaders to disrupt and disorient their traditional thinking styles, to discover new and better ways to make sense of the challenges they face. Caution must be excised, however, to get the ‘temperature right’, and control the heat within a safe space, with the right

support, available at the right time, to help the individual stay within that learning ‘sweet spot’. Importantly, there also needs to be an appropriate level of both individual and organisational tolerance of failure.²⁷

Colliding perspectives expand the number of lenses through which a leader can analyse complexity and challenge their existing mental models.²⁸ Individuals are encouraged to view the world through the eyes of different stakeholders, including that of patients, carers and other members of the multidisciplinary team, and by standing in their shoes, learn to identify and manage conflicting paradigms. Ideally combined with peer coaching, partnered with different disciplines, these colliding perspectives provide ‘the who’ that is inclusive and embraces a range of diverse thought.²⁹

Elevated sense-making is the final piece, ‘the how’, that leads to transformational change.³⁰ Not only must structured reflection (through reflective practice groups or action learning sets) be facilitated to allow leaders to reflect on their development over time and integrate their experiences with new found perspectives, but their development should be guided by experienced coaches or mentors.

It is vital that these three conditions are provided within postgraduate medical training, whether through activities embedded informally within the work environment, or formally via a targeted approach within leadership development programmes. Although value can still be extracted from opportunities that do not provide these conditions, leadership talent will remain untapped and dormant within healthcare organisations unless these are met.³¹

Informal leadership development

The common perception of leadership as an optional extra remains pervasive throughout the medical workforce. Combined with a ‘curriculum lag’, whereby there is a delay in implementing and adopting the latest evidence into training, the development of leadership competencies remains somewhat tokenistic.³² The stars are aligning, however, and the importance of leadership development in both undergraduate and postgraduate medical curricula is slowly being realised.³³

The message is clear. Leadership development does not begin or end at any particular stage of training. Leadership is for all doctors, at every stage, and should not be postponed until doctors are formally appointed to a leadership or management position. Leadership is rather a developmental process on a lifelong continuum, with individuals nurtured to help recognise and fulfil leadership roles, especially in the earliest of stages of their careers.³⁴

Everyday leadership experiences are commonplace within psychiatric clinical settings, where decision-making is complex and ethical tensions arise through divergent views, roles and responsibilities within teams.³⁵ Although often undervalued, these present opportune leadership development experiences where, among a range of other activities, leadership can be developed through acute crisis situations, multidisciplinary meetings, mentoring junior colleagues, medical education, clinical governance and quality improvement projects. It is important to recognise, name and make sense of these everyday leadership experiences within training, through supervision, and allow trainees to recognise the value of ‘little l’ leadership within their teams.³⁶

More formal opportunities also exist through representative roles available locally, regionally and nationally, that can all lead on to providing more enhanced leadership experiences and the three primary conditions of vertical leadership development in their own right. Likewise, voluntary and additional professional activities can provide excellent leadership experience. For example, roles available within Royal Colleges, special interest groups, trade unions, healthcare regulators, the General Medical Council, or as a governor for healthcare and affiliated organisations.

Irrespective of the particular opportunity, whether formal or informal, obtaining feedback is critical for gaining insight into the trainees’ own perception of their leadership capabilities, and the perceptions held by others of their behaviours and performance.

Integral tools within psychiatric training for facilitating such structured feedback are the Mini-Peer Assessment Tool and Direct Observation of Non-Clinical Skills (DONCS) workplace-based assessments. These are used across the General Medical Council-approved curricula for both core and specialty psychiatric training within the UK, to assess a trainees performance and allow trainees to demonstrate their leadership capabilities.^{37,38}

Originally founded on The CanMEDS 2005 Physician Competency framework,³⁹ DONCS are applicable to a range of diverse non-clinical skills, and structuring feedback on leadership experiences around the seven domains can at times feel convoluted and ambiguous.

Table 1 has been conceptualised from the evidence base to help suggest key competencies for psychiatric leaders within a DONCS assessment, and aims to support both trainees and trainers attaining and delivering feedback.^{39–42} *Table 1* Your guide to a Leadership and Management DONCS domain DONCS descriptor Medical expert As a medical expert, the psychiatric leader integrates the other six intrinsic roles (as below) to negotiate complexity, uncertainty and ambiguity, while contributing to continuous improvement and maintaining the highest standards of clinical knowledge, person-centred care and professional values. Communicator As communicators, psychiatric leaders will develop trusted interpersonal relationships with and between individuals. They will accurately elicit, synthesise and convey relevant information, in both oral and written form, to develop a shared understanding between stakeholders of the relevant issues, problems and plans at hand. Collaborator As collaborators, psychiatric leaders will work effectively in partnership with patients, carers and extended multidisciplinary teams of expert professionals. This will take place in multiple locations, within and across organisational boundaries, to deliver optimal patient care and prevent, negotiate and resolve interpersonal conflict. Manager As managers, psychiatric leaders will participate in the improvement of healthcare delivery, manage resources appropriately, develop competence in health informatics and contribute to the effectiveness of the team, organisation and system they work within. Health advocate As health advocates, psychiatric leaders will promote diversity and inclusion. They will utilise their expertise and influence to identify and advance the health and well-being of individual patients, communities and populations. Scholar As a scholar, the psychiatric leader pursues continuous personal and professional development. They will critically evaluate information, facilitate and create a safe space for the mentoring and learning of others, and contribute to the creation, dissemination and integration of evidence-based knowledge into practice. Professional As a professional, the psychiatric leader engages with healthcare regulation; maintains the highest standards of personal, professional and ethical behaviour; embraces a compassionate and inclusive approach and is committed to reflective practice. They support the well-being of both themselves and the staff around them.²

Formal leadership development

There are a plethora of leadership development programmes, schemes and other opportunities available throughout the UK. This can be confusing for both trainees and trainers alike, occurring both in and out of training programmes, with a diverse range of requirements, levels of involvement and financial commitment.

Attempting to provide a brief description of these opportunities, *Table 2* outlines a sample of the variety of leadership and management training that is currently available to psychiatric trainees within the UK. It is important to remember, however, that there is an almost constantly evolving stream of new opportunities depending on interests and geography, and that this table is likely to be quickly outdated. *Table 2* Leadership and management training availability to psychiatric trainees (correct as of 2020/21) Eligibility/target Key points Fellowships (12 months) Outside of local education provider National National Medical Directors Clinical Fellow Scheme⁴³, a On completion of the Foundation Programme Funded, out of programme, centrally recruited to national organisations. Apprenticeship model, developed in collaboration with UK Government and arm's length bodies, mentored by senior national leaders and undertake a range of project and policy work. Welsh Clinical Leadership Training Fellowship⁴⁴, a C/ST3 and above Scottish Clinical Leadership Fellowship Scheme⁴⁵, a C/ST2 and above Northern Ireland (NIMDTA) Achieve, Develop, Explore Programme for Trainees (ADEPT)⁴⁶, a ST4 and above Local/regional Darzi Fellowship Programme – London South Bank University⁴⁷, a C/ST3 and above Funded, out of programme, individually recruited to local/regional organisations through NHS Jobs. Undertake London South Bank University PG Cert in Leadership in Health, alongside work-based fellowship challenges. Future Leaders Programme – Health Education Yorkshire and Humber⁴⁸, a C/ST3 and above Funded, out of programme, individually recruited to local/regional organisations through NHS Jobs. Undertake PG Cert of their choice, alongside work-based fellowship challenges. Within local education provider National Royal College of Psychiatrists' Leadership and Management Fellow Scheme⁴⁹ ST4 and above Sponsored, in programme experience, utilising special interest time, individually recruited to by local/regional organisations. Face to face (7 days, London/Liverpool), with work-based application. Royal College of Physicians' (London) Chief Registrar Programme⁵⁰, a ST4 and above Funded, in or out of programme experience, individually recruited to by local organisations. Face to face (5 days, London/Liverpool) and 40–50% protected time to practice leadership and quality improvement. Courses and programmes National Royal College of Psychiatrists' Leadership and Management for Trainees and New Consultants⁵¹ Available to all Self-funded, face to face (1 day). NHS Leadership Academy Edward Jenner (6

² DONCS, Direct Observation of Non-Clinical Skills.

weeks)⁵² Available to all Free, online (5 h per week), with work-based application. NHS Leadership Academy Mary Seacole (6 months) or Rosalind Franklin (9 months)⁵² Core or higher training, respectively Predominantly self-funded (circa £1000), sponsorship and bursaries available *ad hoc*. Online (5 h per week) and face to face (Mary Seacole 3 days/Rosalind Franklin 8 days – regional), with work-based application. NHS Wales 1000 Lives ‘Improving Quality Together’⁵³ Available to all Free, online (bronze) and face to face (silver, 2 days), with work-based application. Northern Ireland (NIMDTA) ENGAGE Clinical Leadership and Improvement Programme⁵⁴ ST5 and above Funded, face to face (1 day, 7 evenings). NHS Education for Scotland Leadership and Management Programme (LaMP)⁵⁵ C/ST3 and above Funded, online and face to face (2 days), with work-based application. Local/regional Learning to Lead – East Midlands Leadership and management programme (3 years)⁵⁶ On completion of the Foundation Programme Funded, face to face (3 days), with work-based application through a multi-professional quality improvement project. Chief Residents’ Management and Leadership Programme – Health Education East of England⁵⁷ ST5 and above Funded, centrally recruited, face to face (10-day Judge Business School ‘mini-MBA’), with work-based application and supported leadership role. Postgraduate education Master’s in Medical Leadership (MSc) Various institutions offer ‘step-on, step-off approach’ from PG Cert to PG Dip to MSc (1–3 years)^{58,59} Available to all Predominantly self-funded (£2500–£25 000), sponsorship and bursaries available. Part time, moderate workload, variable online versus face to face. Master’s in Business Administration (MBA) Various institutions, some offer healthcare specialties or NHS endorsement (2–3 years)^{60,61} Available to all Predominantly self-funded (£15 000–£90 000), sponsorship and bursaries available. Part time, heavy workload, variable online versus face to face.^{3,4}

Such formal leadership development could be conceptualised through a tiered approach (*Fig. 1*). Firstly, basic generic professional capabilities are provided in leadership for all doctors via an integrated approach within local training programmes. A second tier then provides enhanced local and regional leadership development offers for future service and divisional leaders. Then finally, at the upper tier, nationally coordinated, advanced programmes and fellowships, are delivered for aspiring organisational- and system-level leaders. *Fig. 1A* tiered approach to leadership development. FMLM, Faculty of Medical Leadership and Management.

Discussion

It is important to note that leadership development does not suit a one-size-fits-all approach, and that the evidence does not suggest that any particular activity should be completed before another.³

Up to 90% of learning occurs informally, through often spontaneous, unstructured activities embedded within the work environment.⁶² As revealed through the developmental journeys of medical, clinical and managerial National Health Service chief executives,⁶³ although formal leadership development can be transformational for some, it is insufficient in isolation.

Leadership development can often be better attributed to engagement with inspirational role models, and through the opportunistic experiences that emerging leaders seized because they could, and because they were motivated to make a difference.

For this very reason, it is vital that we overcome the shortage of role models with protected characteristics. Those in medical leadership positions must reflect the wider workforce and communities we serve.⁶⁴ It is not permissible to

³ NIMDTA, Northern Ireland Medical & Dental Training Agency; NHS, National Health Service; PG Cert, Postgraduate Certificate; MBA, Master of Business Administration; MSc, Master of Science; PG Dip, Postgraduate Diploma.

⁴ Predominantly non-clinical (although some do allow limited ongoing clinical activity), and therefore often require an extension to training via out-of-programme experience approval.

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allow ourselves to fall victim to a complex range of social, cultural, political, economic and historical factors, whether unconsciously or otherwise, that marginalise and disempower aspiring leaders from diverse backgrounds.

Equality and diversity should be a top priority for all individuals and organisations. We must counteract the deeply embedded prejudice and discrimination that have become endemic within modern society.⁶⁵ No matter what the characteristic, whether it be gender, sexual orientation, race, religion or any other characteristic that differs from the majority of leaders, these individuals do not easily fit within a structure that is coded towards the 'snowy white peaks of the NHS',⁶⁶ and this must be overcome.

To build this diversity into our psychiatric leadership, and that we need within our mental health services, we must embrace the 'lived experience' of talented leaders regardless of demographic differences, and adopt an inclusive leadership approach.^{67,68} After all, organisations with greater inclusion, rather than merely diversity, are proven to perform better, with greater improvement and innovation, higher levels of morale, and new insights that maximise the potential of employees.^{68,69}

As Vernā Myers puts it 'Diversity is being invited to the party; inclusion is being asked to dance'.⁷⁰

Multiple strategies can be employed to improve diversity and develop an inclusive approach,⁶⁵⁻⁷² but it is no easy task. Fundamentally, it is a cultural change. All doctors, and particularly existing leaders, must engage with these groups, create a psychologically safe space, listen to their stories, confront the hard truths laid bare by their experiences, and challenge the status quo, making diversity and inclusion a personal priority. Allies from non-disadvantaged or less discriminated against groups can confront and have a powerful impact on the behaviour of others. They must not just question what privileges they have been afforded that others might not, but question and reflect on the absence of challenges and barriers that they have not had to overcome but others might. Crucially, they must then act, working within the organisation and system to counteract and mitigate these for others.

Individuals should not feel like 'outsiders'. We should rather recognise an individual's need to belong and proactively seek role models with greater diversity, to make the inclusion of leaders with protected characteristics explicit and visible. This allows those from marginalised groups to identify with the existing leadership, see themselves as leaders and, crucially, feel empowered to seize those opportunistic leadership experiences that are so crucial for their development. In combination, active career sponsorship will be crucial to retain and advance their leadership talent, with mentorship being a powerful mechanism for both the individual and the organisation.^{68,73}

It truly is an inclusive leadership approach that is required. Demographic diversity in isolation, is insufficient. Active role-modelling and the support of key allies in existing leadership positions is essential to provide equitable access to formal and informal leadership development.

Just as we would expect within clinical practice, trainees of all backgrounds must be supported by experienced trainers who expose them to increasingly uncomfortable challenges, yet who provide them with the psychological safety net to take risks, experiment and develop 'on the job'.

Conclusions

Mental health services face unprecedented challenges on an almost daily basis. To survive in this world, and lead quality improvement towards more preventative, holistic and personalised care, doctors must develop a deep understanding of leadership and effectively demonstrate the core values and behaviours expected of medical professionals.

Greater attention must be paid towards medical leadership development and an inclusive approach, whereby all doctors, from every background, are supported to advance. This has never been more important. The view of leadership development being an optional extra within medicine, or a skill set to be developed later in a medical professional's career, is outdated.

No matter which one of the many diverse interventions are pursued, doctors must engage with, and be supported in, both informal and formal leadership development. This is a collective responsibility, and much more must be done to ensure equity of access to leadership development for all, from the earliest of stages in a doctor's career.

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We confirm that all authors meet the four ICMJE criteria for authorship, being equally involved in the design, drafting and revision of the article.

Declaration of interest

None.

1.1.40 Effects of the COVID-19 pandemic on provision of electroconvulsive therapy

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date

2022-06

Abstract

Aims and method

COVID-19 has had a heavy impact on healthcare provision worldwide, including delivery of electroconvulsive therapy (ECT). A survey was completed in the UK and Republic of Ireland in April and July 2020 by 95 and 89 ECT clinics respectively.

Results

In April 2020, 53% of the clinics provided only emergency treatment and 24% had closed. Reasons included unavailability of anaesthetists, infection control measures and staff sickness. Restrictions persisted in July, with disruption to an estimated 437 individuals' treatment and poor outcomes, including clinical deterioration and readmission.

Clinical implications

Risk stratification, longer clinic sessions, improvements in ventilation, regular virus testing, pragmatic staff rostering and availability of personal protective equipment will protect against service disruption in subsequent waves of the pandemic.

Contents

- *Effects of the COVID-19 pandemic on provision of electroconvulsive therapy*
 - *Method*
 - *Results*

- Discussion
- * Recommendations
- Data availability
- Declaration of interest

pmc Recent editorials in the *BJPsych*¹⁻³ concerning the effects of COVID-19 on psychiatry were written at the outset of the pandemic. It would perhaps have been impossible for their authors to have predicted what has been by far the most devastating effect of the pandemic on psychiatric care: suspension or reduction of normal service provision. This has included minimisation of face-to-face care and, crucially, limited provision of one of the most effective psychiatric treatments, electroconvulsive therapy (ECT).

ECT typically involves aerosol-generating procedures (AGPs), including bag-mask ventilation, suction of secretions and, less commonly, laryngeal mask or endotracheal airway insertion and removal.⁴ It was apparent early on in the pandemic that ECT might pose a risk of viral transmission between patients and healthcare professionals, and that alterations to practice might be needed to ensure safety. However, it quickly became apparent that provision of ECT was rapidly diminishing in most areas and even grinding to a halt in some. Anecdotally, anaesthesia staff had been redeployed in many localities but, although anticipated, significant levels of staff sickness and shielding were yet to be encountered.

We present the findings of a survey conducted at two time points during the pandemic. The aim of the study was to establish the nature, extent and effects of any disruption to ECT services, with a view to establishing how obstacles to full service provision might be overcome in due course.

The survey was conducted by the ECT Accreditation Service (ECTAS), the department of the Royal College of Psychiatrists responsible for the setting and monitoring of clinical standards in the delivery of ECT services across three regions of the UK (England, Wales and Northern Ireland) as well as in the Republic of Ireland. The survey did not cover ECT clinics in Scotland, where standards are set and monitored by the Scottish ECT Accreditation Network.

Method

Each ECTAS member clinic was sent a link to an online survey via the network's email discussion group during two 1-week periods in April and July 2020. The questionnaire was developed following consultation with clinical experts from ECTAS. Reminders were sent to non-responding clinics 2 days before the closing dates. Because this was a retrospective survey of clinicians and did not influence patient care, ethical approval was not required.

In addition to the questions set out in *Table 1*, respondents were asked for the total number of patients at their clinic who had had their treatment affected by the pandemic since 16 March 2020, including those who would otherwise have received ECT but had not. *Table 1* Survey responses from ECT clinics in England, Wales, Northern Ireland and the Republic of Ireland

Questions	Responses, n (%)	April 2020	July 2020
Is your ECT service currently being affected by the COVID-19 pandemic?	Yes	84 (88)	69 (78)
	No	11 (12)	20 (22)
What is the reason?	a	Lack of availability of anaesthetists	49 (52)
	b	Increased PPE/environmental requirement	43 (45)
	c	Required infection control procedures have reduced treatment capacity	48 (54)
	d	Staff sickness/shielding	43 (45)
	e	Staff redeployed	3 (3)
	f	Other	20 (21)
What has been the impact on service provision?	a	No service provided at present	23 (24)
	b	Reduced number of sessions	12 (13)
	c	Service restricted to most urgent/severe cases	50 (53)
	d	Other	14 (15)
What has been the effect on patients who would normally have received ECT prior to the pandemic?	a	Having ECT at a different clinic	16 (17)
	b	Reduced frequency of ECT	20 (21)
	c	Not having any ECT, in-patient, duration of stay potentially increased	47 (49)
	d	Not having any ECT, discharged from hospital	17 (18)
	e	ECT course curtailed	35 (37)
	f	Continuation/maintenance ECT stopped	46 (48)
	g	Clinical condition worsened, probably as a result	18 (19)
	h	Admitted to hospital	3 (3)
	i	Detained in hospital	1 (1)

¹ ECT, electroconvulsive therapy; COVID-19, coronavirus disease 2019; PPE, personal protective equipment.

² Multiple responses were allowed for these questions.

³ These options were not listed in the March 2020 version of the survey.

⁴ 'Other' category included clinic/theatre space or equipment needed by another service, and staff being redeployed to other areas.

⁵

Results

We are aware of 108 ECT clinics in existence in the four regions covered by this study; of those, 98 are members of ECTAS and were sent surveys to complete. In total, 95 clinics (97%) submitted responses to the survey in April 2020 and 89 (91%) in July 2020. Thus, our data cover 89% and 82% of all existing clinics at the two time points respectively.

The main findings are summarised in *Table 1*. Of 95 clinics, 84 (88%) were being adversely affected by the pandemic in April 2020: 50 (53%) were restricting ECT to the most urgent and/or severe cases and 22 (23%) were providing no service at all. By July, of 89 clinics, 69 (78%) were still affected, with 38 (43%) restricting cases and 8 (9%) remaining closed.

Additionally, the 364 patients who had had their treatment affected by the pandemic since 16 March 2020, including those who had had ECT withheld, had risen to 437 by July 2020. One clinic alone had had the treatment of 41 patients affected.

Discussion

Our survey shows that the vast majority of ECT services have been, and continue to be, adversely affected by the COVID-19 pandemic. Obstacles to delivery of ECT have been, and remain, various.

Anaesthetists and operating department practitioners were withdrawn from ECT lists to staff enlarged intensive care units (ICUs), despite most ICUs never having even neared capacity. This affected over half of the clinics at the beginning of the pandemic, with some still experiencing problems by July 2020, when the first peak of COVID-19 infections had long subsided.

Some ECT suites, with no means for adequate ventilation, have been unable to safely host a treatment that potentially involves AGPs. Even those suites that were adequately ventilated or have since been fitted with ventilation systems may continue to operate at reduced patient capacity. Many require patients to fully recover in treatment rooms owing to limited space for safe distancing between patients elsewhere and repurposing of recovery areas for doffing of personal protective equipment (PPE). Even in suites that retain separate recovery areas, the treatment room must be left fallow after any AGP for a set period before cleaning in preparation for the next patient. In some clinics this is as long as 30 min, depending on the frequency of air changes the room.

Treatment rooms require full cleaning between patients, and staff members spend a lot of time donning and doffing PPE. These necessities at best halve patient throughput.⁵ Some ECT services run from suites without adequate ventilation have instead delivered treatments in general hospital operating theatres,⁶ which are subject not only to the restrictions listed above but also necessitate vying for time and facilities with surgical teams. Additionally, poor supply of PPE may have temporarily limited ECT provision in some hospitals.

The resultant loss of productivity has been devastating for many patients. It has led to services variously cancelling all ECT or prioritising only the sickest patients; some clinics have stopped out-patient treatment. Widespread cessation of continuation and maintenance ECT has led to recurrence of severe illness, and delays in initiating acute courses have resulted in worse patient outcomes, particularly in life-threatening illness. Admissions and even formal detentions in hospital have occurred or been lengthened as a consequence.

⁵‘Other’ category included patients being treated at a neighbouring clinic, and list length reduced to allow time for use of PPE and decontamination of facilities between patients.

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Recommendations

Looking to the near future, it is imperative that ECT services remain functional even if there is a second wave of COVID-19 infections this winter. Guidance published in September 2020 jointly by four anaesthesia organisations in the UK⁷ takes a pragmatic approach towards COVID-19 risk stratification that might prove helpful in increasing patient turnover. Crucially, it asserts that in-patients who are regularly tested for the virus and are on wards where COVID-19 patients are not being treated should be considered low risk. Previously only a small minority of out-patients who were shielding at home and regularly tested for the virus had been considered low risk. For treatment of low-risk patients, staff need wear only basic PPE (an apron, gloves and a surgical mask, with consideration of eye protection), usual recovery areas can be used and treatment rooms do not require full cleaning between patients.⁷

However, patients in medium- and high-risk groups will continue to present for ECT. Some clinics may require improvements in ventilation to facilitate faster throughput of such patients. It is essential that any shut-down clinics be reopened without delay, following liaison between infection control, anaesthesia and ECT staff. Psychiatric staff must work closely with anaesthesia colleagues to develop pathways enabling out-patients to access ECT, including regular fast-track virus testing.

It would be all too easy, with the benefit of hindsight, to criticise decisions made at the outset of the pandemic to redeploy anaesthetists, en masse, in anticipation of a surge in ICU usage of far greater magnitude than ultimately occurred. But it is important that the same situation does not recur and that staff are pulled from delivering ECT only if ICUs have a genuine need for the personnel and careful consideration of the balance of negative outcomes concludes that such action is unavoidable. PPE must be kept available. Lastly, the need to lengthen or widen ECT lists into afternoon sessions or on more days of the week must be seriously considered by healthcare providers, with job planning and prioritisation of staffing for ECT services made to facilitate this.

We thank Eve Blanchard and Sinead Rogers of the ECT Accreditation Service for organising and collating the results of the survey and Professor George Kirov for his suggestions regarding this paper.

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Data availability

The data that support the findings of this study are available from the corresponding author on reasonable request.

R.B. analysed the data and wrote the initial draft manuscript. R.C. was involved in designing the study, wrote the draft abstract and revised the manuscript. V.S. was involved in designing the study and revised the manuscript. All authors gave final approval of the version to be published and agree to be accountable for all aspects of the work.

This research received no specific grant from any funding agency, commercial or not-for-profit sectors, but the survey was facilitated by employees of the Royal College of Psychiatrists, London.

Declaration of interest

None.

1.1.41 Supporting people in mental health crisis in 21st-century Britain – ERRATUM

Andrew Molodynski Stephen Puntis Em Mcallister Hannah Wheeler Keith Cooper

date

2022-06

Contents

- *Supporting people in mental health crisis in 21st-century Britain – ERRATUM*

pmc In the original published article, country names were missing from the author affiliations. This has now been corrected.

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1.1.42 Extracurricular pursuits

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date

2022-06

Abstract

Dr Dignan’s poetry, her care, and her enthusiasm should be lauded. There are also many other non-medical pursuits that may make us better doctors. But it is difficult to know which of these are effective or practicable.

¹

Commentary on... Evensong. See this issue.

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 - *What’s best for our skills?*
 - *What’s best for us emotionally?*
 - *What’s best for healthcare funders?*
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pmc In medical school we used to debate whether we would prefer to be a kind doctor or a clever one. Of course, most of us wanted to be both. But when we were ill ourselves, if we had to choose we were sure we would want a clever doctor to deal with serious conditions and a kind one for the minor things.

There is a related rift in mental health services between psychodynamic work and evidence-based medicine. Certainly, most patients are given one or the other. Corinne Dignan in her article¹ focuses on something more on the psychodynamic side, that we are in danger of forgetting: the feelings and the shared experiences that she neatly calls the person behind the diagnostic labels. In this commentary I focus on this specific suggestion, rather than the general topic of medical humanities.

To clarify, she is not pushing us to become psychotherapists. She sees a beauty in each person, the special moments in each life and the treasured memories that gradually disappear in dementia. She experiences shared memories as special objects that will die unless a person keeps them alive. Indeed, as long as one person keeps them alive, part of the departed person still exists. In some senses they do; the memories exist, and we may sometimes feel that the person does too. This is a point that I’ve not seen so well treated elsewhere. Each experience, or at least an echo of it, continues to exist for as long as someone thinks about it (akin to the tree in the quad²). Dignan’s article serves to warn us not to forget John Eccles’s World 2 (subjective knowledge) as opposed to Worlds 1 and 3 that doctors usually focus on (physical objects and objective knowledge).³

I’m pleased that Dr Dignan is not pushing us all to be poets (I might rebel). Instead, starting from a traditional learning hierarchy of medicine–psychiatry–subspecialty–specific job,⁴ she adds another layer. She proposes that the medical humanities – a vast conglomeration of fields – is a rich hunting ground for broadening experiences. Not only rich, but necessary: I am going slightly beyond her words here, but she seems to believe that exploring the humanities makes us better people, more complete and more able to relate to others.

Dignan’s aims are commendable and her poem is gorgeous. By publishing it, some of the memories she shared with her grandmother will endure for as long as this journal, perhaps in a cloud on a distant planet. Her point deserves to be applauded, explored and amplified.

This commentary started with the question of which kind of doctor serves patients best. We serve patients directly, but also indirectly by serving the systems around them. In the UK, the General Medical Council (GMC) says that a good doctor will ‘make the care of your patient your first concern.’⁵ But not your only concern. ‘Good medical practice’ also includes duties to our own knowledge and skills; to other patients; colleagues; our personal health; the medical profession; and the public. I will comment on a few of these that relate to Dignan’s article.

What's best for our skills?

I'm convinced that everyone becomes usefully dubious of their own intuitions if they regularly spend time with *Thinking, Fast and Slow*.⁶ Kahneman, and many others, have demonstrated that one of the most pervasive of all thinking defects is narrow framing, in other words failing to think broadly enough about a problem.

So for what it's worth, here are some of my favourite thought-broadening activities for psychiatrists, admittedly evidence-light. (a) We could learn from psychologists, many of whom are explicitly trained to become 'scientist practitioners'. It's a lifelong challenge.^{7,8} (b) Some of my best colleagues love long-distance holidays. Who knows which came first? They may have been broad-minded even before the first long-haul trip. (c) In my job, watching two siblings bicker and play can produce a delightful impression of them as parts of the stream of social humanity. It also produces useful objective observations. But are these valuable enough to justify the second child missing school to attend? For the impression, no. But for the observations: perhaps for one session and not subsequently. (d) As Francis Bacon noted in 1597, 'Reading maketh a full man, conference a ready man, and writing an exact man'. Of course, all three parts are relevant to a modern psychiatrist. Reading autobiographies and complex fiction can extend the range of people we empathise with.⁹ And, no doubt, by 'conference' he was referring to respectful participation in a multidisciplinary team.

What's best for us emotionally?

Many doctors need a protective carapace, so they don't become too dispirited by demanding patients. Others need to suppress their enthusiasm for over-engaging with patients. Other doctors (one thinks particularly of researchers) need to give full flow to their meticulous tendencies. Overall, we should try to find a happy, productive, middle course that works for us personally.¹⁰ Part of this might include keeping a personal diary – for ourselves and those who come after us.

Dignan's aspiration is that we should all follow her example, and become more empathic. I hope some of us do. But I'm not optimistic. The classic example is the people travelling to give a lecture on good Samaritans, who step over a sick person, especially if they feel rushed.¹¹ Allow me to give a personal anecdote of my own failure to transfer attitudes between relationships. During my time as a junior psychiatrist I felt sympathy towards a man whose Huntington's disease destroyed the relationships in his family: but I didn't notice the same process happening in my own family at the same time (due to my father's multiple sclerosis).

What's best for healthcare funders?

Dignan advocates that we should spend more time with patients. In my experience, most doctors wish this. But how much time is justified? In many units, a ward assistant will be given the role of making patients feel comfortable and listened to; some of them have a delightful, naturally reassuring manner that hardly relies on personal knowledge. Usually, the history taking is delegated to junior doctors. That system creates good histories, good relationships and good training.

But the more senior doctors need to be quick, more distanced, less emotionally involved. It sounds like a shortcoming, but it isn't: their distance makes a necessary contribution to the thinking of a diverse team. The older psychiatrists typically have a wider social circle and have known vastly more patients: they have all exceeded the Dunbar number of 150 people that we can personally relate to.¹² Even more distance is needed by doctors in poor countries: if they have only 5 or 10 minutes per patient, constant personal involvement will overwhelm them.

What's best for the future of healthcare?

As a field, we need different things: practitioners exploring literally everywhere for insights, with the more distant explorers widely spread out, not following others, to cover the vast, less promising terrain. Even after our explorers have found a promising activity, as Dignan has done, it's fiendishly difficult to prove that it's worthwhile.¹³

We discussed these issues in our continuing professional development (CPD) group recently. One consultant said it was only her impending retirement that made her feel safe enough to say that getting to know the patients was highly undervalued, and actually disapproved of by managers. Another felt it had to be conducted as a 'guerilla activity' because managers saw it as detracting from the necessary work. The group found art and writing activities useful for patients, but there were no takers for creating any form of art themselves.

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Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

This work received no specific grant from any funding agency, commercial or not-for-profit sectors.

Declaration of interest

None.

1.1.43 Friston's free energy principle: new life for psychoanalysis?

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2022-06

Abstract

The free energy principle (FEP) is a new paradigm that has gain widespread interest in the neuroscience community. Although its principal architect, Karl Friston, is a psychiatrist, it has thus far had little impact within psychiatry. This article introduces readers to the FEP, points out its consilience with Freud's neuroscientific ideas and with psychodynamic practice, and suggests ways in which the FEP can help explain the mechanisms of action of the psychotherapies.

Contents

- *Friston's free energy principle: new life for psychoanalysis?*
 - *Friston's forebears*
 - *Free energy*
 - *Free energy and psychopathology*
 - *Psychotherapeutic implications*
 - *Conclusions*
 - *Declaration of interest*

pmc Today's psychiatrists are pragmatists, on the look-out for what 'works' and sceptical about the grand theories that held sway in the previous century. But ideology cannot be wholly avoided, nor theoretical controversy evaded. Current psychiatry's pantheon includes evidence-based practice, DSM diagnosis and neuroscience. The search for evidence is theory driven. Diagnostic profusion raises questions about the medicalisation of human suffering. Despite extraordinary recent advances in neuroscience, their impact on everyday psychiatric practice has been modest.

The purpose of this article is twofold: first, to introduce readers to an overarching model of brain function associated with the mathematical psychiatrist Karl Friston, the free energy principle (FEP), which has been influential in neuroscience generally, but thus far has caused relatively little stir within psychiatry or clinical psychology. My hope is to redress that. Second, I make the case that FEP can revitalise the psychoanalytic psychotherapies, marginalised by the inexorable rise of cognitive-behavioural therapy (CBT) as the dominant psychological therapy paradigm.

It should be noted that FEP is deliberately described by Friston as a 'principle', akin to the principles of natural selection or gravity. The evidence for its validity is circumstantial rather than direct, and its detailed neuronal mechanisms and clinical implications remain to be fully explored.

Friston's forebears

Friston's project builds on the work of a number of pioneering predecessors and their concepts. These include Erwin Schrödinger, Heinrich Helmholtz, the Claudes – Claude Bernard and Claude Shannon – and Thomas Bayes. We live in an entropic universe. Broken cups don't spontaneously reassemble. Coffee cools once poured. Stars burn out. The exception is life itself. Quantum physicist Schrödinger¹ coined the term 'negentropy' to describe how living matter, Canute-like for its lifetime, reverses this cosmic tide towards disorder and homogeneity.

The key to negentropy is homeostasis. As Bernard famously put it, the condition of a free life is the stability of the interior milieu – whether one is a unicellular amoeba or, like Schrödinger, a Nobel-prize winning primate. Homeostasis, and the more general processes of allostasis,² resist the forces of entropy, physiologically and behaviourally. Inherent in homeostasis are boundaries: cell membranes, the skin, the brain within its skull. Janus-like, homeostasis faces outwards towards the environment and inwards towards the *milieu interieur*. Temperature sensors in the skin tell us it's a hot day; the sympathetic nervous system activates sweat glands, the brain tells us to fling off jumpers, move into the shade, etc., all in the service of resisting being entropically fried. Note that homeostats vary in 'precision' – some are highly sensitive, whereas others tolerate a great range of variation.

Friston had the insight and mathematical sophistication to see that the negentropic homeostatic principle applies not just to the organism as a whole but to the brain itself.^{3,4} The brain's job is to counteract entropy and to maintain internal stability on behalf of the organism whose processes and behaviour it controls and directs; this applies, reflexively, to itself.

The FEP goes back to the ideas of 19th-century polymath Hermann von Helmholtz, updated by artificial intelligence (AI) neuroscientists Geoffrey Hinton and Peter Dayan.⁵ Naively, we tend to think of vision as a camera-like image passively projected onto the visual cortex, or the auditory system as microphone-like, responding indiscriminately to the prevailing phonic universe. In the Helmholtz model the *brain makes its own world*. Our sense organs, external and internal, are constantly bombarded by a vast range of stimuli from an ever-changing environment. To operate with maximum efficiency, the brain selects out the 'meaning' of its sensations, attending only to those that are relevant to its 'affordances'⁶ – its specific ecological niche – and especially to input that is anomalous or novel.

Working in the 1950s at the Bell telephone company laboratory, Claude Shannon saw that this 'meaning' could be quantified – as 'bits' of information. Gregory Bateson, anthropologist and family therapy guru, called these 'differences that make a difference'. White noise is chaotic, entropic and devoid of information. Language, whether spoken, sung or gestured, is structured, ordered, negentropic. The measure of informational energy is 'surprise', i.e. how unexpected a signal is. In the board game Scrabble, the letter 'x' conveys more information than 'e' because it is relatively unusual, applying to a smaller range of words, and so in calculating the score, is 'worth' more. The brain's aim is constantly to reduce informational entropy and maximise meaning.

A crucial building block for the FEP is the concept of the Bayesian brain. The Reverend Thomas Bayes, a late 18th-century clergyman and founder of probability theory, grasped, Doris Day-like, that the future's not ours to see. Yet, to survive and adapt we need to know, moment to moment, 'what is going on' – in ourselves, in the interpersonal world

and in the physical world. On the basis of prior experience, the Bayesian brain⁷ continuously estimates the likelihood of future events. Probabilities are computed by comparing current states of affairs with past occurrences, estimating the extent of correspondence between them, factoring in the likelihood of errors in both memory and perception, and ending with a portion that represents that which cannot be predicted. This is ‘prediction error’, which must, in the service of negentropy, be minimised as far as is possible – prediction error minimisation or PEM.

The brain, ‘top-down’, uses Bayesian probabilities to clarify ‘bottom-up’ input, extero- and interoceptive:⁸ ‘My stomach is complaining, but it’s not surprising – I overdid it on the pudding, so it’s probably not cancer’; ‘I know that tune, I’ve heard it so many times – yes of course, it’s the Beatles’ Yellow Submarine’; ‘Is that a stick or a snake? Come on, no adders in city centres, probably safe to pick it up’.

Free energy

Now to the free energy principle itself. ‘Energy’ equates to information, albeit physically embodied in patterns of neuronal impulses, synaptic transmission (‘fire together, wire together’⁹) and the neurohormonal environment. Prior models of the world, top-down, ‘bind’ incoming bottom-up information. Energy *unbound*, or prediction error, reflects novelty in need of binding – and so forestall the dangers of entropic chaos.

Circumstantial evidence for the FEP is the fact that more neuronal fibres reach the eye downwards from the brain than travel upward towards the visual cortex. Whenever possible, the brain ‘tells’ the eye what it is likely to be seeing. The FEP postulates a hierarchical series of neuronal interactions, starting from the least to the most complex, from the periphery to the central nervous system, from specificity to abstraction, most of which operate below conscious awareness. At the level of the eye itself the retinal receptors are activated: ‘round, two dots and a straight line between’. Top-down, even in a 1-month baby, this will elicit an answering smile (‘face equals security’). Once language arrives, verbal concepts shape perceptions: ‘Oh of course, that’s a face’. At the highest level is mentalising – thinking about thinking: ‘I wonder why bearded faces always make me feel slightly unsettled? Perhaps it’s reminiscent of my scary grandfather’.

The FEP visualises a series of ‘conversations’ in which top-down ‘priors’ ‘bind’ bottom-up input into probabilistically recognisable meanings. Each level can be thought of as a meaning–action boundary. Ascending the hierarchy, the Bayesian process ensures that the most mathematically probable pattern prevails across these statistical boundaries or ‘Markov blankets’.¹⁰ Prediction error is minimised by ‘binding’ bottom-up energy (informational as well as physiological) by top-down generative models based on pre-existing patterns and concepts. Thus is order preserved, entropy eschewed. We know what we like and, mostly, see what we want and expect to see.

But there will always be a discrepancy between our pre-existing models of the world and incoming sensations, an excess of energy that cannot be bound and will have to be passed onto the next level up of the hierarchy. Lockdown excepted, we don’t live huddled in ‘dark rooms’.¹¹ The environment is constantly in flux; we need to explore as much as conserve – to find new sources of food, suitable mates, interest and excitement. Surprise, calibrated by the brain as the discrepancy between expectation and incoming sensation, is a proxy for free energy – and hence entropy. Surprise is both vital to survival but also potentially entropic, disruptive or even life-threatening. This represents the prediction error aforementioned. The brain minimises such surprise/error by whatever means possible.

At this point the role of affect becomes important. Free energy is aversive and can be thought of as representing mental pain. Conversely, ‘binding’ free energy is rewarding and therefore motivating. The role of affect, positive and negative, is to drive the free energy minimising processes. This is another ‘AI’ – active inference.

The idea of active inference captures a number of psychological processes central to psychological health. First, action or agency. Given that incoming stimuli are inherently subject to error and imprecision, the brain increases precision by movement – approaching an ambiguous stimulus source, turning the head to use foveal rather than peripheral vision, switching lights on in order to see better, etc. Second, top-down model revision. Now we know what that vague shape really ‘is’ – a cat, clothes strewn on the floor, etc.: ‘Let’s listen more carefully. Oh, that’s not the Beatles at all, it’s the Beach Boys’. Third, and vitally in the case of social species such as our own, active inference is enhanced by recruiting help or ‘togetherness’: ‘Did you hear something, or was I just imagining it?’; ‘You know about ’70s music – what was that group’s name?’. Friston & Frith call this ‘duets for one’ and have worked out the mathematics of such collaborative Markov blankets.¹² Fourth, if all else fails, by choosing or fashioning environments that conform to the

brain's pre-existing models of the world: 'I can't stand modern music. Let's go over to Classic FM'. This last aspect is captured by the psychoanalytic concept of 'projective identification', in which we shape our interpersonal world, often deleteriously, to conform with expectations: 'You psychiatrists are all the same – never there when I need you'.

Free energy and psychopathology

The FEP has clear implications for those who work in mental ill health, and especially who favour psychological methods of treatment. Consider depression, typically triggered by loss, trauma or multiple setbacks. Adversity is widespread – poverty, inequality, racism – but not all succumb. To understand resilience, we need an illness model that encompasses not just events, but individuals' responses to them. Attachment research shows that those who are securely attached are able to repair the inevitable ruptures to which all are prone, often through the typical sequence of protest, rage, grief and mourning.¹³ As children, securely attached people have had caregivers they could depend on to acknowledge their pain, tolerate protest and help them to move on. Repeated episodes of everyday rupture–repair cycles help build this resilience.

The free energy released by the rupture is bound by the child's knowledge that help is at hand and that their epistemically trusted caregiver will provide a generative model to counteract the free energy associated with ruptures: 'Don't worry love, I'm just going to the loo, I'll be back in a minute'. In the 'still face' paradigm, parents are asked to freeze their facial expression for 1 minute while talking or playing with their child.¹⁴ Securely attached children continue actively to try to re-engage with their caregivers in the confident expectation that they will be 'back soon'. For insecurely attached children, by contrast, rather than rupture–repair, cycles of rupture–despair or rupture–disappear are the norm. Their caregivers have either themselves been overwhelmed by their child's unhappiness and so despairingly abandon attempts to alleviate it; or repress the impact of the child's mental pain and so 'disappear' emotionally. Both leave the child alone to find ways to bind the free energy the rupture evokes. When their caregiver's face freezes they look away, become miserable and regressed, and often resort to self-soothing rituals such as rocking or emotional dissociation.

Such insecurely attached children are primed in later life for depression in response to loss or trauma or, in extreme cases, to developing post-traumatic stress disorder. The ingredients of free energy minimisation needed to maintain psychological equilibrium are for them problematic. Active inference is compromised. They tend to be passive rather than active. They stick with limited and simplistic and inflexible 'top-down' models such as 'It's no use trying to make things better, it never works' or 'Feelings are dangerous, best to keep them buried'. They find it hard to trust people and so can't 'borrow' an intimate other's brain with which to process feelings and build up alternative ways of viewing the world.

Psychotherapeutic implications

The most commonly used therapy for depression, CBT, attempts to address these deficiencies. Therapists encourage patients actively to test their negative 'hypotheses' by looking more closely at their experiences and by exploring alternative top-down models to account for them ('Maybe my boyfriend didn't answer his phone because he'd run out of battery, not because he doesn't love me'). But CBT has its limitations. 'Treatment-resistant depression' is common.¹⁵ People with personality disorders do badly with standard CBT, often refusing to engage or dropping out.¹⁶ The FEP provides explanations for this. From an FEP perspective, one way to minimise free energy is to gravitate towards or engender environments that confirm one's view of the world, however negative. Depression relegates sufferers to emotionally impoverished relationships, stereotyped and simplistic top-down models, and thus becomes a self-fulfilling hypothesis, resistant to psychotherapeutic interventions. In addition, these negative top-down priors are 'inferentially inert', i.e. inaccessible for modification.

A degree of chaos/uncertainty/free energy needs to be tolerated before new generative models can evolve. Homeostatic imprecision needs to be tolerated for a while. The holding and 'negative capability' of the therapist's 'borrowed brain' paves the way for a more complex, nuanced top-down reset. Given that people with personality disorders notoriously find it difficult to trust others, the brevity and defocus on the therapeutic relationship in standard CBT limits the scope for such fundamental change.

Moving from depression to an FEP perspective on trauma, the latter creates an overwhelming influx of free energy for which there are no available top-down models with which to bind it. Thoughts of cruelty, neglect and abuse remain

in the realm of the unthinkable and are therefore ‘defended against’ by repression or dissociation.¹⁷ However, when jointly considered – under a shared Markov blanket – these bottom-up unprocessed experiences can be bound with the therapist’s encouragement and expertise into manageable narratives. However painful, they become less overwhelming, a source of new ways of thinking and psychic reorganisation. As the patient begins to feel that the therapist is safe, reliable, compassionate and empathic, so everyday ruptures – session-endings, holiday breaks and misunderstandings – are repeatedly repaired via model revision (‘Maybe the weekend break does not inevitably mean I’m forgotten’), and the trust this engenders can be generalised into the patient’s everyday life.

We can see here how contemporary psychoanalytic psychotherapy and revitalised Freudian ideas resonate with the FEP. Freud started off his working life as a neurologist. Like Friston, he conceptualised the brain’s aim as reducing psychic energy, typically through action and ‘word representations’ – i.e. transmuting free energy into thinkable thoughts. He saw unbound energy (which he later transmuted into ‘libido’) as potentially disruptive and responsible for the symptoms of psychological illness. Psychoanalysis was designed first to evoke and then to quieten this trauma-related unbound energy. To achieve this, three key psychoanalytic procedures are free association, dream analysis and analysis of transference.

The ‘virtual’ nature of the psychoanalytic relationship brings both top-down and bottom-up components of the FEP process into focus, enabling them to be mentalised rather than enacted. Free association taps into the mind’s normally unvoiced upward-welling stream of consciousness, counteracting the elusiveness of affect seen in the rupture–despair/disappear attachment pattern. This enables the range of top-down responses to be enhanced and aversive free energy minimised. At the top-down level, in a process comparable to the immune system’s lexicon of antigen-activated antibodies, dreaming is the means by which the mind generates a repertoire of narratives with which to bind the free energy which life’s vicissitudes engender. Transference analysis turns the spotlight on the limited varieties of top-down narratives that sufferers use in their dealings with intimate others to minimise free energy. The enigmatic ambiguity of therapists’ persona enables patients to experience, reconsider and extend the top-down assumptions with which they approach the world of intimate others.

Psychoanalysis has tended to self-isolation, sequestered from cross-fertilisation by other disciplines. The Friston–Freud consilience opens up new possibilities. Psychoanalytic and attachment-derived mentalisation-based therapy (MBT) is now established as a highly effective therapy for borderline personality disorder, previously considered untreatable.¹⁸ MBT leads to big reductions in medication use, suicide attempts, hospital admission and unemployment among people with borderline personality disorder, as compared with treatment as usual.

MBT is both practically and conceptually consistent with the FEM. It encourages patients (a) to identify the bottom-up feelings that fuel their self-injurious actions, (b) to pause and think of different ways of handling these, i.e. to tolerate a quantum of free energy with the help of the therapists’ ‘borrowed brain’ and (c) through mutual mentalising (therapist and patient together forming a neurobiological ‘bubble’) to generate more complex and adaptive models of the self and significant others. The result is manageable surprise: confounding sufferers’ negative assumptions about the world, becoming less overwhelmed by unbound affect (fewer ‘melt-downs’) and facilitating greater resilience.

Conclusions

If rehabilitation of the psychoanalytic method in the light of the FEP comes as a pleasant surprise, this is consistent with its principles. As in Mark Twain’s trope, rumours of psychoanalysis’s death have been greatly exaggerated. In place of despair or disappearance, the FEP suggests that repair is possible. FEP-grounded psychoanalytic approaches such as MBT are now known to help those with profound mental distress. They also suggest a scientifically sound account of the interpersonal and neuronal mechanisms by which psychological change comes about.

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Declaration of interest

None.

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1.1.44 ‘Choose Psychiatry’ goes virtual: experiences and learning from the online 2020 National Psychiatry Summer School

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Abstract**Aims and method**

COVID-19 has forced many educational events to go ‘virtual’. We report on the first online student-run National Psychiatry Summer School (NPSS). Evaluation of the online format and content was undertaken through survey feedback from almost 400 attendees.

Results

The NPSS positively affected attendees’ perceptions of psychiatry as a career choice. The virtual format was positively received, with benefits including breaking down traditional barriers of geography and cost.

Clinical implications

Post-COVID-19, a hybrid future of mixed virtual and face-to-face events is likely. Our work shows the viability of this and unique gains it might offer, and offers experiential learning on challenges encountered for others who wish to trial further virtual conferences.

Contents

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pmc COVID-19 has presented many changes, including a rapid move to virtual teaching.¹ Online conferences have become the ‘new normal’, providing numerous new challenges and opportunities for medical education.² ‘Choose Psychiatry’ initiatives by the Royal College of Psychiatrists (RCPsych) have also adapted to these changes. The National Psychiatry Summer School (NPSS) was one such event, planned from the outset as a virtual event with RCPsych sponsorship and successfully hosted online over 2 days in July 2020. To our knowledge, it was the first virtual summer school led by medical students with collaboration across devolved nations of the UK.

The NPSS had three primary aims: (a) to promote psychiatry as a career; (b) to help compensate for clinical placements lost during the pandemic; (b) to reduce geographical, financial and time-frame barriers to attendance. The first of these has been a common theme for other initiatives.³ However, the other two reflect innovative attempts to offset losses accrued during the COVID-19 pandemic and tap into novel opportunities from this disruption. Two secondary aims were to explore underrepresented subspecialties within the undergraduate curriculum and to evidence high-quality medical student-led initiatives.

We report the practicalities and learning from hosting this online event, present feedback data on the content and novel format, and offer proposals for the future optimisation of student engagement and recruitment through technology. We also consider the future of advancement of hybrid models and events that will likely combine virtual and face-to-face aspects, much of which is applicable to other online conferences.

Method

Free-text feedback and ratings on a range of questions were collected on both days of the NPSS and a total of 726 feedback forms were completed (383 for day 1 and 343 for day 2), accounting for just over 81% of attendees. Merging the survey data produced a total of 379 responses.

Participants gave informed consent for their anonymised data to be subsequently analysed and disseminated in future research and promotional materials. Ethical approval was not required as the purpose of the study was to evaluate and improve a service. No formal research methodology was used beyond descriptive analysis of the survey data.

Survey data collection

The majority of attendees were based in the UK (347/379); of those specifying a country, 7 were from Wales, 15 from Northern Ireland, 28 from Scotland and 87 from England. International attendees came from (1 from each country unless otherwise stated): Albania, Brunei (2), Canada, Egypt, Hungary, India (2), Ireland (2), Kuwait, Malaysia, Oman, Pakistan (3), Poland, Romania, Saudi Arabia and the United Arab Emirates (3).

In total, 215 attendees were current medical students, 104 were sixth form students, 13 were doctors and 33 were current/post-graduate students in other fields, including biomedical sciences and psychology.

Feedback responses

Attendees were asked to rate (on a scale of 0–10) how likely they were to choose a career in psychiatry/mental health before and after the event. The mean score increased from 5.66 (s.d. = 2.61) to 7.31 (s.d. = 1.95) (*Fig. 1*). They also completed a six-point questionnaire on various aspects of the event (*Table 1*). Feedback was very positive for the event; for example, across the 379 survey responses, over 99% of attendees ‘strongly agreed’ or ‘agreed’ that the presenters appeared enthusiastic about the subject and over 98% of attendees ‘strongly agreed’ or ‘agreed’ that, overall, this event was high quality. *Fig. 1* Attendee likelihood rating (a) before and (b) after event. *Table 1* Subjective attendee ($n = 379$) ratings of the 2020 National Psychiatry Summer School

Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
‘The presenters appeared enthusiastic about the subject’	84.96	14.25	0.53	0.26	0.00
‘Overall, this event was of a high quality’	79.95	18.73	0.53	0.53	0.26
‘The event was well organised’	86.81	12.14	0.53	0.26	0.26
‘This event was successful in promoting psychiatry’	75.99	22.96	0.79	0.00	0.26
‘The event length was adequate’	56.73	33.51	7.92	1.58	0.26
‘There were enough breaks during the day’	38.79	40.63	11.87	7.92	0.79

Free-text survey responses

Formal qualitative methods were not used, but free text was used to identify key themes in feedback from attendees. In total, 180/331 respondents from day 1 and 132/297 from day 2 provided qualitative free-text feedback. Attendees were asked whether there were ‘any other topics you wished we had covered?’. Popular responses included (but were not limited to) ‘Child and adolescent psychiatry’, ‘Perinatal psychiatry’, ‘Addiction psychiatry’, ‘LGBTQ mental health’, ‘Intellectual disability psychiatry’, ‘Psychotherapy’ and ‘Patients with lived experience’. Other responses referred to specific disorders or topics covered on day 2.

Attendees were asked to provide feedback to help improve future events, from which we identified 20 major themes: 10 on the format of the online event (*Table 2*) and 10 on its content (*Table 3*). *Table 2* Major themes regarding the online format of the 2020 National Psychiatry Summer School identified from qualitative data analysis

Format theme	Example quote
Accessibility	‘The fact that it was free and I was able to attend despite being from [...] was very useful.’ (Theme 1)
Medical student hosts	‘I feel that the hosts played a massive part in making the day enjoyable and the way they went about changing it to suit the audience’s needs, like the sixth former talk during lunchtime, would be something I am very thankful for. I am very inspired by the two of them.’ (Theme 2)
Quality	‘The event was incredibly well organised and done so much more professionally and with fewer technical problems than other virtual conferences arranged by larger organisations with more qualified staff.’ (Theme 3)
Organisation	‘I think the day was very well organised, it was truly one of the best events I have attended.’ (Theme 4)
Technology	‘It was amazing that you stuck to time and covered such a breadth of topics with speakers who were confident using the technology and extremely passionate about their subject areas.’ (Theme 5)
Social media use	‘It was great to get a good conversation going on Twitter – almost like networking (but not quite!).’ (Theme 6)
Interactivity	‘Although difficult to do, I think the talks could’ve been more interactive i.e. using the poll/voting tools available on Zoom.’ (Theme 7)
Providing post-event resources	‘Perhaps in future (with the permission of the speaker of course) it would be possible to record sessions so if some people are not able to make it they would be able to watch at a later date.’ (Theme 8)
Target audience	‘Perhaps there could have been different sessions available at different times/in breakout rooms at the end depending what stage you were in that you could choose to attend.’ (Theme 9)
Zoom fatigue	‘I would have wanted would be maybe a couple more breaks, just couldn’t bear to miss any talks yet my eyes are definitely aching after a long day of screen-staring.’ (Theme 10)

Table 3 Major themes on the content of the 2020 National Psychiatry Summer School identified from qualitative data analysis

Content theme	Example
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quoteSpeakers‘Very well delivered webinars, speakers extremely interesting, enthusiastic, and knowledgeable about their subjects.’ (Theme 11)Diversity‘Diverse range of topics, and very glad to see that topics that aren’t addressed enough (Islamophobia, Race, Equality) are being discussed and we can learn how, as medical students, to tackle these in healthcare and in our daily lives.’ (Theme 12)Representation of subspecialties‘I think the timetable has been very well developed to cover a wide variety of interesting topics that are otherwise neglected on many medical school’s psychiatry curriculums’ (Theme 13)Lived experience‘Hearing about people’s real lived experiences of mental health and working within the sector was really inspiring.’ 14Patient simulation‘I enjoyed the actor scenario and use of patient scenarios in the second and third lectures of the day. I always find this useful to put the information being given into the context of the real clinical world.’ (Theme 15)Interest for non-psychiatrists‘I loved it all, and that’s coming from someone not actually pursuing psychiatry as an occupation.’ (Theme 16)Compensation for lost experiences‘Attending this summer school has re-lit the excitement in me about applying to medical school which seemed to have died down a bit in lockdown.’ (Theme 17)Earlier exposure‘At the University of [...], we have psychiatry placements in our final year which were initially supposed to be early next year for me! It was great to get exposure to the speciality through the conference.’ (Theme 18)Choose Psychiatry‘I had slight doubts about choosing psychiatry but no more, this event has only deepened my passion for this career.’ (Theme 19)College engagement‘I hope you offer a summer school like this in future, and all the Royal [medical] colleges should do the same. I will look at signing up to the RCPsych now!’ (Theme 20)

Discussion

Practicalities of running the virtual 2020 NPSS

Psychiatry summer schools are one of the UK’s Choose Psychiatry initiatives and one of many enrichment activities encouraging students to choose psychiatry.⁴ The first UK psychiatry summer school took place in 2009, organised by King’s College London.⁵ These free-of-charge educational experiences have since expanded nationally (hosts have included Liverpool, Wessex and Leeds), ranging from one day to full week programmes.

The 2020 NPSS was not designed to make a profit, and funding for the online platform was provided by the RCPsych. The event was instigated, co-organised and co-hosted by the two medical student authors (P.V and N.N), who were PsychSoc Presidents at their respective universities, Queen’s University Belfast and the University of Manchester, during this period. The programme was organised within approximately 1 month. It featured 18 diverse, eminent and award-winning doctors from a range of UK geographical locations, including RCPsych faculty staff. Thought was given to selecting speakers from subspecialties typically underrepresented on the undergraduate medical curriculum, such as eating disorders and global forensic psychiatry (*Fig. 2*). Speakers were ultimately recruited based on the organisers’ personal professional networks and experience of seeing speakers at previous face-to-face events. No speaker charges were incurred. The decision to use Zoom Video Webinar was made based on the hosts’ previous experience using the platform, which has control functions and security that allow attendees and panellists different privileges (speakers can share slides, sound and video without risk of interruption from the audience and it protects against the new phenomenon of ‘Zoom bombing’). For the NPSS, a 500-participant webinar license (£134.40 for that month) was added onto a pre-existing PsychSoc Zoom Pro meetings account (£14.39 a month). *Fig. 2*National Psychiatry Summer School 2020 programme.

Before the programme’s release the event was advertised on Facebook, Twitter and Instagram using Queen’s University Belfast and Manchester PsychSoc social media accounts. The event was open to all interested, including sixth formers as well as medical students. In total, 480 tickets, all free of charge, were available per day, with no restrictions or limitations in numbers by university or school. In total, 1029 expressed initial ‘interest’ in attending on Facebook, and the Eventbrite event page had 9747 views. Tickets were limited by Zoom platform capacity, and on both occasions all tickets were ‘sold out’ within 12 h. Tickets were released in two batches: the first on 29 June and the second 13 July 2020. The full programme was released on 11 July.

The 2020 NPSS had a total of 434 attendees log in overall on day 1 and 412 attendees on day 2.

The online format: digital advantages and challenges

The 2020 NPSS has demonstrated that moving conferences online creates new challenges to overcome but can provide exciting novel opportunities. Organising a successful online conference can typically be achieved in a shorter time frame than similar in-person events. Once a suitable platform is chosen, there is no need to book a venue, catering, accommodation and so forth, and focus is solely on assembling the best possible programme. In comparison, the annual National Student Psychiatry Conference receives a minimum funding of £1500. Organisers are no longer constrained by geographical barriers (travel reimbursement costs and far greater time commitments) and the speaker pool is therefore much wider, time-zone permitting.

Moving conferences online can increase medical student and sixth form attendance and early career engagement, both nationally and internationally. Attendance at the NPSS overall was higher than at previous in-person National Student Psychiatry Conferences. Virtual forums can hold a greater capacity than a physical space at a much lower cost. The NPSS ‘sold’ 480 tickets. In comparison, previous National Student Psychiatry Conferences have sold approximately 122 tickets (Brighton and Sussex, 2018), 130 (Cardiff, 2019) and 156 (Bristol, 2020); historically, medical students from the host institution form the largest proportion of attendees at these face-to-face events. Cost access barriers to events are also overcome; attendees no longer incur travel expenses and can instead attend from the comfort of their own homes (theme 1 in *Table 2*), and attendance was particularly high for students from all three devolved nations when compared with the aforementioned conferences. The removal of travel costs, alongside the cost of accommodation, tickets and so forth contributes to an overall cost reduction for each attendee, helping to reach prospective doctors and future psychiatrists, especially in hard-to-recruit areas, and students from less advantaged backgrounds.

Attendees valued having medical student hosts and organisers (*Table 2*, theme 2). Prior to COVID-19 restrictions, collaboration between PsychSocs from two different countries was rare; but collaboration pooled perspectives from two institutions and networks, for both advertising and speaker recruitment. Consequently, there was an overall increased awareness of PsychSocs as a whole, and we predict future increase in medical student engagement with their local PsychSocs.

The quality and standard of an in-person event does not appear to have been lost – as reported in feedback (*Table 2*, theme 3). This included appreciation of keeping to programme timings, day structure and excellent organisation (theme 4). The hosts prompted the speakers on their available time and the appropriate number of audience questions, which was greatly valued by the audience, with comments such as ‘The event was incredibly well organised and done so much more professionally and with fewer technical problems than other virtual conferences arranged by larger organisations with more qualified staff’ (theme 3).

There are, however, challenges with online learning. Practice runs increased speaker confidence and minimised technical difficulties on the day, but the schedule was also purposefully designed to allow for some speaker delays and yet remain on time (*Table 2*, theme 5). Even with such precautions we experienced some technical difficulties on the day, including joining an online platform with inadequate internet connection or from a hospital/clinical trust from which access was blocked.

The attendees also appreciated the ‘buzz’ the conference had on Twitter (*Table 2*, theme 6). The NPSS ensured that all the speakers’ Twitter handles were made available to the attendees by displaying them on the screen in breaks.

Audience capacity varies across online platforms and payment schemes. Online free events may attract higher rates of ticket reservation, as attendees face no financial loss in not attending. Some who booked tickets did not attend and, conversely, some wished to attend but were not able to as all tickets had ‘sold out’. Organisers may wish to oversell ticket capacity, but to what extent this should be done is debatable, as there may be a risk of reaching attendee capacity on your platform and leaving some disappointed, particularly if there are some more popular talks from high-profile speakers. Several organisations livestream events across platforms but this may not be suitable for all. Interaction between attendees was limited, as the ‘chat’ function was disabled (*Table 2*, theme 7) because neither organiser had enough time to monitor this while managing other tasks.

We propose that recordings and slides should be made available to attendees following an event, but permission from each speaker must be sought and sensitive information removed (*Table 2*, theme 8). It has been suggested that distributing recordings post-event may reduce live attendance, but the extent of this is unknown. The use of breakout rooms and opportunities they can provide are limitless: perhaps icebreaker games, debates or concurrent workshops,

which can allow for interactivity between attendees (but require a larger organisation committee to manage). Breakout rooms can target specific audiences, for example ‘psychiatry at medical school’ or ‘psychiatry within the foundation programme’ (*Table 2*, theme 9). Overall, we recommend targeting medical student and sixth form students separately to help meet the differing expectations and knowledge of these two groups while maintaining relevance, as shown by Wyke and colleagues.⁶

The length of the day and sessions should be considered: day 2 feedback suggests that sufficient activity-free breaks are welcomed and should be scheduled within the event programme (we had one additional break on the day 2 programme) to prevent ‘Zoom fatigue’ (*Table 2*, theme 10). Overall, attendance reduced throughout the day, but joining remotely provides attendees with flexibility to ‘dip in and out’ of the event, only attending for speakers they wish to hear.

The content: maintaining quality speakers and topics in a ‘saturated marketplace’

Diverse, passionate and knowledgeable speakers are essential to convey the ethos of Choose Psychiatry (*Table 3*, theme 11). Attendees noted and appreciated the importance of the presented topics, including lived experience (theme 14), topics less commonly addressed (such as Islamophobia, race and equality) (theme 12) and subspecialties neglected on many medical schools’ psychiatry curriculums (theme 13). Attendees highlighted appreciation for the two medical student presentations (by P.V and N.N.), which were described as ‘more relatable’ and ‘easier to digest’. Virtual conferences may offer junior colleagues significantly more opportunities to present, and raising the voices of doctors from a variety of clinical standings and locations is equally important. Interactivity throughout the course of the two days included several speakers opting to include audience polls, as well as taking questions from the audience both during and after their talks. In addition, there was patient simulation, where Dr Fernando had invited an actor to play the patient while a medical student took their history (theme 15). Varying the options for student interaction, utilising audience polling, question platforms, chat features and the previously discussed breakout rooms are reported to maximise student engagement online.⁷

Feedback further highlighted the importance of patients’ mental health problems for all healthcare workers, not just prospective psychiatrists (*Table 3*, theme 16). For any medical specialty, it is vital for medical students to consider the mental health of their patients: parity of esteem and valuing mental health equally with physical health were key takeaway messages from the NPSS.

The 2020 NPSS was for some their first experience of psychiatry and/or medical education as a whole, as noted by the unanticipated but welcome large sixth form presence (not seen at past National Student Psychiatry Conferences). Feedback demonstrated how virtual events compensated for lost work experience and provided support for applications to medical school (*Table 3*, theme 17). Further support included providing medical students (a proportion of whom had psychiatry rotations cancelled or reduced because of COVID-19) with an insight into the specialty. Furthermore, the NPSS provided earlier, accessible psychiatry education to medical students who otherwise experience psychiatry rotations later in undergraduate clinical years (theme 18). Virtual psychiatry events may therefore help to mitigate the concerns regarding reduced psychiatry teaching and in turn engender future interest and boost recruitment.⁸

Lastly, the NPSS helped some students to consider pursuing psychiatry as a career (*Table 3*, theme 19), a notion further strengthened by ‘before and after’ ratings (*Fig. 2*). Following the event, there was a clear demand for future similar events and maintaining accessibility. Advertising these opportunities (such as becoming an associate member of the RCPsych) during programme breaks might sustain engagement and long-term recruitment (theme 20).

Conclusions

COVID-19 created a need for online educational learning.² Our survey data showed that the 2020 National Psychiatry Summer School had a positive impact on attendees' perceptions of psychiatry as a career choice, and demonstrated how virtual medical education events can successfully engage large audiences while simultaneously reducing the historical geographical and financial barriers to beyond-curriculum teaching. The survey showed that the virtual format was positively received by our attendees.

The full potential of virtual events has yet to be fully realised, with a continuous evolution of, and learning from, innovative formats. Future work may further inform us of the benefits of virtual medical education events, and more formal qualitative and quantitative methods may be employed.

We believe there may be scope to run events that specifically target, engage and encourage sixth form students from all backgrounds; 'schools only' events offer a strong and fruitful possibility for psychiatry.⁶ Although these virtual events offer a myriad of opportunities, such as increasing access for medical students in the UK's devolved nations, it is important to recognise that they simultaneously reduce the networking opportunities. Post-COVID, the progress we have made with eco-friendly, online alternatives should not be lost, without compromising important aspects of face-to-face meetings that act as a 'social glue' in terms of networking.⁹ Events are most likely to encompass hybrid models and discussion remains on how these can be best utilised within psychiatry, medical education, recruitment and engagement. We must also recognise the risk of only certain groups being able to attend the in-person parts of hybrid events, with other groups 'excluded' from the social element of the events when attending virtually.

We thank Clare Wynn-Mackenzie, Royal College of Psychiatrists Careers Manager, for her support and advice, the Royal College of Psychiatrists for its support.

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Data availability

The data that support the findings of this study are available from the corresponding author, P.V., upon reasonable request.

All authors met all four ICMJE criteria for authorship, jointly conceiving the study, writing the draft article and approving the final article.

The Royal College of Psychiatrists funded the purchase of the online platform account, via a one-off grant and a portion of its annual funding to the UK's PsychSocs. The research presented in this article received no specific grant from any funding agency, commercial or not-for-profit sectors.

Declaration of interest

None.

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1.1.45 The Royal College of Psychiatrists' Leadership and Management Fellow Scheme

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date

2022-06

Abstract

The Royal College of Psychiatrists' Leadership and Management Fellow Scheme aims to develop and support a new cohort of leaders within psychiatry. This article provides an introduction to the scheme, which is accessible to all higher trainees with the support of their host organisation. We explore its development, structure and how it is evolving to provide a strong platform for achieving the College's ambition to benefit patient care by embedding a culture of medical leadership within mental health services.

Contents

- *The Royal College of Psychiatrists' Leadership and Management Fellow Scheme*
 - *Evidence in practice*
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pmc The Royal College of Psychiatrists' (RCPsych) Leadership and Management Fellow Scheme has been developed by the College's Psychiatric Trainees' Committee (PTC), the Leadership and Management Committee (LMC) and the Centre for Advanced Learning and Conferences (CALC).

It is designed to support the formation of a national network of emerging medical leaders within psychiatry. It builds on the General Medical Council's Generic Professional Capabilities framework¹ and, in accordance with the Faculty of Medical Leadership and Management's leadership and management standards for medical professionals,² it provides an enhanced understanding of medical leadership at an individual, team, organisational and systemic level.

The College has committed to 'provide high quality face-to-face training in leadership and management' that specifically meets the needs of 'psychiatrists making the transition to consultant grade'.³ This scheme, despite the necessity to adapt to an alternative delivery model as a result of the SARS-CoV-2 pandemic, fulfils that commitment. It realises the vision of both the LMC, 'to develop and support psychiatrists as leaders and managers',⁴ and of the PTC, to support trainees in having 'greater autonomy over their careers through in-programme developmental opportunities'.⁵

It is critical that future doctors develop leadership values and behaviours as core attributes, and learn about leadership,

followership and team working.⁶ For this to be successful, however, and for psychiatrists at every level to assume leadership responsibility, trainers and training organisations must ensure that leadership development is given parity with achieving clinical and academic competencies. It is only through this mechanism that we will truly achieve the notion of ‘expert leadership’⁷ within psychiatry.

This paper supplements Till *et al*⁸ which explores the importance of leadership, leadership development theory and opportunities available for psychiatric leadership development.⁸ We focus specifically on the development and structure of the RCPsych Leadership and Management Fellow Scheme as a mechanism to develop emerging medical leaders within psychiatry.

Evidence in practice

The evidence for leadership and leadership development in healthcare is clear.⁹ An engaged medical workforce with capable, high-quality leaders has consistently been demonstrated to be integral to driving improvements and supporting high-quality care.^{10,11}

Complementary to this, there is a growing call at a national level for services funded by the National Health Service (NHS) to strengthen their approach to leadership development and talent management,¹² with future doctors ‘developing an appreciation of leadership at an early stage’.⁶

Leadership development, however, does not suit a ‘one size fits all’ approach. There is little robust evidence for the effectiveness of specific leadership development schemes and difficulty in evaluating their effectiveness.⁹ As a result, multiple leadership development programmes have emerged at a national, regional and local level, with various approaches undertaken to meet the diverse needs of doctors, depending on their stage of training, specialty and location.⁸

Traditionally, leadership development programmes have focused on so-called ‘horizontal’ leadership development, where individuals attend courses run by external providers which focus at an individual level on ‘what leaders need to know’: developing their knowledge, skills and competencies.¹³

Individual interventions alone, however, are insufficient.¹⁴ Developing leadership crucially depends on context, and leadership development must take place in the context in which an individual works. Within healthcare, this should develop organisational allegiance and engagement in the quality and safety agenda of organisations, maintain a systems focus to meet the challenges of increasingly integrated health and social care services, and develop a strong network between tomorrow’s leaders.¹⁵ Furthermore, supported by a recent systemic review,¹⁶ mixed external and internal faculty is crucial, with project work and mentoring increasing the likelihood of good organisational outcomes.

The RCPsych Leadership and Management Fellow Scheme draws lessons from this knowledge, other schemes, and the latest educational leadership theory, to combine a national training programme with a local apprenticeship model, so that fellows not only experience ‘horizontal’ leadership development but are also exposed to ‘vertical’ leadership development.¹³

‘Vertical’ leadership development focuses on ‘how leaders think’, advancing interdependent styles of more complex, systemic and strategic thought.¹³ It relies on three primary conditions: ‘heat experiences’, ‘colliding perspectives’ and ‘elevated sense-making’.¹⁷ These are described further below, with illustrative quotations reflecting how fellows experienced these ways some of the scheme’s fellows have experienced these are reflected in their illustrative quotations below. Fellows consented to anonymised quotes from evaluation data being included in publications.

Heat experiences place fellows in challenging situations where there is a degree of risk. Fellows experience this both in the classroom and through the leadership projects undertaken in their place of work. This is the ‘what’ that disrupts and disorients their traditional thinking to discover new and better ways to make sense of the challenges they face as they assume increasing leadership responsibility: “‘The service development project consolidated our more abstract learning. It helped me get first-hand experience of the challenges faced being a leader, how I might need to develop and adapt my leadership style in different situations, and to become more self-aware and collaborative in my approach to leadership’.”

Colliding perspectives, on the other hand, are the ‘who’. Fellows are exposed to leaders both across the system and within their local organisations, including patient and carer leaders. When combined with the community of learning that they establish with their peers from around the country, fellows are enabled to gather different views and opinions,

challenge their existing mental models¹⁸ and see the world through diverse new perspectives: “‘I valued the opportunity to work with different trainees across the country, hear from eminent leaders about their leadership journeys, and meet individuals within the management hierarchy of the organisation. It allowed us to share experiences and learn from each other, to de-mystify senior leadership roles, and to connect and gain better understanding of those in managerial roles’.”

Elevated sense-making is the final piece, the ‘how’. In combination with their ‘consulting pairs’, where fellows are partnered to coach each other through the scheme, and senior mentoring locally, fellows are afforded the space to reflect and begin integrating their experiences and new perspectives, to advance their action logics¹⁹ and leadership effectiveness: “‘The opportunity to reflect and role-play was very useful and very powerful. It enabled me to see the consequences of my behaviour and how it might affect others. My experience of working with my organisation mentor was also very positive, she really helped me work through fervent leadership dilemmas’.”

Development

The RCPsych Leadership and Management Fellow Scheme was founded through a joint venture between the College’s Psychiatric Trainees Committee, the Leadership and Management Committee and the Specialist Advisor for Workforce. It was first proposed to the Education and Training Committee in February 2017, and although originally modelled on the Royal College of Physicians’ (London) Chief Registrar Scheme, it adopted an alternative model and evolved to embrace a more inclusive approach.

To achieve this, the scheme was modified to be potentially accessible to all higher trainees in psychiatry, including those in less than full time (LTFT) training, without any extension to the duration of their training. It occurred ‘in-programme’, across a 12-month period, averaging 1 day per week, utilising trainees’ protected special interest time. This minimised provider costs, with no requisite for funding fellows’ salaries or clinical backfill.

Medical directors from mental health providers across the UK were highly supportive of the scheme, and in the absence of central funding, were prepared to make a financial investment of £2000 per trainee, with full or partial self-funding (including via the trainee’s study budget) excluded to maximise equity of access and ensure organisational commitment.

With this early adoption, a competitive tendering process was pursued, with the RCPsych Centre for Advanced Learning and Conferences (CALC) being selected above highly competitive offers from multiple business schools and the Faculty of Medical Leadership and Management (FMLM) to deliver the national leadership development training programme.

Recruitment was delegated to host organisations and supported by training-programme directors, with statements required that fellows had been identified and nominated through an open and competitive process, as determined locally.

We welcomed the first cohort of RCPsych Leadership and Management Fellows in September 2019, with an initial intake of 30 fellows from 19 different service providers; over half were female (57%) and from Black and minority ethnic communities (63%).

Structure

The RCPsych Leadership and Management Fellow Scheme is designed to support the formation of a national network of emerging medical leaders within psychiatry and develop their confidence and ability to operate within and lead across a range of mental health organisations and systems to improve patient care.

It combines a bespoke, high-impact leadership development training programme with a local apprenticeship model, where fellows are mentored by senior medical leaders within their organisations and proactively engage in a variety of leadership projects.

National training programme

Building on the College's extensive experience in providing highly regarded leadership and management training, the evidence-based bespoke leadership development training programme is facilitated by the programme faculty, in conjunction with outside expertise where relevant. It is designed to enhance a range of practical knowledge and skills that consider leadership from the perspective of four behavioural domains relating to self, team, organisation and system, as outlined by the FMLM's Leadership and Management Standards for Medical Professionals.² A detailed up-to-date programme is available from the College on request.

Although originally designed for face-to-face learning, the implications of the SARS-CoV-2 pandemic were felt with our first cohort, and we took this as an opportunity to adopt an exciting new digitally focused approach, with the same content delivered virtually.

A central focus of the programme is to develop an underpinning community of learning, as fellows are afforded the space to reflect on their own leadership style, and conditions are established in which collaborative relationships can be optimised as they network with peers, share their experiences and learn collaboratively from best practice across the multiple organisations they represent.

Fellows are additionally uniquely exposed to inspirational national leaders from across the system, with guest speakers, including a number of prominent psychiatric leaders with national roles both within and outside the College, integrated throughout the programme.

Local mentoring and support

Fellows are supported and mentored throughout the scheme by a senior medical leader within their organisation, who commits to a minimum of six mentoring sessions throughout the 12-month duration of the scheme when nominating a fellow. This is a key aspect of the scheme and is essential to the success of the fellow's role.

The expectation is for the mentoring role to be held by the medical director or a nominated deputy of sufficient seniority and, where appropriate, individual project supervision may be delegated to a clinical director.

In conjunction with this, fellows should also have opportunities to shadow at an executive level and with key external health and local authority partners. This aims to generate a deeper understanding of healthcare leadership and management within the wider social, political and economic context.

Leadership projects

A fundamental component of the scheme is the development of fellows as apprentice leaders through their engagement in a variety of leadership projects within their local organisations.

The exact nature of leadership projects is negotiated and managed locally between the fellow and their mentor. Fellows can join existing larger projects or develop their own smaller projects, although it is stipulated that they should be guided to ensure that all projects are of strategic or operational significance to the organisation, ensuring that fellows make a meaningful contribution and organisations gain a return on their investment. Some examples of leadership projects are given in *Box 1*. **Box 1** Examples of leadership projects undertaken by RCPsych Leadership and Management Fellows 2019–2020 Trust-wide leadership and training in quality improvement Quality improvement projects related to high-dose antipsychotic prescribing, reducing restrictive practices under the Mental Health Act, and the co-production of service developments to amplify the patient voice and improve patient experience Trust-wide policy developments related to the management of dual diagnosis, COVID-19, video consultations, physical health management and electrocardiogram (ECG) monitoring Pathway developments related to naloxone prescribing in general hospitals, management of medically unexplained symptoms, attention-deficit hyperactivity disorder (ADHD) in child and adolescent mental health services, and clinical decision units within forensic services

Recognising that projects can evolve, emerge and falter for various reasons, not least a worldwide pandemic, successful completion of the RCPsych Leadership and Management Fellow Scheme is not conditional on the 'success' of a fellow's

project. There is an explicit recognition that learning can occur irrespective of this, and that a fellow's success is rather more meaningfully determined by their engagement with the programme, their reflective practice and their mentor's feedback, with their learning, growth and leadership development assessed throughout the scheme.

Benefits

Boxes 2 and 3 summarise two fellows' experiences of participating in the scheme, with *Box 4* outlining the intended benefits of the RCPsych Leadership and Management Fellow Scheme for individual fellows, the organisations in which they work, and for patient care. *Box 2* Vignette 1: a fellow's experience of the RCPsych Leadership and Management Fellow Scheme 'I feel this fellowship has provided me with the foundations to further acquire the knowledge and skills that are relevant in the context of leading a complex healthcare system. The opportunity to lead a trust-wide project with the support of my mentor allowed me to work collaboratively with multidisciplinary professionals across organisations and think about change management and sustainability in a very different way. Combined with the deeper insight into leadership theories I gained through the national training programme, and the reflective nature of the sessions, which I particularly enjoyed, I now feel more confident in leading service improvement projects and in engaging with diverse stakeholder groups. Furthermore, I found that being part of a national scheme, whilst being supported locally by a senior mentor, helped me build links and network with peers and senior leaders both locally and nationally. This was a unique feature of the scheme and I have no doubt it will help me in my future role as a consultant in the organisation.' *Box 3* Vignette 2: a fellow's experience of the RCPsych Leadership and Management Fellow Scheme 'One of the great advantages of the scheme was the direct support from a senior mentor to get "hands on" in a significant trust-wide project. Like many other trainees, I had previously been involved in small-scale projects, but had never been given responsibility for developing such a complex intervention across multiple community teams. Whilst simultaneously daunting and exciting, I found the direct support of my mentor invaluable in negotiating the complexity of the trust systems, while working collaboratively with a number of colleagues from different backgrounds, including project management, IT and senior managers, in addition to key clinical staff who would be delivering the intervention. Throughout the scheme my mentor was able to help me keep on track with the project and helped me to identify and keep in mind the vision of we wanted to achieve. I now feel much more able to lead change, effectively advocate for improved patient care, and am better prepared for the challenges of starting as a consultant.' *Box 4* Intended benefits of the RCPsych Leadership and Management Fellow Scheme

Benefits for patients and the organisation High-quality care: increase the number of highly skilled medical leaders able to develop and foster collaborative practice and high-quality care Improved services: bring an enthusiastic and fresh perspective with committed time to help improve the safety and quality of your services and help create a culture of continuous improvement Enhanced medical engagement: fellows hold mutually enhancing conversations with trainees, senior leaders and management to boost the performance of the organisation Emerging medical leaders: invest in your local talent and nurture the next cohort of medical leaders within your organisation

Benefits for the individual Heightened self-awareness: gain a deeper understanding of which aspects of yourself enable or constrain your leadership Discover your inner leader: begin or continue the process of discovering and releasing your leadership potential Mentoring, networking and support: learn from senior medical leaders and develop an inspiring network of like-minded peers, including from within the RCPsych Leadership and Management Fellow Scheme Alumni Network, which fellows will be invited to join on completion of the scheme Leadership and management skills: develop your understanding and a widening repertoire of leadership competencies and skills that will help you be a better medical leader and apply for associate fellowship of the Faculty of Medical Leadership and Management Followership skills: gain a greater understanding of the role that followers play in the co-construction of leadership identities Career autonomy: take control of your career and increase your confidence in extending your portfolio and building a local and national profile

Evolution

The RCPsych Leadership and Management Fellow Scheme is an evolutionary process and key to its future development will be feedback from both fellows and mentors, the needs of our healthcare system and the sociocultural needs of the wider society we lead within.

Although the College has a well-established reputation for delivering leadership and management training, this is the first developmental scheme for trainees. It emerged organically, being co-produced by those for whom it was intended. The scheme will continue to be developed on this basis in order to further adapt and respond to the specific needs of higher trainees in psychiatry, provide value to the sponsoring organisations and achieve FMLM accreditation.

We are proud of our first cohort in 2019–2020, who despite the SARS-CoV-2 pandemic all successfully completed the scheme. We are also pleased to have been able to adapt to an exciting new digitally focused approach for 2020–2021, allowing for more regular contact that will be supported by a new online platform to promote networking, shared learning and reflection.

We acknowledge the challenges that the loss of face-to-face learning involves, particularly regarding the development of close and trusting relationships, but believe that a digital approach will be critical for the future. It not only ensures that mental health services are capable of weathering the current storm, but also that leadership capabilities within the psychiatric workforce are still developed and able to rise to future challenges as we deal with the mental health implications of the SARS-CoV-2 pandemic alongside the implementation of the NHS Long Term Plan.²⁰

Reassuringly, however, although we and many others look forward to the return of face-to-face learning, research from the Centre for Creative Leadership²¹ has highlighted similar levels of results for online leadership training, while providing the additional benefits of increased convenience and accessibility.

Combined with increasing confidence and familiarity with digital engagement, we will therefore integrate these opportunities as face-to-face learning returns and embrace a more blended approach. We hope that this increased flexibility will widen access to the scheme for Category 1 less than full time (LTFT) trainees (i.e. those with health reasons or caring responsibilities) and for those living at a greater geographical distance from the College, by reducing face-to-face learning.

Providing additional value, current alumni have been invited to facilitate action learning sets, and to join the programme faculty for future cohorts. They have also established an RCPsych Leadership and Management Fellow Scheme Alumni Network. This will be integrated with the RCPsych Leadership and Management Committee and future cohorts of the RCPsych Leadership and Management Fellow Scheme. It aims to maintain links between fellows as they become future leaders within mental healthcare across the UK, nurture the next generation through near-peer mentoring, promote collaboration across the system, develop shared learning and good practice, and strengthen the connection between mental health services and the College.

The success of this scheme highlights the appetite for strong medical leadership among progressive healthcare organisations throughout the UK, who recognise the importance of advanced leadership development schemes for aspiring organisational and system leaders.

The scheme has also unearthed a wider unmet need for leadership development among specialty doctors, new consultants and other groups; they of course have their own unique challenges that deserve appropriate recognition. Appreciating this, the scheme is diversifying and strengthening its leadership faculty in order to improve its offer, strengthen its resilience and develop greater resources from which to further develop the leadership and management skills of the wider membership.

Conclusions

Leadership and management is for all doctors, for all psychiatrists at every level. It is not just for those with formal roles within organisational hierarchies who hold designated leadership positions. Nor is it about stand-alone heroic individuals: it collectively lives among us as a professional body and we must learn to nurture, support and value one another.

The RCPsych Leadership and Management Fellow Scheme is just one step towards developing leaders in psychiatry. Through the combination of a national training programme with a local apprenticeship model, both formal and informal leadership development is provided, where emerging leaders have a safe space to take risks, experiment and develop ‘on the job’.

It is important to recognise, however, that leadership development does not suit a ‘one size fits all’ approach. Whether through this scheme or another, we each have a responsibility to collectively develop and establish a culture that nurtures leadership talent and ultimately improves the lives of people with mental illness.

We thank Dr Aideen O’Halloran for her initial support of the scheme, alongside Dr Kate Lovett, Dr Ian Hall, Dr Wendy Burn, Ms Karla Pryce and Ms Michelle Braithwaite for helping us reach where we are today. We also thank our inaugural cohort of fellows and mentors for taking a risk and supporting our initial pilot, along with our guest speakers, who have offered their valuable time to nurture the next generation of psychiatric leaders.

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Data availability

The data that support the findings of this study are available from the corresponding author, A.T., upon reasonable request.

All authors met the four ICMJE criteria for authorship, being equally involved in the design, drafting and revision of the article.

This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Declaration of interest

A.T. founded the RCPsych Leadership and Management Fellow Scheme in collaboration with M.H. and D.S., with H.C. assuming oversight following her appointment as Associate Registrar for Leadership and Management. D.B.K. and R.G. were inaugural RCPsych Leadership and Management Fellows in 2019–2020.

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1.1.46 A model for specific goals for in-patient treatment linked to resources and limitations in out-patient treatment – ERRATUM

Virginia Davies

date

2022-06

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- *A model for specific goals for in-patient treatment linked to resources and limitations in out-patient treatment – ERRATUM*

pmc In the original published article, the country name was missing from the author's affiliation. This has now been corrected.

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1.1.47 A visual step-by-step guide for clinicians to use video consultations in mental health services: NHS examples of real-time practice in times of normal and pandemic healthcare delivery – ERRATUM

Gemma Johns Jacinta Tan Anna Burhouse Mike Ogonovsky Catrin Rees Alka Ahuja

date

2022-06

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- *A visual step-by-step guide for clinicians to use video consultations in mental health services: NHS examples of real-time practice in times of normal and pandemic healthcare delivery – ERRATUM*

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1.1.48 Response to Beale

A. 26. FRCPsych

B. 26. FRCPsych

date

2022-06

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 - *Declaration of interest*

pmc We write to add our personal experience of 30 years of consultant psychiatric practice and of having a son with a long history of serious psychiatric problems to endorse Chloe Beale's powerful indictment of current mental health service failures. Having found our son in his room 2 weeks ago attempting to hang himself, we called 999. The ambulance arrived within a few minutes; he sat for 9 hours in the ambulance outside A&E before being seen by a series of three mental health nurses with questionnaires and was then summarily sent to walk home, still actively suicidal, past a famous 'suicide spot'. We were not informed that he had been discharged. We had rung to ask what was happening and were summarily dismissed by one of the nurses with the cryptic comment that he had been 'signposted to the Road' (apparently a counselling charity). This actually meant he was given some leaflets. Thankfully he had enough wish to live to ring us after a cold walk and we provided such support as we are able, as we have for several years.

He had therefore been put through exactly the process of checklist assessment, meaningless non-intervention of 'weasel words', legalised neglect, and dangerous and unfair self-guarantee of safety that is described by Beale. This useless approach has therefore, of course, made both him and us feel there is no point in contacting the service again, nor of suggesting anyone else do so.

As doctors and psychiatrists, it has always been our training and teaching that the person/patient was our prime concern, but this is clearly no longer the case. Protection of the system from the rightful needs of patients is the current priority in psychiatric services. The amount of energy and time put into that process now is almost unbelievable and extremely damaging, not only to patients and their families. It is an example of the stigmatisation and dismissal of psychiatric problems, even by staff working in the specialism, that is returning psychiatry to the hopeless laughing stock that it had been before the last war and which we and our teachers and colleagues had done so much to try to turn into a valued and respected medical specialism. Only the sort of fundamental re-humanisation and recovery of professional standards of treatment set out by Beale in her last paragraphs can return psychiatry to self-respect and our patients to proper care.

Beale's paper should be required, albeit uncomfortable reading for all involved in psychiatric care ('mental health' are two more weasel words which demean psychiatric illness). Let us hope that Beale's call to arms is heeded for the sake of our patients.

Declaration of interest

None

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1.1.49 Evensong: how the medical humanities can strengthen a patient-centred approach to both physical and mental health conditions

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date

2022-06

Abstract

The medical humanities may offer an antidote to the unconscious depersonalisation of patients into clinical variables and diagnoses at the hands of physicians, cultivating a patient-centred and individual approach to the management of both physical and mental health conditions. The emphasis on the person behind the diagnosis helps physicians to remain motivated and compassionate in the face of increasing social and organisational pressures that threaten this human connection. As a doctor and the relative of a patient with dementia, I reflect on the way in which poetry has helped to translate my experience as a relative into improving my own practice as a doctor. This article includes one of the poems I wrote during my grandmother's illness to aid reflection on the patient perspective I gained during her time in hospital, and also a brief commentary exploring the influence this process has had on the interactions I now have with my patients.

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- *Evensong: how the medical humanities can strengthen a patient-centred approach to both physical and mental health conditions*
 - *Presenting complaint*
 - *Past medical history*
 - *Investigations and management*
 - *Declaration of interest*
 - * *Supplementary material*

pmc We all have our stories. Our triumphs and our failures, the people we love, the landscapes we create and the goals we pursue; all those days, from the greatest moment to the most mundane, come together to form the fabric of a life.

Presenting complaint

One of the great privileges of a physician is that our patients share their stories with us, and our eyes witness the momentous: the first cry of new life, the last sigh as old age departs it, and countless tears, smiles and occasional bursts of anger that our involvement in these stories inevitably brings. During my time as a doctor, however, I have noticed that by assigning the role of patient to these individuals within our own narrative, we often, however unconsciously, deprive them of their individual story. They become lists of vital signs, blood results and diagnostic difficulties, the faces of medical conditions that leap out of textbooks into the hospital beds in front of us, embodying the frailty and mortality that is truly such a small part of who they really are.

Past medical history

I first became sensitised to this when my grandmother's memory faded with vascular dementia, which followed the stroke she suffered while I was at medical school. Her story was lost to the doctors caring for her on the ward, and the impression that they formed of the truculent and demented old woman who obstinately refused her medication was infinitely removed from the independent, active and astute lady of just a few weeks earlier, the one with a roguish twinkle in her eye who loved to sing, laughed often and always cheated at playing cards. This was compounded by the resistance that we, as her relatives, experienced when attempting to engage with the doctors in our new role as proponents of her story, finding that our attempts at advocacy were rejected as an irrelevant distraction from her medical care.

The condensation of a rich and complex individual into the black and white of a clinical diagnosis does our patients a disservice, but it is a phenomenon that many doctors report in their professional practice. For my grandmother it contributed to delays in her diagnosis, a lack of appropriate stroke rehabilitation, a void of professional support and an inexorable decline into depression, incontinence and pressure ulcers. The strain of increasing service demands without a correlating increase in resources and support stands as an obvious culprit, but the influence of compassion fatigue and the unconscious desire to protect our own sanity and emotions when treatments fail and operations do not go to plan cannot be ignored.

Investigations and management

Reflecting as both a physician and a relative, I realised that I too frequently overlooked the person behind the confused and wandering patients on my ward; I was also too ready to make assumptions about the quality of life of octogenarians, and I recognised the previously unacknowledged dread of the demands of relatives during visiting time while my pager chimed and my list of daily tasks multiplied before my eyes.

To lend some perspective, I started to organise my thoughts and reflections on paper, and soon found that verse provided a structure and rhythm that helped me to understand how I could progress in my own practice and, in my own small way, help families in similar circumstances to my own. The process of writing helped me realise the unique opportunity we have as physicians to gain such an insight into another person's life, and the responsibility of ensuring that we allow patients and their loved ones to tell us a little about the most important things in their lives. Once we understand where a patient has come from, we are in a better position to help them navigate the difficulties they encounter whilst in our care and to ensure that their story can continue in a way that is most congruent with their values. Support from other members of the multidisciplinary team is crucial in providing this holistic care, and the engagement of therapists in rehabilitation, psychologists in support or the chaplain in blessing should not be underestimated.

I wrote this particular poem to give voice to a part of my grandmother's story, highlighting the beautiful things that I remember about her and that I hoped would provide an insight into the person she was and the things that she loved before her illness. To me the process of writing this poem served as a reminder to give all my patients the chance to tell their story, to see past the observation charts and appreciate what truly makes up their lives. Only then can we hope to treat our patients with the compassion and understanding that we hope our own loved ones will experience at the hands of medical professionals; by ensuring that this process starts first with us.**Evensong**I remember the ardent goldfinches:a charm in your camellias,cheeks sanguine as the Eucharist.A joyful celestial choir exuding praise and glory for long sweet days of Litha.All Gods and old Gods exalted in unison.I remember the last slivers of sunlighting shrinking vestiges of the rapeseed harvest.We waded together along faded paths which led to the field where horses rose as

monoliths in the fading gloom. I remember the smell of hot sweet apples; the spoon crushing vaulted pastry roof, sinking to the bubbling nave. Skin still scored and prickling from circlets of thorns, the jealous brambles constraining their inky treasures. You laughed at their bite and spleen. I remember the hoary birch branches, prising the silvery vellum from the resisting trunk. Dancing and unravelling, widdershins around the bole; sinuous snakes entwining our ankles, threatening to topple, threatening to fall. I remember because now you cannot. A ghost mind astray, reneging on its past. Though your smile tells me that something flickers far back in your mind: a fading spark, in the darkness.

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Declaration of interest

None.

Supplementary material

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1.1.50 Perspectives: involving persons with lived experience of mental health conditions in service delivery, development and leadership

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Abstract

Globally, there has been an emphasis on the importance and value of involving people with lived experience of mental health conditions in service delivery, development and leadership. Such individuals have taken on various roles, from peer support specialists and other specialised professions to leadership in mainstream industries. There are, however, still obstacles to overcome before it is possible to fully include people with lived experience at all levels in the mental health and related sectors. This article discusses the benefits, both to the individual and to the public, of involving persons with lived experience in service delivery, development and leadership.

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 - * *Peer support specialist: Syd Gravel (Canada)*
 - * *Social worker: Thandiwe Mkandawire (Zimbabwe)*
 - * *Advanced lived experience practitioner: Mark Sanderson (UK)*
 - * *Psychiatrist: Raluca Mirela (Romania)*
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pmc The World Health Organization (WHO) describes advocacy as ‘an important means of raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments. Advocacy can lead to improvements in policy, legislation and service development’.¹ By this definition, people with lived experience of mental health conditions (hereafter referred to as ‘persons with lived experience’) have increasingly become the driving force behind advocacy and awareness work globally, and have entered the mental health workforce in various capacities of service delivery, from peer-to-peer support work to professional occupations in the field of mental health and human rights.

The all-encompassing objective of lived experience involvement is development and leadership and to create communities in which people with lived experience are able not only to survive but rather thrive with a mental health condition.

Obstacles for lived experience involvement in service delivery, development and leadership

Despite the growing acknowledgement of the value of lived experience, there are still a number of obstacles to overcome before it is possible to fully include people with lived experience at all levels. We are embedded in frameworks of shared values and beliefs – social, cultural and environmental factors that directly and indirectly influence psychopathology.² Our experiences throughout our life journeys largely determine the nature of our perceptions and our attitudes towards notions. Although there is undoubtedly a complex connection between culture and mental illness, negative perceptions and insensitivity result in stigma, discrimination and violations of human rights. The language used to talk about mental health also creates barriers because the way in which we understand, and subsequently express, experiences can be easily misinterpreted and consequently negative assumptions are made about others. It is therefore imperative to obtain clarity in the distinction between terms such as ‘mental health’ and ‘mental illness’.³ People continue to believe that individuals with mental health conditions are violent, mad, lazy, possessed by demons⁴ and incapable of positively contributing to society and the economy. Negative stereotypes and inaccurate portrayals such as these affect help-seeking behaviour and result in an unwillingness of those suffering to seek support from loved ones. People ought to be cognisant that when they perpetrate and share negative stereotypes, it has an impact on the entire recovery process and it affects not only those who struggle with mental illness but also those working in the mental health field. The fact is that negative perceptions lead to prejudice at home, in the workplace, within local communities and within our healthcare systems.³

Apart from these attitudinal barriers, social determinants of mental illness,⁵ including poor education, unemployment and poverty, further hinder opportunities for people with lived experience to develop leadership potential, pursue their passion for mental health work and follow a career in mental health advocacy and service delivery. Specifically, poor education along with a lack of access to adequate information are contributing factors that result in low mental health

and human rights literacy among the more disadvantaged people with lived experience who are subjected to social and economic inequalities.⁵

Lived experience in development and leadership

Lived experience advocates who have pursued a passion to improve mental healthcare and services have been using their own experiences and recovery journeys as a means to highlight the gaps, not only within the mental healthcare system but also within other societal systems outside of the healthcare sector. Lived experience advocates have, of course, also challenged the status quo and taken a stand on a human rights perspective as the foundation of change, transformation and systems strengthening. Building on this, there is growing recognition of the value of persons with lived experience as agents of change through contributing their unique expertise, in-depth knowledge of navigating systems, first-hand experience of segregation and discrimination, and their ability to provide high-level and practical solutions. This recognition places persons with lived experience as experts by experience and leaders of development and change, through their influence on policy and practice.

At a global level, there is evidence that mental health guidelines, strategies and policies have notably become more consistent in including lived experience perspectives and recognising those experiences as integral to service development, implementation, monitoring and evaluation. Engagement with persons with lived experience is critical to identify the flaws in the system – what others may perceive as a complex breakdown in the system may often be repaired with simple, practical, cost-effective and innovative solutions proposed by the users of that particular system or service.

The Global Mental Health Peer Network (GMHPN), an international lived experience organisation, was established to enhance the voices of persons with lived experience across the world and has a specific focus on leadership development. That focus derived from the recognition of the obstacles (described above) that ultimately deny countries the expertise and value that people with lived experience are able to contribute to improving the accessibility and quality of mental healthcare and services at the local level. The GMHPN's executive structure is designed to develop new global lived experience leadership and create a sophisticated platform for diverse lived experience voices to be at the forefront of change. Empowerment as a critical element in leadership development is built into the GMHPN structure. Lived experience leaders are appointed to the GMHPN Executive Committee as representatives of their respective country or region, and ultimately serve in an advisory capacity, contribute to the development of strategies to achieve common advocacy goals and ultimately influence policy and practice.

The benefits of people with lived experience in leadership positions is evident from the following statements (all statements in this article appear with the permission of those named). “‘Since I have been appointed as the Deputy Representative for the African Region on the GMHPN Regional Executive Committee, it has given me the courage to think big. It has made me a person with a mission, to bring some meaningful changes on how people perceive mental health, not only in my country Zimbabwe but in Africa. This has given me a chance to dream big about how people with psychosocial disabilities throughout the world should live – with dignity and stigma-free.’ (Angelica Mkorongo, Zimbabwe) ‘Learning from shared experiences from other GMHPN members has largely widened my horizon to see what can be achieved through lived experience advocacy. Gatherings of such courageous individuals with high calibre from diverse geographical and cultural settings for the common cause of lived experience advocacy is really eye-opening. This has greatly impacted my understanding of mental health being a global issue. I can definitely certify that my engagement as Country Executive Committee representative for Ethiopia is the greatest empowering, uplifting, and inspiring experience I ever had in my journey as global mental health advocate and as a person with lived experience.’ (Eleni Misganaw, Ethiopia) ‘My position as regional representative for Africa on the GMHPN Regional Executive Committee means a lot for me as a person, and for persons living with mental health conditions in my country. It is validating of our experiences and an opportunity for me to join other global voices to make mental health matter. It is also a wonderful global opportunity to de-stigmatize mental illness and advocate for better inclusion policies with regard to persons with lived experiences, especially in a region like mine where mental illness is generally considered taboo, due to witchcraft or spiritual attacks.’ (Marie Abanga, Cameroon) ‘My role in the GMHPN on the Regional Executive Committee enables me to empower individuals with lived experiences, bring forth issues such as local laws and civil society support, and bring together the larger issues of universal rights concerning mental health, such as basic income and housing, employment rights and peer and ally support networks. This position allows me to gain insight and mobilize resources to address challenges unique to the cultural understanding of mental health in South East Asia, allowing a culturally relevant solution-focussed approach.’ (Anjali Singla, India) ‘My role on the GMHPN Regional

Executive Committee is a vitalizing booster to what sometimes feel like a rocky up-cliff journey, and an active propeller to encourage lived experiences to be part of the strategy in building mentally healthy workplaces. It is crucial to share best practices within and across regions so we do it together, and in a way that respects local cultures and thoughts.’ (Enoch Li, China)”

Lived experience in service delivery

Persons with lived experience have not only been users of services but many have become service providers themselves – something that would never have been imagined just a few decades ago. However, in our experience, even today it is still unimaginable in some countries that someone with a mental health condition can in fact be meaningfully employed, let alone employed within the mental healthcare workforce.

Several GMHPN Executive Committee members (with lived experience) from across the world are service providers in various capacities – some of these members kindly provided insights into their work and shared the benefits of being a person with lived experience who is providing a mental healthcare service.

Virtual support group facilitator: Sandra Ferreira (South Africa)

“I facilitate online mental health support groups during the COVID-19 pandemic. The virtual platform has provided participants from across the world the opportunity to voice their experiences during the pandemic and discuss the impact on their mental health. One of the most interesting observations that I have drawn from this experience was that many of the participants were actively involved in advocacy and awareness work in their respective countries. This is not uncommon as our struggles often lead to the need to better the road for those that may follow, aligned with a need to be relevant, to be valued and to make a difference. Essentially, giving us a purpose. In its purest form, this virtual support group has been a space to “unmask”, to breathe easy, and to be free – not only during current struggles of dealing with the pandemic and the restrictions it has imposed on our daily lives but also to just be yourself without judgment. The greatest benefit from providing a support service is the validation that through helping others, we are helping ourselves become better human beings, more knowledgeable advocates, and most importantly, more empathetic supporters of humankind.”

Founder of an online peer support platform (CARA Unmask): Bernard Ang (Singapore)

“Reflecting back on my journey with depression, I wish I could have opened up about my mental health issues to someone who listened and understood. My experiences led to me founding CARA Unmask (caraunmask.com), an online peer support platform that encourages people to reach out earlier rather than later, to have a chat about their mental health. We recognize the direct benefits that come from wanting to share valuable lived experiences, which creates purpose, cultivates a sense of gratitude, facilitates personal growth and simply paying it forward. Peer support is evidence-based and proven to work effectively, side-by-side with clinical support for a sustainable long-term recovery outcome.”

Peer support specialist: Syd Gravel (Canada)

“It was worrisome at first – that first peer meeting. Knowing how complex and confusing things had been for me being mentally injured by a traumatic incident at work. Now, the psychologist was asking me if I would be willing to meet others who were also injured in similar situations. The goal was to see how we could help each other by sharing our experiences so that we would realize that we were not alone. I was not even sure I knew how to help myself let alone someone else. I wondered how this conversation could even start – how was this meeting going to help me? How could sharing my situation help someone else? That was 32 years ago and since that evening of our first peer support meeting, I have never looked back, as we created a bond that never waned. We are in touch with each other, to this day. I am now a full-time consultant on trauma management and peer support development for First Responder agencies and author to several books on the subject. Amazing isn’t it, how when life throw us lemons, we can learn to make lemonade.”

Social worker: Thandiwe Mkandawire (Zimbabwe)

“During my training as a clinical social worker, my therapist once said to me “We all become therapists because we all have psychological pain we are trying to heal, to find our true selves and in doing this work, not only do we help others, we also help ourselves”. The healing of the mind, as is any form of healing, is painful and difficult as it takes honesty, vulnerability, courage and bravery to face your emotions and engage in the necessary war of fighting the rhetoric in your mind. Working in the field of mental health and listening to service users and carers share their stories and their truths in support groups, at awareness campaigns or clinic days at the hospitals, fighting through self-stigma and societal stigma and discrimination, allowed me to realize that experiences are as unique as the person, a person’s truth cannot be classified as greater or lesser than the next person’s. My experience is my truth and it needs to be shared’.”

Advanced lived experience practitioner: Mark Sanderson (UK)

“I have worked in mental health services since 2016. I started as a volunteer on an inpatient ward, where I had been a previous inpatient. After 6 months of volunteering, I was employed into a paid peer support role. Within my first year I won a runner up prize for innovation, which boosted my confidence. I continued to grow in the role and was constantly given opportunities to contribute to service development and presented at various conferences and training sessions. I am currently pursuing a Master’s degree in Mental Health Recovery and Social Inclusion. I continued to advance in my career and obtained a non-peer position, which involved supporting the discharge process of service users from the ward into the community. Alongside this role I worked with the senior management team to develop a senior peer support position within the inpatient setting and simultaneously was working with another manager to develop a senior peer support position for the community. In around four and a half years I have worked my way from a volunteer to an Advanced Lived Experience Practitioner and have found my studies to play an essential role in my development. Moving forward I aim to continue developing in lived experience roles within the NHS.”

Psychiatrist: Raluca Mirela (Romania)

“Working in child and adolescent psychiatry as a person with lived experience and as a former victim of psychological and physical child abuse was often more of an emotional curse than a benefit, because I deeply empathise with the children for whom I felt responsible. My frustrations resulted from working with families that were not used to a bio-psychosocial approach – and they often asked me why I am talking so much about their child, because they just wanted the medical certificate (in order to apply for disability aid). They were not familiar with taking children to other specialists like neurologists, paediatricians, or to psychotherapy, and mostly refused to do so by justifying that they do not have money or time (even if they receive a paid medical leave to take their children to the doctor). Despite the emotional burden, working with compliant families and seeing the improvement in their child’s health (mentally and emotionally) gives me enormous joy and a motivational boost.”

Discussion

Global recognition of the importance of the role of persons with lived experience in mental healthcare has gained momentum, with academics, clinicians, researchers and mental health organisations placing emphasis on improving the status quo through peer support systems and improved service delivery.

Caution, however, must be exercised in our approach and we must take into account the implications of the diverse experiences of individuals in their mental health recovery processes and recognise that ‘many people with lived experience lack the confidence or ability to articulate their views, particularly if they contradict the status quo and especially when speaking to people who hold similar roles to those who have taken choices away from us’.⁶

Nevertheless, there is no denying that there is potential for leadership development of persons with lived experience in mainstream industries. Mental healthcare organisations ought to take the lead in driving initiatives by wisely employing the insights of persons with lived experience. Strategies for peer support-based service delivery is encouraged because having the support of a peer who has been exposed to similar experiences has a way of allowing for meaningful

conversation in a safe environment. The conventional hierarchy of clinician and client or patient does not apply in peer support systems, as the focus is placed on peer relationships and the development of trust among peers. The challenge, however, lies in ensuring that the discipline of lived experience in mental healthcare does not become too codified or regulated, as it will lose its real purpose and lose what is the most important reason for someone's existence.⁷

It is likely that people who enter the field of mental healthcare do so because of their desire to help others and often also because of their personal experience of mental health conditions. In principle, having lived experience and having knowledge of service delivery and its corresponding processes provides them with an 'advantage' of being in a better position to step into another's shoes and be truly empathetic to their clients' or patients' needs and vulnerabilities. In most cases people choose to become therapists to make a difference in someone else's life, to be appreciated for making a difference in society and to help others who have struggled with similar painful experiences as they did.⁸

Given the above, by empowering persons with lived experience by means of education and by developing and maintaining leadership roles there will undoubtedly be a positive move towards improvement in mental health recovery. Therefore, stakeholders are encouraged to further explore the value of peer support as well as the personal experiences of clinicians for improved mental health recovery and improved quality of service delivery. Lastly, all stakeholders must ensure that they take into consideration the inputs and recommendations of persons with meaningful and authentic lived experience and implement them in their strategies and policies.

Charlene Sunkel is founder and chief executive officer (CEO) of the Global Mental Health Peer Network, Roodepoort, South Africa. **Claudia Sartor** is deputy CEO of the Global Mental Health Peer Network, Roodepoort, South Africa.

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Declaration of interest

None.

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1.1.51 Adverse childhood experiences and adult self-harm in a female forensic population

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Abstract

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Aims and method

This study aimed to investigate the prevalence of adverse childhood experiences (ACEs) among patients in a female forensic psychiatric in-patient medium-secure unit, and to analyse the link between ACEs, adulthood self-harm and associated comorbidities and risk factors. The study used a cross-sectional design, with data gathered from the anonymised electronic health records of patients.

Results

It was found that there was a high prevalence of both ACEs and self-harm among this patient group, and that there was a relationship between the two; those with more ACEs were more likely to have self-harmed during adulthood. Of the individual ACE categories, it was also demonstrated that emotional abuse had a significant association with adulthood self-harm.

Clinical implications

In medium-secure settings for women, implementation of trauma-informed care will be beneficial because of the high number of those with mental disorders who have experienced adversity during their childhood.

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pmc Adverse childhood experiences (ACEs) are stressful or traumatic life events that occur before 18 years of age.^{1,2} Having a history of ACEs is not uncommon: in a national household survey of adults residing in England, 47% of participants reported at least one ACE.³ Research on ACEs has demonstrated links between ACEs and self-harm.⁴ In a female prison population, all types of childhood abuse and neglect were more prevalent in those who self-harmed compared with those who did not, with significant associations between adulthood self-harm and both childhood emotional and sexual abuse.⁵ ACEs have a cumulative effect on health outcomes, with higher numbers of ACEs predicting more adverse health outcomes.⁶

This study occurred on Spring Ward, the female ward of River House Medium Secure Unit (MSU) in South London and Maudsley NHS Foundation Trust. Since opening in April 2008, the ward has offered a multidisciplinary biopsychosocial approach to support women toward recovery and reintegration into the community.⁷ In 2017, following the success of implementing the Healing Trauma programme (a gender-specific intervention for trauma victims),⁸ a trauma-informed care approach was introduced. Implementation involved team consultation, presentation and a training session on Stephanie Covington's Becoming Trauma-Informed Programme.⁹

This study was conducted as part of a service evaluation to determine the prevalence of ACEs in a female MSU cohort and to explore the relationship between ACEs and adulthood self-harm. Links between ACEs and adulthood self-harming behaviours, violence and comorbidities (such as personality disorder) will be explored, which will enable us to better understand the present and future needs of patients.

Aims

Our first aim was to establish the prevalence of ACEs in patients in a female MSU, using a structured ACE questionnaire. Second, we aimed to establish the prevalence of adulthood self-harm, personality disorder, alcohol and drug misuse, and history of violence among female in-patients in the MSU. And finally, we aimed to explore the relationship between ACEs and adulthood self-harm.

Method

Design and procedure

The main study utilised a cross-sectional design, using medical records. The researchers conducted a thorough review of each patient's electronic medical records. Using previously recorded information, the amount of ACEs were calculated by the researcher, based upon the trauma history recorded in the patients records.

Participants

All patients who were admitted to or were receiving continuing treatment on the ward between April 2008 and July 2019 were considered eligible for participation in this study. Criteria for admission to the ward include being over 18 years of age, committing an offence or having a significant history of violence. All patients are sectioned under the Mental Health Act 1983 (MHA) throughout their admission. The ward can accommodate 15 patients. Because of the relapsing and remitting nature of the mental disorders of many patients, several patients had multiple admissions during the study period; for these patients, data was gathered from medical records documented during their most recent admission.

Initially, 68 participants were included in the sample. Two participants were excluded from the analysis because of insufficient information in their medical records regarding their childhood, taking the final sample to 66 participants. Demographic and clinical information included age on admission, ethnicity, primary diagnosis, MHA section, personality disorder, alcohol and drug misuse, and violence history. Ethnicity was recorded into subsections: White British, Black British, Black African, Black Caribbean, Asian and other. Primary diagnosis was recorded into three categories, according to the ICD-10: schizophrenia spectrum disorders (codes F20–F29), mood [affective] disorders (codes F30–F39) and personality disorders (codes F60–F69).¹⁰ MHA sections of all patients were recorded into categories: forensic (section 37, sections 37 and 41, sections 47 and 49, and sections 48 and 49) and civil (section 3).¹¹

Data collection and analysis

Exposure to adverse experiences up to 18 years of age was assessed for each participant, following a thorough review of their medical notes; ACE history was summarised by a ten-item version of the Adverse Childhood Experiences Questionnaire.¹² The ACE questionnaire consists of ten binary (yes/no) questions that assess exposure to emotional, physical and sexual abuse; emotional and physical neglect; and household dysfunction, including domestic violence, substance use and incarceration. Participants' self-harm history since 18 years of age was obtained via medical records, along with comorbid personality disorder, alcohol and drug misuse, and history of violence. Self-harm was coded as a binary variable, with the presence of self-harm being recorded if there was any mention of self-harm or suicide attempt in adulthood mentioned in the medical records. ACEs were extracted from records of patients' trauma history recorded in psychological and psychiatric reports contained in their medical records. Personality disorder presence was defined as a previous diagnosis of any type of personality disorder. Alcohol and drug misuse were defined as any positive history of problematic use of alcohol or drugs. History of violence was defined as any violence history before the event leading to admission. Each of these variables were recorded as dichotomous (yes/no) variables.

Data was analysed with the Statistical Package for Social Sciences (IBM SPSS, version 25 for Mac).

Ethical approval

Ethical approval was granted by the Research, Outcomes and Service Evaluation Committee, a branch of the Behavioural and Developmental Psychiatry Clinical Academic Group of South London and Maudsley NHS Foundation Trust. The ethical approval included the use of anonymised medical records. This was a service development project using historic clinical records and as such the study was exempt from a need to provide informed consent.

Results

Patients were aged between 18 and 72 years at admission (*Table 1*). The sample was primarily Black and minority ethnic, and most patients had a primary diagnosis of schizophrenia, schizotypal and delusional disorders (ICD-10 codes F20–F29).¹⁰ The majority of the sample had a history of drug misuse. Over a third of the sample had a history of alcohol misuse, and over a quarter had a comorbid personality disorder diagnosis. *Table 1* Demographic and clinical characteristics of the patient sample

Characteristic	Cases (N = 66)	n (%)
Age at admission (years), mean (s.d.)	38.40	(±11.37)
Age categories (years)		
<25	10	(15.2)
25–34	13	(19.7)
35–44	26	(39.3)
45–54	12	(18.2)
55	5	(7.6)
Ethnicity, n (%)		
White British	20	(30.3)
Black British	13	(19.7)
Black African	13	(19.7)
Black Caribbean	10	(15.2)
Asian	2	(3.0)
Other	8	(12.1)
Primary diagnosis, n (%)		
F20–F29, Schizophrenia, schizotypal and delusional disorders	57	(86.4)
F30–F39, Mood [affective] disorders	4	(6.1)
F60–F69, Disorders of adult personality and behaviour	5	(7.6)
Comorbid personality disorder, n (%)	20	(30.3)
Alcohol misuse, n (%)	25	(37.9)
Drug misuse, n (%)	34	(51.5)

Number and prevalence of ACEs

In the total sample, the mean number of ACEs was 2.89 (±2.35) (*Table 2*), with ACE number showing a positively skewed distribution. Within the sample, most individuals (n = 54, 81.9%) had experienced at least one ACE during childhood; of the total sample, 28.8% had experienced two to three ACEs and 37.9% had experienced four or more ACEs. Among the ACE categories, emotional and physical abuse were the most common, and the rarest ACE was incarceration of household members (*Table 2*). *Table 2* Main study prevalence of number of ACEs and each category of ACE

Cases, N = 66	Number of ACEs, mean (s.d.)	Number of ACEs, n (%)
0	12	(18.2)
1	10	(15.2)
2	21	(31.8)
3	14	(21.2)
4	35	(7.6)
5	46	(9.1)
6	57	(10.6)
7	67	(10.6)
8	74	(6.1)
9	80	(0.0)
10	91	(1.5)
11	100	(0.0)
ACE, n (%)		
Emotional abuse	27	(40.9)
Physical abuse	27	(40.9)
Sexual abuse	20	(30.3)
Emotional neglect	26	(39.4)
Physical neglect	20	(30.3)
Parental separation or divorce	26	(39.4)
Violence against mother	8	(12.1)
Household alcohol/drug misuse	13	(19.7)
Mental illness in household	21	(31.8)
Incarceration of household member	2	(3.0) ²

² Within the sample, two was the most common amount of ACEs (56% of the sample experienced two or more ACEs) and emotional and physical abuse were the most common ACE categories. ACE, adverse childhood experience.

Number of ACEs and adulthood self-harm

Adulthood self-harm in the sample was analysed. It was determined that over half of the sample had self-harmed during adulthood ($n = 36, 54.5\%$). Because of the positive skewed nature of the number of ACEs, we ran a Spearman's correlation to assess the relationship between number of ACEs and adulthood self-harm on the total sample of 66 patients. There was a statistically significant positive correlation between number of ACEs and adulthood self-harm ($r_s(64) = 0.45, P < 0.001$). Following this, binary logistic regression was performed to ascertain the effect of increasing number of ACEs on the likelihood of adulthood self-harm. The binary logistic regression model was statistically significant ($\chi^2(1) = 15.11, P < 0.005$). The model explained 27.4% (Nagelkerke R^2) of the variance in adulthood self-harm, and correctly classified 75.7% of cases (specificity 83.3%, sensitivity 69.4%). For every one-point increase in number of ACEs, individuals were 1.62 times more likely to self-harm as adults.

ACE categories and adulthood self-harm

We conducted an analysis to determine whether there was any association between individual ACE categories and adulthood self-harm. The total sample who had self-harmed during adulthood was analysed to determine the prevalence of each type of ACE within this category. In those who had self-harmed during adulthood, emotional abuse was the most common ACE ($n = 22, 33.3\%$), followed by physical abuse ($n = 19, 28.8\%$), emotional neglect ($n = 19, 28.8\%$) and physical neglect ($n = 17, 25.8\%$). Estimates of the odds ratio for each of the ten ACEs ranged from 1.38 (95% CI 0.47–3.99) for sexual abuse to 8.05 (95% CI 2.07–31.39) for physical neglect. However, statistically significant associations with adulthood self-harm were only seen for emotional abuse, physical abuse, emotional neglect and physical neglect. These relationships were then further explored by Pearson's χ^2 -tests and Fisher's exact tests, which confirmed that four categories of ACE had a statistically significant association with adulthood self-harm: emotional abuse ($\chi^2(1) = 13.37, P < 0.001$), physical abuse ($\chi^2(1) = 4.62, P = 0.032$), emotional neglect ($\chi^2(1) = 5.94, P = 0.015$) and physical neglect ($P = 0.001$, Fisher's exact test, two-sided).

Multivariate binary logistic regression was conducted to determine whether emotional abuse, physical abuse, emotional neglect and physical neglect maintained their statistically significant association with adulthood self-harm when all four categories were accounted for. In this model, 31.2% (Nagelkerke R^2) of the variation in adulthood self-harm was explained by these four ACE categories. This model correctly classified 71.2% of cases (specificity 80.0%, sensitivity 63.9%). When accounting for emotional abuse, physical abuse, emotional neglect and physical neglect, only emotional abuse maintained a statistically significant relationship with adulthood self-harm ($P = 0.034$), showing that being emotionally abused increased the likelihood of adulthood self-harm by 7.36 times (Table 3). Table 3 Multivariate binary logistic regression to analyse the association between emotional abuse, physical abuse, emotional neglect and physical neglect, and adulthood self-harm

Variables	Bs.e.	Waldd.f.	Significance	Exp(B)	95% CI for Exp(B)	Lower	Upper	Step 1
Emotional abuse	1.9970.9444	4.77	0.034	7.36	1.0347.3641	1.158	46.805	Physical abuse
Physical abuse	0.5070.9050	3.14	0.075	1.66	0.6020.1023	0.549	Emotional neglect	
Emotional neglect	0.9651.1160	7.48	0.007	2.62	1.03870.3810	0.433	3.395	Physical neglect
Physical neglect	1.9271.1382	8.68	0.003	6.80	1.0906.8680	0.739	63.859	

3

This multivariate binary logistic regression model included all adverse childhood experience categories that were individually significantly associated with adulthood self-harm. It was run to determine whether statistical significance was maintained when all the categories were accounted for; only emotional abuse remained significantly associated with adulthood self-harm.

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Discussion

This study was the first to analyse the prevalence of ACEs, adulthood self-harm and their relationship in a female MSU population in the UK. Multivariate binary logistic regression revealed a statistically significant association between an increasing number of ACEs and increased likelihood of adulthood-self harm. Emotional abuse was shown to have a statistically significant association with adulthood self-harm.

We found a high prevalence of ACE exposure in this female MSU cohort, with over 80% of individuals experiencing at least one ACE and 56% experiencing more than two ACEs. The prevalence of ACE exposure among this female MSU group was higher than the 47% prevalence in the general adult population of the UK.³

Within this population, there was a high prevalence of adulthood self-harm. Adulthood self-harm in our sample was reported by 54.5%, similar to the rates reported by Ribeiro et al¹³ (whose MSU population overlapped with ours), who found that 46.7% had a documented history of self-harm before MSU admission. Baker et al¹⁴ interviewed female patients in a medium-secure setting and discussed their experiences of self-harm; an overarching theme discussed was that of ‘the traumatised individual’, suggesting that individuals linking their traumatic experiences to self-harming behaviour is not uncommon. The high prevalence of ACEs amongst the female MSU population indicates that a trauma-informed approach to care in MSU settings for women is crucial. Application of ‘universal trauma precautions’ is necessary, to ensure that all who have been exposed to ACEs receive care that is not only growth-promoting, but also less likely to cause re-traumatisation than standard care.¹⁵

We found a statistically significant correlation between an increasing number of ACEs and the likelihood of adulthood self-harm. This is similar to research by Cleare et al,¹⁶ showing that those with a history of repeat self-harm were significantly more likely to report exposure to multiple ACEs. Moreover, our finding of a statistically significant relationship between emotional abuse and adulthood self-harm supports the research by Howard et al,⁵ who found a statistically significant association between emotional abuse and self-harm in a sample of female prisoners.

It was advantageous to focus on those admitted to a single female MSU over the past 11 years, as there is limited data regarding this population. Use of electronic medical records to obtain data meant minimal information was missing and there was low attrition. In this niche population, we achieved a good sample size; only around 12% of the 3500 MSU beds in the UK are occupied by women.¹⁷

The ACE questionnaire is limited as it provides no information regarding the severity, degree, duration, timing or quality of each ACE component, which may differ significantly from person to person. Furthermore, data collected about self-harm behaviours could have been improved by using the Inventory of Statements about Self-Injury questionnaire,¹⁸ examining the type, frequency, severity and reasons for the behaviour. Further research could focus on collecting more in-depth childhood histories from patients, or using self-harm measures that capture frequency and severity.

Limited research is also available in forensic psychiatric settings, specifically MSUs, and nationwide research into ACEs and self-harm within these units could be beneficial. Furthermore, the neurodevelopmental and psychological mechanisms by which ACEs and self-harm are linked need exploration.

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Data availability

The data that support the findings of this study are available from the corresponding author, R.H., upon reasonable request.

I.S. was involved in data collection, data analysis and writing of the manuscript. R.H., P.B. and M.F. contributed to writing the manuscript.

Declaration of interest

None.

1.1.52 The recording of mental health consultations by patients: clinical, ethical and legal considerations

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Abstract

The topic of patients recording healthcare consultations has been previously debated in the literature, but little consideration has been given to the risks and benefits of such recordings in the context of mental health assessments and treatment. This issue is of growing importance given the increasing use of technology in healthcare and the recent increase in online healthcare services, largely accelerated by the COVID-19 pandemic. We discuss the clinical, ethical and legal considerations relevant to audio or visual recordings of mental health consultations by patients, with reference to existing UK guidance and the inclusion of a patient's perspective.

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Why do patients record healthcare consultations?

Recording consultations is increasingly accessible for patients as smartphones and electronic devices with recording capabilities have become ubiquitous in modern society. The integration of these devices into healthcare has been accelerated by the COVID-19 pandemic, which prompted a global upsurge in the use of telemedicine.¹ Many digital platforms that are used for online consultations, including Zoom and Microsoft Teams, have in-built recording functions.

Several reasons have been suggested for why patients record healthcare consultations. These include enhancing their understanding of healthcare information, replaying clinical encounters, sharing these with others and for therapeutic purposes.² Some patients hold digital copies of consultations to evidence the care received and to support any future complaints or litigation;² this may particularly be the case if patients have had prior negative healthcare experiences or lost trust in healthcare providers. For some patients, digital recordings provide a sense of ownership over their health information.²

Advice from professional bodies

The General Medical Council (GMC) recommends that doctors make arrangements, wherever practical, to support patients in understanding and retaining health information; such support is described to include accommodating a patient's wish to record relevant conversations.³ They clearly state that doctors must obtain patients' consent to conduct visual or audio recordings of them.⁴ However, the GMC currently does not provide formal guidance on the management of other circumstances in which patients record healthcare interactions. For example, should clinicians encourage patients to record them for reasons other than understanding and retaining information?

The Medical Defence Union (MDU), Medical Protection Society (MPS) and British Medical Association (BMA) advise that patients do not require the doctor's permission to record their healthcare consultations.⁵⁻⁷ This is because information disclosed during a consultation is confidential to the patient, not the doctor, and a recording is therefore not a breach of confidentiality in itself. Similarly, where recordings are made entirely for personal reasons, they are unlikely to engage the Data Protection Act. The MPS further advises that a doctor's duty of care should prevail over any reluctance to engage in filming by patients.⁶

Although patients can record healthcare consultations, it is less clear how the recorded material can be utilised. The MPS declares that, since 'the content of the recording is confidential to the patient, not the doctor' this means that 'the patient can do what they wish with it'.⁶ However, the BMA advises that healthcare staff can request the removal of recorded materials posted online;⁷ furthermore, refusal of this request could result in litigation owing to misuse of the professional's private information. Depending on the nature of the posting, it could potentially violate the Protection from Harassment Act 1997, the Malicious Communications Act 1988 or the Communications Act 2003.⁷

Interestingly, none of the above organisations specifically refer to the mental health or mental capacity of the patient making the recording, despite the unique considerations this brings.

The Mental Health Act

The Mental Health Act Code of Practice applies to patients detained under the Mental Health Act 1983. It states that ‘when patients are admitted, staff should assess the risk and appropriateness of patients having access to mobile phones and other electronic devices and this should be detailed in the patient’s care plan’.⁸ It does not directly comment on the use of devices for recording healthcare encounters; nonetheless, it seems reasonable to apply the principles of the above statement to this situation. The terms ‘risk’ and ‘appropriateness’ suggest that professionals should consider the safety of healthcare consultations being recorded, and the suitability of the context, content and intended use(s) of any recording. These factors will vary according to individual patients and situations, demonstrating the need for a person-centred approach. If valid clinical reasons exist for denying access to electronic devices under the Mental Health Act, professionals should consider whether these extend to the recording of consultations. In the same way that clinicians note restrictions on access to personal items, they should document any reasons for preventing a patient from recording healthcare interactions. This is important for medico-legal purposes and to alert other professionals of identified risks.

Clinical benefits of patients recording mental health consultations

The recording of healthcare consultations could help patients to remember vital information, such as self-help strategies, medication advice and suicide safety plans. This is particularly useful in psychiatry, given that concentration and attention are impaired in various mental disorders. If the patient is acutely agitated or distressed during the consultation, this could further limit their recall of conversations. Viewing the healthcare encounter when feeling more relaxed could improve a patient’s adherence to medical recommendations. This could also empower patients and make them feel more involved in their care by allowing greater time for information processing.

Recordings make it easier for patients, especially those with poor recall, to inform family members about their health. This could further involve families in decision-making processes in the interests of providing holistic care. The previous recording of healthcare consultations could additionally aid decision-making processes for patients who lack mental capacity. For example, they could demonstrate a person’s previously expressed wishes and values, which the team could refer to when determining the patient’s best interests. This could therefore promote autonomy as an ethical principle for patients with mental illness.

Recorded consultations also potentially offer more accurate, detailed and undisputable accounts of healthcare interactions than those that are formally documented, especially for lengthy clinical encounters where clinicians must summarise vast amounts of information.⁶ Consultations recorded over time may help patients to chart their progress and response to care.

Risks of patients recording mental health consultations

Despite the above benefits, there are several risks of recording consultations. First, this could potentially restrict the quality and quantity of information gathered throughout doctor–patient interactions. Patients may be less likely to disclose sensitive information, particularly if they intend to share the recording with others. This could influence their diagnosis and treatment, while also indirectly affecting the risks to the patient and to others. For example, a patient may withhold details of thoughts to harm family members if they are sharing the recording with these persons, limiting the validity of clinical risk assessment. Similarly, the doctor may less freely ask probing questions that expose a patient’s vulnerability if they are aware of the recording being widely distributed. For these reasons, clinicians should discuss with patients which aspects of healthcare consultations they wish to record, the purpose(s) of the recording and whether this could affect their engagement or ability to provide honest information. Ideally, patients and clinicians should reach a mutually agreeable decision and work together to mitigate any potential impact on psychiatric assessment.

Some patients may lack the mental capacity to decide whether they wish to record healthcare consultations and how to use the recorded information. In such circumstances, patients could act without understanding the benefits and risks associated with their intended use(s) of the recording. This could result in harm to the patient and/or them making a decision that they later regret when they regain mental capacity. For example, a patient with mania may report reckless spending and display disinhibited behaviour during their consultation, but impulsively decide to record this and post the content online. The patient may be incapable of understanding and appraising the consequences of doing

this, including heightening their risk of financial abuse and vulnerability. Furthermore, they may not recognise that they are demonstrating symptoms of mental illness, and this lack of insight could result in the unintended sharing of confidential health information. In this situation, the person would seemingly lack the mental capacity to record their healthcare encounter; consequently, the healthcare professional would have a professional and legal duty to act in their best interests. Healthcare professionals must remember that mental capacity is assumed until proven otherwise, and unwise decisions do not equate to the loss of mental capacity.⁹

Clinicians should be mindful of the content of healthcare consultations and patients' reactions to this. Discussing sensitive topics such as suicidal thoughts, self-harm and abuse can evoke strong emotions and distress. Any intense negative emotions encountered by the patient could be re-experienced on viewing recorded consultations; in the absence of appropriate support, this could trigger acute distress and heighten the individual's risk to themselves in that present moment. Clinicians should advise patients accordingly of these risks and agree an appropriate safety plan to address them.

Social media sites are increasingly popular in modern society and some patients may post their recorded consultations on such platforms. This could result in both positive and negative comments from the public and their health information being shared beyond the original intended audience. Sharing of clips with partial information may also be misleading without providing a fuller picture of the relevant context. Clinicians should consider discussing these risks and benefits with patients, including how public reactions to private health information could affect their mental state.

Risks to other patients and persons

Healthcare professionals must protect the safety, dignity and privacy of all patients. A common concern is that healthcare recordings may include the voice, image or details of other patients in the vicinity of the recording. This could potentially breach their privacy rights under Article 8 of the European Convention on Human Rights.^{7,10} The increased use of single bedrooms in mental health units lessens this risk; however, in-patient mental health wards are often louder than other environments and professionals should consider whether other patients are visible or audible in the background. In such circumstances, it seems best practice that the patient is offered an alternative environment for the consultation to be recorded in. If this is not feasible, the recording may need to be prevented to preserve the confidentiality and privacy of other patients. The proximity of colleagues to the recording should also be considered to protect their privacy and to avoid indirectly compromising patient confidentiality, such as by capturing a colleague's discussions relating to others.

The content of healthcare conversations can include details of third parties whose confidentiality should be protected.¹¹ For this reason, when patients request access to their medical records, content relating to external persons is usually omitted before granting access.¹¹ A similar process should apply to recorded consultations, with the doctor ensuring that the recorded material does not breach the confidentiality of others.

Further ethical and legal considerations

Owing to the nature of mental illness, some patients lack the mental capacity to make decisions regarding their care. For example, approximately 40–60% of psychiatric in-patients have been estimated to lack capacity regarding treatment decisions.^{12,13} This means that recorded consultations may not accurately reflect a patient's desires and opinions, especially if these change throughout the course of the person's illness or if treatment is being provided against their wishes (under the principles of the Mental Capacity Act or the Mental Health Act). These factors should be considered when interpreting prior recordings made by patients.

Covert recording

Studies have estimated that 26–40% of healthcare recordings by patients are made covertly.¹⁴ Reasons for this behaviour include distrust in the healthcare system, lack of knowledge regarding policies for ‘open’ recording and fear of recordings being prevented by clinicians.^{14–16} Covert recordings have been used in disciplinary proceedings by the GMC,^{5,17} although the BMA highlights that most recordings support the actions of doctors.⁷ To reduce covert methods, some authors have suggested that clinicians should encourage patients to visibly record their healthcare interactions.^{14,15} This could build trust, encourage shared decision-making and promote an open and honest culture within organisations. This also provides an opportunity for patients and clinicians to work together to maximise the benefits and reduce the risks of any recording, while ensuring that important non-verbal interactions are captured in any media. The practice of clinicians encouraging healthcare recordings likely requires organisational support and a clear organisational framework to support and govern this activity.

Recordings made by carers or relatives

For some patients, their carers or relatives may attend their healthcare appointments and record consultations on their behalf. All patients who have mental capacity can refuse the recording of their health information by others, but for those without mental capacity, clinicians must consider whether any recording is in the person’s best interests. This is particularly relevant in child and adolescent mental health settings, where parents are commonly involved in their children’s healthcare. In the UK, children aged 13 years and above are typically deemed to have the mental capacity to access personal health records and accept or refuse parental access to these; however, there is no strict age threshold, and some children achieve mental capacity earlier than others.^{18,19} Children with the relevant mental capacity should be permitted to record their consultations and to give or deny their parents permission to do so. The healthcare professional must also consider any safeguarding concerns or relationship dynamics that could influence third party recordings and their clinical assessment. For example, children could less freely report difficulties at home if their parents are filming healthcare encounters. For patients with neurodegenerative conditions or chronic mental illness, early discussions about their healthcare preferences and other’s involvement in their care could aid decision-making about recording consultations if and when mental capacity is reduced in the future. A potential benefit of recording healthcare appointments by parents or carers is that this can provide an easily accessible record and evidence of access to care when attending multiagency meetings with education and social care agencies, especially when neglect is a concern.

Patient perspective

The following gives a patient’s (N.R.’s) view on the subject. “Having spent considerable time in psychiatric and therapeutic appointments as a patient, I was initially shocked when learning of the lack of clear national guidance regarding patients’ recording of appointments in mental health settings. This lack of guidance leaves the patient vulnerable to breaches in confidentiality, potentially in cases where mental capacity is lost for the patient, and they inadvertently disclose potentially embarrassing information in public forums. We must consider the potential humiliation that service users could feel when errors occur with the use of such recordings. At the same time, recordings could provide a sense of security to patients and give them greater confidence in their care.”

“Ideally, there would be an independent method or platform that manages and stores recordings of healthcare consultations. This way, they could be used for the benefit of patient care and/or for medico-legal purposes, while protecting patients from some of the risks.”

Summary

Clinical services must adapt to accommodate evolving patient preferences and work collaboratively with patients to ensure that health information is appropriately and safely stored and shared with others. The recording of healthcare consultations offers several benefits to patients; however, it may also sometimes risk their privacy, safety and dignity or that of others. We recommend the establishment of clear national guidelines regarding the recording of mental health consultations. These guidelines are needed to protect both patients and professionals and are urgently required, given the increasing use of teleconsultations in mental healthcare. Such guidelines would need to acknowledge the broad range of settings and circumstances in which consultations can be recorded, including in-patient wards, home visits, community settings and online. Particular consideration needs to be given to specialist groups such as children and adolescents, patients with intellectual disabilities and persons with cognitive impairment. Furthermore, the views of numerous stakeholders must be considered, including patients, carers, multidisciplinary team members, and legal and ethical experts.

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Declaration of interests

None.

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1.1.53 Examining the effects of national initiatives to improve the physical health of people with psychosis in England: secondary analysis of data from the National Clinical Audit of Psychosis

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Abstract

Aims and Methods

To examine whether national initiatives have led to improvements in the physical health of people with psychosis. Secondary analysis of a national audit of services for people with psychosis. Proportions of patients in ‘good health’ according to seven measures, and one composite measure derived from national standards, were compared between multiple rounds of data collection.

Results

The proportion of patients in overall ‘good health’ under the care of ‘Early Intervention in Psychosis’ teams increased from 2014–2019, particularly for measures of smoking, alcohol and substance use. There was no overall change in the proportion of patients in overall ‘good health’ under the care of ‘Community Mental Health Teams’ from 2011–2017. However, there were improvements in alcohol use, blood glucose and lipid levels.

Clinical implications

There have been modest improvements in the health of people with psychosis over the last nine years. Continuing efforts are required to translate these improvements into reductions in premature mortality.

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pmc Concerns have repeatedly been raised regarding premature mortality among people with schizophrenia and other psychotic disorders.^{1–6} People who experience psychosis die on average 10–20 years earlier than the general population.^{7,8}

Factors contributing to this inequality may include economic disadvantage, health risk behaviours and difficulties accessing and adhering to medical treatments.^{9–11} These frequently translate to poor physical health, and psychotic disorders are strongly associated with unfavourable outcomes for a range of physical health measures: smoking status, weight, serum glucose levels, blood pressure and serum lipids.^{12,13} These issues can be compounded by metabolic side-effects of antipsychotic medication,^{14–17} and an increased risk of cardiovascular disease is widely accepted as the primary mediator of reduced life expectancy.^{4,18–20}

National initiatives

In 2014, the National Institute for Health and Care Excellence (NICE) produced recommendations to guide screening and intervention for common physical health problems experienced by people with psychosis.²¹ The same year, NHS England announced a new Commissioning for Quality and Innovation (CQUIN) framework, providing financial incentives for physical health screening and interventions within secondary mental health services.²² The ‘Positive Cardiometabolic Health Resource’ was published, with support from the Royal Colleges of Psychiatrists, Physicians, Nursing and General Practice, establishing a user-friendly manual for clinicians providing care to patients with severe mental illness.²³

Since these initiatives were implemented, there is some evidence that the quality of physical healthcare delivered to patients with psychosis has improved.²⁴ However, there are ongoing concerns that this has not translated to an improvement in patients’ health. A recent study found that cardiometabolic risk factors were already pronounced in those presenting to services with a first episode of psychotic illness, and that physical health deteriorated during the first year of treatment.²⁵

In light of these apparent contradictions, we aimed to investigate whether physical health has improved among people with psychotic disorders. We conducted a secondary analysis of data gathered over the past 9 years, during national audits of services for people with psychosis.

Method

All data for this study were collected during two audit rounds conducted as part of the National Clinical Audit of Psychosis (NCAP) by the Royal College of Psychiatrists.²⁶ Both examined services providing care to people with psychotic disorders in England. A ‘core’ audit generated data on people under the care of community mental health teams (CMHTs), with three rounds of data collection in 2011, 2013 and 2017. A ‘spotlight’ audit collected additional data on the quality of care received by people with first-episode psychosis (FEP) who received care from early intervention for psychosis (EIP) teams. Three rounds of the spotlight audit were conducted in 2014, 2018 and 2019. All National Health Service (NHS) Provider Trusts in England with CMHTs and EIP teams that provided care to patients with psychotic disorders were invited to take part in these respective audits.

For both audits, all participating organisations were asked to provide an anonymised list of eligible patients who fulfilled inclusion criteria during a 12-month ‘sampling window’ before the point of data collection. From each list, 100 patients were randomly selected for inclusion in the audit. For the CMHT audit, patients were eligible for inclusion if they had an active period of care with a participating CMHT, were aged 18 years and had an established diagnosis of schizophrenia or schizoaffective disorder (ICD-10 codes F20/F25) recorded during the 12-month sampling period. Patients were excluded if they had received in-patient care or care from an EIP team during this period. For the EIP audit, patients were eligible for inclusion if they had an active period of care with a participating EIP team, were aged 14 years and had a diagnosed ‘first episode’ of any psychotic disorder (ICD-10 codes F20-F29) recorded during the 12-month sampling

period. For the purposes of this study, we excluded any patients whose host organisation did not participate in all three rounds of the respective audit.

For both audits, staff from each organisation were asked to conduct a retrospective review of case notes from the sampling window, and extract data to complete an online data collection tool. The tool included questions on physical health measures, quantifying patients' smoking status, alcohol use, blood pressure, body mass index (BMI), serum glucose, serum lipids and whether they were known to use illicit substances. The data collection tools for both audits were based on NICE guidance for management of psychotic disorders.²¹ They were developed in collaboration with patients and providers of psychiatric services, and carer representatives with lived experience of supporting patients with psychotic disorders. The tool was piloted by six volunteer trusts before the main audit, to ensure that the process was understandable and acceptable.

During the development of this project, the National Research Ethics Service and the Ethics and Confidentiality Committee of the National Information Governance Board advised that formal ethical approval and individual participants' informed consent were not required because this was a secondary analysis of audit data and patient-identifiable data were not being collected. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

Exposure, outcome measures and covariates

The primary outcome measures for this study were whether patients were considered to be in 'good health', according to for seven discrete physical health measures and one composite measure. The seven measures of good health were smoking status (not currently smoking, e.g. non-smoker or ex-smoker), alcohol use (no recorded 'harmful or hazardous' alcohol use), illicit substance use (no recorded illicit substance use), blood pressure (normotensive, i.e. <140/90 mmHg), BMI (within normal range, i.e. 18.5–24.9), serum glucose (within normal range, i.e. fasting blood glucose <5.5 mmol/L and/or random plasma glucose <11.1 mmol/L and/or hemoglobin A1C <42 mmol/mol) and serum lipids (within normal range, i.e. total serum cholesterol <5.1 mmol/L and/or high-density lipoprotein >1 mmol/L and/or non-high-density lipoprotein <4.1 mmol/L). The definition of good health for each measure was based on the standards implemented by the national Mental Health Commissioning for Quality and Innovation analysis.²² To be considered in good health for the composite measure, patients had to fulfil the criteria for good health for all of the seven discrete measures.

In addition, patients' age and gender were recorded, to provide demographic information about the overall sample for each audit.

Statistical methods

We used SPSS (version 26 for Windows)²⁷ to analyse the study data. For each round of the audits, the proportion of patients with good health were calculated for each of the physical health measures and the composite measure. The variation in these proportions between each round of the two audits was then examined with binomial logistic regression.

Variation in demographic characteristics (age and gender) were compared between the CMHT and EIP audits, using *t*- and ²-tests, respectively.

For many patients, data were not recorded for some of the physical health measures (presumably because it was not available in the clinical records, possibly because of patients refusing to undergo investigation or provide information).²⁸ Missing values were not included in the analysis.

Results

For the CMHT audit, 57 NHS Provider Trusts submitted data for all three rounds. Data from 16 752 sets of case notes were analysed (4618 from the first round in 2011, 4785 from the second round in 2013 and 7349 from the third round in 2017). For the EIP audit, 54 NHS Provider Trusts submitted data for all three rounds. Data from 20 611 sets of case notes were analysed (2158 from the first round in 2014, 8768 from the second round in 2018 and 9685 from the third round in 2019).

Table 1 summarises the demographic characteristics (age and gender) for the total samples of the CMHT audit and EIP audit, respectively. Across the three rounds, patients in the CMHT audit were significantly older than those in the EIP audit, with mean ages of 47.11 years and 29.66 years, respectively ($t(37\ 361) = 156.94, P < 0.001$). In the CMHT audit, 65.6% of the total sample were men, compared with 64.2% in the EIP audit, which was not a statistically significant difference. *Table 1* Demographic characteristics of people with psychosis in the CMHT and EIP audits

	CMHT audit	EIP audit
Age, mean (s.d.)	47.11 (± 12.02)	29.66 (± 9.47)
Difference in age between audits was statistically significant as determined by <i>t</i> -test:	$t(37\ 361) = 156.94, P < 0.001$	
Gender, <i>n</i> (%)	Male 10 989 (65.6)	13 232 (64.2)
	Female 5763 (34.4)	7379 (35.8)
Difference in gender between audits was not statistically significant as determined by χ^2 -test:	$\chi^2 = 1.23, P = 0.267^1$	

Table 2 summarises the proportion of CMHT patients in good health according to each of our outcome measures (including the composite measure), and the variation in these proportions over time across the three rounds of the CMHT audit. There were variable amounts of missing data for each of the seven outcome measures, meaning that the composite measure could only be used for 31.3% (5243/16 752) of CMHT patients. *Table 2* Proportion of people with psychosis with good health outcomes at each round of the community mental health team audit

	2011	Audit 2013	Audit 2017	<i>n</i> / <i>N</i> / <i>n</i> / <i>N</i> %/%	Odds ratio (95% CI), <i>P</i> -value	Odds ratio (95% CI), <i>P</i> -value	Odds ratio (95% CI), <i>P</i> -value
Smoking	1694/4016	1769/4286	2784/6342	42.2/41.3/34.9	Reference	0.97 (0.89–1.06), 0.566	1.07 (0.99–1.16), 0.090
Alcohol use	2691/3197	2887/3387	5686/6410	84.2/85.2/88.7	Reference	1.09 (0.95–1.24), 0.244	1.48 (1.31–1.67), <0.001
Illicit substance use	3377/3888	3699/4243	5281/6332	86.9/87.2/83.4	Reference	1.03 (0.90–1.17), 0.689	0.76 (0.68–0.85), <0.001
Body mass index	502/1202	571/2587	992/4537	22.8/22.8/22.1	Reference	0.96 (0.84–1.10), 0.572	0.95 (0.84–1.07), 0.406
Blood pressure	1900/2593	2191/2946	3642/4855	73.3/73.7/75.0	Reference	1.06 (0.94–1.19), 0.371	1.10 (0.98–1.22), 0.107
Blood glucose levels	1449/2297	1502/2690	3393/4332	63.1/55.8/78.3	Reference	0.74 (0.66–0.83), <0.001	2.12 (1.89–2.36), <0.001
Blood lipids	924/2186	1143/3002	2350/4152	42.3/35.6/56.6	Reference	1.00 (0.89–1.12), 0.998	1.78 (1.60–1.98), <0.001
Composite measure	33/100	434/1372	76/286	3.3/31.2/2.7	Reference	0.74 (0.46–1.22), 0.294	0.80 (0.53–1.21), 0.348

There was some evidence of improvement in health. CMHT patients in the third round were significantly more likely than those in the first round to be in good health according to measures of alcohol use (odds ratio 1.48, 95% CI 1.31–1.67, $P = 0.001$), blood glucose levels (odds ratio 2.12, 95% CI 1.89–2.36, $P < 0.001$) and blood lipids (odds ratio 1.78, 95% CI 1.60–1.98, $P < 0.001$).

However, CMHT patients in the third round were less likely to be in good health for the illicit substance use measure (odds ratio 0.76, 95% CI 0.68–0.85, $P < 0.001$), i.e. a higher proportion of CMHT patients were using illicit substances in 2017 compared with 2011. The proportion of CMHT patients in overall good health according to the composite measure was consistently low across all three rounds of the audit, and decreased from 3.3% in 2011 to 2.7% in 2017, although this was not statistically significant.

Table 3 summarises the proportion of EIP patients in good health according to each of our outcome measures (and the composite measure), and the variation in these proportions over time across the three rounds of the EIP audit. Similarly, there were variable amounts of missing data for each of the seven outcome measures, meaning that the

1

CMHT, community mental health team; EIP, early intervention in psychosis.

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composite measure could only be used for 56.4% (11 625/20 611) of EIP patients. Table 3

Measure	2014 Audit	2019 Audit	n	N	n/N	%	Odds ratio (95% CI), P-value
Smoking	885	1808	4015	7832	4581	8487	49.05 (1.35-4.0), Reference 1.10 (0.99-1.22), 0.08
Alcohol use	1620	1853	7021	7774	7749	8526	87.49 (1.34-1.39), Reference 1.34 (1.15-1.57), <0.001
Illicit substance use	1182	1905	5711	7831	6410	8517	62.17 (1.65-1.86), Reference 1.65 (1.48-1.83), <0.001
Body mass index	460	1044	2314	6667	2662	7566	44.13 (0.68-0.77), Reference 0.68 (0.59-0.77), <0.001
Blood pressure	924	1106	5513	6733	6314	7750	83.58 (0.75-1.06), Reference 1.10 (0.99-1.22), 0.08
Blood glucose levels	721	803	5071	5525	6175	6733	89.89 (0.99-1.63), Reference 1.27 (0.99-1.63), 0.06
Blood lipids	506	741	3546	5416	4265	6564	68.36 (0.75-1.04), Reference 0.88 (0.75-1.04), 0.14
Composite measure	37	1543	422	4465	576	5617	2.49 (3.02-5.98), Reference 4.25 (3.32-6.52), <0.001

This audit also showed improvements in some of the measures of health over time: notably, those relating to smoking (odds ratio 1.22, 95% CI 1.11–1.35, $P < 0.001$), alcohol use (odds ratio 1.43, 95% CI 1.23–1.68, $P < 0.001$) and illicit substance use (odds ratio 1.86, 95% CI 1.68–2.07, $P < 0.001$). Furthermore, the proportion of EIP patients with overall good health was significantly higher in the third round compared with the first (odds ratio 4.65, 95% CI 3.32–6.52, $P < 0.001$), although this remained the minority (10.3%). Also, EIP patients in 2019 were significantly less likely than those in 2014 to be in good health for the BMI measure (odds ratio 0.69, 95% CI 0.60–0.79, $P < 0.001$).

Discussion

This study corroborates previous findings that the physical health of people with psychosis remains poor, despite an improvement in physical health screening and intervention following national initiatives implemented in England since 2014.²⁴

Both CMHT and EIP audits showed improvements in health according to some of these measures, and deteriorations in others. The proportion of patients in overall good health according to a composite measure was low across all rounds of both audits, but did improve significantly post-2014 for those patients receiving care from EIP services.

Unhealthy weight remains a particular area of concern, with large proportions of patients in poor health according to BMI across all rounds of both audits, and a significant deterioration over time in the EIP audit. This supports existing evidence that weight management is challenging for patients with psychotic disorders.^{29,30}

We did find some evidence of a modest improvement in rates of smoking amongst patients under the care of EIP services post-2014. This contradicts recent studies where results have been more pessimistic,^{25,31} but would be in line with previous research suggesting a change in the epidemiology of smoking, with a gradual reduction in smoking in younger age groups.³² This improvement over time was not reflected in the CMHT audit, where patients were on average significantly older.

There was also a marked reduction post-2014 in the proportion of patients under the care of EIP services who were using illicit substances. This contrasted with the CMHT audit where the proportion increased slightly over time.

Strengths and limitations

Data were obtained from large, heterogenous samples over a 9-year period: all NHS Trusts in England with CMHT and EIP services that provided care to patients with psychotic disorders were invited to participate in the respective audits. These data therefore represent a variety of different settings, and we would expect that results would be generalisable to similar patient groups across the country. The primary outcome measures we used to assess physical health are universally recognised as clinically important, and the thresholds for good health were based on national standards that have been widely used elsewhere.^{33–35}

However, this study does have important limitations. First, this is an observational study and we do not know what caused the changes we observed. Although they may reflect changes in services during this period, other changes in society are affecting population health,³⁶ and these could be responsible for some or all the differences we detected.

The EIP and CMHT audits were conducted at different times, both before and after the CQUIN framework was implemented, and used different selection criteria. Differences in the physical health of patients between the two are therefore likely to reflect the differing clinical and socioeconomic demographic characteristics of the patients in each audit, as well as different processes of care. We were able to examine changes in physical health over time within each audit, by comparing different rounds. However, as each service provided a random sample of eligible patients at each round, subsequent rounds of the same audit did not necessarily include the same cohort, and so we are unable to make inferences about changes in health at the level of individual patients even within the same audit.

For both the EIP and CMHT audits, we were able to examine physical health measures before and after the introduction of the Commissioning for Quality and Innovation programme.²² Although the introduction of the programme was associated with a marked increase in the proportion of patients who were offered interventions for their physical health,²⁴ we found only limited evidence that this resulted in changes to the health of people under the care of CMHTs.

These data were produced from retrospective case note audits at each round, and are therefore dependant on accurate reporting and documentation of events at the time of occurrence. Clinicians working in CMHTs and EIP services may not have had full access to records held by primary care, where some physical health screening may have occurred.

Also, there were variable amounts of missing data for each primary outcome measure, meaning that the composite measure could only be used for a relatively small proportion of the overall sample. However, the proportion of missing data did generally improve over subsequent rounds of each audit, possibly reflecting the previously noted incentivised improvements in screening rates and recording.²⁴

Implications

We found some evidence that overall health improved for patients with psychotic disorders under the care of EIP services between 2014 and 2019. However, we did not find evidence of a similar improvement for patients under the care of CMHTs between 2011 and 2017.

This may reflect differences in the model of care implemented by EIP services. Typically, these services advocate a more 'intensive' programme of intervention, with a focus on relatively smaller case-loads, proactive engagement and an increased frequency of contact.³⁵⁻³⁹ Although this approach is primarily intended to address psychiatric symptoms, multiple sources have suggested additional benefits for patients' overall health, including increased levels of screening for physical health problems.⁴⁰ EIP services may, therefore, have been better placed to implement changes resulting from the national initiatives rolled out in 2014.

However, the difference may also be because of differences in demographic and clinical characteristics between patients in the CMHT audit and the EIP audit. Patients in the EIP audit were younger on average, and were also likely to have had a shorter duration of psychiatric symptoms (as this audit specifically examined patients with a diagnosed 'first episode' of a psychotic disorder). These patients may have been more accepting of interventions intended to improve their physical health and, therefore, have seen greater improvements – even if CMHTs and EIP services had implemented identical changes since 2014.

It may even be the case that people in younger age groups have become more 'health conscious' in recent years regardless of any intervention, as suggested by some epidemiological studies.³² However, this seems unlikely in these cohorts in light of previous findings that patients on EIP case-loads already had pronounced cardiovascular risk factors, even at the point of first presentation.²⁵

Both audits identified some isolated areas of improvement in specific measures. Interestingly, these differed between the patients in the CMHT audit, where there were improvements related to alcohol use, serum glucose level and lipids, and the EIP audit, where there were improvements in alcohol use, smoking and illicit substance use. Again, these changes may relate to demographic differences in the patients under the care of these respective services. Older patients may be more receptive to those that they perceive as reducing their risk of major cardiovascular events, such as reduction in serum glucose and lipids.

However, these varying improvements may also be because of differences in the treatment approaches adopted by CMHTs and EIP services. These findings merit further research to identify the factors explaining these variations, as well as the improvement in overall good health seen among those treated by EIP services. There may be elements

where each service outperforms the other; for example, access to staff with training in physical health interventions, or improved links with primary care. Cohort or case-control studies could be used within CMHTs and EIP services to examine what interventions are associated with favourable physical health outcomes at an individual patient level. Qualitative studies to explore the perspectives of patients with psychosis may also identify effective strategies for improving patients' physical health. It may also be of interest to include other services, such as assertive outreach teams, in future studies.

The fact that the EIP audit showed an improvement in rates of illicit substance use over time, but the CMHT audit showed the opposite, is an intriguing finding and of unclear significance. It does not seem to reflect the current understanding of the changing epidemiology of illicit substance use,⁴¹ and suggests that EIP services have been able to implement effective measures to support people in abstaining from illicit substances.

Interestingly, the one measure where both CMHTs and EIP services improved over time was alcohol use. Many drug and alcohol services in the UK are now provided by third-sector organisations rather than NHS mental health teams.^{42,43} The fact that both CMHTs and EIP services were able to effect improvement suggests that effective liaison with external organisations may be a key strategy for improvement, rather than attempting to deliver more services with internal infrastructure, which may already be overstretched.

Both audits showed specific areas where standards of physical health worsened over time. The findings related to patients' weight are particularly concerning: the proportion of patients with a healthy BMI fell significantly across the three rounds of the EIP audit, and was universally low in the CMHT audit. Weight gain is a well-recognised and particular troubling side-effect of many antipsychotic medications.¹⁷ Given the implications of obesity for subjective well-being, medication adherence and therapeutic outcomes in the context of treatment for psychosis, and associated diabetes and cardiovascular risk and likelihood of premature mortality,⁴⁴⁻⁴⁶ improving interventions in this area needs to remain a focus for researchers. To date, studies of current weight management programmes for people with psychosis have produced mixed results.⁴⁷⁻⁴⁹

In addition to these findings, it is also important to note that the majority of patients did not have adequate information recorded for all seven of the physical health measures recommended by nationally agreed standards. Only around half of patients in the EIP audit, and a third of those in the CMHT audit, had usable data recorded for all seven measures. The reasons for this are unclear from this project, and may reflect barriers to physical health screening, such as refusal, lack of provision or inadequate documentation. Clearly, accurate monitoring is required, and will be the focus of quality improvement activities before future rounds of the national audits.

In conclusion, we found limited evidence that overall health improved for patients with psychotic disorders under the care of CMHTs, following the enactment of national initiatives in 2014, although there was some evidence of improvement in specific areas. There was more substantial evidence of improvements for those patients under the care of EIP services. This may be a result of differences in CMHT and EIP services' abilities to implement effective changes in policy and procedures, or demographic and clinical differences in their respective patients. However, these findings merit further research into the processes underlying the improvements in health, to improve the standard of care for people with psychosis.

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Data availability

All authors had access to the full study data-set. The data-set is held by the NCAP team at the College Centre for Quality Improvement, Royal College of Psychiatrists, and could be made available on request.

M.J.C. formulated the presented research question, designed the study and supervised the work. R.W. and S.N. performed the statistical analysis. R.W. drafted the manuscript and designed the figures. B.T., E.W., A.Q., V.G., P.F. and J.S. were involved in gathering and processing the NCAP data, and commented on drafts of the manuscript.

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Declaration of interest

None.

pmc ‘Nature is the future’ reads the design on Elli’s sweatshirt, and yet there is nothing natural about Elli or what lies ahead for her. Elli is an android robot, designed to closely resemble a certain 10-year-old girl, who lives with her ‘Papa’ – a man whose real daughter went missing 10 years earlier. Papa keeps Elli in his home as a daughter and sexual companion, and together they reminisce on times when she was alive. So goes the premise of *The Trouble with Being Born*, directed by emerging Austrian filmmaker Sandra Wollner.

Controversial for obvious reasons, the film was withdrawn from the 2020 Melbourne International Film Festival when two forensic psychologists publicly expressed their opposition to its inclusion in the programme. They cited concerns about the film’s alleged normalisation of sexual interest in children and its possible exploitation by paedophilic audiences, reigniting a national debate about film censorship. Certainly, the film is ethically challenging and difficult to watch at times, but it has much to offer artistically and psychologically.

The Trouble with Being Born is a masterful study of trauma, grief, memory, loneliness and the nature of human (and non-human) relationships. Breathtaking in its complexity and vision, the film explores its disturbing subject matter in a detached (perhaps dissociative) formalistic style, reminiscent of Michael Haneke, Wollner’s older compatriot. Far from endorsing the perverse relationship between father/adult and daughter/child, the film is a techno-dystopian parable, warning its audience of the egregious consequences of humanity’s attempts to technologically circumvent and transcend the terrible but ordinary vicissitudes of life.

The story pivots when Elli gets lost in the forest surrounding her house and is discovered by a man who gifts her to his elderly mother, Mrs Schikowa. Elli is re-programmed to be Emil – a likeness of Schikowa’s brother, who died 60 years earlier. Triggered by reminders of his previous life as Elli, Emil’s identity and memory become entangled with Elli’s and he becomes increasingly unpredictable, leading us to the film’s tragic climax.

Elli and Emil are two ghosts in a machine who haunt the people they left behind, and their unnatural resurrection leads to unnatural consequences. Both Papa and Schikowa are trapped in their grief and guilt – Papa will not confront his loss and keeps himself frozen in the moment of his daughter’s disappearance and Schikowa foolishly revisits and attempts to repair her childhood experiences with Emil. Despite its futurism, *The Trouble with Being Born* bears a sense of the archetypal in its exploration of primal anxieties around death, incest and aloneness.

The storytelling in this film is not straightforward and the audience is not left with an answer to the existential question implied by the film’s title. Yet the crafted confusion of past and present, and the moral morass we are offered in this film, are signs of Wollner’s penetrating insight into the disorder and ambiguity of human nature and experience.

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1.1.54 List of reviewers 2021

date

2022-06

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pmc On behalf of the editorial board, the Editor-in-Chief would like to thank the following for their contribution as peer reviewers in the period from January 2021 – December 2021. Their anonymous work for the journal forms the foundation to its success, and is highly appreciated.

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1.1.55 Michael King, MD, PhD, FRCP, FRCGP, FRCPsych

Helen Killaspy Email: h.killaspy@ucl.ac.uk

date

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- *Michael King, MD, PhD, FRCP, FRCGP, FRCPsych*

pmc Formerly Professor of Psychiatry, University College London, and Director of the Division of Psychiatry, University College London, UK

Professor Michael King, who died on 10 September 2021 aged 71, made numerous important contributions in primary care psychiatry, including risk prediction and the evaluation of complex interventions for mental disorders. However, his research interests went much further than this. Always curious and with an insatiable intellectual appetite, he was an academic polymath, often drawing on approaches from other fields and applying them to psychiatric research. He was particularly fascinated by subjects that were difficult to study, such as improving mental health at the end of life for people with cancer, the role of spiritual beliefs in mental well-being, and the mental health and stigma experienced by people from sexual minorities. Michael was a brilliant methodologist and a prolific researcher, producing almost 800 peer-reviewed publications, attracting over £45 million in grant income and supervising 30 PhD students over the course of his career. He was also tremendously generous and effective in supporting the development of junior clinical and non-clinical academics, many of whom are leaders in their fields today.

Michael believed that visibility was key in addressing homophobia in society and, as an out gay man, he was also a courageous advocate for the rights of LGBT people, drawing on the scientific evidence to make his case. In the 1990s he was instrumental in changing how the cause of death was recorded for victims of AIDS, to mitigate the associated stigma without compromising the collection of accurate statistics. His research into male victims of sexual violence influenced the current legal definition of male rape. He was often called as an expert witness in cases of child custody involving lesbian and gay parents. He also gave expert evidence to the Church of England Synod on same-sex marriage and the ordination of LGBT ministers. In 2001, with Annie Bartlett, he co-founded the Royal College of Psychiatrists' LGBT special interest group (now the Rainbow SIG). Michael contributed hugely to the work of this group, presenting at numerous conferences and providing wise counsel to the College on relevant, often contentious, matters of policy. He was able to remain calm, even when seriously provoked, always presenting his arguments in an empathic, open and assured way. At the time of his death, he remained the foremost expert in LGB mental health in the UK and an international leader in this area. He also weathered a number of attacks on his reputation as a consequence of his courage in speaking up for sexual minorities. Although he was not someone who sought accolades or prizes, he was honoured to be invited to give the prestigious Beattie Smith lecture at the University of Melbourne in 2017, in recognition of his immense contribution to this field.

Michael was one of two brothers born in Christchurch, New Zealand on 10 February 1950, to Bruce, a farmer, and Patricia King. He completed his medical studies at the University of Auckland in 1976 before moving to the UK to train in family practice. In 1981 he began his training in psychiatry at the Maudsley Hospital, remaining firmly

invested not just in psychiatry but in medicine and primary care throughout his career. He was awarded Membership and Fellowship of the medical Royal Colleges of all three specialties. He trained in psychiatric epidemiology at the General Practice Research Unit of the Institute of Psychiatry and gained both an MD (University of Auckland 1986) and PhD (University of London 1989) prior to his appointment as senior lecturer in the Department of Academic Psychiatry at the Royal Free Hospital School of Medicine in London. He became the Head of Department in 1995 while he was still only a Reader and, under his energetic and inspiring leadership, the Department rapidly expanded. Later, when the Medical School became part of University College London (UCL), he became Director of the UCL Division of Psychiatry, a role he retained until 2014.

As an adult, Michael learnt Spanish, French and German and developed a number of long-standing international collaborations, particularly in South America, Europe, India and Australasia. He was also an excellent clinician, setting up the psychosexual service at Camden and Islington NHS Foundation Trust for which he was the consultant psychiatrist for 30 years.

Michael met his life partner, Professor Irwin Nazareth, in 1984 at the Gay Medical Association. They celebrated their civil partnership in 2006 and married in 2017. In 2019 he contracted a rare non-tuberculous mycobacterium (NTM) infection, later found to be connected to the extremely rare lung condition pleuroparenchymal fibroelastosis, from which he died. As was typical of his approach to life, finding that no patient support group existed, he established one, NTM Patient Care UK (www.ntmpatientcare.uk). Michael is survived by Irwin, two nieces and a nephew. He is very much missed by his family and by his many friends and colleagues across the world.

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pmc Nice White Parents is a podcast series about an ordinary middle school in New York.¹ It charts how, over the school's 50-year history, White parents have consistently, and almost always unwittingly, exercised their enormous unsaid power in the public education system to directly and indirectly hamper the school's mission of providing a progressive and integrated education to children of all racial and socioeconomic backgrounds.

One of the most striking messages from the series is how White parents have been able to game all aspects of the education system and hoard resources for their own children. The White parents covered in the series had more time, influence and resources, and were therefore much better equipped to navigate the system and advocate for their children than Black and minority ethnic parents in the same city. Although the White parents were making seemingly justifiable and rational decisions, the collective impact of their decisions has been to perpetuate long-standing racial inequalities that go back several decades.

Listening to this podcast series, it was hard not to draw parallels with what I see as a clinician in the UK's National Health Service (NHS). Some scenarios that I encounter regularly bear an uncanny resemblance to it, such as parents ferociously seeking referrals to multiple agencies and specialists to get diagnoses for their children by lobbying multiple doctors and seeking second opinions. Other scenarios are less directly analogous, but nonetheless relate to power dynamics and individuals' ability to navigate a complex system – wealthy professionals seeking NHS referrals on the basis of private medical reports, and individuals demanding specific investigations or treatments on the basis of informal conversations with medical family members or friends.

The nature of a publicly funded system, whether it is health or education or any other sector, is that every decision needs to be seen through two lenses – at the individual and the population levels. The traditional medical paradigm, and more specifically recent movements such as patient-centred care, encourage us to favour the individual lens. The danger of this, as we are seeing very powerfully in 2021 with the COVID-19 pandemic, is that it ignores the vulnerable, the less powerful and the voices that cannot shout as loud. Resources are inevitably finite and so each decision we take about one individual or one family can have very real and profound repercussions for many others.

Of course, not all White patients are manipulative, and not all manipulation is by White patients. But as the podcast series points out, nobody talks about White parents, and likewise in medicine, we rarely talk about White patients. Just like the ‘nice White parents’ in New York, my White patients are not acting maliciously and they are not fundamentally against the NHS values of compassion and equality. The problem is rather that they are rarely cognisant of their power and, more importantly, the system simply works better for those who can game it.

As we seek to achieve greater equity in healthcare, is it time we talked more about White patients?

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1.1.56 Mental Capacity Legislation edited by Rebecca Jacob, James Gunn, and Anthony Holland, Second Edition, RCPsych/Cambridge University Press, June 2019, Hardback, ISBN 9781108480369, £29.99 — CORRIGENDUM

Martin Curtice

date

2022-06

Contents

- *Mental Capacity Legislation edited by Rebecca Jacob, James Gunn, and Anthony Holland, Second Edition, RCPsych/Cambridge University Press, June 2019, Hardback, ISBN 9781108480369, £29.99 — CORRIGENDUM*

pmc This book review has an error in the title: *Mental Capacity Legislation* was in fact edited by Rebecca Jacob, Michael Gunn and Anthony Holland. We apologise for the error.

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1.1.57 Characteristics of global retractions of schizophrenia-related publications: A bibliometric analysis

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2022-8-01

Abstract

Objectives

The growing rate of retraction of scientific publications has attracted much attention within the academic community, but there is little knowledge about the nature of such retractions in schizophrenia-related research. This study aimed to analyze the characteristics of retractions of schizophrenia-related publications.

Materials and methods

The Web of Science was searched for eligible studies. A bibliometric analysis was conducted to describe the characteristics of the retractions using R software and Excel 2019. Content analysis was conducted to examine the essential components of retraction notices.

Results

A total of 36 retracted publications with 415 citations were identified from 1997 to 2021, of which, 83.3% occurred in the last decade. The overall retraction rate was 0.19%, with most of them (29; 80.56%) from the United Kingdom. The retractions were published in 33 journals, and the 2020 IFs ranged between 0.17 and 49.96 (Median = 3.93). The retractions involved 21 research areas, particularly in Psychiatry (19; 52.78%), Neurosciences and Neurology (10; 27.78%), and Psychology (7; 19.44%). Data issues (17; 42.22%), administrative errors of the publishers (5; 13.89%), and study design (4; 11.11%) were the top three reasons for retractions.

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Conclusion

This study provides an insight into retractions of schizophrenia-related publications. Institutional governance should be further strengthened to improve the scrutiny of publications, prevent continuing citations, and erroneous propagation after retraction.

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Introduction

Retraction of peer-reviewed scientific publications is becoming more common. The growing rate of retractions with the increasing scientific publications in recent years has attracted much attention. Numerous reasons for retractions include concerns about data quality, and research misconduct, such as redundant publication, plagiarism, copyright infringement, unethical research, and peer review manipulation (1). The main objectives of retraction are to ensure research integrity rather than to punish authors, and to alert the academic community that these publications' findings are not credible and should not be cited (2, 3). In the process of creating innovations, research outputs play a vital role as an important medium for information communication and presentation of findings. The filtering of these publications deserves attention, as the risk of disseminating inaccurate information and results of poor-quality research increases with the rapid expansion of ongoing research (4). For instance, to date, 196 articles related to COVID-19 have been retracted due to various reasons (5). If research articles are fraudulent, they could lead to catastrophic consequences on human health. In 1998, Dr. Andrew Wakefield and his colleagues unethically conducted research on children and concluded that there was a link between measles, mumps, rubella (MMR) vaccine and autism; consequently, thousands of parents refused MMR vaccines for their children which caused an outbreak of fatal measles (6). This misinformation continued to spread for at least 12 years, which had an immeasurable health impact on families with children with autism and also resulted in a huge financial cost to verify the accuracy of this finding (6). Another paper that was retracted from *The Lancet* due to doubtful data authenticity (7), claimed that hydroxychloroquine was ineffective in treating COVID-19 and even caused arrhythmias, which provoked a strong reaction in the scientific community and the public (8).

The retraction rate of scientific publications across many fields has been increasing in recent years. One study found a retraction rate of 0.38 per 10,000 publications in all fields in 1985, 2.03 in 2000, and 5.95 in 2014 (9), while another study found an average rate of 2.5 per 10,000 between 2013 and 2016 in all fields (10). A recent report found that the

retraction rate has increased 10 times in veterinary medicine and animal health publications during the period between 1993 and 2019 (11). The trends of retractions varied by publication year (9) and research field (12, 13). The most common reason for retraction is academic misconduct, such as fraud or suspected fraud, duplicate publications, and plagiarism (13, 14).

Previous studies have reviewed the retracted literature in different specialties of medical fields, such as nursing and midwifery (15), neurosurgery (16), hematology (13), and anesthesiology (1). However, few studies have focused on the mental health literature (17). Schizophrenia is a severe mental disorder characterized by disturbances in perceived reality and behavior, such as persistent delusions, hallucinations, disorganized thinking, negative symptoms, and cognitive impairment (18–20). Approximately 1 in 300 people are affected worldwide, and its global disease burden has increased 11.4% from 1990 to 2019 (21, 22). Beyond the disease itself, relevant stigma and violations of human rights associated with schizophrenia can have a significant impact on the individual's family, work, and social function (23–25). Additionally, schizophrenia patients have a shorter life expectancy when compared to the general population (18). Due to these features, schizophrenia is one of the most important areas of research in psychiatry and medicine.

A bibliometric analysis showed that the research on schizophrenia has been increasing in recent years, involving a wide range of research areas, including Psychiatry (69.8%), Neurosciences (20.7%), Clinical Neurology (12.4%), Pharmacology and Pharmacy (9.6%), and Genetics/Hereditry (3.4%) (26). Schizophrenia related research has mainly focused on epidemiology, etiology, and treatment aspects, but the findings remained variable and at times controversial (18). Ensuring academic rigor is important for the medical advancement in schizophrenia and other fields of medicine. False research results could mislead the academic community or drive researchers in wrong directions, leading to much wasted research resources and negative impact on patient care and recovery (27, 28). Timely retraction is an important measure to prevent erroneous findings from being propagated. However, the nature of retractions in schizophrenia-related publications is unknown.

Bibliometric analysis has been widely used to examine the research trends in a specific field. Compared with traditional descriptive reviews of the literature, it is based on two components: one is the performance analysis that can provide the general characteristics of relevant publications, such as the number of publications, publication years, authors, institutions, countries, and journals; the other is science mapping, which examines and visualizes the relationships between research constituents such as co-citation analysis, bibliographic coupling, co-word and co-authorship analyses. In recent years, bibliometric analysis has been used to explore the characteristics of retractions in academic fields such as rehabilitation (29) and oncology (12). However, to the best of our knowledge, no bibliometric analysis on schizophrenia-related publication retractions has been published. As such, we performed a bibliometric analysis and content analysis of the characteristics of retracted publications on this topic, including publication years, sources, research areas, citations, and reasons for retractions.

Materials and methods

The retracted publications on schizophrenia-related studies were searched from the Web of Science Core Collection in the database of the Web of Science (WoS). The search term was “TI/AB = *Schizophrenia OR Schizophrenias OR Schizoaffective OR Schizophreniform OR Psychosis OR Psychotic OR Schizophrenic Disorders OR Disorder, Schizophrenic OR Disorders, Schizophrenic OR Schizophrenic Disorder OR Schizophrenic Disorders OR Dementia Praecox OR Schizoaffective disorder OR Psychotic Disorders.*” The article type was limited into “*Retracted Publications and Retractions.*” A comprehensive screening procedure was conducted manually to avoid false positive or negative results.

The R software and Excel 2019 were used to summarize the characteristics of retractions, including the published year, countries, journals, and research areas. The Journal Impact Factor (IF) in 2020 was used for impact analysis of the journals. Given the rapid growth of journal impact factors, a 5-year IF was used to describe the impact of journals, as it is more stable compared to Immediacy IF. Furthermore, an IF without journal self-citation was used to reduce the potential inflation of IF because self-citation of journals could result in a higher IF value (30). In addition, content analysis was used to examine the reasons for retraction by reviewing the retraction notices. To analyze the transparency of retraction notices, this study included the following four essential components as previously recommended (3): initiators, cause, whether there was consensus between editors and authors on the retraction decisions, and whether retractions were related to the post-publication review (such as comments on PubPeer).

Results

A total of 19,176 publications on schizophrenia-related publications were searched in WoS from its inception to the search date (20/03/2022). Forty retractions were found after limiting the study types, four articles were discarded due to irrelevant topics or duplications in the process of data cleaning. Thirty-six publications from 1997 to 2021 were finally included in this study; of all the retractions, 83.3% ($N = 30$) occurred in the last decade. The overall retraction rate was 0.19%, and the years of retraction were between 2002 and 2021. The distribution of publication year, retraction year and annual citations are presented in *Figure 1*. The delay between publication and retraction time (year) ranged from 0 to 10 years with an average of 1.89 years (standard deviation = 2.22 years). The total citations of the 36 retracted publications were 415, with the most citations arising from a single publication (151) (31). The citations of the 36 retractions during the recent ten years accounted for 49.9% (207) of the total citations. *Figure 2* presents the distribution of research areas of the retracted publications. The top three included Psychiatry (19, 52.78%), Neurosciences and Neurology (10, 27.78%), and Psychology (7, 19.44%).

The retracted publications were from 15 countries or regions. *Table 1* shows the top five countries where the publications originated, including the United Kingdom (29; 80.56%), the United States (8; 22.22%), China (8; 22.22%), Canada (7; 19.44%), and Germany (7; 19.44%). *Table 2* shows that the 36 retractions were published in 33 different journals. The IFs of the journals (in 2020) ranged between 0.17 and 49.96, with a median of 3.93. The Journal of Developmental and Behavioral Pediatrics ($IF = 2.22$), Journal of ECT ($IF = 3.63$), and Psychiatry and Clinical Neurosciences ($IF = 5.12$) each retracted two publications, respectively. A total of 17 journals (47.2%) were related to Psychology and Psychiatry.

Countries/regions with retractions of schizophrenia-related studies.

Region	<i>N</i>	% ^a
The United Kingdom	29	80.56
The United States	8	22.22
China	8	22.22
Canada	7	19.44
Germany	7	19.44
Portugal	5	13.89
Spain	5	13.89
Iran	3	8.33
Japan	3	8.33
Sweden	3	8.33
India	2	5.56
Ireland	2	5.56
Armenia	1	2.78
Netherlands	1	2.78
Switzerland	1	2.78

N, number.

^aSome publications involved more than one country; therefore, the total percentages were more than 100%.

Journals with retracted publications on schizophrenia-related studies.

Journal	<i>N</i>	IF (2020)	IF (5 years)	IF without self-citations
Psychiatry and Clinical Neurosciences	2	5.19	4.80	4.92
Journal of ECT	2	3.64	3.01	3.29
Journal of Developmental and Behavioral Pediatrics	2	2.23	3.23	2.14
Nature	1	49.96	54.64	49.32
American Journal of Psychiatry	1	18.11	17.83	17.53

continues on next page

Table 1 – continued from previous page

Journal	N	IF (2020)	IF (5 years)	IF without self-citations
National Science Review	1	17.28	17.58	16.65
American Journal of Gastroenterology	1	10.86	12.59	10.43
British Journal of Psychiatry	1	9.31	10.24	9.10
Schizophrenia Bulletin	1	9.30	9.438	8.719
Alzheimer's Research & Therapy	1	6.98	8.08	6.65
Translational Psychiatry	1	6.22	7.097	5.995
Biological Psychiatry-Cognitive Neuroscience and Neuroimaging	1	6.20	4.55	–
International Journal of Neuropsychopharmacology	1	5.18	5.17	5.03
Journal of Psychiatric Research	1	4.79	5.38	4.69
Journal of Clinical Psychiatry	1	4.38	5.40	4.15
Scientific Reports	1	4.38	5.13	4.17
Journal of Ethnopharmacology	1	4.36	4.49	3.97
British Journal of Clinical Psychology	1	4.13	4.33	3.93
Annals of Translational Medicine	1	3.93	4.63	3.47
Clinical Neurophysiology	1	3.71	4.57	3.24
Psychiatry Research	1	3.22	3.405	3.123
BJPsych Open	1	3.20	3.45	3.04
European Journal of Clinical Pharmacology	1	2.95	3.27	2.81
Neuropsychiatric Disease and Treatment	1	2.57	3.20	2.49
International Journal of Clinical Practice	1	2.50	2.726	2.404
Neuropsychobiology	1	2.33	2.30	2.31
New Genetics and Society	1	2.18	2.26	1.57
General Psychiatry	1	2.00	–	–
Human Psychopharmacology-Clinical and Experimental	1	1.67	2.81	1.61
Language and Speech	1	1.50	1.68	1.41
Clinical Linguistics & Phonetics	1	1.35	1.65	0.90
Actas Espanolas De Psiquiatria	1	1.20	2.07	1.13
Sante Mentale Au Quebec	1	0.17	0.24	–

IF, impact factor; “–”, not reported in Web of Science.

Supplementary Table 1 shows the characteristics of the retractions. All the 36 retraction notices reported the reasons for the retraction. In sum, nine (25.0%) retraction notices did not report who were the initiators, 24 (66.7%) did not report whether there was consensus between editors and authors on the retraction decisions, and 28 (77.8%) did not report whether retractions were related to the post-publication review. *Table 3* lists the reasons for retraction as indicated by relevant journals, which include eight categories: data issues (17; 42.22%), administrative errors of the publisher (5; 13.89%), copyright (3; 8.33%), plagiarism (2; 5.56%), redundant publications (2; 5.56%), study design issues (4; 11.11%), ethical issues (1; 2.78%), and others (1, 2.78%). Based on the classification of reasons for paper retraction outlined by the Committee on Publication Ethics (COPE) (2), 11 (30.56%) out of the 36 retracted publications were due to honest errors, including occasional errors made in the original database or experimental data (7; 19.44%) and improper data manipulation (4; 11.11%).

Reasons for retracted publications on schizophrenia-related studies.

Reason	Type	N	%
Data issues (17, 47.22%)	Honest error (Data error)	11	30.56
	Misconduct (Suspicious fabrication)	2	5.56
	Invalid data	3	8.33
	Unreplicable results	1	2.78
	No original data	1	2.78
Administrative errors of publisher	–	5	13.89
Study design (4, 11.11%)	Inconsistency with original study design	3	8.33
	Unclear methodology	1	2.78
Copyright	Material or data used without authorization	3	8.33
Plagiarism	–	2	5.56
Redundant publication	–	2	5.56
Ethic issue	No ethical approval	1	2.78
Others	No permission to publish by the author	1	2.78

Discussion

This is the first bibliometric study on retractions of schizophrenia-related publications. We identified 36 retractions among 19,176 publications on schizophrenia-related studies. The overall retraction rate was relatively lower (0.19%) compared with other fields such as neurosurgery (7.3%) (16). Three-quarters of retractions occurred during the past decade (2011–2021), a trend similar to the retractions in the obstetrics literature where 76% of retractions occurred in the recent decade (2009–2019) (27). This is likely to be related to the overall growing number of academic publications, which may lead to increased academic errors. Additionally, publishers have promoted the awareness of scrutiny of publications (29). Academic misconduct has become a priority in the review procedure for many journals. Currently, many guidelines to standardize the process of retractions are available; of them, the most authoritative guidelines were issued by the COPE (2). The number of retractions has grown since the COPE guidelines were published in 2009 (29). Our analysis revealed that the average gap between publication and retraction time was 1.89 years, which is shorter than the retractions in other fields such as nursing and midwifery (2.3 years) (15) and life science research (3.8 years) (9). A longer delay in retraction may be associated with a more negative academic impact. The erroneous research findings may mislead other researchers, resulting in a waste of time, effort, and resources, and may even harm research participants (27). The high citations of retracted publications suggest that these retractions continued to have a certain impact on the schizophrenia research field as some were still cited even after retraction. Thus, a prompt retraction process is needed and clear signs and labels, such as attaching a clear watermark to the retraction (32), may be helpful in preventing further citations of retracted publications.

The retracted publications identified in this study involved 21 research areas; however, it should be noted that one retracted article may involve more than one research area. More than half of the retractions were classified in the field of Psychiatry (52.78%). The retractions also involved some experiment-based research areas such as Neurosciences, Neurology, Pharmacology, Pharmacy, and Behavioral Sciences. A previous study (29) found that publications based on basic experiments were more likely to be retracted for academic misconduct. Certain countries such as the United Kingdom, United States, China, Canada, and Germany were associated with the most retractions. However, these countries also contributed to the most publications in schizophrenia-related research; the United States contributed the most publications, followed by the United Kingdom, Germany, China, and Canada (26). Most retractions were published in journals related to Psychology/Psychiatry, such as the American Journal of Psychiatry, British Journal of Psychiatry, and Schizophrenia Bulletin. Given the small number of retractions per journal, we could not examine the correlation between the number of retractions and the impact factor of the journals involved. Previous studies on the relationship between retraction rate and journal impact factor found mixed results including positive (33), negative (15), and also non-significant associations (13).

This study analyzed all the retraction notices comprehensively to understand the degree of transparency of retractions. Incomplete information regarding the retraction notices will prevent any assessment of their historical and academic significance, while inadequate information can mislead or distort the readers and provide a biased view (34). Thus, promoting the transparency of the retraction notices is vital to maintain the scientific integrity by acting as a warning or

discontinuation measure (35). Although the COPE released a guideline to formalize retraction notices, there has been little or no change to improve the transparency (3). In our study, although the reasons for schizophrenia-related retractions were reported, the other three essential components (e.g., initiators, whether there is consensus between editors and authors on the retraction decision, and whether retractions are related to the post-publication review) were mostly lacking. Possible reasons may include stigma (e.g., fear of reputational damage or legal responsibility), inconsistent requirements regarding the retraction notices between journals (34) and difficulties in implementation. Thus, reform in reporting retractions can encourage authors and publishers to explain the issues clearly and standardize the information provided among journals.

Overall, 86% of retractions of schizophrenia-related studies were attributed to author-related reasons. The most common reason was data issues, of which 64.7% were honest errors. For example, one paper published in *Nature* (111 citations) entitled “Microglia-dependent synapse loss in type I interferon-mediated lupus” was retracted due to the non-replicable results in the follow-up experiments (36). Another highly-cited paper entitled “Expression of Oct-6, a POUIII domain transcription factor, in schizophrenia” suggested that Oct-6 may be a marker of the neuropathology associated with schizophrenia (37). The data was suspected of being fraudulent; thus, the authenticity of this finding was in doubt. Other studies were retracted due to incomplete data (38), lack of original data (39), or errors in data processing that led to biased conclusions (40). These findings highlight the importance of data accuracy, integrity, and data double-checking.

In contrast, 13.89% of the retractions were due to journal or publisher reasons, such as administrative errors, suggesting publishers should enhance their measures to avoid such errors (16). Three retractions were due to inconsistencies between the contents or research methods and the original study design (41–43). For example, Ninomiya et al. (41) examined the long-term efficacy and safety of blonanserin for first-episode schizophrenia, which was retracted as subjects did not satisfy the inclusion criteria. Incorrect or inappropriate research results could mislead researchers, the public, or even entrepreneurs, resulting in wasted research funds, selection of ineffective drug treatments, and unethical profit-making (4, 44). A study may be invalid or potentially harmful if it does not align with the content of the original study registration. All clinical trials need to be registered before implementation, such as in the International Clinical Trials Registry Platform (ICTRP) supported by the World Health Organization (45). The aim is to ensure adequate knowledge about the research, increase research transparency, and strengthen the validity and value of the scientific evidence base (45).

The lack of ethical governance is another reason for retractions. One paper from the *American Journal of Gastroenterology* with 151 citations was retracted 10 years after publication; one of the reasons was having no local ethics committee approval (31). Thus, authors, editors and publishers should strengthen the consideration and review of all submitted research information including appropriate ethical approvals. The range and frequency of retraction reasons varied between different academic fields. For example, in both dentistry and obstetrics, redundant publications, and plagiarism were the most common reasons (27, 46), while in the field of pharmacy, falsification, or data manipulation were the most frequent (47), which are in contrast to our findings in schizophrenia-related research. The development and application of Plagiarism Detection software, such as iThenticate and Turnitin (16, 46), may contribute considerably to preventing plagiarism issues. Previous studies have proposed the notion of a “publish or perish” culture to explain the research misconduct issues (1, 9, 48). Quantity and quality of publications are associated with academic ranking, promotion and reputation; further monetary incentives in research commonly occur in some institutions/countries (49). Personality traits combined with highly competitive pressures appear to drive some researchers to falsify or fabricate data (1). Moreover, one study in China found that the majority of survey respondents considered that the current academic assessment system contributes heavily to academic misconduct and needs to be reformed to create a healthy academic environment (50). This supports the importance of developing appropriate academic assessment criteria for researchers. We suggest that the publication of good-quality research is a collaborative effort between organizations, publishers, journals and authors to ensure transparency in reporting, prevent research misconduct and disclose any research limitations.

There are several limitations to this study. First, following relevant guidelines of bibliometric analysis (51) and previous studies (52–54), the WoS was used in the literature search. However, the possibility that some studies may be missed could not be excluded. Second, some retraction notices were conservative in stating the reasons for retraction and the information was limited. For instance, where the study results were not reproducible, it was unclear whether this was due to research misconduct or honest errors. Thus, the retraction notices should be standardized to improve transparency. Third, not all academic misconduct could be uncovered by publishers or readers, therefore retraction rates may well be

underestimated.

Conclusion

This study provides an insight into retractions of schizophrenia-related research. The distribution of the retractions varied across countries, journals, and research areas. The number of annual retractions has risen over the past decade with the implementation of existing retraction guidelines, and honest errors account for most retractions. Transparency in reporting retraction notices should be implemented. Researchers should employ measures to ensure the authenticity of their research data. Institutional governance needs to improve the scrutiny of publications and prevent continuing citations and erroneous propagation after retraction.

Data availability statement

The original contributions presented in this study are included in the article/*Supplementary material*, further inquiries can be directed to the corresponding authors.

Author contributions

PC and Y-TX: study design. PC, X-HL, ZS, YM, and Y-TX: data collection, analysis, and interpretation. PC, Y-LT, and Y-TX: drafting of the manuscript. CN: critical revision of the manuscript. All authors approval of the final version for publication.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Supplementary material

The Supplementary Material for this article can be found online at: <https://www.frontiersin.org/articles/10.3389/fpsy.2022.937330/full#supplementary-material>

[Click here for additional data file.](#)

1.1.58 Have You Seen the NEWS Today? - a QI Project

Harleen Kaur Birgi*Presenting author.

date

2022-06

Abstract**Aims**

The main focus of this QIP was to improve the documentation of NEWS (National early warning scores) and subsequent escalation as appropriate in an Old Age Psychiatric Ward setting. This would in turn lead to improved Physical health outcomes, especially in the COVID-19 pandemic.

Methods

The NEWS chart is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, when patients present to, or are being monitored in hospital. This will ensure that patients who are deteriorating, or at risk of deteriorating, will have a timely initial assessment. This should supplement clinical judgement in assessing the patient's condition.

Early detection and escalation of deteriorating NEWS leads to improved patient outcomes and referral to the appropriate specialties, for subsequent management.

The initial phase of the QIP comprised of retrospective data collection surrounding the recognition and documentation of NEWS on an 18-bedded Old age Psychiatric ward. This period spanned the 2nd wave of the pandemic, from November- December.

Potential interventions were implemented in the form of raising NEWS awareness by educating nursing staff via teaching sessions, displaying posters all over the ward and nursing station. Team also reviewed all NEWS charts everyday during ward management rounds which served as a daily reminder for the staff measuring the observations.

NEWS of & greater than 3 was defined as the threshold for escalation.

Following change implementation, data were collected to capture the progress made over a month.

Results

Analysis of data pre and post- interventions displayed a significant improvement in escalation of unwell patients from 26% to 60%.

Conclusion

Improved outcomes and early detection of potentially deteriorating patients, leading to early transfer of patients to an Acute Medical setting and better overall management.

Raised awareness and understanding of physical health management in Mental Health nurses.

The QIP was presented at the Trust QI Forum meeting and was met by an overwhelmingly positive response. In order to enhance NEWS recording an electronic format is now being adapted. There is also a consideration around providing regular NEWS teaching sessions to all inpatient staff across the trust.

Contents

- *Have You Seen the NEWS Today? - a QI Project*

pmc

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1.1.59 A Quality Improvement Project (QI) on Screening for Rapid Eye Movement Sleep Behaviour Disorder (RBD) in Patients Referred to Trafford Memory Assessment and Treatment Service (MATS), Part of Greater Manchester Mental Health Trust (GMMH)

Rachel Moir Ruth Pye-Jones Amit Sindhi Boben Benjamin*Presenting author.

date

2022-06

Abstract

Aims

Lewy Body Dementia (LBD) is predicted to be under-diagnosed in the general population. RBD is one of the four core clinical criteria for the diagnosis of LBD. Longitudinal studies of RBD show strong association with LBD, so there is potential for early identification of LBD and subsequent management. We aimed to screen 100% of patients referred to Trafford MATS for RBD.

Methods

We performed three Plan-Do-Study-Act (PDSA) cycles; in the first cycle we introduced a validated RBD screening question, from the DIAMOND-Lewy study, to the initial memory assessment proforma. This asked ‘Have you ever been told that you “act out your dreams” while sleeping (punched or flailed arms in the air, shouted or screamed)?’

In the second PDSA cycle, we delivered a RBD and LBD educational package to the specialist memory nurses who undertake the initial assessments. In the third PDSA cycle reminders were sent to the team to use the new assessment proforma.

We collated data from patients who had undergone an initial memory assessment between 06/04/21-22/06/21 from the trusts electronic database.

Results

Initial baseline data showed that 0% of initial assessments screened for RBD; at the end of PDSA one this was 100% and 75% at the end of PDSA two. This increased to 100% at the end of the last PDSA cycle. The main reason for non-completion of the screening question was use of the old proforma.

4/152 patients screened positive; patients were diagnosed with Alzheimer’s disease, delirium, vascular dementia and mixed Alzheimer’s disease and vascular dementia, respectively.

Conclusion

The introduction of a RBD screening question into the MATS initial assessment proforma improved screening for RBD. We think the variation in screening compliance rates was likely due to practitioners using old assessment proformas, hence sending reminders of the new proforma.

A limitation of the project was that some patients did not have a bed partner, which makes identification of the disorder more difficult.

Since the completion of the project, we have circulated a news bulletin through the Dementia United charity to raise awareness of our QI project nationally and also discussed the project with the Lewy Body society. Whilst our project has not yet identified a patient with LBD, we feel that introducing this screening question is a very easy and reproducible change to implement and RBD should be screened for in all memory patients.

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- *A Quality Improvement Project (QI) on Screening for Rapid Eye Movement Sleep Behaviour Disorder (RBD) in Patients Referred to Trafford Memory Assessment and Treatment Service (MATS), Part of Greater Manchester Mental Health Trust (GMMH)*

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1.1.60 Developing Inpatient Management Strategies for Behavioural and Psychological Symptoms of Dementia (DIMS-BPSD)

Jennifer Parker Ryan Beazley Stephen De Souza*Presenting author.

date

2022-06

Abstract

Aims

This project details the development of a Quality Improvement Project aiming to review and improve the management of behavioural and psychological symptoms of dementia (BPSD) on an old age psychiatry ward. BPSD refers to a constellation of non-cognitive symptoms and signs which arise in people with dementia, including disturbed perception, thought content, mood or behaviour. Examples include agitation, depression, apathy, repetitive questioning, psychosis, aggression, sleep problems, and socially inappropriate behaviours. BPSD arise in 5/6 of people with dementia over the course of their illness and are associated with a deterioration in cognition and progression in dementia plus secondary harms such as falls and hospitalisation. Pyrland Two ward is a mixed gender specialised organic old age psychiatry inpatient unit serving the county of Somerset. Most patients have a diagnosis of dementia, are being cared for using either MHA or MCA legislation and exhibit one or more BPSD. There was no structured or formalised approach to the management of BPSD at inception.

Methods

A point-in-time audit was conducted to produce baseline measurements of BPSD management on the ward, measured against NICE criteria. Plan-Do-Study-Act (PDSA) methodology was employed to incorporate incremental quality improvement interventions such as a ward-round checklist and staff education.

Results

Baseline: (n = 14) 4/14 formally diagnosed with BPSD. 6/14 were prescribed antipsychotic medications, of which 1/6 fully met NICE standards. 2/14 had structured assessment tools used. Results following introduction of improvement methods: (n = 8) 8/8 formally diagnosed with BPSD. 7/8 were prescribed antipsychotic medications, of which 4/7 fully met NICE standards. 7/8 had structured assessment tools used.

Conclusion

It was possible to see modest improvements in the ward-based management of BPSD using quality improvement methodology, including more favourable psychotropic prescribing. However, total patient numbers are small and further interventions, such as more PDSA cycles, may add value and encourage sustainability.

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- *Developing Inpatient Management Strategies for Behavioural and Psychological Symptoms of Dementia (DIMS-BPSD)*

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1.1.61 Training Non-Medical Staff for SARS-CoV-2 Swab Collection on a Psychiatric Old Age Ward

Joanna Legg Sophie Ouabbou Susan Hay*Presenting author.

date

2022-06

Abstract**Aims**

In the second half of 2020 patients admitted to Highgate Mental Health Centre had to isolate in their rooms until a negative SARS-CoV-2 test result was obtained. This was stressful for both patients, who were unwell in their mental state, and staff. Swabs for PCR testing were only being collected by junior doctors which meant that out of hours, this responsibility would fall exclusively upon the duty doctor. There were often significant delays to obtain a sample. We decided to train non-medical staff on an old age ward so that the responsibility of collecting samples could be shared with nurses and healthcare assistants.

Methods

In November 2020 we held one training session with several members of staff from our ward. In the following days we did one to one training sessions with the members of staff who, due to their shifts, were not available for the original training session. We excluded admissions that happened prior to SARS-CoV-2 being mandatory, those where the patient refused to be swabbed, and those patients who were transferred from another institution already with a pre-admission swab.

Results

There were 37 admissions, of which we included 30 based on the exclusion criteria. 17 admissions occurred prior to training and 13 after the training sessions. Prior to training, it took 1.059 days to obtain a sample and it took 0.846 days after the training sessions.

Conclusion

Providing a training session to enable nurses and healthcare assistants to take samples for SARS-CoV-2 testing reduced the amount of time between admission and obtaining a swab sample. We therefore shortened the first step of the process that leads to obtaining a negative result and enable a patient to come out of isolation.

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- *Training Non-Medical Staff for SARS-CoV-2 Swab Collection on a Psychiatric Old Age Ward*

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1.1.62 Improving Access and Confidence in Learning Lessons From Serious Incidents: A Quality Improvement Project Aimed at Junior Doctors

Cornelia Beyers Eleanor Parkinson Rajendra Harsh Sameer Nardeosingh Dolapo Oseji Alice Packham Nick Conway Renarta Rowe Ruth Scally Joshua Rochelle-Bates Onaiza Awais Farhaana Surti*Presenting author.

date

2022-06

Abstract

Aims

Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) previously developed some methods of learning lessons following serious incidents. However, despite various systems available, frontline junior doctors were not regularly exposed to important learning opportunities. This potentially resulted in doctors not being aware of learning from serious incidents, and not feeling embedded within the organisation, with potential effects on their training experience. As we identified an unmet need within the Trust in learning lessons from serious incidents amongst junior doctors, we aimed to improve access and confidence in learning from serious incidents by starting a Quality Improvement project on this theme.

Methods

The current approach involved a comprehensive quarterly bulletin circulated by email to staff. An initial survey confirmed that this was not very effective in delivering learning lessons information to junior doctors.

Using a QI driver diagram, we identified potential areas for change. Selected change ideas were sequentially trialled including shortened email bulletins, supervision templates and remote learning lessons sessions. Initial PDSAs highlighted difficulties with communication via email, with many trainees failing to read/engage with this format.

Results

The use of remote interactive learning sessions yielded positive results, with improvement in the confidence in learning from Serious incidents. We therefore continued to refine this method to wider groups.

During the COVID-19 pandemic we experienced multiple setbacks and created a timeline to support team morale, maintain team energy, visualise progress and motivate the team. We therefore managed to persevere and strengthened the group by recruiting members to the team and complete the project.

Conclusion

The team have been able to create a sustainable, effective and interactive short teaching session which has shown to be effective in engaging trainees in this vital area and help us meet our aim. This format further has the potential to be refined and implemented locally and nationally.

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- *Improving Access and Confidence in Learning Lessons From Serious Incidents: A Quality Improvement Project Aimed at Junior Doctors*

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1.1.63 Safety of Delivering Eating Disorders Day Treatment Programme on the Virtual Platform in (COVID-19) Pandemic

Adaora Obiekezie Claudia Friel Mohammad Tayeem Pathan*Presenting author.

date

2022-06

Abstract

Aims

Intensive treatment for eating disorders include day treatment programme and specialist inpatient. COVID-19 pandemic led to lockdown in the UK on the 23rd March 2020. Adult Eating Disorders Day Treatment Programme in Surrey started delivering their care on the virtual platform from that date. It offered a combination of ‘virtual’ only and ‘blended’ care (virtual and in person) for more than a year. This service evaluation examined the safety of delivering intensive eating disorders treatment on the virtual platform.

Methods

Data from March 2020 to March 2021 were retrospectively collected from Electronic patient record. Two clinicians collected the data on age, referral origin, accommodation, employment status, diagnosis (subtype), length of illness, comorbid mental and physical health diagnosis, duration of day care treatment, medication, admission weight and BMI, discharge weight and BMI, changes in bloods and ECG, acute hospital admission, risk-to-self events, admissions to Specialist Eating Disorders Unit and reasons for discharge.

Results

Data indicated that 21 patients were admitted in day treatment programme over 1 year period. 10 patients had solely virtual treatment and 11 patients had blended day treatment programme. 11 patients had anorexia nervosa restrictive subtype, 5 patients had Anorexia Binge purge subtype and 5 patients had Anorexia Nervosa, Unspecified.

Average length of illness was 4.49 years. Mean age for the group was 24.7 years and most patients lived with family (n 18) and were unemployed (n 11). More than 2/3rd (76%) patients had comorbid mental health diagnosis and 48% (n 10) had comorbid physical health diagnosis.

Average length of admission was 5.26 months. Mean BMI on admission was 15.3 (Range 12–19) and mean BMI on discharge was 16.9 (Range 13.65–22).

Safety and outcome data indicated that there were no serious incidents recorded in that time period. 1 (5%) patients required admission to acute hospital as their physical health deteriorated. 8 (38%) patients required specialist inpatient admission as the day care did not affect any changes to their eating behaviours, and 4 (19%) patients had events indicating self harm episodes(19%).

Conclusion

Our service evaluation data indicated that it is relatively safe to deliver day treatment programme on the virtual platform. Weekly face to face physical health monitoring (weight, BP, Pulse, temperature) and regular physical health investigations (Blood tests and ECG) were integral part of managing risks to health. On the other hand, delivering day treatment programme on the virtual platform has enabled the day treatment programme to prevent any significant outbreak of COVID-19 in a vulnerable group of patients and allowed them to receive uninterrupted support during pandemic.

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- *Safety of Delivering Eating Disorders Day Treatment Programme on the Virtual Platform in (COVID-19) Pandemic*

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1.1.64 Timeliness and Quality of Response to Referrals Received by a Psychiatry Liaison Service for Older Adults During a Pandemic

Nirja Beehuspoteea Robyn-Jenia Wilcha Amelia Edwards Agnes Mbazira*Presenting author.

date

2022-06

Abstract

Aims

To improve timeliness of response and provide a committed plan to referrals received by the liaison service for older adults in Croydon University Hospital. Background: A quality improvement project in 2019 aimed to evaluate effectiveness of the liaison referral pathway. A questionnaire distributed to ward staff revealed some comments regarding 'non-committal advice' given by the liaison team.

Methods

Data were collected from 44 referrals received by the liaison team in June 2021. Variables included referral date, reason for referral, date of first assessment, plan documented in the notes, date and details of committed plan of action.

Multi-disciplinary team (MDT) discussion identified that more committed advice could be provided by the following, which were implemented at the start of September 2021. Huddle at the start of each day to triage and allocate referrals to appropriate members of MDT. Prompt discussions with senior members of the team following assessment to discuss diagnosis and management. Team teaching sessions were organised once a week, in the form of case-based discussions and role play, to improve communication skills, confidence and history-taking. Data were then collected from 48 referrals received in September and October 2021.

Results

Of the 44 patients in June, average time taken from point of referral to assessment was 1.27 days and to providing a concrete plan 1.80 days.

Of the 48 patients between end of September and October, average time to assessment was 1.31 days and to providing a concrete plan 1.88 days.

In June, 75% of patients were seen on same day or within one day and 50% had a concrete plan within one day.

In September/October, 65% of patients were seen on same day or within one day and 52% had a concrete plan within one day.

Conclusion

These results highlight that assessments by older adult liaison service require detailed collateral history, investigations and MDT discussions.

While ‘obtain collateral history’ may not seem as committed a plan as prescribing medication, it remains an important part of old age psychiatry.

Given the rapid turnover of patients and increased pressures during the pandemic, it is the responsibility of the liaison team to communicate effectively with the wards and offer a timeline for completion of plan.

Following above changes, another questionnaire has been sent to request feedback on effectiveness of the liaison team.

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- *Timeliness and Quality of Response to Referrals Received by a Psychiatry Liaison Service for Older Adults During a Pandemic*

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pmc This second edition book reviews significant changes to the Mental Capacity Act (MCA) and readily accomplishes its aim to help clinicians in their daily practice. It is a short book of seven chapters and 120 pages and is written in an engaging style, being expertly presented with the use of sub-headings and crafted case studies, and avoiding large tracts of boring text.

Although all chapters are pertinent, the chapters on assessment of capacity and best interests stand out. Sage advice and clarity in breaking down the constituents of the capacity assessment elucidate the intricacies of assessing capacity that can be taken for granted at times in the hurly burly of clinical work. The best interests chapter updates the reader on the plethora of Court of Protection case law that has emerged and how the person's wishes have become central to the process.

An overview of Deprivation of Liberty Safeguards (DOLS) describes how issues with their use nationally provoked their reform and the subsequent development of Liberty Protection Safeguards (LPS), due to take the place of DOLS in autumn 2020. The chapter reviewing LPS provides a great starting point for understanding their practical use, although we await the associated Code of Practice to further flesh this out. Helpful chapters specifically address MCA use in the acute hospital (cleverly based on one sequential case study looking at realistic scenarios) and social care settings. My favourite chapter was the final one, which considers clinical ambiguities in the assessment of capacity which can often be clinically vexing, e.g. patient ambivalence, fluctuating capacity, unusual values/belief systems, self-harm, and consent and refusal of treatment.

This is a book for the jobbing clinician of all specialties, not just mental health. It provides a succinct yet comprehensive review that all healthcare professionals can benefit from. For students – both medical and nursing – this should be a required text. My only suggested improvement would have been to include a section on how the reader can access online MCA resources to help them keep abreast of developments. I hope the learned authors of this book continue to provide future editions as MCA case law evolves, including the inevitable future emergent case law, à la DOLS, from the introduction of LPS.

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pmc *Nutt Uncut* is a profile of psychopharmacology and healthcare policy development as much as an autobiography of Professor David Nutt. Regarding his desire to inform the public about the risks of psychoactive substances (legal and illegal), he has had the courage of his convictions to persevere with work in the field and to provide answers founded on research evidence.

Early in Nutt's career, anti-vivisection activists bombed his workplace and he was 'put under the protection of the anti-terrorism police'. In 2009, he was sacked as chair of the UK's Advisory Council on the Misuse of Drugs, a statutory public body. The affair attracted widespread media attention. Nutt also described how the Cabinet Office deleted a chapter on the harm caused by alcohol from an independent report that it had commissioned and to which he had contributed. The Cabinet Office had taken advice from the drinks industry, a striking conflict of interest. Political, economic and vote-driven prejudices could supplant the best scientific evidence in policy-making. Nutt has encountered many other hurdles in his work. When planning to investigate the therapeutic effects of magic mushrooms (psilocybin) on depression, challenges included gaining research ethics committee approval, then obtaining the illegal drugs legally.

Politicians' substance misuse mantra seems to be 'once illegal, always illegal'. No drug has been removed from those listed as controlled substances in the Misuse of Drugs Act 1971, despite more recent research on relative harms. The Psychoactive Substances Act 2016, which Nutt designated 'the most repressive piece of legislation in the UK for 400 years', likewise marginalised risks. Misinformed international drug policy can also have untoward consequences: when the United Nations allowed police forces to seize the precursor of ecstasy, it resulted in black market trading of more hazardous alternatives.

Nutt's book achieves his goals, to 'put into the public domain, in non-specialist terms, the truth about psychiatric disorders and their treatments' and to counter 'extreme and unfounded claims' about drugs. It is also an absorbing read for clinicians who want to brush up on their psychopharmacology and to appreciate better the convoluted paths of government health policy decision-making.

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1.2 2021

1.2.1 The effects of COVID-19 on self-harm in UK prisons

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date

2020-7-16

Abstract

Self-harm is a major international public health concern and is especially prevalent among prisoners. In this editorial, we explore recent trends in prisoner self-harm during the coronavirus lockdown, and consider strategies for improving the prevention and management of self-harm in prisons as we emerge from the pandemic.

Contents

- *The effects of COVID-19 on self-harm in UK prisons*
 - *Declaration of interest*
 - * *Supplementary material*

The frequency and severity of self-harm have been increasing within UK prisons over recent years, with rates far exceeding those observed in the general population.¹ We postulated that the coronavirus pandemic could adversely affect the mental health of prisoners and further increase rates of self-harm, given the rapid changes and reductions to prison regimes and the negative psychological effects of quarantine.² However, internal reports from Safer Custody Units in 31 prisons where healthcare is provided by CareUK (R. Green, personal communication, 2020) have revealed fewer implementations of ACCT (assessment, care in custody and teamwork) processes since lockdown; these processes initiate care plans for prisoners at risk of self-harm or suicide. Across the 31 prisons, there were 1079 ACCTs implemented in February 2020, compared with 828 in April 2020, a relative reduction of just under 25%. Furthermore, a closer analysis of eight of these prisons revealed overall reductions in recorded incidents of self-harm, decreasing by a third from 324 in February 2020 to 214 in April 2020. There are many possible reasons for these apparent reductions, with important lessons to be learned.

The accurate recording and maintenance of ACCT processes is a legal requirement stipulated in Prison Service Instructions,³ supporting the reliability of the above figures. However, minor acts of self-harm may be more likely to be missed or unrecorded during the pandemic owing to potentially reduced face-to-face contact with prisoners and staffing issues. There have been national reports of fewer Accident & Emergency attendances for various health problems,⁴ raising the possibility that prisoners have similarly been less likely to seek healthcare interventions for self-harm throughout the lockdown. A reduction in ACCTs is also not synonymous with reductions in self-harming behaviour, as multiple factors, including staff discretion, affect ACCT implementation; furthermore, Humber et al found that ACCTs were more likely to be opened following identification of risk factors for self-harm or suicide, rather than following an act of self-harming behaviour.⁵ The data are, however, mirrored by internal reports of recent reductions in prison violence and referrals to mental health teams, as well as fewer calls to see prisoners already known to mental health services (R. Green, personal communication, 2020). These data may not be representative of all prisons, owing to individual differences between establishments, but those included encompassed all security levels and prisoners of varying age, gender and sentence type.

Assuming that self-harm rates have dropped, why might that be and what can we learn for future self-harm risk management? First, although numerous negative psychological consequences are associated with confinement and social isolation,² spending increased time in cells has probably reduced prisoners' exposure to negative and intimidating behaviours, such as bullying, threats and violence from other inmates. This could increase their overall sense of safety and security. Previously, prisoners may have resorted to self-harm to express their safety concerns, occasionally using this behaviour as a last-resort measure to seek transfer to segregation or another prison.⁶ Furthermore, conflicts with other inmates can cause significant emotional distress, and the most frequently cited reason for self-harm is emotional dysregulation.⁷ Prisoners may be less likely to experience such tensions in the context of reduced peer contact.

Anecdotally, drug use has recently decreased within prisons, probably owing to suspension of prison visits and enhanced difficulties in trafficking illicit substances into custodial settings. There are multiple links between drug use and self-harm, although it is difficult to establish causality.⁸ For example, prisoners may harm themselves while intoxicated because they have less conscious control of their actions, or while withdrawing because of unpleasant physical symptoms. Substance misuse is linked to the aetiology, perpetuation and relapse of various mental disorders, including psychosis, which are associated with increased rates of self-harm and violence. Stress, anxiety and depression may be induced by problems such as accumulation of debt, extortion and violence arising from drug use.⁸ Prisoners may self-harm to communicate distress about these difficulties or to seek escape from them.

The anticipated negative influence of coronavirus on prisoners' mental health may have encouraged a more pro-active approach among all staff to identify and support prisoners at risk of mental distress. This could have resulted in timely interventions before symptoms escalated to involve self-harm or require high-level input, potentially explaining the apparent decreased number of ACCTs and referrals to mental health teams. Although there have been staffing

shortages due to COVID-19, staff who are present may have more time for one-to-one conversation with prisoners, owing to fewer violent incidents and group activities requiring their attention. Staff morale may also be higher owing to greater public recognition of ‘key workers’, which could improve the quality of their interactions with inmates. Furthermore, prisoners may feel more valued, having witnessed various measures being implemented to protect their health. Increased societal cohesion has been observed during prior public health crises, with less differentiation between societal groups and more focus on ‘coming together’ and responding collectively to tackle emergent issues;⁹ anecdotally, this same cohesion has been observed within prisons. Prisoners may also feel better connected to wider society owing to increased communication about external affairs throughout the pandemic. Feeling part of a group is associated with increased self-esteem; particularly among young people, self-harm can be used to achieve a sense of belonging when this is felt to be lacking.⁷

The pandemic has created more of a ‘level playing field’ within prisons, as many of the previously extended rewards for good behaviour are no longer feasible for reasons of infection control, whereas others, such as telephone access, have been made more widely available to increase support for all prisoners during the crisis. This is likely to have reduced feelings of injustice and inequity among prisoners, which can sometimes fuel mental distress and make institutional adjustment more difficult. It could be argued that increasing access to such privileges helps to improve mental well-being; furthermore, it may increase prisoners’ sense of self-worth, an important factor related to self-harm, as those who previously enjoyed fewer rewards may have felt inferior to fellow inmates.

Although prison visits are temporarily suspended, approximately half of English and Welsh prisons have provided secure phone handsets to risk-assessed prisoners,¹⁰ and some have been trialling virtual family conversations through video platforms; therefore, contact with family and friends may have actually increased for some prisoners, albeit through electronic methods. Such contact can provide much-needed emotional support and act as a protective factor against suicide and self-harm. Increased communication may also alleviate concerns about loved ones and make prisoners feel better connected to outside society. However, the effects of this may vary, and prisoners at the greatest risk of suicide and self-harm, particularly those with serious mental health problems, are more likely to be alienated from support networks; contact with family and friends may be unchanged for these individuals.

Interestingly, suicide rates among the general population have initially dropped during the immediate aftermath of prior national disasters.¹¹ This has been attributed to evolving social connectedness and a renewed sense of vigour and purpose, which may shift a person’s focus to surviving. Worryingly, this has previously often represented a ‘honeymoon period’, with subsequent increases in suicidality among the general population;¹¹ the same may occur with rates of prisoner self-harm. Although there are several possible reasons self-harm may have recently decreased in prisons, there are also multiple mechanisms by which COVID-19 could have profound negative effects on prisoners’ mental health. It is likely that prisons will maintain current reverse cohorting and shielding measures for some time; this is essential to protect against ‘explosive outbreaks’ of the virus, but it further heightens the need for vigilant monitoring of mental well-being, given that prolonged quarantine is associated with poorer psychological outcomes.² Reasons for engaging in self-harm vary widely between prisoners, and changes to prison regimes will likely affect different prisoners differently, depending on individual coping styles, personalities and the presence of pre-existing mental health problems. Prisons must be mindful of these differences and potential future challenges to pre-emptively plan strategies for preventing and treating any future increase in suicidal and self-harming behaviours. Potential difficulties could arise if social distancing measures are eased more quickly in wider society, as this dissonance could reduce prisoners’ sense of ‘social connectedness’ with outside communities and worsen feelings of isolation. Where possible, prisons should coordinate their pandemic responses with external society, ensuring clear communication to prisoners throughout the process.

Multiple measures already exist within prisons to prevent and effectively manage self-harm; examples include ACCT processes, mental health screening and support services, peer support schemes such as ‘Listeners’, and various initiatives for promoting staff understanding of self-harm and positive prisoner–staff relationships.^{12,13} Assuming that the recent reductions in recorded incidents of self-harm and initiations of ACCT processes equate with actual reductions in self-harm in prisons, we must consider what can be learned from the pandemic to improve prisoner safety post COVID-19. The data highlight a need for mental health to be addressed in the prison as a ‘social whole’, with an enhanced focus on preventive social measures to reduce self-harm and creating therapeutic environments; the importance of a whole-prison approach, and of environmental stressors, has been identified previously.^{12,13} A recent rapid evidence assessment identified a lack of research on protective factors for self-harm in prisons;¹³ consequently, researchers, prison staff and inmates need to work together to identify factors helping to reduce self-harm in recent months and how these could be

sustained in the future. For example, prisons could consider continuing increased provision of certain ‘privileges’, such as telephone and video communications with external support networks, and must continue implementing strategies to reduce bullying, violence and substance misuse. The increased forms of communication available to prisoners and methods for facilitating in-cell activities should also continue post COVID-19. Importantly, staff must remain alert to any potential future deteriorations in mental health and increases in self-harm throughout the pandemic, ensuring that the negative psychological effects of quarantine are reduced wherever possible, while protection from coronavirus is maintained.

We thank Juliet Lyon CBE (Chair of Independent Advisory Panel on Deaths in Custody) and Jenny Talbot OBE (Director of the Care not Custody programme at the Prison Reform Trust) for their support in proofreading the editorial.

Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2020.83>.

[click here to view supplementary material](#)

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All authors were involved in the planning and creation of content for the editorial, and all authors reviewed the final manuscript.

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1.2.2 Model for ethical triaging of electroconvulsive therapy patients during the COVID-19 pandemic

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2020-8-19

Abstract

Electroconvulsive therapy (ECT) is an essential treatment for severe mental illnesses such as depression with suicidality and catatonia. However, its availability is being threatened by resource limitations and infection concerns due to the COVID-19 pandemic. This may necessitate the triage of patients for ECT but there is no established ethical framework to prioritise patients. We offer an application of an ethical framework for use of scarce medical resources in the ECT setting.

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Electroconvulsive therapy (ECT) is the most effective acute treatment for severe depression.¹ It is also effective in reducing psychotic symptoms in treatment-resistant schizophrenia and in treating mania and catatonia. The National Institute for Health and Care Excellence (NICE) treatment guidelines for ECT² and the Royal College of Psychiatrists' position statement on ECT³ state that ECT should be a first-line treatment where rapid response is required because of high suicide risk, poor oral intake or other conditions where the patient's physical health is at risk. These guidelines also state that valid informed consent should be obtained without pressure or coercion, in the context of significant stigma, discrimination and controversy associated with the treatment.² A substitute decision maker should be available to patients lacking capacity to give consent, as there is increasing evidence that patients lacking capacity have equivalent⁴ to superior responses⁵ to ECT compared with capacitous patients. Despite its impressive effectiveness and broad spectrum of effect, ECT has experienced at least 20 years of decreasing in-patient use in the USA. In 2017 a study reported that only 1 in 10 US hospitals offered ECT and only 1.5% of severely depressed in-patients received ECT,⁶ the most effective treatment for severe depression. These trends are also evident in the UK and Ireland.⁷ Furthermore, the use of ECT is controversial and has its detractors and some consider it unacceptable in modern psychiatry.⁸

With the COVID-19 pandemic, ECT challenges have compounded from a problem of getting patients to accept ECT to an additional challenge of struggling to continue providing ECT for existing patients. Already scarce ECT resources have been further reduced by lack of personal protective equipment (PPE), restriction of anaesthesia and limited institutional support.⁹ The International Society of ECT and Neurostimulation (ISEN) has published a position statement on ECT during COVID-19 which includes classifying cases into elective, urgent/essential and emergency and suggests triaging patients to reduce demand for ECT.¹⁰ This recommendation to triage patients is a relatively novel situation for many ECT practitioners, who are more accustomed to a 'first come, first served' situation in routine ECT practice. We suggest a useful ethical model that can be used in conjunction with existing ethical frameworks to assist ECT practitioners to take a consistent approach to triaging patients for ECT, rather than relying on individual institutional norms

or clinician intuition.

General medical ethics applied to ECT

A commonly accepted framework for medical ethics uses the ‘Georgetown principles’ of beneficence, non-maleficence, autonomy and justice. Ottosson & Fink¹¹ suggest the following ECT-specific considerations for each principle.

Beneficence

The highest priority for ECT should be patients who would gain the most potential benefit from the treatment (e.g. those with psychoses and involuntarily committed or with depression with high suicidality), have the potential for fast response (e.g. catatonia) and have the highest risk to life or long-term disability.

Non-maleficence

Given that mortality with ECT is lower than overall mortality associated with general anaesthesia,¹² and lower than if the patient had not received ECT,¹³ the main side-effect of concern is cognitive impairment. However, the cognitive impairment is often transient, lasting for a shorter period than the therapeutic effect of ECT and can be minimised using empirically derived dosing of ECT.¹⁴

Autonomy

ECT ideally should be administered with the patient’s consent. However, no patient should be denied ECT just because they lack capacity to consent to treatment. Ottosson & Fink make a distinction between weak paternalism in the patient’s best interests and authoritarianism that discounts the patient’s autonomy. Prescribing ECT with a substitute decision-making process or in patient’s best interests is increasingly supported by recent evidence of equivalent to superior outcomes in patients lacking capacity to consent to ECT.⁵

Justice

There are three broad forms of distributive justice: egalitarian (equal access), libertarian (the right to social and economic liberty) and utilitarian (maximise public utility). During a time of limited resources, Emanuel *et al*¹⁵ argue that a utilitarian approach is the most appropriate, i.e. emphasising population outcomes by triaging patients who are most likely to respond and derive the most benefit from ECT with the least risk of harm to the patients and the ECT team. This could even mean pausing ECT for a patient with low utilitarian potential in order to start ECT for a patient with high utilitarian value.

For the purposes of this discussion, the context is that of a predominantly public or taxpayer-funded healthcare system rather than one that is predominantly insurance or self-funded. The former system is more likely to face the problems of scarce resources requiring healthcare rationing¹⁶ and the libertarian aspects of justice may be less dominant.

What has changed for ECT during COVID-19?

Beyond decreased ECT availability, there are at least five other factors to take into account when considering ECT during COVID-19: disruption of routine care delivery during the crisis, leading to increased risk of harm to patients' health; increased risk of patients getting COVID-19 owing to lack of ECT (e.g. delayed discharge from hospital while their illness resolves more slowly and higher vulnerability to COVID-19 among severely mentally ill patients⁹); increased risk of patients getting COVID-19 while attending for ECT (e.g. repeated out-patient appointments for ECT, requiring patients to travel more frequently); increased risk to the team delivering ECT, due to the higher risk of infection from patients receiving general anaesthesia and potential aerosolisation of patients' respiratory material; utilisation of highly skilled staff during a time of scarcity, in particular the services of anaesthetists, who could otherwise be redeployed running intensive treatment units (ITUs).

How should we ethically triage ECT patients during COVID-19?

Emanuel et al¹⁵ provide a four-point framework to guide rationing of scarce healthcare resources during COVID-19: (a) maximise benefits; (b) treat people equally; (c) promote and reward instrumental value; and (d) give priority to the worst off.

Maximising benefits is achieved by prioritising limited resources for saving the most lives and with maximal improvement in patients' lives after treatment. Treating people equally refers to not letting a patient's financial resources or status affect treatment allocation. Promoting and rewarding instrumental value is giving priority to those who can save or have saved others. Lastly, giving priority to the worst off could be interpreted as giving priority to the sickest or to younger people, who would have lived the shortest lives if untreated. *Table 1* lists Emanuel et al's principles, with a column added describing how they could be applied to an ECT setting. *Table 1* Ethical values to guide rationing of scarce healthcare resources in the COVID-19 pandemic, adapted for electroconvulsive therapy (ECT)

Ethical values and guiding principles	Application to COVID-19 pandemic	Specific ECT applications
Maximise benefits	Save the most lives	Receives the highest priority
Treat people equally	First come, first served	Used for selecting among patients with similar prognosis
Promote and reward instrumental value (benefit to others)	Prioritise in-patients with severe psychotic depression, lethal catatonia, neuroleptic malignant syndrome, manic delirium	Prioritise patients with severe psychotic depression, lethal catatonia, neuroleptic malignant syndrome, manic delirium
Give priority to the worst off	Sickest first	Used when it aligns with maximising benefits
	Youngest first	Used when it aligns with maximising benefits such as preventing spread of the virus ¹

Deprioritise patients with predictors of poorer outcome to ECT (e.g. personality disorder, depression that is more chronic or treatment resistant, without suicidality or dangerousness)

Deprioritise patients with high medical risk during ECT

Deprioritise patients who must expose themselves to greater risk of COVID-19 infection to access ECT (e.g. living far from the ECT facility)

Give higher-dose ECT and avoid milder ECT modalities, to minimise number of sessions and patient and staff risk of exposure to COVID-19

Save the most life-years – maximise prognosis

Receives the highest priority

Treat people equally

First come, first served

Should not be used

Use random allocation to prioritise patients with similar prognosis

Random selection

Used for selecting among patients with similar prognosis

Promote and reward instrumental value (benefit to others)

Retrospective – priority to those who have made relevant contributions

Gives priority to research participants and healthcare workers when other factors, such as maximising benefits, are equal

Prioritise patients who are healthcare workers or work in essential services

Deprioritise patients who pose a higher risk of infecting the ECT team, to conserve ECT resources

Prospective – priority to those who are likely to make relevant contributions

Gives priority to healthcare workers

Give priority to the worst off

Sickest first

Used when it aligns with maximising benefits

Prioritise younger pre-morbidly well patients with acute onset of an ECT-responsive psychiatric disorder

Youngest first

Used when it aligns with maximising benefits such as preventing spread of the virus¹

¹

Based on Emanuel et al's four-point framework.¹³

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Applying these principles to clinical scenarios

Applying Emanuel et al's principles and the ECT-specific considerations outlined above, a high-priority patient might be a young healthcare worker in your healthcare institution with no psychiatric history and admitted for an acute onset of psychotic depression, catatonic symptoms and a serious suicide attempt, whose family is supportive of ECT. Two clinical scenarios are presented for further discussion.

Scenario 1

A 33-year-old labourer with a long history of well-controlled schizophrenia is brought to the psychiatric emergency room with symptoms suggestive of acute onset of stuporous catatonia (mutism, negativism, posturing) and poor oral intake for 2 weeks. His BMI is 16, he is clinically dehydrated and his blood pressure is borderline hypotensive. Although he has no clear symptoms of COVID-19, he lives in a large accommodation facility with dozens of people who have tested positive for COVID-19. The facility already follows recommended infection control procedures and screening, instituted several weeks before this presentation.

This is a challenging clinical scenario where there is a psychiatric emergency (catatonia with poor oral intake) that is highly responsive to ECT, but in a patient with a primary psychiatric condition (schizophrenia) that may not be indicated for ECT as a first-line treatment and moderate to high risk of having COVID-19. Using the proposed ethical framework below, the patient's youth and catatonia would satisfy the principles of 'maximising benefits' and 'giving priority to the worst off', but it would be contrary to the principle of 'promoting and rewarding instrumental value', as treating the patient would expose the ECT team and other patients to a significant risk of getting COVID-19, especially if the ECT unit is not fully prepared to deal with suspected or positive COVID-19 patients.

As with many ethical scenarios, the initial approach to resolution would be a medical solution. If the patient's catatonia responds to high-dose benzodiazepines (e.g. lorazepam), then there would be no need to consider the use of ECT. If benzodiazepine treatment failed, a negative result on polymerase chain reaction testing for COVID-19, the lack of other patients requiring ECT and the availability of specialised treatment facilities (e.g. negative-pressure rooms) might mitigate the risk of infection of ECT team members and allow ECT to proceed in an ethical fashion.

Scenario 2

Another challenging scenario is that of a 67-year-old woman who is admitted to a psychiatric ward for the in-patient treatment of major depressive disorder with acute suicidality. She also has a history of borderline personality disorder, comorbid generalised anxiety disorder and panic disorder and has not previously experienced much response to full courses of psychotherapy and adequate pharmacotherapy. She consented to a course of ECT and had already received five sessions before a fellow ward patient was diagnosed with COVID-19. The entire ward is quarantined as a result. The patient is keen to continue her ECT course as she has not yet felt any improvement and other treatment options have been relatively ineffective.

This scenario has a patient with both positive (depression, older age) and negative (history of personality disorder and anxiety) predictors for ECT response,¹⁷ no response to the first five ECT treatments and a significant risk of having presymptomatic COVID-19. The principle of 'maximizing benefits' is less clear here, as her prognosis of responding to ECT is mixed, and the principle of 'promoting and rewarding instrumental value' would discourage continued ECT, at least until she is cleared of COVID-19. The other two ethical principles, of 'treating people equally' and 'giving priority to the worst off', may be useful to help clarify the ethical position. The former might suggest that other patients in the same ward who are also receiving ECT with similar prognosis would have an equivalent claim for ECT and the

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patient's request for continued ECT should not give her higher priority. The latter would further refine this point by considering the severity of the woman's psychiatric diagnosis and perhaps giving sicker patients priority to ECT (e.g. a patient with severe psychotic depression, who is also highly likely to respond to ECT).

What is the road forward for ethical triaging for ECT during COVID-19?

Where treatment resources are limited, fair allocation of resources requires careful consideration of all relevant ethical issues in the context of the local resources and situation. The ideal solution is to ensure adequate ECT resources, so that both high- and low-priority patients can receive high-quality ECT. This requires deliberate short- and long-term planning and negotiation for scarce resources within healthcare systems, the exploration of new ECT resources (e.g. advanced practice nurses for both anaesthesia and ECT delivery,¹⁸ dedicated ECT suites to avoid competition with surgical needs) and adequate PPE for ECT staff and patients. The current COVID-19 crisis has placed significant strain on healthcare resources for many months, and at the height of the pandemic many non-emergency non-COVID services were suspended to divert resources to deal with the COVID-19 emergency. This has resulted in a significant backlog of untreated patients, with consequent increased pressure on already scarce resources. Furthermore, as healthcare systems reorient themselves to provide routine care and begin to deal with the backlog, there remains a need to maintain social distancing and scrupulous hygiene, for instance deep cleaning operating theatres and equipment between each patient, which will reduce efficiency and capacity. For all these reasons, these pressing ethical dilemmas about how to prioritise patients must be addressed to ensure that patients with non-COVID disorders continue to have their healthcare needs met fairly and equitably in a fully accountable way. These efforts should be a priority even after the COVID-19 situation eventually resolves. Given the SARS outbreak in 2003¹⁹ and the current COVID-19 outbreak,⁹ which both caught most of the world largely unprepared, there is a strong ethical imperative to prepare for the future third coronavirus outbreak or, indeed, second or third waves of COVID-19 either locally or globally.

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P.-C.T. conceived the idea for the paper, J.T. contributed to the ethical aspects of the paper and C.L. contributed to the ECT aspects of the paper.

Declaration of interest

C.L. is the Medical Director of Neurostimulation at the Northside Clinic, Ramsay Health Care, Australia, and reports personal fees from Ramsay Health Care, outside the submitted work.

Supplementary material

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[click here to view supplementary material](#)

1.2.3 Does COVID-19 pose a challenge to the diagnoses of anxiety and depression? A psychologist's view

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Abstract

The COVID-19 pandemic has led to predictions of a widespread mental health crisis. However, this makes little sense when fear and anxiety are so understandable in context. The individualisation and medicalisation of normal human reactions disconnects us from our feelings and from the appropriate solutions, in relation to the pandemic and more generally. We have an opportunity to challenge this pervasive way of thinking, and thus be in a position to create a fairer society that is better for everyone's emotional well-being.

Contents

- *Does COVID-19 pose a challenge to the diagnoses of anxiety and depression? A psychologist's view*
 - *The truth behind the headlines*
 - *Who is promoting the narrative – and why?*
 - *Reframing the problem, reclaiming the discourse*
 - *Collective trauma needs a collective response*
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The COVID-19 pandemic is one of a series of interlinked global emergencies that will affect everyone on the planet.¹ But it is important to challenge the idea that, as numerous headlines are telling us, we are now facing a 'pandemic of mental health disorders'.² We are apparently due for 'an epidemic of clinical depression'.³ The Mental Health Foundation found that six out of ten people were anxious about the crisis and at risk of 'persistent and severe mental health problems'.⁴ We are exhorted to learn the lessons from China and prepare for 'a public mental health crisis'.⁵

Yet if ever there was an example of our reactions being appropriate in the circumstances, this is it. It has never been more obvious that the thoughts, feelings and behaviours we call 'mental illness' are defined in relation to social norms. Suddenly, being too scared to leave the house for fear of contracting a fatal disease, and spending most of the day washing our hands and wiping down doorknobs, are not signs of 'OCD' but of a responsible citizen. Arguably, the 'abnormal' people are now the four in ten of us whose anxiety levels have not increased. Who can say how we ought to be feeling at such a time?

Never was there a clearer illustration of the fact that judgements about who is 'mentally ill' are social not medical ones. So, where do we draw the line between 'normal' and 'abnormal'? Can such a line even be drawn? As Miranda Spencer notes in her analysis of US media responses, the messages to the public are deeply confusing: "'Becoming more anxious in response to COVID 19 would be normal if you are mentally healthy and a sign of illness if you're not, although apparently some normal people might experience so much anxiety that they, too, could now be seen as mentally ill. And [...] everyone is now to practice behaviors that in the past would be a sign that they had OCD, but now are considered reasonable... unless one goes "too far"'.⁶"

These contradictions are not new, although the pandemic has thrown them into sharp relief. They lie at the heart of

psychiatric thinking. In this article, I will discuss the implications for the diagnoses of ‘anxiety’ and ‘depression’ and by extension for all psychiatric diagnoses. I will argue that the pandemic gives us a chance to challenge, rather than reinforce, the narrative of ‘mental health/illness.’

The truth behind the headlines

First, it is worth looking behind the dramatic headlines to see whether people are in fact more distressed than before. Interestingly, this is not the general picture. A UK survey of over 74 000 people has shown that, despite an initial decline in happiness before the lockdown, well-being rose during the first 3 weeks of April 2020 and anxiety levels fell for people both with and without psychiatric diagnoses.⁷ Where increased distress has been identified, an initial survey suggests that this is occurring for very obvious reasons.⁸ Those with children at home, a pre-existing health condition, exposure to the virus, high estimates of personal risk and facing loss of income were more likely to be feeling anxious and low in mood.

As with every crisis, the impact is far greater on those who are already more vulnerable, whether through physical illness and disability, having an abusive partner, bringing up children without support or living in poverty. COVID-19 and its consequences are not hitting us all equally. In ordinary language, people with more to be exhausted, depressed and anxious about are feeling more exhausted, depressed and anxious. However, the general picture is, in the words of Shevlin et al, of a population that is ‘largely resilient.’⁸

It is also worth noting that people with a psychiatric history are not necessarily those in most distress. This is not to deny that some people are suffering greatly, especially if they suddenly find that their usual services are unavailable.⁹ But equally, it is untrue and even patronising to assume that everyone in this group will fail to cope. In fact, some have described managing better than usual, as they draw on talents for survival that the officially ‘normal’ population may lack. One person tweeted: ‘For those of us who already live with trauma or the significant impact of mental health on our daily life we are perhaps more prepared/less complaining about self isolation, surviving on low income, restrictions in movements and facing cuts in our health/social care services’. Psychiatric survivors have set up an impressive list of peer networks and resources in response to the pandemic,¹⁰ including a set of ‘lived wisdom’ strategies drawn from ‘hard won expertise learned through traversing challenging life experiences’.¹¹

‘Most of us are managing our feelings reasonably well in these difficult circumstances’ is not such an eye-catching headline, but it appears to be a more accurate one. It is also consistent with research, which shows that, although crises and disasters are painful, the vast majority, including front-line staff, will cope without needing specialist mental health support.¹²

Who is promoting the narrative – and why?

How and why is the ‘mental health pandemic’ narrative being promoted when it is contradicted by the evidence and the reality on the ground? Part of the answer may lie in the high-profile public health campaigns in schools, the media and so on, which urge us all to ‘talk about mental health’ – this mysterious, indefinable but apparently fragile state of mind – more or less constantly. We are encouraged to use the ubiquitous term ‘mental health’ as a synonym for ‘how we all feel’ in relation to any state of mind short of complete contentment. We then become legitimate targets for mass professional and technical monitoring and intervention, focused not on the real-life situations that evoke our reactions, but on the newly defined ‘mental health problems’ themselves. Moreover, while it is still generally believed that only a minority of us is ‘mentally ill’, the new discourse reminds us that ‘we all have mental health’. This apparently innocuous, indeed nonsensical, phrase draws us all into the realm of surveillance and potential ‘treatment’. The trend is as much of a global epidemic as the coronavirus, and just as hard to counter. But the idea that we are facing two simultaneous pandemics – a physical health one and, by a tragic coincidence, a ‘mental health’ one too – simply makes no sense at all.

To give a relatively benign example of how this plays out in practice, Public Health England has promoted a commendable message of ‘It is normal to feel anxious in a crisis’ and has suggested a range of common-sense strategies and supports. However, the campaign headline urges us to ‘look after our mental health’.¹³ The phrase immediately pulls us back into an individualising, subtly pathologising narrative that evokes not collective resilience and resourcefulness, but anxiety about how easily we might become unable to cope.

A more concerning example comes from an article in *The Lancet Psychiatry*.¹⁴ It sets the scene by predicting an increase in ‘anxiety, depression, self-harm, and suicide’, along with warnings that quarantine and isolation also raise the risk for substance misuse, gambling and so on. This is used to justify a call to fund a major international research programme of ‘paramount importance’ and ‘urgent need’. Demonstrating a bizarre disconnect between the very real social ills that are likely to result from the pandemic (‘the potential fallout of an economic downturn [...] increasing unemployment, financial insecurity and poverty’, etc.) and the suggested remedies, the article lays out a vision of monitoring the entire population for ‘causal mechanisms associated with poor mental health’. Those who lack the required ‘digital resources’ to permit this unprecedented intrusion into their personal lives through ‘digital phenotyping [...] to ascertain early warning signs for mental ill-health’ will be pursued through telephone calls. Even if people manage to avoid exhibiting the digital markers of unacceptable levels of (say) loneliness, they will still come under pressure to adopt ‘a mentally healthy life’ supported by ‘mechanised interventions’, once such a concept has been ‘mapped out’ in one of the many putative research studies. Expert-defined and delivered training in ‘elicit[ing] community support’, exhibiting ‘altruism and prosocial behaviour’ and other desirable qualities that have been systematically eroded by austerity and a neoliberal agenda over the past 40 or so years will then be available.

In fact, people have been spontaneously forming self-help communities across the country without waiting for an app to instruct them or being required to complete a rating scale about their ‘mental health’ afterwards. This article represents a terrifying combination of opportunism and empire-building. Not a single new research study is needed to confirm that being poor, jobless, isolated, ill and bereaved makes people unhappy, or to work out the appropriate remedies.

Reframing the problem, reclaiming the discourse

There is emerging evidence for long-term neurological effects in some COVID-19 patients, and this certainly needs funding and research; but these are not ‘mental health’ problems, although often conflated with them. One of the reasons it is important to counter these dire predictions is to stem an unnecessary rush to ‘treatments’, both psychiatric and psychological. Psychiatric drugs benefit some people, but with nearly a quarter of us already being prescribed them,¹⁵ we do not need to increase the well-documented risks of dependence and withdrawal. Equally, we know that formal psychological interventions are unnecessary for most, and can actually be harmful if implemented too early.¹² In fact, the media experts have nothing specialist to recommend; with or without a psychiatric history, we are advised to keep up social connections, exercise, maintain a routine, not watch too much news and distract ourselves from gloomy thoughts.⁶

If we are not facing an outbreak of ‘anxiety disorders’ and ‘clinical depression’, but human reactions to difficult circumstances, it is time to reclaim some of the territory increasingly occupied by the ‘mental health’ discourse, and translate it back into ordinary language. Deconstructing ‘I have depression’ into ‘I feel miserable and hopeless’ makes it obvious that the first response should not necessarily be to prescribe a pill (although that might have a role) but to look for reasons for those feelings. Similarly, the statement ‘I’m worried and scared’ invites us to ask, in line with the well-known survivor slogan, not ‘What is wrong with you?’ but ‘What has happened to you?’ In the context of a pandemic, the answers are not too hard to find and the solutions are obvious, if not always easily available. In the current jargon, popular in both psychology and psychiatry, we need a formulation – a shift from ‘patient with illness’ to ‘person with problem’.¹⁶ The pandemic poses a particularly stark challenge to these diagnostic assumptions which, like an ever-mutating virus, have infected not just our mental health system but our whole society; and the Global Mental Health Movement (<https://www.mhinnovation.net/organisations/movement-global-mental-health-mgmh>) is transmitting it even further. As soon as we start assuming the existence of an entity called ‘depression’ or ‘anxiety’ – whether a medical or a psychological one – that people *have*, in the same way that they might ‘have’ a tumour, a broken leg or a viral infection, we are in trouble. As colleagues and I have argued in a recent outline of a conceptual alternative to the diagnostic model, these very real and painful experiences are better seen as what we *do* – in other words, as meaningful patterns of responses to threats.¹⁷

This applies beyond ‘anxiety disorders’ and ‘clinical depression’. Diagnostic categories are described as unscientific even by the professionals who draw them up.¹⁸ A large body of evidence (see, for example, [acestoohigh.com/research/](https://www.acestoohigh.com/research/)) tells us that the various forms of distress diagnosed as ‘psychosis’, ‘bipolar disorder’, ‘personality disorder’ and so on are causally related to experiences of trauma, abuse, neglect, loss, poverty, unemployment, discrimination and inequality. The hostile voices that some people hear often echo the words of real-life abusers. People who have been hurt and rejected may be angry and distrustful. In other words, when placed in context, these very real and agonising

experiences are also understandable responses to adversities. While it may take time for the personal story to become clear, a formulation-based approach assumes that ‘at some level, it all makes sense’.¹⁹

Collective trauma needs a collective response

If we allow psychiatric diagnoses to individualise and depoliticise our responses, we will simply revert to a way of life that, even before COVID-19, was leading many people to self-harm, despair and suicide. Instead, we need the courage to stay connected with our feelings, and the feelings of those around us, not file them away in boxes marked ‘anxiety disorders and depression’. People who have lost their jobs are likely to feel desperate, but we don’t have to describe this as ‘clinical depression’ and prescribe drugs for it. Those with backgrounds of severe trauma may find that their worst memories are being triggered, but we don’t have to describe this as a relapse of their ‘borderline personality disorder’.²⁰ The economic recession that will follow the pandemic may lead to as many suicides as austerity measures did, but we don’t have to say that ‘mental illness’ caused these deaths.

The COVID-19 pandemic is an opportunity to implement what we already know about universal human needs for social contact, financial security and sufficient material resources, protection from trauma, abuse and neglect, especially in early years, decent healthcare, and a sense of purpose and belonging. As an editorial in *The Lancet* puts it, COVID-19 is ‘overturning core values, norms, and rules that sit at the heart of long-standing market-oriented political agendas’ and presenting us with the need for ‘re-making the social contract’.²¹ It is giving us an opportunity to reduce income inequality.²² In other words, as urged by Psychologists for Social Change, we need to ‘Build back better’ so that ‘participation, community, trust and connection might be valued over status, individualism, and competition.’²³ We already know that these measures will do more to reduce fear and misery than any number of psychological or psychiatric interventions.

Psychologists use the term ‘trauma’ to describe difficult events that overwhelm our usual ways of coping. In ‘collective trauma’, there is a challenge to the lifestyle, values and identity of a whole society.²⁴ In the case of COVID-19, the crisis extends beyond national borders and, like the climate change crisis to which it is linked, raises profound questions for our whole way of life. Community action around common purposes is healing for all of us. Journalist Johann Hari, who has described his own escape from the ‘mental illness’ identity, prefers the term emotional health, not mental health. In his words: ‘This is a collective crisis and giving people exclusively individual solutions is not going to work’.²⁵ As he says, many people were already ‘in quarantine’, marginalised from society; we already had a rise in distress linked to ‘junk values’; and ‘depression and anxiety are not malfunctions. They are signals’. The real ‘antidepressants’ are financial security, human connection and having a sense of value and purpose. The real crisis is one of meaning.

The more we can challenge the ‘mental health’ narrative, the clearer our current dilemmas and future directions will become. It is not a pandemic of ‘mental health’ problems that we need to fear, but a pandemic of ‘mental health’ thinking.

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Declaration of interest

L.J. is an independent trainer and offers training in formulation and the Power Threat Meaning Framework (PTMF). She has published books and articles on formulation and is one of the lead authors of the PTMF.

Supplementary material

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1.2.4 Does coronavirus pose a challenge to the diagnoses of anxiety and depression? A view from psychiatry

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Abstract

Some authors have suggested that the emergence of the novel coronavirus, SARS-CoV-2, and the subsequent pandemic has meant that the constructs of pathological anxiety and depression are meaningless owing to widespread anxiety and depressive symptoms. This paper examines what is required to make a diagnosis of a depressive or anxiety disorder and how this may differ from fleeting symptomatology in response to specific situations or stimuli. All people experience the emotions of both anxiety and depression, but far fewer have a persistent anxiety or depressive syndrome which interferes with their quality of life and functioning. The pandemic and its issues are then discussed, and existing studies examining the reactions of people living through the pandemic are presented. Finally, the paper examines possible ways to cope at times of increased stress and how we can try to protect ourselves from long-term mental health sequelae of chronic stress.

Contents

- *Does coronavirus pose a challenge to the diagnoses of anxiety and depression? A view from psychiatry*
 - *History of SARS-CoV-2*
 - *Studies of anxiety and depression symptoms since the arrival of SARS-CoV-2*
 - *Discussion*
 - *Conclusion*

– *Declaration of interest*

* *Supplementary material*

One of the challenges of conducting studies to examine the prevalence and frequency of anxiety and depression is that these terms describe symptoms rather than a diagnosis. Everyone has experienced these as symptoms at some point in their lives. Diagnoses are made on the basis of a recognised cluster of symptoms associated with anxiety and depression. One of the difficulties is that these terms are also used in general parlance to describe short-lived emotional changes which can occur as an emotional reaction to a stimulus or event, rather than a full-blown syndrome that affects the individual's quality of life. Indeed, if we as a species did not experience anxiety responses in threatening situations, we would undoubtedly have become extinct as we walked over cliff edges, faced up to dangerous carnivores, or generally partook in dangerous and risky behaviour. Levels of anxiety and depression also vary between individuals without necessarily being pathological. For example, we will all know some members of our social circle who are thrill-seekers and attracted to danger, whereas others are much more risk averse. Similarly, some people seem to be happy and philosophical at all times, whereas others are more pessimistic and prone to feel low and miserable at the slightest upset. Overall, therefore, population studies are fraught with difficulties in accommodating this area of potential self-reporting bias. For a diagnosis of anxiety disorder or depression to be made, an individual should be experiencing a range of symptoms associated with the anxiety and depression, and the symptoms should be apparent for a period of time (not just hours or minutes but weeks or months) and sufficiently severe that they interfere with the person's ability to function fully in their home, work, social or private leisure settings. The consistency of the emotional symptoms is inherent in diagnostic instruments such as the ICD,¹ and widely different prevalence figures may be obtained in self-report questionnaires unless the same criteria are applied.

In medical and psychological parlance, stress is a physical, mental or emotional factor that causes bodily or mental tension. Stresses can be external (from the environment, psychological factors or social situations) or internal (e.g. illness). Stress, both recent and in childhood, is known to affect mental well-being. The coping ability of the individual affects whether or not stress results in deterioration of mental well-being.² Different individuals subjected to similar trauma and stress do not all react in the same way; whereas some will experience lasting symptoms, other will seem to have hardly any lasting sequelae.

Population studies examining the prevalence of anxiety and depression have demonstrated that these are among the most common conditions in diverse societies. The World Health Organization (WHO) estimated that in 2015 the prevalence of depression was 4.4% globally; however, this figure varied with gender, with women having a prevalence of 5.1% and men 3.6%. Depression also increased with age in adulthood, peaking in both genders at age 55–74 years, and varied among different countries. The lowest rate of 2.6% was found in men in the Western Pacific region, and the highest rate of 5.9% in women in the African region. These rates of depression were found to have increased by 18.4% since 2005.³ For anxiety, the prevalence was estimated to be 3.6%. As with depression, anxiety disorders are more common among females than males (4.6% compared with 2.6% at the global level). Again, anxiety disorders were found to have increased since 2005 by 14.6%. As depression and anxiety are often comorbid disorders, it is not accurate to combine these two figures.³

A recent large study in the UK examined adults for a range of physical and mental disorders (BioBank UK). A questionnaire asking about mental disorders found that 21.2% had received a diagnosis of depression at some time in their lives and 14% had been diagnosed with anxiety. The sample who answered the questionnaire were not representative of the whole population, as the participants were aged 45–82 years, with 53% aged 65 or over, 57% were female and 45% had a degree (compared with census data in which 23% had a degree).⁴

History of SARS-CoV-2

On 31 December 2019, the WHO was informed of an outbreak of pneumonia of unknown cause in Wuhan City, in Hubei Province, China. It was then announced on 12 January 2020 that a novel coronavirus had been identified in samples from infected individuals. This virus was referred to as SARS-CoV-2 and the associated illness as COVID-19. China acted by completely closing down Wuhan and Hubei Province, but this was not before the virus seemed to have travelled widely globally. In the UK, people arriving from Wuhan or those believed to have been in contact with SARS-CoV-2 were quarantined, but transmission within the UK and people affected by the virus who had not been abroad was first documented on 28 February 2020. The WHO declared a pandemic on 11 March. On 15 March, following observations of a larger outbreak in northern Italy, the UK government asked people to work from home if possible, avoid unnecessary travel and avoid contact with others. Anyone with symptoms suggestive of SARS-CoV-2 was asked to self-isolate, and those over the age of 70 years, pregnant women and people with underlying conditions were asked to self-isolate for at least 7 weeks. However, on 20 March, the four governments of the UK shut all schools, restaurants, pubs, indoor entertainment venues, non-food or non-essential shops, and banned people from meeting anyone they did not live with. People were prohibited from leaving their homes except for one period of exercise per day and to obtain essential food supplies or attend to medical needs. At all times, people were asked to stay at least 2 metres away from those they did not live with (social distancing). On 13 May 2020, some adjustments to the requirements were made in England only, with people being allowed to exercise as much as they wished and to drive to an area to exercise; everyone who could not work from home was urged to return provided they could remain at least 2 metres apart, and plans were made for children to return to school in June. The devolved governments of Wales, Scotland and Northern Ireland maintained their 'stay at home' policies. On 14 May 2020, the WHO reported 4 248 389 cases of COVID-19 globally and a worldwide death toll of 292 046.⁵ In the UK, as of 09:00 h on 23 May, over 35 000 people had died having tested positive for the virus,^{6,7} although other sources state that the number of actual deaths of people with symptoms suggesting COVID-19 was much as 55% higher than this number.⁸ Other countries worldwide have had varying numbers of cases and deaths, and widely differing responses to the pandemic.

Studies of anxiety and depression symptoms since the arrival of SARS-CoV-2

Given that we are facing an unknown and unseen threat to our health and survival, it is unsurprising that there have been increased numbers of people complaining of symptoms of stress, anxiety and depression. A population survey of 1210 respondents from 194 cities in China found that 28.8% of respondents reported moderate to severe symptoms of anxiety, 16.5% reported moderate to severe depressive symptoms and 8.1% reported moderate to severe levels of stress. Almost 85% were spending 20–24 h each day at home, and over 75% were worried about family members contracting COVID-19. Women, students and those who reported poorer general health were more likely to report distress.⁹ Among healthcare workers in China (over 60% from Wuhan), a much higher proportion reported psychological symptoms, with over 70% suffering from distress, more than half having symptoms of depression, and over 44% having symptoms of anxiety. Unsurprisingly, those working on the front line were more likely to report symptoms, as were those working within Hubei Province.¹⁰ In a Spanish population survey, 18.7% of the sample had depressive symptoms, 21.6% anxiety symptoms and 15.8% post-traumatic stress disorder symptoms. Fewer symptoms were found among older people, those who were economically stable and those who felt they had adequate information about the pandemic. A greater number of symptoms were found in women and those who had symptoms consistent with the virus, and those who had a close relative with symptoms were more likely to report distress. Reported loneliness was also predictive of more psychological symptoms.¹¹ A Turkish study using the Hospital Anxiety and Depression Scale¹² and the Health Anxiety Inventory Health Anxiety¹³ found that almost 24% were above the cut-off to suspect depression, and more than 45% were above the threshold for anxiety. Being a woman, living in an urban area and having a history of psychiatric disorder were found to be risk factors for anxiety, and being female and living in an urban area were risk factors for depression. Women with chronic physical disease and a psychiatric history were at greater risk of health anxiety.¹⁴

Discussion

Overall, it can be seen that anxiety and depression are normal emotions existing within the population and experienced to a greater or lesser extent by all people over time. The SARS-CoV-2 pandemic has led to great changes in our way of life, as well as a real fear that we and our loved ones may contract a potentially life-threatening disease. In addition, front-line workers, including healthcare workers, are under increasing stress and heavier workload. It is therefore not surprising that there is an increase in the symptoms of anxiety and depression in the general population, particularly in people working in front-line healthcare. In addition, many people have been indoors with restrictions on physical activity and an inability to visit friends and family. This is even more poignant and damaging as many are not able to be with loved ones at the end of their life and are unable to attend funerals.

The National Health Service has issued guidance for the population to look after their mental health. This includes setting a structure to the day whether or not you are working, making time to speak to friends and family using remote methods, and looking after diet and exercise, as well as restricting the amount of new reporting an individual is watching if this is leading to distress.¹⁵ Preventive measures such as these may help to reduce some of the symptoms. Indeed, structuring the day and including a balance of activities which give a sense of mastery as well as those that give pleasure can be helpful in combating depressive symptoms.¹⁶ Ensuring a good balanced healthy diet and adequate hydration, and avoiding smoking, alcohol and drugs are also useful in reducing anxiety and depressive symptoms.^{16,17} Working on sleep hygiene and trying to get a good sleep at night using tried and tested methods can also be useful.¹⁷ Exercise is also important and known to be beneficial to our mental state¹⁸. Extreme isolation such as that recommended in the UK for those aged over 70 years and those with severe pre-existing medical conditions may have a detrimental effect not only on physical health and the ability to withstand infection but also on mental health.

Conclusion

Overall, it can be seen that anxiety and depression are ubiquitous human emotions which occur in response to certain situations and stimuli. These symptoms are usually reversible once the situation changes. However, continued stress at this time may result in longer-term anxiety and depressive syndromes. There are some practical steps we can take to try to limit the effects of the current situation on our own mental health as well as that of our loved ones and our patients.

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Declaration of interest

Supplementary material

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1.2.5 Is COVID-19 changing psychiatry?

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Abstract

Two articles on the potential impact of the current coronavirus pandemic on psychiatry reveal agreement on many points, but opposing positions on the methodology, philosophy and politics of psychiatry's response. This points to the need for psychiatry to audit its approach to evidence when agility is required.

Contents

- *Is COVID-19 changing psychiatry?*
 - *Declaration of interest*

All disasters stress-test the societies they impinge upon. The current coronavirus pandemic is no exception. In this issue of *BJPsych Bulletin*, two authors^{1,2} consider the impact the virus might have.

Perhaps surprisingly, there is much agreement. Neither finds dire forecasts of an imminent psychiatric epidemic convincing, although both recognise that there are risks, for some more than others. Both are concerned that the understandable worries associated with COVID-19 may be excessively medicalised and recommend interventions that will limit this. They also implicitly agree that diagnosis is central to psychiatry's identity and validity, focusing on how diagnostic procedures should respond to a change in our average level of fear, though from opposing positions.

Behind the disagreement lies a clash of methodology as well as philosophy and politics. Like the mills of God, orthodox research into diagnostic validity and reliability both improves diagnosis and clarifies its flaws painstakingly but glacially, through peer-reviewed publication and replication. In contrast, networks of critical professionals and patients can both flag difficulties and propose persuasive solutions, using conferences and social media to promote them rapidly as 'grey literature', for incorporation into reports from stakeholder organisations. Crises demand rapid responses, and the rapidly rising tide of concern about the quality of academic literature on COVID-19 suggests that our current approach to evidence lacks agility when that is needed. We hope that these articles spark a conversation about how psychiatry should audit its response to the pandemic, so it can learn and improve.

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Commentary on... Does COVID-19 pose a challenge to the diagnoses of anxiety and depression? A psychologist's view; and Does coronavirus pose a challenge to the diagnoses of anxiety and depression? A view from psychiatry. See this issue.

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Declaration of interest

D.M.F. is on the editorial board of *BJPsych Bulletin*.

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1.2.6 COVID-19, medical education and the impact on the future psychiatric workforce

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Abstract

Since the start of the COVID-19 pandemic the UK's National Health Service (NHS) has been transformed to meet the acute healthcare needs of infected patients. This has significantly affected medical education, both undergraduate and postgraduate, with potential long-term implications for psychiatric recruitment. This article discusses these ramifications, and the opportunities available to mitigate them as well as to enhance the profile of psychiatry.

Contents

- *COVID-19, medical education and the impact on the future psychiatric workforce*
 - *The recruitment crisis in psychiatry and its wider workforce implications*
 - *The impact of COVID-19 on medical education*
 - *The impact of COVID-19 on mental health*
 - *Opportunities to mitigate the potential impact of COVID-19 on recruitment into psychiatry*
 - *Conclusions*
 - *Supplementary material*

When it became clear that the first two cases of SARS-CoV-2 infection reported in the UK in January 2020¹ represented an emerging pandemic, the National Health Service (NHS) completely reconfigured its services. To meet the needs of patients diagnosed with COVID-19, elective treatments were cancelled, face-to-face appointments moved online and huge numbers of healthcare workers were redeployed. While mass transfers of staff to front-line roles were facilitated, movements of other healthcare workers were delayed or cancelled: 20 000 junior doctors due to rotate training placements on 1 April 2020 were informed by Health Education England that, except in exceptional circumstances, their

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Declaration of interest: None.

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rotations were cancelled.² At the same time, medical students throughout the country faced widespread disruption of their studies.³ Both these events have resulted in a significant number of undergraduate and postgraduate medical trainees missing out on psychiatry placements, with potentially significant consequences for future recruitment into the specialty. These have not gone unnoticed.⁴

The recruitment crisis in psychiatry and its wider workforce implications

Concerns about recruitment into psychiatry are not new. A review of medical student career choices over 40 years demonstrated that the number choosing to specialise in psychiatry has remained constant – at 4–5% – despite the increasing mental health needs of the population.⁵ Surveys of career choices of foundation doctors show a similarly fixed number applying for core psychiatry training.⁶ A recent estimate suggests that, if the projected increase in Certificate of Completion of Training (CCT) holders is accurate (based on numbers applying to training), by 2033 there will be a per capita reduction in psychiatrists of around 11%.⁷

A number of reasons for this crisis have been suggested. These include stigma towards the profession, perceived lack of a scientific basis to diagnosis and treatment, and erosion of the role of the psychiatrist within mental health teams.⁸ Poor teaching and clinical experience at medical school have also been implicated.⁹ In contrast, experience of psychiatry during foundation training has been found to have a positive influence in choosing the specialty.^{10,11} During medical school, the length, quality of teaching and types of patient interaction have been identified as important.¹²

Knowledge of the push and pull factors for the specialty has led to the development of a number of initiatives to promote recruitment. University-based enrichment activities^{13,14} such as Psych Socs,¹⁵ special study modules (SSMs) and summer schools have emerged to support and encourage medical students with an interest in the field. Nationally, the Royal College of Psychiatrists (RCPsych) has developed the Psych Star Scheme and student Associate role, to enable enthusiastic medical students to further their interest in the field.¹⁶ Following graduation, ‘flexible pay premia’ encourage applications for hard-to-fill posts,¹⁷ including psychiatry. In parallel, the RCPsych’s Choose Psychiatry campaign promotes psychiatry to medical students and foundation doctors through the use of videos, social media and podcasts.¹⁸

All of these complement the recent expansion in the number of psychiatry posts within the UK Foundation Programme. This was a direct response to concerns regarding recruitment into psychiatry and was recommended in the 2014 Broadening Foundation Programme report.¹⁹ It is recognised that the structure of the NHS and provision of healthcare need to change to meet the challenges of treating a population that is older, with increasing numbers of chronic health conditions. It emphasised the need for the Foundation Programme to provide broad-based training for junior doctors, giving them adequate experience and education in community and mental healthcare.¹⁹ Key for psychiatry was the recommendation that 22.5% of Foundation Year 1 (FY1) doctors and 22.5% Foundation Year 2 doctors (FY2) should have a post in psychiatry.¹⁹ Alongside the hope that this would boost recruitment into the specialty, it also represented an acknowledgement that there are numerous skills, including communication, empathetic understanding and multidisciplinary learning, acquired within a psychiatric placement, that are valuable whatever specialty the post holder ends up practising in.²⁰

Despite this increase, many foundation doctors still have limited clinical experience of psychiatry. To address this the RCPsych, alongside the UK Foundation Programme, has developed Psychiatry Foundation Fellowships.²¹ These offer access to additional education and supervision resources to support doctors with an interest in the field during their foundation years through to specialty application. Academic Foundation Posts in psychiatry offer opportunities for trainees interested in research, directly challenging the negative assumptions regarding the lack of scientific basis to the field.⁸ Additionally, pilot Longitudinal Integrated Foundation Training (LIFT) posts in psychiatry are being developed, following the success of these in general practice.²²

A recent announcement by the RCPsych suggests that these initiatives are working. In England, fill rates for core psychiatry training have increased for the third year running, with almost 100% of places filled for August 2020.²³

The impact of COVID-19 on medical education

On 12 March 2020, all doctors in the UK were informed that they would need to respond ‘rapidly and professionally’ to the challenge of COVID-19 and might be required to work in areas outside their usual practice.²⁴ Although it was initially suggested that foundation doctors currently in mental health placements would not be redeployed,² different local arrangements meant that some were moved from psychiatry to front-line roles.²⁵ This was followed by the cancellation of all medical training rotations in April, May, June and July.^{2,26}

There are approximately 15 000 foundation doctors in the UK,²⁷ and thanks to the changes to the Foundation Programme, a significant number now undertake a post in psychiatry across their 2-year foundation training. One-third of these were due to start on 1 April 2020 but did not. If undertaking a high-quality psychiatry post during foundation training increases the likelihood that a trainee will apply to the specialty,²⁰ this is likely to have a negative impact on the recruitment cycles for 2021 and 2022.

Undergraduate medical education has also faced significant upheaval. In the early weeks of March 2020, universities across the UK suspended face-to-face teaching and other educational activities. For medical students this meant the widespread cancellation of their clinical and elective placements,³ and a move to online education. While final year medical students were being fast-tracked through pre-registration to support the front line,²⁸ students in other years missed out on vital educational experiences.²⁹ The impact of these changes is already emerging.³⁰ A recent survey of final year medical students found that over a third had their final year objective structured clinical examinations (OSCEs) cancelled and almost half had assistantships cancelled, with significant effects on self-reported ratings of preparedness to start as FY1 doctors.³⁰

For psychiatry recruitment, the effects could be profound. Psychiatry placements often take place in the penultimate year of medical school. These students will now move into their final year, where the focus is on preparing for practice, with little time in the curriculum to make up for missed clinical placements. Given the uncertainty regarding the status of clinical placements during a second wave of the pandemic, it is highly likely that further year groups will similarly miss out on vital face-to-face psychiatry experience. In addition, the impact of the cancellation of the SSMs, elective placements and other enrichment activities, known to be key to fostering positive attitudes to a career in the specialty,^{13–15} is perhaps more concerning. These activities are available throughout medical school. The legacy of these losses therefore, means that the after-effects of the pandemic on psychiatric recruitment could be felt for years.

The impact of COVID-19 on mental health

The potential impact on recruitment is particularly concerning given the postulated effects of the COVID-19 pandemic on the population’s mental health.³¹ There is already evidence of psychological sequelae in those who were infected with SARS-Cov-2.³² More broadly, the impact of the public health measures, including shielding, social distancing and quarantine, is starting to emerge; a recent national survey demonstrated an increase in mental health problems across all age groups in April 2020.³³ In the longer term, the consequences of the predicted economic recession³⁴ will further increase psychiatric morbidity. These effects will be against a back-drop of a pre-pandemic predicted increase in mental healthcare needs within the population³⁵ and ongoing workforce supply difficulties.³⁶

Opportunities to mitigate the potential impact of COVID-19 on recruitment into psychiatry

What can be done and what are the opportunities? Over the coming months, there will hopefully be some time to consider what we can do to mitigate any negative impact the acute response to COVID-19 has on recruitment into psychiatry. There are a number of dimensions to this.

Foundation trainee rotations have now resumed. In addition to the recommendations for these placements made by the RCPsych,³⁷ trainers should take the opportunity to highlight some of the positive effects the NHS response to the pandemic has had on the delivery of mental healthcare, for example the cross-specialty collaborations demonstrated by initiatives such as the CoroNerve,³⁸ the potential for telehealth, or new research avenues such as the role of the immune system in emerging psychiatric symptoms.³² These clearly demonstrate how central psychiatry is to the health and scientific communities’ response to COVID-19, helping challenge many of the negative views of the specialty.

For those doctors who missed out on their chance to undertake a psychiatry foundation post, there are other opportunities for their potential enthusiasm to be encouraged. Existing initiatives for foundation doctors should be strengthened,³⁹ with targeted invites to those doctors affected by the cancellation of rotations, if possible. For FY1 doctors there remains the opportunity to undertake taster days in psychiatry as FY2s. These are usually limited, but given the flexibility foundation doctors demonstrated to facilitate the NHS's acute COVID-19 response, supporting them to make up for lost clinical experience by extending these seems reasonable.

Foundation doctors are increasingly not applying directly to specialty training, instead undertaking F3 and F4 years.⁶ The expansion of clinical fellowships in psychiatry – which offer full access to supervision and the other educational opportunities that core trainees receive – may offer alternative opportunities for those who missed out first time round.⁴⁰

The Medical Schools Council has outlined the need for clinical placements to restart,⁴¹ with priority given to those closer to graduation. Further cohorts of medical students are therefore likely to be affected by the loss of clinical experience in psychiatry. In recent years, virtual work experience programmes have been developed to support school-age students considering a career in medicine.⁴² Universities should consider learning lessons from these, to create virtual psychiatry placements, with an emphasis on patient interaction and high-quality clinical teaching. This could complement the number of psychiatric summer and autumn schools that have already moved online.⁴³

Although developing imaginative alternatives to face-to-face clinical placements is important, it is essential that this does not become the default. Positive attributes of undergraduate psychiatry education include time on placement, working directly with the multidisciplinary team and the influence of role models from within the psychiatric team.⁴⁴ It is hard to see how these can be achieved remotely. The continued facilitation of face-to-face psychiatry experience for medical students should therefore remain a priority.

It has been suggested that time for enrichment activities such as SSMs should be redirected towards core clinical placement activity.⁴¹ It is vital that undergraduate psychiatry departments are involved in these discussions. Not only are enrichment activities in psychiatry important for recruitment, they help fight stigma towards the specialty and the patient population. These should be viewed not as optional extras, but as essential to creating a generation of doctors who view mental illness in parity with physical illness.

One of the positive outcomes of the COVID-19 pandemic has been the speed and readiness with which medical education departments have adapted to the use of online learning. The Medical Schools Council is recommending the use of a number of online platforms to support undergraduate education.⁴⁵ It is vital that psychiatric education is embedded throughout these. The potential for moving SSMs and other psychiatric enrichment activities online should also be fully explored. The use of webinars has greatly expanded as a result of the pandemic, with the RCPsych producing a number that are freely available, and grand rounds and journal clubs now frequently take this form. Delivering psychiatric education this way offers great scope to widen the potential audience, with the main barrier being the lack of awareness among potential attendees. At a national level these resources should be highlighted within the Choose Psychiatry campaign. More locally, promotion of online educational material should be embedded within induction for medical students and via local postgraduate education departments.

The expansion of simulation for psychiatry is another area of potential.⁴⁶ These courses should be re-offered to those who missed out on their clinical placements, as well as expanded to supplement loss of clinical experience of future students. Although much postgraduate education remains online, face-to-face foundation simulation programmes continue. A number of providers have already developed psychiatric simulation courses for foundation doctors, but frequently these are available only to trainees undertaking a psychiatry post. The skills of managing risk, communication, human factors and de-escalation, inherent in these courses, are key outcomes of the Foundation Programme Curriculum⁴⁷ and could easily be incorporated into existing programmes. Through their inclusion alongside other 'core' subjects, psychiatric simulation courses would reduce stigma as well as encourage some to consider a future career in the specialty.

Conclusions

Developing a set of strengthened undergraduate and postgraduate psychiatric educational resources can only benefit future recruitment into the specialty. But as autumn continues, we are now facing the second wave of COVID-19 cases. Although the redeployments of healthcare workers and cancellations of placements were necessary first time round, it is essential that we reflect on their impact. Understanding the effects of the acute management of the COVID-19 pandemic on psychiatric recruitment is vital to inform decisions regarding future suspensions of medical student attachments and movements of trainee doctors. These must try to balance the acute requirements of COVID-19 patients with the need to ensure that there is an adequate psychiatric workforce to address not only the current, but also future mental health repercussions of the pandemic.

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Supplementary material

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[click here to view supplementary material](#)

1.2.7 Running a journal club in 2020: reflections and challenges

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2020-11-13

Abstract

The online environment brings both challenges and opportunities. The skills learned in journal clubs remain highly relevant where the ability to critique rapidly generated information and apply evidence to patient care is vital. Creativity and flexibility are needed to ensure that learners' needs are met and efforts are made to involve those who may not be naturally drawn to online environments. This article explores how journal clubs have been approached in the past, both in person and more recently online, considers techniques for maintaining engagement in online teaching and proposes new approaches for future journal clubs.

Contents

- *Running a journal club in 2020: reflections and challenges*
 - *Journal clubs of the past*
 - *Journal clubs online: what we know so far*
 - *Techniques for maintaining engagement with online learning*
 - *Recent learning following COVID-19 restrictions*
 - *Journal clubs of the future*
 - *Declarations of interest*
 - *Supplementary material*

The Royal College of Psychiatrist's curriculum for core trainees requires the development of critical appraisal knowledge, skills and habits for practising evidence-based medicine (EBM).¹ Since 1999, critical appraisal skills have been assessed in MRCPsych written examinations.² It is accepted that attending a journal club offers trainees a key opportunity to learn and practise critical appraisal skills. Attending and presenting at a journal club are recommended for all trainees, being a workplace-based assessment (WPBA) for core trainees within their curriculum and required for annual review of competency progression (ARCP).¹ Monitoring of attendance and reinforcement of its importance are likely to vary within UK deaneries and internationally.

Journal clubs of the past

Doctors assembling to review current literature has been recorded as far back as 1875.³ However, recent difficulties in engaging doctors in journal clubs have been discussed.² In 2009, Agell wrote of a 'journal club syndrome,' in which he reported an observed correlation between reported 'mishaps' preventing trainees from engaging in the learning process and the timing of their scheduled presentations.⁴ This somewhat cynical view highlights the long-standing anxieties and struggles with engagement that trainees might face.

In 2008, Deenadayalan et al recommended establishing an overarching goal for a journal club which is reviewed and agreed by participants, recording and expecting attendance, establishing sustainable leadership with access to a statistical expert as needed and providing incentives such as food.⁵ Other aspects, such as article choice, are also specified. In psychiatry, Swift built on these strategies, highlighting the importance of structure, clear aims, a social aspect for the group and discussing selection of the facilitator (with critical appraisal and teaching skills but also able to provide enthusiasm and approachability for more junior colleagues).^{2,6} Moving away from the traditional format by introducing 'evidence-based journal clubs' has been suggested.^{2,7} Such sessions would address a specific clinical problem by referring to available literature.

Journal clubs online: what we know so far

Although the COVID-19 pandemic resulted in a rapid move to online learning, journal clubs have existed in the virtual world for some time. These can take the form either of synchronous learning, when a teacher is present at the same time as students, or of asynchronous learning, when a teacher directs study but is not present when the learning takes place.

Many asynchronous options for journal review have been developed, supporting the face-to-face meetings. MacLaren et al have discussed the internet possibilities, using social media platforms such as Facebook, Twitter handles and Mentimeter as a means to widen potential journal club participation and support learning.⁸ Other e-sources are available for accessing mental health information, an example being the Mental Elf, which has used blogs, social media and gamification to incentivise users.⁹

There has been a recent surge of asynchronous Twitter journal clubs,¹⁰⁻¹³ in which participants contribute via tweets over a specified time period (typically between 1 h and 1 week), providing free participation, open journal access, time efficiency and a diverse international forum for discussion. Instructions for those wishing to set up an asynchronous journal club can involve a number of steps, including incorporating other social media platforms and considering the most convenient time for its target audience, to make their establishment accessible to all.¹⁴ Plante et al note that content may be unregulated and that some might struggle to learn from reviewing past discussions, and suggest that Wiki Journal Club (a website that allows collaboration in writing summaries, critical analysis and reviews of chosen papers, similar to Wikipedia) overcomes these barriers by providing editorial and professional moderation, easily referenced and referred to.¹⁵ MacRae et al found a significant improvement in critical appraisal skills among participants of their surgical journal club, compared with a control group, but acknowledged that those involved in a Twitter journal club are likely to be more motivated than the general surgeon population.¹⁰

Synchronous online journal clubs have had less exploration. Among Lin & Sherbino's suggested steps for setting up an online journal club is the added possibility of 'live' video panel discussions using technology such as Google 'Hangouts on Air' and YouTube.¹⁶ More recently, the *BJPsych* has collaborated with university psychiatric societies to help successfully launch live virtual journal clubs, with student presentation followed by expert-panel discussion.¹⁷ A

similar approach has been followed with dental trainees, highlighting the benefits of accessibility, ease of interaction and effective learning.¹⁸

Although additional online options may increase the potential for journal club participation, they are unlikely to suit all trainees. Twitter is the most popular form of social media communication among healthcare professionals,¹⁹ but the exact prevalence of use among doctors, or more specifically trainees, is to our knowledge not reported. If medical education becomes dependent on social media platforms, the risk is that some will be alienated or simply not reached.

Techniques for maintaining engagement with online learning

Difficulties in engaging learners online are a recognised challenge for educators; traditional face-to-face teaching methods cannot simply be adopted in the online environment.²⁰ Additional considerations are needed (*Box 1*). Box 1 Instructor considerations for maximising engagement in online learning Consider three domains: cognitive, affective and managerial²¹ Existing face-to-face options cannot simply be replicated online; a new approach is needed²⁰ Initial resistance is to be expected and learners may need additional support at the outset²⁴ Clinical scenarios improve perceived relevance/authenticity²⁴ Consider the diversity of the group and individual learner needs and preferences^{25,26}

Coppola et al proposed that the online instructor's role has three domains: cognitive, affective and managerial, achieving a balance between imparting information effectively, communicating approachability, enthusiasm and intimacy, and being an effective organiser and administrator.²¹ A recent Best Evidence in Medical Education (BEME) review describes techniques used by educators to maximise student engagement online, necessitated by COVID-19.²² These include the need for effective organisation and structure, and varied options for student interaction, such as using online chat features, polling, hand-raising and breakout rooms.²² Warren et al argue the need for flexibility in this process, incorporating different learning modalities, considering technical resources and support.²³ Engagement can still be delayed unless a learner is willing to change habits and thus suspend their disbelief in a new approach, with additional support and time needed for them to do so.²⁴

Online learning is often more effective when activities are 'authentic', using complex clinical scenarios and tasks to increase the perceived level of relevance for the learner.²⁴ In the current climate, using cases or studies involving COVID-19 specifically might assist with this.

One must consider all students rather than just the most vocal or communicative.²⁵ Haggis proposes that teachers address student diversity by shifting their approach away from the struggling learners towards a more dynamic stance, considering the overall student–teacher interactive process.²⁵ Problematic areas need to be addressed, including acceptance of the wide range of students' experience, motives, interaction and communication preferences. The instructor could consider using diverse examples when setting problems/tasks and fostering social relationships within the group, while still respecting the student's own responsibility for driving their learning and seeking help.²⁶ Forcing some students to contribute, when not part of a shared collaborative process, could endanger their autonomy and motivation.²⁷

Recent learning following COVID-19 restrictions

In 2020, since the COVID-19 pandemic, psychiatry training has depended on online technology to replace all face-to-face journal club meetings. Within months, our use of platforms such as Zoom and Microsoft Teams became the 'new normal' and the only option for teaching and networking. Although some participants were already familiar with the array of online options, many may not have been and could still be struggling to keep up.

Within South West London and St George's Mental Health NHS Trust, we have continued to run a weekly journal club using the virtual platform of Microsoft Teams, supported by a WhatsApp group to offer further discussion as needed. Efforts were made to boost the effectiveness of the journal club by recruiting additional higher trainees to support the sessions, increasing the level of support offered to the lead presenter and making particular efforts during journal club meetings to encourage all to contribute. Although the numbers in the virtual room have been noticeably higher than those in face-to-face meetings before March 2020 – up to two or three times as many – engagement levels have been difficult to measure, with many of those present in the virtual room not taking an active part. In the absence of visual cues, with most turning off their screen camera and not using the 'chat' function, we struggle to assess who is actively

engaging in the group and who finds it useful. Several trainees have commented on missing the social aspect of the group.

As it has become unclear how long COVID-19 restrictions will continue, morale has declined. The initial high level of discussion has not been maintained; not all trainees have appeared confident to engage, either by speaking openly, using the written chat/Q&A function or through the WhatsApp group. This experience is, of course, likely to vary between different hospitals, trusts and deaneries, depending on the confidence of trainees, as well as the ethos and culture of the organisation.

Reflections and feedback from trainees are continuously sought and contribute to future planning (*Box 2*), but we are aware that those most disengaged from the process are less likely to communicate their needs. *Box 2* Lessons learned from recent experience Assessing and maintaining engagement in online forums is a challenge Uncertainty about the future can be unsettling and disempowering for some trainees Trainees feel a loss of the social aspect of journal clubs Learning and training opportunities have been threatened by clinical workload, technological limitations and noisy surroundings Facilitator encouragement, support and continuity are critical Trainees appear to appreciate a flexible approach, such as presenting articles in pairs, structuring their session in varied ways and focusing on different aspects of the paper. Some are interested in statistical methods and details, whereas others prefer to focus on how the research relates to previous and future research or how they can make use of the data in their practice

Journal clubs of the future

Journal clubs continue to be a valued part of psychiatry training, offering a key opportunity to learn and practise critical appraisal skills, presenting skills, critical thinking and structured discussion. There is no current alternative within the RCPsych curriculum that offers these opportunities, and journal club remains a WPBA for core trainees.¹ The current pandemic reminds us how critical evidence-based medicine is to our practice, with a flurry of new research on COVID-19, and the need to recognise how new research should be integrated into practice. The transition to online journal clubs now requires a new set of organiser and administrator skills, which is a challenge in some departments. Even before 2020, journal clubs were struggling with participant engagement.^{2,6} Online journal clubs might be embraced by those with research or education focus; but there is a high risk that others could feel excluded. Others might be starting to get online fatigue.

Considering techniques for effective engagement in online teaching can enhance our ability to facilitate journal clubs.^{20–23} The use of clinical problems and specific tasks, similar to the previously introduced evidence-based journal clubs, may provide additional relevance and authenticity for learners.^{6,7,24} Considering the diverse range of learner needs and preferences is advised.²⁵ The online platform potentially supports educators in managing diversity by improving accessibility, in particular for those shielding or working on a different clinical site. Publicising and encouraging the use of additional asynchronous learning resources^{8,9} such as Twitter journal clubs to support sessions¹⁴ is worthwhile.

When running future synchronous online journal clubs, instructors need to transform their approach, not only in offering appropriate guidance and knowledge, but also in helping to establish an approachable atmosphere, optimising the potential for discussion and collaboration.²² Trainee uncertainty about the future and feelings of social loss need to be acknowledged, as does the consideration of variability in resources and skills, with limited availability of functioning computers for some. Trainees have fed back that they appreciate additional guidance on presentation style, paper choice and additional resources. They have expressed a preference for flexibility, not defining the style of presentation and allowing the option of multiple communication forms (speaking in person, typing in the written ‘chat’, as well as using WhatsApp and other social media platforms). A challenge of measuring active participation remains, as the administrative resources required to record contributions might not be feasible within all training programmes. Forcing contribution could endanger trainee autonomy,²⁶ although it should be recognised that it is an expected and important part of the trainee curriculum.¹

This article can only be the start of a more complex discussion and re-evaluation of the function, purpose and delivery of online journal clubs and the part they play in the psychiatry curriculum, as well as considering the level of support provided to trainees and by whom. Collaboration and discussion between professional educators in neighbouring training programmes will help explore and expand the wider networking potential of journal clubs.

We thank the core trainees at South West London and St George's Mental Health NHS Trust whose opinions and views contributed to the conclusions of this article.

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I.M. developed the concept for the article, wrote the main draft and revised it following comments from the other authors. M.S. and C.A. substantially contributed to the design, made critical revisions and approved the final version. All authors are accountable for the work.

Declarations of interest

None.

Supplementary material

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1.2.8 Digital psychiatry and COVID-19: the Big Bang effect for the NHS?

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2020-10-21

Abstract

The COVID-19 pandemic has brought untold tragedies. However, one outcome has been the dramatically rapid replacement of face-to-face consultations and other meetings, including clinical multidisciplinary team meetings, with telephone calls or videoconferencing. By and large this form of remote consultation has received a warm welcome from both patients and clinicians. To date, human, technological and institutional barriers may have held back the integration of such approaches in routine clinical practice, particularly in the UK. As we move into the post-pandemic phase, it is vital that academic, educational and clinical leadership builds on this positive legacy of the COVID crisis. Telepsychiatry may be but one component of 'digital psychiatry' but its seismic evolution in the pandemic offers a possible opportunity to embrace and develop 'digital psychiatry' as a whole.

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 - *Is digital psychiatry safe, effective and acceptable to patients and clinicians?*
 - *Potential barriers to implementing digital psychiatry*
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The COVID-19 outbreak has posed an unprecedented challenge to healthcare systems and to society as a whole, with millions infected globally and tens of thousands of deaths in the UK alone. Stay-at-home and lockdown guidance was instituted to ensure that the National Health Service (NHS) had the capacity to deal with a possible surge in COVID-19-related presentations, not least as NHS staff were equally affected by quarantine and sickness challenges. Remote consultations, or ‘telemedicine’, hitherto a somewhat niche offering in the NHS led primarily by technology enthusiasts, saw an explosive growth, with the New York Times reporting: ‘Telemedicine arrives in the U.K.: “10 years of change in one week”’.¹

The urgent need to deliver patient care effectively and safely in the pandemic was supported by new NHS guidance² that facilitated a rapid rollout of remote consultations in most areas of psychiatric practice.

This occurred despite the pre-existing cautionary digital guidance from the Royal College of Psychiatrists echoing the General Medical Council (GMC) in its advice that ‘standards expected of doctors [...] apply equally to digital and conventional consultation settings’ and that doctors must give ‘consideration to the potential limitations of the medium used’.³ In particular, for psychiatrists, perhaps more than any medical specialties, there have been long-standing concerns of loss, potentially harmfully so, of the ability to pick up by distance the subtle interpersonal cues of the mental state examination.

‘Telepsychiatry’ is not new. Defined as the provision of psychiatric services remotely through various technological communication platforms,⁴ technology-based mental healthcare has been in operation for several decades. Samaritans, the well-known telephone helpline service, started its operations in 1953. However, a more important contemporary phrase is ‘digital psychiatry’, which moves beyond just the digital delivery of a consultation to the provision of an on-demand, highly personalised, confidential and secure care made available through an easy-to-use, intuitive interface. However, digital psychiatry is much more than that. Rethinking conventional psychiatry, heavily reliant on the written and printed word to store medical information, often distributed by traditional methods such as by post, to move to a world where digital tools can record, analyse and make intelligent interpretations of data will require a clinical, administrative and intellectual evolution.

The NHS Long Term Plan outlines its vision of every patient (in England) being able to access digital services – at least at the primary care level – by 2024, putatively saving 30 million patient trips and over £1 billion/year in costs.⁵ However, the possibility of delivering a socially distanced but safe and effective service has provided a fresh fillip for the adoption of digital health in both primary and secondary healthcare. Will the relatively enthusiastic adoption of virtual assessments provide a template for the wider rollout of new technologies in clinical practice beyond the pandemic?

If such promise is to be realised, remote consultations, digital self-help, electronic patient record systems, triaging using artificial intelligence (AI) and a range of other digital tools will need to be scaled up sustainably, paying attention to patient preference, patient safety and clinical outcomes, including the concept of precision psychiatry. This article outlines the key factors that need urgent consideration to ensure the integration of digital solutions in routine clinical practice.

Is digital psychiatry safe, effective and acceptable to patients and clinicians?

The justifiable clinical concern of coronavirus infection during the pandemic has shifted the fulcrum of safety significantly away from face-to-face consultations. The use of telemedicine in post-disaster situations is well-established.⁶

Systematic reviews demonstrate substantial evidence to support the effectiveness of remote psychiatry.^{7,8} Most of the evidence has emerged from the need to overcome accessibility barriers to psychiatric care, for example in areas isolated owing to disasters such as hurricane Katrina or to their geographical location, such as rural Canada and Australia. Studies looking at the effectiveness of remote clinical work are mainly head-to-head and non-inferiority studies demonstrating equivalence with face-to-face interactions. These show effectiveness comparable with face-to-face assessments in terms of patient engagement, validity/reliability of assessments, and clinical outcomes.^{9,10}

Rapidly emerging evidence shows that telepsychiatry is being successfully utilised globally, in the wake of the COVID-19 pandemic. Yellowlees et al¹¹ reported the process, challenges and lessons learned from a rapid conversion of a direct psychiatric clinic to a virtual one within the space of 3 working days in Northern California. Rosic et al¹² provided an interesting patient and provider perspective on the transition to a virtual clinic following the onset of the pandemic in Canada. Sharma et al¹³ have discussed a similar transition in a child and adolescent setting in Seattle. Duan & Zhu¹⁴ have described the development of mobile phone and social media-based platforms to provide psychological care in China. These examples demonstrate the point that COVID-19 has propelled the global psychiatric community into a new era with the use of technology in delivery of psychiatric care.

Remote access has been noted to be effective for treating a variety of conditions, such as depression, anxiety, post-traumatic stress disorder (PTSD) and psychosis. It has been particularly useful for individuals who face specific difficulties attending out-patient appointments, such as some with psychosis and social anxieties, and social difficulties such as housing instability.

In child and adolescent psychiatry, we have evidence for the effectiveness of digital psychiatry for the psychiatric assessment and management of attention-deficit hyperactivity disorder and early psychosis, as well as delivery of therapy for obsessive-compulsive disorder and tic disorder.¹⁵ Hantke et al¹⁶ demonstrated the effectiveness of remote working in a variety of older person's settings, such as nursing home, community and hospital settings for individuals with cognitive, functional and sensory impairment. Such interventions have also been associated with reduced transfers to hospital and benefits for patients with limited mobility.

Benefits have been shown in criminal justice and other forensic settings, where safety concerns about physical movement of high-risk patients can be mitigated through remote assessments and remote expert testimony.¹⁷ Remote psychiatry has also been demonstrated to have a positive impact on the assessment and management of individuals with intellectual disabilities, with some data showing no loss in therapeutic engagement compared with face-to-face assessments and even some evidence for improved engagement among children with severe anxiety and autism.¹⁸ In addiction psychiatry, remote treatment of opioid use disorder produced similar outcomes as face-to-face treatment in both general¹⁹ and obstetric settings.²⁰

Interestingly, healthcare providers were more likely than patients to express concerns regarding adverse effects of remote assessments on therapeutic alliance.⁷ Although there is considerable evidence for remote therapy,²¹ Norwood et al²² found that working alliances were inferior compared with face-to-face work, even though symptom reduction was equivalent.

However, the (few) studies on the topic tend to report overall high levels of satisfaction with digital consultations,²³ including for children and adolescents.^{15,24}

Bashshur et al²⁵ identified telemedicine as a cost-effective solution for triage, consultation, prescribing medications, provider-to-provider discussions, appointment scheduling and reminders. Furthermore, the study also found that remote interventions in primary care were at least as effective as traditional care.

Given these effectiveness and experience data and the evidence that telepsychiatry is cost-effective compared with face-to-face treatment, one must question the historical factors limiting adopting technological solutions in the value-driven public NHS.

Potential barriers to implementing digital psychiatry

The potential barriers to digital working fall into three broad categories – regulatory concerns, technological hurdles and human factors.

NHS practice is influenced by several bodies, including the GMC, the medical Royal Colleges and medical defence unions, clinical guidance from the National Institute for Health and Care Excellence (NICE), and local and national commissioning protocols involving a host of stakeholders, such as clinical commissioning groups, NHS trusts and so forth. None preclude digital working, and indeed all generally support the principles. However, their nature, number and potentially conflicting messaging can make them inherently resistant to swift changes, even for interventions with proven clinical benefit and cost-effectiveness.

There is a wide variation in the technological maturities among mental health providers across the country. Technological and security concerns include clinical governance issues, safeguarding, legal liability, confidentiality and secure storage of digital information, with worries about reliability of technology and variation in bandwidth across the country.

Human factors can be a potent barrier, with clinician anxieties centring on: building rapport in a digital interview; being ‘recorded’, with potential consequences for personal liability; and perhaps most powerfully, the lack of personal incentives to change. The densely populated nature of the UK may make some accessibility problems seem less relevant. The edict of *primum non nocere* – first do no harm – is so embedded in medics’ psyche that it perhaps makes clinicians inherently cautious about change. This is likely only exacerbated by many doctors’ adverse perceptions of restrictive, stifling information governance rules and regulations.

For patients and carers, lack of access to technology on account of financial, technological, physical or cognitive factors may be a barrier. Global evidence, however, demonstrates that patients show a clear preference to having alternatives in addition to face-to-face assessments.

The COVID-19 crisis demonstrated that all these barriers can be rapidly overcome. NHSX provided timely and much needed guidance and assurance on the use of a variety of methods to enable and support working.³ Despite inevitable hiccups, internet and technology solutions worked in a manner perhaps not attainable had the pandemic occurred say even 5 years ago. Clinician and patient experiences have surely buried the ‘unacceptable’ argument.

Digital psychiatry: the future

Recent experiences have exemplified the differences between older-fashioned ‘telepsychiatry’ and the innovations possible with ‘digital psychiatry’. Doing ‘the same’ but via video calls is limited progress, though perhaps the initial leap made by most clinicians. A variety of platforms have been made available with new features such as: a waiting room (simulating clinics); multiple participants (to enable multidisciplinary team working); a screen sharing feature to show written information (to aid explanations and education during the clinical interview); and inbuilt capability to email or message the patient, carer or other colleagues and to save these communications directly in the electronic clinical records. Recent developments have also shown clinician benefits beyond ‘just’ the flexibility of working from home, including examples of offering more flexibility in hours of work and timings of clinics, such as evening and weekend working (no longer needing office buildings to be kept open). Asynchronous meetings are allowing staff to read, comment on and contribute to documents outside of the ‘standard meeting’ time, as well as message and add written comments as meetings progress.

Simultaneously, there have been some anecdotal concerns about ‘sharing’ one’s home environment with others, whether colleagues or patients, alongside some sense of fatigue at engaging many participants online without full human engagement. The range of competing platforms is potentially confusing and we are still learning to navigate these, and when and how to use the novel technologies within.

But while we attempt to master the etiquette of how and when to speak across large meetings, digital solutions have also emerged to support home-based care for our patients. From the surge in the use of digital apps for mental health and well-being to the rise in digital prescribing, digital dictation and even digital therapies as people adapted to the lockdown world, technology has felt more palpable for both clinicians and patients. Innovations such as AVATAR therapy for

auditory hallucinations in chronic schizophrenia or individualised risk stratification using AI machine learning to ‘read’ patient records that are currently being piloted seem that much closer to routine practice.

Although the outcomes for patients receiving digital psychiatric care do not seem to be inferior to in-person care, we need better data about the subgroups of patients for whom this might not hold true. For example, early evidence suggests caution for individuals with cognitive impairment, at high-risk, with significant concomitant physical health needs and so forth. National data-sets from agencies such as NHS Digital or the Care Quality Commission may help inform this.

The legal, ethical and regulatory framework relating to remote consultations also needs clarification. Both patients and clinicians need to feel safe participating, and key issues include consent, capacity, confidentiality, need for chaperones, safeguarding for vulnerable patients, escalation arrangements, security of data and indemnity for clinicians. Early and successful resolution of these issues will avoid the stifling of innovation and will enable a more rapid adoption of wider digital enhancers to patient care.

The theme of integration is key to the NHS Long Term Plan and features prominently in the new community mental health framework.²⁶ Digital psychiatry in its broadest sense offers a unique opportunity to realise this integration, albeit virtually, of primary care, social care, third-sector partners, the criminal justice system and other stakeholders working with patients and clinicians to improve clinical outcomes. From virtual meetings to seamless patient-owned records, the possibilities are limitless.

A central feature of UK health policy and service delivery is its focus on person-centred care and this is particularly true for psychiatric practice and training.² Co-production has largely been absent in the evolution of digital psychiatry and it is vital that patients and carers have a central role in further rollout of this new technology. Current guidance issued for the pandemic will need to be updated on the basis of emerging evidence on indications and pathways and it will also need to take into account patient and professional feedback.

Workforce implications will need to be carefully considered. Roles and responsibilities for clinicians working remotely need to be clearly defined. Current arrangements enable the enforcement of national regulatory jurisdictions, and this might be challenged by some forms of virtual working. For example, licensure arrangements across several states in the USA have been relaxed to allow licensed clinicians to work remotely from outside normal state boundaries. This may be particularly relevant for countries such as the UK, where there has been a traditional reliance on international healthcare workers to provide an adequate clinical service: both an opportunity and challenge in working with clinicians outside of traditional workforce bases emerge.

Finally, the workforce will need appropriate training to deliver remote consultations safely and effectively. Currently, in the UK there are no curricula-specific training requirements, either at core or higher specialty level, for psychiatry trainees to demonstrate competence in digital skills that may be considered essential to good clinical practice, e.g. managing digitally enabled consultations, extracting clinically meaningful data from electronic patient records or prescribing evidence-based digital apps. Examinations may be moving online, as is the case with MRCPsych examinations beginning later this year, but embedding digital literacy in the training and assessment framework will require a significant shift in culture and practice.

Conclusions

The COVID-19 pandemic has given the NHS permission to rapidly review its ways of working to embrace technological advances. These offer the potential of flexible home-based consultations for clinicians and patients; the opportunity to connect multiple agencies more quickly to deliver a person-centred care plan; accessibility to communities who might otherwise not be reached; a window into the personal and home life of our patients; and all this potentially with a smaller carbon footprint and lower costs.

However, if we are to fully tap into the potential gains of digital psychiatry, we must realise how much more than this is on offer: an integrated use of technology in mental healthcare, supported by multidisciplinary, diverse teams of technologists, designers, health and care professionals and those with lived experience. It is about agile methodologies, user research, behaviour-change science, data science and social science blending together in organisations with less hierarchical power play and a more pragmatic and courageous approach to risk, as has been the case during this pandemic.

Our aspiration for digital psychiatry should reflect the expectations of the internet age – on-demand entertainment on a mobile digital device, real-time customer logistics so that one knows where a parcel is and the name of the driver, universal standardisation of our experience through ‘operating systems’ that allow fine-grained personalisation. We have much more to achieve than remote consultations, and certainly far more than doing video calls. And it is truly ‘digital’ platforms – ubiquitous computing through standardised operating frameworks on highly personalised and network-connected mobile devices – that have allowed us to achieve the adoptions we have in a matter of months.

We propose that what we have described as the barriers to adopting digital psychiatry are solved through harnessing the values, culture, practice and technological capabilities of the internet age.

Although the growth of digital psychiatry in the NHS may have been more of an evolution than a revolution, with the right leadership, training, research on digital innovations, and the necessary clinical, ethical and legal guidance we can dispel the digital darkness and usher in a new era of integrated, personalised and accessible psychiatric care. We call on the Royal College of Psychiatrists to set up a task force to develop national guidance to ensure that the Big Bang effect of COVID-19 on digitisation of clinical practice and training is sustained and amplified in the future.

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All eight authors are responsible for the article concept and design. S.D., S.A., R.R., S.M. and A.S.P. undertook the literature review and contributed to writing the first draft of the manuscript. H.R., J.S.B. and D.K.T. contributed to critically revising the final manuscript. All eight authors have reviewed and approved the final manuscript.

Declaration of interest

None.

Supplementary material

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1.2.9 College Members whose deaths were reported at Council meetings between October 2019 and October 2020

date

2021-02

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Bandali, Sameer Kamaluddin

Member

Beckett, Henry Dale

Member

Bethell, Maxwell Slingsby

Fellow ~ Over 40 Years member

Bhaumik, Sabyasachi

Honorary Fellow

Carroll, Bernard James

Fellow ~ Over 40 Years member

Fleminger, John Jack

Fellow ~ Over 40 Years member

Gosselin, Jean-Yves

Fellow ~ Over 40 Years member

Heine, Bernard Edmund

Fellow ~ Over 40 Years member

Holden, Hyla Montgomery

Member ~ Over 40 Years member

Kanakaratnam, Gunaseelan

Fellow ~ Over 40 Years member

Kanjilal, Gopal Chandra

Fellow ~ Over 40 Years member

Kolakowska, Tamara

Retired

Member ~ Over 40 Years member

May, Kathleen Mackenzie

Member ~ Over 40 Years member

Mirza, Yousuf Kamal

Consultant

Member

Scott, John Clelland

Fellow ~ Over 40 Years member

Sirag, Ahmed Osman

Retired

Fellow

Wat, Hong-Yun Karen **Member**

Alexander, David A

Honorary Fellow

Alexander, Eric Richardson

Member ~ Over 40 Years member

Allan, Frances

Member ~ Over 40 Years member

Beauchemin, Barbara Susannah Seymour

Affiliate

Burkitt, Eric Aylmer

Fellow ~ Over 40 Years member

Dadds, Violet Elsie

Member

Davies, Roy James

Fellow ~ Over 40 Years member

de Mowbray, Michael Stuart

Member

Denham, Maureen Milburn

Member ~ Over 40 Years member

Engelhardt, Wolfram Detlev Achim

Member

Fenton, Thomas William

Fellow ~ Over 40 Years member

Forrest, Alastair John

Fellow ~ Over 40 Years member

Gallagher, Elizabeth Gibb

Member ~ Over 40 Years member

Garry, John William

Fellow ~ Over 40 Years member

Gillham, Adrian Bayley

Fellow

Gray, Anne Margaret

Fellow ~ Over 40 Years member

Grimshaw, John Stuart

Fellow ~ Over 40 Years member

Hamour, Mohamed Abdelaal

Member

Hersov, Lionel Abraham

Fellow ~ Over 40 Years member

Iskander, Trevor Nagib

Member ~ Over 40 Years member

Kelleher, F Joseph

Member ~ Over 40 Years member

Knox, Stafford Joseph

Fellow ~ Over 40 Years member

Leslie, Nasnaranpattiyage Don George

Member ~ Over 40 Years member

Macleod, Iain Roderic William

Member

Masih, Harnek

Member

Matthews, Peter Charles

Member ~ Over 40 Years member

McNeill, Desmond Lorne Marcus

Fellow ~ Over 40 Years member

Nasser, Zeinab Abdel-Aziz Ibrahim

Member

Rogers, Paul Haydon

Fellow

Ryle, Anthony

Fellow ~ Over 40 Years member

Todes, Cecil Jacob

Fellow ~ Over 40 Years member

Youssef, Hanafy Ahmed Mahmoud

Fellow ~ Over 40 Years member

Arie, Thomas Harry David

Honorary Fellow

Pant, Anshuman

Member

Smith, Eileen Dorothy

Fellow ~ Over 40 Years member

White, Daniel Paul

Member

Chan, Chee Hung

Member

Coia, Denise Assunda

Honorary Fellow

Duddle, Constance May

Fellow ~ Over 40 Years member

Dunlop, Joyce Lilian

Fellow ~ Over 40 Years member

Hickling, Frederick W

Fellow ~ Over 40 Years member

Hilary-Jones, Evan Peter

Fellow

Jones, David Alun

Fellow

McGovern, Gerald Patrick

Fellow ~ Over 40 Years member

Pant, Anshuman

Member

Pathak, Rudresh Kumar Dinanath

Member

Smith, Eileen Dorothy

Fellow ~ Over 40 Years member

White, Daniel Paul

Member

D'Orban, Paul T

Retired

Fellow ~ Over 40 Years member

Hewland, Helen Robyn

Retired

Fellow ~ Over 40 Years member

Hughes, John Samuel

Retired

Fellow ~ Over 40 Years member

Imrie, Alison Wendy

Consultant

Member

Lader, Malcolm Harold

Emeritus Professor

Fellow ~ Over 40 Years member

McLaughlin, Jo-Ann

Retired

Member

Mubbashar, Malik Hussain

Consultant

Fellow ~ Over 40 Years member

Robinson, John Richard

Retired

Fellow ~ Over 40 Years member

Washbrook, Reginald Alfred Hryhoruk

Fellow ~ Over 40 Years member

Gillis, Lynn

Retired

Fellow

Kenyon, Frank Edwin

Retired

Fellow

Palmer, Bob

Fellow

Rana, Mamoon

West, Donald

Fellow

Brown, Philip Morrison

Fellow – North Division

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1.2.10 Introducing the new culture section of *BJPsych Bulletin*

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date

2021-02

Abstract

This editorial launches the new culture section in the journal. Without any unchallengeable definition of ‘culture’, potential contributors may consider submissions under four headings: the arts and humanities relating to practice; regulatory culture; becoming a cultured practitioner; and psychiatry’s cultural context. A new article type, ‘Cultural reflections’, has been created, and submissions may reflect any appropriate methodology, including those from the arts. Peer review (from methodologies outside psychiatry if appropriate) will assure quality. Our objectives are to establish *BJPsych Bulletin* as the ‘journal of record’ for cultural studies relevant to psychiatric service delivery and demonstrate equivalent quality between them and scientific studies.

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The ‘mission statement’ of *BJPsych Bulletin* appears at the top of its Instructions for authors. It reads, ‘*BJPsych Bulletin* prioritises research, opinion and informed reflection on the state of psychiatry, management of psychiatric services, and education and training in psychiatry’.

We try to provide what psychiatrists need to practise well. With our daily professional lives governed by scientific evidence and policy delivery, the utility of audits, guidance reviews, clinical recommendations and service-related research is obvious. However, we believe that psychiatrists also need excellent cultural understanding and culturally informed practice to deliver what our patients need from us. We have therefore created a new Cultural Section, with

an associated article type, 'Cultural reflections', to allow submission of articles that do not fit the currently available Journal frameworks.

What do we mean by culture?

Like baldness or serious professional misconduct, culture is something we have little trouble recognising but great difficulty defining. Jahoda observed that the definitions of culture commonly used in psychological science are mutually incompatible, not amenable to empirical testing and suggests that we define it by usage rather than semantically.¹ As editors of the journal, if someone wishes to submit something they consider 'cultural', we recommend that they think in terms of four headings: the arts and humanities concerning practice; regulatory culture; the cultured practitioner; and the cultural context within which psychiatry operates.

The arts and humanities concerning psychiatric practice

The arts and humanities are what we usually think of when 'culture' is discussed. However, while a vibrant psychiatric literature on these topics continues, a historical perspective suggests that mutual engagement and understanding between these worlds has declined. The famous painting of Pinel unchaining the inmates of the Salpêtrière, painted in 1895, illustrates not a consequence of the French Revolution but the benefits of an empirical psychiatry based on observation that prioritises patient benefit without presuming prior theory.^{2,3} This active, empirical approach still characterises psychiatry.⁴ Nevertheless, psychiatrists are now represented as theorists, more interested in investigation than benefiting our patients,⁵ and sometimes entirely indifferent to them.

As the humanities' awareness and understanding of psychiatrists has diminished, so has our involvement with them. The conjunction of psychiatric, surrealist and philosophical thought between the 1920s and 1960s contributed to the development of both postmodernist thinking and antipsychiatry.⁶ Yet, even the memory of those connections now seems lost to us, and we are invited to consider them as if they are alien to our tradition and we had never responded.^{7,8}

To encourage a rapprochement and interchange that takes into account the progress made since the middle of last century, we will seek to publish not only cultural thinking by psychiatrists but also work by practitioners of other methodologies. It is often forgotten that the visual arts, music, poetry and literature are also methods for exploring the world, especially our subjectivities. For psychiatry, the subjectivity of our patients is part of our core business, and we are no longer so restricted by the limits of paper and physical printing. We therefore do not necessarily require that a submission to the culture section is in the form of a conventional academic paper, provided that it addresses a cultural issue that has an impact on psychiatric practice and meets our quality standards.

Regulatory culture

The arts and humanities are often seen as a counterpoise to excessive regulation. However, there is also regulatory culture, which operates to deliver the intentions of a regulatory regime when circumstances are indeterminate and discretion is essential.⁹ It can be thought of as the set of explicit or implicit attitudes and intentions expressed through norms, routine policy and everyday practice. It has become an explicit part of financial regulation, and firms are reviewed to ensure that their management structures deliver it.¹⁰ Within the National Health Service (NHS), regulatory culture is much more variably instituted¹¹ and an audit model may not capture many of its necessary components.¹² We therefore wish to publish articles relevant to improving the regulatory culture of psychiatric care, as the level of variation found suggests an ongoing and urgent need.

The cultured practitioner

The mission of *BJPsych Bulletin* focuses on topics that affect what we do in our daily practice. The norms and values that our culture instils do precisely this. For example, social constructs such as masculinity and societal power gradients predict the balance between a response style of decisiveness versus accommodation.¹³ The concept of specifying moral principles in practical, situational terms is well-established in biomedical ethics.¹⁴ The same is needed for cultural influences, as professional practice cannot be detached from its cultural environment.¹⁵ Patient (service user) groups have begun developing this from an antipsychiatry perspective.¹⁶ We believe that practitioners need explicit accounts of how psychiatrists should express our discipline's best culture in daily practice. We will seek articles that relate the practice of psychiatrists to aspects of culture, applied to the benefit of their patients.

Culture and society

Psychiatrists are taught their discipline as applied science. However, it is also one of society's institutions, tasked with performing an essential role. The Parthenon can be described entirely in engineering and aesthetic terms, but those perspectives do not explain how the Parthenon functioned. We also need to know that it was a Greek temple to Athena, the tutelary goddess of ancient Athens. To properly understand what our discipline delivers, and why, we need to be aware of how it is situated in our culture, how it maintains itself and the drivers that shape the services it delivers. Science is but one of these, and funding not only limits policy but also follows it. We are therefore interested in publishing articles that will let us map psychiatry's 'cultural geography', for example patterns of influence with other institutions, such as the law and politics, cultural drivers of research or service prioritisation, or the role of the relationship between psychiatrists and patients in shaping our clinical culture. We believe that having a clearer account of these will enable our profession to develop and deliver more effective services.

Quality assurance

Cultural commentary from many perspectives is becoming increasingly widely distributed (e.g. [medium.com](https://www.medium.com); [quillette.com](https://www.quillette.com)) and, without expertise, quality can only be judged on its language and plausibility. Even 'fact-checking' may fail when, as often occurs in cultural scholarship, accuracy lies in the awareness of multiple interpretations, rather than allegiance to one. *BJPsych Bulletin* has two great strengths as a forum for cultural research and scholarship in psychiatry. Being open access, it has a potential reach similar to that of the online commentaries just mentioned. However, it also has a mature peer-review system. This combination gives it the potential to become the cultural 'journal of record' for our profession, as peer review will be applied to all the section's submissions, and articles and correspondence can be published from outside the profession. As we have seen above, at present, our cultural memory may be too short. Given the section's intended scope, psychiatrists will not be in a position to judge the quality of all potential submissions. Therefore, we plan to create a panel of reviewers covering the full range of methodologies, including the arts, to ensure that all articles will be evaluated by a respected peer in the field, as well as receiving a psychiatric review.

Submitting articles

Articles should be submitted as 'Cultural reflections'. Since the section is new, as the Culture Editor I will be pleased to discuss possible submissions at an early stage with potential authors. The purpose of such discussions is to ensure that the submission is in a form that meets the goals of the section and is suitable for forwarding for peer review.

Our hope for the future

I have argued above that psychiatry needs to engage with culture to deliver best practice. I hope that the new section will support this by helping to establish cultural studies of all kinds as being of practical value to service delivery and demonstrating that the evidential quality of these studies is comparable with the best of scientific research.

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None.

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1.2.11 Patterns and motivations for method choices in suicidal thoughts and behaviour: qualitative content analysis of a large online survey

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date

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Abstract

Background

Choice of suicide method can strongly influence the outcome of suicidal behaviour, and is an important aspect of the process and planning involved in a suicide attempt. Yet, the reasons why individuals consider, choose or discard particular methods are not well understood.

Aims

This is the first study to explore method choices among people with a history of suicidal behaviour and individuals who have experienced, but not enacted, suicidal thoughts.

Method

Via an online survey, we gathered open-ended data about choice of methods in relation to suicidal thoughts and behaviours, including reasons for and against specific means of harm.

Results

A total of 712 respondents had attempted suicide, and a further 686 experienced suicidal thoughts (but not acted on them). Self-poisoning was the most commonly contemplated and used method of suicide, but most respondents had considered multiple methods. Method choices when contemplating suicide included a broader range of means than those used in actual attempts, and more unusual methods, particularly if perceived to be lethal, 'easy', quick, accessible and/or painless. Methods used in suicide attempts were, above all, described as having been accessible at the time, and were more commonly said to have been chosen impulsively. Key deterrents against the use of specific methods were the presence of and impact on other people, especially loved ones, and fears of injury and survival.

Conclusions

Exploration of method choices can offer novel insights into the transition from suicidal ideation to behaviour. Results underscore the need for preventative measures to restrict access to means and delay impulsive behaviour.

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Background

Suicide is a leading cause of death worldwide.¹ In England, the 2014 Adult Psychiatric Morbidity Survey found that a fifth of adults (20.6%) reported thoughts of taking their own life at some point, and one person in 15 (6.7%) has made a suicide attempt.² Choice of method is one of the most important determinants of whether suicidal behaviour is fatal, and a key aspect of the process and planning involved in a suicide attempt. Indeed, earlier studies have shown that gathering information and access to means of suicide are known indicators of high suicidal intent and risk.^{3,4} Yet, previous literature has mostly focused on prevalence of methods, and associations with gender, age and mental disorder.⁵ How or why individuals consider, choose or discard particular methods are not well understood.

Epidemiological studies have shown that different methods, and combinations of methods, vary not only in relation to lethality, but also in the extent to which they predict subsequent suicidal behaviour and ‘method switching’.^{6–10} Their wider impact can also vary, not least by virtue of the exposure and potential clustering/‘contagion’ effects associated with more public, unusual and ‘newsworthy’ methods.¹¹ Indeed, avoiding ‘excessive detail of the method [...] to prevent simulative acts’ remains to date the only official regulation for the reporting of suicide in the UK.¹²

This clearly points to the importance of better understanding the cultural and cognitive availability of different methods of suicide. Previous studies in this emerging field have identified these as key drivers in people’s method choices, but have explored their significance in relation to a relatively narrow range of methods and with generally small study samples.⁵ Furthermore, earlier literature has tended to focus on fatal and non-fatal suicidal behaviour, overlooking its immediate, and generally less understood, precursor: suicidal ideation. Understanding the psychological processes preceding a suicide attempt is crucial for the potential to intervene, as is knowing what prevents the majority of individuals in distress from acting on thoughts of suicide, at a particular moment and/or over time.

The stability, or otherwise, of method choices also warrants further attention. A recent systematic review found that a third of individuals (33.3%) switch methods between successive episodes of self-harm, and almost half (42.11%) between an episode of self-harm and suicide.¹³ Based on prevalence of methods, there appears to be no discernible or predictable pattern to such means switching.^{9,13} Exploration of meanings, motivations and mechanisms may, however, offer valuable new insights. For example, a study in Austria showed that, despite method switching between episodes of self-harm being common, choice of means in the time immediately preceding a suicide attempt is often stable, and focused on a single method.⁸

Aims

The present study aimed to investigate, for the first time, first-person accounts of the factors deterring and prompting consideration and/or use of specific methods of suicide among people with a history of suicidal behaviour and those who have experienced, but not enacted, suicidal thoughts. Dominant models of suicidal behaviour point to this as an important distinction, with potential for novel insights into the transition from suicidal ideation to behaviour.^{14,15} Given the disproportionate risk of suicide in men in the UK,¹⁶ gender differences in method choices were also explored, in relation to both suicidal ideation and behaviour.

Method

Online survey

Data were gathered as part of a wider study of method and location choices in relation to suicidal thoughts and attempts in the UK (QUEST, Qualitative Understanding of Experiencing Suicidal Thoughts^{17,18}). A national online survey inviting people to share their experiences of suicidality was advertised through suicide prevention organisations such as Samaritans UK, online forums, social media and special interest groups. Study posters and leaflets were also placed on university bulletin boards, at local branch offices of relevant charities, in the National Suicide Prevention Alliance newsletter and were mailed out to supporters of the charity Campaign Against Living Miserably (CALM).

The 16-item anonymous survey asked participants if they had ever experienced suicidal thoughts and, if applicable, to describe in an open-text format whether this involved a specific method or methods, and why. Those who reported prior

suicidal behaviour were then asked the same question in relation to their suicide attempt/s. All questions were optional, and no word limit, prompting or structure were imposed on open-ended responses. This also meant that multiple methods and/or reasons for (or against) using different means of suicide could be provided. Further information was gathered about the specific location or locations of suicidal thoughts and behaviours; about suggestions for preventative measures at different locations; and sociodemographic details (see Supplementary Appendix available at <https://doi.org/10.1192/bjo.2021.15> for a copy of the full survey).

Links to further information about the study and to support services for those experiencing suicidal thoughts were available both at the beginning and the end of the survey. All participants gave informed consent to participate in this study, and all research materials and procedures were reviewed and approved by the Psychology Department Research Ethics Committee at Middlesex University (reference: ST019-2015).

Statistical analysis

Open-ended survey responses were coded through a multi-stepped approach. Suicide methods were classified using the intentional self-harm (X60–X84) codes of ICD-10.¹⁹ Reasons for engaging in specific methods were analysed inductively for content,²⁰ and an additional coding category was created to capture deterring factors, where reported. Three coders (D.F.St-H., H.M., N.E.-G.) coded 10% of the data, with substantial interrater reliability (Kraemer's kappa 0.774) (see Supplementary Appendix for a full description of the coding protocol and details of interrater reliability in relation to individual code categories).

Survey data are presented as frequencies or percentages, as appropriate. Variations in method choices were analysed using chi-square tests (for categorical variables) and *t*- and Mann–Whitney *U*-tests (for continuous variables). All statistical analyses were performed at a 5% level of significance.

Results

We analysed the responses of 1398 people (Table 1). Of these, 68.5% identified as females, 29.5% as males, and 2.0% as transgender/gender fluid. Participants had a median age of 32 years (range 16–73), and around a third were aged between 18 and 30 years old (37.7%). The majority of the participants described themselves as White (92.8%), heterosexual (74.7%), and non-religious (53.0%).

Table 1 Self-reported characteristics of the participants

Characteristic	n	(%)
All participants (n = 1398)	1398	100
Prior suicidal ideation only (n = 686)	686	49.1
Prior suicidal behaviour (n = 712)	712	50.9
Age, years: median (range)	32 (16–73)	
<18 years old, n (%)	120 (9.4)	8.6
18–30 years old, n (%)	483 (37.7)	37.7
30–45 years old, n (%)	224 (37.0)	37.0
45–60 years old, n (%)	259 (38.3)	38.3
>60 years old, n (%)	436 (34.0)	34.0
Gender, n (%)		
Female	896/1308	68.5
Male	390/618	63.1
Transgender/gender fluid	12/690	2.0
Sexual orientation, n (%)		
Heterosexual	923/1235	74.7
Bisexual	457/591	77.3
Gay/lesbian	466/644	72.4
Ambivalent/unsure	167/1235	13.5
Asexual	69/591	11.7
Any religion (versus none), n (%)	98/644	15.2
White	106/1235	8.6
Black and minority ethnic	48/591	8.1
Asian	58/644	9.0
Mixed race	19/1235	1.5
Ethnicity, n (%)	7/591	1.2
White	12/644	1.9
Black and minority ethnic	20/1235	1.6
Asian	10/591	1.7
Mixed race	10/644	1.6
Ethnicity, n (%)	572/1217	47.0
White	262/581	45.1
Black and minority ethnic	310/637	48.7
Asian	147/1236	92.8
Black and minority ethnic	548/588	93.4
Asian	599/648	92.4
Black and minority ethnic	47/1236	3.8
Mixed race	24/588	4.1
Black and minority ethnic	23/648	3.5
Mixed race	14/1236	1.1
Black and minority ethnic	3/588	0.1
Mixed race	11/648	1.7
Black and minority ethnic	28/1236	2.3
Mixed race	13/588	2.2
Black and minority ethnic	15/648	2.3

¹ Denominators vary because of missing data.

² = 16.12; *P* < 0.001.

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All participants reported prior thoughts of suicide. Of these, 686 respondents (49.1%) had experienced suicidal ideation but not engaged in suicidal behaviour; 712 (50.9%) reported having engaged in at least one suicide attempt. The latter subsample included a higher proportion of women, but did not differ significantly from the former in relation to the other sociodemographic characteristics captured (*Table 1*).

Self-reported method choices: suicidal thoughts

When asked about previous thoughts of suicide, all but a small minority of respondents reported having considered a specific method, or methods ($n = 1279$, 91.5%). For most ($n = 799$, 57.2%), multiple methods had been contemplated (median 2; maximum 10), at different times or over time. On average, respondents with a prior history of suicidal behaviour reported having considered more suicide methods than those who had never attempted suicide (mean 2.17 (s.d. = 1.48) v. 1.84 (s.d. = 1.3), $P < 0.001$), with no significant difference between male and female respondents.

Overall, self-poisoning was the most frequently contemplated method of suicide (809/1398, 57.9%), including when only one method was considered (220/480, 45.8%). Approximately a quarter of the participants had experienced thoughts of suicide by hanging (381, 27.3%) or jumping from a high place (330, 23.6%) and fewer had considered self-harm by a sharp object (275, 19.7%), train (208, 14.9%) or other vehicle collision (208, 14.9%; all other methods were mentioned by under 10% of the participants).

There were some significant differences in the suicide methods contemplated by those who had and had not engaged in suicidal behaviour. The latter were more likely to cite relatively unusual methods such as crashing a vehicle (thoughts only versus behaviour: 85/686 (12.4%) v. 41/712 (5.8%); $\chi^2 = 18.74$; $P < 0.001$) and handgun discharge (thoughts only versus behaviour: 36/686 (5.2%) v. 21/712 (2.9%); $\chi^2 = 4.72$; $P = 0.030$), whereas those with a history of suicidal behaviour were more likely to report thoughts of suicide by hanging, strangulation or suffocation (behaviour versus thoughts only: 229/712 (32.2%) v. 153/686 (22.3%); $\chi^2 = 17.10$; $P < 0.001$), self-poisoning (behaviour versus thoughts only: 489/712 (68.7%) v. 320/686 (46.6%) $\chi^2 = 69.56$; $P < 0.001$) and self-harm by a sharp object (behaviour versus thoughts only: 159/712 (22.3%) v. 116/686 (16.9%); $\chi^2 = 6.50$; $P = 0.011$).

Self-poisoning and self-cutting were more commonly reported by female respondents, compared with males (self-poisoning, females versus males: 606/896 (67.6%) v. 151/386 (39.1%); $\chi^2 = 90.7$, $P < 0.001$; self-cutting, females versus males: 193 (21.5%) v. 60 (15.5%); $\chi^2 = 6.1$, $P = 0.013$). In contrast, male respondents were more likely to have considered death by hanging, strangulation and suffocation (males versus females: 131 (33.9%) v. 221 (24.7%); $\chi^2 = 11.65$; $P = 0.001$) and, but less frequently, by gasses and vapours (males versus females: 27 (7.0%) v. 31 (3.5%); $\chi^2 = 7.81$; $P = 0.005$), or handgun discharge (males versus females: 30 (7.8%) v. 24 (2.7%); $\chi^2 = 17.35$; $P < 0.001$).

Suicidal behaviour and method choice ‘switching’

Fewer, and often different, methods choices were described in relation to actual suicide attempts (median number of methods reported in relation to suicidal behaviour 1; maximum 7). Self-poisoning was again the most commonly reported method in this context (555/712, 77.9%), particularly among female respondents who had attempted suicide (females versus males: 426/506 (84.2%) v. 104/171 (60.8%); $\chi^2 = 41.1$, $P < 0.0001$). This was followed by self-harm by sharp object (118/712, 16.6%), hanging (103/712, 14.5%; males versus females: 37 (21.6%) v. 64 (12.6%); $\chi^2 = 8.1$, $P = 0.004$), and jumping from a high place (60/712, 8.4%).

A small proportion of those who had considered self-poisoning when contemplating suicide (47/602, 7.8%) reported having adopted a different method or methods when engaging in suicidal behaviour. Relatively less common methods, such as jumping/falling from a height, drowning or vehicle collision, were reported considerably more frequently in relation to thoughts than actual suicidal behaviour.

Among respondents who had made one or more suicide attempts, the vast majority who had considered jumping/falling from a height (137/197, 69.5%), or in front of a train (96/116, 82.8%) or other vehicle (54/86, 62.8%), had not then attempted suicide by these specific methods. This was also observed in relation to suicide by gasses and vapours (24/33, 72.7%), chemicals and noxious substances (28/45, 62.2%), drowning (52/77, 67.5%), crashing of a motor vehicle (38/48, 79.2%), and less frequently reported methods such as handgun discharge (17/22, 77.3%), and smoke, fire

and flames (7/10, 70%). A smaller, but considerable, proportion of those who had contemplated suicide by hanging (143/246, 58.1%), sharp object (91/209, 43.5%) or poisoning by alcohol (29/84, 34.5%) had also then used different methods when attempting suicide.

Motivations for and against method choices

Self-reported reasons for considering one or more methods of suicide were varied and often multiple. In describing their motivations for contemplating or attempting suicide by a specific method or methods, most respondents focused on more than one factor, particularly when discussing suicidal thoughts (815/1238, 65.8%, maximum 11; 359/679, 52.9% mentioned more than one reason in relation to suicide attempts, maximum 8).

There were some interesting differences in the reasons given for considering a specific method when contemplating suicide, as opposed to engaging in suicidal behaviour (*Fig. 1*). *Fig. 1* Self-reported motivations for method choices in relation to suicidal thoughts ($n = 1398$) and suicide attempts ($n = 712$).

Effectiveness, accessibility, ease and speed of a suicide method were the most commonly cited reasons for contemplating suicide by a specific method, alongside the wish to minimise pain and violence. Almost 70% of participants who stated one main reason for contemplating suicide by specific means cited one of these factors (287/423, 67.8%). However, when respondents commented on their motivations for attempting suicide by a given method, accessibility became the single most recurrent concern (reasons for suicidal behaviour versus ideation (all participants): 316/712 (44.4%) v. 319/1398 (22.8%), $^2 = 104.3$, $P < 0.0001$), and impulsivity a more frequently cited reason (behaviour versus ideation: 86/712 (12.1%) v. 85/1398 (6.1%), $^2 = 22.8$, $P < 0.0001$), particularly among women (females versus males: 70/506 (13.8%) v. 12/171 (7%), $^2 = 5.6$, $P = 0.018$).

Accessibility was the most commonly reported reason for attempting suicide by a specific method even when excluding motivations for self-poisoning (the most common method of suicidal behaviour in the participants), and in relation to each method individually (alongside method ease and/or effectiveness for attempts by chemicals and noxious substances, other gasses and vapours, and handgun discharge). The only exceptions were attempts by jumping or lying in front of a vehicle (including trains), for which method effectiveness was the most frequently cited reason (13/45, 28.9%), and smoke, fire and flames (for which, however, only three participants provided data).

When discussing suicidal behaviour, ease of method remained among the more frequently cited reasons for choosing a specific method, but speed, effectiveness and the desire to minimise pain and violence were less commonly mentioned than in relation to suicidal thoughts (speed, behaviour versus ideation: 62/712 (8.7%) v. 272/1398 (19.5%), $^2 = 39.4$, $P < 0.0001$; effectiveness, behaviour versus ideation: 86/712 (12.1%) v. 364/1398 (26.0%), $^2 = 54.8$, $P < 0.0001$; minimising pain and violence, behaviour versus ideation: 99/712 (13.9%) v. 300/1398 (21.5%), $^2 = 17.6$, $P < 0.0001$).

Among those who had engaged in suicidal behaviour, effectiveness appeared to be a marginally (but significantly) greater concern for males (males versus females: 29/171 (17.0%) v. 54/506 (10.7%), $^2 = 4.7$, $P = 0.03$) and reducing pain and violence for females (females versus males: 82/506 (16.2%) v. 14/171 (8.2%), $^2 = 6.8$, $P = 0.009$). In total, 10% of respondents reported having used a specific method of suicide following exposure to that method (via family and friends as well as media reports). Less common reasons, in relation to both suicidal thoughts and behaviour, included a desire for privacy and to avoid interruption, to minimise the impact on loved ones and other bystanders, or to maximise pain.

Some of the differences in the decision-making around suicidal thoughts versus behaviour were reflected in the motivations for contemplating a specific method in those who had engaged in suicidal behaviour and those who had not. In particular, accessibility of method was more frequently mentioned by those with a history of suicidal behaviour (behaviour versus thoughts only: 180/712 (25.3%) v. 139/686 (20.3%), $^2 = 5.0$, $P = 0.025$), alongside perceived lethality (behaviour versus thoughts only: 205/712 (28.8%) v. 159/686 (23.2%), $^2 = 5.7$, $P = 0.017$) and, less often, a wish to maximise pain (behaviour versus thoughts only: 32/712 (4.5%) v. 9/686 (1.3%), $^2 = 12.41$, $P < 0.0001$). Respondents who had never acted on suicidal thoughts were instead more likely to mention wanting to minimise the impact on others (thoughts only versus behaviour: 116/686 (16.9%) v. 83/712 (11.7%), $^2 = 7.9$, $P = 0.005$), including and especially family and friends (thoughts only versus behaviour: 63/686 (9.2%) v. 43/712 (6.0%), $^2 = 4.9$, $P = 0.026$), and, in smaller numbers, to be in an isolated location where one's attempt and body would not be discovered (thoughts only versus behaviour: 21/686 (3.1%) v. 10/712 (1.4%), $^2 = 4.4$, $P = 0.035$).

Concern about the impact on others was also a key theme in the responses of participants who mentioned motivations for not using specific methods (57 respondents discussed discarding a particular method of suicide for this reason), alongside fears around survival (potentially with injuries, $n = 58$), and of not 'getting it right' ($n = 51$). Further deterring factors included concerns over the violent/painful nature of a method ($n = 35$), its 'messiness' ($n = 11$) or slowness ($n = 7$), lack of access ($n = 19$) or privacy ($n = 5$), and the discarding of a method having used it previously ($n = 4$) or researched it ($n = 9$).

Discussion

Main findings and interpretation

Although specific methods, and composite methods, have been associated with a higher risk of death and subsequent suicidal behaviour, epidemiological analyses of repeat hospital admissions for self-harm have concluded that 'method of self-harm is fluctuating and unpredictable'.⁹ The results of this exploratory study of first-person accounts suggest that, although indeed changing and complex, method choices are reasoned, personally and culturally meaningful, and a crucial element of the processes and planning involved in attempting (or desisting from) suicide. With very few exceptions, individuals who had contemplated suicide had considered a specific mean (or, more often, means) of taking their own life, even when they had never then engaged in suicidal behaviour. Almost 90% described a particular reason, or set of reasons, for considering or discarding such method/s.

To date, method choices have primarily been investigated in relation to completed suicide and suicide attempts.^{5,21,22} This is the first study to explore patterns and motivations for method choices in relation also to suicidal ideation, which is a surprising gap in knowledge given that 10–20% of individuals experiences lifetime suicidal ideation.^{2,23} Suicidal thoughts are a known risk factor and immediate precursor of suicidal behaviour, and key to understanding the transition from 'suicidal ideation to action'.^{14,15} In relation specifically to methods choices, suicidal thoughts provide some important insights into the acceptability and cognitive availability of different means of suicide. In other words, they can help us understand which methods are cognitively available to individuals in crisis (in a given sociocultural context), and what makes them more or less 'attractive' to them.

In this study, self-poisoning was the most commonly contemplated method of suicide. However, most respondents had considered multiple methods of suicide, particularly those who had also engaged in suicidal behaviour. These included a fairly wide range of potential methods and, especially among individuals who had never attempted suicide, relatively uncommon means such as jumping or lying in front of a moving object, drowning, handgun discharge and crashing of a motor vehicle. In England and Wales, self-harm involving a moving object, drowning or fall and fracture accounts, all together, for 12% of all suicides,²⁴ and only 1% of hospital presentations for self-harm.¹⁰ Firearm use, although a common suicide method in countries with less stringent gun control such as the USA,²⁵ is even rarer in the UK, accounting for less than 2% of all suicides²⁶ and 0.03% of self-harm hospital presentations.¹⁰ Although these are only a small proportion of completed suicides and hospital presentations for self-harm, such methods tend to be disproportionately reported in the media,¹¹ which may reflect and account for their over-representation and over-availability in people's suicidal thoughts (in the UK, most suicides are hanging¹⁶ whereas most hospital presentations for self-harm involve self-poisoning¹⁰). Almost 10% of the participants explicitly identified exposure to a given method as a primary motivation for considering it as a means of suicide. Even more common reasons were perceived method ease, accessibility, speed and effectiveness, alongside the desire to minimise pain and violence.

However, the range of methods described in relation to actual suicidal behaviour was narrower, as were respondents' motivations for using such methods. Over three quarters of respondents attempted suicide by self-poisoning, with many switching to this method having also considered more violent or unusual means. For almost half of the participants, choice of attempt method was primarily dictated by accessibility, and ease of method and the minimisation of pain were more common concerns than perceived speed or likelihood of death. An exception was jumping/lying in front of a vehicle, for which method effectiveness was the most frequently cited reason (see also Marzano et al¹⁸).

In relation to all methods, lethality appeared to be a greater concern for male than female respondents, and impulsivity less common, as also reported elsewhere.^{27,28} Together with the increased use of methods other than self-poisoning,²⁹ this might contribute to the disproportionate risk of suicide in men.

Of note are also some of the differences between respondents who had contemplated but never engaged in suicidal behaviour, and those who had previously attempted suicide. The former were more likely to mention wanting to minimise the impact on others, especially family and friends, and, in smaller numbers, to be in an isolated location where one's attempt and body would not be discovered. This points to the presence and impact on bystanders and loved ones as important 'dissuaders' in relation to suicide. Indeed, these were also among the most frequent reasons for not attempting suicide by a specific method. Other common deterrents were fears of surviving with injuries and of 'not getting it right'.

Interestingly, impulsivity was not a more common theme in those who had attempted suicide *per se*, but was cited more frequently in relation to suicidal behaviour than ideation. This finding lends support to the idea that individuals who attempt suicide may not have significantly elevated trait impulsiveness, compared with 'ideators'; however, they may have higher impulsiveness when in a negative state.³⁰

Strengths and limitations

We analysed rich descriptions of people's choice of methods in relation to suicidal thoughts as well as behaviours, with strong interrater reliability, and no prompting, structure or limit to the answers that could be provided. This exploratory, inductive approach is rare with samples as large as the current study's, and allows for appropriately powered statistical analyses, as well as more nuanced, in-depth analyses of particular groups or methods, including the different images, myths and cultural scripts that exists around – and against – specific means of suicide (as presented elsewhere in relation to railway suicide¹⁸).

However, findings were based on a self-selected, predominantly female sample, and may not necessarily be representative of all individuals who consider, attempt or indeed die by suicide, within the UK and more widely. National and cultural variations in suicide method choices suggest the need for replication with broader and more diverse samples,²⁵ in a wider range of community and clinical settings.

Given the exploratory nature of this study, we did not gather systematic information about potentially important factors such as prior psychiatric and family history, nor about the sequence or temporality of suicidal thoughts and behaviour. This limits the conclusions that may be drawn in relation to method switching, escalation and substitution, and prevented us from making inferences about age differences in method choice. Further, longitudinal studies could usefully investigate how the frequency, intensity and intent of suicidal thoughts and behaviour may affect method choices in different groups and communities. A more structured approach to gathering information about deterring factors could also offer important insights into how best to prevent, and 'dissuade' from, specific means of suicide, in different contexts and locations.

Implications

Previous research has concluded that 'people's risks or needs [cannot be] based simply on the method of harm',⁹ or the potential lethality of that method. The results of this study also suggest that the methods people consider when contemplating suicide are often not the ones that are then enacted in a suicide attempt, nor are they necessarily chosen for the same reasons. Nonetheless, exploring method choices is far from a fruitless activity, and can usefully inform preventative initiatives.

Consistent with earlier literature, our findings suggest that cognitive and physical availability are key drivers in the choice and prevalence of suicide methods. The former appears to be particularly relevant in the context of people's suicidal thoughts, with methods perceived to be 'easy' and lethal featuring highly in individuals' so called 'ideation menu'.³¹ The latter (i.e. the accessibility of a given method), becomes especially important in the context of a suicide attempt, and impulsivity relatively more common. This clearly underscores the need for preventative measures that restrict access to means and delay impulsive behaviour, such as the erection of barriers at high-risk locations and reduced pack sizes of paracetamol.³² Avoiding depictions and descriptions of suicide methods in the media may help limit the cognitive availability of specific means, particularly for methods portrayed as lethal, easy, quick and painless. This may be especially important in the reporting of celebrity suicides. A recent meta-analysis found that when the suicide method used by a celebrity was reported, there was an associated 30% increase in deaths by the same method.³³

In clinical settings, exploring the decision-making around specific methods may help challenge unhelpful myths and misconceptions, identify areas of ambivalence and hope, and develop appropriate safety and treatment plans. At public-health level, factors known to attract individuals and subgroups to lethal means of suicide may be challenged via targeted communication and media strategies, and common ‘dissuaders’ reinforced. However, the risk and unintended consequences of different approaches to means and ‘myth-restriction’ need careful thought and evaluation, whether in the context of means-restriction counselling³⁴ or as part of wider public health approaches. Further research is needed in this area, but the risks and ethics of how and where research findings are disseminated and ‘translated’ need careful attention to avoid reinforcing the acceptability and availability of (lethal) means of self-harm.

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Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjo.2021.15>.

[click here to view supplementary material](#)

The data that support the findings of this study are available on request from the corresponding author (L.M.). The raw data are not publicly available as they include qualitative quotes that could compromise the privacy of research participants.

L.M. and J.-M.M. designed the questionnaire. I.K. and B.F. designed the coding protocol and tool; D.F.St-H., H.M., N.E.-G. coded all open-ended data. L.M., I.K., B.F. and D.K. analysed the data. L.M. and D.K. searched the literature, and wrote the first draft. All authors interpreted the data and edited the manuscript.

Network Rail on behalf of the rail industry. Funders had no role in the research or in the decision to publish.

Declaration of interest

None.

ICMJE forms are in the supplementary material, available online at <https://doi.org/10.1192/bjo.2021.15>.

1.2.12 The texture of narrative dilemmas: qualitative study in front-line professionals working with asylum seekers in the UK

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Abstract

Aims and method

Asylum seekers are required to narrate past experiences to the UK Home Office, doctors, lawyers and psychologists as part of their claims for international protection. The Home Office often cites perceived inconsistencies in asylum interviews as grounds for refusal of their claims. A number of processes affect asylum seekers' abilities to narrate past experiences fully to the professionals interviewing them. The dilemmas around disclosure that asylum seekers face have received little attention to date. This work aims to explore the perspectives of UK-based medico-legal report-writing doctors, lawyers and psychologists whose work involves eliciting narratives from asylum seekers on the processes that affect asylum seekers' abilities to disclose sensitive personal information in interview settings. Eighteen professionals participated in semi-structured interviews in individual or focus group settings to discuss, from their perspectives of extensive collective professional experience, the narrative dilemmas experienced by asylum seekers with whom they have worked.

Results

Professionals identified a number of processes that made disclosure of personal information difficult for asylum seekers. These included asylum seekers' lack of trust towards the professionals conducting the interview, unclear ideas around pertinence of information for interviewers, feelings of fear, shame and guilt related to suspicions around collusions between UK and their country-of-origin's authorities, sexual trauma and, occasionally, their own involvement or collusion in crimes against others.

Clinical implications

Recommendations are made on how to improve the interview environment to encourage disclosure. These have important implications for future research and policy initiatives.

Contents

- *The texture of narrative dilemmas: qualitative study in front-line professionals working with asylum seekers in the UK*

- *Method*
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The UK, as a signatory to the 1951 United Nations Convention and Protocol Relating to the Status of Refugees, has an obligation to consider applications from individuals fleeing persecution in their countries of origin.¹ The UK Home Office assesses applications through initial and substantive interviews with asylum seekers, who are expected to narrate their past experiences to demonstrate their reasons for seeking asylum. The United Nations High Commissioner for Refugees defines an asylum seeker as ‘someone whose request for sanctuary has yet to be processed’.² A refugee is defined as ‘someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion’ according to the 1951 Refugee Convention.¹ In the year ending June 2018, the UK Home Office received 27 044 applications for international protection and granted 14 308 of them.³ The Home Office sometimes rejects asylum claims based on perceived inconsistencies in asylum seekers’ accounts of their past experiences.⁴ Asylum seekers may have to narrate these experiences to other professionals, including asylum tribunal judges (when rejected asylum claims are subject to appeal), medico-legal report-writing doctors and psychologists (for forensic reports to provide medical evidence in regards to the person’s asylum claim), legal professionals (for witness statements), and psychologists and other therapists (for the treatment of mental health problems).

Asylum seekers’ abilities to disclose information about their past experiences may be affected by various psychological and cultural factors, particularly where there is a history of trauma. Studies on resettled refugees indicate that asylum seekers who have sustained multiple traumas in the past often report high levels of post-traumatic stress disorder (PTSD) and depression.^{5,6} It is well documented that asylum seekers who have had many traumatic experiences will avoid disclosing such memories.⁷ Research suggests that external factors such as the interview room setting and the behaviour of Home Office officials can serve as triggers for traumatic memories.⁸ Currently, little is known about the range of dilemmas faced by asylum seekers when making decisions about the content of their narrated accounts, such as omitting or altering information, sometimes on the instructions of or under the influence of other people.⁹ Professionals working with asylum seekers offer a unique vantage point to guide an exploratory study of these dilemmas, as they are able refer to their extensive professional experience with a variety of asylum seekers. A small sample of individuals with refugee status were interviewed separately about dilemmas they experienced when narrating their past experiences to professionals. This constitutes a complementary study which is currently being prepared for submission.

Method

Participants

Eighteen professionals were recruited from fourteen different organisations that provide clinical and legal support to asylum seekers in England. The research study was advertised through direct email outreach requesting interviews with individuals whose work involves eliciting accounts from asylum seekers. Organisations were identified using chain sampling based on existing professional connections. Current and former Home Office decision makers were also invited to participate, but no individuals accepted the opportunity to do so.

Written informed consent was obtained from all participants. All procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. All procedures were approved by the University College London ethics committee (reference 8133/003).

Data collection

Data were collected between July and December 2017 through face-to-face interviews, conducted either individually or as focus group interviews. Three professionally homogenous groups of doctors or lawyers were interviewed using a focus group discussion format. *Table 1* shows the distribution of professionals. Focus group discussions were chosen as an appropriate method of data collection for a feasibility study because of their inherent 'dynamic quality of group interaction'.¹⁰ Three therapists were interviewed individually owing to practical constraints. *Table 1* Characteristics of study participants

Participant	Research group	Occupation	Gender	Years in profession
P1	Therapist	Psychotherapeutic worker	Male	10
P2	MLR focus group 1	Psychiatrist – MLR writer for NGO	Male	37
P3	MLR focus group 1	Medical doctor – MLR writer for two NGOs	Male	22
P4	MLR focus group 1	Medical doctor - MLR writer for two NGOs	Female	57
P5	MLR focus group 1	General practitioner and MLR writer	Female	20
P6	Therapist	Psychologist at an NHS service and MLR writing volunteer for an NGO	Female	5
P7	Lawyer focus group	Legal officer for NGO	Male	30
P8	Lawyer focus group	Immigration solicitor at law firm	Male	13.5
P9	Lawyer focus group	Immigration solicitor at law firm	Female	11
P10	Lawyer focus group	Legal officer for international NGO	Male	Undisclosed
P11	Lawyer focus group	Immigration caseworker for law firm	Male	10
P12	Lawyer focus group	Immigration caseworker for law firm	Female	4+
P13	MLR focus group 2	Former general practitioner and MLR writer	Female	27
P14	MLR focus group 2	Clinical psychologist	Female	13
P15	MLR focus group 2	Director of NGO and clinical psychologist	Female	32
P16	MLR focus group 2	Former general practitioner, independent forensic physician	Female	30
P17	MLR focus group 2	Clinical psychologist	Female	12
P18	Therapist	Psychotherapist and director of NGO	Male	25

Semi-structured interviews involving open-ended questions were conducted. The authors of this paper designed the interview schedule collaboratively, with input from a small team of psychologists and lawyers with critical insights into the effects of credibility concerns inherent to the UK's asylum adjudication on asylum narratives. The interviews were structured to encourage professionals to reflect on how asylum seekers they worked with experienced the process of narrating past experiences.

Questions included the following. (a) Have you experienced situations where your clients' narratives evolved or changed over time? (b) In what ways have these narratives changed? (c) What do you think is the impact of the location in which asylum seekers are talking to professionals such as yourselves, and/or the presence of an interpreter, on the type of

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MLR, medico-legal report; NGO, non-governmental organisation; NHS, National Health Service.

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narrative that they are able to share?(d)Are there any causes that you might be able to attribute to late disclosure of additional or changed information, based on your experiences?(e)Do you think it's difficult for all asylum seekers to talk about what's happened to them in their past, or more for certain asylum seekers compared to others?

Data analysis

Interviews were recorded and transcribed verbatim. A thematic analysis approach was used to identify patterns of experiences of different professionals and across the interviews.¹¹ The data-set was double-coded by one author (P.A.) who collected the data and another (M.V.W.) who was not familiar with the content of the interviews prior to coding. The entire data-set was coded descriptively, and key themes were identified that were evident across the data-set. Two research questions drove decisions about the 'keyness' of a theme.¹¹

The authors collaboratively interpreted codes and themes in the data. A third author (Y.W.) input the data into NVivo version 10. The research team were cognisant of the theoretical framing that drove the interview schedules and their own analytical skillset that informed the coding. Following Braun and Clarke's reflexive thematic analysis approach, the research team focused on 'reflexive and thoughtful engagement with their data'.¹² (a)What are the dilemmas faced by asylum seekers when narrating their past experiences to different professionals, as understood by professionals who work with them?(b)What factors may inhibit an open discussion of the past experiences that asylum seekers are required to narrate in their claim?

The richness of the data is demonstrated in the Results section through the use of quotes from the data-set that illustrate the key themes in the data.

Results

The four main themes of processes influencing asylum seekers' narratives that emerged from the interviews are reported here. These are: (a)omission of information as a narrative dilemma;(b)alteration of information as a narrative dilemma;(c)embellishment of information as a narrative dilemma;(d)influence of trauma on disclosure.

The term 'narrative dilemmas' refers to the dilemmas experienced by asylum seekers when narrating their past experiences to professionals interviewed for this research. Other issues that emerged from the data included the effects of individual identity and interview environment on disclosure. These are addressed in the Discussion section.

Omission of information as a narrative dilemma

The majority of participants revealed that they had worked with asylum seekers who had omitted a piece of information at least once during their claim for asylum. A medico-legal report-writing doctor presented the example of an asylum seeker who had been imprisoned in a police station and jail, and refused to divulge details of her experiences in the police station. In his opinion: "“This wasn't that she didn't remember. She clearly did. It was much more of a conscious choice of choosing not to re-engage with something that she knew she would find distressing. And there was a sort of moral component to it that she felt she didn't want to be defined by what had happened' (P2, psychiatrist, male).”

Participants described situations in which asylum seekers they worked with did not volunteer information. These included when the information was of a sensitive nature such as sexual trauma, if they were unclear about the pertinence of a piece of information for the interviewer, or when they were asked a direct question in one interview but not in another.

Participants expressed the collective view that asylum seekers who had perpetrated acts of betrayal or violence often did not disclose these experiences in the first interview or meeting with a professional. This was also the case for experiences of sexual violence (particularly for men). Participants attributed this to feelings of guilt, shame and stigma, as well as lack of trust in the professional. Participants reflected that that asylum seekers sometimes omitted information owing to fear of repercussions from people who exercised control over them, such as human traffickers or state authorities in their countries of origin whom they sometimes suspected of colluding with UK state authorities. According to participants,

asylum seekers they worked with may doubt the confidential nature of interviews with UK professionals and as a result omit information.

Alteration of information as a narrative dilemma

Participants shared a common experience that the asylum narratives they heard from their clients were altered over time. This often included delayed disclosure of some aspects of asylum seekers' past experiences. Information disclosed later would replace information that had been omitted as mentioned above or fabricated for reasons discussed below. Participants were of the opinion that asylum seekers sometimes disclosed more new information in the setting of an increasingly trusting relationship with the interviewer over time, on advice of a friend or family member, in response to changing levels of stigma in the community or in situations of external pressure such as being under oath in court.

Participants shared a variety of changed narratives that they had observed in their professional experience, from minor details such as changes of dates to the disclosure of new significant traumatic events such as rape. Examples reported included asylum seekers who said they escaped their country of origin in a specific month and then later changed it to another because they could recall the season but not the dates. In addition, they recounted incidents where some asylum seekers claimed that they entered the country later than they had, based on advice from friends to conceal the number of years spent undocumented before claiming asylum for fear that their claims would be refused on that basis.

A doctor interviewed an asylum seeker who, according to previous interview records, had allegedly been trafficked directly to the UK. However, she later disclosed that she had, in fact, been trafficked to a different country and had subsequently escaped and paid a smuggler to enter the UK. She had fabricated that part of her claim based on the advice of a friend.

A lawyer reported that he had seen many asylum seekers who had downplayed their membership of anti-government groups, based on unfounded warnings from others that asylum claims from members of such proscribed organisations were likely to be refused.

A male asylum seeker who had divulged information about a rape to the doctor preparing his medico-legal report called the doctor years later to have his account of this significant event redacted. He denied having ever mentioned it and wanted his statement altered, despite the doctor's records clearly documenting his previous account of the rape. The doctor attributed this to a wish to take control of the recollection of a past experience in which control had been taken away from him.

It was the common experience of participants that survivors of human trafficking had been given information by their traffickers, such as names of locations they had crossed in order to reach the UK, and that they had believed this information and repeated it in their interviews. Some survivors of trafficking had been specifically instructed to tell a fabricated story and complied because of threats, or owing to the power they perceived their trafficker to have over them. For example, several participants gave examples of traffickers who subjected individuals to 'juju' rituals exploiting their spiritual beliefs,¹³ in order that the individual would feel 'bound' to the trafficker and compelled to comply with their demands for fear of (often life-threatening) reprisals against themselves or loved ones. "I certainly have seen a number of victims of trafficking who are told that if they don't cooperate – for example, if they don't cooperate with the full story, which the trafficker has given them – then the trafficker will do the same thing to their younger sister as they did to them' (P2, psychiatrist, male)."

A medico-legal report-writing doctor had worked with an asylum seeker who drastically changed her narratives. He thought this was because the asylum seeker's abuser was present at the first interview, had acted as an interpreter for her and had controlled what was told to the doctor.

A further medico-legal report-writing doctor who visited asylum seekers in detention recalled receiving a phone call from an asylum seeker the day after the examination. The doctor reported that this asylum seeker had shared her decision to disclose new information that she had previously withheld about the sexual violence she had endured, after seeking the advice of a friend. Participant 6 explained: "With the minor details or changes in dates, and things, I would say that's memory. With more significant, kind of, omissions, I guess, I would say it's normally trust." (P6, psychologist, female)"Participants were of the opinion that sometimes the asylum seekers they worked with lied to

protect the lives of others. Others who identified with their abusers may have wanted to protect the abusers and change their narratives accordingly.

Embellishment of information as a narrative dilemma

A medico-legal report-writing doctor had seen a survivor of a ‘blood feud’ who had embellished his past experiences by fabricating that he was an only child. Whereas in the survivor’s view this ‘would make my story stronger’, according to the doctor, it had the opposite effect when it was uncovered. Similarly, a lawyer shared his experience of what he viewed to be a recent trend: “‘We see a lot of these [nationality redacted] boys, they come from a background of very limited education, shepherds, and then have an experience of living in a conflict zone, domestic violence, their father’s been murdered in front of them, and then maybe they’ve decided to add on a torture story because somebody’s told them that won’t get you asylum and you need to have been tortured [to get asylum]. Maybe they have been and maybe they haven’t, but a whole lot of other bad stuff has happened to them.’ (P7, lawyer, male)”

Psychologist participants explained that often when asylum seekers embellished their symptoms, there were likely clinical explanations for their behaviour, for example, the individual attempting to get help for their unmet needs. “‘The things she was presenting with were not consistent with any formal diagnosis ... however, she desperately wanted to get her needs met but it was almost as though she’d heard other people had done it so therefore she put that into the pot to be sure that I would recognize that she needed help. That’s how I interpreted it, actually’ (P13, doctor, female).”

Influence of trauma on disclosure

Participants reported that in some situations they interpreted the silence of an asylum seeker as indicative of the most severe parts of their traumatic history. Participants thought this inability to verbalise such experiences highlighted the effects of sustained periods of intimidation and subordination on survivors of trafficking and/or servitude and torture, such as the inability to develop an identity or narrative of their own. Sexual trauma, linked to feelings of embarrassment, shame and humiliation, was cited as one of the most difficult experiences for asylum seekers to disclose. Participants attributed this to fears of social stigma and resultant social exclusion. Participants reflected on their interactions with asylum seekers who they thought did not self-identify as victims of abuse, and expressed the opinion that the skewed self-perception of some asylum seekers affected how they presented certain experiences to their interviewers. This was particularly the case with victims of childhood abuse, according to participants, who may not have understood their experiences as constituting abuse and had fragmented memories of their past. Childhood trauma was explained as having particularly prolonged and longstanding effects on individuals, influencing their ability to disclose such events, and seen as potentially leading to intensified symptoms of PTSD. Re-experiencing phenomena and avoidant behaviours are core symptoms of PTSD.¹⁴ All participants spoke about the ‘fragmentation’ of memories that can occur in PTSD, which can lead to ‘gaps’ in the individual’s narrated history, which in turn can lead to ‘inconsistent’ accounts.¹⁵

Participants across all interviews also spoke about their assessments of the effects of dissociation on the asylum seekers’ ability to disclose a full and complete history. Some shared experiences where individuals had appeared to them to lose awareness of their surroundings and their sense of self, inevitably resulting in a lack of clarity or coherence in the narrative. Participants also analysed individuals’ desire to avoid thinking about the traumatic memories as manifesting itself by avoiding talking about the traumatic event, and avoiding external reminders of the traumatic event, which complicated disclosure. For example, a participant shared her experience that clients often use vague expressions and euphemisms when talking about traumatic experiences instead of clearly disclosing a description of the sexual experiences. “‘People use vague terms as part of their PTSD defence and avoidance, about “them” or “that man”, “those people” or “the work”’ (P15, psychologist, female).”

All professionals detailed a myriad of body language indicators of distress, including restlessness, reddening eyes, crying, movement of jaw muscles, hyperventilation and body clutching, as well as other PTSD symptoms described above. Participants continually underlined the importance of non-verbal cues in their professional roles in order to provide corroborating evidence for any clinical conclusions and noted that non-audible features of clients’ accounts were mostly absent from transcripts of Home Office interviews.

The focus group discussions produced consensus over the majority of issues reported this section. There was a minor point of contention in the second focus group discussion with medico-legal report writing doctors regarding the balance between their roles as impartial witnesses and their urge to express their sympathy for the asylum seekers they work with.

Discussion

This exploratory research investigated the processes involved in asylum narratives that changed over time from the perspectives of professionals who work with them. This study revealed the unique vantage points of doctors, lawyers and psychologists with years of collective experience working with asylum seekers from different countries with different types of asylum claims, in professional relationships ranging from singular interviews to long-term therapeutic work.

One of the key findings of this research is that, according to participants in this study, asylum seekers may sometimes select what information to disclose based on their perceptions of its pertinence to the particular interview or interviewer. This is particularly significant given that asylum seekers are interviewed by a range of different professionals and suggests that they make decisions about what information to share with each professional. Most participants conveyed that the time available to build a rapport with the asylum seekers they interviewed was directly related to the level of disclosure they subsequently received from the asylum seekers, owing to the development of a trusting relationship. The different professional standpoints and the difference in time available to participants, such as the length of the interview, the number of appointments, and the duration of the professional relationship, affected the type of information disclosed to them. The findings suggest that any expectation that asylum seekers make full disclosures of their past experiences is unrealistic because disclosure is a prolonged process which often cannot be achieved in a singular interview. Similarly, expectations around the accuracy of detail in a narrative, or consistency over time, are incompatible with the processes of human memory, particularly in individuals suffering from PTSD. Participants mentioned additional factors that contributed to narrative dilemmas experienced by the asylum seekers they worked with, which were in line with previous studies on the influence of the interview environment, including physical features of the room, the gender of the interviewer and the role of interpreters, as well as interviewer expectations of emotional congruence from asylum seekers.^{9,16-21} However, as our study focused on professionals' perceptions of the decision-making processes that drove some asylum seekers' disclosures, we chose to focus on types of dilemmas and their relationship with asylum seekers' traumatic past experiences.

This is a small sample study, whose results cannot be generalised. Furthermore, interviews did not follow an identical format, owing to adjustments made to accommodate individual participants' time constraints, which may have affected the content of the interviews. As this study adopted Braun and Clarke's reflexive thematic analysis method,¹² a collaborative approach was taken that focused away from coding consistency and towards a nuanced reading of interview data.

A limitation of this study was that majority of the participants were white British; future research in this area should endeavour to recruit a more diverse sample, which would additionally allow another layer of analysis, i.e. of the relationship between professionals' ethnicity and asylum seekers' disclosures.

Overall, our findings demonstrate that it is potentially unrealistic to expect that asylum seekers will be able to disclose their past experiences in a complete manner to professionals, particularly in a single interview. It also highlights that there are a number of dilemmas that can affect asylum seekers' decisions around disclosure to professionals interviewing them, which are closely connected to their past traumatic experiences, present strong emotions about stigma and repercussions, and ongoing difficulties navigating the asylum process in the UK.

The scarcity of clear and accessible information about the procedures of asylum adjudication in the UK¹¹ renders asylum seekers susceptible to unhelpful advice from well-meaning friends or instructions from controllers, as conveyed by participants who reported incidents where asylum seekers had altered or fabricated elements of their narratives as a result of advice from friends or instructions from controllers. This demonstrates the need to interrogate what appears to be a 'choice' on the part of the asylum seeker to disclose or not disclose information, when in fact this may be a distressing dilemma arising out of trauma, fear and the control exercised by others such as traffickers, or due to misinformation or misunderstanding about what is 'best' for their asylum case.

Participants considered that the experiences of asylum seekers who had been survivors of trafficking or modern slavery,

sexual trauma, captivity in detention or prison, torture, and childhood traumas negatively affected their ability to discuss their past experiences openly. Such experiences were thought to render such individuals intimidated, devoid of power, mistrustful and suspicious. Our findings also suggest that details of traumatic events were sometimes not revealed to participants, and that on occasion traumatic events were revealed gradually over the course of a trusting professional relationship or following the perceived safety of successfully being granted leave to remain in the UK. These changes were seen by the professionals as a means by which asylum seekers exercised control over which aspects of their narrative they would share, and by doing so tried to regain some of the control that had been taken away from them when they had been subjected to abuse and torture in the past. Psychologists, psychiatrists and psychotherapeutic workers who had a professional understanding of the psychological needs of asylum seekers conveyed the importance of paying attention to the coherence between symptoms and the content of narratives to identify whether presentation of symptoms was a result of traumatic experiences or a misguided way of eliciting the help the individual felt they needed.

It is important to note that all participants spoke about the effects of fragmented trauma memories, which were said to lead to gaps in oral histories, leading to dislocated narratives and inconsistent accounts. These inconsistencies are sometimes cited as a reason for refusal in letters from the Home Office.⁴ Notably, a hostile asylum system and its 'culture of disbelief' was cited as a further source of trauma for some asylum seekers, who experienced anxieties as they anticipated being disbelieved or discredited; this supports recent literature on the effects of immigration detention.^{22,23}

Our findings have a number of practical implications for professionals who interview asylum seekers, and for policy makers and researchers. (a)The participants involved in this study conveyed that professionals conducting interviews can take measures to understand the process of disclosure in its complexity with the aim of making the interview environment conducive to gaining asylum seekers' trust and making them feel relaxed enough to disclose their full history. Participants recounted that certain individuals looked upon the notion of confidentiality with suspicion, or found it difficult to disclose sensitive personal information in front of professionals or interpreters from their own country and preferred instead to speak with foreign professionals. These are important factors to be considered when setting up an interview that requires disclosure of sensitive personal information. Participants' recommendations include considering in advance and where possible adjusting features of the interview setting to suit the specific needs of clients, such as lighting and noise levels, as well as the gender of the interviewer or interpreter; increasing interviewer awareness of PTSD symptomatology; and incorporating non-verbal information shared by the client, such as signs of distress or symptoms of PTSD, into interview notes.(b)Participants conveyed that professionals working with asylum seekers should treat them as individuals rather than a category of people and engage with their individual needs and dilemmas in a non-judgemental manner. Participants in our study explained that they perceived it as their task to understand and clarify the content of narratives and the reasons for any inconsistencies, in order to place the narratives in the context of the individual's asylum claim. This is indicative of a broader structural issue relating to the asylum interview, which, by requiring an individual to produce a narrative that is continuously consistent, places more emphasis on synthesising often traumatic histories into a coherent format, rather than addressing the health and welfare needs relating to these traumas.(c)We also recommend that future research focuses specifically on the experiences and opinions of asylum seekers and seeks their perspective on the issues that influenced any changes in their accounts over time.

We thank the individuals who agreed to share their experiences with us. We also thank Dr Stuart Turner, Professor Jonathan Smith and Dr Nick Midgely for their guidance.

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Data availability

All authors had access to the study data (i.e. recordings and transcripts) for the purpose of analysis and interpretation. Access is ongoing until publication is completed. Anonymised data can be made available upon request from authors.

P.A. was responsible for the study and interview material design, recruitment of participants, data collection by conducting interviews, data analysis, drafting manuscript, reviewing multiple manuscripts and approval of final version for submission. M.v.W. was responsible for data analysis and interpretation, drafting manuscript, reviewing multiple manuscripts and approval of final version for submission. C.K. was responsible for initial development of the study concept, supervision of study including design of interview and data analysis, review of multiple manuscript drafts and approval of final version for submission. F.B. was responsible for supervision of study including design of interview and data analysis, review of multiple manuscript drafts and approval of final version for submission. Y.W. was responsible for data analysis, drafting manuscript, and final approval for publication. All authors agree to be accountable for all aspects of the work.

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Declaration of interest

P.A., M.v.W., C.K., and F.B. received grants from Oak Foundation during the study. C.K. is the Royal College of Psychiatrists Lead on Refugee and Asylum Mental Health.

Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2020.33>.

[click here to view supplementary material](#)

1.2.13 Encouraging recruitment into psychiatry: practical initiatives

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Abstract

This article highlights key findings from a recent Royal College of Psychiatrists project showing that many UK medical schools are embracing the dual challenge of raising students' interest in psychiatry and ensuring that all doctors can support patients with mental illness. It focuses on two novel approaches to boosting recruitment into psychiatry: I'm a Medic Get Me Out of Here, an online outreach activity enabling schoolchildren to ask questions of health professionals in real time; and a living library, which creates a safe space for dialogue where topics are discussed openly between human books (professionals) and readers (undergraduate students) to challenge stereotypes. It is recommended that sharing these and other examples of good practice will help all medical schools encourage recruitment in psychiatry more widely.

Contents

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- *Showing initiative – encouraging students to choose psychiatry*
 - * *Excellence in teaching*
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- *Case studies: two novel approaches to increase students' interest in psychiatry*
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Showing initiative – encouraging students to choose psychiatry

Over the past two years, the Royal College of Psychiatrists (RCPsych) has gathered and analysed information from medical schools and students to produce practical guidance on how to enhance the undergraduate experience of psychiatry. After hearing many positive examples of activities and initiatives, as well as finding out what students found less appealing, they identified four key action areas for medical schools: excellence in teaching; high-quality psychiatry placements; leadership from psychiatrists; and psychiatry-based enrichment activities.

Excellence in teaching

To start with, the focus should be on students' experiences of psychiatry teaching in the classroom or lecture setting. Many students fed back that they would like psychiatry content to be more prominent earlier and throughout the course. Not only would this reflect how psychiatry is an integral part of medicine (rather than just an add-on), but it would allow students to explore at an earlier stage their potential interest in helping patients recover from episodes of mental illness.

A widely held view was that learning in 'real-life' contexts should be further promoted, through simulation teaching, learning videos, case-based discussions, testimonies from people with lived experience as patients or carers, and lectures involving a panel of psychiatrists working in a range of subspecialties. The 'living library' initiative outlined later in this article is an example of this.

Students also highlighted the importance of accentuating how psychiatry is unique in its integration of science with a whole-person approach, and the role it has in driving the most exciting medical advances to transform treatments and foster overall health and well-being globally.

High-quality placements

Providing high-quality psychiatry placements is an intuitively sensible way to increase the number of students interested in it as a career. Of the 792 students who participated in our survey, 52.2% said they were more inclined to choose psychiatry after their placement.

But what does a good placement look like? *Fig. 1* illustrates a few components of medical students' experiences of psychiatry placements. *Fig. 1* Students' experiences of placements in psychiatry. A total of 792 students throughout the UK completed the survey. Note: it is rare to find undergraduate settings providing opportunities for undergraduates to offer talking therapy to patients under supervision, as students may not have received enough training to be able to

deliver this. Source: unpublished survey run by the Royal College of Psychiatrists between 15 October 2018 and 7 January 2019.

While there is no singular ‘best’ model for placements, students did report aspects that were more positive.

They particularly enjoyed the variety of experiences provided by psychiatric placements, in contrast to other specialties. Appeal also lies in the ability to talk to patients, more so than in other placements, and learn their history in greater detail. Some medical schools have set up longitudinal placements to provide the opportunity to follow patients during several weeks and observe the longer-term benefits of psychiatric interventions.

Introducing medical students to patients and clinicians in extreme environments such as prisons or secure hospitals arguably has a larger impact on improving attitudes to psychiatry. Archer et al¹ showed that a single-day visit to Broadmoor Hospital, a high-security psychiatric hospital in Berkshire, was effective in changing the attitudes of medical students towards forensic psychiatry, with 75% of participants stating that their attitude towards psychiatry had improved.

There is a common stereotype of psychiatrists working alone with patients. To combat this, students need to meet all members of the multidisciplinary mental health team. This will ensure that they understand how extensively professionals from a range of disciplines work together to treat patients’ needs holistically.

Students need to understand how psychiatric care fits into the healthcare system and see for themselves the high level of need. One way to do this would be for psychiatric placements to be better combined or coordinated with placements in other specialties and *vice versa*. The students would be able to (a) witness the interactions between general practitioners (GPs), doctors from other specialties and psychiatrists, (b) understand the benefits of integrated psychiatric care and (c) gain further skills in psychiatry, which will be helpful whatever specialty they end up choosing.

How can medical schools help students make the most of their placements? Some students said that they would like to feel better prepared before starting their placements in psychiatry. Budd et al² had previously suggested that this is important, particularly addressing their potential fears and negative perceptions of the specialty. The RCPsych’s Choose Psychiatry guidance for medical schools includes suggestions of what inductions might cover based on feedback from students, including: basic guidance on the type of symptoms to expect from patients with different illnesses and how they should respond; a briefing on procedural issues involved in working in psychiatric settings, including health and safety; and information on how a placement in psychiatry might affect their own emotions and mental health (www.rcpsych.ac.uk/become-a-psychiatrist/choose-psychiatry).

Medical students also said that they need reassurance about getting adequate mental health and well-being support. Some medical schools have set up Balint groups to provide a safe space for students to discuss their emotional reactions to their patients’ experiences. These should be supported and further expanded where possible.

Leadership from psychiatrists

Everyone can remember someone who inspired their career choices. Medical students highlighted the importance of talking to inspiring consultant psychiatrists and trainees during their time at medical school. Some suggested that medical schools could create a ‘bank’ or database of psychiatry mentors.

To raise the profile of psychiatrists in undergraduate education, the RCPsych encourages medical schools to reflect on whether their senior leadership teams are composed of a multispecialty and diverse group of individuals, including psychiatrists, so that students can see them in leadership roles.

Psychiatrists’ progressive and thoughtful leadership could play an integral role in driving the strategic direction of medical schools. The RCPsych advises medical schools to ensure that psychiatric education is designed and led by psychiatrists with both clinical and educational expertise, and that students are presented with up-to-date research in psychiatry throughout the medical curriculum.

Enrichment activities

How can you help immerse students in psychiatry? Many medical schools have implemented enrichment activities to enhance students' exposure to and experience of psychiatry, which are highly valued by the medical students we talked to.

Psychiatry societies ('PsychSocs') are student-led university societies set up to raise the profile of mental healthcare among medical students and to promote careers in psychiatry. Several next steps are recommended both locally and nationally to take advantage of PsychSocs to improve recruitment into psychiatry – including fostering enthusiastic mentoring by local psychiatrists via 'buddy schemes' and continuing to share ideas and learning across the country, as explained by Pandian et al³ earlier in 2020.

The Psychiatry Early Experience Programme (PEEP) provides medical students with the opportunity to shadow core trainees in psychiatry. This initiative was developed by South London and Maudsley NHS Foundation Trust and King's College London Medical School. Given the success of the scheme, students asked for improved availability and access to such schemes.

Special study modules (SSMs) or student-selected components (SSCs) in a psychiatry-related subject are short courses and/or projects in subjects that students can select according to their personal interests. They offer opportunities to learn in innovative ways and have been recommended by the General Medical Council.

Career enrichment courses (often referred as summer, autumn or winter schools) offer an intensive programme of lectures, seminars, debates and networking opportunities to students who are considering a career in psychiatry.

Psychotherapy schemes give medical students the unique opportunity to deliver psychotherapy to one patient for an extended period. Yakeley et al⁴ highlighted that projects that involve medical students offering psychodynamic therapy (under the close supervision of staff) have contributed to an increase in the number of students choosing psychiatry as a career.

Extra-curricular initiatives to give students further opportunities to spend time with people with mental illness are also being developed across the country. The Time for Dementia initiative is an example of collaborative work that has had a demonstrable impact on students' understanding of people with dementia.

Other schemes offered by the RCPsych that can be promoted to medical students include the Psych Star scheme, Student Associate membership, and Divisional and Faculty prizes.

Case studies: two novel approaches to increase students' interest in psychiatry

The RCPsych project highlighted that students who were in the early stages of their medical course were more likely than peers later in the course to feel uninformed about psychiatry. Some students in the later years of study also felt that there was a lack of information on mental health and psychiatry and wanted to be better informed.

A key recommendation made by students was to raise awareness of psychiatry at an earlier stage in their medical course and at secondary-school level. The following case studies provide examples of how this recommendation could be implemented.

A 'living library'

Greater Manchester Mental Health NHS Foundation Trust decided to use an innovative approach based on the 'living library' concept, where experienced clinicians working in their respective fields ('the books') were available 'on loan' to students ('the readers'). This was implemented to improve the student experience, enrich students' learning, provide them with an insight into other professions, encourage the sharing of institutional knowledge and develop interprofessional learning.

The concept is designed to build a positive framework for conversations that can challenge stereotypes and prejudices through dialogue. It is based on the idea of interprofessional learning (defined as 'when professionals learn with, from

and about each other’) that has been identified as an innovative strategy that can help bolster the medical workforce.⁵ Literature reviews suggest that learning with, from and about other healthcare students has the potential to improve communication between professionals and, ultimately, care for patients.⁶

Figure 2 depicts the book covers that were designed and displayed for students to help decide which ‘book’ they wanted to borrow. *Fig. 2* Living library book covers, designed by Lorna Dawson, Greater Manchester Mental Health NHS Foundation Trust.

In total, 25 living-library cards were made available to students on placement within the trust.

After signing up to the library and reviewing potential book choices, all readers were given a library card and were invited to reserve one of the books at a slot during the morning. There were six slots available throughout the day and readers would have around 20 min with each of their books. In theory, each reader could have conversations with six of the nine books.

In total, 22 readers booked places on the event, 13 of whom attended. *Figure 3* shows which disciplines were the most popular and *Fig. 4* describes what attracted the readers to them. *Figures 5* and *6* show the impact of the initiative on readers’ views about both professions and the benefits of interprofessional practice. *Fig. 3* Responses of students ($n = 13$) to the question: ‘Which living book(s) did you read?’. *Fig. 4* Responses of students ($n = 13$) to the question: ‘What attracted you to the living book(s) you selected?’. *Fig. 5* Responses of students ($n = 13$) to the question: ‘Do you feel that your experience at the living library changed your views about another profession?’. *Fig. 6* Responses of students ($n = 13$) to the question ‘Has the living library changed your views about the benefits of interprofessional practice?’.

After the event, 9 (69%) of the 13 respondents rated their overall experience of the living library as ‘Excellent’ and 4 (31%) as ‘Good’; 100% of respondents would recommend living books to others; 11 readers (85%) strongly agreed that the living library was a good way to challenge prejudices and encourage interprofessional learning, with the other 2 (15%) also agreeing with this.

I’m a Medic Get Me Out of Here

I’m a Medic, Get Me Out of Here (shortened to I’m a Medic) is an online, student-led outreach programme, funded by Health Education England and designed to provide equality of opportunity for all school students to engage with the National Health Service (NHS) workforce. The aim is to help inform schoolchildren about a particular career and let them explore whether that career could be for them. The idea is based on research showing that young people start to develop their career aspirations early in secondary school, if not earlier.^{7,8} Findings from a survey with over 20 000 children showed that parents (and parents’ friends), the TV and media were most likely to influence children’s career aspirations. Less than 1% of children had heard about the jobs through people coming to their school.⁷

I’m a Medic was trialled in psychiatry for the first time in 2019. With supervision from teachers, schoolchildren had secure access via a website to healthcare professionals, who answered questions in real time during a 30-min lesson. An online moderator was available for each chat. Pupils could also post a question to be answered at a later stage.

Three healthcare workers took part as individuals: a consultant psychiatrist (N.H.), a mental health nurse and an NHS mental health trust’s head of human resources, responsible for managing and advising a wider team. Four healthcare teams based in various locations across England took part as a group: an arts therapy team, an early intervention team, a home treatment team and a psychiatry ward team.

Students were mainly in year 8 (generally 11.5–13 years old) from schools across England. A total of 47 classes from 20 schools participated in 40 live chats. Over 1000 students logged in, with approximately 85% participating in live chats, asking questions or leaving comments. Students could vote for who they felt they most engaged with and who answered their questions to their satisfaction. *Figure 7* depicts the words most often used by students in these conversations. *Fig. 7* Frequent words used by schoolchildren in live online chats in the I’m a Medic, Get Me out of Here programme. The size of the word represents its popularity.

Students often asked what led healthcare workers to choose their jobs. They would, for instance, ask questions such as ‘What encouraged you to take this job?’ or ‘What inspired you to start what you’ve done?’.

They also asked healthcare workers about their qualifications and the qualifications they would need to attain certain roles in the sector. These were mostly focused on GCSE qualifications, as opposed to A-Levels.

When discussing mental illnesses, students focused heavily on more commonly known illnesses such as depression and anxiety, including how to discuss or treat them.⁹

During focus groups, students fed back that they particularly enjoyed the ability to interact directly with healthcare workers, in real time and in a ‘conversational’ way. Being able to vote also contributed to the engaging nature of the experience.

Additionally, interacting online provided some distinct advantages that face-to-face interactions might not provide. The first one is the ability for children in remote areas to interact with professionals who may not have visited the schools in person. Second, students often appreciated the opportunity to ask questions anonymously without being judged by their peers: “‘It was better because you’re not actually speaking to them. It’s, like, all the questions that you ask online you might feel embarrassed to ask them to their face. Then they just find out, because it’s easier to type it than to actually say it.’ I said some stuff that I would not have said in real life, online. So, it’s just easier to, like, speak anonymously.’”

This benefit was also highlighted by their teachers: “‘Some of the quieter girls and boys definitely asked a few questions that flagged them up on my radar.’”

Data also suggest that the personal and direct nature of the experience helped achieved the desired impact: “‘I think [I connected most with] Neel because of the job that I wanted to be, and he, kind of, helped me, because I’m bad at science, he helped me how to get through it and what qualifications I need. So, that, kind of, helped.’”⁹

Fifty responses were collected through a post-survey questionnaire. 82% of the children ($n = 41$) agreed/strongly agreed that they had learnt more about ‘what it’s like to work in healthcare’ and felt that they knew more about what they would need to study to get their ideal job; 66% ($n = 33$) agreed that they might get a job working in healthcare, and 60% ($n = 30$) said that they would enjoy working in healthcare. This is an increase from the pre-survey, with responses to those questions being 43% and 45%, respectively.⁹

Conclusions and future plans

The findings and recommendations detailed in the RCPsych Choose Psychiatry guidance for medical schools and the two case studies included in this article would help lay the foundations for developing a strong medical workforce, comprising both psychiatrists and doctors working in all specialties able to give people with mental illness the best possible care.

The RCPsych project highlighted that students’ consideration of both the importance of mental healthcare in medicine and psychiatry as a career were largely determined by: the integration of psychiatry courses into the curriculum as widely and as early as possible, the high quality of placements in psychiatry, the students’ ability to be in contact with inspiring psychiatry leaders and the availability of enrichment activities to enhance students’ exposure to, and experience of, psychiatry.

Opening up the living library to medical students in the early years of studying could also help increase the number of students choosing to enrol in psychiatry enrichment activities – such as psychiatry modules or psychiatry societies – which in turn will hopefully drive up numbers choosing psychiatry as a career.

We know that schools may have limited resources for careers advice. I’m a Medic is a time-efficient and gratifying initiative that can reach many students without them needing to be taken out of school or disrupting the timetable.

The next step will be to produce a practical booklet to support PsychSocs with their activities. It will include the ideas given above and many others that may not have been considered or shared otherwise, following a consistent framework. The booklet would be particularly helpful to PsychSocs around the UK, but could also be used by foundation doctors and other trainees.

N.H. will contact all UK PsychSocs for contributions but welcomes any authors (from undergraduates to consultants) who wish to contribute. Feedback for this project is also welcome. Please contact the corresponding author.

Meanwhile, the RCPsych is creating an online hub showcasing case studies of psychiatry extra-curricular activities at medical schools across the UK. The case studies will be represented visually on a map of the UK, and users will be able to click to reveal more information about an initiative which will explain how the activity works and may highlight its impact on students' interest in psychiatry and/or mental healthcare more generally.

Medical schools are also encouraged to use the Gatsby Wellcome Neuroscience Project run by RCPsych to integrate the latest research on neuroscience into their curriculum.

Examples of good practice of how students are being inspired to learn about better mental healthcare have been compiled into a practical guidance published on the RCPsych website as part of the Choose Psychiatry campaign.¹⁰

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Data availability

The data that support the findings of this study are available from the corresponding author, N.H., upon reasonable request.

N.H. led in the co-ordination of the article, wrote the sections on 'Living Library' and 'I'm a medic get me out of here' primarily, edited drafts of the whole article and approved the final version. Z.M. wrote the section on 'Showing Initiative' primarily and edited drafts of the whole article and approved the final version.

N.H. is on the editorial board of the *BJPsych Bulletin*.

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1.2.14 Scaling-up Health-Arts Programmes: the largest study in the world bringing arts-based mental health interventions into a national health service

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Abstract

The Scaling-up Health-Arts Programme: Implementation and Effectiveness Research (SHAPER) project is the world's largest hybrid study on the impact of the arts on mental health embedded into a national healthcare system. This programme, funded by the Wellcome Trust, aims to study the impact and the scalability of the arts as an intervention for mental health. The programme will be delivered by a team of clinicians, research scientists, charities, artists, patients and healthcare professionals in the UK's National Health Service (NHS) and the community, spanning academia, the NHS and the charity sector. SHAPER consists of three studies – Melodies for Mums, Dance for Parkinson's, and Stroke Odysseys – which will recruit over 800 participants, deliver the interventions and draw conclusions on their clinical impact, implementation effectiveness and cost-effectiveness. We hope that this work will inspire organisations and commissioners in the NHS and around the world to expand the remit of social prescribing to include evidence-based arts interventions.

Contents

- *Scaling-up Health-Arts Programmes: the largest study in the world bringing arts-based mental health interventions into a national health service*
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 - *Melodies for Mums (arts partner: Breathe Arts Health Research)*
 - *Dance for Parkinson's (arts partner: English National Ballet)*
 - *Stroke Odysseys (arts partner: Rosetta Life)*
 - *Conclusions*
 - *Supplementary material*

The field of arts and mental health is a constantly and rapidly expanding area of research. We now have numerous publications, in the UK and globally, suggesting a strong link between arts-based interventions and improvement in mental and physical health outcomes.¹⁻⁹ This invaluable body of research has shown the clinical effectiveness of the arts for the treatment of an array of mental and physical health problems, as diverse as anxiety, depression, cancer, cerebral palsy and stroke, among others. However, such research has yet to offer solutions that are readily scalable, implementable and cost-effective, and that can be employed in primary and secondary care settings in the National Health Service (NHS) or equivalent health services in other countries. Furthermore, these art interventions face limitations, including the lack of a continuous stream of funding, limited partnerships with commissioners and funders, insufficient clinical evidence and difficulties in their implementation in existing clinical pathways.

The SHAPER project

The Scaling-up Health-Arts Programmes: Implementation and Effectiveness Research (SHAPER) project aims to start addressing the above gaps in the evidence base. SHAPER is a multidisciplinary programme funded by the Wellcome Trust, and is being run by the Institute of Psychiatry, Psychology & Neuroscience at King's College London and by the Department for Behavioural Science and Health and the Institute of Mental Health at University College London. The project aims to scale up three existing community arts interventions: Melodies for Mums (for women with postnatal depression), Dance for Parkinson's, and Stroke Odysseys. These three interventions have been developed and piloted on a small scale, offering promising results within their rehabilitation scopes.¹⁰⁻¹⁴

SHAPER was designed following an intensive 6-month scoping process involving stakeholders at different levels, including artists, clinicians, patients, researchers and commissioners. The aims were to create a programme that meets specific needs in the healthcare sector, to scale up interventions that already had promising efficacy pilot data and to involve high-quality arts interventions led by experienced partners (e.g. Breathe Arts Health Research, the English National Ballet and Stroke Odysseys). It has the ambition to be inclusive of the larger patient population (including those not already engaged in the arts) and, importantly, to be scalable and commissionable by the healthcare sector.

The ambition of the programme is thus to embed arts interventions within a large academic health science centre, King's Health Partners (KHP), establishing their delivery in the medium- to long-term future. As an academic health sciences centre, KHP's academic and clinical partners (King's College London, Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, and South London and Maudsley NHS Foundation Trust) bring together research, education and clinical practice for the benefit of the patients. SHAPER's objective is to study the three arts interventions embedded within existing clinical pathways in order to scale them up to reach larger numbers of people across KHP and the community, examine possible mechanisms of efficacy and provide implementation evidence.

The SHAPER programme intends, ultimately, to enable clinical commissioning groups (CCGs; i.e. the 'payers' in the NHS) to commission the three interventions, so that they can continue to be delivered in the future. To attain the aims mentioned above, three levels of effectiveness must be assessed: (a) clinical effectiveness, considering the real-world impact on health outcomes and whether these are meaningful to clinical practice; (b) implementation effectiveness, in terms of uptake, suitability, acceptability and feasibility of the interventions; and (c) cost-effectiveness, to develop strong business plans for commissioners. Since the interventions selected are at different developmental stages, an additional ambition of SHAPER is that the implementation science methodologies developed in this programme will allow the creation and evaluation of an implementation model that could be used across future arts interventions, tailored to different stages of development and delivery.

The adopted research, a three-pronged hybrid type II effectiveness-implementation evaluation, is the gold standard of modern implementation science that blends components of clinical effectiveness and implementation research.¹⁵ This strategy will allow the research team to simultaneously test the clinical intervention and the implementation strategy, and our team has used it successfully in previous scale-up research at King's College London.^{15,16}

The programme is in the process of obtaining ethics committee approvals. Consent will be sought from all research participants and stakeholders involved in these studies.

Cross-cutting implementation and health economics evaluation

An innovative aspect of the SHAPER programme is that, in addition to the clinical effectiveness of the interventions, a systematic approach will be taken to simultaneously evaluate their implementation effectiveness and cost-effectiveness. Implementation effectiveness refers to the uptake, suitability, acceptability and feasibility of the interventions. This will help us to identify not just 'if', but also 'why' and 'how' the interventions work and for whom, and will support our understanding of how they can be successfully delivered within clinical pathways. This approach of simultaneously assessing clinical, implementation and cost-effectiveness of an intervention is supported by the recently emerged 'hybrid' research designs – which offer a framework for these different elements of effectiveness to be assessed in parallel.¹⁵ Overall, the SHAPER programme is conceptualised as a hybrid type II design, in which the clinical and implementation effectiveness are given equal weight in the design of the evaluation across the three focal interventions.

The evaluation of how the interventions are implemented within clinical pathways will further capture barriers and

drivers of implementation as well as unintended consequences for patients and providers. Existing implementation theory and direct work with a wide group of stakeholders of the interventions (including patients, arts and clinical providers) will inform the implementation evaluation throughout the programme.^{17,18} Along similar lines, the cost-effectiveness evaluation will cover health economic evaluations of the implementation and delivery costs and associated savings, service utilisation and related analyses. Implementation and cost data will be captured through a mixed-methods approach comprising a variety of qualitative and quantitative data collection techniques, including structured interviews and psychometrically established measurement scales.¹⁹

In bringing these three studies together, the SHAPER programme aims to bridge the gap between small-scale arts interventions and their large-scale implementation into pathways within the NHS for improved physical and mental health in people with postnatal depression, Parkinson's disease and stroke.

Here, we offer an overview of the three interventions and of the implementation and cost-effectiveness evaluation adopted within SHAPER.

Melodies for Mums (arts partner: Breathe Arts Health Research)

Postnatal depression affects at least 12.9% of new mothers, with symptoms including fatigue, anhedonia, insomnia and irritability.^{20,21} However, challenges surround the fact that there is still no complete treatment solution: although pharmacological treatments have had positive results, these are hampered by low uptake and adherence among mothers.^{22–24} Psychotherapy has also produced mixed results, as well as similar challenges regarding low uptake or delayed treatment.^{21,25–27} However, many mothers engage in community group activities with their babies, such as attending mother–infant play groups. These activities have been identified as ways of relaxing mothers, providing good sources of social interaction, decreasing the monotony of each day and providing a sense of personal fulfilment.²⁸

Moreover, there is a growing body of evidence demonstrating the effects of community group singing on mental health.^{29,30} Singing to new babies is practised in cultures around the world, and research has demonstrated valuable benefits, such as improving mother–infant interaction and reducing distress in babies.^{31–33} Listening to music during pregnancy is also associated with higher levels of well-being and reduced symptoms of postnatal depression in the first 3 months post-birth, while daily singing to babies is associated with fewer symptoms of postnatal depression and higher levels of well-being, self-esteem and perceived mother–infant bond.¹⁰ Consequently, there is a strong theoretical background indicating that singing could support mothers with postnatal depression.

Breathe Arts Health Research's Melodies for Mums offers free, community-based singing sessions to women with symptoms of postnatal depression in London boroughs (*Fig. 1*). A previous study led by researchers in the SHAPER team has shown that this intervention, already implemented in some London boroughs, results in faster improvements in symptoms when compared with usual care.¹¹ Specifically, the study recruited 134 women with symptoms of postnatal depression and found that, in women with moderate to severe depression, there was significantly faster improvement in symptoms in the singing group than in the group play workshops for mothers and babies. *Fig. 1* Melodies for Mums session delivered by Breathe Arts Health Research. Image credit: Richard Eaton.

The planned two-arm randomised clinical trial (SHAPER-PND) aims to establish effectiveness in a larger sample (400 participants) and to analyse the factors affecting economic and implementation potentials for this intervention. Participants will be assigned to either a 10-week singing intervention or a 10-week active waiting-list control group, where they will be encouraged to attend community mother–baby activities. Singing sessions will be delivered in children's or community centres and each group will have 8–12 mothers and their babies. Mothers and their babies will be invited to sit in a circle and learn songs from all over the world, from vocal 'motherese' style noises to lullabies and more complex songs. They will be invited to hug or stroke their babies while singing and to add simple musical instruments (maracas, drums, hand chimes and others) to increase mother–baby interactions. Mothers will also be invited to develop their own songs about motherhood and their babies, creating a shared experience with other participants, thereby increasing their sense of inclusion.

A package of demographic, mental health, biological and social measures will be collected from mothers and babies at set time points throughout the intervention, and up to 36 weeks post-randomisation. In addition to the clinical effectiveness outcome (an improvement in depressive symptom score according to the Edinburgh Postnatal Depression

Scale), we will put equal weight on the implementation science and economic data assessments. For biological outcomes, we will collect saliva and hair samples to assess stress and hormonal markers, including cortisol, oxytocin and cytokines. We will also conduct qualitative interviews with a subgroup of mothers who self-report particular risk factors for postnatal depression, to explore how singing interacts with specific contexts.

Dance for Parkinson's (arts partner: English National Ballet)

Parkinson's disease is a chronic neurodegenerative condition affecting over 145 000 people in the UK alone, with a prevalence expected to rise by around 18% between 2018 and 2025, to over 168 000, and to double by 2065.³⁴ Parkinson's disease is a complex disorder characterised by a range of motor symptoms, including slowness of movement (bradykinesia), tremor and gait impairment, and non-motor symptoms such as anxiety, depression, sleep dysfunction, autonomic problems, mood disturbances and cognitive decline, with a profound negative effect on quality of life.³⁵ Although there are no treatments that can affect the progression of this condition, evidence is emerging that physical activity and certain types of exercise, including a range of dance-based exercise, can improve motor symptoms, functional mobility and stability, and result in some cognitive improvements, reduced pain, depression and anxiety, decreased social isolation and improved quality of life.^{36–38}

Dance for Parkinson's is an existing programme delivered by the English National Ballet (ENB) for people with Parkinson's disease (*Fig. 2*) across multiple venues in the UK, including London, Ipswich, Cardiff, Liverpool and Oxford. The sessions are being delivered by ENB-trained dance artists and currently host people with Parkinson's and carers. These sessions are popular and lend themselves to the requirement of a large-scale randomised study so as to provide robust evidence of dance being accepted as a potential therapeutic option in the pathway of care for Parkinson's disease. *Fig. 2* Dance for Parkinson's session delivered by the English National Ballet. Image credit: Laurent Liotardo.

As part of the SHAPER project, the study will be supported by the Wellcome Trust and will take place at the internationally renowned Parkinson's Foundation Centre of Excellence at King's College Hospital and King's College London. It will be a two-arm randomised controlled trial (SHAPER-PD-Ballet) to investigate the clinical efficacy of the intervention in a larger sample (160 participants), graded by the severity of their Parkinson's (mild, moderate and severe). Participants will be randomly allocated to receive 12 weekly ballet classes delivered by a team of ENB-trained dance artists and musicians, lasting approximately 75 min and incorporating live music, dance, rhythm and voice. A comparator group will continue on conventional treatment regimes. Participants will be followed up for up to 6 months post-intervention, and those allocated to the comparator group will be offered participation in the ballet sessions at the end of the project.

The clinical aspect of the study will, for the first time, use a range of clinically validated outcome measures, including the comprehensive version of the Non-Motor Symptom Scale developed at King's College Hospital. Secondary outcome measures include assessments of both motor and non-motor symptoms, such as cognitive decline, mood, sleep and pain. Additionally, wearable sensors will provide an objective measure of the Parkinson's signs as well as mobility and balance. Assessment quality will be checked by a 'masked/blinded' rater.

A unique aspect will be that all participants will be offered participation in a substudy of electrodiagnostic measures, which will employ transcranial magnetic stimulation coupled with electroencephalography and electromyography to investigate the effects of the intervention on neural networks and brain activity.

Implementation and economic data will be collected to assess acceptability, appropriateness and feasibility of the intervention on a large scale and its potential to be adopted and sustained as a cost-effective and beneficial adjuvant therapy. All measurements will be conducted at baseline (before the start of the intervention), immediately post-intervention between 3 and 6 months post-intervention to explore the acute and chronic benefits.

To our knowledge, this is the first randomised controlled trial investigating the effects of ballet dancing on people with neurological disorders.

Stroke Odysseys (arts partner: Rosetta Life)

Stroke is a leading cause of disability in the UK and worldwide, and approximately two-thirds of stroke survivors leave hospital with disability.³⁹ There are over 1.2 million stroke survivors in the UK, projected to exceed 2 million by 2035. Stroke costs the UK an estimated £25.6 million annually.⁴⁰ Recent data from the Sentinel Stroke National Audit Programme shows that nearly 40% of patients between August and November 2017 left hospital with moderate to severe disability (modified Rankin scale, 3–5).⁴¹ Indeed, the transition from hospital to home after a life-changing event such as a stroke is extremely difficult both for the individual concerned and for their family, friends and caregivers. Fragmentation of health services often means that information provision relating to discharge is poor, which may also contribute to delays in discharge from hospital.

Stroke Odysseys, a post-stroke performance arts intervention, has been co-designed by artists and developed by the organisation Rosetta Life in a unique partnership with south London stroke communities. It is an intervention using performance arts to support recovery, agency and well-being in stroke survivors (*Fig. 3*). The intervention was initially developed and funded by King's and Guy's and St Thomas' Charity and has been delivered in four London boroughs.¹³ *Fig. 3* Stroke Odysseys tour performance. Image credit: Rosetta Life.

Stroke Odysseys has three stages – clinical intervention, community intervention and stroke ambassadors – all of which will be replicated in this study. During the clinical intervention, while the patient is in hospital, the sessions will run for 60 min for groups of 6–8 patients in neuro-rehabilitation wards. These sessions will be led by a trained movement artist and a singer, and will involve movement, performance exercises, vocal warm-ups and singing. Dance practices will be rooted in improvisation, somatic dance theory and carnival/folk dance. Then, in the community stage, patients will be invited to perform their own stories in a 12-week performance intervention, working with performance arts towards creating a new perception of their own identity post-stroke. The performance is based on skills acquired in movement, music, song and spoken word, which has not only demonstrated benefits on perception of disability and cognition, but also aims to manage the anxiety and depression that affects one-third of stroke survivors.^{42,43} Finally, in the third stage, participants who complete the community intervention will be invited for training to become advocates for life after stroke: 'stroke ambassadors'. Stroke ambassadors support the running of the programme in hospitals, assisting artists, recruiting participants and performing. Stroke ambassadors also speak at conferences and at regional stroke association groups and are members of an integrated performance company that create performance works to advocate for life after stroke. The study aims to recruit 75 new ambassadors. The main aim of the study is to evaluate the implementation, impact and experiences of a community-based performance arts programme (Stroke Odysseys for stroke survivors) using mixed methods (interviews, observations and surveys) prior to and after each programme stage, and carry out non-participant observations during the workshops. A series of implementation measures will be used as well as clinical outcome measures, including the Oxford Participation and Activities Questionnaire, a patient-reported outcome measure that assesses patients experiencing a range of health conditions. In addition, a health economic evaluation will be performed to cost the resources used in implementing the programme, and to evaluate wider service utilisation and associated costs before and after participants complete the programme and any changes in their quality of life profile.

Conclusions

Our ambition is that the SHAPER programme will not only provide conclusive clinical and mechanistic evidence on the three studies described above, but also offer an invaluable resource to shape the future of arts interventions within the realm of rehabilitation for a range of other mental and physical health conditions.

SHAPER also presents as a unique opportunity to build a strong evidence base on the clinical effectiveness, implementation and mechanisms of arts interventions. Such a knowledge base will bring arts interventions into mainstream psychiatric care and put them on an equal footing with other pharmacological and psychosocial approaches.

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Supplementary material

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[click here to view supplementary material](#)

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1.2.15 Femi Oyebode

Abdi Sanati¹

date

2021-02

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- *Femi Oyebode*

Professor Femi Oyebode does not need any introduction. He is one of our greatest experts in the field of descriptive psychopathology. In recent years, he has taken over the influential psychopathology textbook *Sims' Symptoms in the Mind*. He is also an authority on delusional misidentification syndromes and rare psychiatric disorders. As someone who is interested in psychopathology, I have always found Professor Oyebode's writing very informative and an amazing read. I finally met him a few years ago at the International Congress of the Royal College of Psychiatrists. He has also edited a book on literature and psychiatry (*Mindreadings: Literature and Psychiatry*), written one on the theatre (*Madness at the Theatre*) and published six volumes of poetry.

Professor Oyebode, first I wanted to thank you for your time for this interview during the lockdown! Having read your work, I wanted to start the interview with a question on the humanities. How important do you think the humanities are for psychiatry?

I think the humanities are important for the whole of medicine, and not just psychiatry. The medical humanities include moral philosophy, ethics, medical history and literature, among others. I focus on literature, which is my expertise. The aim of literature in medical humanities is to help us grasp the living experience of others. It can help us with the living experience of our patients too. We can emphasise the subjective experience of our patients using literature as an entry point.

¹

Abdi Sanati meets Femi Oyebode, Honorary Professor of Psychiatry and consultant psychiatrist, Institute of Clinical Sciences, University of Birmingham, UK

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Do you think reading fiction can help psychiatrists to improve their understanding of their patients' narratives, especially in the era of assembly-line psychiatry, when the narratives are lost in the rigid system?

It is a complex question and I will try to answer it in a roundabout way. If one is thinking of the best use of literature for psychiatry, I would recommend reading the autobiographies or memoirs of people who have suffered from mental illness. Even more so when the author is a professional writer. Writers have the gift of language to describe complexities of those experiences in words. Being familiar with those descriptions would help the psychiatrist to communicate better in their practice. Going back to fiction, I think you were right to bring it up. It is an interesting human activity. One of fiction's tasks, if I might put it like that, is to help us live the lives we have not experienced ourselves. It engages our brains and inner life to understand the reality we have not experienced and the possibilities that come out of that reality. Fiction enables us to appreciate a multiplicity of contexts without the need to experience them directly.

I think fiction is also important in helping us understand moral dilemmas. I have to admit I found more moral lessons in Victor Hugo's *Les Miserables* than in textbooks!

I agree that fictional accounts are important. My example is Albert Camus' *The Plague*. It is a multilayered and complex work. At one level, it is about Oran, a city in northern Algeria, facing the challenge of a plague epidemic. At another level, it is a metaphor for the Resistance in Nazi-occupied France during the Second World War. It explores the nature of freedom and the difficulties of choices one has to make. In the struggle with the COVID-19 pandemic we have faced similar choices – choices that include risking our lives as healthcare professionals while going out to work, which we do every day. Fiction has the power to help us see these choices and understand their complexities.

What do you think about the role of visual arts in helping us understand the human condition?

I have to admit I am not an expert in painting but as a West African I know a bit about sculpture. Nevertheless, I agree that the visual arts can be helpful. For example, when we look at a painting that captures the instant and fixes it in time, we can see details that we may miss on a casual, cursory view. Again, looking at a painting can potentially help us to understand human gestures and bodily attitudes and to see these in more detail. It sharpens the eye and enables us, in the clinic, to recognise postures and see subtleties we would not usually see.

As you know, I am the chair of the Philosophy Special Interest Group at the Royal College of Psychiatrists. One reason psychiatry attracted me was the philosophical issues embedded in it. Do you think we should teach philosophy in training?

It is not an easy subject to teach! It is not well known, but I have a PhD in Philosophy of Mind, so I am familiar with the academic side of philosophy and the teaching of philosophy. As psychiatry is conceptual, we need to think clearly and listen intently. And philosophy could help. However, I am not sure how easy it is to teach. In addition, many philosophers of psychiatry seem not to understand that psychiatry is a practice and is much more than mere concepts and ideas. You have to deal with the facts before you can make decisions. You cannot only take time to think. Philosophy benefits psychiatry immensely with regard to conceptual reasoning but I don't recommend formal teaching in the same way that I don't recommend formal teaching of literature in psychiatry training and having exams for it. Both subjects are very enriching but when we try to teach them they can feel very dry. For that reason, I doubt that we need to have formal teaching on them.

I do agree that we need to increase the interest in philosophy and literature and hopefully we will succeed. I am interested in your comment on philosophers without clinical experience. Looking at the philosophy of psychiatry's literature on delusions, you encounter several discussions on Capgras delusion, which is rare. I always wondered what is the reason for this preoccupation with Capgras delusion. There is also another issue when non-medics try to explain to me how medicine works. My colleague Dr Jonathan Hurlow coined the term 'non-medicsplaining' for this!

Yes, it is because when you come from purely thinking professions and you don't practise psychiatry, you might not know that in psychiatry, thinking is reactive to and constrained by the facts before you. If you don't do it properly, and in time, the patient would come to harm.

What do you think of the status of psychopathology in training? One of the reasons that I became interested in psychiatry was reading Andrew Sims' *Symptoms in The Mind*, which you are in charge of now. It saddens me to see psychopathology is somehow side-lined in training.

I think psychopathology is the heart of psychiatry and it is the case wherever you go. You need to know the phenomena you encounter in the clinical setting. Some make a mistake in comparing it to anatomy, as something that is already done and completed. It is an error to think that psychopathology is just a collection of definitions. It is a living and dynamic subject. This can pose a problem in writing about it. People always look for certainty, whereas psychopathology is dynamic and there is always some uncertainty in it. What I do is start with some definitions and then elaborate to show how complex it is.

In the world of what I call assembly-line psychiatry, patients move from team to team and from practitioner to practitioner and there is hardly any chance to make a proper psychopathological examination. What is your opinion on that?

I agree with you that the American DSM approach is very destructive, as it treats psychiatry like baking a cake and involves certain boxes to be ticked and certain recipes to be followed. It is a very basic approach. For example, in depression, the person must suffer from low mood for a certain period of time. But what is important is what is the nature of the experience of low mood. What does it consist in? What is it the person is feeling that we refer to as low mood? And, is it merely a variant of sadness or something intrinsically distinct? The checklist approach has weakened psychiatry.

When we talk of psychopathology we mainly focus on the Western tradition. What about psychopathology from non-Western countries? I remember in 2008 when I was in Accra, I attended the African Association of Psychiatrists and Allied Professionals. I have to say that they were very inclusive and had a patient as a keynote speaker. In that conference a colleague from Uganda, Dr Catherine Abbo, had research in which she translated case vignettes from textbooks and presented to local people in villages. Interestingly, they had local names for schizophrenia and mania. For depression, they said the person was ‘thinking too much’.

I did some work in this area many years ago. I have to add I didn't want to be pigeonholed as a cultural psychiatrist! Nevertheless, I wrote that there are deep problems with translation of words and technical terms. The translation of emotion terms can be problematic even across Western languages, which have a linguistic affinity. In English psychiatry, the term ‘anxiety’ is thought of as a psychological term. However, the word ‘anxiety’ derives from ‘angst’, which is originally a German word. In German, *angst* refers the feeling of choking. Surprisingly, a term that we take to mean an emotional experience actually refers to a physical experience. This means that we always need to be attentive to the concept that is sitting inside the word. Take the Yoruba language. If you speak Yoruba and want to translate it into English, the word for sadness, *Ìrònú*, can be translated literally as thinking hard or inner pain. But a Yoruba person does not think a person who is sad is thinking hard or has inner physical pain – he spontaneously understands that the term refers to sadness. In English, we think of mood as measured on a vertical axis, either up or down. But this notion makes no sense in Yoruba. The important question is whether the actual subjective experiences, across cultures, are similar or not, given the diversity of concepts underlying the language terms. Edward Sapir and Benjamin Whorf believed that language structured experience. This thesis of theirs is controversial and no longer accepted. For example, Eskimos have several words for snow. But does that mean that they can distinguish between different types of snow better than other people? I think when you have words for something it is probably easier to discriminate. The Western dominant view has probably influenced the way we experience the world.

That shows there is a good case for inviting more people from the non-Western world to our conferences.

The problem is money! In an ideal world that would be brilliant. We could have proper communication based on willingness to discuss.

Hopefully, with the development of technology we can do it more online.

It could be, but there are still problems. I am finishing the new edition of *Symptoms in the Mind*. My current content editor lives in India and we were scheduled to have a meeting online but the electricity there was cut off. There is still a disparity of access to resources that prevents optimal online communication.

I am glad that you are still writing new editions of *Symptoms in the Mind*. It is an important book for professionals and trainees alike.

I want to do one more. Currently, I am writing the seventh edition. Everything in life depends on health and I am not as young as I was. I am also writing a book on rare psychiatric symptoms.

Perhaps you need an understudy to learn and take over. That person has big shoes to fill! Thank you very much for your time.

1.2.16 Referral of patients with emotionally unstable personality disorder for specialist psychological therapy: why, when and how?

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2021-02

Abstract

Although we commonly work with patients with emotionally unstable personality disorder (EUPD) in community mental health teams (CMHTs), only some enter evidence-based psychological therapies. Many patients are not considered ready to engage in specialist treatments and remain in CMHTs without any clear focus or structure to their treatment, which is unsatisfactory for patients, clinicians and services. We present a fictional case and synthesise available literature and lived experience to explore readiness and ways to promote it. We highlight relevant issues for trainees to consider in practice. Patients with EUPD who have not received specialist treatment can be considered in terms of the transtheoretical model's stages of change. Identifying a patient's stage can help guide how to increase readiness for referral and decide when to refer. Interventions available to all health-care professionals which may promote readiness include: psychoeducation, personal formulations, crisis planning, goal-setting, peer support, distress tolerance skills, motivational interviewing and mindfulness.

Contents

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Case scenario

You are a psychiatry specialty trainee in a community mental health team (CMHT) seeing Miss ML in a routine appointment. She is a 29-year-old woman with emotionally unstable personality disorder (EUPD). She presents repeatedly with suicidal thoughts and has had numerous psychiatric admissions. She uses cannabis and alcohol in a binge pattern. She self-harms regularly, typically following difficult interpersonal events. You often feel unsure how you are helping Miss ML other than monitoring her mental state and risk and reviewing medication. At times you have felt irritated with her; she expects help but does not seem to help herself.

In the appointment, Miss ML requests therapy. She says she wants help with all the bad feelings, and wants to stop cutting but does not know how. She asks you why she feels like this, and what does personality disorder even mean? Miss ML complains that nobody understands her or is helping her. She asks you directly: 'Are you going to refer me for therapy?' You feel anxious as an earlier referral was declined by the personality disorder service. You feel an enormous pressure to say you will refer her again. What will you do?

In this paper we consider the following questions: •*Why* am I referring for psychological therapy? •*When* should I refer for psychological therapy? •*How* can I help a patient reach a stage where they are ready to engage in psychological therapy?

Introduction

We commonly work with patients with EUPD in secondary care mental health services. The prevalence of EUPD in this setting is estimated at 20%,¹ and it is associated with considerable suffering, psychosocial impairment and high resource use.² A number of evidence-based treatments are available, developed from cognitive or behavioural therapies (e.g. dialectical behaviour therapy, schema-focused therapy) or from psychodynamic/psychoanalytic origins (e.g. mentalisation-based treatment, transference-focused psychotherapy).³ A significant number of patients, however, will never enter such treatment. There are many different reasons for this, but a proportion of patients do not reach a stage where they are considered 'ready' to enter treatment. This potentially represents a lost opportunity to improve functioning and reduce suffering.

Patients with EUPD who are not ready for specialist treatment may remain in CMHTs, which poses recognised difficulties. Chaotic and risky behaviour and social problems often interfere with treatment. Resolving these 'exclusion criteria' can seem unrealistic.⁴ Professionals report feeling isolated and inexperienced and that CMHTs are an interim 'no man's land', where referrals for specialist treatment are difficult. Patients report experiences of not being helped and being passed around services (*Box 1*).⁴⁻⁶

When considering psychological treatment for EUPD, the National Institute for Health and Care Excellence (NICE) advises considering the patient's choice and preference, willingness to engage, motivation for change, ability to work within a therapeutic relationship and availability of support. However, they make no recommendations regarding how to increase a patient's readiness for psychological therapy.⁷

A systematic search was conducted to identify literature addressing enhancing readiness of patients with EUPD for therapy. The EMBASE, PsycINFO and CINAHL databases were searched using the National Health Service's Healthcare Databases Advanced Search from inception to January 2019, combining terms relevant to personality disorder (personality disorder*, EUPD), therapy (therap*, treat*) and readiness (readiness, prepar*). None of the studies identified specifically examined methods to increase readiness in EUPD. A theoretical model suggesting factors influencing treatment readiness in personality disorder was identified. Internal (patient) factors included: cognitive (problem recognition, belief in ability to change), affective (emotional states and regulation), volitional (motivation and pursuit of goals), traits (impulsivity), relating (ability to trust and form a therapeutic alliance) and comorbidity (co-occurring psychiatric or medical illnesses). External factors included those related to the patient (current life stressors, support network and practical barriers to attendance) and service factors (accessibility, availability, staff skill and motivation).⁸

Practical management

Why am I referring?

Clinicians should be mindful of why they are referring *this* patient at *this* time? Although specialist EUPD treatments have demonstrated effectiveness, referrals which are declined or do not lead to treatment may lead to patients developing negative views about services and damage confidence in their ability to change.

Indicators that a patient is not currently suitable for psychotherapy include: gross instability of accommodation or finances, marked chaotic or risky behaviour, and harmful or dependent alcohol or drug use.

If considering referral despite such factors, the clinician should regard their own countertransference and whether they are referring as a defence against feelings of anxiety, despair or even countertransference hate (see below). It may be more appropriate to acknowledge their own and the patient's feelings and construct a plan to work towards referral using the interventions suggested below. *Box 1* Patient perspective. 'It felt unjust, unfair and I was mystified when I was told I was not ready. The consultant spoke to me like a child. They explained it was better to wait than fail trying, which I appreciate more now but I was furious at the time. 'The main issue affecting my readiness was alcohol. I had tried and failed to stop drinking for years. Alcohol was my coping mechanism and they wanted to me to stop but without giving me other ways to cope. No service knew what to do with me and I was passed around. Eventually I found Alcoholics Anonymous who really helped, they tolerated my erratic behaviour and through them I met a community of other people with lived experience of alcohol misuse and some with personality disorder. A homeless charity provided practical support. Eventually my CMHT consultant arranged a joint meeting with the alcohol service and the personality disorder service to try and find a way forward. This felt like a special gesture and that they were serious about helping me. I wonder if I had sometimes been testing teams to see if they cared. 'Becoming ready for therapy took years and was like chipping away at a rock. I attempted suicide four times. Maybe if joint meetings and developing clear plans had occurred sooner I would have been passed around less and my journey would have been quicker and smoother.'

Patients may be displeased at a suggestion that they are 'not ready', and this this should be communicated with care and validation. Senior team member support may be beneficial. *Box 2* contains an example of how this could be discussed with a patient. *Box 2* Communication suggestions for clinicians about readiness. 'It is really positive you have asked for help with [list problems]. This is an important first step. To take things forward from here and to benefit from a specialist therapy, you would first need to address [specify issues]. The reasons for this are, e.g. •Therapy focuses on how you think and feel. For therapy to work, you need to be in touch with how you are thinking and feeling. [Alcohol/illicit substances] can block or numb your thoughts and feelings, which although it can help in the short-term, will stop therapy working. We want to work with you, but you will need to reduce [alcohol/illicit substances] and we can support you through this. •Therapy can at times make people feel very distressed and uncomfortable. At the moment, owing to [self-harm/active suicidality], we do not think it would be safe for you to start therapy as it could increase this. We will think with you about your crisis plan and ways to help you reduce [self-harm/suicidal thoughts]. I realise what I say may be frustrating, but there are things other than therapy that can help such as [suggest interventions], which may also help us in working towards a referral for therapy.'

When should I refer?

Readiness for referral can be considered in terms of the transtheoretical model of stages of change;^{9,10} in particular, the *precontemplation*, *contemplation* and *preparation* stages.

Patients in the precontemplation stage are not aware of having a problem, and there is no current intention to change behaviour. They would be unlikely to recognise a diagnosis of personality disorder or any contribution of personality traits to their problems. They do not see a requirement to change their behaviour or have psychological therapy. Some patients may report a wish to change in response to external pressure, e.g. from family or social services. Once external pressure is reduced, engagement may dwindle.

Patients in the contemplation stage are aware that a problem exists and are seriously thinking about overcoming it but have not made a commitment to take action. They have awareness of difficulties relating to personality traits and express

wishes to address these and change their behaviour. They are considering the benefits of change in comparison with the energy and effort of change.

Patients in the preparation stage combine intention and some behavioural change. They have made some reductions in problem behaviours but have not yet taken effective action, although they intend to do so soon. They would be likely to recognise a diagnosis of personality disorder, have the intention to change and be making small behavioural changes, e.g. reducing self-harm or substance misuse. We suggest that patients in this stage are most appropriate for referral.

The transtheoretical model has previously been applied to EUPD by Livesley in his integrated treatment model.¹¹ This highly developed framework for treating personality disorder combines and coordinates different treatment modalities. Our simpler pragmatic approach is aimed at generalists and is not a specialist treatment. Only one study has examined the stages of change in relation to EUPD; it showed that patients in precontemplation were most likely to drop out of specialist treatment.¹²

Readiness for referral is also related to the services available, which may have differing referral criteria and work with patients at different stages of readiness. Liaison with the local personality disorder service (see below) will help clarify this and determine the likelihood of successful referral.

How can I help a patient with EUPD become ready to engage in psychological therapy?

The transtheoretical model also describes the processes by which change occurs.^{9,10} The processes of change that are important in the precontemplation and contemplation stages include: consciousness raising (increasing awareness of the causes and consequences of their problems), self re-evaluation (assessment of self-image with and without problem behaviours) and environmental re-evaluation (assessment of how behaviour affects their environment, including relationships). Processes that are important at later stages but which seem significant in EUPD include: self-liberation (belief that change is possible and commitment to act), contingency management (consequences of taking steps in a particular direction), counterconditioning (learning healthier behaviours to substitute problem behaviours) and stimulus control (avoiding triggers of behaviour).

Many commonly used interventions (see below) utilise one or more of these processes, which may help patients to progress from one stage to the next. They can be used by any healthcare professional when trying to enhance readiness for referral. The choice of intervention will be guided by the patient's current stage of change, preference and available resources. We suggest focusing on one intervention at a time to avoid care becoming confused.

General principles

Some strategies and clinical issues are relevant at any stage of readiness.

Common service factors

Successful treatments for EUPD (specialist or generalist) have common factors including: •Focus on the therapeutic relationship, empathy and validation;•promotion of patient self-agency;•helping patients identify their emotions and the connections between events, emotions and behaviours;•clinicians observant of their own thoughts and feelings and an active system for support and supervision.¹³

Structured clinical management is a manualised generalist approach utilising these factors and may be effective.¹³

Transference and countertransference

Clinicians should be aware of their thoughts and feelings towards patients with EUPD and how these may influence interactions and decision-making. Thoughts and feelings commonly evoked by these patients include: anxiety, rescue fantasies, anger, guilt, failure and even hate.^{14,15} If not processed, clinician responses can be unhelpful or even dangerous; for instance, malice, when the clinician may be sadistic or cruel, and aversion, which tempts the clinician to abandon the patient.¹⁵ These dynamics can also be played out at a systems level and affect whole teams or services.

Managing countertransference is vital to accepting, tolerating and containing such feelings. A sudden decision to refer or discharge a patient needs to be assessed for whether it is an acting out of the countertransference. Although this is a complex field, one approach is for the clinician to first recognise their thoughts and feelings, digest and try to understand them, then consider their response to them and whether this seems appropriate or not.^{16,17} Supervision or Balint groups can be used to explore transference and countertransference reactions.

Trauma

Patients with EUPD may have experienced trauma and during the assessment phase should be sensitively asked whether they wish to disclose trauma. Trauma-informed approaches advocate thinking ‘what happened to you?’ as opposed to ‘what is wrong with you?’

A number of principles of trauma-informed care overlap with the general principles discussed above. These include trusting and transparent relationships between clinicians and patients, collaboration, patient empowerment and choice. Clinicians should also be mindful of the risk of inadvertent re-traumatisation in their interactions with patients.¹⁸

Some patients may agree with a formulation describing how traumatic experiences might influence interpersonal problems, and may meet caseness for EUPD but disagree with a ‘personality disorder’ diagnosis. In this situation, the authors suggest trying to ascertain which problems and goals are a priority for the patient to address, with further discussions delegated to specialist personality disorder and trauma services to determine which therapeutic approach may be appropriate initially. There is debate regarding the overlap of personality disorder and complex trauma, but this is beyond the scope of this article.

The possibility of active trauma, e.g. domestic violence, should also be considered, both for patient safety and as it would impair readiness. Clinicians can provide advice, support and signposting to relevant organisations and consider whether safeguarding is indicated.

Specialist personality disorder services

If a patient is not ready to engage in specialist treatment, personality disorder services should provide advice and support to CMHTs. This can include linking a personality disorder service team member to each CMHT. This liaison service can help by discussing referrals, advising on interventions and providing feedback if referrals have been declined or treatment not initiated. Joint meetings and shared planning on how to increase readiness should be offered. Some services use a shared active list of patients in the pre-treatment stage as a means of supporting and sharing responsibility with CMHT members. In addition, personality disorder services should develop and provide training locally.⁷

Continuity

Therapeutic alliance and relational continuity are of particular importance when working with patients with EUPD; change of team members can be experienced as a re-enactment of loss or abandonment and thus should be avoided where possible.^{13,19} However, this is challenging in CMHTs with turnover of staff and trainees.

Although junior doctors change rotation it is essential for their training to gain experience in assessing and managing patients with EUPD. The transition between trainees should be recognised as potentially difficult and planned for with clear communication and structure. Personal formulations, crisis plans and goals should be handed over to aid continuity.

NICE provides little guidance on the role of care coordinators in EUPD.⁷ More broadly, the Care Programme Approach is indicated for patients who are at high risk and require multi-agency support, active engagement, intense intervention and support with dual diagnoses.²⁰ Whether patients meet this threshold is decided on a case-by-case basis. A recent Royal College of Psychiatrists position statement recommends that all patients in Tier 2 services (and above) be allocated a long-term lead clinician who can support the patient through the engagement process.¹⁹ In our experience, patients with EUPD present with a very wide range of functioning, risk and support needs, and we suggest that care coordination is decided on a case-by-case basis. Most CMHTs would require a significant increase in the number of care coordinators to facilitate meaningful input for all patients with EUPD. Possible alternatives include use of support workers and peer support workers, with appropriate supervision, as a source of continuity and assistance with goals. However, if more than one clinician is working with a patient, clear communication and coordination are essential to avoid splitting or a confusing approach.

Validation

Patients with EUPD may have experienced invalidating environments.^{21,22} Validation and the process of listening and understanding is central to many therapies for EUPD.^{23,24} Levels of validation include: being attentive and alert, enquiring then reflecting back the patient's reported thoughts and feelings, reflecting back observed non-verbal communication, and validating the patient's experience based on the current context and their personal history.²⁴

Interventions suggested for patients in precontemplation stage

Psychoeducation

Educating patients (and significant others) about EUPD is an intervention in itself.²⁵ The diagnostic criteria, e.g. difficulty with relationships, emotion dysregulation, impulsivity and hypersensitivity, can be linked to examples offered by the patient.¹³ Giving the diagnosis can be used to stimulate reflection. Information can also be provided about the range and nature of treatments available.

Personal formulation

Providing a diagnosis alone is insufficient; co-constructing a personal formulation is key in exploring a person's understanding of their problems.¹⁹ One approach is the '5 Ps' model (problems, predisposing, precipitating, perpetuating and protective factors). Through this process, ways to avoid or challenge precipitating and perpetuating factors and strengthen protective factors can be identified, as can goals to work towards.¹⁷

Goal-setting

Clarifying a patient's goals, identifying obstacles to goal attainment and considering how therapy might assist with these may increase motivation to enter treatment.²⁶ Encouraging a patient to evaluate how they and their life may look different in relation to their goals could be part of this. Goals should be specific, with defined patient and professional responsibilities. The clinician can help identify manageable short-term treatment aims with achievable steps. Long-term goals, e.g. those relating to employment, can give direction to the treatment strategy.⁷

Crisis planning

Collaborative crisis planning is important as part of risk management and can be seen as an early form of treatment contracting. It promotes safety and quicker recovery from crises. Steps include identifying triggers, thoughts and feelings associated with an emerging crisis, actions that can avert an escalating crisis and actions to avoid when in crisis.¹³

Substance misuse

Clinicians should assess the level of misuse regularly and clarify its function. Active substance misuse reduces the benefits of therapy, and harmful or dependent users are unlikely to be accepted into specialist treatments. NICE advise referring patients with EUPD and dependence on alcohol or substances to appropriate services; the care coordinator should remain involved and provide information on community support networks, e.g. Alcoholics Anonymous.⁷ Distinctions can be made between patients using as a form of self-harm, using to manage emotions, and dependent use, although overlap does occur. If the use is viewed as self-harm, general strategies to reduce self-harm can be applied, such as delaying use after an urge, distraction, relaxation or finding other outlets. Chain analysis can explore and link events leading to use.¹³

Distress tolerance skills

These skills help patients to manage intense emotional states, recognise triggers and endure negative emotions so that problem-solving can occur. Distress tolerance skills include distraction, self-soothing, relaxation and acceptance.^{27,28}

Housing and finances

Stressors such as housing and finances may affect readiness for treatment.⁸ Support in stabilising a patient's social situation is a therapeutic intervention and may support building a therapeutic alliance.¹³ Maslow's hierarchy of needs could be used as a visual psychoeducational tool to explain the importance of addressing physiological and safety needs before focusing on 'higher' needs.²⁹

Interventions suggested for patients in contemplation stage

Motivational interviewing

Fluctuating engagement may be related to ambivalence about change.³⁰ Using an overly directing style with patients can result in resistance or passivity. Motivational interviewing involves helping patients to say what they want to change, identify why (pros and cons of change), gain confidence in their ability to change and consider how they might change.³¹ Motivational-based interventions can increase motivation and confidence, and decrease substance use and risky behaviours.^{26,32}

Mindfulness

Mindfulness emphasises being present in the moment and increases awareness and acceptance of experiences, which fosters emotional processing and distress tolerance.³³ Mindfulness offers insight into the ‘process’ of specialist treatments, as it creates a space between thoughts and feelings.³⁴ Improvement in attention and impulsivity was demonstrated when mindfulness was practised alongside general psychiatric care in patients with EUPD.³⁵

Peer support groups

Learning from other patients at different stages of change can provide patients with evidence that change is possible. Service user network (SUN) projects are community-based support groups for patients with EUPD. They can help patients develop ways of coping and reduce crises. Use of SUN projects is associated with improved functioning and reduced use of services.³⁶

Offering a range of interventions

Specialist treatments are a significant commitment for patients in terms of time and emotional expenditure. Initial use of lower-intensity or alternative therapies, e.g. art, music or movement, could provide an introduction to the nature of therapy, attending to a frame and developing a trusting relationship with a therapist. Therapies which are not based on verbal communication may also be more acceptable to some patients. Although these are not evidence-based treatments for EUPD, their completion could lead to referral for specialist treatment.

Volunteering or employment

Activities that help create structure and promote responsibility and confidence in ability to change may be beneficial. Some CMHTs have access to employment advisers with experience working with people with mental health problems, who can be particularly helpful.

Table 1 groups the interventions suggested above into internal and external factors and according to the stage of change of the patient. Table 1

Interventions which may increase readiness for referral for specialist treatment	Factors affecting readiness	Stage of change
<ul style="list-style-type: none"> • Psychoeducation regarding personality and diagnosis • Personal formulation • Collaborative goal-setting • Crisis planning • Distress tolerance skills • Address substance misuse • Psychoeducation regarding therapy • Collaborative goal-setting • Mindfulness • Motivational interviewing • Lower-intensity or alternative therapies, e.g. art, music or movement therapy • Peer support groups, e.g. SUN project 	Internal	Precontemplation
<ul style="list-style-type: none"> • Key worker or peer support worker • Support for dependents or carers • Support or signpost regarding domestic violence or other safety issues • Support or signpost regarding social stressors, e.g. accommodation, finances • Support with employment or volunteering • Address practical barriers to attendance, e.g. bus pass • Support or signpost regarding social stressors, e.g. accommodation, finances • Liaison with personality disorder service 	External	Contemplation

Should I discharge?

‘Precontemplation’ suggests that change will be considered at some time in the future. Experience suggests this does not always occur, raising the issue of how to manage such patients. To the best of our knowledge, no evidence exists regarding whether to continue to try to engage patients in a CMHT or discharge them. Opinions and practices vary.

We suggest that patients in precontemplation should be offered interventions as above, with an agreement between patient and clinician regarding timeframe and responsibilities, e.g. attending appointments, setting goals, and following crisis plans. After the agreed timeframe, if there has been no clear benefit or effort to work towards goals or adhere to responsibilities, then discharge could be considered. NICE advises discussing the discharge process with the patient and agreeing a care plan with steps to manage distress, cope with future crises and re-engage in the future.⁷ This should be clearly communicated to the general practitioner, including how they can access support.

However, this approach may be challenging for patients with repeated risky behaviour. It may be more pragmatic not to discharge but to focus on promoting safety, emotion and behaviour regulation, and social stability. It is noteworthy that being within a CMHT may offer some containment and stability, even if this is not readily apparent. That said, there are potential negative effects of prolonged unfocused CMHT input, including ineffective resource use and the fostering of dependence as opposed to recovery. As noted already, clinicians should also be mindful of discharging in response to their countertransference.

Limitations

There are limitations in applying the transtheoretical model to EUPD. It has typically been used in single health behaviours, e.g. smoking or alcohol misuse, whereas multiple complex behaviours are present in EUPD. We also note that a binary ready/not ready approach is an arbitrary and artificial oversimplification of what is a complex dynamic process, and it could be used inappropriately to obstruct access to treatment. However, our systematic search did not identify any evidence regarding increasing readiness in EUPD and, in the absence of other suggested frameworks, we believe our model is pragmatic and can aid clinical thinking and decision-making.

Conclusion

EUPD is commonly encountered in mental health services, but some patients are not at a stage where they are ready to engage in specialist treatments. No guidelines exist regarding how to manage such patients, and prolonged unfocused treatment in CMHTs is not ideal.

We suggest that readiness for referral can be considered in terms of the transtheoretical model of stages of change. A range of approaches and non-specialist interventions exist which can enhance readiness and which can be used in a shared plan working towards referral for specialist treatment. Further research is required into which approaches may best increase readiness and what best practice is for patients who, despite intervention, remain unable to engage in specialist treatment.

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Declaration of interest

None.

Supplementary material

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1.2.17 Healthcare poverty-inequality and government quick fixes

Claire Hilton

date

2021-02

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- *Healthcare poverty-inequality and government quick fixes*

I welcome the editorial by Peter Byrne and Adrian James¹ on poverty-inequality, and their note about lessons from history. Reports indicating the damage to health caused by poverty-inequality in Britain go back at least as far as Benjamin Seebohm Rowntree's study of York around 1900, Julian Tudor Hart's 'inverse care law' in 1971, and the government-commissioned and suppressed Black Report of 1980.² The narrative of governments abandoning some of the most deprived and vulnerable people in society is ongoing.

As Byrne and James point out, people with severe mental illness today have an additional layer of disadvantage, a 'lower status conferred on them', a state of 'subcitizenship', due to stigma and marginalisation, associated with societal and government disinclination to resource care for them. This too is long term. In 1908, psychiatrist William Stoddart³ accused the asylum leadership (which had statutory responsibility for the care of mentally unwell people) of having 'excessively economical tendencies', neglecting their patients, the subcitizens of their time. This neglect was associated with adverse outcomes, such as excess morbidity and mortality from physical illness: in asylums, the death rate from tuberculosis, a poverty-related potentially preventable disease, was ten times higher than in the community. Then, as now, it was convenient for the authorities to attribute high rates of physical illness to a person's underlying mental disorder, rather than providing resources to allow services to support those patients adequately, whether in the asylums of the past or in the community today.

Government bodies have repeatedly sought the cheapest short-term measures for managing mental disorders, overlooking social and environmental root causes of the problems and failing to consider longer-term health and social benefits of adequate resourcing. Sometimes these principles extend to public health more generally. Perhaps the most outstanding recent demonstration of a quick-and-cheap government fix was the advice at the beginning of the COVID-19 pandemic for everyone to take vitamin D, based on the finding of high mortality from COVID-19 in Black and minority ethnic groups, who are particularly likely to have low levels. If vitamin D has any effect, it appears to be non-specific.⁴ In other words, the quick-and-cheap fix did not work. Rather, COVID-19 deaths, as Byrne and James remind us, are

associated with social deprivation, which may also be associated with low vitamin D. Vitamin D won't fix the real problems.

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1.2.18 The climate crisis and forensic mental healthcare: what are we doing?

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Abstract

The climate crisis poses the greatest threat to human health this century. Mental health services will be called on to address the psychological consequences of its effects on peoples' lives, particularly the socially disadvantaged and those on low incomes. However, healthcare systems are also contributors to the climate crisis. This editorial discusses how services can continue to provide care while contributing less to climate change. Specifically, it suggests what services such as forensic mental healthcare, which is constrained by legal, political and resourcing concerns, can do differently.

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 - *Declaration of interest*
 - *Supplementary material*

Ten years ago, *The Lancet* identified climate change as the largest threat to human health in the 21st century.¹ Changes in the environment and biodiversity, alongside unpredictable natural disasters, will have consequences for both the somatic and mental health of the world's population. Individual and collective mental health are likely to suffer owing to anxiety over fluctuating living conditions, loss of means of income, broken social bonds and conflict linked to resource scarcity, with low income and socially disadvantaged groups most likely to be affected.²⁻⁴

Mental health systems will play a significant role in responding to the psychological fallout of the climate crisis. Services will have to respond to experiences of trauma following natural disasters and longer-term mental health concerns, such as depression and anxiety, linked to changes in lifestyles, environmental damage and resource scarcity.³ A study

conducted 1 year after the 2005 Hurricane Katrina in New Orleans, USA, found that 40% of 144 surveyed residents had a probable mental illness, half of which were classified as severe. This contrasted with a survey conducted between 2001 and 2003, which estimated that 16% of respondents in the region had any type of mental illness.⁵ The authors attributed this to destroyed or damaged housing and property, consequent dislocation and associated losses of employment and community ties.

The healthcare sector's contribution to the problem

Most causes of climate change are well acknowledged: overreliance on fossil fuels, poisonous greenhouse gas emissions, unsustainable agricultural practices. Yet paradoxically, while being tasked with managing much of the future damage to human well-being, healthcare systems are themselves contributors to the climate crisis. In the USA, a 'top emitter', 7.6% of national emissions (defined as carbon dioxide, methane and nitrous oxide) come from the healthcare sector (1.72 tCO₂e/capita).⁶ This is the equivalent to 141 coal power plants. In the UK, the healthcare system contributes 5.4% (0.66 tCO₂e/capita); the average across the European Union is slightly lower: 4.7% (0.49 tCO₂e/capita). A 'lower than average emitter', India's healthcare system contributes 1.5% to total emissions (58 times less than the USA per capita).

These contributions derive from the manufacture of pharmaceutical products; the large amounts of resources needed to run equipment, heat buildings and transport patients or staff to appointments; and the disposal of waste products.⁷ As health and social care services constitute a substantial part of every country's economic and social activity, the magnitude of their contribution may be understandable. However, given the preventive and life-saving functions that healthcare systems provide, significant questions remain – how can healthcare systems provide perennially improving, high-quality care while contributing less to the climate crisis? And what does this mean for sectors particularly constrained by legal, political and resourcing concerns, such as forensic mental health services – especially when the number of forensic in-patient beds has been increasing in many North American and European states?⁸

'Sustainability' in mental healthcare: the ideal...

Recent efforts have attempted to embed the concept of 'sustainability' into routine mental healthcare. Sustainable mental health services are those that weave sustainable thinking into decision-making at all levels. The Joint Commissioning Panel for Mental Health and the Centre for Sustainable Healthcare⁷ identify four basic principles that settings should adhere to. Services need to (a) promote patient self-management, (b) prioritise prevention instead of response to illness, (c) adopt sustainable methods of energy use and (d) increase efficiency in service provision (*Fig. 1*). These principles should not be understood as detracting from the necessity for gold-standard clinical care for those who need acute, urgent treatment to manage severe mental illness. This reactive medicine must still be available but with practitioners cognisant of a sustainable approach and alert to the notion that embracing these principles can help lower or buffer the growing future need for such care. *Fig. 1* Four basic principles for sustainable mental healthcare.

What do these principles look like in practice? Taken together, these recommendations aim to develop sustainable resource use. The more mental illness is prevented and managed in the community, the less secondary care services will be called on. When services are engaged, they should minimise and embrace clean-energy use and maximise efficiency, so that time, resources and medications are not wasted. Specific aims include avoiding hospital admissions that might have been identified earlier and managed in primary care; the development and monitoring of targets to reduce carbon emissions, including seeking more efficient methods of heating buildings and transporting food, medicines and materials, and reducing amounts of waste; enabling patients to self-manage symptoms in the community where possible; offering horticultural therapies, walking groups and psychological interventions instead of prescribing unnecessary medication; offering telephone or online interventions; and reducing the number of missed appointments.⁹

... and the reality in forensic settings

However, the transferability of these aims to forensic settings is not immediately apparent. Forensic services are high cost and provide care to patients who are, in law and fact, deprived of their liberty. Patients are placed in care following the commission of a crime or when risk of harm is too difficult to manage in general or out-patient services. Thus, forensic settings reflect failures elsewhere to prevent or manage mental illness and antisocial behaviour. They require resource-intensive security measures; services may be reticent or unable to promote patient self-management owing to seriousness of illness or the custodial attitudes of staff and policy makers; patients may be kept within inappropriately high levels of security because of political or media attention; and they typically rely less on volunteers and carers from the local community to help manage patient recovery and run services than other health services might. Accordingly, efforts to meet the aims of prevention, self-management and reducing carbon emissions could face extra barriers.

Some suggested steps forward

So, what can forensic services do? All services should develop a sustainable development plan. Such a plan details aims, objectives, strategies and priorities for improving local environmental and socioeconomic impacts and should set measurable targets.¹⁰ These should reference national or regional standards for reducing carbon emissions. These plans are already required by healthcare providers commissioned by standard contracts in the National Health Service in England and Wales. Patients should be involved in developing targets and action plans. This should be complemented by routine monitoring of procedural and substantive outcomes, including, for instance, whether sustainability is incorporated within a service's mission statement or the ways in which it is included in decision-making structures, reductions in waste and energy use, or the number of meals produced using food grown on-site. Plans can draw on the four basic principles described earlier (*Fig. 1*).

Steps should be taken to integrate patients into local communities to promote self-management of symptoms, prevent mental health problems or risky behaviour due to social isolation or deskilling, and thus reduce need for services. Peer support programmes run by former forensic services patients or carers, work for patients outside secure settings, and proactive attitudes towards granting leave could all be helpful. Treatment paradigms such as the recovery approach and the Good Lives Model that aim to improve the quality of patients' lives holistically, promote recovery and target criminogenic factors as well as treating mental disorders should be used to increase the chance of successful rehabilitation that carries through into the community and reduces future service use.^{11,12}

Punitive attitudes that discourage the placement of patients in lower levels of security closer to the community should be tackled by implementing training programmes that educate all staff on the antecedents, symptoms and prognoses of patient diagnoses and thus encourage a therapeutic mindset. The unnecessary use of medications should be avoided. When tension or aggression is present on a ward then the use of verbal de-escalation techniques by appropriately trained staff might avoid the requirement for 'as needed' (p.r.n.) medications.¹³

Finally, individuals working in secure services should develop a network to (a) share sustainable development plans and best practices, (b) identify challenges unique to forensic settings and (c) connect with individuals in general mental health and somatic care who have already developed such networks (e.g the Centre for Sustainable Healthcare in the UK). Forensic services should be aware of how they contribute to and can help alleviate the consequences of the greatest threat to human health in the 21st century. To avoid doing so would be to ignore our guiding principles of reducing harm and improving lives.

Jack Tomlin is a Research Fellow in the Department of Forensic Psychiatry, University of Rostock, Germany.

Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2020.36>.

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1.2.19 Clozapine prescribing: comparison of clozapine dosage and plasma levels between White British and Bangladeshi patients

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date

2021-02

Abstract**Aims and method**

To compare differences in clozapine doses and plasma levels between Bangladeshi and White British patients. Following ethical approval we identified all current Bangladeshi and White British patients on clozapine maintenance in an east London clinic. We carried out univariate and multivariate regression analyses to examine associations between clozapine doses and ethnicity, age, gender, smoking status and weight. We also compared plasma clozapine levels of the two groups.

Results

On univariate analysis White British patients had on average 85 mg higher doses than Bangladeshi patients ($P = 0.004$). Older age, male gender and smoking were also associated with higher dose. On multivariate analysis only age and smoking status remained significant. A greater proportion of Bangladeshi patients had high plasma clozapine levels compared with White British (30.76% *v.* 20.75%), although the difference was not statistically significant.

Clinical implications

Our findings point to the need for the broadening of data collection on ethnic differences in clozapine prescribing within big data-sets such as Prescribing Observatory for Mental Health (POM-UK). Ethnopharmacological variations can inform more person-centred guidance on prescribing.

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Clozapine is a unique antipsychotic that demonstrates superior efficacy in people with treatment-resistant schizophrenia and is recommended for treatment in such cases.¹ The response rate in these individuals is around 40%.² Clozapine has been shown in several pharmacoepidemiological studies to show superior long-term efficacy in terms of reducing hospital admissions.³ It also surpasses other antipsychotics in reducing self-harm⁴ and overall mortality.⁵

The pharmacological basis for the unique efficacy of clozapine in treatment-resistant schizophrenia is not clearly understood.⁶ Clozapine treatment is associated with a number of adverse effects.^{7–9} Unlike for most other antipsychotics, the decision to stop clozapine is taken more often by prescribers than by patients, and for reasons of adverse effects more than for lack of efficacy.¹⁰ The Prescribing Observatory for Mental Health (POM-UK) conducts national audits of clozapine use in the UK, gathering detailed information, for example that clozapine prescribing for people with schizophrenia is higher in men than in women.¹¹ Although the POM-UK audit collects ethnicity data, it does not compare prescribing practices or variations between ethnicities.

Ethnopharmacology relates to the study of substances used medicinally by different ethnic groups and examines variations in our body's processing of drugs based on ethnicity, including pharmacogenetics. It is known that prescribing rates for clozapine vary, ranging from less than 10 patients per 100 000 people to nearly 180 patients per 100 000 people.¹² Variations in dosage may be due to variations in prescribing practice and/or the patient's metabolism. At either end of the spectrum patients may be 'poor metabolisers' or 'ultra-rapid metabolisers'. Metabolic variation can be genetic, but it can also be environmental (e.g. due to cigarette smoking). Ethnic variation in metabolism along the cytochrome P450 has been known for a few decades.¹³ Drug clearance is represented by the concentration-to-dose (C/D) ratio in blood plasma under steady-state and trough conditions. A very low C/D ratio indicates an ultra-rapid metaboliser, whereas a very high C/D ratio indicates a poor metaboliser. In the USA, clozapine C/D ratios, measured in (ng/mL)/(mg/day), typically range from 0.6 (male smokers) to 1.2 (female non-smokers). Inhibitors (including fluvoxamine and oral contraceptives) and inflammation can also increase clozapine C/D ratios.¹⁴

The British National Formulary recommends titrating clozapine to a dose of 300 mg/day if tolerated, which can be further increased up to a maximum dose of 900 mg/day.¹⁵ Despite varied estimates of response threshold, plasma levels can be useful in optimising treatment. According to the Maudsley Prescribing Guidelines, in those not responding to

clozapine, dose can be adjusted to give plasma levels in the range 0.35–0.5 mg/L (a range reflecting a consensus of the above findings). The guidelines also mention that plasma levels may help in decision-making in those who are not tolerating clozapine, for example by a reduction to a dose guided by the plasma level range mentioned above.¹⁶ It is documented that plasma levels of clozapine may be higher in ‘Asians’.¹⁷ This was a study from Singapore in which ‘Asian’ patients were noted to have more than twice the effective clozapine concentration-to-dose ratio than ‘Caucasian’ patients. This very high C/D ratio would suggest a higher prevalence of poor metabolisers in this population. We are not aware of any similar studies in South Asians or in the Bangladeshi population.

We looked at two self-assigned ethnicities as accepted by UK census.¹⁸ The London Borough of Tower Hamlets (an administrative unit within the city) has a unique ethnic composition, being home to the largest Bangladeshi population in England.¹⁹ The Bangladeshi population accounts for almost one-third of all residents, closely followed by the second largest ethnic group, White British (31%).²⁰ This unique ethnic composition provided a particular opportunity for research into differences in prescribing of clozapine and differences in plasma levels documented between these two ethnic groups. We recognise that our study is not equipped to look into actual genetic and epigenetic differences between the two populations. However, comparing distinct subgroups, i.e. White British and Bangladeshi, we minimise the heterogeneity in each group and make the results more relevant to the populations being studied.

The primary aim of this study was to compare prescribed doses of clozapine in the Bangladeshi population with those in the White British population. The secondary aim was to see whether the odds of plasma clozapine levels being above 0.5 mg/L (the upper limit of the recommended therapeutic range) were increased by belonging to Bangladeshi ethnicity compared with White British.

Method

All patients receiving clozapine (through the National Health Service) in Tower Hamlets are registered to the Tower Hamlets Clozapine Clinic. All such patients receive clozapine blood monitoring at the clinic and they are registered with the Zaponex Treatment Access System (ZTAS), which is an on-line patient data-base for monitoring treatment.

The study proposal was approved by the ethics committee of the local healthcare provider (East London NHS Foundation Trust). We collected cross-sectional data from the Tower Hamlets Clozapine Clinic as on 21 November 2018.

We defined ‘maintenance dose’ as a dose for which the patient is no longer having blood monitoring as frequently as weekly, which generally indicates that the patient has been taking clozapine for at least 18 weeks after dose titration. We took this as a proxy measure for maintenance dose of clozapine for the purpose of the study. On 21 November we identified 79 Bangladeshi and 52 White British patients receiving clozapine in their maintenance phase. We carried out univariate linear regression analyses for ethnicity, age, gender, smoking status and weight, followed by multivariate regression analyses on the variables that were statistically significant on univariate analysis.

For our secondary aim we searched for results of clozapine plasma level tests conducted on the participants. Of the results available in the clinic’s records, 78 were obtained from the people of Bangladeshi ethnicity and 53 were from the people of White British ethnicity. We calculated how many of these results were above 0.5 mg/L. Subsequently we analysed whether the odds of an individual recording a plasma level above 0.5 mg/L was increased if they were of Bangladeshi ethnicity compared with White British ethnicity.

The study did not gather any new data but analysed data that were already available in the clinic’s electronic patient records.

Results

Ethnicity, age, gender and smoking status were all significantly associated with clozapine dose (significance was borderline for gender) (Table 1). White British participants received on average 85 mg/day higher doses of clozapine than Bangladeshi participants. Older people received on average 39 mg/day higher doses for each decade of increasing age. Women received on average 67 mg/day lower doses than men, but the difference was only borderline significant. Non-smokers received on average 81 mg/day lower doses than smokers. Weight was not significantly associated with dose in our sample. Table 1

	Univariate analysis	Multivariate analysis
Mean dose, mg/day	435.18	435.4
Mean dose difference, mg/day	51.3	51.3
95% CI	(12.3 to 114.8)	(12.3 to 114.8)
Difference	0.11	0.11
95% CI	(0.004 to 0.216)	(0.004 to 0.216)
Dose by ethnicity		
White British (<i>n</i> = 52)	435.18	435.4
Bangladeshi (<i>n</i> = 79)	349.68	349.68
Dose by smoking status		
Smokers (<i>n</i> = 59)	427.97	427.97
Non-smokers (<i>n</i> = 72)	348.59	348.59
Dose by gender		
Female (<i>n</i> = 36)	334.72	334.72
Male (<i>n</i> = 95)	402.1	402.1
Dose by weight		
Weight (per 10 kg)	1.2	1.2
95% CI	(15.9 to 13.5)	(15.9 to 13.5)
Dose by age		
Age (per decade)	38.9	38.9
95% CI	(12.3 to 65.6)	(12.3 to 65.6)

58.8)0.048*¹

When we tested variables known to influence clozapine dose in a multivariate model comparing age (per decade), gender, smoking status and ethnicity, only age and smoking status remained statistically significant. Difference based on ethnicity was no longer statically significant at the 5% level, although the trend was towards White British having higher doses. As weight was not significantly associated in univariate analysis, we did not carry out multivariate analysis on this variable.

Of the 78 results of plasma clozapine level tests obtained from Bangladeshi participants, 24 (30.76%) had levels higher than the upper limit of the therapeutic range. Of the 53 results obtained from White British participants, 11 (20.75%) had levels higher than therapeutic range. The odds ratio of a higher (above 0.5 mg/L) plasma level in a Bangladeshi individual was calculated to be 1.697, although this was not statistically significant as the confidence interval crossed 1 (Table 2). Table 2

	Plasma level >0.5 mg/L, <i>n</i> (%)	OR (95% CI)
Bangladeshi (<i>n</i> = 78)	24 (30.76)	1.697 (0.748–3.852)
White British (<i>n</i> = 53)	11 (20.75)	

Discussion

Key findings

We are aware of several factors that could affect clozapine dose. We found that Bangladeshi participants, women, younger participants and non-smokers received lower doses. When we looked at our dosage data using the multivariate model only, smoking status and age were statistically significant. However, it is possible that we were not sufficiently powered with our sample size to demonstrate the difference in dosing between Bangladeshi and White British ethnicity. There was a trend towards White British participants needing higher doses. We are aware that other factors might also have influenced dosage (e.g. co-prescribing), but this information was not available in the clinic's regular monitoring records.

We examined records of plasma clozapine levels to explore whether higher plasma clozapine concentrations were more likely to be reported in those of Bangladeshi ethnicity compared to White British ethnicity. We found that, despite receiving lower doses, Bangladeshi patients were more likely to have higher plasma concentrations of clozapine when tested. This would support the suggestion of a higher prevalence of high C/D ratios and poor metaboliser status

1

P < 0.05.

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among Bangladeshi patients taking clozapine. For simplicity of analysis, we used the Maudsley Prescribing Guidelines reference therapeutic plasma level to analyse the plasma level data as a binary variable. This study is not designed to assess the therapeutic plasma range for clozapine. The data-base for clozapine plasma levels did not have a record of associated variables. We used existing clinic data for our analysis and were limited by the data that were routinely collected.

Bangladesh and Bangladeshi populations

Bangladesh is a new country, created in 1971 from a division of Pakistan decided on the basis of linguistic differences (eastern Pakistan was predominantly Bengali-speaking), and previously separated from British India on the basis of religion when Colonial rule ended in 1947. Bangladesh is in the eastern part of South Asia, which has a high internal ethnic homogeneity, with 98% identifying themselves as ‘Bangalees’.²¹ In fact some residents of Tower Hamlets arrived in the UK before the country was formed and many are second generation. It is also recognised that people from the Sylhet region are the strongest subgroup within this population. However, they also identify themselves as Bangladeshi. Ethnicity is a different construct in each society and may merge with local notions of ‘race’, national identity or other invented traditions.²²

There is a body of literature in cultural psychiatry in which the UK’s Bangladeshi population has been studied (e.g. in Mental Health Act detention data). Information such as ours has implications in terms of global health and can inform prescribing in other countries, especially in Bangladesh, a country of 169 million people. Schizophrenia is the most common diagnosis in mental health settings in Bangladesh, according to a World Health Organization report across in-patient units, mental hospitals and community-based clinics.²³ We believe that such information and guidance has significant public health implications both in Bangladesh, as well as for migrant populations of Bangladeshi origin across the globe. We also believe that assuming large populations are monolithic, for example as implied by concepts such as ‘Asian’ and ‘Caucasian’, risks overgeneralisation and misses out on differences within these groups. Having smaller clearer groups might allow a granularity in our understanding that would otherwise not be possible.

Ethnicity, pharmacology and study populations

Ethnicity is reported to be an important, but often ignored factor in psychopharmacology. A number of ethnically specific variations have been found in the genetic and non-genetic mechanisms affecting pharmacokinetics and dynamics of psychotropic drugs, which might underlie differences in drug prescribing and response across ethnicities. Although some of these ethnic differences might be partially explained by genetic factors, a number of ethnically based variables such as diet and cultural attitudes could potentially have a significant impact.²⁴ This might include differences in smoking habits between Bangladeshi and White British patients or levels of comorbidity. Very few studies have analysed biological basis and metabolic variations in relation to clozapine. A notable exception is the above-mentioned 2005 study from Singapore and even then there are difficulties with what the terms Asian and Caucasian mean.¹⁷ We acknowledge that our study design does not offer the opportunity to explore these variables in detail. Although there has been some research into ethnic variation in clozapine tolerability and effective dosing, a significant evidence base is still lacking.

Most studies in the field are case–control studies such as ours, comparing small samples of broad ethnic entities or case series, sometimes with a more distinct ethnic group. The 2005 Singapore study comparing 20 ‘Asian’ patients from Singapore with 20 ‘Caucasian’ patients from Australia reported that the mean clozapine dose for the Asian group was 176 mg/day, whereas for the ‘Caucasian’ group it was 433 mg/day.¹⁷ A more recent study found that ‘East Asians’ (Chinese in the sample) had a clinically relevant reduced clozapine clearance (suggesting higher prevalence of poor metabolisers) compared with ‘Caucasians’ (Italians in the sample).²⁵ However, the ethnic groups ‘Asian’, ‘East Asian’ and ‘Caucasian’ are, in our opinion, too broad and heterogeneous to safely generalise the findings in a clinical setting.

We also discovered that findings were not always consistent. Results from a study conducted in south London by the South London and Maudsley NHS Trust reported no significant differences in clozapine dosage prescriptions between in-patients from White, Black and Asian ethnic groups.²⁶ Although the overall study sample was large, the clozapine sample for which ethnicity was noted was only 188 and included only in-patients, whereas we compared all patients on

clozapine (community and in-patients). As the south London study also included all ethnicities, once again we would argue the categories were too broad. The 11 'Asian' patients included in the study did receive a lower mean dose of clozapine but this was not statistically significant. In another recent study the researchers concluded that clozapine bioavailability did not vary between Maori and European patients.²⁷ Therefore one needs a more nuanced approach rather than generalising diverse minority groups as monolithic.

Studies that examined more coherent ethnic identities lacked control groups. A review of 1256 records from Novartis Pakistan (one of the monitoring systems for clozapine treatment) were analysed and the average maintenance dose was found to be 230 mg/day.²⁸ A study involving 162 Taiwanese patients with refractory schizophrenia reported a mean dose of 379.5 mg/day (range: 100–900 mg/day).²⁹ The only other study on the Bangladeshi population was a small case series comprising 21 patients in a tertiary care centre in Bangladesh, which revealed that most of the patients with treatment-resistant schizophrenia (64%) responded to clozapine doses of 50–200 mg/day and the remaining patients who responded to treatment required doses of 250–500 mg/day.³⁰ In these reports without a control group one can argue that prescriber factors such as prescribing culture, habits or even cost could have influenced the prescribed dose as opposed to patient factors.

Clinical and research implications

We believe that the information obtained from our study is important as it provides an opportunity to explore variation in tolerability and effective dosage controlled for prescriber factors. Even with relatively small numbers we found a statistically significant difference in dosing of clozapine. Although we did not find statistically significant odds of high plasma levels in Bangladeshi participants it is possible that the study was not sufficiently powered to elicit the statistical significance. Of note, high plasma levels were reported in Bangladeshi participants despite the lower mean prescribed dose, indicating a higher C/D ratio and possibly higher prevalence of poor metabolisers in the Bangladeshi population.

For more comprehensive exploration of these issues, we believe there is need to analyse 'big data'. POM-UK audits have the opportunity to do this. We would like this national audit to analyse dosage and tolerability variation data across ethnicity. Similarly, data on plasma clozapine levels held in central repositories might offer sufficiently large samples to enable study of ethnic variations and could steer research in cytochrome-P450 variations between populations. If such variation is clearly documented, it could inform prescribing guidelines on a more cautious and conservative approach when titrating patients of Bangladeshi ethnicity on clozapine.

We also suggest that studies of ethnic variations in clozapine doses and plasma levels should select more coherent ethnic groups and be mindful of heterogeneity within minority populations.

We thank Frank Röhrich, MD, FRCPsych, consultant psychiatrist, Medical Director and Honorary Professor of Psychiatry, and Anthony Khawaja, MA(Cantab), PhD, FRCOphth, consultant ophthalmic surgeon, for their advice on statistical analysis.

Rahul Bhattacharya is a Consultant Psychiatrist and Associate Clinical Director for Community Services in Tower Hamlets, East London NHS Foundation Trust and an Honorary Senior Clinical Lecturer at Barts and the London School of Medicine, UK. **Leah White** is a Consultant Old Age Psychiatrist with East London NHS Foundation Trust and an Associate Fellow of the Higher Education Academy, London, UK. **Laura Pisaneschi** is Lead Nurse for the Tower Hamlets Clozapine Clinic, East London NHS Foundation Trust, UK.

Data availability

The data that support the findings of this study are available from the corresponding author, R.B., upon reasonable request

R.B conceived the project and data analysis, obtained ethical approval, wrote the first draft of the paper and responded and amended the paper in response to comments from peer reviewers. L.W. collected the data from the Tower Hamlets clozapine clinic and has reviewed the manuscript. L.P. was the Lead Nurse for the Tower Hamlets clozapine clinic and helped in accessing data-bases and facilitated data collection.

Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2020.59>.

[click here to view supplementary material](#)

1.2.20 Tom Arie, CBE, FRCP, FFPH, FRCPsych (Hon)

Claire Hilton

date

2021-02

Contents

- *Tom Arie, CBE, FRCP, FFPH, FRCPsych (Hon)*

Professor Emeritus of Health Care of the Elderly, University of Nottingham, UK

Tom Arie was an old age psychiatrist who steered proactive, treatment-focused mental health services for older people onto the UK policy agenda. This vital step ranks alongside other ‘firsts’ that created the specialty of old age psychiatry: in 1949, Aubrey Lewis established the first dedicated older people’s psychiatric assessment ward and appointed Felix Post consultant; in 1955, Martin Roth demonstrated the error of the premise that all mentally unwell older people were ‘senile’; and in 1958, Sam Robinson established the first comprehensive old age psychiatry service in the UK.

Tomas Arje was born into a Jewish family in Prague on 9 August 1933. In 1939, after 5 months living under Nazi occupation, Tom and his parents fled to England, 2 weeks before war broke out.¹ They settled in Reading, where his parents worked for the BBC, monitoring Nazi broadcasts. In 1952, he went up to Balliol College, Oxford, to read classics. After 2 years, with a first in ‘Honour Moderations’, he followed his growing yearning and swapped to medicine.

Interested in the study of the hospital as a small society, he trained in psychiatry at the Maudsley Hospital, London, and in social medicine at the London (now, Royal London) Hospital. At the Maudsley, working with Felix Post, he found old age psychiatry spellbinding. At the London, Professor Jerry Morris introduced him to social medicine and its leaders. By the time Tom was appointed consultant psychiatrist at Goodmayes Hospital, Essex, in 1969 (‘an unposh place [...] Most people thought I had taken leave of my senses!’)² he was personally acquainted with National Health Service and social policy leaders, including Chief Medical Officer Sir George Godber.

Tom and a few other newly appointed consultant psychogeriatricians – a ‘happy band of pilgrims’ as one described them – began to meet. Through Tom’s links, they negotiated the content for the Department of Health and Social Security’s blueprint for service development, *Services for Mental Illness Related to Old Age* (1972). A year later, and growing

in number, the group became the Royal College of Psychiatrists' Group (now Faculty) for the Psychiatry of Old Age. Tom chaired the first meeting – and then supported the election of Felix Post as chair, meanwhile continuing to inspire and nurture behind the scenes.

Away from policies and politics, Tom led an enthusiastic multidisciplinary clinical team characterised by a low hierarchical structure, high morale and positive expectations. Unusually for the 1970s, it included a plethora of part-time women junior doctors, who later became leaders in their own fields. The team pioneered ways to improve the health and well-being of older people, including using domiciliary assessments routinely. They achieved good clinical outcomes and their work highlighted the fallacy of commonplace ageist assumptions. They repeatedly evaluated all aspects of their work in a way that today would be labelled 'quality improvement', but for Tom was an instinctive, effective and fruitful way of working.^{3,4} His creative approach seeped into new teams led by those he inspired.^{3,4}

In 1977, Tom was appointed Professor of Health Care of the Elderly at Nottingham University. There, he modelled and led a joint geriatric–psychiatric team. His department was a magnet and inspiration for politicians and clinicians. In the 1980s, with wide admiration for UK psychogeriatrics and an international lack of trained psychogeriatricians, the British Council, the UK's international cultural relations body, sponsored psychogeriatric courses. These 'Arie courses', based on the 'Arie model', took place in the UK (Nottingham), Australia, Israel, Korea, Poland, Portugal and elsewhere, creating significant long-term impact. Tom was Vice President of the Royal College of Psychiatrists in 1985–1986. He was made CBE in 1995 for services to medicine. He was awarded a College honorary fellowship in 2001 and the Old Age Faculty lifetime achievement award in 2012. The British Geriatrics Society bestowed their highest honour on him, the Founder's Medal, in 2004.

Tom's goals were humane and idealistic. Some of his ideas were, perhaps, too idealistic, and could not break through bureaucratic, administrative and ideological fashions. He fought for dignity for older people, always sensitive to the moral and medical aspects of their care, not just advocating but also agitating for them. Tom's style, and what he enjoyed doing most, was to 'make grass grow in the desert – enthusing, fostering, encouraging, making things happen, fighting my corner'.² Providing for some of society's most vulnerable people seemed to be an echo from his childhood.

Outside work, Tom was a creator and collector, particularly of friends and paper. He and his wife Eleanor (also a doctor) were always wonderfully hospitable, with their enormous rustic kitchen being the social hub of their home. He read voraciously on many subjects. When a neighbour opened a 24/7 second-hand charity bookshop in her garden shed, he would wander over and browse. He took pleasure in rescuing books from there and the local charity shops that he thought needed love and attention in his hands and on his bookshelves. He kept vast swathes of his personal archives neatly filed, including his diaries; I e-mailed him recently: on what precise date in 1970 did he present a certain report on his work at Goodmayes? The answer flew back a few hours later.

'I count my blessings every day', Tom would say. His close-knit family meant the world to him – and he to them – Eleanor and his children Laura, Sophie and Sam, and grandchildren Blake, Zak, Max, Lucy, Eli and Milo, and his wider family. Tom died of cancer at home on 24 May 2020 with his family around him. Now, with his passing, may his memory and his teachings continue to be a blessing to others and inspiration to future generations.

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1.2.21 Changing practice: assessing attitudes toward a NICE-informed collaborative treatment pathway for bipolar disorder

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date

2021-03

Abstract**Background**

Bipolar disorder is a chronic mental health condition, which can result in functional impairment despite medication. A large evidence base supports use of psychological therapies and structured care in the treatment of mood disorders, but these are rarely implemented. e-Pathways are digital structures that inform and record patient progress through a healthcare system, although these have not yet been used for bipolar disorder.

Aims

To assess the perceived benefits and costs associated with implementing a collaborative NICE-informed e-pathway for bipolar disorder.

Method

Healthcare professionals and people with bipolar disorder attended a workshop to share feedback on e-pathways. Data were collected through questionnaires ($n = 26$) and transcription of a focus group, analysed qualitatively by a framework analysis.

Results

Patients and healthcare professionals welcomed the development of an e-pathway for bipolar disorder. There were five elements to the framework: quality and delivery of care, patient–clinician collaboration, flexibility and adaptability, impact on staff and impact on healthcare services.

Conclusions

Identification of benefits and costs ensures that future development of e-pathways addresses concerns of healthcare professionals and people with bipolar disorder, which would be essential for successful implementation. Recommendations for this development include making e-pathways less complicated for patients, ensuring sufficient training and ensuring clinicians do not feel their skills become invalidated. Limitations of the study, and directions for future research, are discussed.

Contents

- *Changing practice: assessing attitudes toward a NICE-informed collaborative treatment pathway for bipolar disorder*
 - *Bipolar affective disorder*

- *Care pathways*
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Bipolar affective disorder

Bipolar affective disorder has a lifetime prevalence of between 1 and 2.5% of the population.^{1,2} It is diagnosed on the basis of current or prior manic or hypomanic episode(s);³ however, low mood that is frequently persistent⁴ and can meet criteria for a depressive episode is more common.^{5,6} The disorder is further characterised by functional impairment⁷ and increased mortality rates, including from suicide.⁸ The estimated cost to the UK is £5.2 billion annually, with direct National Health Service (NHS) costs of £342 million.^{9,10} Biological, psychological and social treatment paradigms are used,¹¹ and treatment pathways differ between patients in depressed versus manic episodes, and in patients who are between episodes.¹² Pharmacological interventions reduce relapse and treat episodes, if used appropriately¹² Similarly, psychological interventions specifically developed for adults with bipolar disorder improve symptoms and prevent relapse and admission to hospital.^{13,14} These interventions include enhanced relapse prevention, group or individual psychoeducation,^{15–17} cognitive–behavioural therapy and family-focussed therapy.¹⁸ Group psychoeducation arguably has the strongest evidence base. Research over the past 15 years has concentrated on resource light strategies, with groups integrated within existing treatment pathways (e.g.^{19,20}). However, these evidence-based treatments are not widely available within the NHS.

Care pathways

Care pathways represent a formalisation of the process that underlies care and usually incorporate one or more protocols and guidelines, provide a record of care and a variance record to show where deviations from the planned pathway have occurred.²¹ Computerisation, thereby creating e-pathways, should allow pathways to be integrated with guideline-based decision support, the electronic health record and the clinical workflow.²² The entry point to an e-pathway is through an initial care plan. The patient engages in the development of a formulation and the only outcome measure is CollaboRATE, a rating scale for patients that measures how involved they feel in their care. The e-pathways would be accessible to patients, both in the session and accessible through the Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust website, therefore encouraging individuals to be aware of, and request, evidence-based care. The treatment strategies suggested by the e-pathway would be delivered as part of a collaborative care plan. e-Pathways therefore have the potential to improve access to, and use of, the current evidence base and guidelines, to embed values of co-production by building a shared understanding of the difficulties faced by people with bipolar disorder, and to allow formal evaluation of deviations. e-Pathways thus enable identification of resource gaps, training needs and guideline weaknesses. Our NHS mental health trust has an expressed commitment to develop a series of e-pathways that incorporate clinical algorithms. e-Pathways require collaboration between our NHS trust and the electronic patient record provider, and is still under development for bipolar disorder. A pilot showed that the original proposed software package was too time-consuming for clinicians to use. The focus is now shifting to examine options to develop the e-pathway, using the existing capabilities of the electronic patient record supported by a bespoke trust-led software package.

Algorithm based care

Algorithm-based care refers to the use of clinical algorithms either to aid diagnosis or treatment. Clinical algorithms often comprise step-by-step instructions, often presented in flow-chart form, to guide the clinician.²³ Studies of unipolar depression have revealed that the use of algorithms markedly improves outcome.^{24,25} In bipolar disorder, the Texas Medication Algorithm Project²⁶ has revealed feasibility and efficacy in a public health setting. This has been replicated in a Brazilian study.²⁷ Our model incorporates the concurrent use of three algorithms, biological, social and psychological, with different algorithms for patients who are currently in a depressive episode; in a manic, hypomanic or mixed episode; and out of episode (yielding a total of nine algorithms). The algorithms are being produced iteratively, and are based on National Institute for Health and Care Excellence (NICE) guidelines, with support as needed from other clinical guidelines – notably that produced by the British Association of Psychopharmacology¹² and by the extant evidence base. An example algorithm is shown in *Fig. 1*. Fig. 1 Psychological pathway for out-of-episode bipolar disorder. Note: Entry onto the pathway is determined by a healthcare practitioner that the patient has bipolar disorder and is currently not in episode. Green and red arrows demarcate ‘yes’ and ‘no’, respectively. A diamond box indicates a decision, and rectangular boxes indicate an action. Behind each of these boxes is the necessary information to make a collaborative decision or action, for example: behind ‘Positive screen for sleep disorder?’ there is a rationale for screening for sleep disorders, and a description and screening tools for sleep apnoea and restless leg syndrome. If patients screen positive, the algorithm takes them to the ‘Resolved?’ decision box, where initial advice is given to address the sleep disorder. If this fails to resolve the situation, the algorithm takes the patient and healthcare practitioner to ‘Refer to sleep clinic’, in which information is provided to inform the decision to refer to local clinic, and if appropriate, a referral form. The algorithm next presents a choice of five options, and the information behind the boxes allows the healthcare practitioner to action the choice, or to flag if the resource is not available, e.g. group psychoeducation. The individual can follow the flow chart, e.g. starting with CBT-I and progressing with some individual psychoeducation delivered by the care coordinator, until the individual has confidence to sign up to group psychoeducation. Once this is complete, the patient and healthcare practitioner may feel that psychoeducation or sleep-work is not appropriate. If ‘Further psychological input needed?’ is answered ‘no’, the patient is discharged from the psychological pathway, and continues on the biological and social pathways. An asterisk indicates that it is outside the scope of the National Institute for Health and Care Excellence guidelines. CBT-I, cognitive-behavioural therapy for insomnia; DBT, dialectical behaviour therapy; IPT, interpersonal therapy.

Practice change

The movement from the existing structure of care to an alternative in which treatment decisions are made within a framework provided by algorithms, which, in turn, are incorporated into an e-pathway, represents a significant change in practice within our large organisation. Implementation of such a change requires careful consideration.²⁸ In health-care, it has been argued that allowing staff to define problems and formulate solutions facilitates even those change processes that are initiated by managers.²⁹ Here, we therefore sought to explore the views of healthcare professionals and people with bipolar disorder; specifically looking at the benefits and costs that are relevant to the development and implementation of an e-pathway for bipolar disorder, to steer and facilitate this change.

Method

Study design and setting

Data collection took place in a single session, a day-long workshop organised by the e-pathways team, to present the bipolar disorder e-pathway for discussion.

Recruitment and participation

Various methods were used to invite healthcare professionals and people with bipolar disorder to the workshop. The workshop was advertised twice via the Trust's weekly bulletin, which is sent to all employees of the Trust. Individuals who had shown earlier interest in the event from a previous bulletin were also directly invited, and invitations were cascaded within the trust, such as via the allied Health Professional Senior Leadership Team. Finally, an open invitation was extended to a bipolar disorder patient/carer group, and other individuals who had previously shown an interest in e-pathways. A combination of open invites and targeted recruitment ensured that feedback from the workshops spanned a variety of occupations and provided a range of perspectives. In total, 28 people attended the workshop. Members of the e-pathway team were also in attendance. Not all attendees provided their job roles within the NHS Trust, although occupations of those in attendance included clinical psychologists, peer-support workers, student nurses, consultants and community psychiatric nurses. Two employees of the NHS Trust in attendance also indicated they had a diagnosis of bipolar disorder, allowing them to provide further insight from the perspectives of healthcare professional and patient. Finally, one person from the bipolar disorder support group was in attendance, as was a carer for a family member with bipolar disorder. In total, three participants had bipolar disorder.

Format of the workshop

The day included presentations from the bipolar e-pathways team, including presentation of the algorithms that were on display throughout the day, a presentation from a person with bipolar disorder within the Trust, and two focus groups, one of which gave feedback on the pathway during a semi-structured group discussion that incorporated open-ended questions, with prompting for further elaboration. The second focus group explored the training implications of the e-pathway; however, as this was not a focus of the present study, no data were recorded from this group, although all participants from this second focus group completed the questionnaire at the end of the workshop. Attendees had free choice of breakout group. Two of the participants with bipolar disorder attended the focus group that was transcribed.

Data collection

Transcription of focus group

At the start of the discussion, those within the focus group were made aware that the session was to be transcribed. Before beginning, participants were reassured that their responses would remain anonymous. Audio recording was not possible because of logistical constraints. As such, the researcher transcribed the discussion by hand. As much detail was gathered as possible, and where individual fragments were missed, a summary of the speaker's point was instead made. The handwritten transcription was later transferred to computer and checked for accuracy by the researcher.

Questionnaire

A questionnaire was designed before the workshop, to explore views about the development of an e-pathway for bipolar disorder. All respondents were made aware of the purpose of the questionnaire. The questionnaire (see *Table 1*) was distributed and completed at the end of the day. Following the session, responses were compiled into a document for analysis *Table 1* Bipolar e-pathway questionnaire
Question 1 How do you think an e-pathway for people with bipolar disorder will affect the quality of care you/the Trust deliver/receive?
2 Would you welcome the development of such a pathway? What do you see as the advantages?
3 Do you have any concerns about the pathway? Are there potential negative consequences?
4 In what way do you think support, guidance and/or training could be developed to improve the quality of care you deliver/receive?
5 Do you have any further comments about the Bipolar Pathway?
6 Would you be interested in helping to develop the pathway? If yes, please give your contact details below

Data were analysed by framework analysis,³⁰ to systematically establish relationships within the data to answer relevant questions through the generation of a framework. This method of analysis, developed for applied policy research, is becoming increasingly used within healthcare and medical research.³¹ It allows the flexibility to examine ideas that arise from the data during analysis.³² Themes can be described as concepts that aim to describe the data.³¹ We followed the five stages to framework analysis: familiarisation, identification of a thematic framework, indexing, charting, and mapping and interpretation.

Ethical approval

As a service evaluation, this study did not require consent to be granted from Newcastle University nor NHS Research Ethical Committees. However, all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. Participants acknowledged their consent to discuss the topic before participating in group discussions.

Results

In total, 26 questionnaires were submitted at the end of the workshop. All respondents indicated that they welcomed the development of the e-pathway for bipolar disorder. Through analysis of the questionnaires and focus group, we developed an analytic framework that comprised five key concepts: quality and delivery of care, patient–clinician collaboration, flexibility and adaptability, impact on staff and impact on healthcare services.

Quality and delivery of care

Participants were asked how they felt the quality of care, and care delivery, would be affected as a result of implementation of e-pathways. Overall, healthcare professionals and patients felt that the implementation of an e-pathway for bipolar disorder would improve care. A key theme was that the consistency of care would improve, and that there would be a sense of equality of care. Another benefit for the implementation of e-pathways was that it was felt that clinicians would be more likely to deliver care concordant with NICE guidelines, which would be associated with improved outcomes for patients. “I’d hope it will create a more consistent baseline to good practice in offering evidence-based interventions whilst understanding the subtleties of why sometimes we alter our treatments’ (questionnaire, no role given).”

Furthermore, a theme arose from the discussion that having standardised care and the ability to record treatment progress would allow clinicians who regularly deviate from NICE guidelines, without sufficient justification, to be ‘flagged’. This could assist with highlighting areas where care is consistently substandard.

A further concept that arose was that e-pathways would be expected to facilitate the development of evidence-based and value-based treatment strategies. One healthcare professional indicated: “I think it has enormous potential in improving the quality of care of service users and helping staff in deciding/delivering evidence-based practice’ (questionnaire, consultant clinical psychologist).”

Furthermore, another respondent felt that the e-pathway would help to: “[i]mprove the consistency of approach – aligned to the evidence base of what works [and] support recording of decision making about treatment and variance from NICE recommendations’ (questionnaire, psychologist).”

Overall, following analysis, the idea that the quality and delivery of care would improve was widespread; however, care must be taken to ensure equality of availability of interventions.

Patient–clinician collaboration

The collaborative relationship between clinician and patient as a result of e-pathways, including a more holistic approach to care, increased co-production, and increased patient engagement also emerged from the data. A presumed benefit of e-pathways would be the ability to include the patient in the decision process of treatment, as both clinician and patient could view the algorithm within e-pathways, and discuss options relating to each stage or intervention. Most questionnaire respondents raised the idea of increased collaboration as a result of e-pathways, with many also indicating they believed it would be a more holistic model of care. “It should improve quality outcomes and service user experience by ensuring informed decisions about elements of care packages, ensuring consideration to be given to a holistic bio-psycho-social approach [...] better engagement with interventions and service due to collaborative transparent approach’ (questionnaire, no role given).”

However, a potential barrier arose in the physical appearance of the algorithm: “Showing [a] patient the visual form would be overwhelming. I feel overwhelmed looking at the flow chart. It could be easier to follow or more friendly looking or I would not show it to a patient’ (focus group, psychologist).”

Therefore, consideration must be given to the appearance of the decision-tree, or how it could be better presented to patients to prevent this being a barrier.

The final element of collaboration related to family members or carers, with one healthcare professional indicating e-pathways would be: “[An] extra resource to utilise when working with clients and their families’ (questionnaire, no role given).”

e-Pathways were perceived as providing an effective way to maintain collaboration between the patient and those involved in their care, including carers, family members and clinicians.

Flexibility and adaptability

Flexibility and adaptability refer to how e-pathways for bipolar disorder could change to provide optimal care. In relation to concerns regarding implementation of e-pathways, one respondent indicated: “‘Possibility of being a little rigid but [a] clinician can utilise [their] own clinical decision making to justify care and treatment going forward in care plans, progress notes, etc.’ (questionnaire, community psychiatric nurse).”

Participants emphasised the importance of ensuring that clinicians were aware of the scope to use their own clinical judgement to deviate from the treatment algorithm, with justification and to adapt treatment to suit specific groups and to be flexible to accommodate management of other co-morbidities. One concern that arose from several healthcare professionals related to individuals with co-morbidities and adapting e-pathways to suit other groups, such as adolescents or the elderly: “‘Need to ensure co-morbidities are understood and that people don’t forget about problems that don’t fit under this diagnosis’ (questionnaire, no role given).”

Healthcare professionals suggested that broadening the e-pathway process to support both pre-engagement and recovery would be important in improving care for patients with bipolar disorder. For example, pre-engagement could include enabling the patient to be able to access resources relating to the algorithms and/or interventions before commencing treatment. “‘If public-facing it could introduce the patient early for [their] own research or mood diaries’ (focus group, consultant).”

Similarly, healthcare professionals believed it would be beneficial if e-pathways could be adapted to support both post-engagement recovery.

Impact on staff

Respondents reported that they felt that the implementation of e-pathways would have an impact on staff such as clinicians and mental health nurses, and that clinicians would benefit from the more structured guidance and clearer expectations, which may increase clinician confidence. “‘I think a downstream advantage may be that clinicians come to supervision with clearer expectations and questions e.g. ‘We got stuck doing X, how can I approach this with the client?’, which would drive the quality of care’ (questionnaire, psychologist).” “[The] principle of an e-pathway which will guide clinicians is excellent, having information and interventions/guides will enhance confidence’ (questionnaire, consultant clinical psychologist).”

However, sufficient guidance was felt to be needed to ensure that individuals were aware of their job role expectation with regard to delivery of e-pathways: “‘There must be greater clarity re job role expectations – who is expected to deliver what and how this fits within [the] broader job role’ (questionnaire, psychologist).”

One benefit that was identified was the idea of an aspirational pathway, that e-pathways provided the standard of care that should be aspired to, which could give staff a clearer sense of purpose and boost morale. However, this could present a possible barrier: some clinicians stated that they may feel frustration if they are unable to deliver the recommended standard of care such as through a lack of resources. One respondent indicated that this could be ‘demoralising’ (focus group, practitioner adolescent services). Another indicated: “‘[The] clinician may become overwhelmed if there are no staff resources to develop care or do not have training to implement certain groups or one to one session’ (questionnaire, no role given).”

This sense of an impact on staff was mirrored by a potential impact on patients: disappointment if a recommended intervention was not available in all areas. This was thought likely to be especially difficult for individuals in rural areas, or those with limited mobility that are unable to travel: “‘[The] risk of it being a “postcode lottery” – shows what should be offered but if not available in that service [due to lack of funding in a particular location]; it would be frustrating for the service user’ (questionnaire, no role given).”

A further cost stemmed from concerns regarding increased pressure and demands on staff: “‘Support to engage with the pathway, staff feeling overwhelmed and overloaded and pressured to discharge’ (questionnaire, consultant clinical psychologist).” Although some indicated they felt implementation of e-pathways could be time-saving and reduce their workload, others indicated the pressures staff already faced could present an issue in terms of uptake. A further factor

that could affect staff is the idea of ‘process-driven care’. Several healthcare professionals voiced concerns that e-pathways would become a ‘tick-box exercise’ (questionnaire, perinatal mental health team). “‘We need to ensure we are using it with purpose, not because we have to’ (questionnaire, no role given).”

One issue was that the implementation of e-pathways would become a method of monitoring staff performance as opposed to a tool to provide guidance and resources. One respondent on the questionnaire indicated that, despite the stated purpose of e-pathways to provide support for and not to assess clinicians, they were concerned that it may ‘become part of a performance framework’ (questionnaire, no role given).

Also, a key issue to implementation was the concern that it ‘takes the art out of nursing’ (questionnaire, no role given) or ‘[I] worry that it might unwittingly invalidate care working skills’ (questionnaire, psychologist); namely, that it may lead to a loss of instinct and clinical judgement.

Impact on healthcare services

This concept relates to how implementation of e-pathways would affect healthcare services, with concerns relating to cost, training and resources. “‘My underlying concern is how it would be implemented, resources, staff, training [...] and being put into practice’ (focus group, practitioner adolescent services).” One key benefit raised was that implementation of a system such as e-pathways would facilitate the auditing process: “‘Agree it may help to highlight gaps in resources and help us think about how to tackle this’ (questionnaire, no role given).”

For example, if the treatment algorithm regularly recommends an intervention that is not available in one locality, it is easier to identify where care or resources are falling short.

A barrier with a potential to affect the implementation of e-pathways was training, with many healthcare professionals indicating the necessity of sufficient training to ensure correct implementation and use of e-pathways: “‘Need to establish [the] training needs of staff of different professions and peer support workers and experts by experience. Some of this will be awareness and care skills, some related to specific interventions’ (questionnaire, no role given).”

A specific concern related to training around interventions, as many believed there were currently insufficient practitioners trained in the interventions that would be recommended within the treatment algorithm. This relates to similar concerns regarding availability of resources. A further concern related to insufficient supervision being in place to support training and implementation.

Discussion

Overall, healthcare professionals and patients welcomed the development of the e-pathway for bipolar disorder, and helped to define several benefits supporting the implementation of e-pathways, including improvements in the quality and consistency of care, increase in good practice and NICE-concordant care, clearer guidelines resulting in increased satisfaction for clinicians, a more collaborative approach to care and ability to monitor care and resources. If e-pathways are to be successful, the benefits identified by patients must remain central to development and implementation. However, it is arguably of at least equal importance to establish the barriers that could hinder implementation in order for necessary solutions to be developed. Costs and possible recommendations are discussed below.

In keeping with previous research,³³ healthcare professionals feared loss or invalidation of care skills, clinical instinct and confidence in unsupported clinical decision-making by trainees. The potential liability consequent on deviations from the algorithm was also a concern. This highlights the importance for the pathway team of adequately communicating that the standard of care recommended in e-pathways is aspirational, and that healthcare professionals should feel able to use clinical judgement and deviate from the algorithm. This further emphasises the importance of collaborative algorithm development.

The algorithm was seen as ‘overwhelming’ for healthcare practitioners and patients because of its apparent complexity. A further concern was that irrelevant aspects of the treatment algorithm would still be visible for some patients, such as the inclusion of medications that could be contraindicated. One individual suggested that a more user-friendly version, such as a simplified paper handout, could be developed. A further suggestion was that a ‘step’ within the algorithm could change colour to indicate when it is completed, to make the visual aspect of the flow, charts more

intuitive and easier to follow from a patient perspective. These recommendations need to be considered in the e-pathway design and a combined approach may be needed in which the healthcare practitioner and patient are able to see the whole algorithm to give a sense of the treatment journey and future options with a more focused view of the immediately relevant treatment decisions. Healthcare practitioners felt that effective training and resources would be central to successful implementation for e-pathways. This replicated experience elsewhere,³⁴ and is a timely reminder that sufficient resources need to be allocated to training

It was notable that although the bipolar e-pathway team saw the identification of gaps between best practice and actual practice as an important function of the e-pathway – a way of identifying gaps in training and provision, and of informing service development – these gaps appeared to raise anxieties in the workshop attendees. This will need careful consideration during the process of e-pathway development.

This project had several limitations. First, as this was a valuable opportunity to have access to a task-specific group of healthcare professionals and people with bipolar disorder, the research had to be as pragmatic as possible. As such, only one researcher undertook data collection and because of logistical constraints, and data from only the most relevant focus group were transcribed. Further detail, which may have helped to answer the research questions, may have therefore been missed. Because of the lack of transcription, it may have been beneficial to validate the derived transcript and arising themes with participants; however, this was not possible within the current study. Additionally, one researcher carried out the qualitative analysis, which may have made it more susceptible to subjectivity. The researcher also developed the analytical framework, and this was discussed and refined with other members of the team.³⁵ A further limitation is that few people with bipolar disorder responded to the invitation to the workshop, and therefore feedback was primarily from healthcare professionals. Although clinicians will use e-pathways in day-to-day practice, implementation will affect patients through the care and interventions they receive. As such, it is vital to gain an understanding of the views of patients in the development and implementation process. Therefore, this process would have benefitted from further contributions from people with bipolar disorder. One patient in attendance agreed that they would take the concept of e-pathways to their bipolar support group, with feedback shared in a less formal setting, and their input will help to shape the development of the pathway.

This research assessed attitudes toward a treatment pathway that is yet to be implemented. Although it is essential to ascertain stakeholders' views throughout development, it is also important to assess the system once in practice. Future research should examine the use of e-pathways once implemented. This could either be a quantitative assessment of the magnitude of change in care, using outcome measures as described in studies above, such as ratings on self-report measures and rates of hospital admission. If the e-pathway functions correctly, it would be predicted that patients with bipolar disorder will have lower rates of readmission and relapse. A qualitative methodology, as used here, could examine healthcare professionals and patients' views (e.g. at the onset of implementation and 1 year later), to determine whether the perceived benefits of e-pathways are realised in practice, and if the costs identified in the current research are sufficiently overcome.

In conclusion, the provision of e-pathway-supported, algorithm-informed care has huge potential to inform service development, identify training needs, enhance collaborative clinical decision-making, streamline processes and improve quality of care. There are considerable hurdles to overcome before the development and subsequent delivery can occur, but an optimised e-pathway has the potential to improve outcomes and equity for patients with bipolar disorder.

Data availability

Data available on request due to privacy/ethical restrictions.

A.L.E. collected, collated and analysed the data, and wrote the first draft of the manuscript and co-ordinated input from other authors. J.L. supervised the qualitative analysis and data collection. S.W. provided overview of the project. G.D. led on the e-pathway development work and E.C.-T. led on its application to service development. All authors contributed to study design and write-up, and agreed the final version of the manuscript.

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Declaration of interest

None.

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1.2.22 ‘Mad agency’, reflections on Goya’s ‘The Madhouse’

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Abstract

We must remain open to revising and expanding the important but incompletely understood philosophical categories of agency and responsibility in light of what can be learned from atypical states and behaviour. A reflection on images – here, Goya’s great Madhouse scene, and photographs of Mad Pride events since the 1980s – is shown to provide assistance towards this end.

Contents

- *‘Mad agency’, reflections on Goya’s ‘The Madhouse’*
 - *Some basic distinctions*
 - * *Actions and movements*
 - * *Phenomenal character of agency*
 - * *Self- and other-assigned agency*
 - * *Mental and overt agency*
 - * *Proximal and distal agency*
 - * *Deliberative and absorbed agency*
 - *Images: ‘dark freedom’ in Goya’s ‘The Madhouse’ and Mad Pride parades*
 - *Supplementary material*

“‘vast regions of agentic self-awareness lie unmapped, and much work remains to be done before we have a clear idea of exactly what it is like to be an agent’ (Bayne: pp. 182).¹”

Agency, and its relationship to responsibility, are issues over which philosophers have yet to find entire agreement. The above passage by Timothy Bayne was written some time ago and preceded his own valuable clarifications. Yet the subjective experience (or phenomenology) of the personal action that philosophers call agency (the term is explained

more fully below) remains, as Bayne says, unmapped, as do related value-based (or normative) questions about responsibility. Nowhere is this more evident than at the juncture of agency, responsibility and mental disorder. And it is in the spirit of sketching some corners of Bayne's map that I offer a few remarks about agency and disorder, shortened here, at risk of oversimplifying, to 'mad agency'.

What follows is intended to complement recent research in which psychiatrist-philosopher Mohammed Rashed examines the philosophical concepts grounding mental health activism. The first analysis of its kind, his is a respectful but stringent account of the recognition sought by activists, locating their demands within contemporary political philosophy, and providing guidance as to how those demands might be met.² In the present essay, I suggest that some of the ambiguity and complexity entailed in the categories of madness, agency and responsibility can be approached and perhaps illuminated through a reflection on images. I use a familiar painting by Goya, on the one hand, and on the other, photographs of Mad Pride marches and public events since the 1980s. The message from what follows is simple. Even applied to normal states and behaviour, conceptions of agency and responsibility may be incompletely understood. We must remain open to revising and expanding them in light of what can be learned from atypical states and behaviour. And for this purpose, images seem able to offer powerful assistance.

Both agency, and responsibility in relation to it, are contested topics. But few would dispute that personal responsibility can be appropriately assigned only when there is some degree, or form, of (personal) agency. The converse may not hold; arguably, there can be agency in the absence of full responsibility. Philosophical accounts of agency and responsibility differ, but as is indicated by legal exculpating factors such as ignorance, compulsion and duress, ascriptions of responsibility will sometimes be withheld, even from what appear to be voluntary actions. In keeping with much discussion about agency and responsibility, the two terms are sometimes merged; in other places, as will become apparent, they need to be separated.

Some basic distinctions

A group of contrasts drawn from philosophical discussions of agency are introduced here: actions and movements; the proprietary phenomenal character of agency (how it feels subjectively) in contrast to interpretations about, or judgements over it; self- and other-assigned agency; mental and overt agency; agency emanating from more and less proximal and distal intentions; and more and less deliberative and absorbed agency.

Actions and movements

The 'sense' of agency, as we seem to experience it, is sometimes used by philosophers to mark the contrast between true actions (those we voluntarily undertake ourselves) and mere movements. This is the difference between lying down and unintentionally falling, for example.

Phenomenal character of agency

When agency is involved (in lying down), two distinct parts have been recognised: the phenomenological feeling of doing it oneself (known as its proprietary phenomenal character) and the interpretation or judgement we make about that feeling (the awareness that, rather than either falling, or having been pushed to the ground, one *lies down*). Both phenomenal feelings of agency, and the interpretation or judgement we – and others – make about our agency, enter into the following discussion.

Self- and other-assigned agency

Complicating questions about self-assigned agency and responsibility arise when we speak of agency and responsibility, whether as felt agency or as judgements about one's agency, and these are ostensibly magnified when mental health is part of the mix. Self-assigned agency and responsibility, whether as feelings or judgements, will not be entirely reliable guides if they are distorted by disorder. Examples of that distortion are the self-blaming depressive, who exaggerates their personal responsibility ('It's all my fault'), or the grandiosity of the narcissistic personality's boast ('All thanks to me') illustrate. Similarly, the proprietary phenomenal character of agency appears to be absent in some psychotic experience, as suggested by what are known as 'inserted thoughts'.

When agency (and responsibility) is judged to be present, by others or by oneself, may thus depend on the opinion of psychiatric experts. And asked whether those with psychiatric diagnoses possess agency, the expert's answer will usually be, it depends – on the situation, the nature of their disorder, the particularities of the thoughts and actions in question, and so on – and thus on case-by-case clinical observation and judgement.

Mental and overt agency

Discrepancies between felt agency (and responsibility) and agency (and responsibility) with normative force imply that some judgements about agency (and responsibility) may be inaccurate, or unreliable. (Philosophers speak of ascriptions of agency and responsibility as possessing normative force when they are *accurate* (as the moral realist might put it) or *appropriate*). Yet such inaccuracy or unreliability will arise from multiple factors. Mistaken or distorted self-assigned agency and responsibility are also associated with varying cognitive styles and socialised habits in normal populations; for example, the widespread tendency to deflect blame onto others, or take sole credit for achievements more accurately attributed to many. They will then be culturally local: other times, places and cultures might rely on different substantive norms. Not only disorder, and non-disordered personality bias, but also any number of social and cultural expectations can thus shape judgements of agency and responsibility, self- and other-assigned. And given that disorder, personality and culture are inextricably entwined in any given instance, these distorting factors may not be separated easily or, in many instances, helpfully.

With regard to judgements about agency, whether made by oneself or another, it will be worth noting that there are mental as well as more outward bodily, actions. When Thomas Jefferson spoke of the 'illimitable freedom of the human mind', he referred to our immediate ability to recall the past, envision the future, rehearse what might have been as well as what was – indeed our ability to direct our thoughts at all, to form intentions, revise and renounce earlier attitudes, to call up memories and imaginings. This kind of agency, associated with the notion of rational capacity, has sometimes been denied those with mental disorder, even while it was said to be possessed by prisoners in chains, and those trapped in ill and unresponsive bodies.

Ascriptions of responsibility also sometimes extend to these inner efforts of mental agency. For some mental actions, we hold ourselves responsible and are also held responsible by others ('This is an uncharitable thought, but ...' it might be said, or 'You mustn't think like that ...'). That said, whether such responsibility is ever rightly ascribed to one's own mental 'actions' is a contested matter, as is the applicability of the term 'agency' to them. (I am grateful to David Foreman for pointing out that ethical systems differ over this point. Only some Christian theology acknowledges the sinfulness of 'immoral thoughts,' for example.) And the exactness of the parallels between mental agency and the overt agency we exhibit to the world are similarly debated. The structure of mental action has been seen by some to differ in not involving intentions, or initiated by decisions, or reasons, for example, whereas others insist that mental agency is the originating source of all agency, outer as much as mental.^{3,4}

The details of these additional differences need not detain us here, as long as it is acknowledged that some of what we humans do involves our inner as well as our outer lives, and that the coherence of mental agency must be understood within the whole, including personal-level intentions and more overarching goals, that may not manifest in any way that is outwardly evident. Examples of such expansive goals over mental health might include the aim to maintain psychic stability and avoid or reduce personal suffering.

Proximal and distal agency

Another feature of agency, occurring with both mental and overt agency, are the less and more direct and immediate forms it takes, for each of which we are also, sometimes, held responsible, both by others and perhaps ourselves. Examples of less direct and immediate agency include Elster's 'imperfect rationality', when we outwit ourselves, anticipating and engineering outcomes we are unable to produce directly and immediately.⁵ Often, we do so aware (or not unaware) of the process as we manipulate our beliefs and feelings to achieve desired ends. The way cognitive-behavioural therapy is widely supposed to work employs this approach, both for mental agency, where the power a person has to change beliefs and attitudes is used to bring about changed feelings, as well as directing what is said and done. The effectiveness of such imperfect rationality cannot be guaranteed, of course. Cognitive-behavioural therapy has now quite self-consciously adopted its classical ancestor in the imperfect rationality practises of those who recommended care of the soul that aimed to expunge all negative and unproductive feelings (debatably, all feelings of any kind), through a programme of self-analysis and cognitive therapy. We are free to, can and should adjust the beliefs on which our feelings rest, it is supposed. (Even in their own time, and almost ever since, owing to the influence of Aristotelianism, the excessive responsibility for controlling thoughts and feelings accepted by the Stoics were derided as unrealistic and undesirable.) Outcomes of agency that are more and less immediate and direct have been described as emanating from intentions that are 'proximal' and 'distal', respectively, with imperfect rationality exhibiting the latter.^{6,7}

Deliberative and absorbed agency

As examples of more planful and less immediate (or proximal) agency illustrate, particular instances of agency, whether mental or overt, fall within complexes of goals, deliberations, purposes and plans – even very long-term aims and dreams. This nesting of agency within its broader setting has also been recognised to involve a consequence in terms of phenomenology: although recognisable feelings may be associated with agency, not all agency is immediately felt. Agency often occurs as part of a seemingly effortless, automatic and non-conscious flow of engagement with the world. In that case, it leaves little space for, and bears little resemblance to, conscious deliberation, or the felt sense of actively doing, rather than passively experiencing. Typically, indeed, felt agency is 'recessive', in being confined to the margins of attention.¹ Much of everyday life, and more than philosophers always acknowledge, involves this kind of agency, as the case of habitual action illustrates. With skills like driving, we usually proceed with little or no conscious awareness of our complex responses. When we engage in practical or creative endeavours with full, undistracted absorption, we have been described as undertaking 'skilled coping',⁸ and awareness in the latter experience is said to be immersed rather than detached.⁹

Images: 'dark freedom' in Goya's 'The Madhouse' and Mad Pride parades

The above contrasts have been drawn from within disparate theories, and only fuller accounts of each can determine their compatibility, and the final plausibility of the theses put forward here. Nonetheless, felt agency and 'freedom'; self- and other-assigned agency (and responsibility); the effects on agency and responsibility wrought by personality style and cultural norms as well as by disorder; mental agency and agency in the outside, shared world; and more and less direct, and more and less 'online' or conscious, and deliberative, forms of agency. all seem likely part of a rough sketch of the territory, although each element still wants for a fuller analysis.

In what follows, I try to elucidate some of the features of mad agency (and responsibility) with the help of images: a much-interpreted painting, showing the inside of a madhouse at the beginning of the 19th century; and photographs of Mad Pride parades. Why turn to images? Arguably, imagery can communicate qualities of agency that are hard to capture in language alone. And pictorial commentary, as we will see, offers suggestive associations worth exploring. Moreover, in addition to written descriptions, and long before the present-day use of images, pictorial traditions shaped how mental health and ill health, disorder and madness were apprehended and understood.¹⁰ This ancient, long-lived, visual record may have something more to teach us.

'The Madhouse', Goya's magnificent depiction of the madhouse in his hometown of Zaragoza, was painted between 1812 and 1813. Unlike the more positive images from the Reform era that followed, Goya's several pictures of that institution have been judged to depict unutterable suffering and awfulness, even depravity. In a typical description, the

painting's only light source is said to be: "a barred window high up on the wall, clearly meant to repress the figures below. These figures are distinct characters, all engaged in grotesque and pitiable behaviour - one wears what seems to be a wild-feathered headdress, another is fighting in a tricorne hat, another makes a gesture of blessing to the viewer, whilst many of the others are naked . . . this painting could be meant as a denunciation of then-current practice in that area . . . Some of the figures can also be interpreted allegorically, as a gallery of parodies of powerful figures in society, such as the clergy or the army (the man in the tricorne)." (Gilman: pp. 129–30).¹⁰

With its striking use of darkness and light, the picture shows 'a world of darkness opposed to the world of light', in keeping with Goya's 'emphasis on the soul as the dark hiding place of terror', for example.¹⁰

Echoing this negative interpretation, the actions of the inmates have been described by Robert Hughes as 'delusory gestures of power'.¹¹ However free, responsible and agentic these transgressive gestures appear to be, this 'power' (to use Hughes' word) will not guarantee that full, or perhaps any, responsibility could be appropriately ascribed, by the inmates themselves or by observers. There are bars on the window. The inmates' agency in the outer world is limited. Yet delusory or not, each seems to reflect a kind of inner, mental agency (power, or freedom). In trying to fathom those 'delusory' gestures, it is worth noting that Goya's fascination with, and many works depicting, madness, have been singled out for their humane and sympathetic attitudes. Goya located madness among the common presences of human life, it has been explained. He saw it a natural part of the human condition, reflecting his creed that nothing human was alien to him. (Hughes attributes to Goya a well-known medieval saying, attributed to Terence, to this effect.) And few subsequent depictions of madness behind bars are as sympathetic, at least until we reach 20th century pictures such as Bellows' 'Dance in a Madhouse' (1917) and other images showing asylum entertainments.

Arguably, then, Goya's attitude toward his subject matter was expressive of sympathy, not revulsion. Conforming to that positive conception is a revealing passage from another 20th century commentator. Presenting mad agency as a certain, transgressive 'dark liberty', Michel Foucault observes of the madman in the hat in Goya's painting: "[the figure] leaps out, by virtue of the silent language of his well-muscled form and the wild, marvelous freedom of his youth, a free human presence who affirms his birthright as though this were the beginning of new era. "The Madhouse" speaks . . . [of] those new bodies, brought into the light in all their vigour, and whose gestures, if they call up their dreams, sing above all of their dark liberty." (Foucault: pp. 530–1).¹²

What dark liberty is this? Where does the mad agency lauded by interpretations like Foucault's fit among the forms of agency sketched earlier? I propose that the 'freedom' expressed in the painting anticipates something that we only entirely recognise now as a consequence of political events: it is a demonstration of the powerfully 'freeing' and healing transgressiveness and ludic exhilaration celebrated in today's Mad Pride activism, rhetoric and writing.

We are tempted to agree with Hughes that the gesture of power is merely delusory – a mistaken parody of real agency – or even a feeling of agency distorted by disorder-wrought cognitive error. Yet, in light of writing by mad activists, we also perhaps begin to see a quality inviting attitudes of hope and delight, rather than abject despair, in the gestures of Goya's inmates. To cite just one example of such writing: "Madness is the new rock "n" roll! . . . All of us who've experienced "deep sea fishing" will know the sensation of heightened awareness, of consciousness enhanced . . . of feelings of wonder and terror that can't be verbalized . . ." (Morris: pp. 207).¹³

Generally, what we see in images is limited by what we expect to see, and what we suppose the artist wanted us to see. We might guess that the inmates in the asylum were performing for an audience, perhaps even engaging in such display for monetary reward, as did the inmates at English asylums during the same era.^{10,14} (I am grateful to David Foreman for drawing my attention to this possibility.) Were this so, the actions depicted by Goya are replete with the features of classic rational agency, and a pretence. But whether or not it is a pretence, later events and subsequent understanding allow us to go beyond the constraints imposed by what we would expect, and what, intentionally or not, Goya may have conveyed. From today's perspective and understanding, we can see it differently. To illustrate this interpretive shift, we might turn to Bellows' 'Dance in a Madhouse', where movements have been dismissed as 'wild and uncontrollable', and reflecting passive ('melancholic') postures.¹⁰ Yet here, too, and contrary to Gilman, the central female figure in Bellows' picture also reveals something joyous, triumphant, freeing, enlivening and, perhaps, empowering.

Goya's madhouse has parallels and echoes in today's Mad Pride activism, some of them quite evidently self-conscious. Here we find not only resistance to the mental health system, and solidarity, but repeated emphasis on 'the celebration of difference'. 'Celebration' is a useful encapsulation, suggesting exhilaration and joy. Its object is more than mere difference, however. What is being celebrated? Minimally, the 'creativity of mad people, pride in a unique way of

looking at life, the validity of such a distinct way of life ...' (Sen: pp. 5)¹⁵ are grounds for pride and reason for celebration. Enumerating elements of the demand for recognition of mad identity, Rashed emphasises that Mad Pride discourse includes a range of attitudes and interpretations. It emphasises mad identity, creativity, spirituality, suffering and the gifts that, although valuable, are dangerous.^{2,16} Each of those aspects (identity, creativity, spirituality, suffering and dangerous gifts) offers grounds to applaud and celebrate.

Images of broadly 'celebratory' Mad Pride parades (in Canada, the USA, the UK, Ireland, Belgium, France and Australia, for example), provide us with readily recognisable descendants of our madhouse scene. Here are flamboyant and excessive dress, gesture and performance; here are the seeming freedoms and agency associated with the transgressive, the parodic and ludic. Unlike the barred madhouse, the street now forms the stage for performance. The demands for political recognition, I suggest, provide examples of agentic forms identified earlier, and perhaps anticipated by Goya.

By recognising that agency works in many ways, indirect as well as direct, and through imperfect as well as perfect rationality, we may regard the mad gestures in Goya's painting as not only exhilarating, and felt, although ultimately delusional agency and freedom, but also as healing, consoling, emboldening, strengthening and even, yes, freeing. Like the antics of the marchers celebrating Mad Pride, these gestures may convey the shoring up of what is depleted, diminished and misunderstood by the surrounding culture, or concealed through prejudicial expectations.

Viewed as a kind of self-help or self-care, the gestures depicted in both Goya's and the later celebratory, Mad Pride images, can also be likened to the indirect agency of imperfect rationality. Arts-based healing rituals, healing effects and the mental health benefits of expressive therapies have been acknowledged since ancient times, and are well documented.¹⁷⁻¹⁹ Their proponents speak of the way such activities integrate mind and body in a unified, healing whole; the 'act of responding to what is given, imagining its possibilities and reshaping it in accordance with what is emerging', is described as akin to that found in all imaginative play, and improvisation (Levine: pp. 71).¹⁶

The agent may not seek anything further through their exuberant gesture, or even be alert to broader intentional or purposive context within which it occurs. Their agency may reflect the obliviousness of intense absorption. Moreover, it may not be agency with outer effects. In contrast to the powerless inhabitants of the madhouse, today's activists bring about real world, consequential political outcomes (changed cultural attitudes, for example, and more enlightened mental health policies). Yet even without doing so, the gestures of Goya's figures may be seen to intimate certain forms of distal, immersed agency, as Foucault's analysis may be taken to suggest.

Reviewing the discourse and tenets of Mad Pride activism, Rashed notes four main elements, as we saw: demands around identity and culture, creativity and spirituality, distress and disability, and finally, madness as a 'dangerous gift'.² Among the demands identified by Rashed and these activists, I have tried to suggest that none quite convey the healing and freeing power captured in the ludic, the parodic and the transgressive that are so evident in today's Mad Pride parades and celebrations and, in light of them, we are now able to recognise as foreseen in the dark liberty of Goya's madhouse.

About the dangerous gifts of madness, it has been explained that '... we are members of a group that has been misunderstood and persecuted throughout history but has also been responsible for some of its most brilliant creations' (Du Bru: pp. 259).²⁰ Any incautious ability to violate convention and social norms will be dangerous, including such gifts, it must be conceded, and will likely bring its own exhilarating phenomenology, as well as fateful and often self-defeating consequences. The demands of mad activism can be met, perhaps, only with the openness, imagination and negotiated agreement of the larger culture.

Such negotiated agreement requires a preparedness to revise and expand accepted ideas about social norms and concepts of mental health, as I have pointed out elsewhere.²¹ Among those social norms and concepts of mental health, it has been proposed here, are ideas about agency.

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Supplementary material

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1.2.23 The current state of training in psychiatry of intellectual disability: perspectives of trainees and trainers

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Abstract

Aims and Method

Twelve intellectual disability psychiatry trainee representatives and 13 training programme directors were surveyed to assess the current state of training, to establish what motivated specialty trainees to choose intellectual disability psychiatry, and to explore issues that might affect retention.

Results

The combined survey response rate was 83%. All trainees had chosen intellectual disability psychiatry after experience in either their personal or working life. Overall, specialty trainees were satisfied with their training; the majority felt supported to meet training requirements. Trainee isolation was the main concern for current trainees.

Clinical implications

Recruitment for specialty training in intellectual disability psychiatry is acknowledged to be a concern for workforce planning and could affect access to and quality of psychiatric care for people with intellectual disability. The results of this survey could be used as a guide to improve efforts to attract trainees. Acknowledging and reducing trainee isolation could improve trainee morale.

Contents

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People with intellectual disability have higher rates of mental health problems than the general population, estimated at between 30 and 50%.^{1,2} The complex interplay of predisposing biological, psychological and social risk factors for an individual with intellectual disability will have a significant effect on their presentation, which may not fit the ‘classic’ models of psychiatric presentations. Associated physical health problems such as epilepsy and sensory and communication problems can further complicate the presentation of psychiatric disorders. Social and environmental factors have a major role. Mental capacity, choice and control are also important issues to consider. These factors can make working in the specialty of psychiatry of intellectual disability challenging yet highly interesting and rewarding. Owing to clinical complexity, psychiatrists rarely work alone; there is a strong emphasis on multidisciplinary working and regular co-working with social care. However, psychiatrists may work as the sole doctor within a multidisciplinary team. These teams may be geographically distinct, at some distance from each other and based away from mainstream psychiatry colleagues.³ This can pose particular challenges for trainees in intellectual disability psychiatry, and there is evidence to suggest that trainees can feel isolated.⁴

Speciality training in psychiatry of intellectual disability in the UK comprises 3 years of training after attaining membership of the Royal College of Psychiatrists. This is in order to attain the Certificate of Completion of Training in Psychiatry of Learning Disability awarded by the General Medical Council (GMC). Trainees apply for a training post in a specific geographical area of the UK and usually rotate between a range of community and in-patient posts.

Recruitment in psychiatry in the UK has long been acknowledged as a concern in terms of workforce planning, with a lack of trainees recruited to fill gaps left by those retiring.⁵ Recruitment at the level of core training continues to be less than required – in 2012, 78% of year 1 posts were filled⁶ – and has remained static, with 78% of posts being filled in 2018.⁷ The ‘Choose Psychiatry’ campaign by the Royal College of Psychiatrists has aimed to improve recruitment to the specialty and successfully bolstered numbers of doctors entering core training by 30% between 2017 and 2018; however, the overall picture is that entry rates into the specialty remain similar to those of 2012.⁸

Once trainees have completed core training, they apply for specialty training posts. The fill rates for specialty training posts in psychiatry of intellectual disability do not compare favourably with those of other similarly sized subspecialties. Whereas fill rates have fluctuated for the other psychiatric subspecialties, recruitment has been especially poor in psychiatry of intellectual disability, where there have never been more than 30% of vacancies filled in each recruitment round since 2017.⁹ This is in spite of it scoring higher than general adult psychiatry (GAP), old age psychiatry, or

child and adolescent psychiatry for overall trainee satisfaction in the 2019 GMC National Training Survey.¹⁰ Clearly, recruitment to the specialty is a challenge. It is predicted that there could be a shortfall in consultants in the specialty by 2033 of between four and 26 full-time-equivalent posts.¹¹ Such data suggests a significant effect on the psychiatric care this vulnerable population will receive.

In order to inform future efforts to improve recruitment, we undertook a survey to investigate the reasons current trainees chose psychiatry of intellectual disability. We also assessed the current status of intellectual disability training in the UK by surveying the opinions of individuals currently in training and their trainers.

Method

Setting

This survey was aimed at trainers and trainees currently working in psychiatry of intellectual disability in the UK. All training programme directors (TPDs) and the network of Regional Trainee Representatives for psychiatry of intellectual disability were approached in order to obtain a spread of opinion across the four nations.

Ethical considerations

An introduction to the survey gave potential respondents information regarding the aims and objectives of the survey. Implied consent was assumed by completion of the survey. The survey was created and agreed by the Specialty Advisory Committee of the Faculty of Psychiatry of Intellectual Disability.

Data protection

Participants were approached using the email address provided to the Faculty. Once the survey link had been used, no further identifiable personal information was required.

Survey design

A pilot survey of TPDs had been undertaken 1 year previously; the findings from this, along with information from the 2018 GMC Survey Specialty Specific Questions, were used to design the survey questions. The survey was created with SurveyMonkey and consisted of nominal and free-text questions. All questions requiring more than a 'yes' or 'no' response had free-text responses. Functionality and content validity were assessed by the authors, including both trainees and consultant psychiatrists.

The adaptive questionnaire design used two separate versions, depending upon whether the respondent identified as a trainee representative or as a TPD. Each version posed the same questions but from the perspective of either a trainee or a trainer. (The full survey is available in the supplementary material, available online at <http://doi.org/10.1192/bjb.2020.68>).

Survey distribution

The survey link was emailed to the regional trainee representatives and TPDs in the specialty for each of the regions. The survey remained open for 6 weeks during early 2019. There was no incentive offered to complete the survey. A reminder email with a link was sent 1 week prior to the closure of the survey period.

Response rate

There are 16 regions of the UK, with a total of 40 intellectual disability psychiatry specialty trainees, each represented locally by a trainee representative and a TPD. From the perspective of the trainee representatives, one region did not have an allocated representative, and one regional trainee representative was on long-term leave. Therefore, 12 of a possible 14 regional representatives responded, giving a trainee response rate of 86%. Of the TPDs, three individuals from the possible regions did not respond. The response rate for the trainers was 81%, giving a combined survey response of 83%. All returned surveys were fully completed with no missing answers.

Analysis

All nominal responses were collated using the SurveyMonkey software. Primarily quantitative data were produced. The free-text answers were analysed separately by the four authors, and responses from the participants were used to illustrate the qualitative findings of the study.

Results

Respondent demographics

Of the trainee respondents, one was an ST4 trainee, two were ST5 and nine were ST6. For one area of the UK, there was no response from either the trainee representative or the TPD.

Analysis of responses

Recruitment: the attraction of psychiatry of intellectual disability for a prospective trainee

Factors influencing choice of psychiatry of intellectual disability training

Trainees were asked about their core training experience. The majority of the trainees had completed a post in psychiatry of intellectual disability, or in both psychiatry of intellectual disability and child and adolescent mental health services (CAMHS). One trainee had completed neither. Trainees were asked to use free text to explain what factors had led them to choose higher training in psychiatry of intellectual disability. All 12 trainee representatives commented that their core training post had influenced their decision-making with respect to higher training options, from 'opening their eyes' to psychiatry of intellectual disability to 'cementing a decision'. Other factors influencing their choice included seeking a good work-life balance and working within a multidisciplinary team. Medical school experiences were viewed as important, with one trainee having been influenced by a lecture given in medical school.

Personal experience outside medical training also had a strong influence for some respondents, with one trainee having worked with people with intellectual disability in a social care setting as a medical student, and another having a close family member with intellectual disability.

Fifty-four per cent of TPDs reported that core trainees in their area were required to undertake a developmental psychiatry post (CAMHS or intellectual disability) as part of their training, whereas 31% reported that this was not mandatory within the local training programme. The remainder were unsure. Currently, although competencies in developmental

psychiatry are an important part of the core psychiatry curriculum and are best met through gaining experience in a developmental psychiatry post, this is not an essential training requirement.¹²

The role of dual training in improving recruitment

Dual training opportunities are now being considered as an option to improve the breadth of training, to meet the needs of a changing population and to improve recruitment. The only approved option currently available with psychiatry of intellectual disability is CAMHS, and very few training posts are advertised for this combination at present.

Trainees were asked whether they would have considered applying for dual training had it been available. Ten of the 12 trainees confirmed that they would have, with the majority opting for general adult psychiatry (GAP) or old age psychiatry. The reasons for choosing these subspecialties included the cross-over of cases, in particular, for individuals with mild or borderline intellectual disability in GAP, and those with dementia in old age psychiatry. More general reasons included a wider range of job opportunities for the future and an extension of training. From the perspective of trainers, 12 of the 13 TPDs responded that they would consider offering dual training posts. Most trainers also suggested considering dual training with forensic psychiatry. Other suggestions were GAP, old age psychiatry and CAMHS. Again, the reason cited for these choices was the overlap of the specialties. Dual training combining forensic psychiatry with intellectual disability was mentioned by one trainer as a need from the perspective of workforce planning in order to meet the requirements of the Transforming Care Programme.¹³

Retention: the current state of psychiatry of intellectual disability training in the UK

Special interest sessions

Special interest sessions are an opportunity for trainees to broaden their perspectives and portfolio, to gain further experience and to understand other specialties allied to psychiatry of intellectual disability. Trainees should be able to spend up to a day each week on a special interest session or research of their choice. All trainees responded that their special interest sessions met their training needs. *Figure 1* illustrates the breadth of options currently used by trainees. Fig. 1 Special interest sessions. ADHD, attention-deficit hyperactivity disorder; ASD, autism spectrum disorder; ID, intellectual disability; SOTP, sex offender treatment programme.

Trainers responded that a wide range of special interest opportunities were available in their area or in neighbouring areas. According to trainees, barriers to accessing the sessions included a lack of time, conflict with other clinical commitments and difficulties travelling outside one's own trust for specific services.

Psychotherapy training

Half of the trainees surveyed responded that adequate supervised psychotherapy learning opportunities were available to them. Of those able to access these opportunities, 100% responded that the modalities available met their training curriculum needs.

The barriers to adequate opportunities, according to trainees, included a lack of supervision, with team psychologists often having their own students to supervise. Trainees sought clarity on the requirements for psychotherapy training, with a lack of formally agreed methods of supervision being cited as a barrier to accessing adequate experience.

The TPD responses were similar, with 46% responding that there was limited or no availability of psychotherapy opportunities available. Free-text responses mentioned the need for clarification of exactly what was required in terms of training needs for the intellectual disability population, and that a broad interpretation of what a psychotherapy learning opportunity entailed was required in order to allow a trainee to gain adequate experience.

Research

As illustrated in *Fig. 2*, trainees were generally positive about accessing research opportunities in psychiatry of intellectual disability. Barriers cited by both trainees and trainers included a lack of protected time to undertake research and a clash with clinical commitments. Trainees found accessing research networks difficult, as well as knowing how to engage with an appropriate supervisor in the local area with specific intellectual disability research interests. It was acknowledged that it can be difficult to complete research projects during the 3 year training period. However, TPDs were very positive about research opportunities and all stated that they knew of research opportunities for trainees. *Fig. 2* Trainee responses: are you adequately supported to carry out research?

Clinical governance: audit and quality improvement

Responses indicated that audit networks have been established, and that 70% of trainees had a great deal or a lot of support to access these opportunities. Trainees reported that the consultant body tended to be experienced in this area and could offer support and project opportunities. Trainees also responded positively regarding access to quality improvement training, with 90% having lots of or moderate support. This appeared to be supported by pre-existing networks in place. However, with quality improvement being a relatively new entity, the lack of consultant experience in this area was cited as a barrier. This was reflected in the TPD responses, with two of the 13 (15%) respondents mentioning lack of experience and training of consultants in quality improvement as a barrier, along with a need for more clarity as regards training requirements in this area.

Out-of-hours experience

Psychiatry of intellectual disability trainees are required to gain experience of emergency psychiatry, part of which includes being on an on-call rota for out-of-hours work. The rotas can vary regionally. As shown in *Fig. 3*, most trainees participated in a GAP rota; the trainees undertaking this rota found it a positive experience owing the opportunity to gain to increased emergency psychiatry and Mental Health Act experience as a trainee. There were some opposing opinions, however, with some trainees stating that the GAP rota did not give them enough out-of-hours experience in psychiatry of intellectual disability. Overall, trainees were positive, and out-of-hours work was found to meet training needs. The responses of the TPDs reflected those of the trainees; overall, they felt that the experience met training requirements. *Fig. 3* Psychiatry of intellectual disability (ID) out-of-hours experience.

Less than full time (LTFT) training

Of the 12 trainees, three were LTFT trainees. All replied positively regarding whether the current psychiatry of intellectual disability training programme supported their training needs. TPD responses were generally positive, indicating a belief that LTFT trainees receive adequate support to meet their training needs. However, it was noted that it can be more difficult for these trainees to access conferences and courses. One TPD stated that the support offered to LTFT trainees was a strength of the training scheme.

Retention: trainee well-being and support

All trainees responded that they felt supported in the training programme. Regular contact with approachable TPDs was cited as important. Trainees mentioned regular academic programmes and meetings with other trainees and clinicians as important aspects of trainee support. Supervisors who were available and approachable maintained this support.

One area has introduced a scheme allowing trainees to give feedback to neutral senior colleagues about training needs, which is then fed directly to the local TPD and Specialist Training Committee; this was reported by the local TPD to have been received positively.

Trainers and trainees both acknowledged trainee isolation; 30% of TPDs and 36% of trainees stated that they had experienced or noted trainee isolation personally. Reasons given for this were that psychiatry of intellectual disability is a small training scheme spread over wide geographical areas; therefore, in some areas, there are limited opportunities to meet with other trainees regularly. Solutions currently in place include a continuing professional development forum and digital solutions such as intellectual disability trainee WhatsApp groups. A lack of appointments to certain geographical regions, or trainees leaving posts, has also added to isolation in some regions.

Discussion

The aim of this survey was to assess trainees' reasons for choosing psychiatry of intellectual disability and to find out more about the current state of intellectual disability training in the UK. The survey had a good overall response rate, with 86% of regional trainee representatives and 81% TPDs responding.

In terms of choice of specialty, it was apparent that previous experience within the specialty was critical to the choice of the majority of trainees. In the main, this was core training experience, but trainees highlighted other experiences such as medical school lectures as having an effect. The influence of experience in working with individuals with intellectual disability on choice of future work has been demonstrated widely, including in other health services, for instance, in Australia.¹⁴ It is concerning, therefore, to find that at least one-third of areas do not currently require core trainees to undertake a clinical placement in developmental psychiatry. At present, a review of the curricula is being undertaken by the Royal College of Psychiatrists; therefore, there is potential for this to change in the future.

Recruitment strategies need to include lobbying for more core psychiatry trainees to have opportunities to rotate through psychiatry of intellectual disability. Forging links with medical schools and offering regular experiential and teaching opportunities would also raise the profile of psychiatry of intellectual disability. Current intellectual disability trainees have presented at the National Student Psychiatry Conference in order to improve knowledge of the specialty and access to further experiences.

It was apparent that current trainees were very interested in the option of dual training with another specialty to broaden training opportunities and experiences. This finding is in keeping with the findings of a recent survey of dual trainees in old age psychiatry and GAP¹⁵ and fits with recommendations from the Shape of Training review (2013),¹⁶ which aimed to broaden training experiences to meet changing patient requirements. The option of dual training is currently being explored by the Psychiatry of Intellectual Disability Specialist Advisory Committee as part of the curriculum rewrite process and should also be considered by the wider Faculty. However, the current system of advertising training numbers may be a barrier to offering further dual training opportunities. The system allows very little flexibility, which will need to be addressed.

Overall, trainees and trainers responded positively to questions about current training. All the trainees felt supported, including positive responses from LTFT trainees. Trainees felt supported to undertake special interest sessions and had undertaken a broad range of these. Responses to questions about research opportunities were more varied, with common barriers cited by both trainees and trainers; these were mainly due to a lack of protected time to undertake research. Psychotherapy training, where available, was reported to be of a quality such that trainees were able to meet the requirements of the curriculum, but it was clear that there were some regions where trainees were unable to access adequate supervision and support. Out-of-hours experience varied between regions, but overall trainees felt that this met their training needs.

A third of both groups reported trainee isolation. Reduced recruitment to training posts in certain regions and trainees leaving the specialty were among the reasons given for this. Trainee isolation has been reported previously in the literature,⁴ and physical isolation can be further compounded by feelings of stigma by association – the process by which relatives, friends, support staff and associates feel stigmatised by contact with a stigmatised or marginalised group, such as those caring for a vulnerable patient group with intellectual disability who face marginalisation and disadvantage in their daily lives.³ Acknowledgment of this as an issue continues and there is ongoing work in this area. Psychiatry of intellectual disability trainees are now invited to join 'Basecamp', an online forum where trainees can communicate with each other, ask questions and raise concerns. It is managed by the national trainee representatives who meet regularly with the Faculty of Psychiatry Intellectual Disability Executive Committee and the Specialty Advisory Committee. On a more local level, regular meetings with TPDs, academic sessions and trainee networks have reduced trainee isolation

and have received positive feedback locally. Trainee support groups for issues specific to intellectual disability trainees have worked well for geographical networks of trainees.³

In the current climate of political and economic uncertainty, recruitment to medicine in general is a challenge. Doctors are choosing to take longer breaks between foundation and specialty training,¹⁷ and recruitment to core training posts remains static.^{6,7} Psychiatry has traditionally been considered a less glamorous ‘Cinderella specialty’, losing out in recruitment to the larger medical specialties. As a small subspecialty, intellectual disability psychiatry loses out again among the psychiatric subspecialties.⁹ Investment in recruitment with campaigns such as ‘Choose Psychiatry’¹⁸ will go some way towards increasing awareness of the benefits of training in psychiatry in general. It is also hoped that the introduction of foundation fellowships¹⁹ will encourage high-quality trainees into psychiatry.

For intellectual disability psychiatry training specifically, there is further scope to highlight the results of the GMC National Training Survey data⁷ and overall trainee satisfaction rates, which reflect favourably on intellectual disability training. The positive results of this survey also highlight the benefits of intellectual disability training in terms of trainee support, scope for LTFT training, and flexibility in special interest sessions and research. Opportunities to experience intellectual disability psychiatry are widening and include an intellectual disability psychiatry taster programme that has been developed successfully in the West Midlands.²⁰ The development of foundation programme posts in intellectual disability psychiatry could increase exposure to the specialty, and there is scope to broaden this further, with five foundation posts currently available in the UK. The 2019 National Intellectual Disability trainee conference, held in Cardiff, offered discounted entry for medical students and for foundation and core trainees. Such national events showcase the scope of opportunity within intellectual disability psychiatry and give opportunities for all, including medical students, to contribute posters and presentations, increasing audience participation and interest.

A strength of this survey was its good response rate, at 83%, with full completion of the returned questionnaires. The survey covered multiple geographical regions for both trainees and TPDs. There was one geographical region with no representation from either trainer or trainee. However, the accuracy and generalisability of the findings were limited by the low overall number of participants. The selection of only trainee representatives and TPDs could have led to bias, for example, toward selecting those trainees with a more positive training experience. The personal characteristics of a trainee representative could also cause bias, with such representatives potentially being more engaged and having more awareness of opportunities in their local area. TPDs may offer a better training experience to trainees on placement with them and therefore assume that all other posts in the respective deanery are also positive. Sending the survey out to all trainees was considered; however, when this has been attempted with similar surveys in the past, the response rate has been poor, and data protection requirements led to further complications. It was felt that targeting trainee representatives was likely to lead to a better response rate and a broader picture of training across the UK. The fact that certain regions did not have a response from both trainee and TPD could have biased results, with those regions potentially having empty posts or reflecting areas with more challenging training experiences or less engaged trainers. Broadening the scope of the survey to capture the views of core trainees who did not choose intellectual disability psychiatry, and the reasons why, would be of particular value for future recruitment.

Conclusions

This survey of trainers and trainees across the UK indicates that, overall, intellectual disability trainees are broadly positive about their training and feel supported, with adequate training opportunities. Trainee isolation is a theme that has been highlighted and might be remedied by the improvement of trainee networks. The survey demonstrates that there is scope to continue improving training opportunities, in particular for psychotherapy and research. The opportunity for dual training was popular with the survey cohort; this is a potential key finding in terms of recruitment.

Trainees have provided insight into their reasons for choosing the subspecialty. Hopefully, this will guide improvements in recruitment to this rewarding subspecialty of psychiatry. The survey showed that a key motivator for trainees selecting this specialty was having had a core training placement in intellectual disability. Increasing the availability of such opportunities may not only help to bring people into the subspecialty, but also ensure that all trainees have a good grasp of intellectual disability psychiatry, which is important whatever specialty of psychiatry they ultimately choose. Recruitment to psychiatry is a continuing concern, with current and long-term impact on patient care to be considered. This survey contributes to a much broader picture that needs further research to investigate key motivators and barriers regarding choice of higher training specialties.

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Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2020.68>.

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1.2.24 The effectiveness and cost-effectiveness of integrating mental health services in primary care in low- and middle-income countries: systematic review

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Abstract

Aims and method

This systematic review examines the effectiveness and cost-effectiveness of behavioural health integration into primary healthcare in the management of depression and unhealthy alcohol use in low- and middle-income countries. Following PRISMA guidelines, this review included research that studied patients aged 18 years with unhealthy alcohol use and/or depression of any clinical severity. An exploration of the models of integration was used to characterise a typology of behavioural health integration specific for low- and middle-income countries.

Results

Fifty-eight articles met inclusion criteria. Studies evidenced increased effectiveness of integrated care over treatment as usual for both conditions. The economic evaluations found increased direct health costs but cost-effective estimates. The included studies used six distinct behavioural health integration models.

Clinical implications

Behavioural health integration may yield improved health outcomes, although it may require additional resources. The proposed typology can assist decision-makers to advance the implementation of integrated models.

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Burden of depression and unhealthy alcohol use

Depression and unhealthy alcohol use are worldwide public health problems. Depression is the single most significant contributor to global disability, accounting for 7.5% of all years lived with disability.¹ Unhealthy alcohol use accounts for 5.9% of all global deaths and 5.1% of the entire global burden of disease,² and >80% of this occurs in low- and middle-income countries. Individuals suffering from depression and unhealthy alcohol use are at increased risk for poorer health outcomes from other illnesses, such as tuberculosis, maternal and infant conditions and HIV/AIDS.^{3,4} In low- and middle-income countries, societal impacts related to depression and unhealthy alcohol use can exceed healthcare costs.^{5,6} The affected populations have higher rates of unemployment, reduced job functioning and lower educational attainment.⁷

Despite the existence of cost-effective interventions for these conditions, up to 90% of individuals living with mental illnesses in low- and middle-income countries lack access to care.^{8,9} Moreover, in low- and low-middle-income countries, only 1% of the population with substance use disorders has access to minimally adequate treatment.¹⁰ Factors like low levels of public expenditures, reliance on out-of-pocket payments, preferential funding of hospital-based models of care and significant workforce shortages reduce the availability and accessibility of mental healthcare.^{11–13}

Typology of behavioural health integration in high-income countries

Behavioural health integration into primary care is thought to be an effective way to reduce the treatment gap in resource-constrained settings.¹⁴ Nonetheless, the vast majority of studies assessing the effectiveness of this integration originate in high-income countries. A meta-analysis, including mostly studies from high-income countries, found moderate-quality evidence that brief interventions in primary healthcare can reduce alcohol consumption in unhealthy drinkers compared with minimal or no intervention.¹⁵ Similarly, research studies from high-income countries revealed significantly better outcomes for adults with depression treated with collaborative care management compared with care as usual.^{16,17}

In high-income countries, different integration models have been classified based on the nature and level of coordination between highly specialised providers. Several high-income countries have developed their own classification adapted to their health system, and these typologies are commonly used in research and healthcare management. For example, the United States Substance Abuse and Mental Health Services Administration conceptualised a typology based on the degree of collaboration between primary care and behavioural healthcare specialists.¹⁸ At the most basic level, specialists refer patients to another location (coordinated care). At the intermediate level, providers deliver care at the same site but do not share treatment plans (colocated care). At the highest level of integration, specialists are part of the same team with a unique treatment plan, and the patient experiences a single system (integrated care). Collaborative care management, the most commonly studied integration models in high-income countries,¹⁹ is most often located in this highest level of integration. However, we are unaware of the existence of a typology built specifically for low- and middle-income countries.

Behavioural health integration in low- and middle-income countries

In low- and middle-income countries, researchers have studied task-shifting, often referred as task-sharing, which is the use of non-specialist primary health workers (such as general practitioners or nurses) and lay health workers to deliver mental health interventions and increase the availability of mental healthcare services.^{20–22} A review of evidence found that interventions delivered by lay health workers may increase the number of adults recovering from depression, reduce symptoms for mothers with perinatal depression and decrease the quantity of alcohol consumed by unhealthy drinkers.²³ In another review, Seidman and Atun²⁴ found task-shifting to hold potential for cost-saving and efficiency improvements in health systems in the care of tuberculosis and HIV/AIDS. Evidence for mental health conditions is unclear.²⁴ Both reviews found minimal relevant economic studies.

This systematic review aims to summarise the evidence of effectiveness and economic evaluation of the behavioural health integration of the management of depression and unhealthy alcohol use into primary healthcare in low- and middle-income countries. For the purpose of this review, all types of economic evaluations (such as cost-minimisation, cost–utility, cost–benefit and cost-effectiveness analysis) were included.²⁵ We included all types and levels of severity of depression and unhealthy alcohol use. Additionally, we propose a typology to characterise the models of behavioural health integration in low- and middle-income countries, using the evidence of the experimental studies included in the review. This typology could assist hospital and district managers, programme planners and policy makers in their decisions to improve the availability of mental healthcare services.

This systematic review is part of the formative phase of Project Detection and Integrated Care for Depression and Alcohol Use in Primary Care (DIADA), an implementation research project in Colombia, Peru and Chile, funded by the National Institute of Mental Health. Project DIADA studies technology-enhanced service delivery models for treating comorbid depression and unhealthy alcohol use in primary healthcare in multiple sites in urban and rural Colombia.²⁶

Method

Protocol and registration

We designed this systematic review according to Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines.²⁷ We registered this review in the PROSPERO International Registry of Systematic Reviews (identifier CRD42017057340).

Phase 1: search strategy

This systematic review had five phases. In the first phase, medical librarians developed the search strategy, translating research concepts into controlled subject headings and natural language terms. The search included articles from 1990 to 2017. We chose to start the search at 1990 because before this date few, if any, studies in low- and middle-income countries were utilising behavioural health integration models. The following databases were searched for relevant abstracts: Medline – PubMed (search date 28 April 2017), Web of Science (search date 28 April 2017), PsycINFO (search date 28 April 2017), EMBASE (search date 4 May 2017), Cochrane Central Register of Controlled Trials (search date 28 April 2017) and the World Health Organization’s (WHO) Global Index Medicus (search date 28 April 2017). The search also included relevant conference proceedings, grey literature and review references in related articles (*Table 1*). Abstracts in English, French, Spanish and Portuguese were included based on co-authors’ proficiency in these languages. The search found 8786 abstracts after removing duplicates. Search keywords included, but were not limited to, ‘depression’, ‘alcohol use disorder’, ‘integrated care’ and ‘developing country’. A full list of search terms for all databases searched, including PubMed (Medline), can be found under Supplementary File 1 available at <https://doi.org/10.1192/bjb.2020.35>. *Table 1* Overview of databases searched

Database	Platform	Years covered	Date conducted	No. of results
Medline	PubMed	1990 to current	28 April 2017	2520
EMBASE	Elsevier	1990 to current	4 May 2017	2927
Web of Science	Thomson Reuters	1990 to current	28 April 2017	181
Cochrane Central Register of Controlled Trials	Wiley	1990 to current		

DSR: issue 4, April 2017

Trials: issue 3, March 2017

Methods: issue 3, July 2012

EconEval: issue 2, 201728 April 2017376

(DSR: 31

Trials: 339

Methods: 2

EconEval: 4)WHO Global Index Medicusglobalhealthlibrary.net1990 to current28 April 20171254

(LILACS: 775

WPRIM: 356

IMEMR: 61

IMSEAR: 53

AIM: 9)PsycINFOProQuest1990 to current28 April 20171241Total13 499Total with duplicates removed8786¹

Eligibility criteria

We searched for experimental and non-experimental studies that examined the effectiveness or that performed economic evaluations of the implementation of a behavioural health integration model on the management of depression and unhealthy alcohol use in primary healthcare in low- and middle-income countries. Articles eligible for inclusion were required to meet the following criteria: (a) studies included patients aged 18 years, of any gender and with a diagnosis of alcohol use disorder and/or depression of any severity; (b) studies performed with a population living in low- and middle-income countries as per the World Bank country income classification²⁸ during the year that the study started; (c) studies included patients who received mental health services (in depression and/or alcohol use disorder) in fully or partially integrated primary health services in low- and middle-income countries²⁹ and (d) studies included the integration of pharmacological or psychological interventions, or a combination of both. All study designs were considered. We excluded single-case studies, presentations, abstracts, notes, corrections and studies that did not report effectiveness or economic evaluation outcomes.

Phases 2 and 3: abstract and full-text review

Using previously agreed inclusion criteria, three teams of two researchers per team each independently screened a third of the abstracts and titles (approximately 2918 abstracts). Disputed references (around 11%) were sent to an arbiter who settled the discrepancies. A total of 147 articles (roughly 1.7% of original abstracts) were selected for full-text appraisal of inclusion criteria. In each team in phase 3, one reviewer acted as the primary reviewer, the second reviewer evaluated the work for discrepancies and an arbiter settled the differences. This full-text review identified 58 articles meeting inclusion criteria, 40 of which met study design criteria and provided sufficient statistical data to be included in a subsequent meta-analysis (*Fig. 1*). *Fig. 1* Flow chart of search results.

¹ WHO Global Index Medicus search did not include low- and middle-income countries concept. DSR, Database of Systematic Reviews; EconEval, economic evaluations; WHO, World Health Organization; LILACS, Latin American & Caribbean Health Science Literature; WPRIM, Western Pacific Region Index Medicus; IMEMR, Index Medicus for the Eastern Mediterranean Region; IMSEAR, Index Medicus for the South-East Asian Region; AIM, African Index Medicus.

Phase 4: data extraction

In phase 4, we completed an in-depth data extraction with a previously designed form (*Table 2*). We also completed a standardised assessment of bias of all the included randomised controlled trials, using methods described in the Cochrane Collaboration's tool for assessing risk of bias.³⁰ This assessment of bias included a team of two of the authors independently evaluating the studies across seven categories: random sequence generation, allocation concealment, blinding of participants and personnel, blinding of outcome assessment, incomplete outcome data, selective reporting and other bias. Studies were rated across these categories as having a 'low risk of bias', 'unclear risk of bias' or 'high risk of bias', and all discrepancies on risk classifications were resolved by a third author. *Table 2* Phase 5: list of variables
 Setting of care
 Where does the screening take place?
 Where does the intervention occur?
 Where does the follow-up take place?
 Human resources
 Who screens?
 Who delivers the clinical intervention?
 Who prescribes?
 Who provides additional services?
 How is supervision done?
 Who refers the patient?
 Who receives the referral?
 Who pays the salaries of the intervention team?
 How is the intervention team paid?
 Who provides training?
 Who receives training?
 Interventions
 Description of the intervention
 Description of the training
 What is the relation between the clinical intervention team and the PHC?
 Elements of the collaborative care management model
 Presence of care managers
 Role of care managers in symptom assessment
 Role of care managers in monitoring treatment adherence
 Composition of multidisciplinary teams
 Existence of patient education programmes
 What is the role of patient data in the care of the patient?²

Phase 5: patterns in the organisation of care of behavioural health integration models

During phase 4, we noticed patterns in the reorganisation of care that enabled the delivery of integrated mental health interventions in the treatment arms. We used the 2018 Joint Commission Ambulatory Accreditation Quality of Care Standards to assess the dimensions of quality of care involved in these reorganisations of care.³¹ We updated the data extraction form used in phase 4, adding variables related to organisation of care, and reviewed all articles once again (*Table 2*). We extracted data by structural coding. During phases 4 and 5, one researcher (L.C.) extracted these data, with a second reviewer (S.B.) assessing the data for discrepancies. An arbiter resolved any differences that the researchers found.

Results

Description of the included studies

The 58 included publications corresponded to 53 unique studies assessing the effectiveness or performing an economic evaluation of behavioural health integration in 19 low- and middle-income countries. Of the 58 articles, 20 took place in a rural setting, 3 took place in semi-urban settings, 23 took place in urban settings, 7 took place in both rural and urban settings, and the settings of the remaining 5 are unclear or unable to be categorised. The vast majority of the studies introduced interventions in primary healthcare, although some interventions were introduced in communities, over the phone or in public hospitals. Of the 55 articles for which this categorisation applies, 22 articles studied only women, 3 studied only men and 30 studied both women and men. Eleven articles came from low-income countries, 19 articles came from lower-middle income countries and 28 articles came from upper-middle income countries. Based on the WHO regional grouping classification,³² 22 articles came from Africa, 15 articles came from the Americas, 13 articles came from Southeast Asia, 8 articles came from the Eastern Mediterranean region and 2 articles came from the Western Pacific region. Two studies counted for both India and Pakistan, which are classified in two different WHO regions (*Supplementary Table 1*).

We found that of the 58 total articles, 46 focused on depression, 9 focused on unhealthy alcohol use and 3 focused on both illnesses. Further, 49 assessed the effectiveness of integration models, 6 performed economic evaluations, 2 performed both assessments and 1 presented a descriptive analysis. Of the 51 publications reporting effectiveness data (8 reported economic evaluation data), 40 focused on depression, 9 focused on alcohol use and 2 presented data related

² PHC, primary health center.

to both conditions. These 51 publications also varied in study design: 36 studies were randomised controlled trials, 7 were quasi-experimental studies and 8 were observational studies.

We found a high risk of selection bias among our studies, owing to a lack of blinding of ‘participants and personnel’; more than 75% of our studies had a ‘high risk’ of this type of bias. This finding was not surprising given the nature of the mental health interventions, for many of which it was not possible to blind the study participants. The effect on the evidence quality is low since the authors used standardised and objective methods for outcome measurement (*Fig. 2*). *Fig. 2* Consolidated risk of bias graph.

Results of the effectiveness studies

Depression

Forty-two articles presented effectiveness data on depression care (Supplementary Table 1). The most frequently studied primary outcome was severity of depression. The treatment arm usually received a psychological intervention like cognitive-behavioural therapy, problem-solving therapy, psychoeducation or interpersonal therapy, whereas the care for the control arm was enhanced with screening only. Thirty-six articles reported that the integration groups had a greater reduction in depression severity than the control groups. Of these 36 articles, 5 articles reported effect size. Overall, differences between arms sustained through secondary follow-ups ranged from 3 months to 36 months post-intervention. Three of the articles that found no difference between the control and treatment groups offered only a general training on mental healthcare to their lay or primary healthcare workers expecting to change their clinical behaviours.^{33–35} Two other publications lacking positive findings selected primary outcomes highly susceptible to confounding.^{36,37} In India, Pradeep et al³⁸ sought to improve treatment-seeking behaviours and adherence to antidepressant medications by enhancing usual care. In Iran, Malakouti et al³⁹ sought to reduce the number of suicides. In Pakistan, Husain et al⁴⁰ compared the effectiveness of psychotherapy to antidepressant medications in reducing depression and improving quality of life. This group compared two integrated interventions without contrasting it to usual care and found no difference between these two arms.

Alcohol use

Eleven articles reported effectiveness data related to unhealthy alcohol use.^{41–51} All 11 used a reduction in alcohol consumption as their primary outcome. Ten of these articles were randomised controlled trials (Supplementary Table 1). Of these, five favoured the intervention arm,^{41,42,45,48,50} five did not show differences between arms or after the intervention^{43,44,46,49,51} and one had unclear results.⁴⁷ For the studies that favoured the intervention arm, only one paper reported effect size ($d = 0.95$).⁵² For most studies, secondary follow-ups showed that statistically significant differences sustained over 3 months to 12 months post-intervention. The two most commonly delivered interventions were screening followed by brief intervention or by motivational interviewing. In Thailand, Noknoy et al,⁴¹ and in South Africa, Rendall-Mkose et al,⁴⁸ found that motivational interviewing arms produced better outcomes than enhanced usual care in improving patient outcomes. In Kenya, L’Engle et al⁴⁵ found that screening and a brief intervention can reduce self-reported alcohol consumption among female sex workers at risk for HIV. In South Africa, Mertens et al⁴⁴ found that patients receiving brief intervention had significantly reduced Alcohol, Smoking and Substance Involvement Screening Test scores. However, in South Africa, Peltzer et al,⁴⁶ and in Thailand, Assanangkornchai et al,⁵¹ found no difference between brief intervention and simple advice as both arms similarly reduced alcohol consumption. Similarly, in South Africa, Sorsdahl and Petersen,⁴⁹ in an uncontrolled before-and-after study, did not find a significant decrease in alcohol use in pregnant women following a brief intervention.

In Kenya, Papas et al⁵⁰ found effectiveness of cognitive-behavioural therapy over treatment as usual in reducing use and attaining abstinence in patients living with HIV. In India, Nadkarni et al⁴² developed a novel and culturally adapted psychotherapy for unhealthy alcohol use delivered by lay health workers, called counselling for alcohol problems. Patients receiving counselling for alcohol problems showed higher remission rates and higher proportion of alcohol-free days than individuals receiving enhanced usual care.

Results of the economic evaluation studies

We identified eight studies performing economic evaluations (Supplementary Table 1). These studies were conducted in Chile, India, Mexico, Nigeria and Pakistan. Six of these studies assessed interventions related to depression,^{52–57} one study evaluated interventions related to alcohol use⁴² and one publication evaluated both conditions.⁵⁸ Four of these studies used a healthcare perspective in their economic analysis,^{52,56–58} two used a societal perspective^{54,55} and two used both perspectives.^{42,53} In economic analysis, a healthcare perspective includes all costs and benefits directly affecting patients, providers and payers.²⁵ Conversely, a societal perspective takes a broader approach to include healthcare plus other private and public benefits and costs related to a given condition. Concerning the type of economic analysis, five studies performed a cost-effectiveness analysis,^{52,55–58} two completed a cost-utility analysis^{42,53} and one study performed both types of economic analysis.⁵⁴ Three studies used modelling techniques^{52,57,58} and five studies used experimental data from effectiveness trials.^{42,53–56}

Two of the articles using modelling techniques^{52,58} utilised the sectoral approach to cost-effectiveness analysis developed by the WHO's 'Choosing Interventions that are Cost-Effective' initiative.⁵⁹ These studies found that a combined intervention of medications and therapy plus proactive case management yielded the highest effectiveness among the alternative options. In a study in Nigeria, Gureje et al⁵⁸ found that a combination of tricyclic antidepressants, psychotherapy and proactive case management had the highest cost-effectiveness ratio, closely followed by tricyclic antidepressants only (approximately 0.5% less cost-effective). In Mexico, Del Carmen et al⁵² found that a medication-only intervention was the most cost-effective, followed by a combination of medication, psychotherapy and proactive case management (approximately 10.5% less cost-effective).

From a healthcare perspective, the economic analyses of the experimental studies showed that the intervention arms had increased effectiveness and costs.^{42,53,54,56} The increased direct costs were associated with increased utilisation of healthcare personnel and medications. These interventions were deemed cost-effective based on the acceptability threshold and commonly accepted values for cost-effectiveness. Using a Markov model, in Chile, Siskind et al⁵⁷ modeled the cost-effectiveness of a stepped-up care intervention throughout the lifetimes of a cohort of Chilean adult females. This study also evidenced increased direct healthcare costs, but found integration to be very cost-effective.

Notably, from a societal perspective, these interventions were found to reduce costs, usually associated with decreased time costs to patients and families, as well as fewer productivity losses.

Models of behavioural health integration

The control arm of the experimental studies included in this review used treatment as usual (minimal or no services) or enhanced usual care. In contrast, to integrate mental healthcare, the treatment arms redesigned their care by selecting at least one of the seven strategic intervention options (*Table 3*). Each strategic intervention option represents a discrete active enhancement to the primary healthcare affecting workforce capacity, information management or daily flow of care.³¹ The behavioural health integration models tested in the research are made up of one or more strategic intervention options. Furthermore, the treatment arms of the 53 studies included in this secondary analysis clustered around 6 of these integration models (*Table 4*). We were unable to include five studies in this secondary analysis: two owing to paucity of data^{55,60} and three owing to use of modelling methods for economic evaluation that did not study any specific behavioural health integration model.^{52,57,58}

Strategic intervention options	Description	Joint Commission standard of ambulatory quality of care (standard label)
1	General training on mental healthcare for lay and primary healthcare workers	Human resources (H.R. 01.05.03)
2	Specific training on mental healthcare skills and interventions for lay and primary healthcare workers	Human resources (H.R. 01.05.03)
3	Addition of dedicated lay or primary healthcare workers to provide mental health services	Human resources (H.R. 01.06.01)
4	Addition of specific mental healthcare tasks to existing lay or primary healthcare workers	Human resources (H.R. 01.05.03)
5	Increased coordination between lay or primary healthcare workers with mental health workers	Provision of care (P.C. 02.01.01)
6	Strategic data management to improve patient outcomes	Provision of care (P.C. 02.01.05)
7	Utilisation of care manager or care coordinator	Provision of care (P.C. 02.01.01)

Information management (I.M. 02.02.01)

Provision of care (P.C. 02.01.05) Table 4 Summary of the integration models and the organisational strategic options used in each model

Strategic intervention options	1	2	3	4	5	6	Models of behavioural health integration	General training on mental healthcare for lay and primary healthcare workers	Specific training on mental healthcare skills and interventions for lay and primary healthcare workers	Addition of dedicated lay or primary healthcare workers to provide mental health services	Addition of specific mental healthcare tasks to existing lay or primary healthcare workers	Increased coordination between lay or primary healthcare workers with mental health workers	Strategic data management to improve patient outcomes	Utilisation of care manager or care coordinator	Type of healthcare workers involved in the model	
1. General training on mental healthcare for lay health workers and primary health workers	Yes	No	No	No	No	No	LHW, PHW,	2. Mental healthcare interventions delivered by lay health workers	Yes	Yes	Not essential but could be added	Not essential but could be added	No	No	No	LHW
3. Mental healthcare interventions delivered by primary healthcare workers	Yes	Yes	Not essential but could be added	Not essential but could be added	No	No	LHW, PHW,	4. Consultation liaison	Not essential but could be added	No	No	Yes	Yes	No	No	LHW, PHW, MHW
5. Stepped care	Yes	Yes	Not essential but could be added	Yes	Yes	Yes	No	LHW, PHW, MHW	6. Collaborative care	Yes	Yes	Yes	Yes	Yes	Yes	LHW, PHW, MHW, care coordinator ³

Models 1–3 rely on building the capacity of non-specialist health workers in primary care, and they represent different task-sharing models. These models heavily depend on organisational strategic intervention options 1–4. Unlike models 4–6, the first three models do not depend on increased coordination between primary health workers, or between the primary healthcare site and other healthcare organisations. There are also minimal modifications in the daily flow of care. Starting in model 4, these integration models increasingly require collaboration and information flows across multidisciplinary teams. Patient-level data is strategically used to improve the care of patients in models 5 and 6.

Model 1: general training on mental healthcare for lay health workers and primary health workers

Seven studies met the criteria for model 1. This model utilises strategic intervention option 1. In this model, following training only, lay or primary healthcare workers (general physicians and nurses) are expected to have an increased ability to diagnose and treat mental health conditions adequately. For example, a study in Colombia⁶¹ compared the diagnostic accuracy and effectiveness of general physicians who had received formal training on mental healthcare to that of similar general physicians who did not. The study found that patients in the intervention arm received better treatment, had increased rates of retention and had lower depression scores than the control arm.

Model 2: mental healthcare interventions delivered by lay health workers

Twenty studies met the criteria for model 2. In addition to general training (strategic intervention option 1), lay health workers also receive specific training, ranging from a few days to 2 weeks (strategic intervention option 2), that prepares them to deliver targeted interventions, such as screening, problem-solving or interpersonal therapy. This model requires that the primary healthcare site either hires new lay health workers (strategic intervention option 3) or reassigns those currently delivering other services (strategic intervention option 4). This model may benefit from having primary health workers (general physicians or nurses) perform supervisory functions. Using this model, a study in rural South Africa⁶² compared the effectiveness of a 12-week course of interpersonal therapy delivered by lay health workers to enhanced care in the reduction of depression among low-income women. Patients in the intervention arm showed a significant decrease in depression symptoms upon completion of the 12-week course.

³

Those strategic options deemed essential for each model are marked with a 'Yes' sign. LHW, lay health worker; PHW, primary health worker; MHW, mental health worker.

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Model 3: mental healthcare interventions delivered by primary health workers

Eleven studies met the criteria for model 3. This model uses strategic intervention options 1 and 2 plus either strategic intervention option 3 or 4. This model often uses flow of care modifications to carve out dedicated time for the primary health workers. A study in rural Thailand⁴¹ compared the effectiveness of nurse-delivered brief interventions versus treatment as usual (e.g. no brief intervention) in the reduction of alcohol consumption among low-income males. Patients in the intervention arm reported a more substantial decrease in drinks per drinking day and frequency of unhealthy drinking assessed 6 months after the intervention.

Model 4: consultant liaison

One study met the criteria for model 4. This model offers the primary health worker access to onsite or telemedicine consultation services from a mental health worker such as psychologists or psychiatrists (strategic intervention option 5), although the primary health worker continues to be the main provider. Consultation services include education, problem-solving and feedback to the primary health worker regarding diagnostic or treatment strategies.^{63,64} Strategic intervention option 5 is essential in this model. A study in Chile³⁶ compared the effectiveness of treatment delivered by general physicians with access to online psychiatric consultation services with that of those without access to this support in the management of urban women diagnosed with depression. Patients in the intervention arm had a statistically significant reduction in their depression scores compared with those in the control arm at 3 months of the intervention.

Model 5: stepped care

Eight studies met the criteria for model 5. This model provides a structured way to match treatment intensity with the patient's needs.⁶⁵ More complicated patients are cared for by a mental health worker (strategic intervention option 5), whereas more straightforward cases remain under the care of the primary health worker (strategic intervention option 4). Some studies used lay health workers, creating a three-level stepped care model (strategic intervention option 3). This model distinctively uses a set of clinical criteria and a pathway of care to systematically step up or step down each case. Thus, this model adds outcome tracking to inform the level of care provided to a patient (strategic intervention option 6). A post-rollout evaluation in Iran³⁹ assessed the effectiveness of a suicide prevention strategy for adults with depression. In this programme, a lay health worker reached out to patients to screen them for depression and referred positive cases to a primary health worker for management and stabilisation. In turn, the primary health worker referred refractory cases to psychiatrists who delivered specialised services.

Model 6: collaborative care management

Six studies met the criteria for model 6. There is variation in the literature regarding the components of collaborative care management, and there are different levels of complexity within collaborative care management itself.⁶⁶ For this systematic review, strategic intervention options 6 and 7 are considered critical. Other collaborative care management elements, such as linkage to community resources, patient self-management support, regular case consultation from a psychiatrist, provider decision support and healthcare organisation support, could also be present.

In China, a study⁶⁷ compared the effectiveness of two modalities of depression treatment for adults aged 60 years. In the intervention arm, general physicians (strategic intervention option 4), primary care nurses serving as care managers (strategic intervention option 7), and psychiatrists (strategic intervention options 5) comprised the treatment team. General physicians received written guidelines for the treatment of depression, as well as in-depth training in the prescription of antidepressants and the appropriate use of referrals to the psychiatrist (strategic intervention options 1–3). Nurses acting as care managers provided psychoeducation to patients and families, assistance with communication between patients and providers, and support for the patient's adherence to treatment. A study psychiatrist was made available in case of referrals. General physicians in the control arm only received written guidelines for depression

treatment, patients' PHQ-9 scores and major depression diagnoses from the screening stage. Patients in the intervention arm experienced significantly greater reductions in Hamilton Rating Scale for Depression scores than those in the control arm.

Discussion

Overview

The findings of this systematic review support the effectiveness of different models of integrating depression and unhealthy alcohol use care in primary healthcare in low- and middle-income countries. Patients receiving treatment in the integrated models tend to have better outcomes compared with those receiving regular care. The evidence appears more robust for depression than for unhealthy alcohol use. The economic analyses indicate that integrated models have higher direct costs to primary health, and that from the healthcare perspective, these models are cost-effective. It is also possible that behavioural health integration saves costs to society by increasing productivity and decreasing time losses, among other benefits. The typology proposed in this article can improve the understanding of the different models of behavioural health integration in low- and middle-income countries. This information can be valuable for policy makers and hospital managers responsible for the organisation and delivery of care. Additional implementation studies are required to further characterise the different models of integration and to understand better the conditions needed for the implementation of each of them.

Increased effectiveness across different settings and populations

The studies included in this review showed that integrated models can improve patient outcomes in different subtypes of depression such as perinatal depression, late-in-life depression, comorbid depression and HIV, and depression associated with trauma disorders in war-affected areas.^{68,69} Previous research shows that some psychological treatments can be as effective as antidepressant medications, with higher retention rates and better continuing outcomes.^{70,71} We found that different psychotherapies can be effectively delivered by an array of integration models. These can be more culturally adaptable,⁷² and possibly less stigmatising than medication-based treatments. They can also be potentially scalable in low- and middle-income countries contexts where community bonding is strong, labour is more available and procurement and distribution chains for pharmaceuticals are precarious.

This systematic review suggests that integration of care for unhealthy alcohol use might produce better outcomes for the general population, pregnant women and people living with HIV in low- and middle-income countries. The control arm of seven included trials compared screening and minimal psychoeducation to screening and brief intervention or motivational interviewing offered in the intervention arms.^{41-44,46,48,51} The enhancement of the control arms could account for the non-positive results, particularly in settings where neither screening nor minimal psychoeducation is routinely offered in primary healthcare. There is evidence that screening alone can affect the patients' behaviours, which could explain the lack of difference between arms in some studies.⁷³ Kaner et al¹⁵ found that screening and brief interventions can reduce alcohol consumption in hazardous and harmful drinkers compared with minimal or no interventions in primary healthcare in high-income countries. Although the findings of the articles included in this review are similar to those in high-income countries, we found few studies targeting unhealthy alcohol use that fulfilled our selection criteria, which may affect the generalisability of our findings. More research in the adequate care of unhealthy alcohol use in low- and middle-income countries is needed.

Increased funding is a necessary, but not sufficient condition to increase access to care

The economic evaluations included in this review indicate that integrated models may result in increased direct costs to primary health, stemming from increased utilisation of personnel and medications. Nevertheless, they may save costs to society.^{42,53,57} These findings are similar to those found in high-income countries.⁷⁴ Given the low levels of spending on mental healthcare in many low- and middle-income countries,¹¹ where the vast majority of primary healthcare sites do not provide access to mental health services, the finding that increasing the availability of mental health services increases direct costs should not surprise. Since low- and middle-income countries favour funding of mental health hospitals,¹¹ new resources should be earmarked to sustain behavioural health integration in primary care. Moreover, the way in which the health system pays or transfers funds to primary healthcare should also be carefully examined. Health economics literature has extensively shown that these payment mechanisms are key determinants of providers' behaviours.⁷⁵ The most commonly used payment mechanisms in many low- and middle-income countries are out-of-pocket, capitation and historically determined allocations;⁷⁶ however, since they are not explicitly linked to outputs or outcomes, they do not provide adequate incentives to increase the availability of integrated services. Recent research in high-income countries has studied the development of new payment mechanisms to promote increased integration and coordination of care for populations with multiple chronic comorbidities.^{77,78} Additional research is needed to specifically adapt payment mechanisms to offset the increased direct costs related to behavioural health integration, thus encouraging primary care in low- and middle-income countries to increase the availability of services.⁷⁵ Importantly, public and private providers may respond differently to these incentives, as evidenced in several studies included in this review where integration models affected patient outcomes in public, but not in private organisations.^{79,80}

Typology of integration for low- and middle-income countries: a tool for decision makers

The reviewed studies tested a variety of models of integrated care for depression and unhealthy alcohol use. We offer a typology of the models in *Table 4* and show how they are built from one or more of seven organisational strategic intervention options. The typology aims to assist decision makers in selecting the models that are likely to work over time in their setting. The strategic intervention options, and the models that flow from them, are not hierarchical but do vary in terms of cost, complexity and how much organisational capacity they require to implement and sustain. Decision makers can choose models that match the characteristics and capacity of their health system and primary healthcare. An appealing complex model may not be the right choice if it is too expensive or requires too much change from the workforce to be implemented or sustained.⁸¹ An integration model that fits well with current programmes and available resources might have a greater effect over time. Since complex strategic intervention options require more resources to implement and sustain, they are more likely to be chosen in higher income nations. Decision makers must consider effectiveness, acceptability, sustainability and scalability in choosing a model to meet their system's needs.

Limitations

This review has several limitations. Some of the studies included in this review were not rigorously designed trials and did not have adequate comparison conditions. For example, some of the studies were post-rollout evaluations and other were pragmatic or quasi-experimental trials. This review focused on the care of depression and alcohol use disorder. Therefore, our findings may not be generalisable to other mental or substance use disorders. Similarly, we excluded studies assessing the effectiveness of psychological interventions for these two conditions in low- and middle-income countries when they did not reflect the integration of these treatments into existing primary healthcare settings. Nonetheless, this systematic review offers important insights into the value and implementation of integrated models in global mental healthcare.

Implications for the global mental health policy field

The findings of this review build on a wealth of knowledge strongly supporting the value of integrating mental healthcare into primary care.^{77,78} The next generation of research should aim to understand the arrangements at the system and organisational levels necessary to scale up integrated models in low- and middle-income countries and to promote the delivery of quality healthcare. In particular, we need to strengthen the instruments used to measure the quality of integration in low- and middle-income countries. Similarly, understanding the reasons underpinning the rampant mental health workforce shortage is critical because behavioural health integration heavily relies on existing and newly available workforce. To a certain degree, a combination of additional funds and targeted payment mechanisms can provide the right incentives to overcome some of these implementation challenges and to sustain quality of mental healthcare. Further research related to payment mechanisms in primary care in low- and middle-income countries is therefore critically needed.

The global mental health field can learn from other successful global health movements. Efforts to address HIV, reduce child mortality and improve maternal health were able to permeate political spaces and become global health priorities, channelling substantive resources, some of which have been used to integrate these services into primary care. At the national level, the experiences of Chile and Zimbabwe where research studies influenced the governments to expand publicly funded mental healthcare programmes can illustrate processes that occupied the political agenda and affected public policy.^{82,83} Furthering our understanding of the operation of behavioural health integration into primary care and bettering our ability to scale up these integrated models can help close the treatment gap and raise the quality of mental care in low- and middle-income settings.

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Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2020.35>.

[click here to view supplementary material](#)

L.C. collaborated in the literature search, compiled the tables and figures, and wrote the first draft. L.C., J.N., W.C.T., C.G.-R. and J.M.U.-R. outlined the aims and purpose of this review and reviewed the search criteria, studies for inclusion and preliminary data tables. L.C., S.M.B., D.T.J. and L.A.M. reviewed the study protocol and final list of included studies. L.C., S.M.B., W.C.T., J.M.U.-R., C.G.-R., J.N., M.J.W., S.C.D. and D.T.J. completed data extraction, arbitered and constructed the tables. L.C., S.M.B., C.G.-R., M.J.W., M.C. and D.T.J. reviewed the study protocol, list of included studies and the data included in the summary tables. All authors contributed to the revision of the typology of integration models. All authors contributed to the revision of multiple drafts. All authors reviewed the final list of included studies, contributed to the structure and ideas presented in this manuscript, and reviewed and approved the final version. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit.

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1.2.25 Follow the money: how is medical school teaching funded?

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Abstract

Growing student numbers are producing greater demand for teaching, and resources allocated for education are being placed under increasing strain. The need for more student clinical placements and more clinician teaching time is expanding. Psychiatrists have successfully drawn attention to the importance of parity between mental and physical illness. We now have a responsibility to ensure enhanced opportunities to teach psychiatry to our medical students. This is set against a background of an increasing number of psychiatry consultants leaving the profession and an already stretched National Health Service environment. Many consultants contribute to teaching but do not have this activity included in their job plans. Although clinics and clinical meetings are inevitably slower when students are present, there is often no backfill provided. As outlined below, trusts receive substantial funding to cover costs related to the teaching of medical students, but most of us don't know what actually happens to this money. Here, we discuss how teaching is currently funded and make recommendations regarding improving accountability.

Contents

- *Follow the money: how is medical school teaching funded?*
 - *Who funds undergraduate teaching?*

- *How are placements funded?*
 - *What is included in the tariff?*
 - *What is the tariff worth (for a year's worth of placements)?*
 - *Where does all the money go and how is it regulated?*
 - *That was over 10 years ago. Have things moved on?*
 - *That's England; what about the rest of the UK?*
 - *Conclusion: use it or lose it!*
 - *Addendum in the time of COVID-19*
 - *Declaration of Interest*
- * *Supplementary material*

As increasing student numbers cause greater demand for teaching, clinicians may struggle to meet the conflicting pressures on their time. This is against a background of an increasing number of psychiatry consultants leaving the profession and an already stretched National Health Service (NHS) environment.

Many consultants who contribute to teaching do not have this activity included in their job plans. Clinics and clinical meetings are inevitably slower when students are present, but there is often no backfill provided. The psychiatry recruitment crisis has been successfully challenged by the Choose Psychiatry campaign;¹ however, to sustain this and encourage retention, jobs need to be manageable and stimulating with contributions to education adequately recognised.

Trusts receive substantial funding to cover teaching medical students, but most of us don't know what actually happens to this money.

In the 1970's film *All the President's Men*, 'follow the money' was the catchphrase, suggesting that the way to shine a light on questionable dealing is to follow financial transfers. Although we are not suggesting that the allocation of funding for medical student education is as questionable, systems for funding education are mostly opaque and surprisingly poorly understood.

So, for those who would like to increase their understanding, we offer some answers to the most frequently asked questions.

Who funds undergraduate teaching?

The world of medical education is nothing if not acronym heavy (*Box 1*). Health Education England (HEE) was established in the *Health and Social Care Act 2012* as a special health authority within the Department of Health. It is a non-departmental public body which supports the delivery of education, training and development of the NHS health and public health workforce.² It provides oversight of strategic planning and development of the health and public health workforce, and allocates (and accounts for) funding for education and training resources on behalf of the Department of Health and Social Care (DHSC). **Box 1** Educational Bodies
HEE Higher Education England An executive body of the Department of Health. It provides coordination for education and training within the health and public health workforce in England.
LETBE Local Education and Training Board Statutory regional committees of HEE, responsible for workforce planning, and education and training.
OFS Office for Students Regulator established in January 2018. It merged HEFCE and OFFA, and inherited their responsibilities, also taking charge of the granting of degree-awarding powers and university titles.
SIFT (now undergraduate medical tariff) Service Increment for Teaching NHS levy that was given out as extra funds to NHS institutions that participate in training undergraduate students
OFFA Office for Fair Access Safeguarded and promoted fair access to higher education by approving and monitoring access agreements
HEFCE Higher Education Funding Council for England Distributed public money for teaching and research to universities and colleges.

From April 2018, the Office for Students (OFS) became the regulatory body for higher education in the UK, bringing together the functions of the Higher Education Funding Council for England (HEFCE), the Office for Fair Access, the

Department for Education and the Privy Council in a single organisation.

Undergraduate medical training is essentially funded in England and Wales by: •DHSC (via HEE) – for clinical placement costs, more for the final years;•OFS – this is because medicine counts as a ‘high cost’ course as opposed to, for example, many arts courses;³•tuition fees paid by the students.

The OFS gives each university a grant based on the number of medical students at their institution. The numbers of students that universities can admit are regulated by the OFS and controlled through its intake targets.

How are placements funded?

The money from HEE is now known as the undergraduate medical tariff or ‘the tariff’ (formerly and often still in fact known by professionals as SIFT (Service Increment for Teaching)). The tariff, set by the Secretary of State for Health, is not a direct payment for teaching but is supposed to cover the additional costs incurred by trusts and other placement providers in delivering medical student teaching.

The money is paid directly to the trusts by HEE, and the amount is based on student numbers that are provided by the university (but not on quality of teaching). So, although the universities are responsible for monitoring the quality of their students’ clinical placements, they have little influence on how the tariff funds are disbursed at trust level. The universities do liaise directly with trusts to determine the number of placements offered and monitor the quality of the teaching provided at those placements. If quality standards are not met by the trusts, the university can in theory withdraw those placements and, consequently, the funding that goes with them. However, for many universities there are no alternative trusts that they can approach. The overall training activity provided by trusts, including that for medical students and doctors in training, is governed by individual learning development agreements between trusts and HEE, which list all education, training and learning activities commissioned by HEE.

Increasingly, patients are cared for in primary care, or by third sector or independent providers. This can lead to practical challenges such as enabling patient contact in patients’ homes. Undergraduate education is rarely considered at the commissioning level, so many providers can decide whether or not to participate in teaching; this adds another level of complexity to the university’s obligation to monitor the quality of teaching, as well as the practical difficulties of securing placements.

What is included in the tariff?

The tariff for undergraduate medical placements was introduced in 2013–2014. Tariffs are adjusted by a market forces factor to compensate for the differences in cost of providing training placements in different parts of the country.

The tariff covers funding for all direct costs involved in delivering education and training, and the list provided by the government is comprehensive:⁴ •direct staff teaching time within a clinical placement;•teaching and student facilities, including access to library services;•administration costs;•infrastructure costs;•pastoral and supervisory support;•trainee study leave and time for clinical exams;•health and well-being (excluding any occupational health assessments);•course fees and expenses (as required to achieve professional registration);•student/trainee accommodation costs;•in-course feedback and assessment;•formal examining;•staff training and development relating to their educational role.

What is the tariff worth (for a year's worth of placements)?

In 2019–2020, a non-medical tariff (for an allied health professional (AHP)) is set at £3720, the medical postgraduate tariff is £11 418 and a medical undergraduate tariff is £33 286.

In summary, in England, teaching one medical student in the clinical years is currently supported by:⁵ •the OFS teaching grant – £1500 per student for the non-clinical years and £10 000 per student during the clinical years (depending on holiday entitlement at different schools, this is about £250 per week for the clinical years); •placement tariff – healthcare providers receive an average tariff of around £36 000 to provide a year's worth of placements to students in the clinical years; •tuition fees – £9250 per year for all years.

AHPs are a core part of the NHS people plan,⁶ and traditional 'medical' tasks and roles are increasingly being taken on by physician associates, advanced nurse associates, nurse prescribers and other AHPs. Although this is welcomed, with many doctors recognising the necessity in terms of long-term workload reduction, in the immediate term, doctors are increasingly asked to teach and supervise AHPs despite the non-medical tariff being substantially lower.

Where does all the money go and how is it regulated?

In 2007, the British Medical Association investigated the use of the tariff (or SIFT, as it was then known) using the Freedom of Information Act. Of the 33 trusts contacted, 23 either did not respond, did not know or did not detail how the money was spent. From the ten trusts that did respond, the most frequent response was that funding had historically been incorporated into their baseline budgets, and its use was therefore not recorded separately. As one trust responded (Orwell would be impressed), 'this income . . . constitutes part of the totality of the Trust's income base and therefore is embedded within the totality of the Trust's expenditure'. Only seven of the 23 trusts could give any information about consultant teaching time, and this tended to consist of a statement that consultants nominally have one PA per week allocated for teaching.⁷

That was over 10 years ago. Have things moved on?

There has been some progress in that most medical schools have developed a 'minimum teaching standards' document that they use as a shared document between them and trusts. New medical schools have had to start this process from scratch and work with their trusts to provide clear explanations of where and how the money is spent. Tariff funding is still often absorbed into trusts' finances, but increasingly trusts are being asked to demonstrate where the money is actually going.

That's England; what about the rest of the UK?

Medical universities in Scotland, Wales and Northern Ireland are funded by the devolved governments in very similar ways to HEFCE, although the fee element of their income varies from no fees (Scotland) to lower fees (Wales) to the same as England (Northern Ireland).

Funding for medical education to the medical universities comes from the higher education budget and then goes to the NHS institutions through an equivalent of the tariff. The scheme in Wales is still named SIFT-W (for Wales); in Scotland, it is the ACT (Additional Costs of Teaching); and the Supplement for Undergraduate Medical and Dental Education (SUMDE) in Northern Ireland.⁸

Conclusion: use it or lose it!

The level of scrutiny regarding this teaching funding currently only goes in one direction. We believe that trusts need to wake up to the fact that if they are being paid for providing teaching to students, they need to be able to demonstrate this in a transparent way. In *All the President's Men*, the assiduous undercover reporters expose Watergate, leading to the downfall of the president of the USA. Following the money when it comes to trust teaching tariffs is likely to show that the funding is generally poorly accounted for and monitored, rather than deliberately diverted. However, in the current financial climate, trusts are unlikely to continue getting these large amounts of money unless they can demonstrate that funds are going where they are meant to go, and where they say they are going, and that the teaching provided is of at least an adequate standard. In the coming year, HEE will be formally gathering information from trusts on how money is being spent, and many trusts are likely to be unprepared. Effective and clear job planning is probably the most obvious way to demonstrate that the funding is going towards the most expensive and essential resource: clinician time. This needs to be evidenced and protected.

With the current workforce challenges, alternatives to consultant teaching should also be considered, and medical students also need teaching and experience of working in a multidisciplinary team. Clinical teaching fellows are higher trainees funded by the tariff, with protected teaching time in their week (typically around 60%), and anecdotally they make a big difference to student experience. AHPs too can usefully support medical student teaching. The use of simulation training and involvement of expert patients, as well as buying sessions for students to attend specialist clinics in other sectors, may also represent good ways of spending the money available.

There is no doubt that by continuing to 'follow the money' we can also improve and track where these precious resources are being used to train safe and competent doctors with the necessary skills to look after our patients' complex needs in the future.

Addendum in the time of COVID-19

We originally wrote this piece in the now seemingly distant days before the COVID-19 pandemic. The points we made in the conclusion are now even more relevant. New problems arise as we are forced into a situation where the necessary teaching of basic psychiatry skills must be accomplished without students being able to attend hospitals and clinics to get direct clinical experience in psychiatry. Also, these students will be qualifying as doctors at a time when there will be even greater needs for the skills necessary to deal with the epidemic of mental illness that will follow COVID-19. It is therefore essential to accelerate our efforts in developing alternative ways of teaching, but this is a time when consultants and their teams have even greater pressure on their 'time to teach' as they prioritise new clinical commitments that arise from the COVID-19 pandemic.

The use of digital technologies can no doubt play an increasingly valuable role in teaching. However, distance learning alone will not be adequate; this is a time when the input of all our clinical colleagues remains vital. Students are not currently on clinical placements and their dates of return are uncertain. However, the tariff continues to be paid to Trusts and they should not lose sight of their responsibility for active involvement in creatively addressing educational and training needs. In particular, the mental health risks of their patients will persist and be even greater after COVID-19. These will be further exacerbated if we allow our students to leave medical school with inadequate training in psychiatry.

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Both authors participated in the writing of this paper and saw the final version. Both meet the criteria for authorship.

Declaration of Interest

None.

Supplementary material

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1.2.26 Patients with young-onset dementia in an older people's mental health service

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Abstract

Aims and method

Currently, no separate service exists for patients with young-onset dementia in Cambridgeshire. These patients are managed together with late-onset dementia patients within old age psychiatry services. To inform service design, we sought to characterise young-onset dementia patients in our population. We first analysed service-level data and supplemented this with a detailed case review of 90 patients.

Results

Young-onset dementia remains a relatively rare condition. Only a small proportion of those referred for assessment receive a diagnosis of dementia. Data collected on presenting complaints, comorbidities, medication and Health of the Nation Outcome Scales scores associated young-onset dementia with a greater incidence of depression than late-onset dementia. Outcomes in the two groups did not appear to differ.

Clinical implications

The data presented here do not suggest a need to create a separate service. Practitioners should be aware of the increased incidence of depression observed in this group.

Contents

- *Patients with young-onset dementia in an older people's mental health service*
 - *Methods*
 - *Results*
 - *Discussion*
 - *About the authors*
 - *Declaration of interest*
- * *Supplementary material*

Dementia is a growing national and international problem with associated personal and societal costs. For example, in Cambridgeshire, the number of individuals with dementia is predicted to increase by 86% from 8600 in 2016 to 16 110 by 2031.¹ Of specific interest are those who develop dementia at a young age. Young-onset dementia (YoD) is defined as a diagnosis prior to the age of 65, a cut-off based on the previous retirement age and not on any biological underpinning.² Both YoD and late-onset dementia (LoD) represent heterogeneous groups of patients, which differ from each other in various features besides age. Although the incidence of dementia increases with age, those who develop dementia at a young age have a different profile of diagnosis compared with older people. A greater proportion of YoD patients suffer from frontotemporal lobar degeneration, and they may experience delays in diagnosis.^{3,4} Furthermore, studies have shown a higher neuropsychiatric symptom burden and greater carer stress.⁵ These differences have prompted discussions regarding the need for a separate specialist service for those with YoD.⁶

Currently, YoD patients are treated together with LoD patients within old age psychiatry services. Referrals are made to the same memory clinic, where patients are assessed by a consultant specialising in old age psychiatry, or by a trainee or middle-grade doctor under their supervision. Over the past 4 years, older people's mental health (OPMH) services have undergone a radical transformation in Cambridgeshire.⁷ In order to inform future service design, we therefore sought to evaluate our patients with established YoD and patients under 65 referred for memory assessment, in comparison with those with LoD.

Methods

This project was conducted as a service evaluation with the relevant internal trust approvals from Cambridgeshire and Peterborough NHS Foundation Trust. The trust covers a population of ~1 000 000 people, of whom >165 000 are over the age of 65. The trust provides the countywide memory assessment service, which receives ~2000 referrals per year. Other condition-specific services exist (for example, for Huntington's disease) and sit within the neurology department at the local acute trust.

Referral data are routinely collected by the trust. Health of the Nation Outcome Scales (HoNOS) data were collected as previously described.⁸ We manually reviewed a sample of 90 electronic patient records. This was divided into data for 30 consecutive patients with an established diagnosis of YoD, 30 consecutive patients with a diagnosis of LoD, and 30 consecutive patients under the age of 65 who had been referred to the memory clinic for diagnostic assessment. For each patient, we searched their records to identify the following: presenting complaint, diagnosis, presence of comorbidities, time from symptom onset to diagnosis, current medication, and scores on the Addenbrooke's Cognitive Examination (ACE) and HoNOS. We attempted to minimise the possibility of interrater variability by looking for specific data and using the same source data in the records (the core assessment). The date of symptom onset was determined from the information provided in the core assessment, which is a mandatory form that includes a detailed patient history,

completed by a clinician for each patient. Data for individuals identified with dementia in the young referral group were combined with data from the YoD group during statistical analysis in order to increase statistical power. ²-test, unpaired t-test and Fisher's exact test were used as appropriate for statistical analysis of the data (see supplementary material, available online at <https://doi.org/10.1192/bjb.2020.89>). *P*-values were not adjusted for multiple testing.

Results

We began by looking at high-level data regarding case-load, referrals and outcomes of people with YoD. In March of 2020, the trust had a total of 5818 registered patients with a diagnosis of dementia, i.e. patients on our electronic patient record but not necessarily currently receiving a service. Of these, 135 (2.3%) were under the age of 65. Of 7473 individuals referred for memory assessment between 2016 and 2020, 210 were under the age of 65, corresponding to 2.8% of all referrals. We re-analysed a large data set of HoNOS scores which we had previously reported, in order to investigate differences in presentation and outcomes between YoD and LoD. This comprised data for 173 patients with YoD and 3553 patients with LoD,⁸ representing the subset of total referrals that had a HoNOS score on admission and discharge. Using this methodology, we found significant differences in HoNOS scores on entry to the services (data not previously presented), with higher scores on the behaviour ($P = 0.01$), cognition ($P < 0.001$), hallucinations ($P = 0.01$) and living conditions ($P = 0.04$) domains in the LoD group; and higher scores for depression ($P < 0.001$), occupation ($P = 0.01$) and 'other' ($P < 0.001$) in the YoD group (Fig. 1). There were no significant differences in the other domains. We have previously published data looking at outcomes based on HoNOS scores for both YoD and LoD. Both groups improved in all domains except cognition, disability and activities of daily living. Although some of these changes did not reach statistical significance in the YoD group, this is likely to reflect the lower numbers in that group.⁸ Fig. 1 Bar chart showing mean scores across HoNOS scales for late- and young-onset dementia on presentation. Late-onset dementia: $N = 3553$. Young-onset dementia: $N = 173$. $*P < 0.05$, $**P < 0.01$, $***P < 0.001$. ADLs, activities of daily living.

In order to conduct a more comprehensive investigation into the differences between our YoD and LoD patients, we undertook a detailed case-note review of 30 cases from each group. The demographic details are given in Table 1. We found significant differences between the YoD and LoD groups in terms of comorbidities ($P = 0.002$ for both cardiovascular and depressive) and medication ($P = 0.0003$ for antidepressants, $P = 0.004$ for donepezil and $P = 0.03$ for benzodiazepines). Specifically, we saw a higher incidence of mood as a presentation (Fig. 2a), a greater variety of diagnoses with less Alzheimer's disease (Fig. 2b), fewer cardiovascular and more depressive comorbidities (Fig. 2c), a generally shorter time from symptom onset to diagnosis (40% diagnosed in less than 1 year for YoD compared with 30% for LoD, although these differences were not significant, nor was the difference in mean time to diagnosis of 27 v. 28 months for YoD v. LoD, respectively, Fig. 2d), and more treatment with donepezil, antidepressants and sedative medication in the YoD group (Fig. 2e). We found no statistical difference in total ACE scores or subscores between YoD and LoD (Fig. 2f). Two patients in the YoD group who initially received a diagnosis of dementia subsequently had that diagnosis removed, as it became clear that their symptoms were a result of other psychiatric disorders. Fig. 2(a) Bar chart showing presenting complaints in each group. (b) Bar chart showing proportions of different diagnoses in each group. (c) Bar chart showing number of individuals associated with different comorbidities in each group. (d) Bar chart showing time from symptom onset to diagnosis in each group. (e) Bar chart showing percentage of patients prescribed different medication classes in each group. (f) Bar chart showing mean ACE scores in each category for each group. $*P < 0.05$, $**P < 0.01$, $***P < 0.001$. Table 1 Sample demographics of late-onset dementia, young-onset dementia and young referrals without dementia groups

	Late-onset dementia	Young-onset dementia	Young referral without dementia
Mean age at diagnosis (s.d.)	83.4 (±6.8)	56.4 (±5.4)	55.8 (±7.8)
Minimum age	72	45	35
Maximum age	97	64	64
Male	141	16	17
Female	161	14	13
Mean age of males	82.4	56.0	54.2
Mean age of females	84.3	56.9	57.6 ¹

1

Age in years.

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We also evaluated 30 cases of patients under 65 years of age referred for memory assessment. When comparing patients referred to our service under the age of 65 with those in the same age group who had received a diagnosis of dementia, we found a number of differences. First, despite the similar average ages of the two groups, there was a greater range in those referred, with one individual as young as 35 years of age who was not subsequently diagnosed with dementia. For total and subscores on the ACE and cognitive scores on HoNOS, those referred scored significantly higher (mean \pm s.d. for total ACE: 84 ± 11 v. 69 ± 17), were less likely to have difficulties with memory as a presenting complaint and were more likely to have neurological comorbidities. The prevalence of diagnosis of dementia in this group was low (27%). No other significant differences were found.

Discussion

The absolute numbers of patients with YoD referred or managed are low, representing just over 2% of referrals and case-load. This is lower than the figure found in the national memory service audit for referral (7%) and at the lower end of the range (0–22%).⁹ It is also lower than many estimates of the prevalence of dementia in this age group.¹⁰ For example, there are an estimated 210 individuals with YoD in Cambridgeshire, but only 135 (64%) of these are currently known to the trust. This difference might be explained by many of the estimates of prevalence being based on epidemiological data, meaning there are likely to be individuals who have the condition but have not yet been diagnosed. Given the increased prevalence of certain conditions leading to dementia in this group, including Huntington's disease and frontotemporal dementia, it is also possible that they are looked after in the relevant specialist neurological clinic rather than by generic mental health services. This may also explain the low percentage in terms of referrals, if doctors in primary care are preferentially referring young patients to neurology rather than psychiatry for assessment.

For the cohort under 65 who were referred for diagnostic assessment, only eight out of 30 (27%) received a dementia diagnosis. This is much lower than national figures for generic memory clinics or those from our previously published audits of our own service, where 60–70% of those referred received a diagnosis of dementia.¹¹ However, this supports previous data from the London memory audit services, where only 15% of those referred under 65 received a dementia diagnosis.¹² Instead, the majority in this group were diagnosed with mild cognitive impairment or other psychiatric disorders. Our analysis of HoNOS scores of patients on entry to the service did not broadly support the idea that YoD patients, at least at presentation, suffer from more neuropsychiatric disturbance. However, the evidence presented here based on HoNOS scores, presenting complaint, comorbidity and medication suggests that this group is associated with a greater burden of depression.

The association of depression with LoD has been well documented, with large-scale studies suggesting that depression is both a prodromal symptom of and a risk factor for dementia, while dementia is itself a risk factor for depression.¹³ A recent meta-analysis reported a prevalence of depression of 25% in those with LoD.¹⁴ This is in contrast to studies of YoD, where depression was found in 66% of individuals.¹⁵ Although assessing depression is difficult in those with dementia, and criteria differ among studies, our data support the idea that patients with YoD may suffer more from depression. From a diagnostic perspective, this is potentially an important consideration when seeing patients in later mid-life who are suffering from mood disorder, which may be comorbid with or indeed be a presentation of YoD. This is also important in terms of management, as depression is both under-diagnosed and under-treated in this population, which may negatively affect prognosis.¹⁵

However, our study did not support previous suggestions of a delayed diagnosis in those with YoD, although we acknowledge the small sample size and difficulty people experience in precisely recalling when the onset of an insidious condition might have been. One possible explanation is that a greater proportion of those with Alzheimer's disease are seen in our service, and fewer of those with rarer and therefore more difficult to diagnose dementias such as frontotemporal lobar degeneration, who may instead be referred to a different service such as neurology.⁴ Another possibility is that our patient population may not be representative of studies in other populations. In terms of socioeconomic background, Cambridgeshire and Peterborough benefit from a slightly higher than average employment rate (78.5% in those aged 16–64 compared with 76% nationwide), as well as a higher percentage working in professional occupations (25.1% compared with 21.5% nationwide).¹⁶ A better socioeconomic background may provide the freedom for individuals to access health services at an earlier stage of the disease, which may be more difficult for those from less advantaged backgrounds. However, this would not explain why a difference between YoD and LoD groups was seen,

as there is no reason to expect a greater effect in one group over another, and we are unaware of any facility for private dementia assessments available in the county.

We were interested to see that two cases initially diagnosed as YoD were subsequently reclassified with a diagnosis of another psychiatric disorder. This is a rare event in LoD and may reflect the lower pre-test probability of dementia in younger people, as well as the frequency of cognitive impairment in other psychiatric conditions. We were reassured that outcomes between patients with YoD and LoD did not appear to differ significantly.

In Cambridgeshire, we have used these data to inform the design of our services for YoD patients. We do not have a specialist YoD team. The low number of patients spread across more than 1300 square miles of a predominantly rural county makes having a specialist team practically challenging. A separate service dealing with YoD would be small by its nature and therefore not robust to any challenge such as staff sickness. Similarly, we do not have specialist clinics within the trust for those with YoD. The data suggesting a high level of psychiatric morbidity in this group make assessment by a consultant psychiatrist appropriate, and we have close links with local neurologists, including cognitive neurologists, for second opinions on cases which might represent Huntington's disease or unusual tau- or synucleinopathies. We do recognise the differences we see in our population and more broadly in the literature in those with YoD and the specific challenges this group can face. Our solution for their management has been to identify an advanced practitioner in each of our community memory teams who leads for YoD. This allows that practitioner to acquire expertise and experience in this area, forming part of a specialist professional group, as well as being part of a larger, multidisciplinary, clinical dementia service, which means the service offer is robust. We have also forged links with our local acute trust to ensure that patients seen in other related services, such as neurology, who receive a diagnosis of dementia are referred to our trust for post-diagnostic support and follow-up. One significant weakness in the data presented here was the lack of direct patient feedback. We do routinely collect quantitative and qualitative data from patients and caregivers. However, owing to incomplete returns from an already small group and not differentiating respondents in terms of age, this remains a significant gap in our knowledge. We will seek to address this in time with a targeted and more detailed assessment of patient experience, as well as detailed exploration of patients' and carers' ideas for service development.

In summary, our data suggest that patients with YoD form a small minority of our OPMH dementia work, and that the size of the population would make the creation of specialist teams difficult when operating over a large area. Young patients referred for assessment were less likely to receive a dementia diagnosis than older patients and were more likely to have psychiatric comorbidities. For those with YoD, their presenting complaint, medication, comorbidity and HoNOS scores all suggested a greater burden of depression. This information has helped us to inform and adapt our generic memory services to ensure a robust response led by staff experienced in this condition.

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Supplementary material is available online at <https://doi.org/10.1192/bjb.2020.89>.

M.Y. was involved in data collection, data analysis and writing of the manuscript. K.M., V.M. and N.D. were involved in data collection. B.R.U. contributed to writing the manuscript.

Declaration of interest

B.R.U. has been PI for a number of drug treatments for dementia for commercial pharmaceutical companies and has received personal fees, is the lead for dementia for the eastern region for the CRN and the clinical director for CPFT, and does occasional case reviews in dementia for the NHS ombudsman, outside the submitted work; B.R.U.'s wife is the lead commissioner for mental health in West Suffolk.

Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2020.89>.

[click here to view supplementary material](#)

1.2.27 What have we learnt from Covid?

Mark Steven Salter

date

2021-04

Contents

- *What have we learnt from Covid?*

Early on in the pandemic, many prisoners were glad to learn of their early discharge. Not long after they reached the imagined freedom of their homes, they found themselves in another prison, their incarceration now managed by an invisible viral cloud. We can learn much from this.

In March, I saw a newly released 33-year-old drug dealer. Via video, his daytime flat looked as dark as a cell. He reported anxiety, but his nightmares were worse – he dreaded return to the time he left his cousin to bleed out in a car park, calling the ambulance before he ran. That was 5 years ago, he said, but why is this coming back to me now?

Over months, peering into the homes of patients like never before, I saw how, denied of their routine contacts with the world, long-managed trauma and abuse were reappearing everywhere. Covid reminds us that all of daily life is an adaptive coping strategy; Palmer¹ dryly calculated that even a patient seeing their general practitioner fortnightly for a year would spend 99.95053272% of their life beyond the medical gaze. We should ask patients less about their symptoms and much more about what they actually do all day.

My drug dealer wasn't hemmed in by fear of some bug. He was responding to social imperatives described by Durkheim² over 100 years ago: the sharing of any strong emotion causes predictable changes in that group; consider the nation's behaviour after Diana's death, or that of Sir Captain Tom. My patient was kept under house arrest by the weekly banging of pots and the sudden ubiquity of fear-linked stimuli: what Daniel Kahneman³ describes as an 'availability avalanche'. We were entranced by Boris at six, exhorting us to 'stay home, stay safe'. We hurried back to an elderly couple of wise institutions: the National Health Service and the BBC, which only months earlier Boris had considered cutting. We can discern another lesson here, at a social scale. We should spend less time exploring our patient's heads and pay more attention to the world around them. We have, after all, chosen to treat the only organ in the body that can vote.

Our sudden distance from our patients was no mere social distancing. Unlike the rest of medicine, psychiatry has almost no tests or devices to refine its efforts. Instead, we rely on our ears, our eyes and sometimes our noses. We started looking and listening from behind a screen. The bravest had only a mask. How odd it felt to be suddenly deprived of – and made to appreciate – those countless tiny cues, the sighs, the diverted gaze and its flinching return, and, most of all, the silences. It was not easy to gauge the pain and poignance of those quiet moments that are the stock

of our trade. Like musicians, so much of our work goes on in between the notes. How do you assure someone of your understanding when you have unleashed waves of grief and tears 4 miles away?

For all the optimistic talk of ‘virtual clinics’ in the future, psychiatrists must be wary. Our work is not like the rest of medicine. Distance deprives us of our most important tool, a potent mix of knowledge, interest, empathy and proximity. Without this, we cannot properly grasp the thoughts, feelings and hopes of our patients.

If medical science has taught us one thing over the past hundred years, it is that human suffering is incredibly complex. Many of our responses, our resort to explanatory biological myths and diagnoses of questionable validity,⁴ or the shrinking of our discharge summaries, all are signs of our instinctive retreat from the bewilderment we feel when confronted by complexity. Psychiatry is stigmatised for its apparent inability to match the ‘precision’ of our more bodily focused colleagues.

Although we claim to give equal weight to the biological and the psychosocial elements of our assessments, the truth is that we are drawn to the former, because they seem less challenging.⁵ Covid’s lesson for psychiatry is clear: psychiatry must face the true complexity of mental illness head-on. If we are seen to do this by the rest of the medical profession, our uncertainty in the face of it could become psychiatry’s touchstone rather than its millstone.

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1.2.28 The case for cautious paternalism in the emergency management of patients with borderline personality disorder

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date

2021-04

Abstract

Principlism is the dominant ethical theory in modern medicine. Autonomy is ‘king’ of the principles espoused and operationalised in consent. Consent is the mechanism by which all medical interactions occur. In borderline personality disorder (BPD) there is often a diffuse sense of self, emotional instability and impulsivity that can lead to medically dangerous non-suicidal self-injury, acute medical intervention and then a withdrawal of consent while the potential threat to the person’s well-being remains high. Claims of lack of capacity lack veracity, and simply acting against the patient’s will may be illegal. Understanding the will and preferences of patients is a step forward, but it is not always possible in time-sensitive situations. A cautious paternalism is therefore warranted both to ensure the patient’s well-being while being honest as to the reasons for this, and to possibly build epistemic trust between the medical system and the patient with BPD.

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 - *The clinical conundrum*
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Principlism has been the dominant force in medical ethics for more than half a century.¹ Its four principles – autonomy, beneficence, non-maleficence and justice – form a common touchstone in medicine, particularly when hard choices need to be made.² Although neither Beauchamp nor Childress, the authors of this bioethical approach, weighted any one of these principles as more important than any other, autonomy has risen as the prominent principle.³ This is not surprising, as autonomy is operationalised into informed consent, the tool doctors use to assess capacity and then engage in clinical action.⁴ Capacity assessment based on principlism is purely process driven, based on whether a patient understands, retains, weighs and answers questions. The content of the decision is explicitly ignored. Where doctor and patient agree, or where the patient agrees with the doctor, an assessment of autonomy through capacity is rarely detailed. There is little need, as all parties agree as to the best approach to take. This is not true, however, when the patient disagrees with the doctor. In these cases, the medical mind is more likely to focus on the issue of capacity, as if it is not present a ‘duty of care’ may suggest a course of action that contravenes the patient’s explicitly stated desires.⁵ Most conventional wisdom and practice dictate that a loss of capacity is, largely, the only legitimate rationale for acting in such a way, and to act differently requires confirmation by the court. Specific mental health legislation is a glaring exception, and efforts to restrict its use or abolish this legislation are occurring in multiple jurisdictions (for example, the new fusion legislation of Northern Ireland). As the risks of a poor outcome increase, so does the doctor’s desire to act differently from the patient’s stated desire, if her desire may have a possible catastrophic outcome. Even if this is the case, the court may honour the patients’ autonomy, despite a guaranteed outcome of death. Put simply, autonomy is king, and to dethrone the king is socially and legally increasingly less acceptable. The question is whether this approach is the best one for patients with borderline personality disorder (BPD).

The challenge of BPD

BPD is characterised by a diffuse sense of self, difficulty in understanding affect, intense unstable interpersonal relationships and impulsivity.⁶ These features of the disorder are pervasive, reaching into all areas of a person’s life. They commonly, but not exclusively, arise in adolescence and cause considerable morbidity to a young population.⁷ Health services are often engaged in the management of patients with BPD, as they are treatment-seeking, recognising their emotional and interactive difficulties and experiencing significant distress because of them. Psychotherapeutic approaches support long-term improvement; however, personal responses to short-term distress often include thoughts of suicide and non-suicidal self-injury (NSSI). Both expressions of suicide and NSSI cause significant distress to health-care workers inside and outside mental health and can be difficult to manage. For actions that lead to self-harm, it can be difficult to ascertain whether the antecedent to the action is an effort to end life, or some other cause such as to regulate emotional distress or ‘feel something’. If the purpose of NSSI is to regulate emotion, then the support and investigation of emergency services may provide sufficient supportive human contact to allow the emotional storm to pass. Now the patient sees no need for treatment, and this can be very distressing to medical staff, particularly if the NSSI is potentially lethal. Life-threatening overdose is an excellent example of this. In these circumstances, medical staff can see the potential danger of non-adherence to emergency treatment, whereas the patient, with a clear sensorium and who clearly understands the information provided, may still demand to go home as their immediate emotional needs have been met.

The clinical conundrum

This is a clinical conundrum: in observing the patient's autonomy, one appears ethically obliged to do what may be (or certainly is) life-threatening. Disregarding the patient's autonomy to preserve life appears ethically dubious, as autonomy is after all king.

Questioning capacity

In such cases, the default position has largely been to question capacity. This is internally consistent with the bioethics of principlism, which is built on a normative moral philosophy. Such normative moralities are not dependent on a series of complex ethical foundations, rather, central to their claim is the idea that the morality of a society's members, common sense and tradition are its basis (see Ref. 2, pp. 3–10, where the notion of a 'common morality' is spelt out). Principlism is, however, in direct conflict with the growth of a human rights ethic, which values autonomy as separate from any such normative requirement. Indeed, this human rights ethic challenges the normative position of enabling one person to do something to another without their consent. This recognises the increasingly diverse components of society and the need to ensure all have equal rights. The Convention on the Rights of Persons with Disabilities (CRPD)⁸ is the clearest example of this. The CRPD, of which most nation states are signatories, requires signatories to uphold the equal rights of those with disabilities, including those with mental health conditions, as being equal to those without such disorders. The basis of this is a social model of disability.⁹ The social model directly challenges the normative tradition of our bioethics, on which ethical clinical practice is based. It suggests that a key problem with the medical model is the way society limits freedom and choices. For example, a medical model states that those who cannot see should not drive. This seems obvious and incontrovertible. The social model of disability challenges this to say that those who cannot see should be allowed to drive, in cars appropriately equipped to ensure they and others are safe, for instance, self-navigating cars. This combination of a human rights ethic and the social model of disability challenges the ethical validity of principlism, its common morality.

In the clinical conundrum described above, the appeal to a failure of capacity usually relates to an inability to weigh the evidence in the balance (by way of process). On these grounds, capacity – and ergo autonomy – fails, and the doctor has a duty of care to step in. This stance is not the case for many people with BPD, who largely retain this ability. This means that preventing a patient with BPD from leaving hospital, as described above, breaches their human right to autonomy. This 'medical model' approach is also challenged by the social model of disability. This model places the need for care in society (for example, by providing care at home) and would not support retaining someone in hospital despite the potentially life-threatening consequences of leaving. There are, therefore, no ethical grounds to act in such a way using either a principlist or a human rights ethic. So, if patients with BPD can make cross-sectional autonomous choices that may have catastrophic consequences, should they be freely allowed to do so?

The third way: will and preferences

Using a purely process approach to capacity clearly fails to ensure the well-being of a patient with BPD in a situation such as a life-threatening overdose if she refuses medical treatment. Simply withdrawing treatment may also fail to ensure the well-being of patients with BPD in the same circumstances. Are clinical staff doomed to fail such patients? The answer to this seems to lie in a clearer consideration of the notion of autonomy. Regardless of whether autonomy is normative (as the bioethicists purport) or idiosyncratic (as the human rights proponents purport), it implies a sense of self, a notion of understanding 'who I am and what I want'. Further, it implies a sense of continuity to these expressed desires, desires that could be reasonably expected to change only slowly over time. Without these two implied requirements, a clear sense of self and a temporal stability to this sense of self, both idiosyncratic and normative judgement become mere chaos, a changeable noise without foundation. This identifies a third way forward: rather than focusing on the capacity process, an understanding of the content of the decision and the context of the person may allow a more nuanced understanding of autonomy and, subsequently, capacity. The focus then shifts from a response to the cross-sectional assessment of how you are now to an assessment of what you may want across time. Such a shift necessarily requires consideration of the content of the decision, as well as the process of decision-making. This has been described as weighing an individual's will and preferences,¹⁰ as opposed to focusing on the process of decision-making in capacity or a cross-sectional assessment of this decision at this time. This appears to be a more

authentic form of considering decision-making capacity.¹¹ In the case of the patient who has taken a life-threatening overdose, this might lead to a completely different decision. Rather than allowing such a person to leave the emergency department, considering their process of decision-making to be intact, they may be kept to ensure their safety based on their longer-term will and preferences (for example, plans for the future). This move towards will and preferences-based decision-making in medicine appears to be a significant step forward. It recognises the individual and idiosyncratic rights of the person. It supports the person to make the best choices for them in their context, and enables the medical system to be clear that it is doing the best for the patient, not simply leaving them to their fate. Although only required in cases of disagreement, this process is likely to be lengthy, and requires information from collateral sources and repeated interviews to develop such a nuanced sense of will and preferences.

The case for a cautious paternalism

None of this is likely to be possible in emergency settings where decisions are time critical. Added to this in people with BPD is a diffuse sense of self, a core characteristic. Such a clear understanding of will and preferences is likely to be an order of magnitude more difficult to understand in such circumstances. The patient herself may not understand her own drives or why life is so emotionally and interpersonally distressing. In these circumstances, the reality of clarifying will and preferences in an appropriate and consistent manner is very unlikely. Rather than defaulting to an obviously flawed argument to suggest the patient lacks capacity, a cautious paternalism may be more honest, supportive and applicable. Despite some of the difficulties for people with BPD in general, a sense of understanding others is clear, and using a flawed system, in which they are considered to lack capacity, simply increases distrust in the medical system and medical model of care. Cautious paternalism recognises the difficulties of a consistent sense of self for people with BPD and of understanding their will and preferences in a timely manner. It does not rely on a tautological suggestion of a lack of capacity for patients who disagree with medical decisions (because you disagree with me, you *ipso facto* lack capacity). Rather, it provides medical support for well-being and potentially increases epistemic trust¹² between the patient and the medical system, a trust that people with BPD have significant problems with. This is likely to require the time and skill to engage with the patient to persuade them of the need for review and reassure them of the intent to support autonomy while at the same time recognising the limits to this inherent in their presentation. If they leave, then accessing support (for example, via family or police) to return them to the emergency department recognises the limits to autonomy implied by this presentation and prevents possible ill-considered catastrophic harm.

Such a cautious paternalism may help to find a way forward that enables people with BPD to both receive adequate medical care in emergencies and develop trust in a system with the possibility of longer-term therapeutic support.

Giles Newton-Howes is an Associate Professor at the University of Otago, Wellington, New Zealand.

None.

Declaration of interest

Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2020.148>.

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1.2.29 Psychoanalysis in the treatment of autism: why is France a cultural outlier?

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Abstract

In most countries, social or behavioural interventions are recommended for autism. However, in France, psychoanalysis is still used, despite objections by patients, families and mental health experts. Supporters of psychoanalysis maintain that the choice of therapeutic approach is a matter of cultural preference, and that objections to psychoanalysis arise from misunderstandings. We argue that more deep-rooted problems are the lack of an evidence base for psychoanalysis and its focus on sexual relationships between children and adults, which demonises mothers and can put children at risk of abuse. Furthermore, psychoanalysis in France is protected from criticism by powerful educational and political networks.

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Psychoanalysis as an intervention for child language disorders

There have always been geographical differences in the practice of medicine, even within Western societies, but in psychiatry, especially child psychiatry, national variations are taken to extremes. The first author realised the enormity of the divide between French and British practices in 2001, when asked to write an endorsement for *The Silent Child: Exploring the World of Children Who Do Not Speak* by Laurent Danon-Boileau.¹ The book's author was described as one of France's most respected child psychoanalysts, with a particular interest in language. The book contained a series of case studies of children who did not have any formal diagnoses but appeared to fit criteria for autism, intellectual disability or dyslexia. As Law² noted in a review, there was no recognition of developments in social cognition and developmental psycholinguistics. Rather, there were confident assertions about the child's inner state, and children's lack of communication was generally attributed to affective and motivational causes relating to psychodynamic factors, rather than to any problems with understanding or formulating language.

To a child language expert, it is surprising that anyone should imagine psychoanalysis, the quintessential talking therapy, would help a child with impaired communication. Yet psychoanalysis is still taken seriously as an intervention for autism in a few countries, with France being the most notable example. This was documented in a film, *Le Mur*,³ produced in 2011 by journalist Sophie Robert. In a series of interviews, child psychoanalysts interpreted language limitations in their young clients through the lens of psychoanalytic theory. The parents were directly implicated in causing autism, and the child's communicative problems were regarded as a reflection of a difficult parent-child relationship. The flavour of the content is conveyed by a few direct quotes from the English transcript. "‘What we can notice when we take care of autistic children is precisely that autistic children are sick of language. That autism is a way to defend themselves from language.’ (Esthela Solano) ‘At the beginning, the child thinks that he is his mother's phallus. Namely that he is this object that would give everything, fill his mother with joy, make her have orgasm . . . The father is there to forbid and at the same time protect the child. That is, to protect the child from the incestuous desire of the mother.’ (Yann Bogopolsky)"

Laurent Danon-Boileau was one of the interviewees. It was illuminating to hear him describe a session with an autistic child; he did not seem to see his part as to facilitate the child's development, but rather to adopt a passive, interpretative role.

Le Mur was shocking for autism experts outside France. Although there are child psychoanalysts in the English-speaking world, they are a small minority and recommendations by the National Institute for Health and Care Excellence⁴ for intervention in autism make no mention of this approach. In the UK, autism is regarded as a neurodevelopmental condition with a predominantly genetic aetiology, and intervention focuses on working directly with social communication and behaviour. The goal is to bring about an improved developmental trajectory, rather than gaining any insights into the deeper meaning of the symptoms.

French cultural and political influences on acceptance of psychoanalysis

It is worth reflecting on how such differences in practice have come about. Language barriers play a part in preventing the flow of ideas across national borders, but this cannot account for the unique status of psychoanalysis in France, where it is celebrated and protected.

Houzel,⁵ in recounting the history of psychoanalysis as a treatment for autism, noted that French society has ‘a very marked cultural identity that results in a certain impermeability to external currents of thought’ (p. 742). For Houzel, himself a psychoanalyst, this has certain benefits: ‘One advantage is a capacity to resist certain fashions that is no doubt greater than elsewhere. That is why France remains today a country where the application of psychoanalysis to the treatment of autists persists in spite of all the attacks that it is subjected to’ (p. 742).

Houzel further noted how French intellectuals are drawn to abstraction and speculative theorisations; these are exemplified by the work of Jacques Lacan, who did not himself work with children but developed an influential system of thought, based on Freudian theory, with its own specific French flavour. Its appeal to French intellectuals remains a mystery to those of us with a less credulous frame of mind, who suspect that when an author writes obscurely it is not because the ideas are brilliant, but because they are using verbiage to hide muddled thinking. As Billig⁶ concluded: ‘academic authors do not advance the cause of critique by putting their readers in a subservient position where authority has to be taken on trust and where obscurity takes priority over clarity’ (p. 22).

Houzel's paper put the development of psychoanalysis in France in a historical context and noted its cultural and political influences, but it also emphasised the extent to which psychoanalysis, as a treatment for autism and related developmental disorders, has come under repeated criticism over recent decades. Some parent organisations have attacked psychoanalysis on the basis that their children are denied the kind of interventions that are routinely available in other countries.⁷ In 2012, a political bill was put forward to the French National Assembly calling on the government to ‘condemn and prohibit psychoanalytic practices in all their forms concerning the treatment of autism’.⁸ In parallel with these developments, there have been a series of National Autism Plans, starting in 2005; there is now significant funding of research from the perspective of autism as a neurodevelopmental disorder and a cadre of French autism researchers with international standing.⁹ Yet French psychoanalysts remain politically powerful and have waged a campaign against those who challenge them, including an attempt to sue director Sophie Robert on the grounds that *Le Mur* misrepresented their views.⁷

Psychoanalytic interpretations of maternal factors in aetiology

Houzel⁵ suggested that the chief reason for rejection of psychoanalysis is a mistaken belief that psychoanalysis blames mothers for their children's difficulties. He argued that this is not the case: psychoanalysis is not adequate for identifying aetiologies, and 'Its quest is more in the direction of meaning than that of cause' (p. 731).

To maintain that psychoanalysis does not blame parents seems disingenuous. There are many varieties of psychoanalysts, and it is true that some, including most British psychoanalysts, overtly state that parents should not be blamed for their child's difficulties.¹⁰ Nevertheless, in France, the role of parents, especially mothers, in causing disorders has been a core feature of psychoanalytic work with children. Briggs¹¹ noted how the work of Bruno Bettelheim had been influential in France, with his view of cold, rejecting mothers (the classic 'refrigerator mother' of Kanner) from whom the child withdraws into his shell. Bates⁷ cited numerous examples of mothers being told bluntly that they were responsible for their child's autism, although the more common accusation was that mothers were overinvolved and 'smothering', with an unhealthy desire for the child that led to the child being unable to achieve a separate identity. *Le Mur*, and a more recent film by Sophie Robert, *Le Phallus et le Néant*,¹² contain several examples of psychoanalysts putting forward such viewpoints.

Bates⁷ noted that these ideas fell on fertile soil in France, as they fitted well with notions of toxic mothers already endorsed by French psychoanalysts. Several relevant quotes by Françoise Dolto, one of the most influential French child psychoanalysts of the last century, can be found on the Freud Quotidien website,¹³ including this on autism: "'The child wants what they see the adult wanting. If they focus the desire of the adult, the source of the desire in them dries up and what remains of it is inflected on their own vegetative material person, causing autism, that is to say disorders of its spatio-temporal reference and of communication. This mental illness, leading in the worst case to infantile dementia in a previously open and intelligent baby, is established in the infant separated from all their references. It has also been called "hospitalism" which, at all levels, depending on the duration of the pain, is in fact a disease of the desire. While needs are preserved, desire loses in this child its magnetic vector calling for communication. but "hospitalism" can also be observed in a family environment, in infants whom the mother or rather the neurotic employee isolates in an obsessive way by exclusive possessiveness, or who is the object of perfect care, technically speaking, given without joy by a depressive adult' (translated by Julien Basch)."

Rejection of the need for a conventional evidence base for psychoanalysis

Houzel also bypassed two further objections to psychoanalysis, which are particularly concerning to any dispassionate observer of French child psychiatry. The first is the lack of any accepted evidence base for psychoanalytic treatments. Houzel⁵ regarded behavioural approaches to intervention as mere fashions in reductionist thinking, and noted that they have not been strikingly successful in gaining understanding of the nature or causes of autism, nor in creating improved outcomes for children. This point has some justification – progress has certainly been slow and there is no miracle cure.¹⁴ The difference compared with psychoanalysis, however, is that these developments occur within a scientific framework that allows one to test the ideas and reject those where the evidence does not fit. Popper¹⁵ used psychoanalysis as one of his classic examples of pseudoscience, able to explain all phenomena but with no possibility of being disproven: if the scientific framework is itself rejected, then any viewpoint is as valid as another. Billig⁶ pointed out that Lacan's supporters ignored attempts by experimental psychologists to evaluate his work, because they regarded orthodox psychology as invalid; yet, even when considered in its own terms, Lacan's citation of evidence was sloppy and inaccurate. Sokal and Bricmont¹⁶ were particularly harsh on Lacan, for producing obscure writings with all the trappings of technical language and concepts but no coherent meaning. Consistent with this, Law² noted that Danon-Boileau¹ did not engage in any discussion of evidence-based practice and indeed seemed to make a virtue of his lack of reading in the area. The impression is that many French psychoanalysts regard themselves as revolutionary thinkers who, in rejecting mainstream science, are challenging the conventional power structures in society. But they ignore the potential for abuse of adults' power over children, who are defenceless against having their thoughts and motivations interpreted in terms of the analyst's unevidenced theory.

Psychoanalytic accounts of sexual relations between adults and children

A different type of critique of French psychoanalysis is highlighted in Robert's most recent film, namely, that it has been used to validate incest and child abuse. Freud, and his follower Lacan, regarded children as sexual beings, strongly influenced by erotic desire for a parent and preoccupied by concerns about castration, lack of a penis or violence. Given that these are seen as universal human desires, incest and paedophilia are regarded as natural phenomena. According to this view, psychic conflicts are largely due to the need to fit in with the norms of a society that strictly prohibits such behaviours and hence to repress natural instincts. The focus on child sexuality was one reason that many of Freud's contemporaries ultimately broke away from him;¹⁷ he was seen as imposing his own dogmatic views, derived from his self-analysis, on others, treating concepts such as the Oedipus complex and castration anxiety as universal, to the neglect of other, non-sexual risk factors for mental disturbances. In *Le Phallus et le Néant*, we see how this viewpoint can open the way for abusive relationships between a powerful therapist and vulnerable children.

The risk of abuse needs to be viewed in relation to a distinct French cultural perspective with regard to an age of consent.¹⁸ In 1977, a group of 60 prominent intellectuals signed a petition that was published in *Le Monde*, coinciding with the trial of three men who had been accused of having sex with 13- to 14-year-old children. The argument in the petition was that children had the capacity to consent to sex, and that adoption of an age of consent was patriarchal and a denial of children's rights. A similar petition was published 1979, in support of a man on trial for having sex with girls between the ages of six and 12. 'Desire and sexual games have their place in the relationship between children and adults' was the argument put forward, with the claim reiterated that children's rights were being abused by denying them sexual gratification.

One signatory of the 1977 petition was Françoise Dolto, a media-friendly psychoanalyst who regularly appeared on a radio programme between 1976 and 1978, where she answered parents' questions. In 1979 she was interviewed by the magazine *Choisir* on the topic of incest; a transcript can be found online.¹⁹ Her responses indicated that she regarded children as willing participants in sexual activity who should take responsibility for their actions. The same website reported quotes from a 1999 book, *L'Enfant, le Juge et la Psychanalyste*, in which Dolto discussed with judge André Ruffo the legal implications of sexual relationships between adults and children. Dolto recommended that children should be taught early that sexual contact with an adult is against the law, so that there will be no doubt about their complicity if they do engage in such activities: "If children knew that the law prohibited sensual privacy between adults and children, well, from the moment an adult asks her, if she accepts, that makes her an accomplice, she doesn't have anything to complain about' (authors' translation)." Dolto continues to be held in high regard in France. Not only has Paris named a street after her, but in 2018 the government printed a special postal stamp in her honour. *Le Phallus et le Néant* makes it clear to what extent her legacy lives on, with interviewees maintaining that children are sexual beings who are capable of behaving provocatively towards their parents, who must repress their 'inner paedophile drive'.

Such discourse is not merely symbolic: it has real consequences for children. Growing unease in French society about the cultish status of psychoanalysis came to a head this year with the publication of a book *Le Consentement* by Vanessa Springora,²⁰ who described how at the age of 14 she was drawn into a sexual relationship with a celebrated 50-year-old writer, Gabriel Matzneff. Matzneff was one of the signatories of the 1977 petition for decriminalising paedophilia. He defended himself by arguing that his relationship with the teenaged Springora and others of her age were love affairs.

No doubt there are many child psychoanalysts who would be horrified at the notion that their methods were being used to defend incest and child abuse. The problem, though, is that if someone were inclined towards paedophilia, then Dolto's version of psychoanalysis would appear very attractive, promoting as it does the idea that sexual relationships between adults and children, while prohibited by society, are a natural and therefore blameless aspect of the human condition. Psychoanalysis can provide professional respectability, a good income and access to vulnerable children. We should be clear: we are not saying that these views are common among French child psychoanalysts. Nevertheless, so long as the psychoanalytic movement in France sets no limits as to what can count as psychoanalysis, it runs the risk of causing harm to children, as well as to its profession.

Continuing power of psychoanalysis in French political and academic life

The key question is no longer how France arrived at this point but rather how it cannot seem to fully get beyond it. Although psychoanalysis is now marginal in France for psychiatry as a whole, it is a different story for the subdiscipline of child psychiatry that has been dominated by this orientation for decades. In 2012, the High Health Authority of France implemented recommendations for the treatment of autism, but they were not obligatory and inefficient psychoanalytical therapies continued to be proposed for individuals with autism.²¹ Even though new generations of physicians are trained in evidence-based treatments, the older generations that were trained to see psychoanalysis as a viable treatment for autism are still in practice. This presence is visible at all levels of the French healthcare system, including public hospitals, clinics and private practice. Perhaps the biggest problem in France concerns the training of clinical psychologists. Psychologists are ten times more numerous than psychiatrists, and they occupy a large number of positions in clinics and hospitals treating children with autism. The second author, an expert for the National University Council (Conseil National des Universités), recently provided a scientific criticism of psychoanalysis as well as quantitative analysis of the training received by clinical psychologists in French universities.²² This analysis demonstrated that of the 26 universities charged with the training of clinical psychologists, half still provide substantial psychoanalytic training. In nine of these universities, the training provided in clinical psychology is *exclusively* psychoanalytic in orientation. Clinicians trained in these institutions are not routinely exposed to evidence-based approaches in the treatment of autism (or other mental disorders, for that matter), and no national examinations or professional licensing criteria require them to have such training before assuming positions at hospitals throughout the country. The French government and university presidents have turned a blind eye to this psychoanalytic monopoly at institutions of higher education.

In sum, the defence of psychoanalysis as a treatment for autism rests on the idea that choice of one form of therapy over another is purely due to cultural preferences and fashion. A deeper investigation, however, reveals that psychoanalysis is qualitatively different from other forms of therapy. It is not only bereft of any evidence of effectiveness, but it is so ill-defined that it is unclear what such evidence would look like. It is only legitimised because it is promoted by authority figures and maintained by circles of power and influence. Moreover, in its more extreme forms, it has potential to cause damage to parents, especially mothers, who are demonised both for being too involved with and too remote from their children, and to children themselves, who are regarded as seducers rather than victims when involved in sexual relationships with adults.

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Author contributions

Both authors contributed to the writing of this article and approved the final text.

Declaration of interest

Supplementary material

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1.2.30 Denise Assunta Coia (Macdonald), DBE, FRCPsych, FRCPSG, FRSE

Alexander L. Macdonald Andrew C. Macdonald

date

2021-04

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- *Denise Assunta Coia (Macdonald), DBE, FRCPsych, FRCPSG, FRSE*

Formerly Consultant Psychiatrist and Principal Medical Officer to the Scottish Government

Denise Coia, who died peacefully on 9 April 2020 at the age of 67 after a short illness, was a leading Scottish psychiatrist with an international reputation. From 2011, on its foundation, she was the first Chair of Healthcare Improvement Scotland (HIS). In this capacity, with great tenacity, she skilfully built a strong and internationally respected organisation that drove through improvements in the quality of healthcare in Scotland. She was courageous enough to assert the organisation's independence from government and Ministers, through the publication of some hard-hitting hospital inspection reports.

She found interesting metaphors to express her thoughts and was often open and candid in doing so. Fearing that, without reform, the National Health Service (NHS) could consume infinitely more resources, she took the opportunity – in an HIS public annual review meeting with the government – to give Ministers a warning about a possible parallel with the fate of the world's only seven-masted schooner, the *Thomas W. Lawson*. In simply adding more masts to compete with steamships, the schooner had not kept pace with the revolution in maritime trade. Ultimately, it failed, sinking in a storm. Denise's message was abundantly clear – there was a need for the NHS to redesign and change with the times to survive.

Throughout her career, and especially in her later years, she championed the mental health of children and young people. Denise passionately believed in investing more in child and adolescent mental health services. She was therefore a natural choice to Chair the Scottish Government/Convention of Scottish Local Authorities (COSLA) Taskforce on Children and Young People's Mental Health. In her last few years, she also served as Convenor of Children in Scotland. In her typically energetic and inclusive way, she initiated a huge listening exercise across Scotland and relished the

chance to talk to hundreds of people but most importantly children, young people and families. Her response when hearing excuses about service failures was that she was listening to what children and young people were telling her and, under her watch, the failures they had experienced would not be repeated.

Earlier in her career as consultant psychiatrist at the Florence St Day Hospital and Leverndale Hospital, Glasgow, where she served from 1987 to 2011, she was largely based in the Gorbals, one of the most deprived communities in Glasgow. It was there that she developed her life-long commitment to improving the mental health of the most vulnerable and disadvantaged in society. She was one of the pioneers of specialist community mental health services across Glasgow. From 1998 to 2006, she served as part-time Mental Health Advisor to Greater Glasgow Health Board. Then, on secondment from her consultant post, from 2006 until her retirement in 2011, she was part-time Principal Medical Officer Mental Health to the Scottish Government. She was an honorary senior lecturer in the Department of Psychiatry in the University of Glasgow.

Denise took considerable interest in medical education and in supporting the development and training of junior doctors. She chaired the General Medical Council (GMC) Quality Scrutiny Group overseeing the quality of postgraduate and undergraduate medical training in the UK. With Professor Michael West, she also led an extensive review into the mental well-being of medical students and doctors, which was published in 2019 under the title *Caring for Doctors, Caring for Patients*.

An only child, Denise Coia was born in Glasgow on 4 June 1952. Her father Joe and her mother Jill (née Dummer) ran a local fish and chip shop in Milngavie, where she was brought up. She attended Glasgow's Notre Dame High School and subsequently won a place to study medicine at the University of Glasgow. She graduated in 1976 and initially trained for a career in obstetrics, but finding this 'boring', she switched to train in clinical psychiatry. She trained in the South Glasgow registrar training scheme based at Leverndale & Southern General Hospital, followed by senior registrar training in the West of Scotland scheme.

Denise had a passionate interest in art. In Glasgow's European City of Culture year in 1990 she established an exhibition from her mental health centre base of artwork by those who had suffered mental ill health and their carers.

Among many official positions, Denise served as Vice President of the Royal College of Psychiatrists UK and Chair of the Royal College of Psychiatrists in Scotland. She was in receipt of many public honours, being appointed Dame Commander of the Order of the British Empire in 2016. She was elected a Fellow of the Royal Society of Edinburgh in 2018.

Even with all her achievements, Denise remained firmly down to earth. She brought *joie de vivre*, laughter and a wonderful sense of humour – always with a sparkle and not without a hint of mischief and self-deprecation. Denise drew admiration and respect from all quarters for her personal courage and straight talking. She had a formidable intellect and enjoyed robust debate but was always ready to see the other side of a well-argued case. She loved socialising and catching up across her wide network of friends and colleagues – and particularly enjoyed exchanging news. This was still evident even in the weeks before her health finally deteriorated – she was always planning the next coffee or lunch. She had many outside interests, including tennis, art, horse riding, skiing and reading.

She met her future husband Archie Macdonald, originally from Benbecula, a marine engineer with Caledonian MacBrayne, at Glasgow University. They married in 1977. She was immensely proud of their two sons, Alexander, a paediatric surgeon in London, and Andrew, an interventional radiologist in Oxford.

Denise leaves behind her beloved husband Archie, her sons Alexander and Andrew and three grandchildren.

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1.2.31 Are summer schools a way to improve recruitment in psychiatry?

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date

2021-04

Abstract

Summer schools are traditionally used to encourage sixth form students to consider a career in medicine. Is it worth attracting students earlier in their school career, concentrating on psychiatry? Wyke et al describe an innovative project attempting to do just that.

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- *Are summer schools a way to improve recruitment in psychiatry?*
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Summer schools – where prospective students are invited to a university or other setting during the holidays – are a well-established way of encouraging students to consider applying for a particular course. They are usually a week long and are aimed at particular groups of students, for example, international students or those from more deprived backgrounds. Although they are traditionally held on campus, there would be scope in the future to run them remotely, depending on the COVID-19 situation.

Medicine has traditionally been and remains a competitive course, but medical schools are also in competition with each other to attract students. The most prized students for financial reasons are international students, as they pay higher fees (one of the reasons COVID-19 presents a financial risk to many universities).

The widening participation agenda – attracting students from more deprived backgrounds – is another financial inducement for universities. Unless universities can prove their commitment to this, which is surprisingly hard to measure and evidence, they are not allowed to charge high-rate tuition fees. Students from such backgrounds are a group often targeted for invitation to summer schools by universities.

The #ChoosePsychiatry campaign has tried to encourage doctors to choose the specialty – and to an admirable extent has succeeded, with rates of juniors going into psychiatry increasing.¹ The campaign to choose psychiatry includes a target audience of sixth formers who have already chosen to study medicine. As the conversation about mental health, especially post COVID-19, becomes part of the national *zeitgeist*, are we missing a trick in not trying to interest psychologically minded students into medicine earlier than sixth form? Wyke et al describe an innovative 1 week summer school for GCSE students, not all of whom had decided on medicine as a potential career.² The week included talks from psychiatrists at different levels of training, groups and debates, and the students met patients and medical students. At the end of the week, students were more likely than before to choose psychiatry as a career, had changed their views regarding social restriction in mental health and had uniformly positive attitudes towards the course.

Some of these students will presumably have gone to the summer school in order to build their CV, having already decided to apply for medicine, but who knows whether a psychiatry spark has been lit in a budding doctor who wouldn't have considered the specialty otherwise?

It may be well be that the resources and expense required for the project, which were not evaluated in Wykes's paper, are not worth the long-term results. It will be very interesting to see how many of these teenagers do study medicine and choose psychiatry. We know that many students interested in psychiatry at the start of medical school are put off by the 'badmouthing' of the specialty by their educators and peers,³ so hopefully those enthusiastic students will not have their initial enthusiasm knocked out of them along the way. Others may ultimately decide not to study medicine, or to study medicine but not choose psychiatry; if so, at least a group of bright adolescents have had their eyes opened to the subject and had stigmatising clichés about psychiatry challenged.

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None.

Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2020.77>.

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1.2.32 When self-harm is about preventing harm: emergency management of obsessive–compulsive disorder and associated self-harm

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date

2021-04

Abstract

Mental health staff may have limited exposure to emergencies associated with obsessive–compulsive disorder (OCD) during postgraduate training. The first time they encounter a person in the midst of severe obsessions, or one who has compulsively self-harmed in response to such obsessions, might be when working on call covering the emergency department. This educational article presents the lived experience of one of the authors as a clinical scenario. The scenario is then used to illustrate the severity of disability and the rates of self-harm and suicide-related mortality caused by OCD. The recognition and assessment of OCD is described, along with what helps in emergency situations. Written informed consent was obtained for the publication of clinical details.

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- *OCD and self-harm*
- *OCD and suicide*
- *Assessment of obsessions and compulsions*
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Scenario

Doctor’s perspective

You are the doctor on call for psychiatry. The emergency department registrar has referred a 37-year-old professional who is in resus with police in a state of extreme distress, with self-inflicted chemical burns from corrosive alkali on her arms and torso, and haemoptysis caused by the associated fumes. This is her 133rd attendance in 4 years. She is repeatedly saying, ‘It’s all contaminated, I need to go’. A member of the crisis team has advised you to refuse the referral, because seeing the patient would reward her attention-seeking behaviour. When you access her records, there is a ‘yellow flag’ advance plan which states she attends the emergency department frequently and should not be seen by psychiatry.

Patient’s perspective

I am the patient. I don’t want to be here. The police restrained me, put me in a cage in the back of a van and brought me to hospital ‘voluntarily’, after finding me walking down the street coughing up blood on my hands and clothes. I’m terrified. I’ve been worrying for several days that I’ve hurt or killed people. I’ve had worries like this since primary school, but things have got worse again lately. Because I keep thinking I’ve killed someone, when the police stopped me I thought they were arresting me for murder. Now I’m in resus, I’m worried the other patients here are hurt because of me. I can feel contamination under my skin that is hurting people, and I have been trying to get it out. I used to use soaps and bleaches, but they didn’t work, so I now use corrosive alkali to try to remove the contamination. I needed to go to the shop to buy more when the police stopped me. I’m scared the staff will get contaminated too, and I don’t want them to touch me. They want me to take off my clothes, and they’re holding me down to try to put a line in my arm, and I can’t. I just need to go. I need to sort out the contamination and I don’t want anyone else to be hurt.

Question 1: How would you respond to the emergency department registrar? (a)Refuse the referral because seeing the patient would reward her attention-seeking behaviour.(b)Refuse the referral because there is a care plan saying the patient should not be seen.(c)Accept the referral and go to assist the emergency department staff as soon as possible.(d)Accept the referral and tell the emergency registrar that you will see the patient only after she has been ‘medically cleared’.

Answer: (c)

Best practice guidance is clear: people attending hospital after an episode of self-harm should all receive a biopsychosocial assessment by a clinician with adequate skill and experience, and this should not be delayed by waiting for medical treatment to be completed.¹⁻⁴ Although the last health service contact for many people who die by suicide was with a general hospital, only around half of people attending emergency departments with self-harm receive a psychosocial assessment.^{5,6} Pejorative terms such as ‘attention-seeking’ persist in clinical practice; they do not justify the withholding of psychiatric assistance, may be related more to animosity and shaming directed by healthcare staff towards people who self-harm, and have no place in advance care planning.⁷ Advance care planning for people who

have attended emergency departments frequently should be co-produced, should never be used to exclude a person from treatment, and must include a preventive care plan as well as a response plan if it is to be effective.⁸ Mental health flagging should be used cautiously: in some settings it has been found to harm rather than help.⁹ In reality, each occasion offers an opportunity to engage, to support, to advocate, to challenge stigma and discrimination, and to play one's part in establishing a trusting, compassionate and respectful relationship with healthcare services.

Doctor's perspective

You go to see the patient as soon as you can. She is clearly distressed, still coughing up blood, asking staff to leave her alone and repeatedly saying 'I need to go, it's all contaminated'. The medical team recommend a chest X-ray to assess haemoptysis, and transfer to the burns unit. Although she is in no state to give a coherent psychiatric history, she is clearly in need of help and your emergency department colleagues are reassured that you have come to assist. You offer her lorazepam and she declines, saying 'I need to go, I'm hurting people'. You assess her capacity to decide whether to stay or go and conclude that she cannot currently use or weigh information about her health, and that it is in her best interests to stay for emergency medical treatment. By remaining with her to explain what is happening, listening to her concerns and encouraging your emergency department colleagues to be patient, you are able to gradually help her calm down sufficiently to accept medical attention without restraining or sedating her.

Patient's perspective

Turning up to advise the medical staff and to help me makes a huge difference. When I'm worried about contamination and in a cycle of compulsions, being in the emergency department is terrifying. 'Medically cleared' is unhelpful: if I leave hospital as soon as I can for fear that I am contaminating and killing the staff and other patients, there will never be a point where I become sufficiently 'medically cleared' to receive psychiatric help. There is an element of immediacy in what is needed, in guiding medical staff to help and to consider my capacity. Looking back now at the injuries I have and how they have affected my ability to work in my profession, I wish more had been done to understand how much I could weigh information when I had serious injuries, but I was also feeling I needed to decline treatment and leave because I was contaminating people.

Doctor's perspective

On mental state examination, she has repetitive intrusive thoughts that she has unintentionally hurt or killed people, and a deeply unpleasant crawling sensation just beneath her skin, which she believes is an unexplained contamination that can spread to others without physical contact. The purpose of chemically burning her skin is not to address emotional distress, nor to inflict pain or injury, but to neutralise this contamination, thus ensuring the safety of others. She describes the risk of dying or losing a limb as 'collateral' for ensuring others are safe. On systematic enquiry, you identify that she eats minimally and only from sealed packets for fear that food is contaminated. She spends long periods walking or running outdoors until she has reached a 'safe' (prime) number of miles. She has significant anxiety associated with non-prime numbers, which feel 'unsafe' and may somehow harm others. In the past she has deleted entire dissertations and research manuscripts before submission because she feared that making a mistake might cause people to die. It is clear from the absence of emotional dysregulation and her history of stable long-term relationships in the social domains of professional work, friendship and personal relationships that she does not have a personality disorder. It is also clear from the absence of hallucinations and the fact that her fears are obsessional rather than delusional that she does not have a psychosis. Therefore you believe that she has obsessive-compulsive disorder (OCD).

Question 2: What is your role in this scenario? (a)Advising medical staff on capacity to make decisions about medical treatment.(b)Diagnostic assessment alongside assessment of needs and risk.(c)Explaining the nature of OCD to the patient, offering hope and ensuring she can access effective treatment following discharge.(d)All of the above.

Answer: (d)

Severity of OCD

Severe mental illness is not defined by diagnosis but by the degree of distress, disability and interference in a person's life. Without treatment, OCD can be severe, disabling and enduring, with major effects on physical health; as well as self-harming, people with OCD may restrict fluid or food intake because of either neglect or obsessions about contamination. Others may have excessive slowness or be ruminating all day and unable to function. Although most people respond to community-based treatment, some people with OCD may need admission to a psychiatric ward to engage in specialist cognitive-behavioural therapy (CBT) and for supervision of pharmacotherapy. The World Health Organization has classified OCD among the top 10 most disabling illnesses in terms of lost income and decreased quality of life.¹⁰ People with OCD may experience significant delays to diagnosis, both from a fear of asking for help and also from delays in healthcare staff identifying the condition.¹¹ One study found that the average time to receiving first treatment for OCD was more than 17 years from the onset of first symptoms, and more than 11 years after fully meeting diagnostic criteria.¹²

OCD and self-harm

In clinical practice, self-harm may be erroneously viewed as always being a means of coping with emotional distress. Self-harm accompanies a wide range of psychiatric disorders, including psychotic, neurodevelopmental, affective, anxiety and personality disorders. People who have self-harmed sometimes encounter prejudice and discrimination from healthcare staff, which inhibits access to effective assessment and treatment.^{13,14} A key issue in formulation and diagnosis is understanding the circumstances, precipitants, intention and motivation behind the self-harm.

Despite commonly experiencing ego-dystonic obsessional fears about causing harm, people with OCD rarely harm others.¹⁵ On the other hand, self-harm is common in OCD, with an estimated prevalence of 7.3%, and takes many forms¹⁶; it is usually ego-dystonic and compulsive in nature. The manifestations can be encountered by many other specialties, especially dermatology; it has been estimated that between 9 and 35% of patients with OCD will present for treatment of complications related to skin damage.¹⁷ Compulsive washing or decontamination with irritant substances such as disinfectants or bleach are among the most commonly recognised compulsions, and people with OCD may present with atopic dermatitis, irritant toxic dermatitis or dry skin eczema.¹⁸ Compulsive self-cutting and decontamination by chemical burning are less common; understanding the intention behind the behaviour is important in making the diagnosis.

Excoriation disorder (skin-picking or dermatillomania) is relatively frequent, with a prevalence between 1.4 and 5.4%;^{19,20} it has gained increasing attention and has been defined as a specific type of obsessive-compulsive and related disorders in the DSM-5 and the proposed ICD-11.²¹ Excoriation disorder can lead to serious complications including infection, physical disfigurement and physical disability.^{22,23} Trichotillomania (hair pulling disorder) has a point prevalence of 0.5–2.0% and predominantly affects female patients;²⁴ similar to excoriation disorder, it has been identified as an OCD type. Rarely, self-surgery such as autocastration has been described as a complication of OCD.²⁵

OCD and suicide

It is important to recognise that people with OCD are at increased risk of suicide.²⁶ A Swedish population-based study found that suicide attempt rates were five times higher and suicide mortality rates ten times higher in people with OCD compared with the general population.²⁷ A systematic review found median rates of suicidal ideation and suicide attempts of 27.9% and 10.3%, respectively, in people with OCD.²³ Comorbid conditions such as harmful or dependent use of alcohol or other drugs, personality disorders or affective disorders increase suicide mortality rates in OCD to between 40 and 82%; however, the risk remains high when OCD is the only condition present.^{22,28}

Assessment of obsessions and compulsions

Obsessions are thoughts which come into one's head over and over again, and will not go away. Often experienced as paralysing and terrifying, they can be about apparently mundane things, such as the idea that something is not clean or that an appliance has been left on. They can also be more obviously upsetting, such as believing that one might stab someone (despite not wanting to) or might have unintentionally killed or harmed someone. Inappropriate sexual thoughts may take a similar form but be difficult to disclose in view of the associated shame. Obsessions can be about one's own body – for instance, having an infectious disease or something dangerous under the skin – and can be associated with intense physical sensations such as a visceral feeling of disgust, crawling skin, feeling contaminated or unclean, or intense physical anxiety or shame.

As well as physical contamination from direct contact with dirt or perceived contaminants, a person may experience mental contamination – feelings and fears that arise without physical contact.²⁹ The source of contamination is human rather than inanimate, and the feelings of dirtiness may come from the individual with OCD. Mental contamination is often associated with another person having abused, betrayed or humiliated the patient. The self may be regarded as 'bad' or 'immoral', and the essence of this badness may be transferred to objects and then passed to others. In this case, the patient's motivation is to decontaminate her 'self' to prevent harm being transferred to others; she also has an over-inflated sense of responsibility and influence in believing herself responsible for this harm.³⁰ Compulsive washing is often less effective in mental contamination, hence in this case the escalation to chemical burning.

Obsessions can follow convoluted paths to extreme consequences. For example, a worry that a light was not turned off might lead to obsessions that a spark of electricity could start a fire and kill people inside the building. A worry that one has left the door unlocked may lead to obsessions that a murderer could break into the house and kill one's family. Common features of obsessions are that they are unpleasant, upsetting and cannot be ignored. A key feature is the recognition that these ideas are not correct, do not make sense or are about something which the person does not want to do; they are 'ego-dystonic'. A patient may say that the rational part of their brain can see that it does not make sense, but that does not stop them from experiencing intense fears that the thought may be true.

Compulsions are repetitive, purposeful physical or mental actions that the individual feels compelled to engage in according to rules or until it feels 'safe', 'comfortable' or 'just right', in order to quell the anxiety, fear, disgust or terror associated with an obsession. Compulsions can involve checking, touching, arranging, decontamination, walking, counting or other physical actions. Alternatively, compulsions may involve mental actions such as praying, reciting or making number patterns. Compulsions are linked to obsessions in that they are used to try to get rid of them or fill the need they create. Compulsions can be resisted temporarily or deferred but almost always end up being performed, as the distress from not doing them is great and continuous. They feel voluntary to the person; they are not being controlled. This means people with OCD often blame themselves or are seen as acting irrationally but with capacity by healthcare staff. Although performing compulsions leads to temporary relief of distress, in the longer term it maintains distress by reinforcing the need to act to seek relief.

When differentiating obsessions, ruminations, delusions and thought interference, it is important to enquire about the nature of the thought. Some people with severe OCD refer to obsessions as 'voices' or speak about compulsions as though they are being ordered; it is important not to assume that these are command hallucinations without detailed examination of phenomenology. In addition to asking whether a patient recognises thoughts as their own, ask how easy it is to distract themselves, whether the thoughts are repeatedly intrusive or ruminative, and whether they fear worse consequences if they do not perform a certain act. When enquiring about compulsions, ask what will happen if the patient doesn't do the action, and how they feel once they have done the action.³¹ Becoming familiar with a symptom checklist such as the Yale–Brown Obsessive–Compulsive Scale will help in developing a systematic approach to enquiry about obsessions and compulsions.³²

Practical management of OCD

When someone is in the midst of terrifying obsessions, calm listening and explanation will help the obsessions and associated anxiety pass. If severe, this may take several hours. In an emergency situation, anxiolytic drugs may help to alleviate anxiety and allow a person to accept medical care, although they may also cause disinhibition and exacerbate compulsions. Anxiolytics should not be used routinely for obsessions outside emergencies.

Although there is discussion about the pros and cons of diagnosis in some psychiatric conditions, OCD is a condition where diagnosis allows for a clear explanation and treatment plan. When meeting a patient whom you suspect has OCD, it is important to confirm the diagnosis; ask for senior help if you are not sure. Once confirmed, you can give the patient hope: explain that it is a treatable condition, give written information about self-help, and ensure that follow-up and access to effective treatment are available. If OCD is identified while on call and an immediate management plan made, the patient should be handed over to the liaison psychiatry team for ongoing support in hospital, initiation or review of drug treatment, and arrangement of appropriate aftercare.

It is essential to ensure that appropriate follow-up and treatment are arranged, including specialist CBT for OCD that includes exposure and response prevention (ERP). Longer-term treatment should follow the recommendations in the National Institute for Health and Care Excellence guidelines:³³ treatment with CBT for OCD that includes ERP, plus the maximum tolerated dose of two trials of selective serotonin reuptake inhibitors or clomipramine for at least 12 weeks each. If a patient still has clinically significant symptoms interfering with functioning, a multidisciplinary review should be undertaken, and the patient should be referred to a multidisciplinary team with specific expertise in the treatment of OCD for assessment and further treatment planning, including augmenting drug treatment and intensive CBT for OCD.

Reflections and considerations

We have used the lived experience of OCD, self-harm and mental health services to illustrate a scenario which may be encountered by mental health staff working on call in emergency departments. This highlights several learning points about OCD, self-harm and on-call working. When on call, working collaboratively alongside other medical specialties is of benefit to patients. When seeing people who have self-harmed, retaining compassion, curiosity and hope for change, and ensuring a skilled assessment every time, can improve both patient experience and clinical outcomes. The recognition and diagnosis of OCD are essential elements of mental health staff's clinical skills; identifying and treating OCD can alleviate significant suffering and disability, and can save lives.

Patient's reflections and considerations

What matters to me in the emergency department isn't just about 'assessment' but is about providing help. There is a longer-term element in considering my ability to recover and to continue working: ensuring that I receive effective long-term treatment for OCD. Being correctly diagnosed with OCD has been life-saving for me. Until that point I was caught in a cycle of obsessions and compulsions which were causing me so much harm as to become life-threatening. I couldn't see a way out other than taking my own life to prevent me hurting or killing other people, but the correct diagnosis has improved things in ways I wouldn't have believed were possible. In the 4 years up to that point I had been brought to the emergency department over 133 times. I nearly died and was ventilated in intensive care after taking overdoses. The police arrested and prosecuted me when I was suicidal and afraid because I couldn't get the right help, and the chemical burns which I believed were necessary to stop the contamination spreading and killing others have caused permanent physical disability, ending my career.^{34,35} In the 2 years since I received the right diagnosis, explanation and drug treatment, although I am still waiting for specialist cognitive behaviour therapy and still spend hours every night terrified I have killed people, I have completely stopped compulsive chemical burning, I have not tried to kill myself, I have not been brought back to the emergency department at all and I have developed an alternative career.

In this context I am the patient, but I've been called worse: 'Frequent Flyer', 'A Waste of Valuable Clinical Time and Resources', 'Very Clever and Manipulative' (written in my notes while I was unresponsive in resus following an overdose), 'That' (as in, 'I'm not touching That'). Self-harm, particularly repeat self-harm, attracts stigma that

is unacceptable, along with stereotypes and assumptions which can distract from the clinical picture. What I need from you is not only your clinical expertise, but your clinical leadership in modelling respect for me and challenging discriminatory behaviour. Your work may be hard, but it is crucial; the difference your attitude and assistance makes can be life-saving and life-changing.

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E.P. co-ordinated the drafting of the manuscript and wrote the sections on OCD, self-harm and suicide. J.R. wrote the section on assessment of obsessions and compulsions. E.M. wrote the patient's perspective sections. D.V. wrote the sections on severity of OCD and practical management. A.B.T. supervised the manuscript and wrote the doctor's perspective vignettes. All authors edited the manuscript and contributed equally to the remaining sections.

None.

Supplementary material

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1.2.33 Predicting short-term suicide risk: allowing for ongoing variation in severity of intent

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Abstract

This article considers the role that assessment of suicidal ideation may have in short-term prediction of suicide. Suicide risk assessment is a multifactorial process and it is assumed that assessment of suicidal ideation is one component. Denial that suicidal ideation has any useful role in risk assessment fails to allow for the marked ongoing short-term variability in severity of intent, which is a common feature of the suicidal state of mind. It is concluded that the assessment of suicidal ideation, provided it is carried out correctly and applied appropriately, should continue to be regarded as a central component of the overall prediction process. A 'two-take' approach to short-term

risk assessment and mitigation is proposed that takes variability in severity of intent into account and includes anticipatory treatment planning for any problems that may occur in the near future.

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When a suicide occurs in one of our patients, as clinicians it is only too easy to blame ourselves even though our care had been exemplary. Nagging doubts easily linger as to whether the suicide might have been prevented if we had done this or that in a different way. It is very important in such circumstances to take a step back, accept that it can indeed be very difficult to predict suicide, let alone prevent it, and acknowledge that occasionally quite inevitably we will not succeed.¹

However, in our day-to-day work we are probably more effective in preventing suicide than we allow ourselves to acknowledge. Such a happening goes unnoticed and is never recorded: a prevented suicide is a statistical non- event for which we get no credit. Yet no doubt it can occur. So even though the task is difficult, it is important that we should continue to scrutinise the effectiveness of our clinical skills, strive to achieve their further improvement and only discard them with caution.

This review focuses particularly on assessment of suicidal ideation, evaluating its role in the care of suicidal individuals and in predicting short-term suicide risk. Assessment of suicidal ideation is regarded as a central clinical component of the overall risk assessment process, which is of course multifactorial and has a wide clinical/social base.² Long-term prediction is a highly questionable exercise and I do not consider it here.

In in-patient care, surely there can be no controversy regarding the importance of suicidal ideation: careful monitoring of any suicidal ideation that may be present is essential. Management of serious immediate risk is incomplete without minute-by-minute awareness of level of intent, and awareness of risk level should be part of any decision concerning a patient being allowed leave the ward. In the out-patient clinic evaluation of risk level, provided it can be shown to achieve an acceptable degree of reliability, should not only help us to determine the risk level at the time the patient is seen: but further it should also guide us regarding ongoing risk, thereby helping to decide the optimal length of time to the next out-patient appointment, as well as clarifying the most appropriate treatment.

Assessment of suicidal ideation criticised

A review of several meta-analyses concerning suicide prediction reached the following conclusion: ‘None of the meta-analyses found that any individual clinical risk factor, including suicidal thoughts and behaviours, was sufficiently accurate as a basis to allocate interventions’.³

Further cautionary advice comes from the National Institute for Health and Care Excellence (NICE), which states in its 2011 guidelines on self-harm: ‘Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm [or] to determine who should or should not be offered treatment or who should be discharged’.⁴

A number of other studies have found that the majority of patients who died by suicide had denied having suicidal ideas at the time of the final interview.⁵⁻⁷ This has been taken to mean that assessment of suicidal ideation is not to be recommended as part of suicide prediction because of its unreliability.

In the face of such a consistent body of evidence suggesting that it has no value, I will review the part that assessment of suicidal ideation might play in short-term suicide prediction. In doing so I will scrutinise the way it is used and asks whether this is appropriate.

Assessment of suicidal ideation looked at anew

Criticisms answered

The assessment of suicidal ideation, although it is a fundamental element of any comprehensive attempt to assess risk, often seems to be taken for granted and not described in any detail even in research literature. The procedure itself has been subjected to criticism and this needs to be answered.

There is no reason to believe that appropriate enquiry concerning the presence of suicidal ideation increases suicide risk. Nor is a person who volunteers to having suicidal ideas necessarily at low risk. Exploration of suicidal ideation is not an isolated exercise. Throughout it must be carried out in full knowledge of the total clinical picture and integrated into the whole therapeutic effort. It is a sensitive empathic reaching out to encourage sharing of distressing and often frightening ideas, as dynamic as any other form of intervention can be. It should not be a questionnaire-type Yes/No interrogation. It should involve progressive exploration of suicidal ideas themselves, their intrusiveness, frequency and acceptance as reasonable, and also of feelings of loss of control, perhaps part of delusional thinking, or of seeing suicide as the only way out of an impossible life situation. The role of ambivalence and personality traits tending towards the impulsive should never be ignored. All this requires gentle patience and warm concern. It is not intended to be a matter of focusing on a patient’s weaknesses rather than strengths: it is simply a guide that can help us make things safe. At all points we need to remember that it is for the benefit of the patient and not, for example, just a way primarily of coping with our own anxieties concerning adverse sequelae if things go wrong. A confident, realistically encouraging attitude is essential: an ambivalent patient will soon pick up doubts on our part and the whole exercise can then become counterproductive. It is never appropriate as a carer to identify with a patient’s despair. It needs to be recognised that aggressive behaviour can occur in parallel with significant suicide risk. Clarify any risk to others. A brusque hurried approach can leave the patient feeling stigmatised and undervalued, as well as encouraging denial of intent or even encouraging suicidal motivation. Discussing together any reasons why denial may occur and how to mitigate them, being available and offering urgent help at any time should suicidal thoughts recur, both represent a mark of respect for the patient’s intrinsic worth.

Although all of this is a complex and difficult clinical task it would be a mistake to lose sight of the important positive part that discussing suicidal ideation can have in caring for suicidal individuals. To carry it out properly is comparable to having responsibility for dispensing medicines: the results of maladministration of either could be dire. So, it is reasonable to expect that each psychiatric hospital ward should ensure that all clinical staff have been well trained in assessing suicidal ideation. Appropriate privacy is important if this sensitive and complex task is to be carried out reliably.

Allowing for variability in severity of intent

To base assessment of ongoing risk on the individual's mental state during a single interview is clearly likely to be highly unreliable. It can mislead not because suicidal ideation is intrinsically valueless in prediction and should be discarded, but rather because such an approach makes no allowance for the marked short-lasting and ongoing variation in severity of intent that is a common feature of the suicidal state of mind. The following case series and studies illustrate this in suicidal individuals during the weeks before death.

Over a 10-year period (1968–1978), 12 deaths by suicide occurred among patients who were under my sole consultant care, either while they were resident in a single psychiatric hospital ward or within 2 months of discharge. They had all expressed suicidal ideation. I knew each of them well, day in, day out, usually over several weeks, yet in spite of my close continuing contact with them and the majority reassuring me about their safety, they ended their lives. In an attempt to understand all this further, I put all their case records together and looked at them as a whole.⁸ A half showed marked variability in severity of suicidal intent, in some even over the course of a single day, with short episodes of corresponding misleading clinical improvement in which suicidal ideas were denied. Variable contact and unresolved stress factors and impulse seemed relevant. For example, one patient happily organised a charity walk from the hospital only to take her own life the following weekend when, still apparently well, she went home on leave to be confronted with an unresolved domestic crisis.

Two later case series consisted of all psychiatric in-patients in the City of Bristol during two separate periods (1982–1984 and 1991–1993) who died by suicide either from hospital wards or within 2 months of discharge.^{9,10} In the two studies, 52 and 61% respectively showed episodes of misleading clinical improvement. Stress was a common background to relapse: 44 and 50% respectively killed themselves when clinically improved but with stress factors unresolved.

Although the number of cases in these three studies was small (12, 27 and 18 respectively) and they bridged a time span of 30 years, the findings were derived from detailed observations at ward level by clinicians responsible for the patients' clinical care and were remarkably consistent. They confirmed that short-term variability of intent exists in a considerable proportion of suicidal patients. This reinforces the view that to judge assessment of suicidal ideation as a predictor of ongoing suicide risk merely on its efficacy when recorded in a single interview ignores a common clinical feature of the suicidal state of mind, namely its variability in severity of intent. To put it bluntly, it asks the impossible of it.

The following discussion focuses particularly on out-patient work but its principles apply to the in-patient situation too. We need to ask: In the face of such practical difficulties what can we do to make prediction of suicide more reliable so that we can rely on it over the short term until the next out-patient interview?

An attempt to take things forward

The approach which is proposed here tries to take into account variability in severity of intent when predicting suicide risk. It is suggested that, in addition to assessing risk specific to the time of interview, any attempt at predicting ongoing short-term risk should also invariably include a projected evaluation of whether suicidal ideation is likely to recur if difficulties are encountered before the next clinical contact with the patient. This represents an attempt to ameliorate the confounding effect of ongoing variation in severity of intent. It also allows anticipatory treatment plans to be laid for any difficulties that may recur, thereby targeting therapeutic efforts more efficiently. Assessment of suicidal ideation remains a central component of the whole process. The following proposed guidance incorporates this approach with regard to follow-up of patients who have recently experienced an episode of significant suicidal feelings. It is provisional, its aim being to highlight the points made in this article and to stimulate debate regarding them. It has not been used clinically nor evaluated in any way. However, it is hoped that, after wider evaluation and any necessary amendments have been made, its principles might prove to be of practical value in taking forward the difficult task of predicting short-term suicide risk.

Out-patient care of suicidal individuals: guidance on assessment of short-term ongoing risk

Remember that predicting ongoing risk of suicide merely on the basis of the patient's mental state at the time of a single interview can be very unreliable. Evaluation of suicidal ideation and intent should be more broadly based and cover the whole of the follow-up period. Remember that ongoing day-to-day variation in severity of intent can be marked. Always give serious consideration to any evidence of suicidal intent, expressed or otherwise. Keep in mind the possible reasons specific to each case why relapse might occur, as well as the overall risk assessment picture. An important trigger for relapse is stress, particularly stress that has previously been present and has not been resolved. Try to assess the likelihood that difficulties, stress related or otherwise, will recur before the next appointment and whether suicidal ideation will complicate them. Overall evaluation should invariably take such anticipated risk into account. Clarify what urgent help could be made available in such a forthcoming crisis, ensure that it would be acceptable to the patient, work through any hesitation expressed regarding seeking that help and review the appropriateness as well as any security provision related to prescribed medication. All this should be integral to the assessment process.

Implementing the suggested guidance

This guidance is put forward in the hope that it might improve our ability both to predict suicide risk in the short term and to target more effectively the ongoing treatment we offer. It is no more than a care plan, but one that not only focuses on the present: it also insists on searching for potential risk at some point in the future. According to it, no assessment of ongoing suicide risk would be regarded as complete without such a 'two-take' approach covering the follow-up period and aimed at what amounts to a moving target. This allows plans to be laid in advance for an acceptable form of urgent help should problems recur. Predicted suicidal ideation at any level of severity without stratification and particularly ideation that is triggered by a stressful event should be taken as sufficient to indicate significant continuing risk.

As mentioned above, variability in severity of intent has been found to occur in about half of patients with suicidal ideation who proceed to suicide.^{8,9,10} In the remaining patients, environmental stress factors that presumably trigger such variability are presumably either absent or do not cause significant problems for the patient. Does the proposed guidance therefore have value only for half of patients? Not necessarily. It is possible that, in other patients, careful anticipatory enquiry might reveal a need to plan help for problems that otherwise would have remained unexpected.

From what has been presented here it is clear that the process of predicting suicide risk even in the short term is a difficult clinical exercise. Regarding someone whose stress factors have not been fully resolved, a letter to the general practitioner (GP) taking all relevant issues into consideration might read as follows: "Suicidal intent appears to be low or non-existent today. This is not in itself a reliable predictor of ongoing suicide risk, which could recur again for a variety of reasons relevant to the illness itself or significant stress. Our discussion today showed that such stress might well recur prior to the next appointment and the patient was anxious about having to face it. Recurrence of suicidal ideation could not be ruled out. We discussed ways in which we could offer urgent help in such circumstances and as a result the patient felt more confident about being able to get through it all. Overall, however, the predicted level of suicide risk must still be regarded as significant, requiring vigilance until I next see him/her."

Great care should be taken before one is ever tempted to suggest that ongoing risk is totally absent in someone who has experienced suicidal ideation in the recent past. In such a situation a letter to the GP might read along the following lines: "The patient denied having suicidal ideas today, stress factors appear to have been resolved, family/social support has always been strong and remains so, and adverse events that might lead to relapse seem unlikely to recur during the follow-up period before I see him/her again. In spite of this reassuring picture, vigilance is required during the follow-up period. This is because relapse, especially if stress related, can occur unexpectedly in anyone who has been at risk of suicide and it is early days since he/she experienced suicidal ideation. I have discussed with him/her the availability of urgent help and as a result he/she feels confident about being able to cope until the next time we meet. For the moment, the predicted level of suicide risk must remain as uncertain."

Conclusions

It is hoped that the dynamic ‘two-take’ approach to predicting ongoing short-term suicide risk that is proposed here might prove to be a useful contribution to the overall risk assessment process by helping to ameliorate the ‘moving target’ problem due to varying levels of intent over short periods of time. Ongoing treatment should also be targeted more precisely as a result of its forward-looking approach. There are several other ways in which assessment of suicidal ideation can have a useful role in caring for suicidal individuals. Its value in detecting a certain group of in-patients especially vulnerable to suicide has been described elsewhere.¹¹ Whatever the setting, shared knowledge of suicidal ideation can also contribute to a therapeutic alliance with the patient, promoting a readiness to discuss suicidal ideas fully and thereby helping to alienate such ideas, making defensive denial less likely. Such mutual collaboration and trust not only have therapeutic and preventive value: they can then also facilitate the process of prediction.

Given this overall picture it seems reasonable to conclude that the assessment of suicidal ideas, provided it is carried out correctly, applied appropriately and always used within the wider context of risk assessment as a whole, can play a valued part in the overall care and prediction of risk in suicidal individuals. Surely it is here to stay.

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Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

Declaration of interest

None.

Supplementary material

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1.2.34 Invisible youth during times of Covid

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Covid-19 continues to devastate, the elderly and those in care homes being particularly vulnerable. However, there is an unexpected population that is at great risk of morbidity due to Covid-19, the adolescent forensic population. This increased morbidity is a result of the care offered by statutory agencies being greatly diminished across all settings owing to the pandemic.

One of the first things that you learn in adolescent forensic psychiatry is that perpetrators are also victims, and it can be hard to distinguish between the two. This does not excuse the crimes they have committed but does add an extra complexity to their treatment. Young people who present with complex forensic issues are particularly vulnerable, often having histories that include early trauma, repeated loss, attachment issues, learning difficulties and mental health problems.¹ This population is notoriously difficult for professionals to engage with, for many of the above reasons but also because of the possible consequences for them and their families of talking about the criminal aspects of their lives. The reduced consistency that services currently provide has affected their engagement and the possibility of a therapeutic alliance, thus increasing risk for themselves and the public.

A further contributing factor to increased morbidity has been school closures and agencies working remotely, leading to reduced access to support and structure, which has exacerbated vulnerabilities. Challenging behaviours were previously mitigated by the provision of education and other prosocial activities; the reduction has led to increased episodes of violence.² This has particularly affected young people with neurodevelopmental disorders and special educational needs, with the effects likely to be long term, complicated by loneliness and a disconnection from their community.

Youth custody has had to be increasingly vigilant to ensure the safety of detainees and prevent Covid transmission. There is a need to isolate those being transferred into custody in the first 2 weeks to prevent transmission of Covid.³ It is known that this is the time of greatest risk of suicide for young people in custody, when young people are now needing to isolate for Covid, thus increasing isolation and risk. Staff shortages, education closure and the need for Covid ‘bubbles’ has meant extended time alone in cells even after those first few weeks, which increases the risk of self-harm and suicide.⁴ Furthermore, the pandemic has led to a backlog in the courts, and concern over community services has meant that more young people are being remanded and for longer periods. It is of note that the majority (63%) of children given custodial remand did not subsequently receive a custodial outcome in 2018.⁵ These factors – extra time in cells and longer time on remand – can mean the compounding of an already traumatic experience for many in youth custody.

Young people with a combination of mental health and forensic issues are placed in secure adolescent psychiatric units to receive appropriate treatment. The effect of the Covid pandemic on staffing in these units has negatively affected the availability of support, and things that are often a lifeline for these young people, such as community access, planned leave and family visits, have been cancelled. A bottleneck has occurred, with transition back to the community being stalled owing to the services around the young person not being readily available to facilitate these moves or provide the relevant opportunities in the community.

Isolated young people with social communication, cognitive or emotional difficulties are at increased risk of exploitation by others in all settings. In the community, risks relevant to this group go beyond the risk of offending and risk to others and include being groomed into gang-related activities. Such gangs appear to have been more active and accessible to this group of young people during this time (including county lines and other criminal exploitation).

We realise that everyone is having a difficult time at the moment but believe it is essential to highlight some of the

issues that this frequently invisible population is experiencing, in the hope that they will not be forgotten.

However, it is not all doom and gloom; with any change there are gains as well as losses, and the gains have highlighted the dedication of the professionals working with this population. They have stepped up to the mark, through increased productivity, improved multi-agency working, increased uptake of virtual conferencing and appropriate information-sharing, with the aim of keeping these young people safe. The young people have noted these efforts and there has been feedback that this way of working has made them feel safer, so we hope, as a network, that we will be able to maintain the benefits as we return to the new normality.

This letter was compiled by the London Youth Justice Child and Adolescent Mental Health Services (CAMHS) Forum, which comprises professionals working in the following services: Youth Justice Liaison and Diversion, Youth Offending Teams (YOTs), Community Forensic CAMHS (FCAMHS), Youth Offending Institutions (YOIs, including SECURE STAIRS implementation) and secure adolescent units.

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1.2.35 Electroconvulsive therapy for severe depression, psychosis and chorea in a patient with Huntington's disease: case report and review of the literature

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Abstract

Aims and method

The psychiatric manifestations of Huntington's disease are myriad and difficult to control. The use of electroconvulsive therapy (ECT) is not commonly considered for this condition. We describe a patient with severe depression, psychomotor retardation, delusions and weight loss who responded to ECT with good control of her symptoms.

Results

Both our case and the literature appear to confirm the efficacy of ECT in the treatment of depression in Huntington's disease and suggest that other psychiatric manifestations of Huntington's are also responsive.

Clinical implications

ECT is an effective and safe treatment that should be considered earlier in the course of the disease in cases that show limited response to pharmacological therapy. It should also be considered as an adjunct to medical therapy that may simplify polypharmacy and allow better control in patients with debilitating psychiatric manifestations of the disease. There is limited and conflicting evidence for its efficacy in chorea.

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Case report

Seven years ago, a 57-year-old woman with a family history of Huntington's disease presented with depression, changes in personality, apathy, anxiety, poor memory and clumsiness. Her genetics confirmed Huntington's disease, with a CAG repeat number of 17/46. Over the subsequent 4 years, her condition was marked by psychiatric symptoms and mild chorea, which responded well to tetrabenazine 25 mg once daily, reaching 25 mg twice daily by 2014. Her mood was controlled with citalopram followed by sertraline. Her main complaints were bouts of introversion and tearfulness, but she remained socially engaged with friends. By early 2015, her swallowing had ostensibly become problematic. However, a speech and language assessment and a gastroscopy determined that her swallowing was normal. By spring 2016, she was starting to fall often, with worsening athetoid movements and increased somnolence. These changes led to a switch in medication to olanzapine at 15 mg per day and an increase in her dose of sertraline to 100 mg a day.

By summer of 2017, her choreoathetoid movements had worsened and were accompanied by weight loss and a deterioration in her mood. She required a short in-patient stay for fluids via a nasogastric tube. A psychiatric review diagnosed

her with a depressive psychosis with retarded affect, mood-congruent delusions and auditory command hallucinations. She believed she did not deserve to eat and drink, and the command hallucinations ordered her not to do so. She had extracampine hallucinations, sensing people at the end of her garden. In light of her clinical state of emaciation and the requirement for support, a trial of bilateral electroconvulsive therapy (ECT) was suggested for her depressive psychosis. A twice-weekly regimen was started, with the aim of optimising seizure length to between 30 and 60 s. In winter of 2017, she received an initial 12 courses of biweekly bilateral ECT treatments using between 75 and 150 mC. Her initial response was favourable and she became euthymic, with remission of her psychomotor retardation, but her psychotic symptoms persisted in the form of command hallucinations despite developing insight. Her delusion of guilt also resolved and, by the tenth dose of ECT, she started to eat and drink again. The initial course of treatment was complete by early February 2018 and, with the exception of her hallucinations, her psychiatric symptoms ceased and insight was retained.

However, the persistence of psychotic symptoms in the absence of a significant mood component led to an additional 12 sessions of bilateral ECT (administered biweekly with 150–225 mC; maintenance treatment consisting of bilateral 150–300 mC treatment biweekly continued into late 2019) with the aim of eradicating the hallucinations. She then developed a respiratory tract infection, which led to a relapse in her psychiatric symptoms with agitation, hallucinations, and marked choreoathetosis and dyskinesia that led to the reintroduction of tetrabenazine. Despite this setback, she did improve following the last 12 doses of ECT. This course was completed in late spring 2019. She was kept on maintenance ECT once per week, with partial remission of the auditory hallucinations, which had reduced in frequency and no longer distressed her. There was a subsequent increase in the frequency of the hallucinations, with preservation of insight, and a corresponding reduction in ECT to fortnightly. She has remained stable on this regimen to date. Her involuntary movements have also improved over that time, although she remains on tetrabenazine, haloperidol and sertraline.

Method

A literature search of PubMed for ‘Electroconvulsive therapy and Huntington’s’ and ‘ECT and Huntington’s’ led to the discovery of 20 papers, 18 of which were in English. Six publications were based on *in vitro* studies and animal studies, leaving 12 publications for review. A further three papers that were not listed in the PubMed search were sourced from references in papers from earlier years. All publications were either single-case reports or retrospective case series; there were no randomised controlled trials or prospective studies.

Consent for publication

Signed informed consent was obtained from the patient described in our case report.

Results

Table 1 shows a breakdown by demographic and disease characteristics of the 37 patients described in 15 studies. Tables 2–5 summarise the predominant psychiatric complaints, the effects of ECT on the number of medications used during ECT treatment, the CAG copy number, ECT treatment and seizure duration. Supplementary Table 1 (available online at <https://doi.org/10.1192/bjb.2020.51>) summarises individual patient details from the literature, including our aforementioned case. Table 1 Summary of patient characteristics and ECT treatment

Characteristic	Median	Sex	43%
Female	(7)	N/A	Age at presentation
20–65	47	Length of psychiatric symptoms (years)	0–222.5
Time from diagnosis to ECT (years)	0–173	Number of courses of ECT	3–418
Seizure duration (s)	5–120	40	Dose delivered (mC)
25–504	–	Lead position (out of 22 documented)	54% right unilateral ¹

Table 2 Breakdown of main presenting symptoms

Major presenting complaint	N
Depression	26 (18)
Chorea	14
(1) Suicidal ideation	13
Psychosis	12 (6)
Dysphagia/dysarthria	10
Hallucinations	7
Aggression	6
Catatonia	4
Psychomotor retardation	4
Inappropriate sexual behaviour	2
Pain/dystonia	1 ²

Table 3 Treatment before, during and after ECT- Study

Before ECT	Changes during ECT	After ECT
Evans et al ¹¹	Chlorpromazine, diphenhydramine	Haloperidol,

¹ N/A, not available.

² In total (sole reason); see text for details.

trazodoneBenzotropine, desipramineRanen et al¹Patient 1NortriptylineFluoxetine, lithiumDesipraminePatient 2NortriptylineDesipramine, haloperidolPatient 3Amitriptyline, carbamazepineNortriptyline added (6 weeks)Droperidol, ChlorpromazinePatient 4Nortriptyline, haloperidol, carbamazepine, lorazepam (catatonia)LithiumLewis et al¹⁴HaloperidolAmoxapineBeale et al³Haloperidol, pimozone, benztropine, diphenhydramine, Reserpine, propranolol, Diazepam (all for chorea)haloperidol, carbamazepineMerida-Puga et al⁴Risperidone, lorazepamClozapine, olanzapineAmantadine, lorazepam, levodopa, carbidopa (catatonia)Nakano et al⁵Risperidone, olanzapineN/A Cusin et al²Patient 1Clonazepam, haloperidol, levetiracetam, lorazepam, quetiapine, risperidone, tizanidine, trazodoneDuloxetinePatient 2Chlorpromazine, citalopram, phenytoinChlorpromazine, citalopram, lorazepam, olanzapine, phenytoinPatient 3FluoxetineAripiprazole, fluoxetinePatient 4Clonazepam, duloxetine, risperidone, trazodoneClonazepam, duloxetine, olanzapine, trazodone, valproic acidPatient 5Clonazepam, duloxetine, olanzapine, trazodone, valproic acidClonazepam, duloxetine, fluoxetine, haloperidol, lorazepamPatient 6Clozapine, duloxetine, fluoxetine, haloperidol, lamotrigine, lorazepam, methadone, milnacipran, trazodone, zolpidemChlorpromazine, duloxetine, fluoxetine, haloperidol, lorazepamPatient 7Duloxetine, olanzapineAmantadine, clonazepam, paroxetine, risperidone, sertraline, trazodone, valproic acidMagid et al⁸Olanzapine, chlorpromazine, aripiprazole, risperidone, haloperidol, fluphenazineCitalopram, mirtazapine, sertraline, trazodoneLorazepam, clonazepam, buspironePetit et al⁹Not mentioned but patient refractory to neuroleptics, antidepressants, atypical antipsychotics and mood stabilisersClozapineMirtazapineShah et al¹⁵Buspirone, divalproex, lorazepam, paliperidone, quetiapine, venlafaxineQuetiapine, olanzapineAdrissi et al¹⁰Patient 1Nortriptyline, quetiapine, tetrabenazineAmantadine, sertraline, quetiapinePatient 2Haloperidol, lorazepamLorazepam, venlafaxinePatient 3Amantadine, baclofen, chlorpromazine, clozapine, gabapentin, lithiumChlorpromazine, clozapine, diazepam, gabapentinPatient 4Bupropion, clonazepam, escitalopram, levothyroxine, lithiumBupropion, clonazepam, escitalopram, levothyroxine, trazodoneOur caseCitalopram, sertraline, tetrabenazineOlanzapineTetrabenazine, haloperidol, sertraline³ Table 4Number of trinucleotide repeats, age of diagnosis, ECT treatments and length of psychiatric symptoms prior to ECTCasesCAG repeat copy numberAge at diagnosis of Huntington's disease (years)Cumulative number of ECT treatmentsPsychiatric symptoms (years)Adrissi et al¹⁰ patient 4394572Petit et al⁹41591820Adrissi et al¹⁰ patient 24251270.5Magid et al⁸435737Adrissi et al¹⁰ patient 14445293Nakano et al⁵445940Lewis et al¹⁴446581Merida-Puga et al⁴4526425Beale et al³46561119Adrissi et al¹⁰ patient 34631416Our case4650407 Table 5ECT seizure length in seconds and treatment characteristicsCasesSeizure duration (s)MeanECT characteristicsDose (mC)Ranen et al, 1Patient 140–12060Patient 220–5037Patient 3 5–352170 Hz pulse width 1 s, duration 2 ms112Patient 420–5539Patient 525–4530(MECTA SR1)Patient 640–5546Lewis et al¹⁴24–140–90 Hz pulse width 1–1.6 ms, 33.3–57.5 J (MECTA SR1)–Beale et al³57–19–(MECTA SR2)72–233Merida-Puga et al⁴42–80–25% (Thymatron DGx)b126Cusin et al²90 Hz pulse width 1 ms, 2–4 sc180–360Adrissi et al¹⁰Patient 125–48–Patient 230–75–10–140 Hz, pulse width 0.25–1 ms, 5–50% (Thymatron IV)d25.2–504Patient 321–84–Patient 421–42–Evans et al¹¹239/6 treatments–(MECTA apparatus)–Our case30–60–(Thymatron IV)75–300⁴⁵⁶⁷

The time to ECT treatment after the diagnosis of Huntington's disease was between 0 and 17 years, with a median of 3 years and mean of 4.42 years. However, the sixth patient of Ranen et al. had previously had ECT for depression before she was diagnosed.¹ The age of psychiatric symptoms at presentation for ECT varied from 0 to 22 years prior, with a median of 2.5 years and a mean of 5.73 years.

³ N/A, not available.

⁴ Double stimulus was administered in Ranen et al's patients, but no further details were provided.

⁵ Assumed to be the USA version with 0.9 A and charge of 504 mC. The lowest percentage given to Merida-Puga et al's patient was calculated according to the half-life method. While no figure was given for the lowest percentage, 25% was the maximum stated.

⁶ Text does not state machine used or charge or current characteristics but states 'stimulus intensities comparable to patients without HD'. 0.8 A is presumed for the purpose of calculation.

⁷

As per specification sheet from the manufacturer, the maximum output is 504 mC with the range calculated based on quoted percentage delivered. This machine is capable of double stimulus, but this was not mentioned in Adrissi et al's paper.

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It should be noted that the diagnostic confirmation of Huntington's was solely clinical prior to 1993; however, despite the availability of genetic testing after 1993 (Huntington disease Collaborative Research Group), diagnosis only preceded presentation in this group of patients after 2013 (Cusin et al's first patient²). Prior to 2013, patients first presented on average 7.4 years *before* the diagnosis of Huntington's was made. After 2013, all patients with psychiatric complaints who went on to have ECT presented an average of 6.6 years *after* the diagnosis of Huntington's had been established. Six patients in total were diagnosed at the time of presentation, although five of them were diagnosed prior to 2013. For example, Beale et al's patient had choreiform movements (and no psychiatric manifestations) from the age of 35, but was not diagnosed until the age of 56 in 1995.³ However, this apparent lag after the introduction of genetic testing is likely to reflect the 16-year gap between Beale et al's paper in 1995 and those of Merida-Puga et al and Nakano et al in 2011 and 2013, respectively.³⁻⁵ Merida-Puga et al's patient was diagnosed following postpartum psychosis and a family history suggestive of Huntington's in her father; she went on to have ECT for catatonia. Nakano et al's patient was diagnosed owing to his brother's recent diagnosis with Huntington's at another hospital, having already received ECT for treatment-refractory psychosis.

Reason for referral for ECT

Table 2 shows a breakdown of the main characteristics of the clinical presentations; 48.6% of patients were referred for depression alone without psychotic features, and psychosis was the main cause of referral in 16%. Many of the referrals for depression alone were from some of the earliest reports, which lacked a clear description of the referral characteristics.^{6,7} The remainder of patients had numerous coexisting factors such as paranoia, delusions and other manifestations of psychosis, including hallucinations^{1,2,4,5,8-11}.

Coexistent motor symptoms were present in 20 patients^{1-3,5,9,10,12-15} (including our case), with chorea being the most commonly used term. Involuntary movement and impaired gait were also terms used without further clarification (e.g. Cusin et al uses both terms for different patients within the same series²). Psychomotor retardation was reported in four patients^{1,2,10} (including our case), with one patient being described as having neurovegetative symptoms (Cusin et al,² patient 3), and coexistent dysarthria/dysphagia in two patients. Catatonia was mentioned in four patients^{1,2,4} (fourth and fifth patient of series, 1 postpartum⁴ and the second patient of series²) but was the primary focus of treatment only in Merida-Puga et al⁴; see Supplementary Table 1.

Effects on psychiatric symptoms

The primary reason for prescribing ECT in all but seven patients (six for psychosis and one for chorea) was depression (Table 2 and Supplementary Table 1). There were universally favourable outcomes in the use of ECT for this purpose. It was reported to be successful in most cases, and the patients who were reported to relapse did so on shorter courses of ECT.^{12,13} However, these were early reports, and there have been numerous subsequent reports of relatively short courses with no relapse. For example, Ranen et al's third patient, who had depression, psychosis and catatonia, only needed five ECT treatments to achieve symptom resolution.

Psychosis responded to ECT in all six patients^{2,4,8,11} who were reported to have it as the primary presentation, which included our case. When coexistent disease such as depression was considered, 12 patients in total had prominent psychosis, and all responded to varying degrees, including our case.^{1,5,9,10} Merida-Puga et al reported refractory psychosis thought to be due to use of depot dopamine antagonists, although the focus of their treatment was the refractory catatonia.⁴

Hallucinations, either auditory (three cases including our case),^{1,11,13} visual (two cases)^{2,10} or both visual and auditory (two cases),^{4,8} also responded well to treatment. The exception was Ranen et al's fourth patient, where this was unclear, although the hallucinations probably improved with the patient's other symptoms.

There were four cases of reported psychomotor retardation, including our patient^{1,10,12} (in addition, speech retardation was reported in Nakano et al); all were described as improved following ECT without further clarification. Benson and Blumer's first patient had a 'temporary recovery'.

Catatonia (second and fourth patients of Ranen et al; second patient of Cusin et al^{1,2,4}) was described in four patients and improved in all. This improvement often paralleled the response to ECT of depression, suicidality and psychosis.

Two of these cases were resolved by relatively short courses of ECT (five treatments for Ranen et al's fourth patient – though their condition was, surprisingly, described as refractory – and seven treatments for Cusin et al's second patient). However, the presence of catatonia was refractory in the remaining two patients. Both Ranen et al's second patient (who relapsed repeatedly) and Merida-Puga et al's patient⁴ (who required withdrawal from long-acting antipsychotics) needed extended ECT courses (4 years for Ranen et al's patient but just over 3 months of an in-patient stay for the latter) to resolve the catatonia, with 35 and 42 ECT treatments, respectively. Merida-Puga et al's patient had a Busch–Francis catatonia score of 26 (total severity) on first admission, falling to 4 after a second hospital admission and discharge.

Our patient required repeated doses of ECT following a relapse of psychosis over 2 years. Eventually, she showed a partial response, with improvements in her mobility and psychomotor retardation. She started to gain weight, although her delusions persisted. Improved gait was reported in six cases, including Lewis et al and the first, fourth, fifth and sixth patients of Cusin et al, who had bilateral frontotemporal and right unilateral (RUL) placement, respectively.^{2,14}

Disorders of eating and/or speech were mentioned for a total of ten patients. Dysphagia was mentioned in two cases (Cusin et al's² second patient and ours) and dysarthria in another two (Cusin et al's third and sixth patients). Both dysarthria and dysphagia were reported for two patients (Cusin et al's fourth and fifth patients). For all six of these patients, their symptoms were described as resolving or dramatically improved. Refusal to eat was described in two patients (Ranen et al's second patient and Magid et al's patient^{1,8}), while poor appetite was described in another two (Ranen et al's sixth patient and Adrissi et al's second¹⁰). Both of Ranen et al's patients were described as improved, but there was no further clarification regarding outcome for the remaining two.

Aggression,^{1,2,10–12,15} inappropriate sexual behaviour^{2,15} and agitation¹⁵ were also mentioned and described as improved.

Only two reports documented improvement using psychiatric rating scales, with the BPRS-E (Brief Psychiatric Rating Scale, Expanded) score dropping from 88 to 38 after 12 ECT sessions in Petit et al's patient, and BPRS dropping from 139 to 68 in Nakano et al's patient (the PANS (Positive and Negative Syndrome Scale) score fell from 139 to 68 in the latter).^{5,9} Both Beale et al and Lewis et al documented improvement in the Hamilton rating scale for depression from 36 pre-treatment to 13 post-treatment in Beale et al and 36 to 10 post-treatment in Lewis et al.^{3,14}

Effects on motor symptoms

Chorea was mentioned in 14 cases,^{1–3,5,9–11,13–15} including our case (three patients of Cusin et al and two of Adrissi et al^{2,10}). Improvement was documented in three cases (Beale et al, Petit et al and Shah et al), although five were described as showing no change (Ranen et al, Lewis et al, Nakano et al, Cusin et al's fifth patient and Adrissi et al's first patient). In two cases, chorea was described as worse (Adrissi et al's second patient and Evans et al). In the remaining four patients, no details were given, despite this symptom initially having been described as present.

Only one patient was treated with ECT specifically for chorea. This patient demonstrated improvement initially and, despite worsening, their chorea never returned to the original level and was sustained at the improved level for a year.³

Our patient showed some response with respect to the choreoathetoid movements, which had become unresponsive to tetrabenazine. The medication had been withdrawn given her depression and fears of worsening those symptoms. Olanzapine, however, did not lead to any improvement in her chorea or psychiatric symptoms. Following a favourable response of the chorea to ECT, a low dose of tetrabenazine was reintroduced with good effect and had no further influence on her mood. Her gait and mobility also improved.

The use of rating scales for motor function was mentioned in only three cases. The Unified Huntington's Disease Rating Scale (UHDRS) motor score was recorded before and after only for Adrissi et al's second patient (27/31 out of a total of 124; their first case had an initial score of 49 with no follow-up score), while Petit et al's patient's UHDRS score decreased from 47 to 37 after 12 treatments and then rose to 57 after 1 year.^{9,10} For most cases, there was no mention of any response, which is not surprising because this was the focus of the treatment in only one of the studies. Surprisingly, despite admitting their patient specifically for the treatment of chorea (there were no psychiatric manifestations), Beale et al used no rating scales to document improvement.³

Effects on cognition

Many of the case reports mentioned problems with cognition, but few documented it with formal scores either before or after treatment. Scores were recorded before and after treatment by Nakano et al (Mini-Mental State Examination (MMSE) 27/26), Lewis et al (MMSE 23/24) and Ranen et al (second and fourth patients; MMSE 20/30 rose to 26 by discharge in the former and was 20/30 rising to 24–26/30 (administered twice) in the latter^{1,5,14}). Cusin et al used the Montreal Cognitive Assessment (MoCA) scale for their patients and described the scores as improved, although they did not publish the values.²

Ranen et al's third patient showed a drop in MMSE from 26/30 to 18/28, with an episode of delirium after his eighth ECT treatment. No further scores were recorded, but the patient was described as 'not completely recovered cognitively'.¹ Adrissi et al's second patient had an initial MoCA of 17/20, but no further score was documented.¹⁰

Effect on medication used

Table 3 documents the treatment at admission; changes, if any, that occurred during the course of treatment for the psychiatric manifestations of disease; and discharge medication for those patients where it was recorded.

In those patients who required a number of drugs to treat the psychiatric manifestations of Huntington's disease, implying difficulty in management, there was not necessarily a requirement for more ECT doses or prolonged ECT treatment. However, in patients with pharmacological treatment resistance and the requirement for many drugs to manage symptoms, there does appear to be scope for significant rationalisation of pharmacological therapy when ECT is used adjunctively. Beale et al's patient and Cusin et al's first and sixth patients all presented between 10.5 and 19 years after diagnosis but responded well to limited ECT treatments and were discharged on much less medication.^{2,3} Only Adrissi et al's third patient, Ranen et al's second patient and ours required extended ECT. It is not clear why there was resistance to conventional treatment in these cases.^{1,10}

However, this was not a consistent outcome; for example, Cusin et al's seventh patient was discharged on more medication after ECT than prior, and Adrissi et al's third and fourth patients were discharged on a comparable number of drugs to those given on admission.^{2,10}

Effect of CAG copy number on disease or treatment

The earliest reference to CAG copy number, and therefore genetic confirmation of the diagnosis, comes from Lewis et al in 1994 – in keeping with testing, which became available after the discovery of the trinucleotide repeat a year earlier by the Huntington Disease Collaborative Research Group. Copy numbers of trinucleotide repeats have no effect on the severity of the disease, but the age of presentation is inversely correlated with increasing copy number.¹⁶

Table 4 shows copy number, number of ECT treatments and length of psychiatric symptoms for cases where this information was documented. Although those requiring more cumulative ECT treatments may appear to be clustered with those with higher repeat copy numbers, Petit et al's and Adrissi et al's second and first patients represent evidence to the contrary.^{9,10} Given that there was only a difference of seven CAG repeats among the 11 patients, there appears to be no significance to this. In keeping with this, the youngest patient in the review, who at 20 years old was likely to have had genetic testing, although the results of this were not documented, responded well to ECT, with his symptoms described as resolved after only seven treatments (Cusin et al's second patient²).

ECT treatment course

Treatment courses varied between three and 42 treatments in total, with a median of eight. Relapse was mentioned in seven cases (Cusin et al's fifth and sixth patients).^{2,4,12,13,15} For Heathfield's patient (who had three treatments) and Benson and Blumer's patients, relapse was described in general terms, with no description of the treatment course in the latter's series.^{12,13} In the remaining patients, it is not clear why they relapsed, except for having received relatively short courses of between five and nine ECT treatments. Merida-Puga et al's patient had treatment-resistant catatonia exacerbated by dopamine antagonists prescribed for her psychosis; this led to relapses and an extended in-patient stay.

Most patients had treatment for up to 1 year (22 patients), although our patient has been undergoing continuing maintenance treatment at increasing intervals for more than 2 years to date. Ranen et al's second patient required treatment for 4 years and Petit et al's patient for more than 1 year.^{1,9} Those requiring extended treatment presumably did so because of continued symptoms^{1,10} (see below).

Patients who had an extended course, arbitrarily taken to be more than 20 treatments (seven patients including ours^{1,4,9,10}), did not have different characteristics from patients with similar symptoms but much less cumulative ECT treatment. Characteristics such as the nature of symptoms, length of time from diagnosis, length of time of psychiatric symptoms, age and sex did not appear to affect the number of ECT treatments. However, refractory catatonia complicating psychosis may have been a factor in extended treatment, with Ranen et al's second patient and Merida-Puga et al's patient⁴ requiring 35 and 42 treatments, respectively.

The four patients who had ECT more than 10 years after diagnosis^{1,2} (Ranen et al's sixth, Cusin et al's first, fifth and seventh patients) also showed excellent responses to ECT with between 8 and 13 treatments.

Length of seizure in seconds

Table 5 shows the seizure duration in the cases where it was recorded.^{1,3,4,10,11,14} Only Beale et al mentioned a reduction in seizure time from 57 s at the beginning of treatment to 19 s by the end. This was for the sole case in which ECT was administered for chorea.³ Our patient required ongoing treatment with increasing doses of ECT, although control of delusions was eventually achieved with seizure lengths between 30 and 60 s.

Dose of ECT treatment

It was not always possible to discern the dose of treatment given, as doses were rarely documented and were not necessarily consistent with other reports.^{1-4,10,11,14} For example, Beale et al's patient was stated as needing 72 mC initially, rising to 233 mC, with a corresponding drop in seizure duration from 57 s initially to 19 s at the end.³ When recorded, the frequency and pulse width varied. Alternatively, descriptions of percentage of maximum charge, where stated, together with the machine used (and its specifications), allowed for calculation of this figure where it was not explicitly stated (*Table 5*).

There did not appear to be any factors to explain why five patients, including our patient, required higher cumulative ECT treatments (Ranen et al's second patient, Adrissi et al's first, second and third patients).^{1,10} More generally, most patients were started on relatively low doses of ECT and titrated as treatment progressed, though this was not always documented. Only Adrissi et al's third patient was started on maximum charge dose of 100% (504 mC) due to refractory psychosis. This was later cut down to 50% (252 mC) owing to a bout of delirium that was subsequently felt to be due to medication. The presence of catatonia in Merida-Puga et al and Ranen et al's second patient may be considered a proxy for severity, but this was not the case for the other two catatonic patients (see above). Likewise, short treatment courses were reported in the earlier studies to be more likely to lead to relapse, but this was not borne out by later studies (see above). Getting the dose and the induced seizure length right appears to take more time in the out-patient setting, as may be expected. The three intense in-patient stays for our patient, Merida-Puga et al's patient and Adrissi et al's third patient (3 months in the latter two cases) allowed this to be achieved more rapidly, but the cumulative doses were all high.^{4,10} Overall, there appear to be no overt factors that predict who is likely to respond quickly or otherwise, although most patients will not require extended treatment based on this review.

Lead positioning

The predominant positions were RUL in 12 patients, one RUL unilateral and bilateral (unspecified), four bilateral (one bilateral frontotemporal, three bilateral) and two bitemporal (Supplementary Table 1).

Conclusion

The diagnosis of Huntington's disease is usually preceded by psychiatric symptoms in cases where family history is absent, sometimes by years.¹⁷ However, as we found in this review, patients are now likely to have an established diagnosis of Huntington's by the time they are considered for ECT. Although a CAG repeat number greater than 36 in the Huntington gene confirms the disease, an increased number of repeats is negatively correlated with age at presentation rather than severity of disease.¹⁶

Psychiatric manifestations of Huntington's disease vary according to the stage of the disease; apathy, for example, is found in 50% of patients by stage four on the UHDRS. Also present are obsessive-compulsive behaviour, irritability and aggression. Depression also increases over time, with only psychosis remaining consistent throughout at 11%.¹⁸

The prevalence of depression is about 50%, compared with anxiety at 17–61%, irritability at 35–73%, obsessive-compulsive disorders at 7–50% and psychosis at 3–11%. The prevalence of hypersexuality is between 2.1 and 30% and is slightly lower in women, whereas the prevalence of hyposexuality is higher at 63% in men and 75% in women.¹⁹ The use of ECT, however, is recommended only for depression on the basis of two of the above series.^{1,14,20}

There appeared to be little in the way of any effect on cognition with the use of ECT, although this was not a primary concern in this patient group. In the few reports where cognition was mentioned, the patients responded well and appeared to retain comparable pre-treatment scores over time, although the numbers were too small for us to draw any firm conclusions. However, Nakano et al's patient, despite comparable pre- and post-treatment MMSE scores (and significantly improved PANSS and BPRS scores), had greatly decreased 99 mTc uptake in the basal ganglia, cingulate gyrus and thalamus on SPECT after 21 ECT treatments compared to pre-treatment SPECT.⁵

There is little consistent evidence regarding the use of ECT for the motor manifestations of the disease. Chorea, a hyperkinetic movement disorder, shows variable response. In the studies considered in this review, chorea often responded to ECT (including for our patient), but this finding was not always documented and thus it cannot be extrapolated to a recommendation given the small number of patients. However, psychomotor retardation and catatonia, which are manifestations of psychiatric disease, all responded favourably, although the presence of catatonia may require more protracted ECT treatment. The reported swallowing issues and weight loss in our patient and others responded well. A situation that appeared terminal in our case has been managed effectively for the patient and her family with good control, for over 2 years following the first dose of ECT.

All the studies considered in the current review were either single-case reports or retrospective case series. There were no comparison or prospective studies. The most striking aspect of this literature was how the choice of ECT as a treatment came to be prescribed. In nearly all cases, ECT was a last resort when all else had failed, with the exception of one case in which it was used for the specific management of chorea.³ Consequently, strict psychiatric criteria were lacking prior to the decision to start ECT. The main concern in using ECT was related to controlling the manifestations of psychosis or depression/suicidality, with concerns regarding other manifestations, such as outward aggression, in only a few cases. Clinical success was documented by a general clinical sense of improvement, serving as an indication of efficacy, with no clearly defined end points. Similarly, the cognitive and motor scoring of patients was haphazard and inconsistent, with only limited numbers of patients having clear objective scoring on any scales – motor, cognitive or psychiatric performance – either before or after ECT was administered in order to monitor patient responses.

It is clear that the preliminary though limited evidence from this review supports the use of ECT for relieving depressive symptoms. However, this is often considered as a last resort when all other interventions have failed. The current review suggests that additional consideration be given to the use of ECT as an adjunct in conventional treatment-resistant cases of depression, as well as for wider psychiatric manifestations of the disease, especially where depressive and psychotic symptoms coexist. These wider psychiatric manifestations and complications, which include psychomotor retardation and hallucinations, appear to respond well to the use of ECT. Where there are wider psychiatric manifestations of Huntington's disease, ECT may not only control these more effectively but could also lead to rationalisation

of polypharmacy. Chorea may be less likely to respond to ECT, and so its use for this cannot be recommended based on the current review. Further investigative work with clear criteria and monitoring may lead to ECT being considered earlier and more often for patients with difficult-to-manage psychiatric manifestations of Huntington's disease.

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Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2020.51>.

[click here to view supplementary material](#)

None.

ICMJE forms are in the supplementary material, available online at <https://doi.org/10.1192/bjb.2020.51>.

1.2.36 Derek Bolton

Abdi Sanati¹

date

2021-04

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- *Derek Bolton*

Derek Bolton is Professor of Philosophy and Psychopathology at King's College London, UK. He is one of the pioneers of the discipline of philosophy of psychiatry. He founded the MSc programme in Philosophy of Mental Disorders at King's, which was one of the few in the world. It was while taking that course that I first met him. He has remained a great teacher and mentor for me and many other colleagues throughout the years. His publications on the concept of mental disorder and the biopsychosocial model are great works of practical philosophy. We managed to catch up in the midst of the COVID-19 crisis and thankfully the technology didn't let us down!

Professor Bolton, you wrote your book on the concept of mental disorder¹ in 2008. What is your view of the development of the knowledge in that field?

When I wrote the book, it was prepared over several years of the MSc course that you attended and which started in the 1990s. At that time, the main contender in the philosophical and conceptual field about the concept of mental disorder was Jerome Wakefield's 'harmful dysfunction' account.² He proposed a naturalistic view according to which,

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Abdi Sanati meets Derek Bolton, Professor of Philosophy and Psychopathology at King's College London.

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apart from any value that concerned human goods and harm, the concept of mental disorder also presupposed a natural fact, a dysfunction, which in his version was elucidated in evolutionary theoretical terms. Wakefield's account was a response to the challenges of 1960s and 1970s, which questioned whether mental disorders were 'natural kinds' as opposed to social constructs. My main task was to interrogate the assumptions of Wakefield's account. As it turned out, I was unable to make it work and came to the conclusion that mental disorder could not be pinned down by 'natural facts' as opposed to 'social facts' and the best way to capture it was in terms of impairment and distress, as in the DSM and ICD, which are as much personal and social as they are natural. What has changed since then (and I do not claim it is because of my book, which was at best an expression of shifting sands) is that attempts to disentangle natural facts about mental disorders have become less attractive, and what remains, the personal and social involvement of mental disorder – what might be called the psychological and social phenomenology – is more accepted. This leaves us with both challenges and opportunities.

What are these challenges and opportunities?

For opportunity, I think the person and the social context emerge as more central. The focus shifts from a disordered brain, or a disordered set of beliefs/behaviour, to the person in a social context with impairment/distress. The social context includes that it is not only (or not even) the patient who is distressed, but the family and extended society. The challenge is that the boundaries between illness and health, between what is and what is not the proper domain of healthcare, are more blurred, more socio-politically contentious. This of course has been recognised as an issue for psychiatry, but increasingly now in discourse about risks to physical health, evident for example in controversies over how to best manage the current pandemic.

Speaking of the boundaries between illness and health, that reminds me of a fairly recent book called *Vagueness in Psychiatry*.³ It argues that there is an inherent vagueness in terms such as health and disorder, which are semantic properties that cannot be corrected by gathering more facts and there always will be borderline cases. The existence of vagueness would not devalue the concept on its own. Do you agree?

It is true. I was brought up in the later Wittgenstein's philosophy school and my PhD was on works of Wittgenstein. In Wittgenstein's early work (the *Tractatus Logico-Philosophicus*) – like in the philosophy of logician and philosopher Gottlob Frege – it was assumed that concepts of course had clear boundaries. In what are called his later works (*Philosophical Investigations* is the major one), Wittgenstein dismantled the idea of clear boundaries. He likened language to a toolbox with lots of different tools for different purposes. If you look at language like that you lose the idea that concepts must have or ought to have sharp boundaries.

With reference to definitions, in some schools of philosophy definition is identifying necessary and sufficient conditions. Could this be part of the problem, where we try to find necessary and sufficient conditions for mental disorder – could moving towards a descriptive way be helpful?

It is an interesting question. If we think of philosophy as a canon and choose the great philosophers of the past few hundred years we see that the use of necessary and sufficient conditions does not feature or hardly features in their work. Philosophers such as Wittgenstein, Heidegger and Russell are example of this. Generally, I don't think concepts are usefully explained in terms of necessary and sufficient conditions. So, in the present context, when Robert Spitzer worked on the concept of mental disorder for DSM-III he was apparently not trying to identify necessary and sufficient conditions, but to identify criteria for its use (I believe he may have used the term 'conceptualisation' rather than 'definition').⁴ When we talk of definition of mental disorder, I think we are typically trying to conceptualise it and identify how it relates to other areas of interest, including personal distress and social impairments, as well as the various life and human sciences. Looked at like this, it is clear that mental disorder is not a fixed thing: the conceptual geography changes with changes in science and culture.

The discussion of social context brings me to your work on the biopsychosocial model. You recently co-authored a book with Grant Gillett titled *The Biopsychosocial Model of Health and Disease*.⁵ What made you interested in it?

In 2010, there was a book published with the title *The Rise and Fall of Biopsychosocial Model* by Nassir Ghaemi, whom I know.⁶ He argued that the biopsychosocial model was empty and without much use. That did puzzle me, as most people I know and whose work I had read seemed to suppose that the biopsychosocial model meant something and was the correct model for science and for practice. Nassir's book was a challenge to what the biopsychosocial model actually meant. He also added that it was a cover for loose thinking.

I remember attending a lecture of his where he argued that the biopsychosocial model was eclectic. If I remember correctly, it followed that the model was to some degree vacuous.

The historical context given in Nassir's book focused on the model mainly in the USA. He saw it as a framework within which competing models of psychoanalysis, social psychiatry and biological psychiatry could coexist and all be true.

In your book with Grant Gillett,⁵ you explored causation at different levels. I was interested in how you separated causation at the biological level from causation at the level of physics and chemistry.

The idea was worked out while writing the book. In his original paper, Engel identified reductionism as a problem for biomedicine, specifically reducing biology to physics and chemistry.⁷ That would exclude a distinctive biological causation and especially would exclude psychological and social causes. The core idea of the book was that there was a causation at the biological level that was above physics and chemistry. For the past 50 years or so biomedicine has developed as an exquisite combination of physics and chemistry but plus a whole new science of regulatory control, bringing in concepts such as functions, ends, positive and negative feedback systems and information flow. Importantly for the biopsychosocial model, these same causal explanatory frameworks also apply in the psychological and social domains. This is a way out of reductionism that can make sense of biopsychosocial causal interactions and the accumulating evidence of them in epidemiology and clinical therapeutics.

I was interested that you found the core of psychological causation in agency. How did you come up with that?

We didn't think about it at first. The primary task was to clarify causation and theoretical concepts of the various associated systems at the biological level. Once it became clearer as above, the psychological had to be understood as a system for regulating (causing) behaviour in the 'outside world'. 'Agency' is a shorthand for this. Also, various pieces of the contemporary scientific jigsaw puzzle fell into place, such as that neuroscience and psychology merge into one another, and that cognition is embodied. As to health problems and biopsychosocial medicine, this approach highlights emerging findings that many physical health problems, and especially the extent of experienced pain and associated impairment, key drivers of service use in long-term conditions, involve psychosocial as well as biological factors, implicating central involvement as well as biological systems below the neck.

In the book,⁵ you mentioned that we do not need to have an explicit theory of causation to accept causes in psychological and social levels. What do you think of psychiatry's engagement with the philosophy of causation?

All medicine purports to make a difference in the lives of patients and in this sense at least it needs some causal assumptions. It is true that we do not know how some treatments work, but when we intervene in different ways, we are supposing that it makes a difference and that is why we do it. The causal assumption is essential in these kinds of applied sciences. It is not unusual to not know how a treatment works but we should not lose confidence if we have evidence from, for example, randomised controlled trials that it is effective.

That reminds me of an anecdote on vaccination. It took several decades to know how the smallpox vaccine worked. If we wanted to wait to know the exact mechanism, millions would have died.

True. And if we contrast it with the present state that different vaccines are proposed for COVID-19, based on detailed models of cellular mechanisms of disease progression and how to interfere with them, it shows how much this field has progressed.

Going back to the reductionism, I found it interesting that you used emergentism as a way to challenge reductionism.

That was interesting. I didn't try to defend emergentism, which is a slippery idea with a complex history. I understood the position simply in terms of evolution, in which increasingly complex forms of life appear, each with characteristic phenotypic traits and associated causal powers.

I think your formulation of the biopsychosocial model is very useful. It could be very informative with concepts such as trauma.

Trauma is of course an important and interesting topic, with a long history in psychiatry and psychology. In terms of the biopsychosocial model we propose, trauma is an environmental stressor that has a direct negative impact on agency. In defining trauma in the context of PTSD, DSM and ICD regard 'helplessness' as a key feature. The position is that the most salient and important outcome in the situation (the person's own survival) is out of their control. This

occurs in acute situations like trauma but also in chronic exposure to severe stressors, implicated in upregulation of psychobiological stress mechanisms and raising risk of many kinds of both mental and physical health problems.

Thank you very much for your time.

1.2.37 Donald West, MD, LittD, FRCPsych

Jeffrey Weeks Philip Graham

date

2021-04

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- *Donald West, MD, LittD, FRCPsych*

Formerly Director of the Institute of Criminology, Cambridge, UK

Credit: Institute of Criminology, Cambridge.

Donald West, who died on 31 January 2020 aged 95 years, made a substantial contribution to knowledge in two areas of relevance to psychiatrists. In 1955 he published *Homosexuality*, a book for the general public. This was a sober, cautious, thorough presentation of the evidence about homosexuality in history, society and psychology, with some case studies from ‘self-confessed’ homosexuals to leaven the dough. It concluded that no doctor should advise a young person to be content with his sexual orientation without a ‘grave warning’ – ‘about the frustration and tragedy that so often attend this way of life’. West’s intention, as he described later in his memoir *Gay Life, Straight Work* (2012), was in fact more ambitious: to help the cause of greater understanding and legal reform, and he risked his career to do so. As he put it in his memoir, ‘For a young, unmarried professional to have stuck his neck out so recklessly seems, in retrospect, quite crazy [. . .]. I was protected by the hypocritical medical label’. Two years later, the Wolfenden Committee, which was sitting at the time *Homosexuality* was published, set up to reconsider the law, made recommendations for modest reform.

West’s book played an important part in changing the climate of opinion towards homosexuality in Britain. Many gay people of his generation and younger found it comforting to read something that confirmed their ‘normality’. It was, however, a further 10 years before male homosexuality was decriminalised in the Sexual Offences Act 1967. Subsequently, West continued to teach and conduct research on sexuality, publishing *Sexual Crimes and Confrontations: A Study of Victims and Offenders* in 1987 and (with Buz de Villiers) *Male Prostitution* in 1992. He also carried out, with Richard Green, a comparative study of controls on homosexuality across countries, published as *Sociolegal Control of Homosexuality: A Multi-Nation Comparison* (1997).

West’s other contribution to knowledge was his study of juvenile delinquency. In 1961, he set up the Cambridge Study in Delinquent Development. This study became one of the major, continuing, prospective longitudinal studies internationally in the field of developmental criminology. It began as a prospective survey of 411 south London boys, aged 8 years in 1961, who have since been interviewed at intervals through their lives. Their own children have been interviewed in more recent years, enabling a rich and extensive range of findings about antecedents and causes of criminality and desistance. Working together with his colleague David Farrington, who joined him in 1969, a number of major publications have emerged, including *Who Becomes Delinquent* in 1973, *The Delinquent Way of Life* in 1977 and *Delinquency: Its Roots, Careers and Prospects* in 1982.

Donald West trained in medicine at the University of Liverpool Medical School, qualifying as a doctor in 1947. While he was studying medicine, he had developed an interest in psychical research, finding in it an alternative to the religious enthusiasms of his parents. He had a lifelong interest in the paranormal, his first post being as research officer to the Society for Psychical Research (SPR). His first book was *Psychical Research Today*, published in 1954. His sceptical attitude to findings in this field did not, however, find favour with his employers and he was advised to find employment elsewhere. Although he doubted the claims of many spiritualist enthusiasts, he was convinced that extrasensory perception had a genuine psychological basis, deserving scientific laboratory research and statistical analysis. Indeed,

he remained committed to studying the paranormal throughout his career, and served several times as the president of the SPR.

He then trained in psychiatry at the Maudsley Hospital and Institute of Psychiatry, where he worked with Peter Scott, the leading forensic psychiatrist of the day. After completing his training, he worked at the Marlborough Clinic in Hampstead. In 1960 he joined the newly established Institute of Criminology in Cambridge as Assistant Director of Research. The founder and director of this institute was Sir Leon Radzinowicz, who was a strong believer in interdisciplinary research. West spent the rest of his career there, as lecturer, reader then Professor of Clinical Criminology. He was Director of the Institute from 1981 until his formal retirement in 1984. At Cambridge he became a Fellow of Darwin College, and was promoted to a personal Chair in Clinical Criminology. He also worked in an out-patient clinic at Addenbrooke's Hospital, Cambridge, as an honorary consultant psychiatrist. He was appointed to the Parole Board on its foundation in 1968 and, after his retirement from the Institute, served as a Mental Health Commissioner (1992–1997).

Donald was born in Liverpool, in a traditional red-brick workers' house near the docks, the only child of John, a catering manager with Cunard, and Jessie. His parents were of working-class origins with high aspirations. He was a sickly child, cosseted by his religious mother, who died when Donald was 11. His father later remarried. He felt the manner of his upbringing left him with chronic shyness and feelings of inadequacy. He won a scholarship to the fee-paying Merchant Taylors' school in Liverpool, from where went on to study medicine at Liverpool University.

His memoir was written with the encouragement of a gay writers' workshop in a manner quite different from his academic style. For many years he attended social meetings of Opening Doors London, the leading organisation for older LGBT+ people. West appeared an austere and, in his own words, a not particularly clubbable person, but he had a dry wit and a wide and eclectic network of friends.

He was in a relationship with the art historian Pietro Raffo for more than 45 years, until Raffo's death in 2000. In 2006, he entered into a civil partnership with Vincenzo. He died on 31 January 2020. Vincenzo survives him.

This obituary is based on one published in *The Guardian* on 23 April 2020 (<https://www.theguardian.com/books/2020/mar/11/donald-west-obituary>).

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The contributors to this refreshing, courageous and remarkable book break the silence about young people living with parental mental illness and the distress they and their immediate and future families experience. The central theme is to enable conversations about difficult experiences of parents and children. Airing personal reflections and experiences risks rejection, stigma, hurt and isolation. Traumatic experiences are often associated with avoidance of reminders and a desire to imagine the world to be different and just, rather than the more abrupt reality of moral fractures in a world where fragile and vulnerable minds are overwhelmed. Parents wanting so much for their children find themselves unable to live up to their own expectations, and at the same time lament that they may be hurting their children inadvertently, just by living with mental illness. Yet, these sentiments are not easily realised, and much time is spent by parents and children in evading or not knowing how the other feels and sees the world, including in their relationships.

The contributors include young people who were raised by people with mental illnesses, some of whom have gone on to become parents and enter the professions that work with children not dissimilar to their past selves. Additionally, in the book, parents offer commentary and children in return reflect on their parents' dilemmas and distress. Although it is painful to confront such realities, all contributors are optimistic, full of gratitude, being mindful of how the world looking back seems so different from how it felt in the moment.

Through a network of conversations, observations, reflections and counter-reflections, the editors provide a form of

scaffolding that helps. They create and display the very process that needs to take place between parents and children facing fears and isolation that come with parental mental illnesses. They reveal how intimate and important sentiments surfaced and were discussed in a reflective fashion by families to arrive at what seems like a more settled and peaceful coexistence, an appreciation of each other's strengths, and ultimately the enduring respect and love that evolve as they show they care so much for each other. That they matter more than they realise.

There is much here for professionals, parents and children, as well as commissioners and policy makers. The first-person accounts are invaluable, articulate and perhaps even a little refined and polite, having been worked at for some time. This makes it easier to hear about some very harrowing moments in the lives of those bearing witness to and living with the silent struggles. I do hope that those affected will read the book and discover they need not be alone and have much to give and have more courage than they might realise.

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1.2.38 Perspectives of GCSE students attending a psychiatry summer school in south London

Clementine Wyke Glori-Louise de Bernier Chun Chiang Sin Fai Lam Clare Holt Sophie Butler Anto Praveen Rajkumar Rajamani Charlotte Wilson Jones

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date

2021-04

Abstract

Aims and Method

This study evaluated a pilot psychiatry summer school for GCSE students in terms of participant experience, effects on attitudes to mental illness and perception of psychiatry as a career option. This was done using the Community Attitudes towards the Mentally Ill scale, career choice questionnaires and a discussion group following the week-long programme attended by 26 students.

¹ See editorial, this issue.

² Joint first authors.

Results

Students were significantly more likely to choose psychiatry after the summer school ($P = 0.01$). There were statistically significant changes in scores for social restrictiveness ($P = 0.04$) and community mental health ideology ($P = 0.02$). Qualitative analysis generated four themes: variation in expectations, limited prior knowledge, perception of the summer school itself and uniformly positive attitudes to psychiatry after the summer school.

Clinical implications

Targeting students at this early stage appears to be an underexplored positive intervention for improving both attitudes towards mental illness and recruitment to psychiatry.

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Introduction

Summer schools allow students to access educational experiences that are not otherwise available to them. They are a successful facet of the Royal College of Psychiatrists' #ChoosePsychiatry campaign¹ and, if well designed, can improve attitudes to psychiatry among medical students.² However, as summer schools are primarily aimed at medical students and foundation doctors, opportunities to experience psychiatry while at school remain limited. A psychiatry scheme for school leavers³ and work experience placements focusing on mental health for A-level students⁴ have been reported with positive outcomes. However, these examples concentrate mostly on those already committed to applying to medical school. Such programmes, especially those with entrance processes requiring evidence of prior interest, tend to favour those already motivated to work in psychiatry. Thus, there is recruitment potential in prioritising those that have little prior knowledge of the subject.⁵ Studies have shown that medical students reporting an interest in psychiatry before medical school are more likely to subspecialise in it in the future.^{6,7} Therefore, the evidence suggests that a summer school for students following their GCSEs would allow them to obtain valuable early experience of psychiatry and hopefully garner a potential untapped interest in psychiatry as a career. The aim of this study was to evaluate the

experiences of GCSE students attending a psychiatry summer school, with a secondary aim of assessing its influence on attitudes to mental illness and perception of psychiatry as a career.

Methods

Setting

The summer school was a joint venture by the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) and the local mental health trust, South London and the Maudsley NHS Foundation Trust. It was a free 5 day programme (see *Table 1*) for GCSE students, with participants recruited from state and private secondary schools within south-east London. *Table 1* Summer school timetable

Monday Tuesday Wednesday Thursday Friday Introduction to Mental Health

0930–1030 Welcome session

Break
1045–1215 Breakaway groups on ‘What is Illness?’ and ‘What is mental illness?’ Psychiatry & Society

0900–1000 The evolution of consciousness

1015–1115 History of Psychiatry

Break

1130–1245 Psychiatry Case 2 (forensic patient) Life as a Psychiatrist

0915–1030 From start to finish

Psychiatrists at varying stages of their careers

Break

1100–1230 Psychiatry Case 3 (patient with FND) Psychiatry Specialties

0900–1100 Quick Fire Specialties

Psychiatrists working in subspecialties, including psychotherapy, affective and psychotic disorders, addictions and eating disorders

Break

1115–1230 Psychiatry Case 4

(CAMHS patient) Looking to the Future

0900–0930 Old Age Psychiatry

0930–1000 Thoughts on Psychiatry

1000–1115 Psychiatry Case 5

(patient with psychosis)

Break

1130–1300 Debate

(joint with medical students)

‘This House believes that social media damages your mental

health’ LUNCH LUNCH LUNCH LUNCH LUNCH 1330–1430 What is Psychiatry?

1430–1500 Myth Busting

Break

1515–1630 Psychiatry Case 1

(patient with PTSD)

Consultant psychiatrist & their patient 1400–1430 Global Mental Health

1430–1715 Psychiatry in the Arts 1345–1600 Extreme Psychiatry

(joint with medical students) 1330–1430 Psychiatry of homelessness

1430–1530 Military Psychiatry

Break

1600–1700 Neuropsychiatry 1400–1600 Life at Medical School & How to Get There

Medical school psychiatry society

1600–1630 Feedback and discussion group³

Selection of participants

Letters were sent to careers advisors at all 15 eligible schools within a 1.5 mile radius of the IoPPN, inviting them to nominate two participants and two waiting-list students each for the summer school. Non-eligible schools were those that only catered for pupils with special education needs or were sixth form only. Each school independently decided on the selection procedure, with the only proviso being that the student should be academically capable of entering a medicine degree course. They did not have to have expressed any interest in medicine as a career.

Curriculum development and structure of summer school

The curriculum was developed and implemented by a volunteer committee of psychiatry trainees, led by the Director of Undergraduate Psychiatry. The programme included a mixture of lectures and small group workshops, in addition to three joint sessions with an established summer school for medical students being held in parallel. Content included daily sessions with patients and their psychiatrists and the breadth of psychiatry subspecialties, but also addressed the wider context of mental illness such as social factors, transcultural applications and the history of psychiatric practice.

Assessment

This was a mixed quantitative and qualitative methods evaluation with ethical approval obtained through the Research Ethics Office at King's College London.

All participants were invited to take part in the evaluation, and participants gave written informed consent. Pre-programme, demographic information and prior exposure to mental illness were collected. Participants' top three career choices, likelihood of choosing a career in psychiatry and score on the Community Attitudes towards the Mentally Ill (CAMI) scale⁸ were obtained pre and post programme.

The CAMI scale comprises 40 items representing the following four dimensions: authoritarianism (the view that the mentally ill are different and require coercive measures), benevolence (sympathetic views towards the mentally ill), social restrictiveness (that the mentally ill are dangerous and need to be separated from society) and community mental health ideology (importance of community care for the mentally ill).^{8,9} It was selected for its utility within a community rather than a professional population, as the sample consisted of school students with no medical training.

On the final day, a short discussion group was run to gather feedback on the summer school experience. All students were informed of the group, and six randomly selected volunteers contributed. The facilitator (G.-L.d.B.) was known to the students, so left the room after posing each question to enable free unconstrained responses, which were recorded.

The contributors were asked three open questions, which were designed to enable discussion and aimed to assess 'before and after' attitudes in relation to the summer school and psychiatry. •Why did you want to come to the summer school and are you glad that you came?•What did you hope to get out of the summer school and what did you actually get out of it?•How did you feel about psychiatry before and after the summer school?

³ CAMHS, child and adolescent mental health services; FND, functional neurological disorder; PTSD, post-traumatic stress disorder.

Statistical analyses

Only one of the participants did not complete post-training preferences for medicine and psychiatry, and these missing values were not imputed. Participants' characteristics and other variables were initially analysed by descriptive statistics. We checked whether the continuous study variables followed a Gaussian distribution by Shapiro–Wilk tests. We employed appropriate non-parametric tests when the continuous study variables did not follow a Gaussian distribution. Changes in the career choices of the participants between the two time points were analysed by McNemar's test or Wilcoxon signed-rank test. Changes in CAMI subscale scores between the two time points were analysed by appropriate tests of statistical significance. All analyses were performed using the statistical software STATA 15.1 (StataCorp, TX, USA).

After transcription of the discussion group, the responses were initially analysed using open coding by a researcher independent of the summer school programme (C.H.). Alongside a second researcher, who had overseen the discussion (G.-L.d.B.), these open codes were grouped into axial codes, which were then further distilled into themes.

Results

Quantitative

Of the 26 participants, ten (38%) were from private schools and the remainder were from state schools. Of the participants, 20 (77%) voluntarily completed both the pre- and post-programme questionnaires. Of these students, 12 (60%) were from non-White ethnicities. Data on demographics and career choices can be found within *Tables 2 and 3*. The majority (70%) reported life experience of mental illness before attendance at the summer school, and 50% had received some school teaching on the subject. *Table 2* Demographic characteristics Demographic characteristic (%) Total number
20 Gender Male 7 (35) Female 12 (60) Not specified 1 (5) Age (years) 15 1 (5) 16 1 (5) 19 9 (45) Ethnicity White 8 (40) Mixed 2 (10) Black/African/Caribbean 6 (30) Asian 4 (20) Experience in mental health Life experience (personal/friends/family) 14 (70) Work experience/volunteering 2 (10) School teaching on mental health 10 (50) Family member working in mental health 6 (30) *Table 3* Career choices Before programme ($N = 20$) After programme ($N = 19$) Choice n (%) 95% CI n (%) 95% CI α First 2 10.00 1.23–31.70 5 26.32 9.15–51.20 Second 2 10.00 1.23–31.70 2 10.53 1.30–33.14 Third 0 0.00 0.00–16.84 4 21.05 3.10–33.14 Within 3 42.00 5.73–43.66 9 47.37 24.45–71.14^{4,5}

According to the measure of a student's likelihood to choose psychiatry as a career, participants were significantly more likely to choose psychiatry after the summer school week ($z = 2.46$; $P = 0.01$). Pre-course, four participants ranked psychiatry within their top three career choices. This increased to nine post-course, which was a statistically significant change (McNemar's $\chi^2 = 5.00$; $P = 0.03$). Two participants ranked psychiatry as their top career choice pre-course, and this increased to five post-course. However, this change was not statistically significant (McNemar's $\chi^2 = 3.00$; $P = 0.08$).

On review of the CAMI scale, there were statistically significant changes in scores pre- and post-programme for both social restrictiveness (viewed less positively, pre: 18.6, post: 16.05, $t = 2.25$; d.f. = 19; $P = 0.04$) and community mental health ideology (viewed more positively, pre: 38.45, post: 40.5, $t = 2.48$; d.f. = 19; $P = 0.02$). There were no significant changes for benevolence (pre: 41.15, post 41.55, $P = 0.54$) or authoritarianism (pre: 20.8, post: 19.8, $P = 0.33$).

⁴ Binomial exact confidence interval.

⁵

One-sided 97.5% confidence interval.

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Qualitative

Qualitative analysis of the discussion group generated 29 open codes and ten axial codes, from which four themes were generated.

Theme 1: Variation in expectations of summer school

The group was divided between those who had positive expectations for the programme and others who described initially feeling less enthusiastic about attendance. Those with an existing interest in medicine or mental health tended to express expectations that the summer school would enhance their knowledge of mental health conditions and provide further insight. *“I definitely wanted to go into medicine so I just wanted to see about the different areas”* *“I hoped to get more informed about different mental disorders... because I’ve been interested in that for a while”*

Others had a more generic reason for signing up to the programme, with half mentioning wanting to keep themselves occupied over the summer holiday or participate in an activity that was both enjoyable and worthwhile. One participant admitted being coerced by his mother to attend. The students discussed their negative preconceptions; some anticipated that the sessions would be wholly didactic in nature, with senior doctors leading and no element of interaction. There was also a concern voiced that, as school students, they may have felt patronised. *“My expectation coming in was that it would be a lot less involved than I thought it would be. I thought it would just be doctors talking over us instead and to us instead of actually letting us discuss”* *“I hoped that I would be treated in a way that wasn’t a GCSE student that’s like dumb and doesn’t know anything, doesn’t really know what they want to do and over dumbed-down for them”*

Theme 2: Limited prior knowledge and exposure to psychiatry

As a group, the participants admitted to very limited previous knowledge about mental illnesses, the scope of psychiatry and the management options available. Most brought up a lack of understanding of the difference between the disciplines of psychology and psychiatry, including those who had been exposed to the topic in lessons and school talks. *“I didn’t know that a psychiatrist was actually a doctor, I didn’t know that mental illnesses were such a wide range and they were so important and there are different ways of dealing with them”* In their personal lives, there was one suggestion of first-hand experience of mental health difficulties and one student whose parent worked in the field. However, familiarity was not necessarily advantageous – the aforementioned parent allegedly refused to talk about their job to their child. Some referenced impressions of psychiatry that had been created and influenced by the media. *“I thought it [psychiatry] was about medicating people and torturing them in a way and putting them to sleep (laughing) I’m serious, I’m actually being serious, because of the movies”*

Theme 3: Perception and experience of summer school

Perception of the summer school retrospectively was consistently positive across the cohort. All felt they had benefited in at least one respect, such as better knowledge of mental health conditions, increased interest in the area or even a sense of privilege from involvement in the programme.

Repeated comments were made about the rare opportunity to associate with professionals and medical students, which was found to be a valuable way of gaining insight from those directly involved in clinical work. Interest was expressed in not only the substance of their work but also personal experiences and perspectives. *“... to talk to actual patients, talk to actual doctors, actual medical students and I think it’s a really amazing opportunity and I wish there were more that were just as easily accessible and just as free and as local”* The daily sessions with past or current patients exploring their experiences of mental illness and treatment were frequently mentioned as a highlight of the programme. The participants appreciated the university-style teaching methods, particularly the interactive components and being given space for further discussion on the topics broached. *“... we have had the opportunity to talk and express our own opinions about other stuff which I didn’t think we’d be able to, and while doing that, also shown a lot of really good stuff about what it’s like to be a doctor or a psychiatrist”* *“We were in actual lecture theatres listening to lectures university style, we were looking at patients... It was really amazing, I got a lot more knowledge and experience out*

of this week then I could have possibly thought. I just hoped I'd get an opportunity to talk about psychiatry but nothing on this kind of scale"

Theme 4: Uniformly positive attitudes towards psychiatry following summer school

In addition to their experience of the summer school as a programme, all participants had a positive impression of psychiatry in itself. Those who began with a limited or negative perspective indicated that prior misconceptions had been challenged and questions had been answered. Psychiatry was compared favourably with other areas of medicine, and psychiatrists as a group were looked upon positively. *"The treatment of the patients has been fulfilling to them [psychiatrists] personally as well. It might be a lot more interesting than the other professions or the other parts of being a doctor, which I guess is a change" "It's also the relationships that they have with the patients. They talk about it like they actually remember them and they actually care which is really nice to know"*

Although not specifically asked about career intentions in the discussion group, most volunteered that they were considering psychiatry as an option for the future as a result of the summer school. This included those who were not previously interested in medicine and also those who had considered becoming a doctor but were focused on other branches of practice. Some had even forged interests in specific subspecialties. *"From the very first day and the very first session, my eyes were really opened as to what exactly psychiatry is about and how it can appeal to somebody like me, especially considering I wanted to be doing a different kind of speciality, like surgery, but now I think I have a much more open viewpoint on the different specialities, especially psychiatry" "This week has changed my perspective so much that I'm actually wanting to go into military psychiatry so yeah it's changed me as a person"*

Discussion

Our evaluation of this inaugural summer school has demonstrated that an educational project such as this has the potential to encourage students yet to start their A-levels to consider a career in psychiatry.

Despite increasing awareness of the importance of mental health in the public domain, participants showed limited knowledge about mental illnesses, including misconceptions about the role of a psychiatrist, a lack of knowledge about treatment options and influence from negative media portrayals of the profession. This indicates that campaigns and media interest¹⁰ do not necessarily translate into awareness of career opportunities, which must be a separate strand of work in parallel with stigma reduction. The improvement in understanding and awareness shown by the time of the discussion group demonstrates the direct effect of the summer school.

Although clinical contact has not always been an essential factor in improving attitudes towards psychiatry,² our experience was that witnessing the doctor–patient relationship and hearing about the effects of the work of a psychiatrist were key strengths of the summer school identified by the participants. In keeping with medical student and trainee experience,¹¹ it appears that role models are also important early on to enable students to visualise their own potential next steps.

This evaluation adds to the body of evidence that educational interventions can change the attitudes of adolescents towards mental illness.^{5,11–15} Although this was not the primary purpose of the summer school, it was a welcome side-effect. It is noted that not all subscales of the CAMI showed significant change pre and post course. However, given how little current comparative data exist on attitudes to mental illness in our population group, further research is required to fully explain these results.

The Royal College of Psychiatrists' current recruitment strategy¹ is inclusive of school students, having aimed to roll out regional sixth-form career events by the end of 2019. We propose that GCSE student events are an area worth exploring further. These may serve to inspire students who perhaps have a less fixed commitment to one career path, have not considered medicine previously or have little knowledge of the scope of psychiatry and still have time to change their A level choices. We felt the following aspects were crucial to making the summer school accessible to a range of students and meeting the national efforts to widen participation.¹⁶ •Enabling students of all socioeconomic backgrounds to participate; it was free of charge and food was provided. •Ensuring there was no competition between private and state schools for places. •Proactive chasing of schools that did not immediately respond (these tended to

be state schools, who were less likely to have a dedicated careers advisor).•Timing the summer school before A-level choices so students had the option to change these if they wanted.

The main limiting factor in this study was the small sample size of 20 students. Our qualitative data from the discussion group did not reach saturation, demonstrating that not all potential data were garnered from this aspect of the evaluation. More discussion groups would be required in further research. In addition, although our cohort comprised a mixed demographic from a diverse part of south-east London, even if they had a variety of motivations, expectations and career interests, the students were still a self-selecting group, with all agreeing to attend a week-long summer school on psychiatry. We did not collect information such as family history of higher education and parental occupations, but doing so would help to assess whether students from all socioeconomic backgrounds were accessing the summer school. A barrier to transferability is that areas without potential funding from a major educational institution such as the IoPPN and a large pool of academics and clinicians to draw upon may find it challenging to provide this intensity of programme for a relatively small number of participants. Finally, as this is a little-studied population, it is unclear which assessment tool is most suited to explore school students' attitudes towards psychiatry.

Conclusion

Targeting students at this early stage appears to be an under-utilised intervention for psychiatry recruitment, and one which offers exciting potential for further work. The participants reported universally positive experiences of the summer school and demonstrated a shift towards considering psychiatry as a future career. There was also a valuable side-effect of more positive attitudes towards those with mental illness. We plan to repeat this summer school in future years and undertake longer-term follow-up in regard to participants' A-level and degree choices and ongoing interest in psychiatry as a career.

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C.W. helped to organise and run the summer school and assisted in the drafting of the paper. G.-L.d.B. ran the discussion group, transcribed and analysed the data and assisted in the drafting of the paper. C.C.S.F.L. led the organisation of the summer school and collection of quantitative data and assisted in the editing of the paper.

C.H. advised on the running of the discussion group and assisted on the analysis and write-up of the qualitative data. S.B. contributed to the organisation of the summer school and assisted in the drafting and editing of the paper. A.P.R.R. performed the statistical analysis of the quantitative data and assisted with editing of the paper. C.W.J. provided oversight and guidance on the running of the summer school and data collection and assisted with editing of the paper.

None.

Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2020.76>.

[click here to view supplementary material](#)

1.2.39 Teaching psychiatry to medical students in the time of COVID-19: experiences from UK medical schools

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Abstract

Aims and method

Education leads for undergraduate psychiatry in UK medical schools completed questionnaires on adaptations made to undergraduate psychiatry education, their impact and what lessons could be learnt for the future.

Results

Respondents from 24 medical schools across the UK reported a major shift to online teaching delivery, with reduced workplace learning and increased use of teleconferencing, online tasks and self-directed learning. Changes were implemented with some faculty training provided, but little additional funding or resources from medical schools or National Health Service trusts. A variety of challenges and opportunities were reported.

Clinical implications

Despite the extraordinary efforts of education leads to maintain undergraduate psychiatry education, the pandemic may affect the development of students' professional competencies and recruitment into psychiatry. Individual clinicians, trusts and medical and foundation schools have much to offer, and need to work with students to replace what has been lost during the pandemic.

Contents

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In the UK, the first lockdown in response to the COVID-19 pandemic was announced on 23 March 2020. This prompted rapid changes in medical education, including withdrawal of students from clinical placements and a shift to online teaching. As the pandemic continues, undergraduate medical educators face difficult choices to ensure a continuing supply of competent medical professionals for the future healthcare system.¹ Clinical skills in psychiatry will particularly be needed to address the significant impact of the pandemic on mental health. Increased depression and anxiety symptoms have been reported, including in young people,^{2–4} and long-term consequences are emerging in those who have recovered from COVID-19.⁵ Furthermore, many healthcare professionals are themselves experiencing symptoms of anxiety spectrum disorders.^{6,7}

To prepare our future doctors for the expected rise in demand, high-quality psychiatric education must not only continue, but also be prioritised. There is no consensus or guidance yet on what and how adaptations to undergraduate psychiatry teaching should be implemented during the pandemic. Although individual institutions outside of the UK have shared their experiences,^{8–11} there has been no work published to date from the UK or on the collective experiences of different institutions. Understanding the experiences of multiple institutions provides a powerful opportunity to share learning and identify the needs of this cohort of students.¹²

Objectives

Our aims were to identify what and how adaptations to undergraduate psychiatry teaching were made in response to the pandemic restrictions, their impact and what lessons could be learnt from the collective experiences of UK medical schools.

Method

We conducted an online cross-sectional questionnaire survey of education leads for undergraduate psychiatry who represent their medical schools on the Royal College of Psychiatrists Undergraduate Education Forum (UEF). The questionnaire was drafted on Microsoft Forms (Microsoft, Richmond, Washington, U.S.; see <https://forms.microsoft.com/>). Questions were based on areas of adaptations identified in Gordon et al's scoping review¹³ and current reports of adaptations in psychiatry teaching from other countries.^{8–10} The UEF contributed to the final design of the questionnaire, which consisted of both open and closed questions, and included the following themes: changes to teaching delivery and content, changes to the psychiatry rotation, changes to assessment, support for learners, faculty development, funding and resources, and impact of adaptations.

Respondents were asked to consider adaptations in the current academic year. As clinical placements in psychiatry in most schools occur in the penultimate year, responses were included only from the 33 registered and publicly funded UK medical schools established before 2018.¹⁴ The Queen Mary Ethics of Research Committee advised that as an evaluation of teaching, research ethics review was not required. The full survey is available in Supplementary File 1 available at <https://doi.org/10.1192/bjb.2021.67>.

The survey was distributed via email to the members of the UEF on 20 November 2020, with one reminder email a month later. It remained open for 2 months and participation was voluntary. Where omissions were present in returned questionnaires, respondents were contacted for clarification.

Data were exported from Microsoft Forms to Microsoft Excel version 16.33 for Mac, which was used to calculate descriptive statistics and create graphs. Open-ended text responses were reviewed to describe adaptations in more detail, and to compile a summary of opportunities and challenges for psychiatry teaching during the pandemic.

Results

Respondents

A total of 24 education leads completed the survey (72.7% response rate). Respondents from schools in all four nations of the UK participated, with 19 from England, 2 from Wales, 2 from Scotland and 1 from Northern Ireland.

Moving to online delivery

Figure 1 shows the changes that were made to delivery of different teaching approaches, with a major shift to online delivery. Fig. 1 Method of delivery of different teaching approaches before and during the pandemic.

Schools differed widely in the percentage of online teaching delivered synchronously, with an average of 66.1% and range of 10–100% ($n = 22$). In the 23 schools where it was used, asynchronous teaching employed a range of existing resources, primarily e-learning resources (82.6%) and recordings of previous content (82.6%) from respondents' own medical schools and e-learning resources obtained through the UEF (73.9%). Of the schools that used asynchronous teaching, 87% created new resources for this purpose. These included new recordings of teaching sessions, simulated patient videos, online modules, workbooks to consolidate materials and guide learning, revision notes, quizzes, question banks and serious games.

Course content

A total of 83.3% of schools reported no change in the content of the psychiatry curriculum; in three of the four schools where a change was made, these had already been planned before the pandemic, and were implemented during the pandemic or brought forward.

The amount of teaching across the six psychiatric subspecialties stayed the same in the majority of schools (*Fig. 2*). For every subspecialty, more schools increased rather than decreased teaching; 25% of schools increased teaching in general adult psychiatry, with no schools decreasing teaching in this subspecialty. The subspecialties that had most decreases in teaching were psychiatry of intellectual disabilities (12.5%), forensic psychiatry (8.3%) and medical psychotherapy (8.3%). *Fig. 2* Responses to the question 'Has the amount of teaching in the following subspecialties increased, decreased or stayed the same?'

Learning approaches

Although 66.7% of schools made no change to the length of the overall psychiatry module, 12.5% increased and 20.8% reduced the length. Also, 66.7% of schools did not change the length of clinical placements; however, respondents noted that in practice, there was reduced time in clinical settings and more time in self-directed learning. This is reflected in 87.5% of schools decreasing the proportion of time students spent in workplace learning (*Fig. 3*). In addition, 33.3% of schools decreased the length of clinical placements. All schools increased the proportion of time students spent completing online tasks, and 62.5% of schools increased sessions officially designated for self-directed learning. More schools increased small group teaching (41.7%) than lectures (21.7%). *Fig. 3* Responses to the question 'Has the proportion of time spent by students learning using the following approaches increased, decreased or stayed the same?'

Clinical placements

A total of 37.5% of schools increased numbers of students placed in in-patient wards, and 33.3% of schools decreased numbers placed in community teams (*Fig. 4*). For most schools, numbers of students placed in home treatment teams (58.3%) and liaison psychiatry (58.3%) stayed the same. *Fig. 4* Responses to the question 'In the current academic year, have the number of students placed in the following clinical environments/subspecialties increased, decreased or stayed the same?'

Most schools placed the same number of students in general adult psychiatry (62.5%), old age psychiatry (54.2%) and child and adolescent psychiatry (54.2%) during the pandemic (*Fig. 4*). General adult psychiatry had the most schools increasing numbers of students placed in the subspecialty (25%), whereas old age psychiatry (25%) and child and adolescent psychiatry (25%) had the most schools decreasing numbers placed.

Teleconferencing in clinical placements

A total of 75% of schools had teleconferencing in some clinical placements, with 20.8% in all placements. The only school where there was no teleconferencing had moved all placements to the in-patient setting. Teleconferencing allowed students to engage in clinical activities remotely from home or from the same location as the clinician. Students observed and participated in out-patient reviews, and joined meetings and ward rounds. One school recruited patients who could be interviewed by students via teleconferencing.

Assessment

Regarding assessment, 66.7% of schools reported that assessment of the psychiatry rotation changed during the pandemic. Changes included reduced demands, such as reduced emphasis on documenting experiences, reduced numbers of workplace-based assessments or case presentations, and reduced attendance monitoring. Despite reduced assessment demands, respondents were clear that standards would not be lowered or compromised.

Some schools shifted toward formative assessments; for example, using an assessed clinic letter or a portfolio of cases, reflections and workplace-based assessments rather than a clinician-observed long case. Greater onus was placed on individual supervisors to oversee satisfactory student performance. Like teaching delivery, assessment moved online. Online platforms, video stations and virtual cases were used to assess clinical skills, case-based discussions and presentations, and logbooks were completed online.

Supporting learners

In 41.7% of schools, psychiatry teachers were involved in developing resources or interventions to support learners' mental health and well-being during the pandemic. Respondents described developing well-being talks and workshops. They established well-being drop-ins, well-being champions, virtual student messes, and pastoral and reflective groups, including for students volunteering in the National Health Service (NHS). Well-being information was provided through newsletters and online platforms. Existing mechanisms to support learners were bolstered or reiterated to students.

Faculty development

In 50% of schools, faculty received some training in adapting teaching in response to COVID-19, with training in online teaching provided in 58.3% of schools. Training led by medical schools included sessions or e-learning modules on delivering remote learning (e.g. blended learning design, platforms), access to e-learning authoring tools, individual discussions with education leads and opportunities to share practice. Such training was less accessible to clinical staff, who received additional support from psychiatry education leads. This included training on online platforms, reflective groups to share practice and ensuring adequate technology at clinical sites.

Funding and resources

A total of 95.8% of education leads received no additional funding or resources from their medical school to deliver psychiatry teaching during the pandemic; only one school reported such support, which was additional funding to develop e-learning materials. Further, 79.2% of education leads received no additional funding or resources from their affiliated NHS trusts. In those trusts that provided additional support, this included laptops for students, computer equipment, funding for consultant psychiatrist time to coordinate placements and support clinicians, and funding for actors or patients to be interviewed by students practising clinical skills.

Student involvement and response

Half (50%) of education leads agreed that students were involved in adapting the psychiatry course (*Fig. 5*). Education leads reported that students had responded positively to adaptations, with 87.5% agreeing or strongly agreeing with the statement. *Fig. 5* Responses to the question 'To what extent do you agree or disagree with the following statements?'

The future

A total of 62.5% of respondents agreed or strongly agreed that the pandemic will change psychiatry education for the better (Fig. 5), and 54.2% of respondents agreed or strongly agreed that the pandemic has raised the profile of psychiatry among medical students.

In 87.5% of schools, the psychiatry rotation will not return to exactly how it was before the pandemic. Changes will include increased blended learning, with respondents noting the advantages of facilitating access from distant placements and the ability to accommodate increases in student numbers. Other changes include keeping modifications in placement structure, online logbooks and the use of resources from other schools.

Discussion

This survey of adaptations to psychiatry teaching from 24 medical schools across the four nations of the UK demonstrates the seismic impact of the pandemic on psychiatry education. *Table 1* summarises both the opportunities and challenges that emerge from the survey data, with proposed solutions to meet the challenges. *Table 1* Opportunities, challenges and proposed solutions for undergraduate psychiatry education during the pandemic

Opportunities	Challenges	Proposed solutions
Students	Accessibility and flexibility of online delivery	Reduced travel
Asynchronous teaching accessible at convenient times	Clinical experiences available remotely, including for self-isolating students	Gaining familiarity with telemedicine
Educational advantages of blended learning and flipped classrooms	Requirements needed for online delivery	Adequate bandwidth and hardware
Limited access to technology in clinical environments	Time spent learning new technology	Experiences of online delivery ‘Zoom fatigue’
Negative impact of isolation on student well-being	Less engaging than face-to-face delivery	Difficulty in engaging with self-directed learning
Clinical placements	Reduced contact with patients, so reduced opportunities to develop clinical skills	In in-patient settings, space constraints and need for social distancing may prevent students from accessing opportunities such as ward rounds in person
In community settings, there are fewer opportunities to engage with patients face to face and learn to be in the room with patients	Travel to face-to-face placements during pandemic	Service changes resulting in last-minute cancellations and timetabling changes
Difficult to get signed off by busy clinicians	Experiences of teleconferencing on clinical placement	Less engaging than face to face
Juggling multiple IT accounts	More difficult for students to participate in clinical tasks	Missing out on pre-brief and debrief before and after consultations
Hard to feel part of the team remotely	Online delivery	Investment in dedicated educational facilities at hospital sites
Scheduling adequate breaks	Interventions to address student well-being	Systems to identify students who are engaging poorly with online learning
Educating students about how to approach online and self-directed learning	Clinical placements	Inclusion of training in psychiatry in foundation programmes and beyond
Increased clinical and communication skills training delivered outside of clinical placements	Honest dialogue with students about the potential for disruption to their learning during the pandemic	Making use of all available opportunities for face-to-face contact with patients, e.g. students shadowing on-call staff
Pairing in-patient and community placements	Ring-fenced time for undergraduate education in clinicians’ job plans	Teleconferencing on clinical placement
Training teachers to include student participation in consultations	Deliberate inclusion of pre-brief and debrief time	Including students in all team activities, e.g. meetings
Including multidisciplinary team members in teaching	Teachers	Accessibility of online delivery
Gaining familiarity with telemedicine	Opportunities for interactivity in online delivery	Increased clinical pressures
Online delivery	Time spent learning new technology with little training	Some students engage less with synchronous teaching, e.g. cameras switched off
Managing unprofessional behaviours	Teleconferencing	Logistical demands of setting up teleconferencing
Difficult to build teacher–student relationships remotely	Increased training on online delivery	Setting of expectations for student engagement with teaching and digital professionalism
Promoting continuity to encourage the building of teacher–student relationships. e.g. same tutor throughout placement	Ring-fenced time for undergraduate education in clinicians’ job plans	Course content
Accessibility of online delivery facilitates	Webinars with external speakers	Attendance at mental health tribunals
Increased involvement of experts by experience	Increased teaching in some subspecialties	Asynchronous teaching
Expanded offer available to students	Standardisation of teaching quality	Service changes (e.g. ward closures) limit some learning opportunities
Access to other learning opportunities (tasters) not possible because of social distancing	Increased online teaching on certain areas to compensate for lost learning opportunities	Inclusion of training in psychiatry in foundation programmes and beyond
Course organisation	Booking and availability of rooms no longer of concern	Same lectures do not need to be recorded multiple times
More immediate student feedback leading to rapid improvement of quali-		

tyExposing underfunding in undergraduate education to justify additional resourcesShowing that online learning can be a solution to accommodating increases in student numbersIncreased collaboration between schools, e.g. sharing resources Some clinicians are less keen to host students and engage in teleconferencingNeed for faculty development for online teachingIncreased administrative burden of organising online delivery and redesigning clinical placements in accordance with public health measures, e.g. staff working from home, social distancing and bubbles Incentives for clinicians to contribute to undergraduate teachingIncreased training on online deliveryIncreased administrative support and resources from medical schools and National Health Service trustsPromoting psychiatry Improved attendance by studentsIncreased recognition of the importance of reflective practice across all specialtiesIncreased focus on student and staff well-beingShowcasing psychiatry as an exemplar of innovations in adapting teaching Reduced opportunities to meet role models with less time on clinical placementReduced opportunities to combat stigma toward mental illness with reduced contact with patients Maximising learning opportunities during shortened clinical placementsIncreased activity of student-led psychiatry societies to promote psychiatryBuilding in opportunities to meet psychiatrists and experts by experienceImplementing specific training on stigma toward mental illnessIncreased postgraduate training in psychiatry clinical skills

Developing clinical skills in psychiatry

The Royal College of Psychiatrists' curriculum recommendations, informed by the General Medical Council's (GMC) 'Outcomes for Graduates',¹⁵ states that an important aim of undergraduate psychiatry education is for 'students to develop the necessary skills to apply [professional] knowledge in clinical situations'.¹⁶

Clinical placements form the bulk of students' experience in psychiatry in the UK,¹⁷ offering opportunities for experiential learning and participation in authentic clinical environments.¹⁸ However, 87.5% of schools were forced to decrease the proportion of time that students spent on clinical placement. Even when clinical placements were possible, service changes and social distancing requirements changed the nature of their learning opportunities. Without these experiences, students may have difficulty in understanding how to apply their professional knowledge in clinical contexts. Indeed, the Medical Schools Council notes that 'it is not possible for students to meet the requirements set out in the GMC's Outcomes for Graduates without undertaking clinical placements'.¹⁹

During the pandemic, schools continued to provide clinical skills, role-play or simulation teaching, with 45.8% delivering these fully online. Although online skills teaching can alleviate students' concerns about reduced patient contact,²⁰ learners feel less prepared to use skills learnt in practice.²¹ In a survey of UK medical students in May 2020, three-quarters felt that online teaching had not successfully replaced the clinical teaching that they received from direct patient contact.²²

A total of 95.8% of schools used teleconferencing on clinical placements, which, though useful, has limitations. For instance, the court judgment on remote Mental Health Act assessments noted that 'a psychiatric assessment may often depend on much more than simply listening to what the patient says ... [and] may involve a multi-sensory assessment'.²³ In consultations by teleconferencing, clinicians face difficulties in reading non-verbal communication, using silence and incorporating physical examination.²⁴ Without the opportunity to see clinicians demonstrating these skills and to practise these skills themselves, students are left with an experience that translates poorly to the face-to-face situations they will encounter in the future. Moreover, clinicians cannot model some skills that are important in face-to-face work, such as preparing consultation rooms or judging physical distances between patient and clinician. Nevertheless, telepsychiatry is likely to be used more widely in the future.²⁵ Early training can foster specific skills, such as conducting mental state examinations by telephone.²⁶ These should supplement, but not supplant, the acquisition of skills for face-to-face interactions.

The shift away from workplace learning was accompanied by an increase in self-directed learning and the use of online tasks. Self-directed learning prepares students for lifelong learning, and online tasks provide the opportunity to develop a broader knowledge base. However, some schools decreased teaching in the subspecialties, with psychiatry of intellectual disabilities, forensic psychiatry and medical psychotherapy most affected. This means that the only available opportunities to learn skills in these subspecialties may have been lost; for example, learning to communicate with people with intellectual disabilities and understanding unconscious aspects of the doctor-patient relationship.

The fact that assessments have continued with no change in standards during the pandemic is reassuring. Indeed, the

greater emphasis on formative assessments and developmental conversations with individual clinicians may provide more opportunities for students to receive feedback.

Attitudes toward mental illness

Reductions in time spent in clinical placements mean that students get less contact with people with psychiatric conditions, which is so important in dispelling stigma toward mental illness.²⁷ The relative shift away from placements in community teams toward in-patient wards during the pandemic may also have unintended consequences; in a meta-analysis conducted before the pandemic, in-patient placements had less effect in challenging stigmatising attitudes than community or mixed placements.²⁸

On the other hand, the greater emphasis placed on the mental well-being of students²⁹ and healthcare staff³⁰ during the pandemic may encourage students to pay attention to their own health and well-being, and raise their awareness of the importance of mental health. Psychiatry teachers are particularly well-equipped, with expertise in both mental health and undergraduate education, to support students.

Recruitment into psychiatry

Experiences during clinical placements affect career choices, with just over half of students reporting that they were more inclined to choose a career in psychiatry following their placement.³¹ Placement factors that encourage students to choose psychiatry include perceived clinical responsibility and influence of teachers as role models.^{32,33} Although an international survey found no relationship between placement length and choosing psychiatry,³² a placement should be sufficiently long for students to get involved in the team and follow patients' progress.³⁴ Shifting away from workplace learning reduces such opportunities and may affect recruitment into psychiatry.

The pandemic has also limited opportunities (e.g. through lack of availability of electives) for fully exploring different subspecialties.³⁵ Tasters, where students spend short periods of time experiencing subspecialties outside of their main clinical placement, demonstrate to students the breadth of opportunities that a career in psychiatry entails.³⁶ Social distancing measures limit access to tasters. Despite these limitations, most education leads agreed that the pandemic had raised the profile of psychiatry among medical students. Increased awareness of reflective practice and a renewed focus on student well-being may have contributed to this. Whether this will translate into more positive attitudes toward psychiatry from other specialties is unclear.³⁷

A call to action in a time of change

The pandemic has been a catalyst for spurring innovations in medical education.³⁸ Even after the pandemic, there will be changes to psychiatry teaching in the majority of schools. Most education leads are optimistic that the pandemic will change psychiatry education for the better. Students have responded positively to the adaptations to teaching and, mirroring the changes predicted by our respondents, want to continue with online lectures and increased access to online resources in the future.³⁹ It remains to be seen whether reactive adaptations implemented during the pandemic will be sustainable, and help to manage another impending challenge: the surge in student numbers resulting from the government temporarily lifting the cap on medical school places.⁴⁰

One year on from the first national lockdown, the course of the pandemic remains uncertain. But what is becoming more certain is the profound impact that the pandemic has had on the way we teach psychiatry. This is most marked in the reduction of clinical placements, which may affect the attainment of key competencies relevant to practice in all branches of the profession, exposure to clinical role models and the challenging of stigmatising attitudes to mental illness and psychiatry. Reduction in clinical placement may also pose a threat to future recruitment into psychiatry at a time when there will be an even greater need for psychiatric skills, to manage increased demand following the pandemic.^{41,42}

This is the time for all of us in psychiatry to unite and rise to the challenges that lie ahead. We call upon individual clinicians, NHS trusts and medical and foundation schools to work closely together and with students, to give this generation the training that they need to best care for patients in the post-pandemic landscape.

Individual clinicians can offer so much to maximise the quality of learning during shortened placements. They can offer opportunities for students to participate fully in the care of patients and foster experiential learning. Trusts continue to receive payment for educating students, even with reduced time spent in clinical settings, and can ensure a more equitable distribution of finances to front-line educators.⁴³ Teaching during the pandemic has required considerable planning and effort from education leads, yet in our survey, few reported receiving additional funding or resources.

Medical schools should incorporate opportunities, wherever possible, for students to meet psychiatrists and experts by experience, to implement training on stigma and support the activities of student-led psychiatry societies.⁴⁴ Lost learning opportunities should be prioritised for inclusion in online teaching programmes both during and beyond medical school. Foundation schools should similarly increase postgraduate psychiatry teaching and the number of posts in psychiatry. Greater collaboration between foundation programme leads and undergraduate educators is important to replace what has been lost during the pandemic.

Undergraduate psychiatry teaching in the UK has undergone extensive adaptations in response to COVID-19. Educators have done a remarkable job to maintain the integrity of teaching in the face of considerable adversity. Lessons learnt during the pandemic will shape teaching in the future. As we start our journey into the post-pandemic world, we hope that readers will heed our call to action. We must not let the pandemic set back decades of progress in the care of people with mental illness.

Strengths and limitations

To our knowledge, this is the first nationwide survey of adaptations in undergraduate psychiatry teaching in any country. There was a good response rate of 72.7%, with responses from all four nations of the UK. By asking education leads about specific areas of adaptations, we may not have captured all the adaptations made at individual schools. Similarly, there was variable completion of open questions and depth in respondents' descriptions of adaptations. As a survey of education leads, we have not explored first-hand the views of students and other clinicians on the impact of adaptations. Lastly, the survey offers a snapshot of adaptations at a particular moment in time, and does not capture longitudinal changes in response to the course of the pandemic.

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We thank the members of the UEF who contributed to the design of the questionnaire and participated in the survey.

Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2021.67>.

[click here to view supplementary material](#)

Data availability

The data that support the findings of this study are available from the corresponding author, A.K., upon reasonable request.

All authors contributed to the design of the study. H.T.T.L. and A.K. wrote the manuscript, and all authors contributed to the final version.

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Declaration of interest

None.

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1.2.40 Authors' reply

Lucy Griffin Katie Clyde Richard Byng Susan Bewley

date

2021-10

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- *Authors' reply*
 - *Declaration of interest*

pmc We thank Dr MacFarlane for his response¹ and welcome his comments about various providers and pharmaceutical agencies as well as freedom of speech.

We did not review the neuroscience of brain sex differences but draw interested readers' attention to a recent review² and accessible analyses of available research.^{3,4} We agree that the art of psychiatric diagnosis depends on the clinician accepting the truth of the patient's own experience. In the absence of objective diagnostic tests, believing and trusting the patient's own subjective narrative is central to the doctor–patient relationship. However, this starts to lose coherence when the doctor must readjust their own understanding of material reality in order to accommodate another's subjective belief. Declaring that 'Despite having the body of a man, I am in all other respects a woman' supposes some inherent essence of gender that many would reject. Reorganising psychiatry to give primacy of gender identity over sex risks breaching the necessary boundaries that exist to maintain the safety and dignity of individuals, groups of people and society more generally.

Without a clear definition of conversion therapy, it is not possible to know the extent of the practice in the UK. Proponents of affirmative care have argued that conversion therapy is anything that might act as a barrier to medical transition.^{5,6} It would follow that attempts to assess and treat coexistent mental illness, or even the process of making an accurate initial diagnosis of gender dysphoria, could be described as conversion therapy rather than the basic standard of clinical care that would apply for any other presentation.⁷

The authors remain opposed to any treatment model designed to coercively alter the sexual orientation of bisexuals, gay men or lesbians. It is crucial to distinguish between sexual orientation and gender identity when the latter comes with an expectation for complex, irreversible medical interventions, described as ‘affirmative’. If sustained, long-term benefits of medical and surgical transition could be clearly and independently demonstrated, it would be appropriate to offer these interventions early, but the evidence is not convincing.⁸ Therefore it is reasonable to exercise therapeutic caution, especially in light of growing concerns about complications and regret,⁹ particularly in younger patients.

Given government moves to criminalise conversion therapy in medical settings, the nature of ‘barriers to treatment’ must be clearly described.⁹ New laws will need detailed supplementary guidance for the benefit of patients, doctors and the criminal justice system. We propose that organisations representing clinicians should help legislators make explicit that neutrally framed therapeutic or exploratory work is not conversion therapy, irrespective of how an individual ultimately feels about their own identity.

In the absence of evidence-based guidelines underpinned by solid research, we cannot make recommendations about treatment pathways, and do not advocate one particular model over any other. We draw readers’ attention to the unexplained increase in referral numbers, the higher numbers of children and young people seeking interventions, and the shift in sex ratio,¹⁰ as such demographic changes are significant and deserving of research and explanation. Doctors should ‘first do no harm’. The bar for informed consent to life-changing, irreversible medical and surgical interventions is necessarily high.⁹ Enhanced service provision and new care pathways should be informed by robust research in this patient group.

Declaration of interest

None

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1.2.41 Freedom to think: the need for thorough assessment and treatment of gender dysphoric children – CORRIGENDUM

Marcus Evans

date

2021-10

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- *Freedom to think: the need for thorough assessment and treatment of gender dysphoric children – CORRIGENDUM*
 - *Editor’s note*
 - *Amendments and clarifications, by Marcus Evans*

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Editor's note

The article 'Freedom to think: the need for thorough assessment and treatment of gender dysphoric children' was published online on 21 July 2020. In response, the *BJPsych Bulletin* received a number of letters both for and against the paper. The letters of complaint raised several similar issues, which were presented to the author for response. At our request, the author has addressed some omissions in the original article, particularly in relation to a declaration of interest of which we had been unaware. Also, some clarifications and additional references have been added to support a number of statements. An updated article is being published and we are publishing this corrigendum outlining the changes made – the original article remains available, as supplementary material to the updated article. We are keen to pursue an informed, transparent debate via the eLetters section, in line with the journal's eLetters policy. See also my editorial 'Publishing controversy' (<https://doi.org/10.1192/bjb.2020.127>).

Norman Poole, Editor of the *BJPsych Bulletin*

Amendments and clarifications, by Marcus Evans

The opening sentences "There has been a 400% rise in referrals to the national gender identity service at the Tavistock and Portman NHS Trust in London over the past 5 years. The profile of referrals has also undergone a major transformation: we have seen a reversal of the gender ratio from two-thirds male:female to two thirds female:male, with a new diagnostic category, 'recent-onset gender dysphoria', making up a substantial proportion." should read: "There has been a 3264% rise in referrals to the national gender identity service at the Tavistock and Portman NHS Trust in London over the past 10 years (from 77 in 2009–2010 to 2590 in 2018–2019).^{c1} The profile of referrals has also undergone a major transformation: we have seen a reversal of the gender ratio from two-thirds male:female to two-thirds female:male, with a recently described clinical phenomenon of as yet uncertain diagnostic significance making up a substantial proportion. This gender dysphoria of recent onset among adolescents (sometimes termed 'recent-onset gender dysphoria' or ROGD, 'rapid-onset adolescent dysphoria'^{c2} or 'adolescent-onset transgender history'^{c3}) lacks an agreed name or established diagnostic criteria, but its emergence has been documented by a number of gender clinics worldwide.^{c4}"

The following should then be added: "Bernadette Wren, the then associate director of the Tavistock and Portman NHS Foundation Trust's Gender Identity Development Service (GIDS), gave evidence to a House of Commons select committee in which she summarised the GIDS intake in the following terms: "many of the young people, and increasing numbers of them, have had a gender-uncontentious childhood, if you like, and it is only when they come into puberty and post-puberty that they begin to question. That now represents a substantial proportion of our group".^{c5}"

The sentence 'The affirmative approach to gender dysphoria has been adopted by the majority of children's services in the UK.' should read: "The affirmative approach to gender dysphoria appears to have been adopted by the majority of NHS and privately provided children's services in the UK. Again, Bernadette Wren stated in the House of Commons: "I work in a service where a lot of the young people – and anybody who wants it – have physical intervention. We have no record of turning people down for physical intervention".^{c5}"

The section 'Cantor says "Although almost all clinics and professional associations in the world use what's called the 'watchful waiting approach' to helping gender diverse children, the AAP statement instead rejected that consensus, endorsing gender affirmation as the only acceptable approach'.¹ This is despite research findings which strongly suggests that most of these cases would eventually desist if left untreated.^{2,3}' should read: "Cantor says "Although almost all clinics and professional associations in the world use what's called the 'watchful waiting approach' to helping gender diverse children, the AAP statement instead rejected that consensus, endorsing gender affirmation as the only acceptable approach'.^{c6} This is despite research findings which strongly suggest that most of these cases would eventually desist if left untreated.^{c7,c8}"

The sentence 'The British Psychological Society's review of the literature found the current medical approach to be "well-intentioned advice [which] is based on extremely limited evidence".¹⁵' should read: "'*Research Digest*, published by the British Psychological Society, reported on an Australian review which concluded that the current medical approach is based on extremely limited evidence.¹⁵"

The sentence 'There is considerable evidence that children are signing up to treatments with long-term implications,

with very little real understanding of the consequences for their future adult lives.’ should read: “‘Children are signing up for treatments that permanently modify their bodies, but they may not fully understand the life-long consequences of their decision or acknowledge the potential risks and uncertainties of treatment. Their ability to provide informed consent has been questioned, including by some clinicians working in gender clinics.’^{c9,c10,c11}”

The following sentence should be added after the first paragraph of the section ‘Patients that regret treatment’: “‘A number of clinicians have called for research into desistance, detransition and regret among gender dysphoric adolescents. The US National Institutes of Health (NIH) Sexual & Gender Minority Research Office (SGMRO) recently named detransition in its report outlining scientific research gap areas in the field of sexual and gender minority health.’^{c12} The 8th edition of WPATH’s Standards of Care will include a section on detransitioning.’^{c13}”

The following was omitted from the declaration of interest statement and should be included: “‘M.E. and his wife Sue Evans have provided witness statements for a UK judicial review examining whether minors are able to provide informed consent for gender-affirming treatments. M.E. has previously raised concerns about such treatments with the Board of Governors and the CEO of the Tavistock Trust. Sue Evans administrates the online pages for a crowd justice fund, which will be used to pay the legal fees of the judicial review. Neither M.E. nor Sue Evans has received or will receive any financial reward for participation in the case.’”

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1.2.42 Publishing controversy

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Abstract

Two recent papers on a controversial topic in this journal attracted significant criticism from readers. This editorial addresses these criticisms and describes changes to be made to the journal’s editorial and review procedures in light of the complaints received.

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- *Publishing controversy*
 - *Changes to editorial procedures*
 - *Declaration of interest*

pmc Psychiatry, like other branches of medicine, is no stranger to controversy. Anthony Clare’s *Psychiatry in Dis-sent*¹ ran the gamut of contested areas – from the validity of psychiatric diagnosis to electroconvulsive therapy and psychosurgery – which are, to varying degrees, still with us. Some have argued that disputes over the concept of mental disorder generally² and certain specific categories³ merely demonstrate that psychiatry is a pseudoscience: psychiatric

diagnosis, unlike the remainder of medicine, is a matter of value judgements rather than ‘hard facts’. In this view, psychiatrists are really just pathologising people who transgress some sort of social norm.

Since the heyday of such arguments, it has been increasingly understood that, yes, values are involved in diagnosis, but this is true also in other medical specialties. In Peter Sedgwick’s memorable phrase, ‘The fracture of a septuagenarian’s femur has, within the world of nature, no more significance than the snapping of an autumn leaf from its twig’.⁴ But we deprecate the first, so consider it disordered. Yet psychiatry remains the more controversial specialty. Bill Fulford draws an analogy between the different ways we use the word ‘good’ when thinking about a ‘good strawberry’ versus a ‘good painting’.⁵ It turns out that there is greater agreement about the former than the latter, hence less conflict and controversy. And what constitutes a person’s very nature and identity is a lot more like paintings than strawberries.

The *BJPsych Bulletin*, representing views within and about psychiatry, cannot evade controversial issues, but neither should we court them for their own sake. At the heart of such controversies are real people with real lives, often ostracised and denigrated. So, we have a duty to be respectful and balanced when articles on controversial topics are accepted for publication. We recently published two papers⁶ on gender incongruence that have attracted a significant number of letters and complaints, particularly regarding Marcus Evans’ opinion piece ‘Freedom to think: the need for thorough assessment and treatment of gender dysphoric children’.⁷ In light of the criticisms, we reviewed the article and have published a corrigendum of clarifications and additional information that provides a stronger evidence base for his arguments. Importantly, Evans has also provided a declaration of interest statement addressing his involvement in a judicial review of gender-affirming treatment for minors.

Changes to editorial procedures

Criticisms of the paper have been discussed by the editorial board. It was never the intention for the board to review the evidence for and against gender-affirming treatment. We appreciate that there are gaps in the evidence base concerning psychological outcomes of gender-affirming surgery,⁸ so see the journal’s role as enabling discussion. We seek to present the suffering caused by prejudice and failings in care systems, address omissions in the evidence base, and enable clinicians and patients to express concerns about ethical practice. The journal’s position is not to censor one or other argument – albeit clarity and care are needed when discussing emotive issues and the potential harms of psychiatric practice. The editorial board have discussed how handling editors should deal with submissions about such controversial topics, and agreed the following recommendations. The Special Articles category currently combines both review and opinion pieces. We will reintroduce Review and Opinion type papers to clarify for readers the nature of the content. We have added to the instructions for authors that Opinion pieces can include references from news items and blogs. We will not accept an Opinion article with reviews solely by the author’s suggested reviewers. As a general rule, editors do avoid this. However, it is now a firm policy for Opinion pieces to ensure that an independent review is always sought, even though this may lead to delays to the peer review process. We may call on editorial board members as required to provide reviews. Reviewer invitation templates will be revised to include a link to the COPE Ethical Guidelines for Peer Reviewers and the Reviewer Support Hub on Cambridge Core (in development). We will encourage reviewers and editors to use sites such as <https://mediabiasfactcheck.com/> to check the level of bias of non-scholarly sites. If an article involves a controversial issue, handling editors will seek to balance it, either in reviews or with a counterbalancing article, commentary or eLetter, although we acknowledge that this may not always be possible.

I appreciate that the published corrigendum and review of editorial processes will, for some, not go far enough. Many of the complainants sought retraction rather than correction and pointed to the distress such papers can cause an already marginalised group of people. I am deeply sorry for the hurt caused and have invited authors of the complaint letters to submit counterbalancing articles and/or eLetters to ensure that the spectrum of opinions is presented. Readers are welcome to submit correspondence by clicking the e-letters tab when accessing the article via the following link: <https://doi.org/10.1192/bjb.2020.72>.

COPE, the Committee on Publication Ethics, has guidelines⁹ for editors considering retraction of an academic paper. Its criteria cover situations where there is clear evidence of unreliability or falsification of data, plagiarism, copyright infringement or manipulation of the peer review process. These do not apply here. Failure to disclose a major conflict of interest can also lead to retraction where non-disclosure has ‘unduly affected interpretations of the work’ by editors and peer reviewers. However, Evans has been candid about his opinions, which are of a piece with his involvement in the judicial review.

Derek Bolton's *What is Mental Disorder?*¹⁰ has long struck me as a fine argument for the constructive value of disagreement. Where concepts are contended, they are subject to competing pressures from the various stakeholders, including patients, carers, doctors, psychologists, social scientists, the general public and politicians. He was referring to disputes about the boundary between order and disorder, health and illness, but it applies to controversial issues within psychiatry generally. In this spirit, the *BJPsych Bulletin* will always strive for open, transparent and respectful dialogue.

Norman A. Poole is Editor of the *BJPsych Bulletin* and a consultant neuropsychiatrist at St George's Hospital, South West London and St George's Mental Health NHS Trust, UK.

Declaration of interest

N.P. is Editor of the *BJPsych Bulletin*.

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1.2.43 International medical graduates: how can UK psychiatry do better?

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Abstract

The National Health Service (NHS) was created 70 years ago to provide universal healthcare to the UK, and over the years it has relied upon international medical graduates (IMGs) to be able to meet its needs. Despite the benefits these professionals bring to the NHS, they often face barriers that hinder their well-being and performance. In this editorial, we discuss some of the most common challenges and the adverse effects these have on IMGs' lives and careers. However, we also propose practical measures to improve IMGs' experiences of working in psychiatry.

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- *International medical graduates: how can UK psychiatry do better?*
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pmc The staff of the National Health Service (NHS) includes many doctors who have trained abroad. Unfortunately, despite their contributions, many international medical graduates (IMGs) face considerably greater difficulties than UK graduates. Longitudinal data clearly show differential attainment of IMG doctors in both postgraduate examinations and more senior clinical, academic and managerial positions.^{1,2} They are also more likely to be reported to the General Medical Council (GMC) for misconduct and to have such complaints upheld.³ This is detrimental to their well-being and risks affecting the quality of care provided by them.

There are many contributing factors, from direct discrimination, through a lack of familiarity with and support from the UK system, to a failure to harness IMGs’ strengths. This editorial will explore this, taking the available evidence and experiences of the authors to propose positive next steps for individuals and organisations.

IMGs: who are they?

Definitions of IMGs: a heterogeneous group

The GMC defines an IMG as someone who has obtained their primary medical qualification outside the European Economic Area (EEA).⁴ However, that simple definition covers a range of complexities. It can encompass a childhood in another culture and different intersectional experiences of nationality, religion, gender and skin colour. It involves medicine studied in a different healthcare system, with nuanced variations in communication and therapeutic relationships. Some things, however, are common to most IMGs: personal and professional loss from the country they left; a need to build a network of friends and embrace a new life; exposure to a new environment and health system; and the hope for a better future, which despite any adversity keeps many motivated to continue. However, every IMG’s journey is unique, and the challenges faced will depend on the interplay of many factors; for example, we note that technically the term ‘IMG’ applies to a White British citizen who studies abroad and returns to work in the UK, yet such an individual is less likely to face attainment gaps.

There is no single route for an IMG to transition into the NHS. Those from an EEA country or Switzerland (not considered IMGs by the GMC) are eligible for full GMC registration and licence to practise medicine in the UK as long as they demonstrate proficiency in English. For other IMGs, the most common method of obtaining registration is by passing the Professional and Linguistic Assessments Board (PLAB) examination,⁵ an initiative designed to ensure parity of medical education and training standards. Post-PLAB doctors are then free to apply to appropriate training schemes, and to work as specialty and associate specialist (SAS) or locally employed doctors. Another route is the Medical Training Initiative (MTI) scheme sponsored by a UK Medical Royal College, faculty or GMC-approved institution for postgraduate training. Some IMGs can also gain registration if they hold a relevant postgraduate qualification from an approved overseas awarding body.⁶ Finally, IMGs can get their registration by applying for a Certificate of Eligibility for Specialist Registration. This requires doctors to demonstrate that their training matches the UK equivalent.⁷

However, once an IMG starts working in the NHS, they are expected to adhere to the norms outlined in the GMC’s

Good Medical Practice guide.⁸ Some trusts invest in providing appropriate induction and extra support; however, there is currently no clear national guidance or requirement for either organisations or IMGs on how to support this transition into the UK.

Data on IMG numbers and specialties/roles

A report from the House of Commons noted that of doctors in non-primary care settings, 13% are from Asia, 9.1% are from the European Union and 4.8% are from Africa.⁹ IMGs account for 60% of non-consultant and non-training doctors currently working in the UK.¹⁰ It is not clear why IMGs are more likely to work as SAS or locally employed doctors. Some might have found these roles more suitable to gain experience before enrolling in formal training, while some might be less interested in the recognised challenges that come with traditional training and consultant roles. However, some people may prefer a more flexible role for reasons including childcare, especially as they might have less family and informal support than British doctors; while others might find it practically easier to obtain such a job. Having said this, it is also likely that for a fair few it is a second-choice career pathway on account of failure to succeed in passing the relevant postgraduate examinations. Having a non-UK primary medical qualification has the largest influence on postgraduate examination attainment; the pass rate in some postgraduate examinations is 35% for IMGs, compared with 80% for UK graduates.¹¹ These attainment differences have also been identified between IMGs and UK graduate doctors training in psychiatry.¹²

Psychiatry is particularly popular among IMGs,¹² who account for 44% of psychiatry trainees.¹⁰ A preference for psychiatry has also been demonstrated in the USA¹³ and among UK doctors from Black and minority ethnic (BAME) backgrounds.¹⁴ The reason for this is not clear, although psychiatry has long had a particular recruitment problem,¹⁵ and it is possible that a need to pass the residence labour market test may be encouraging some to take posts that are more easily available. The authors' own discussions include the reflection that many IMGs may come from cultures where mind and body are not so separated, and find a natural affinity with psychiatry.

IMGs: challenges they face

Practical and cultural aspects to change

Initially, many IMGs need to find a place to live, to become orientated with public transport and potentially to learn to drive on the left side of the road. They need to open a bank account, get a UK telephone and identify where and how to access shops, sport clubs, religious centres and schools. They must adapt to the UK's many regional accents, and learn both local idioms and British colloquialisms. In addition, the first few years are often clouded by financial and visa-related stresses.

IMGs go through adaptation (changes in individuals or groups due to environmental demands) and acculturation (cultural changes resulting from encounters with members of different groups).¹⁶ This includes learning appropriate new behaviours and unlearning behaviours that are no longer appropriate. Refugee doctors merit additional comment. They are also IMGs, but they have had to flee their home countries and lives to escape persecution or other threats. So they often have experienced trauma, more financial difficulties and less certainty regarding visas, leading them to face greater isolation. Cohn et al¹⁷ noted that owing to having to leave their homes rapidly and in fear, refugee doctors might not have all the paperwork required for registration, or may not be able to contact people in their home countries to get relevant documents, which may complicate their ability to fulfil GMC requirements.

Loss of status, discrimination and racism

IMGs often not only leave behind family and friends, they almost always leave a social status, identity and trust that they previously earned and enjoyed. Many take up posts of lower grade or status than expected or warranted by their expertise.^{18,19} IMGs have reported a loss of autonomy in their decision-making,²⁰ and a professional devaluation which can lead to a loss of their confidence to perform or even defend themselves in cases of harassment or where their practice is being scrutinised.¹⁹

Many IMGs still suffer greater levels of direct and indirect discrimination and harassment. IMGs have reported feeling discriminated against by colleagues and at an institutional level.²⁰ Institutional racism has also been evidenced by bias regarding hiring practices of doctors with foreign names.²¹ Subjective bias due to racial discrimination has also been considered a factor associated with the failure of the clinical skills assessment for UK BAME and IMG doctors.²² A third of SAS and locally employed doctors in the UK, who are predominately IMGs, have reported experienced bullying or harassment in their workplaces, mainly characterised by rudeness.²³

Greater rates of complaints

The GMC's *Fair to Refer* report³ shows a disproportionate number of fitness to practise referrals for overseas doctors (2.5 times greater) and doctors from BAME backgrounds (two times greater) compared with White UK graduates, and they are more likely to face harsher sanctions. It is less clear whether this is compounded in IMGs from non-White backgrounds. The report offers potential explanations, including inadequate induction and support, lack of honest and effective feedback, working patterns or contracts that lead to isolation, pervasive insider–outsider dynamics, and a lack of confidence in raising concerns or challenging accusations. This last factor fits with the finding of Jalal et al that IMGs are less likely than UK graduates to report bullying.²⁴ The GMC report has been criticised for not addressing why the GMC tends to give harsher sanctions to referred IMGs and BAME doctors.²⁵

Existing evidence and initiatives

IMGs' perspectives

Wolf et al²⁶ found that IMGs and BAME trainees reported more difficulties, cultural differences and lack of trust with senior doctors, as well as biased assessments and recruitment processes. Hashim²⁷ identified challenges for IMGs in understanding the NHS system and values, learning environments (with a lack of direct guidance), receiving feedback and feelings of being undervalued by colleagues. A survey of IMGs' understanding of the GMC regulatory framework found that many were surprised or confused by the range and specificity of the regulations, including the emphasis on individual patient autonomy.²⁸ It also identified that IMGs could have difficulties with nuances of non-verbal communication and UK social and behavioural norms. A key aspect was the lack of relevant information prior to registration, variable levels of training and support, and isolation in non-training posts.

International literature on interventions

There is a limited evidence base to support interventions, including international examples from Canada,²⁹ the USA,²⁰ and South Africa.³⁰ Two recent literature reviews^{18,24} summarised the following recommendations: individual assessments prior to induction with follow-up; making relevant information available; providing comprehensive information about the role and job; addressing the culture gap (providing supervisors and mentors, understanding clinical and cultural differences); considering different learning styles; buddy systems (for guidance and help); improving cultural awareness from the organisation; and establishing a national induction programme, complementary to local inductions. With regard to refugee doctors, Butt et al (2019) showed that formal support to gain their licence to practise was an effective intervention. Although all these could be potentially effective interventions to improve IMGs' well-being, there still seems to be no consensus regarding which organisations are responsible for implementing them or overseeing these changes.

Work by UK professional bodies

Some GMC initiatives have been put in place to address the differential attainment; these include the optional ‘Welcome to UK Practice’ workshop,³¹ which according to a recent report³² is highly valued by doctors and their supervisors, improving knowledge on ethical issues, GMC guidance and UK practice in general, as well as communication and a focus on patient centredness. It provided opportunities to meet colleagues, share learning and gain support, but the report also suggested that IMGs feel a general lack of support once they are in practice.

The MTI by the Association of Medical Royal Colleges³³ is specifically for IMGs and provides a helpful guide³⁴ to aid with preparation for relocation, as well as providing mentorship on starting the scheme. A recent evaluation of the MTI psychiatry scheme reported that enrolled IMGs highly rated their clinical supervision and overall experience with this initiative.³⁵ The British Medical Association (BMA) website also has a section focusing on IMGs, including information regarding life and work in the UK,³⁶ while we were preparing this manuscript, the BMA sent their very first IMG newsletter, focused on key news and information relevant to IMGs. Online communities are mushrooming to support IMGs while they redefine their identities in a new culture with its evident uniqueness.

This differential IMG attainment also affects membership and representation within the Royal Colleges, as SAS doctors do not have the same rights as fully registered members of some Royal Colleges. Positively, we note that the roles and representation of SAS doctors within the Royal College of Psychiatrists is currently under review. The Royal College of Psychiatrists has a trainee support group which provides guidance regarding the needs of IMG trainees to heads of schools of psychiatry across the UK to improve differential attainment, while the Psychiatric Trainee Committee is currently drafting a guide that will contain sections to support IMGs, including cultural induction to the UK, training pathways, exams and visa information. The college also organises workshops to help supervisors to gain the knowledge and skills to mentor and supervise an IMG doctor, and conferences to foster networking among IMGs. We also recognise that the College has recently established two new professional leads on race equality.

Next steps

Recognising the wider societal issues: Black Lives Matter and Covid-19

The Black Lives Matter movement has re-emphasised the social disparities between White British people and those of BAME and immigrant backgrounds. It reminds us that many of the adverse experiences of IMGs are also encountered by UK BAME medical graduates, notably, discrimination, racism and differential attainment. Compared with their White counterparts, UK BAME doctors underperform academically;³⁵ are more likely to fail their clinical skills assessments;²² are less likely to be accepted into a specialty training programme, apply for consultant posts, or be short-listed for and offered consultant posts; and earn less.³⁷ Wolf et al³⁸ found that perceived difficulty in talking about race with trainees and isolation or non-specificity of interventions were the main barriers to improvement. The Covid-19 pandemic has also shown the different vulnerabilities of BAME staff and patients, many of which are due to fundamental societal inequities, and the need for appropriate support and care.³⁹ As a positive note, it was heartening to see the *BMJ* recently commit a whole issue to the topic of racism.⁴⁰

Recognising IMGs’ strengths: the ‘problem’ is not in the individual

Most discussion still unconsciously locates the ‘problem’ in the IMG rather than adopting a systemic perspective and working to embrace IMGs’ strengths and their knowledge and experience of working in other socioeconomic and healthcare systems.

Many IMGs not only achieve their goals but also go on to subsequently become prominent and respected doctors, leaders in their field and admired by their peers. Within psychiatry, we have many such examples who have succeeded and developed internationally high-profile careers as clinicians and academics; the simplest scan of UK psychiatry’s output and reputation will show its gains from many IMGs. The strengths of an internationally trained, multicultural and multilingual workforce need to be harnessed. *Box 1* summarises our recommendations for positive change,

based on an assimilation of the existing literature, our experiences as IMGs (all but one author) and practising clinicians in the UK, and our application to UK psychiatry. We have provided a suggested clustering of which organisations and individuals might be best placed to provide these. Box 1 Recommendations for positive change, clustered by provider.

Regulatory bodies Continued evaluation and addressing the disproportionality of GMC (and local) complaints and investigations into IMGs. An open and transparent process of data collection and a clear accountability framework to ensure that progress, or its lack, in these areas can be monitored. Host IMG-specific resources and disseminate via NHS trust websites, including sharing of examples of good practice (for example, the MTI, while recognising that there can be specialty-specific challenges and opportunities. The Royal College of Psychiatrists Explicit investigation into differential attainment in the MRCPsych examinations. Explicit inclusion of IMGs in examination and curriculum design. Publishing data on IMG representation on College bodies. Have IMG-specific events, resources and examples of best practice for psychiatrists. NHS trusts Trusts have an IMG champion working with Human Resources to inform all IMG appointments. Trusts' HR staff to receive training to enable them to deal competently with IMG issues. Trusts have explicit policy and action targeting racism, with open publication and updates. Local induction programme specifically for IMGs, mainly during the first 2 years of their career in the UK/NHS. Focused support and mentoring for IMGs new to the NHS. Encourage and facilitate IMGs' interaction with UK graduates (e.g. universities host a Welcome Day for international students). Host events dedicated to local IMGs – to celebrate successful journeys and to foster a sense of community. Continuing professional development events to learn how IMGs' experience in their home countries can contribute positively to improved patient care in the NHS. Individual services, teams, supervisors/mentors and IMGs Link up IMGs with appraisers at the time of starting work so that appropriate mentoring can be organised. Inclusion of modules focused on IMG issues for educational and clinical supervisors. Encourage IMGs to attend local Balint groups. Encourage IMGs to attend local academic days for trainees in specific specialities.¹

Conclusion

Our personal experience – all but one of us are IMGs – has been that UK society is marked by a focus on fairness. This has motivated us to raise some of the issues that many IMGs are currently facing. We are grateful that British society and culture has, largely, welcomed IMGs and given us the freedom to make these comments. However, we also feel that for many local doctors, IMGs can become invisible and their specific strengths and learning needs go unnoticed. We do recognise that each IMG has had a different journey, with many factors affecting their own challenges – gender, ethnicity, skin colour, religion and sexual orientation – just like every non-IMG doctor. Motivated by personal challenges, dreams of a new life or even external factors uncontrolled by them, each IMG has to go through a process of acculturation, and loss of former identity and building of a new one, influenced by their professional and personal experiences.

For IMGs, there is much to learn personally and professionally upon coming to the UK. In healthcare, this includes familiarising oneself with the 'process of regulation, challenging, making appeals' and fostering a culture of 'learning not blaming'. In society, every citizen has the responsibility to respect the rights of others and to treat others with fairness; in return, the UK offers freedom of speech and freedom from unfair discrimination.

UK healthcare systems, regulatory bodies, Royal Colleges, NHS trusts, medical leaders and indeed all of us are responsible for being aware of IMGs' struggles, as these can have long-lasting effects not only on IMGs' careers and lives but also on the care of the patients they serve. If we can start to demonstrate a degree of compassionate curiosity about IMGs, appreciating their diversity and strengths, the new knowledge, skills and wisdom that we will acquire can only lead to better patient care and a happier workforce.

Dr Emmeline Lagunes-Cordoba, Camden and Islington NHS Foundation Trust, and the Department of Health Service

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There is some overlap and the boundaries between these are only suggestions that might benefit from local change.

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and Population Research, Institute of Psychiatry, Psychology & Neuroscience, King's College London, UK; **Dr Raka Maitra**, Tavistock and Portman NHS Foundation Trust, Trainee Support Group, Royal College of Psychiatrists, and Department of Psychosis Studies, Institute of Psychiatry, Psychology & Neuroscience, King's College London, UK; **Dr Subodh Dave**, Trainee Support Group, Royal College of Psychiatrists, and Derbyshire Healthcare NHS Foundation Trust, UK; **Dr Shevonne Matheiken**, East London NHS Foundation Trust, London, UK; **Professor Femi Oyeboode**, National Centre for Mental Health, Birmingham, UK; **Dr Jean O'Hara**, South London and Maudsley NHS Foundation Trust and Department of Psychological Medicine, Institute of Psychiatry, Psychology & Neuroscience, King's College London, UK; **Dr Derek K. Tracy**, Oxleas NHS Foundation Trust, London, UK and Department of Psychosis Studies, Institute of Psychiatry, Psychology & Neuroscience, King's College London, UK. E.L.C., R.M., S.D., S.M., F.O. and D.T. identify as IMGs, and J.O.H. as a UK BAME graduate. The authors note that their own journeys have informed this piece. They further reflect that their challenges, opportunities, and the various intersectional issues they have faced have all been unique, and some have faced greater and lesser adversities than others.

All authors met all four ICMJE criteria for authorship, jointly conceiving and writing the manuscript.

Supplementary material

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[click here to view supplementary material](#)

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None.

1.2.44 The value and benefit of narrative medicine for psychiatric practice

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date

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Abstract

This article describes how applying techniques from literary studies and considering patient histories as texts helps me understand and formulate systemic issues in psychiatric assessments. Psychiatrists are not generally taught to pay close attention to aspects of language, including metaphor and syntax, but I argue that paying attention to the form, as well as to the content, of the stories patients bring us, can make us better attuned to the contexts of their needs and distress, and therefore better placed to help.

Contents

- *The value and benefit of narrative medicine for psychiatric practice*
 - *Reading illness narratives*
 - *Patients as texts*
 - *Narrative education*

– Declaration of interest

pmc My clinic list says that the mother I am about to meet has come for an autism assessment for her son. As it turns out, she has come to tell a story, one she cannot yet make sense of. This particular mother tells me a nativity story. Her opening scene is an acute abdominal pain, ‘like a fire’, bending her in half and making her scream, at an office Christmas party. Not appendicitis, but a surprise of a baby son, born into precarious temporary accommodation, to a single young woman, in late December. Her story included a vivid retelling of his first visitors: ‘three wise women from East London’, she joked, ‘a midwife, a health visitor, a social worker’.

‘Did they come bearing gifts?’ I asked.

‘Forms!’ she replied, but also told me about the three wise women’s support for her instinct, two Christmases later, that something was not quite right with her son. ‘You could call it an epiphany’, she said.

You might wonder why I let her talk like this, encouraged it even, with my gift-bearing question. It took her less than 8 minutes to summarise her first concerns about her son and the following 6 years of worries, that were mostly dismissed by ‘the system’ as naughtiness, wilfulness or lax parenting. As a psychiatrist, my job is to make a diagnosis and formulation, but I also spend time thinking about the narratology in consultations, by which I mean how clinical histories and related stories are framed and presented, because narratives are consequential. They have the capacity to heal or harm. ‘Narrative employment’ is the creation of narratives that help people accommodate and make sense of distress, pain or loss, and find a new sense of inclusion, hope and agency. Too often, this process is carried out against the grain of clinical work.

The privilege and joy of psychiatry is that we look after whole people. We gain skills in decoding subtle nuances of language for evidence of psychopathology and we are trained in understanding symptoms in the contexts of patients’ lives and cultures. Yet, at times, our training and psychiatric practice, with the current hyperfocus on biological aetiology and treatments, hint that we might be dealing with brains in isolation, risking objectifying patients. Literature, which emphasises the use of language, reminds us of their humanity and our own.

In common with other medical humanities, narrative medicine in general, and literary studies in particular, allows psychiatrists to widen the epistemic genres we traditionally draw from, in formulating and answering academic and clinical questions. This is especially important in the 21st century, as our patients live longer, with more illness complexity and comorbidity than in previous generations. Narrative medicine can help us to respond to contemporary health challenges by looking beyond traditional medical sciences.

For example, by attending to the manner in which the mother framed her story as a Biblical illusion, and by acknowledging this with my gift-bearing question, I was better able to read between the lines of the developmental history she gave, hearing her previously unspoken fears of divine punishment and her secret hope for a miracle cure.

Reading illness narratives

Writing in the *BMJ* about the evidence-based treatment of neonatal jaundice and the safety of infants on aeroplanes, Thomas Newman, Professor of Epidemiology and Biostatistics, made a cogent case for the power of stories over statistics, concluding that ‘the brains of human beings seem built to process stories better than other forms of input’.¹ Dreadful things happen, Newman concludes, but when they happen to a storyteller this enables connections with readers beyond what would be possible if the story were recounted by a dispassionate observer. A narrative trajectory offers solutions or hope, which statistics cannot offer.

Arthur Frank develops Newman’s theory further, suggesting that, ‘telling stories is the attempt, initiated by the body’s disease, to give voice to an experience that medicine cannot describe’.² In his classic text *The Wounded Storyteller*, Frank suggests a typology of medical narrative, classifying illness narratives into ‘chaos narratives’, ‘quest narratives’ and ‘restitution narratives’. The restitution narrative, in which the doctor is presented as a hero and the end result is healing, could not be more distinct from the stories psychiatrists often hear in clinic, stories that Frank would classify as chaos narratives, in which one terrible thing after another happens, events which are often temporally dislocated. Frank’s so-called quest narratives are more hopeful, written by patients who have been able to learn from their illnesses and reconstruct a new future. As a psychiatrist, the question of how to respond to ‘the experience medicine cannot

describe' is important. Frank, however, advocates keeping professionals away from written illness narratives. His suggestion seems to be that scientific scrutiny will diminish and devalue patients' accounts. I think he is overly pessimistic and commend his thesis to colleagues seeking to understand, without reframing and rewriting.

Patients as texts

Literary studies have had a direct and unexpected impact on my clinical practice. For example, in my work as a child and adolescent psychiatrist, I apply close reading techniques from literary studies when listening to parents' histories and children's stories. I was influenced by Professor Rita Charon, a physician with a doctorate in English literature.

In her book *Narrative Medicine*, Charon offers a drill for reading texts and likens it to the familiar drill that medical students are taught when reading chest X-rays.³ She invites us to consider a patient's history as a text, deciding, for example, which genre it comes into. It might be a short story, an obituary, an epistolary novel, a Gothic tale, a black comedy, a lyric poem or a parable. She asks us to consider how the patient's narrative is framed, asking: where did this text come from? How did it appear? What does it answer? How was it answered? How does it change the meaning of other texts? What is left out of this text? I use the literary techniques of close reading, where one pays attention to all aspects of the literary devices in a text, including ambiguity, irony, paradox, tone, semiotics, gender, sexuality, colonial status of the narrator. Attending to close reading teaches us to query the meaning of breaks, tempo and the message in the rhythm. Charon invites us to question the narrator's engagement in the story, her access to events, her point of view (vocalisation). Is she remote, sceptical, unforgiving, judging? Charon's point throughout is that studying literature can make us better doctors.

Following Charon's drill has taught me to interrogate patient narratives differently and gave me new insights into their construction. The mother I described at the beginning of this article framed her story as a Biblical natal scene. Her 8-year-old son told a different story, delivering crisp classroom anecdotes in the style of a successful stand-up comic. He had a tabloid headline writer's love of puns and spoke about his aspiration to be a writer of Christmas cracker jokes, a nod, perhaps, to his mother's nativity story. When I shared my formulation, I encouraged him to write it down in his own words, with a punning title. We looked at some YouTube videos of comedians who have spoken about their shared diagnosis.

His most recent school report was written in the form of a lament, a chorus of cries from an exasperated class teacher, appended with a headteacher's refrain of despair. When I sent a copy of my assessment report to the school, I wrote a brief covering note, acknowledging the profound sense of sadness, frustration and failure in the school report and raising the possibility of his disruptive classroom humour being a form of tragicomedy, possibly because the boy himself shared these same feelings. His class teacher wrote a reply framed in educational academic discourse, about performative spaces and classrooms. My hope is that by writing differently about him, she might be thinking differently about him too.

I do not know yet how this clinic story ends. The pages of this little boy's life are still turning. Unlike novels, I am rarely there to witness concluding chapters or the many plot turns of these young lives. The last time his mother and I met, she referred back to her nativity story, reframing the birth as a gift and telling a parable about neurodiversity. The language of implied self-blame and defeat was edited out of her new story. There may be times in future when she writes them back in. I think part of my job is making sure those close to her notice if and when she does.

Narrative education

Thirty years have passed since David Fraser and Leah Smith presented their findings from their surveys of medical graduate cohorts from 1955 to 1982, asking 'what changes would you have made to your education?'.⁴ The responses were overwhelmingly in favour of having more humanities education, particularly in history, art, music and literature. Doctors felt that their education failed to meet the need for their 'skill in dealing with people'. Asked about their regrets about their education, the cohorts said they were taught too much biology and too much chemistry for admission to medical school. For a more satisfying personal life they would have chosen art, history, literature and music, and to work better with patients, they would have chosen philosophy, modern languages, art and psychology.

This is old research, arguably ‘yesterday’s news’, conducted in the USA, and has yet to be repeated in UK graduate cohorts. However, Richard Horton, writing in *The Lancet* a decade later, expressed similar views, lamenting the poverty of scholarship in Western medical schools, which, in my view, remains largely unchanged.⁵ Horton’s arguments feel as current today as when he noted more than two decades ago that medicine is unusual among academic disciplines in that it has no canon of texts. Horton calls this ‘a curious exception’. Horton said that ‘a canonical work should display originality, rigorous argument and a strong writing style’. I would like to suggest that the time has come for us to define a canon of works in psychiatry, spanning novels, creative non-fiction and illness narratives, the study of which can offer real benefit and value to psychiatrists.

As a doctor, there are ethical challenges inherent in writing about patients. I have considered the General Medical Council’s instruction to ‘make the care of your patient your first concern’. Patients are often mandated by court to see me, or are allocated to see me in clinic, with limited choice. Given the power dynamics inherent in these assessments of children and young people who are often vulnerable, I have concluded that most of my patients would be unable to give meaningful and free consent to be written about, even in retrospect. For these reasons, I have written about a fictional patient for the purpose of this article. To do so, I studied many of my assessment reports from the past three years and then wrote new fictitious clinical scenarios, drawing on real themes.

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Declaration of interest

None.

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1.2.45 Raymond Tallis

Abdi Sanati¹

date

2021-10

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Abdi Sanati meets Professor Raymond Tallis, Emeritus Professor of Geriatric Medicine, University of Manchester, UK

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Contents

- *Raymond Tallis*

pmc Professor Raymond Tallis is one of the most eminent polymaths in the UK. He is an Emeritus Professor of Geriatric Medicine, poet, novelist, philosopher and cultural critic. He has published numerous books and articles in different fields, including his regular contribution to *Philosophy Now* under the title of Tallis in Wonderland. I first came across his work in his book *Aping Mankind*.¹ Professor Tallis is politically active and his co-edited book *NHS SOS*,² written at the time of Andrew Lansley's reorganisation of the NHS, continues to be relevant. I met Professor Tallis virtually in the middle of the lockdown.

Professor Tallis, thank you for your time. In the Royal College of Psychiatrists, we recently had a kind of surge in neuroscience and I remember 10 years ago, in *Aping Mankind*, you wrote of 'neuromania'. I wonder if you could elaborate for the readers.

Of course. First of all, I am a great admirer of neuroscience: it is perhaps the greatest cognitive achievement of humanity, because it brings together so many sciences in an area that has such importance. All my own research has been within clinical neuroscience, stroke and epilepsy being my major areas of research. I therefore have no problem with neuroscience. My target is neuromania. What is the difference between neuroscience and neuromania? Neuroscience does acknowledge that the brain is a necessary condition of normal consciousness and behaviour. If you chop my head off my IQ falls precipitously, probably down to zero, I guess! In addition, we are very familiar with the effects of damage: there is often very precise correlation between severe damage to the brain and deficits that follow. There are lower-level deficits in sensation and motor activity and higher-level deficits in cognitive function. So that is neuroscience: it acknowledges the brain as a necessary condition of normal human consciousness, behaviour, awareness and so on. Neuromania, however, claims that the brain is not merely a necessary condition, but a sufficient condition of these things. All that we are as persons can be translated into neural activity.

It might be helpful for your readers to clarify the difference between necessary and sufficient conditions. Let me give you an example. To be knocked down by a bus outside the Royal College of Psychiatrists, it is necessary that I should be outside the Royal College of Psychiatrists. I am very pleased to say that it is not a sufficient condition. Otherwise, everybody outside the Royal College of Psychiatrists would be knocked down by a bus. According to those who embrace neuromania, the stand-alone brain is the sufficient condition for human consciousness, the person and so on. Neuroscience tells us the brain is merely a necessary condition.

One thing we have witnessed is a huge surge in imaging studies, fMRI studies in particular. And they want to say that, for instance, this is what love looks like. Or in terms of psychiatry, this is what, for instance, depression looks like. It is kind of reductionism.

It is, and of course, imaging is particularly seductive. Someone once described the fMRI scan as a fast-acting solvent of the critical faculty. So, if you see an image on a screen you start believing that you are gaining direct access to the truth about our humanity. You mentioned love and it reminds me of a study by Semir Zeki and his colleagues that led them to identify the experience of romantic love with activity in certain parts of the nervous system. The experimental design was, to put it mildly, rather crude. They compared the responses of the brain, recorded by fMRI, when individuals were exposed to pictures of partners with whom they were deeply in love with the responses to pictures of friends. By this means, they claimed to identify brain activity corresponding to romantic love. But of course, that's nonsense. Being in love is like a response to a stimulus. It's not even a continuous condition like being a bit chilly or being a bit cross. It is a very complicated business. It has narrative and cultural contents. And it is associated with all sorts of things, like deciding not to talk to somebody because you are very cross with them. All of those things are incredibly complex, and remote from responding to an external stimulus such as a picture. But Zeki et al's experiment is a good example of how neuromania tries to reduce the life of a person to a succession of cerebral discharges.

I have been thinking about depression because it has many different dimensions. The experience of someone who is depressed is very complex. Trying to reduce it to certain kinds of activities of the brain won't work. They are very different.

Depression has a major narrative content in it. It reflects your interpretation of the world and of your place in it. It encompasses what you are telling yourself about yourself, what you tell yourself about others and what you tell

yourself about the world. These are not going to be connected in any direct or simple way to alterations in neural activity explained by depletions in particular neurotransmitter pathways, even though this may have a causal role.

Another issue that we have in psychiatry and we deal with it a lot, especially in forensic psychiatry, is the issue of free will and responsibility. I have talked to many people and they said, well, neuroscience has solved the problem; there is no such thing as free will. What is your opinion on that?

You will not be surprised to know what my opinion is. I have just finished a book on free will.³ I devoted a section to so-called neurodeterminism and to the neurological experiments that are supposed to demonstrate that we do not have free will.

It is worthwhile looking at the most famous ones conducted by Benjamin Libet, 30 or more years ago, but repeated many times since in different forms. What Libet did was to ask study participants to make a very simple movement, just basically flexing their wrist or flexing their finger, but in their own time, so it was a genuinely voluntary movement. He also asked them to do something else: to time the moment when they felt the *urge* to make the movement by noting the position of a spot moving on a clock face on a screen. At the same time, Libet recorded the so-called readiness potential, which is supposed to be a marker in the prefrontal cortex of preparedness to make a movement. What he found was that the readiness potential preceded the urge to make the move. It was as if the brain were getting geared up to make a move, even before the person was aware of the urge to do so. And it has been concluded from this that the brain, not the conscious person, was calling the shots. The decision to move had already been made before the person had experienced the urge to do so. The readiness potential was ahead by only 0.3 s and there are many reasons for thinking that this might not be significant. But then John-Dylan Haynes and colleagues performed similar experiments around 20 years later. Instead of relying on EEG he employed fMRI. He found that the interval between seemingly relevant neural activity and the urge to make a movement (timed by noting letters passing down a screen) was between something like 5 and 10 s and that looked really serious. In Haynes's study, participants were asked to choose to move either their right hand or their left hand to press a button. That study seemed to indicate that the brain was getting all geared up to make a movement well before the person had made a decision to move.

There are two types of fundamental problem with these studies. There are the methodological problems. But more interesting are the philosophical problems arising from a complete misunderstanding of the nature of human action.

Let me first talk about the methodological problems. There are problems about timing an urge. How long does it take you, as it were, to register an urge to enable you to time it? There was also some question about the nature of the readiness potential. It may well be the case that when I decide to make my movement, it is because I feel like I'm taking advantage of the readiness potential: I am, as it were, sort of surfing a wave. And there are many other methodological problems.

But there are more important problems due to a misunderstanding of the nature of action. Think about the experiment from the point of view of the participant taking part in it. Mrs Smith decides that she is going to volunteer for Professor Libet's experiment. She rings up the laboratory, having seen the advert in the newspaper, makes an appointment for 2 weeks' time, sets her alarm the night before to make sure she does not oversleep and upset Professor Libet. She sets out in the car, having made arrangements for the children to be looked after. She arrives at the research centre and has a blazing row with somebody in the car park because they have taken the parking spot that has been set aside for her. She eventually finds her way to the laboratory. She sits down and listens to Professor Libet, and is persuaded that it is a safe experiment to take part in, despite all the people in white coats and all the intimidating machinery around her and the electrodes placed on her head. She pays attention so that she understands what she has to do. This background makes it evident that her action is not just moving a finger. It's 'taking part in Professor Libet's experiment', and clearly that is not something that is the product of an atomic urge, a bit of willing causing a little movement. Taking part in the experiment is actually much more reflective of the complexity evident in even the most ordinary human actions. Most striking is the temporal depth of the action – setting the alarm to get to the lab on time and so on. And then there's the question of motivation. Perhaps Mrs Smith decided she wanted to take part in the experiment so those clever scientists might find something about brain entity, which might help a little boy next door who has brain injury problems.

It will be evident from this that most of what voluntary human action is about cannot possibly be captured in experiments like Libet's. And what about the other participants in the experiments – Professor Libet and Professor Haynes? They too are agents, and they probably had to apply for a grant a couple of years before the experiments. They had to work out the experiments and undergo training in order to understand how to investigate the questions they wanted to explore.

They had to perform these experiments, and then they had to write all this stuff up.

The point is this: human agency is very complex, and it is not made of little atomic urges and twitches. That is why arguments for determinism based on these kinds of so-called empirical experiments don't impress me the slightest bit. I think they have nothing to say about whether we do or do not have free will.

I assume that Libet and Haynes were not dualists, or perhaps to put it better, substance dualists. They are more physicalists in terms of philosophy of mind. What would they expect to see? Did they expect the person to decide before their brain? In that case, where would be the locus of decision? I wonder what would they expect to see in the case of free will? They said because the brain activity happened before the desire there's no free will. But what about the other way around? Would that be satisfying, if the urge happens before the brain activity? What would the source of the urge be?

It has been said that Libet was a dualist and he somehow thought you and your urges are separate and independent from the things you do. I do not think we can ascribe a clear metaphysics to Libet, apart from a commitment to identifying ourselves with neural activity. And once you identify yourself with neural activity, you identify it with physical events, which are necessarily causally stitched into the flow of other physical events. If I say that my free will is to be identified with neural activity, then of course I have already given up on the possibility of free will.

There are many reasons why we cannot identify exercise of free will or normal agency with neural activity. First, when I'm performing an action, that action is associated with an intention, an intention that is not localised in this moment in time. It reaches back to a past that makes sense of my intention and towards something that doesn't yet exist, a future, which also makes sense of my intention. And without that temporal depth, which doesn't exist in the material world, there will be no such thing as meaningful intentional action.

There is another topic I wanted to discuss. I think in 2012, you edited a book with Jacky Davis called NHS SOS.² How do you see the progress and development of the NHS since then?

I have spent an awful lot of time in the intervening 8 or 9 years, marching, waving banners, writing to MPs and so on, though not in the past year of course, because of COVID. And it seems to me that we've gradually moved to a much more privatised NHS. But it's been done much more subtly. After the Lansley Bill [the Health and Social Care Bill of 2011], and there was an enormous amount of anger about it, they decided they needed to be more subtle. But it's interesting how in the COVID crisis, we've had a brilliant demonstration of how the NHS works and how privatisation and outsourcing doesn't. If you want to waste £37 billion, give it to the private sector – Serco and others – and get them to run Test and Trace. If you want to actually have something that's really successful, get it run by the NHS – that's why the vaccination scheme, which has been disseminated through the vascular tree of the NHS, has worked so well. So, we've had a very interesting comparison between things that are outsourced to the private sector, incredibly expensive, totally wasteful, and things that have remained within the NHS and have been very successful.

Yes, we have this new White Paper 4 that wants to integrate cooperation instead of competition. I might well be wrong but I don't think competition worked.

You're absolutely right. The White Paper at first sight looks really good. They said let's say farewell to obligatory competitive external tendering. Great. Let's say farewell to internal market. Great. Let's integrate health and social care. Great. But... but... but. We need to be very careful for two reasons. First, when you integrate health and social care you're integrating something which is free at the point of need and still mainly publicly provided (health) with something that is overwhelmingly privately provided and is means tested (social care). But when you bring those two together there's the danger that it could go either way: to an entirely publicly provided, free at the point of need service; or to entirely privately provided services subjected to means testing. The second reason relates to the question of who is actually responsible for the 'integrated care system'. It is not impossible that the system could be run from outside the NHS, even from an American firm. We can see how real this possibility is by the gigantic privatisation initiative that is the disastrous Test and Trace. And the recent takeover of nearly 50 general practices in London by Centene in the past few weeks.⁵ So, whereas I like the overall principles in the White Paper, I worry that it could be the opportunity for the biggest privatisation of all.

There is a risk of that. And one thing I have observed is the amount of bureaucracy. That is exponentially growing. People talk about being more lean but I think this is only when they are discussing finances – not many are thinking lean when it comes to paperwork.

If you compare the percentage of funding that is spent on administration with that spent on clinical care, it is much greater in privatised health services than in the NHS as it was. We are still a long way behind, for example, the USA in terms of the proportion of our funding that is spent on administration, but the internal market and the external market with compulsory competitive tendering has closed the gap. So, one would hope that the new White Paper⁴ would genuinely liberate funds, taking them away from bureaucracy and administration and bring them back to the front line of clinical care. But there's no doubt about it – if we have a systemic privatisation, which I feel we could have with an integrated care system, as opposed to episodic privatisation, as we have at the moment, we will spend yet more on administration – as well as converting more of taxpayer's money into profits to be hidden in off-shore tax havens. And also, it'll be more expensive. I mean, think of the States – they spend 18% of their GDP on healthcare, and they have a worse system. Many US citizens have only minimal healthcare coverage.

Thank you very much for your time.

1.2.46 Mental health services for children in care: investigation to elicit outcomes of direct and indirect interventions

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Abstract

Aims and method

The aim of this study was to compare the efficacy of direct therapy and indirect consultation for treating mental health difficulties among looked after children (LAC), and also to identify any demographic or clinical predictor variables for outcomes in this cohort. A retrospective evaluation of mental health outcomes for 104 LAC was conducted. All children received network consultation in combination with or without direct therapeutic work. Outcomes were compared between the groups with and without direct therapeutic intervention.

Results

Those receiving both treatments displayed significantly greater Strengths and Difficulties Questionnaire (SDQ)-rated improvements than those receiving just consultation. Nonetheless, improvements in scores for the latter group were significant relative to baseline. Treatment duration, younger age at referral and start SDQ were all correlated with positive outcomes, while number of address changes predicted higher start SDQ scores.

Clinical implications

Despite the retrospective design of this study, its results can be considered as preliminary findings to guide treatment decisions in LAC.

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Looked after children (LAC) and mental health

Irrespective of circumstances, LAC appear to be disproportionately burdened by an array of adversity, disrupted development and problematic relationships. These challenges commonly manifest as attachment-related disorders, emotional difficulties and maladaptive behaviours. Given the particular vulnerability of this population and the urgency required when dealing with insecure attachment, any research involving an untreated control group would be inherently unethical. Quantitative research in this field has therefore remained sparse, with the vast majority of the literature instead opting to assess case studies and qualitative data. The retrospective nature of the present study means it is able to contribute treatment-related outcome data from a relatively large sample of LAC. Although this naturalistic design is limited in terms of fully controlling confounding variables, it avoids the risk of bias from insufficient blinding and ensures that no child misses out on potentially beneficial treatment.

A comprehensive meta-analysis conducted by Vasileva and Petermann¹ accumulated data from 22 samples of abused and neglected LAC under 7 years old. Across 11 studies, 38.5% of the 3211 eligible child participants were found to have either motor or cognitive developmental delays; these were consistently more prevalent in children fostered by strangers than in those looked after by kin. Similarly, 39% displayed clinically significant internalising or externalising problems, and only 35% of LAC met criteria for secure attachment. The findings of Tarren-Sweeney² indicate that when mental illness goes untreated during these early years, a child's social and emotional development may be jeopardised, and the possibility of a secure attachment appears to reduce with each placement breakdown. Children that entered care at a later age and were exposed to maltreatment were found to score significantly higher on both the Child Behaviour Checklist and the Assessment Checklist for Children, whereas having a permanent placement was highlighted as an important protective factor. Given the cross-sectional design, however, it was difficult to infer causation, and it is equally possible that children with better mental health are more manageable and thus less at risk of having placements break down.

Attachment security appears to be a crucial factor mediating the mental health outcomes of children placed in foster care. Both internalising problems and frequency of mental illness diagnoses diminished significantly for girls removed from institutional care into foster care, but not for boys, in a sample of Romanian children aged 3 and below.³ Subsequent analysis using the strange situation test⁴ revealed that the demonstrated improvements in mental health for fostered girls was fully mediated by the formation of secure attachment. Guyon-Harris et al⁵ examined the longitudinal trajectories of reactive attachment disorder (RAD) based on semi-structured interviews with caregivers. In line with and extending previous conclusions, the sharpest declines in symptoms of RAD were found for children placed in foster care, which was sustained long-term at 8- and 12-year follow-up (73% retention). The vast majority of children with rapidly decreasing symptoms of RAD had been relatively younger when placed in foster care, whereas children entering at an older age displayed persistent and elevated symptoms. Almost all of the original group left in residential care displayed persistent symptoms.

Direct interventions for mental health difficulties in LAC

The MTFC-P, a direct intervention facilitating healthy, securely attached foster parent–child relationships, included 12 hours of training, daily telephone contact with a consultant and a weekly support group for foster carers, while the child attended weekly therapeutic play group sessions.⁶ Secure and avoidant attachment behaviours were assessed at five time points with 3-month intervals. Pre-schoolers in the MTFC-P condition exhibited significantly more secure and less avoidant behaviours than those in regular foster care. Furthermore, the frequency of secure attachment behaviours increased over time for those receiving the MTFC-P intervention but decreased for the comparison group.

Study on Theraplay have shown statistically significant improvements in communication, interpersonal relationships and behaviour as rated by adoptive mothers, but problem-solving, emotional awareness and general functioning were not found to change.⁷ In a related study, on the other hand, weekly Theraplay sessions delivered to 20 LAC over a period of up to 8 months resulted in no significant change on any of the subscales of the Strengths and Difficulties Questionnaire (SDQ).⁸ Follow-up subgroup analysis indicated that girls showed significantly more teacher-rated improvements than boys in terms of hyperactivity, conduct and prosocial behaviour. Taken together with the findings of McLaughlin and colleagues,³ this suggests that girls may perhaps be more able to securely attach to a foster family and so may benefit more substantially from direct intervention.

Dyadic developmental psychotherapy (DDP) is described as a direct, attachment-based intervention involving the delivery of traditional psychotherapy to both the child and their carer.⁹ Wingfield and Gurney-Smith reported that 12 adoptive parents receiving DDP gained increased curiosity, understanding and empathy for their children, while the children reported fewer behavioural problems, improved control over emotions, better relationships with peers and improved sleep.¹⁰ On the other hand, in spite of progress, a number of parents described the sessions as emotionally exhausting, uncomfortable and upsetting. Feedback from therapists delivering DDP has, however, been very positive. Turner-Halliday and colleagues¹¹ reached out to child and adolescent mental health services (CAMHS) in the UK delivering the treatment. DDP was seen as an effective tool for directly tackling complex profiles of mental illness alongside the root causes of both internalising and externalising problems. The inclusion of parents and carers on such an emotionally stimulating journey was seen to indirectly facilitate secure attachment through an improved mutual understanding.

Multiagency consultation for LAC mental health

In an attempt to better combat the wide range of complex and overlapping symptoms of behavioural, mental, social and cognitive disorders presented by LAC, a small body of research has explored the utility of multi-agency consultation. Upon recounting a number of particularly challenging cases where successful outcomes only emerged in the wake of a concerted effort from all available support, Sprince¹² concludes that child therapists have an obligation to appropriately tailor treatments and advice to the specific network of individuals and organisations responsible for the child's care. The consultation model differs from regular therapeutic interventions in that rather than directly treating the child, their network of carers, teachers, social workers and therapists collaborate to tailor solutions to the child's specific needs, difficulties, history and environment.

Swann and York¹³ refer to this multi-agency intervention as 'THINKSPACE', succinctly illustrating the creation of a space where clinicians, service providers and stakeholders can come together to share their diverse perspectives, knowledge and skills to conjure up a holistic picture and systemic solution. Consultation sessions dedicate around an hour and a half to each child, beginning with the construction of a narrative outlining their development, diagnoses and family history. Attendees then contribute their unique perspectives, theoretical knowledge and practical experience to generate realistic and appropriate solutions. Swann and York emphasise the importance of using everyday language, having only one key interviewer and avoiding giving the primary carer direct instructions.

Qualitative data for evaluation of the consultation model have been collected from social workers and clinicians by Dimaro, Moghaddam and Kyte.¹⁴ Feedback from 138 social workers indicated that a vast majority felt that their goals had been suitably addressed by the collaborative consultation sessions, particularly with regard to assessing concerns, understanding behaviours, understanding relationships and planning next steps. However, 37% of those hoping for effective parenting techniques and 41% of those hoping to work more effectively with staff, agencies and local services felt their goal had not been properly addressed. Subsequent focus groups with 12 of the clinicians illuminated a number of key themes. Primarily, they uniformly felt that the sessions allowed them to provide useful, diverse and practical support. They highlighted the utility of clearly defining roles and objectives and spoke positively about the wider systemic effects their input could achieve.

The sole quantitative trial evaluating the effects of consultation on the mental health of LAC was described by Callaghan et al.¹⁵ Psychiatrists, psychologists and therapists from all three tiers of a UK CAMHS came together to collect collaborative feedback from carers of 45 LAC aged between 4 and 17 years. Outcomes were assessed based on scores on the Health of the Nation Outcome Scales for Children and Adolescents and the SDQ, completed at baseline and 5-month follow-up. Although improvements in total SDQ scores did not quite reach significance, scores on an emotional problems subscale did. This data does rationalise further, more rigorous evaluation of the model but is limited in that it did not include an adequate comparison group, and thus the authors responsible for collecting data were not blinded to experimental procedures. Furthermore, of the 39 carers that completed service satisfaction feedback forms, only 51% felt the intervention offered had been efficacious, and 28% felt their young person had not shown any improvement.

A number of key themes have emerged from the literature exploring mental health presentation and interventions among LAC. Primarily, the formation of secure attachment has consistently been highlighted as a crucial factor mediating mental well-being among this population of particularly vulnerable children. This conclusion emerges from the research contrasting foster care with residential care,^{3,5} the success of treatments targeting child-carer interactions,⁷ and the discrepancy between outcomes for boys and girls,^{3,7} and it is aligned with the apparent predictive power of placement stability and age at entry into care.²

Ethical considerations present a major barrier to quantitative research in that withholding potentially efficacious treatment from a vulnerable child can never be justified. However, uncontrolled quantitative data have pointed towards the efficacy of direct work,^{6,7} as has the more abundant qualitative research.^{10,11} The viability of indirect interventions, on the other hand, is far less well evidenced, with the sole quantitative data-set revealing no significant change in SDQ scores¹⁵ despite promising conclusions drawn from qualitative data.¹⁴

Therefore, in this study, we aim to test the following key hypotheses. Consultation with direct intervention is more efficacious than consultation on its own (H1). Consultation on its own is associated with significant SDQ-rated improvements relative to baseline (H2). A lower total number of address changes and longer time in current placement (H3), younger age at point of referral (H4) and female gender (H5) predict more positive outcomes.

Method

Procedure

In collaboration with a Nottinghamshire-based CAMHS, demographic and treatment-related data for LAC that had accessed the service were collected and analysed ($n = 437$). In pursuit of a suitable outcome measure, only those with both start and end social-worker-rated SDQ scores were included in a subsequent outcome analysis ($n = 104$). Characteristics of the full sample were compared with those of the included sample to determine whether or not it was representative. Permission was then requested and granted to access information regarding presenting problems, diagnoses, address changes and family factors stored on the service's Liquid Logic database for the LAC included in the outcome analysis. Information regarding the nature of treatment for each of these closed cases was also collected, allowing the included sample to be divided into a group receiving just consultation ($n = 69$) and a group receiving both consultation and direct work ($n = 28$).

Sample

Between May 2002 and June 2019, data were available for a total of 443 referrals at the time of collection. Of these, 437 had sufficient data to be included in a preliminary analysis describing the sample, comprising 247 boys (56.5%) and 189 girls (43.2%), with one missing data point. Out of the full sample of 437 LAC, a total of 104 children (23.8%) had both a start and end SDQ score, thus meeting the inclusion criteria for the treatment outcome analysis. Of the 333 LAC not included, 196 (58.9%) were still undergoing treatment, and the remaining 137 (41.1%) were missing either a start SDQ score, end SDQ score or both. Of the 59 boys (56.7%) and 45 girls (43.3%) included in the follow-up outcome analysis ($n = 104$), 69 received cross-domain consultation on its own (66.3%) and 28 received direct work in addition to their consultation (26.9%); intervention details were not available for the remaining seven LAC (6.7%).

Measures

The primary outcome measure was scores on the SDQ, a brief and popular tool used for assessing child psychopathology. It is composed of four subscales evaluating difficulties and one accommodating strengths: emotional symptoms, hyperactivity-inattention, conduct problems, peer problems and prosocial behaviours.¹⁶ Acceptable internal consistency and test-retest stability have been repeatedly demonstrated,¹⁷ and scores have been found to correlate meaningfully with those of other prominent diagnostic tools.¹⁸ Change in SDQ score was calculated as the score reported before treatment commenced subtracted by the score following the treatment's conclusion; positive values therefore reflect improvements in SDQ scores.

Regarding categorical predictors, the included LAC were grouped according to ethnicity, gender, disability and adverse experience. Continuous measures included 'waiting time', calculated as the number of days between initial referral and the date the child was assigned to a treatment programme, and 'treatment duration', operationalised as the number of days between the initial referral and the case closure date. 'Time in current placement' was another continuous measure, calculated as the number of days between the most recent address change and the date that data analysis commenced (1 June 2019). 'Total number of address changes' included short-term placements and returns to previous addresses, in an attempt to best represent placement stability. Start SDQ score and age at point of referral were two additional and more self-explanatory continuous variables also included as potential predictors.

Data analysis

Descriptive and frequency statistics were analysed for both the full cross-sectional data-set and the sample included in the outcome analysis. This was followed by a series of one-way analyses of variance (ANOVAs) and independent-samples *t*-tests in order to identify any significant between-group differences. A parallel analysis contrasted the characteristics of the group receiving just consultation with the group receiving both consultation and direct work. This was followed by an independent-samples *t*-test to determine whether the two treatment groups differed from one another in terms of SDQ score changes. A subsequent single-sample *t*-test was used to determine whether SDQ scores within the consultation group improved significantly relative to a baseline of zero. Finally, a predictor analysis considered the full sample of included LAC, commencing with a series of one-way ANOVAs to identify any categorical protective and risk factors. Pearson's R correlation coefficients were then calculated for the relevant continuous measures, with particular attention paid to the factors associated with changes in SDQ score.

Statement of ethical approval

Ethical approval to conduct this study was not required as the project only involved analysis of existing anonymised data. It was registered in and approved by the Research and Development department of Nottinghamshire Healthcare NHS Foundation Trust.

Results

Demographic and clinical findings

In the full sample ($n = 437$), children waited for a mean of 27.7 days (s.d. = 18.4 days, $n = 317$); they had a mean age at point of referral of 11.3 years (s.d. = 4.2 years, $n = 436$) and mean start SDQ score of 17.2 (s.d. = 8.0, $n = 368$). Start SDQ score did not differ significantly between boys and girls ($t = 0.39$, d.f. = 366, $P = 0.70$). A set of one-way ANOVAs contrasted the group characteristics of those included in the follow-up treatment outcome analysis ($n = 104$) with those that had missing SDQ data or were still open cases (Table 1). No significant between-group difference was found for start SDQ score ($F = 0.512$, d.f. = 1, 366, $P = 0.475$), but significant differences were identified for age at referral ($F = 5.175$, d.f. = 1, 434, $P = 0.023$) and waiting time ($F = 8.366$, d.f. = 1, 315, $P = 0.004$). Subsequent independent-samples *t*-tests revealed that with a mean of 12.1 years (s.d. = 4.0) in comparison to 11.0 years (s.d. = 4.2), children with paired outcome data were significantly older at point of referral than those who were excluded ($t = 2.28$, d.f. = 434, $P = 0.023$). With a mean of 21.7 days (s.d. = 11.3) in comparison with 29.1 (s.d. = 19.5), LAC that met the inclusion criteria were also found to have waited significantly less time between referral and choice than excluded participants ($t = 2.89$, d.f. = 315, $P = 0.004$). Table 1 Descriptive statistics contrasting the included with the excluded sample

	Included ($n = 104$)	Excluded ($n = 333$)
Means	12.1	11.0
d.Rang	4.02–17.10	4.20–17.33
nAge at referral (years)	12.1	11.0
d.Rang	4.02–17.10	4.20–17.33
nWaiting time (days)	21.7	29.1
d.Rang	11.30–48.62	19.50–104.25
nStart SDQ	17.8	17.0
d.Rang	7.31–36.10	4.78–41.00

Fifty-nine boys (56.7%) and 45 girls (43.3%) met the inclusion criteria. For the 100 LAC with data available on the Liquid Logic system, presenting disabilities and adverse experiences are displayed graphically in Figs. 1 and 2. The included sample ($n = 104$) presented with a mean start SDQ score of 17.7 (s.d. = 8.3) and a mean end SDQ score of 14.5 (s.d. = 7.4), equating to a mean improvement of 3.1 points (s.d. = 6.6). The mean age at referral was 12.1 years (s.d. = 4.0), the treatment duration was 248.1 days (s.d. = 259.0), time in current placement was 729.7 days (s.d. = 916.8), the total number of address changes was 8.2 (s.d. = 5.9) and, for the 63 LAC with a recorded choice date, the mean waiting time was 21.7 days (s.d. = 11.2) following referral. Sixty-nine of the included participants received cross-domain consultation on its own (66.3%), 28 received direct work in addition to their consultation (26.9%), and intervention details were not available for the remaining seven (6.7%). Fourteen of the participants receiving direct work completed individual therapy (50.0%), five received DDP (17.9%), four were assigned creative therapy (14.3%), two were assigned Theraplay (7.1%) and one was assigned to each of DBT (Dialectical Behaviour Therapy), EMDR (Eye Movement Desensitisation and Reprocessing) and medical review (3.6% each). The distribution of direct treatment interventions is presented graphically in Fig. 3. Fig. 1 Pie chart graphically illustrating the distribution of presenting

¹ * $P < 0.05$, ** $P < 0.001$.

disabilities for the included sample of LAC. ASD, autism spectrum disorder. Fig. 2Pie chart graphically illustrating the distribution of adversities experienced by the included sample of LAC at the hands of their birth families. Fig. 3Pie chart graphically illustrating the distribution of direct treatments allocated to the subgroup of included LAC receiving both interventions.

Combined and consultation-only treatment (H1 and H2)

The group of LAC receiving only consultation work ($n = 69$) was composed of 38 males (55.1%) and 31 females (44.9%). They had a mean age of 12.2 years (s.d. = 4.2) at point of referral and a waiting time of 23.3 days (s.d. = 12.2), and their treatment lasted for an average of 177 days (s.d. = 216.2) They had changed address a mean of 7.9 times (s.d. = 6.7) and had been in their current placement for 789.1 days (s.d. = 1032.6). The group receiving both consultation and direct work, on the other hand, was composed of 17 males (60.7%) and 11 females (39.3%). They had a mean age of 11.9 years (s.d. = 3.1), a waiting time of 17.7 days (s.d. = 8.5) and a treatment duration of 401.4 days (s.d. = 305.2). They had changed address a mean of 8.4 times (s.d. = 4.0) and had been in their current placement for 629.9 days (s.d. = 653.1). Those receiving both direct work and consultation were found to have significantly longer treatment duration ($t = 4.01$, d.f. = 91, $P < 0.001$) and a higher start SDQ score ($t = 2.26$, d.f. = 95, $P = 0.03$) than those receiving just consultation (Table 2). Table 2 Descriptive statistics for the two treatment groups Consultation ($n = 69$) Consultation and direct work ($n = 28$) Means.d. Ranges Means.d. Ranges Age at referral (years) 12.34.22–17.69 11.93.15–16.28 Time in current placement (days) 789.11032.60–4748 662.9.9653.10–3073 28 Waiting time (days) 23.312.21–48 43 17.78.50–34 28 Start SDQ 16.4*8.41–36 69 20.6*8.26–34 15 Treatment duration (days) 177.1**216.20–850 66 401.4**305.20–1205 28 End SDQ 14.37.52–31 69 15.37.71–29 27 Change in SDQ 2.1*6.315 to 18 69 5.4*7.010 to 18 28²

With a mean change of 5.4 points (s.d. = 7.0) on the SDQ in comparison with 2.1 points (s.d. = 6.3), those receiving both direct and indirect treatment interventions improved significantly more than those receiving just consultation ($t = 2.26$, d.f. = 95, $P = 0.026$). A single-sample t -test indicated that those receiving just consultation nonetheless displayed significant SDQ-score improvements ($t = 2.75$, d.f. = 68, $P = 0.008$). These findings are displayed graphically in Fig. 4. A one-way ANOVA found no significant difference in outcomes for the different direct interventions ($F = 0.65$, d.f. = 6, 21, $P = 0.690$). Parallel one-way ANOVAs identified no significant differences when the included sample was grouped by ethnicity ($F = 0.38$, d.f. = 6, 97, $P = 0.890$), disability ($F = 0.70$, d.f. = 4, 95, $P = 0.593$) or adverse experience ($F = 0.65$, d.f. = 5, 94, $P = 0.662$). Across the paired data, mean change in SDQ score did not differ significantly between boys and girls ($t = 0.41$, d.f. = 102, $P = 0.968$). Fig. 4 Bar chart graphically illustrating the mean SDQ-rated improvements for both treatment groups, with error bars representing standard deviations.

Predictor variables of outcome (H3 and H4)

Correlational analysis for the full sample identified a number of factors predicting SDQ-related improvements, as displayed in Table 3. These were: age at point of referral ($R = 0.22$, $P = 0.027$), treatment duration ($R = 0.20$, $P = 0.049$) and start SDQ score ($R = 0.53$, $P < 0.001$). Start SDQ score was also correlated strongly and positively with total number of address changes ($R = 0.23$, $P = 0.021$) and treatment duration ($R = 0.28$, $P = 0.005$). Finally, a negative correlation was found between number of days waiting and total number of address changes ($R = 0.31$, $P = 0.014$). Table 3 Pearson's correlation coefficients for all continuous variables for the included LAC Age at Referral Address changes Time in current placement Waiting time Start SDQ Treatment duration Change in SDQ Age at referral (years) 0.27 ($P = 0.006$) *0.23 ($P = 0.021$) *0.10 ($P = 0.417$) 0.09 ($P = 0.350$) 0.06 ($P = 0.668$) 0.22 ($P = 0.027$) *Address changes 0.27 ($P = 0.006$) *0.37 ($P < 0.001$) **0.31 ($P = 0.014$) *0.23 ($P = 0.021$) *0.12 ($P = 0.253$) 0.05 ($P = 0.655$) Time in current placement (days) 0.23 ($P = 0.021$) 0.37 ($P < 0.001$) **0.21 ($P = 0.098$) 0.10 ($P = 0.345$) 0.12 ($P = 0.256$) 0.023 ($P = 0.822$) Waiting time (days) 0.10 ($P = 0.417$) 0.31 ($P = 0.014$) *0.21 ($P = 0.098$) 0.02 ($P = 0.885$) 0.06 ($P = 0.668$) 0.08 ($P = 0.512$) Start SDQ 0.09 ($P = 0.350$) 0.23 ($P = 0.021$) *0.10 ($P = 0.345$) 0.02 ($P = 0.885$) 0.28 ($P = 0.005$) *0.53 ($P < 0.001$) **Treatment duration (days) 0.06 ($P = 0.668$) 0.12 ($P = 0.253$) 0.12 ($P = 0.256$) 0.06 ($P = 0.668$) 0.28 ($P = 0.005$) *0.20 ($P = 0.049$) *Change in SDQ 0.22 ($P = 0.027$) *0.05 ($P = 0.655$) 0.023 ($P = 0.822$) 0.08 ($P = 0.512$) 0.53 ($P < 0.001$) **0.20 ($P = 0.049$) *³

² * $P < 0.05$, ** $P < 0.001$.

³

* $P < 0.05$, ** $P < 0.001$.

Discussion

In summary, the LAC with paired outcome data ($n = 104$) differed significantly from the rest of the sample ($n = 333$) in that they were older at the point of referral (12.1 years *v.* 11.0 years) and waited for less time between referral and appointment to a treatment programme (27.1 days *v.* 29.1 days). It is unclear why children referred to the CAMHS at an older age were more likely to have completed treatment and received both start and end SDQ scores. For the latter discrepancy, on the other hand, it is plausible that shorter waiting times may result in faster recovery, meaning treatment is more likely to be concluded for those that received it quickly.

The children allocated both consultation and direct work ($n = 28$) differed significantly from those receiving just consultation ($n = 69$) in that their treatment lasted longer and they commenced with a higher start SDQ score (20.6 *v.* 16.4). Given that the former group were receiving two forms of treatment as opposed to one, it is understandable that the overall duration would be longer. As for the higher start SDQ score, this discrepancy is likely to reflect the unrandomised group allocation. Treatments were instead allocated based on the needs of the LAC; those with more severe presentations and exposed to more adversity were more likely to receive both forms of treatment. One important strength of the present analysis is that outcomes were assessed and scored by the child's social worker, a third party with no conceivable bias towards observing an improvement.

Despite more severe presentations, the group receiving both treatments displayed significantly greater improvements in SDQ scores than the group receiving just indirect work (5.4 *v.* 2.1), thus confirming the primary hypothesis (H1). As outcomes for the various direct interventions did not differ significantly from one another, this finding can be interpreted as qualitative support for all the included direct treatment programmes. In particular, it extends the findings of Weir et al⁷ in their endorsement of the efficacy of Theraplay, but it contradicts Francis, Bennion and Humrich,⁸ who did not find a significant change in SDQ score. It also provides concrete quantitative data to validate the qualitative findings of DDP research.^{10,11} Furthermore, it forms a preliminary benchmark for future research evaluating the utility of both individual and creative therapy, which is yet to be evidenced in a population of LAC. Conclusions regarding the other three direct interventions are more tentative given that only one child received each of DBT, EMDR and medical review, but the outcomes are nonetheless promising.

Consultation was found to be independently efficacious at moderating SDQ scores relative to a baseline of zero, thus confirming the secondary hypothesis (H2). This finding opposes that of Callaghan and colleagues,¹⁵ who did not find any significant change in SDQ score following consultation, perhaps owing to their smaller sample size or the shorter treatment duration. On the other hand, it aligns more readily with the qualitative data reported by Dimaro, Moghaddam and Kyte.¹⁴ This finding for the consultation-only group, however, should be viewed with some caution. Clinicians appear to have made a judgement that these children did not merit a direct intervention, most likely owing to less severe presentation. Consequently, the finding that CAMHS consultation was of benefit is promising. However, the other finding that this group showed less significant change than the group receiving both treatments may imply that these children required additional therapeutic intervention, which was not necessarily within the specialist CAMHS remit. The findings, therefore, may rekindle the debate on the needs and resource implications of therapeutic services, often offered by other agencies such as social care and the third sector, that have been substantially lost in recent years in the UK.

The ingredients of the consultation model used in the study sample consisted of collaboration and cooperation among a specific network of carers, professionals and organisations to create a thinking space where the complex needs of the LAC could be assessed, understood and managed by mutual support, clarification of roles, common understanding and practical steps. This is compatible with previous work that endeavoured to illustrate the consultation model.^{12,13} Unfortunately, there are no data available on the rationale or indication for offering indirect intervention. Future service-based clinical studies may consider looking into the rationale for choosing consultation as a treatment, for example, data on goal setting and management plans following initial evaluation. Quantifying gradual systemic improvement in general functioning and long-term life trajectories of LAC as a result of indirect intervention remains a challenge to achieve through retrospective or short-term quantitative research.

Contrary to expectations, hypothesis three (H3) was not supported by the present data-set in that greater length of time

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in current placement did not predict more substantial SDQ-score improvements, nor was number of address changes found to moderate these improvements. However, in line with the findings of Tarren-Sweeney,² the present analysis did reveal start SDQ score to be positively correlated with number of address changes. The causal directionality of this well-evidenced correlation between mental health presentation severity and frequency of placement breakdown is still unclear.

Hypothesis four (H4) was supported by the present analysis, with age at point of referral negatively correlated with change in SDQ score. This demonstrates the benefits of intervention at a younger age and somewhat aligns with the findings of Tarren-Sweeney² and Guyon-Harris et al.,⁵ both of whom endorse younger age at entry into care as an important protective factor. Probably also driven by an increased propensity to develop secure attachment,^{3,5} it is apparent that parallel to younger age at entry into care, early intervention from CAMHS similarly predicts more substantial improvements. In contrast to previous literature endorsing a gender discrepancy,^{3,8} the present data-set displayed no significant difference in start SDQ score across the full sample, nor did boys and girls included in the outcome analysis differ significantly. This lack of support for hypothesis five (H5) speaks positively towards the efficacy and reliability of both consultation and direct intervention. Similarly, treatment outcomes were equivalent across ethnicity, disability and adverse experience, further endorsing the cross-contextual efficacy of both consultation and direct work.

Limitations

Although the present data-set does provide convincing support for both treatment programmes, conclusions cannot be made regarding their relative efficacy as both groups received consultation. Future experimental research should deliver indirect interventions and direct interventions on their own, to two separate groups. Where in the past the risk of one or both treatments being ineffective may have deemed an investigation of this kind unethical, it can be rationalised by the improvements displayed by both groups in the present study. It is possible for the inclusion criteria to be biased towards including individuals that have responded positively to treatment, who are more likely to have had their case closed and to have completed an end SDQ. However, a noteworthy proportion of the included sample appear to have concluded treatment on turning 18 years of age. This would also explain why the included sample had a mean older age. Although previous research does support the inference that treatment-related improvements are attributable to the facilitation of secure attachment, attachment security was not included as an outcome measure in this study. Given widespread evidence for attachment as a crucial mediating factor,^{5,6} it would be advisable for future research to include attachment security as an outcome measure. This may include considering incorporating the strange situation test⁴ to characterise the attachment between a child and their carer as either secure, avoidant or resistant.

Implications

The literature review that commenced this report isolated the formation of secure attachment as a crucial mediating factor in determining the mental well-being of LAC. It also outlined support for direct work in the promotion of mental health in this population and identified a gap in the LAC literature, with indirect consultation yet to be suitably and quantitatively assessed. This report is the first of its kind to contrast direct and indirect treatment-related outcomes for LAC, and it endorses the efficacy of both. Younger age at entry into care and early treatment are further solidified as key protective factors for mental health of LAC, whereas the previously reported effect of gender is undermined. Despite a number of limitations, these findings provide an important quantitative benchmark to guide treatment decisions and future research exploring the efficacy of interventions for this particularly vulnerable population of children.

We thank the management of the looked after CAMHS service, the IT department and the trust research and development department for providing access and support. We also thank the professionals in CAMHS and children's social care who provided space to conduct the study and helped by reflecting on the clinical implications of the findings.

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Data availability

The data that support the findings of this study are available from the corresponding author, P.M., upon reasonable request.

P.M. conceptualised the study and developed it with S.D. S.D. collected and analysed data and drafted the manuscript. P.M. edited and developed the final manuscript.

Declaration of interest

Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2020.147>.

[click here to view supplementary material](#)

1.2.47 Extreme ‘gender critical’ views will alienate many gender dysphoric patients

Neil David MacFarlane

date

2021-10

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- *Extreme ‘gender critical’ views will alienate many gender dysphoric patients*

pmc The authors provide a welcome update of evidence and reasoning for the ‘gender critical’ position, and the problems with the ‘gender affirming’ position that the Royal College of Psychiatrists adopted in 2018. Their argument might have been even stronger if it had included an account of recent complaints about pressures against free enquiry and expression in this area.¹ Such pressures may partly account for the paucity of published gender critical clinical and scientific research. Neither did the authors mention the professional misconduct of a ‘gender affirming’ consultant psychiatrist in a London teaching hospital, which was brought to the public’s attention in 2007 by the campaigning journalist Julie Bindel.² Or, specifically, the influence of the pharmaceutical industry, although that was implied in at least one of the references they cited.³ However, some of their reasoning appears to lean towards an extreme gender critical position, which is inconsistent with mainstream psychiatric practice. They write that ‘there is little to no convincing evidence to support fundamental differences between the brains of females and males’. But a lack of reliable neurobiological pathology is true of most psychiatric disorders, for which psychiatrists routinely prescribe drugs and other physical treatments, quite often coercively. Again, ‘As a pure subjective experience, [gender identity] may be overwhelming and powerful but is also unverifiable and unfalsifiable’. Psychiatric disorders are mainly diagnosed on the basis of what patients report about their ‘subjective experience’, so the requirement that transgender patients must provide substantial additional ‘verification’ of their experiences also suggests that the authors have adopted a double standard. Do they propose that patients with depression or post-traumatic stress disorder demonstrate that their problems are ‘falsifiable’ before they can receive treatment? The authors attempt to distance themselves from ‘conversion therapy’, but many gender dysphoric patients will not find their arguments convincing. They claim ‘there is little evidence’ that transgender conversion therapy ‘is taking place in the UK’, but the 2018 National LGBT Survey found that 13% of UK trans respondents ‘had been offered’ conversion therapy, compared with 7% of ‘cisgender’ respondents.⁴ Conversion therapy for homosexuality is closely associated with psychoanalysis.⁵ The American Psychiatric Association removed homosexuality from its list of disorders in 1973, with strong opposition from psychoanalysts. It took nearly three decades for the London-based International Psychoanalytical Association (IPA) to act similarly, in 2002. It seems likely that the IPA continues to tolerate the view that homosexuality is a disorder, treatable by psychoanalysis.^{6,7} The authors allude to ‘complex intrapsychic conflicts’ but fail to explain what they mean by this or provide a reference.

This suggests an undeclared allegiance to psychoanalysis. Some British psychoanalysts appear to see transgender patients as a growth opportunity.⁸ The gender critical views of the ex-Tavistock London psychoanalyst Marcus Evans have been quoted by the BBC⁹ and the *BMJ*,¹⁰ while journalists have failed to scrutinise his implied claim that psychoanalysis can provide valid clinical opinion. Such scrutiny is especially necessary given the problematic relation of psychoanalysis to homosexuality and its wider history of evading scrutiny of its claims to therapeutic efficacy, validity¹¹ and safety.¹² Psychiatry should retain its gatekeeping role for transgender patients seeking physical treatments or legal gender change, but extreme gender critical views, which at present appear to include special pleading for psychoanalysis, would undermine the consent necessary for that role to be effective.

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1.2.48 Making the case for the family model in in-patient child and adolescent mental healthcare

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2021-10

Abstract

Within paediatrics, young children experiencing physical and emotional distress are admitted to hospital with their parents as a matter of course, recognising the trauma associated with parting children from their carers. Much of this practice is underpinned by our understanding of attachment theory, which also sits as a fundamental tenet of child psychiatry. Yet the culture in psychiatric in-patient hospitals remains to admit young children without their parents, often to units that are geographically distant from the family home. We argue that the practice of admitting lone children to psychiatric in-patient units is likely to be traumatising as well as less effective. We believe this culture requires challenge and change.

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 - *Are we denying children the opportunity to get the help by not routinely admitting parents with them?*
 - *Clinical implications and future plans*
 - *Declaration of interest*

pmc There are currently only seven child and adolescent mental health (CAMH) in-patient units admitting children under the age of 13 in the UK. Of these, just one admits children along with their parent or carer as a matter of course.¹ We believe this standard practice of admitting children without an accompanying parent/carer to be outdated and detrimental to both child and family.

Enter a paediatric ward today and the sight of a parent accompanying their sick child would be commonplace. Indeed, for children of primary school age, and especially those requiring extended treatment over weeks or months, if a parent or carer were not present for much of the admission there would be concerns raised about the adequacy of the care they were receiving from the family. Over the past 60 years, our paediatric colleagues have increasingly recognised the value of parents accompanying their child in order to minimise the child's distress and to improve overall outcomes.² Yet we in CAMH in-patient services continue to admit lone children, often to facilities that are a considerable distance from the family home.

The initial recognition of the trauma caused to children separated from their parents by hospital admission, and the resulting movement to allow parents to stay alongside their children, was significantly led by John Bowlby.³ Bowlby's work in the development of attachment theory has been integral to our understanding of child emotional development and underlies much of our current practice of child psychiatry. Many research studies have confirmed the association between insecure relational family attachment patterns and childhood emotional and behavioural difficulties,⁴ and it is therefore not surprising that we see an increased prevalence of insecure attachment patterns in the clinical population of the children we care for.^{5,6} Given this, it seems illogical that in-patient CAMH practice continues to admit unaccompanied children, placing children at risk of the double trauma of separation from parents and admission to a mental health setting.

Children exist within and respond to the wider system around them, of which the family is the predominant part. Often the journey that brings a child to an in-patient admission involves the breakdown and disruption of this family system.⁷ Any therapeutic intervention must take this into account and address it. The attachment relationship between a parent and child is a dynamic process that we believe can only be really understood by directly observing their interaction. Admitting the parent and child together allows clinicians to assess attachment patterns directly and to establish to what extent disruption in relational security is driving and/or maintaining the child's mental disorder. It is not uncommon for a parent's own emotional difficulties to affect their attachment relationship and we know that a parent's mental health represents the most important correlate for all domains of the child's potential mental health difficulties.⁸ Many parents of children in in-patient CAMH services have significant backgrounds of trauma and it is common to see the effects of intergenerational trauma displayed in a child's behaviour or for a traumatic response to be triggered in the parent by this behaviour. This understandably can make it impossible for any parent to implement any behavioural strategies suggested by professionals. If parents are part of the admission, this helps the team to develop the trust required to undertake the therapeutic work needed and address these issues more readily.

We should not be surprised that some parents understandably find the idea of abandoning their distressed, frightened child with professionals in an institution far from home for a potentially prolonged period unacceptable. This may mean that the family refuse the admission that they need. By preventing parents from accompanying their children are we denying families the potential to get the help they require? Alternatively, some parents, exhausted by the challenge of trying to care for their child, may be eager to accept an admission to hospital, thus gaining respite from the responsibility of care. However, a hospital admission can strengthen the medicalisation of the child's difficulties, and handing over the care of the child to a clinical team may further promote a family's belief that the child needs to be 'fixed' by professionals or disempowers parents if the child's symptoms dissipate once they are in a hospital setting.

Even if a child's mental disorders are not driven by disrupted relationships, it is vital that the parents/carers can be fully involved in their child's care, as they will become the child's care team on discharge. In all cases the parents/carers of a young child need to become part of the solution for that child rather than continuing to fuel the problem or to believe that only professionals can help.

Are we denying children the opportunity to get the help by not routinely admitting parents with them?

Although we strongly believe that the benefits of parents being admitted with their children to in-patient CAMH settings are clear and meaningful, we recognise that, given this is not routine, there are clearly arguments opposing it.

There is evidence that the practice of admitting lone children and focusing on individual work with the child alone is effective.^{7,9} It may therefore be argued that the additional admission of the parent is unnecessary. A study measuring the outcomes of child in-patient admissions in England and Wales demonstrated their effectiveness and calculated the average cost of a child in-patient admission, but it did not compare the units that do not admit parents with the one that does.⁷ We therefore do not know whether this assumption is correct and clear evidence exists that more can be achieved when children are admitted with their parent or carer than when the child is admitted alone.¹⁰

We note that some children with emotional or behavioural difficulties can benefit from time away from the family home, particularly when ongoing stress in the child–parent relationship is the main source of their distress. We would argue that removing the child from the home temporally is unlikely to address the difficulties long term and intensive work is required with parents to make the systemic change that will be required for the child to benefit when discharged. Although this family work can, and does, happen on an out-patient basis, it is often difficult for parents to attend regularly,¹¹ particularly when children are admitted a long way from home.

Finally, we also recognise the considerable financial implications as well as disruption to family life for siblings at home when a parent is admitted with their child.⁷ Again, we would argue that the long-term consequences of having a child with significant behavioural and emotional problems is in itself disruptive and costly, with long-term negative consequences if not addressed. We would, however, also argue that the family's financial needs could be more actively addressed societally and appropriate reimbursement made available.

Clinical implications and future plans

We have argued that a clinical model that promotes parents accompanying their child during an in-patient CAMH admission is beneficial, therapeutic and should be considered normal practice. We believe the current practice of admitting lone children under the age of 13 to be outdated and anti-therapeutic. We recognise that no specific clinical trials have been undertaken to support this model in mental health settings but we note that our paediatric colleagues have not been required to provide such evidence for their culture and the acceptance of parents on their wards to change; common sense has prevailed by itself. Admitting a child to an in-patient ward is a radical treatment option and including parents in this approach significantly adds to the intensity. We argue, however, that the involvement of parents or carers is fundamental to making the most of this period of family upheaval and is in the best interests of both the child and the family.

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Both authors contributed equally to the conceptualisation and writing of this paper.

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Declaration of interest

None.

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1.2.49 Freedom to think should not mean freedom from evidence and experience

Peter Swann Timothy Swann Reubs J. Walsh

date

2021-10

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- *Declaration of interest*

pmc Evans made a number of inaccurate statements in his originally published article, which subsequently resulted in the publication of a corrigendum. Some of the inaccurate statements and implications for scholarship and clinical practice are referred to in our letter, which was first submitted on 23 August 2020. Gender identity is a pertinent and timely topic, given the current moral panic around transgender individuals. Evans¹ states several fallacies that risk increasing the stigma towards transgender and non-binary individuals. Throughout, motivated reasoning that seeks to describe transgender individuals as inherently disordered is apparent. This manifests in the very limited selection of evidence cited and in unsupported claims made contrary to the bulk of existing evidence.

It is also important to put the letter in context. The consensus among the World Psychiatric Association,² Royal College of Psychiatrists, American Academy of Child and Adolescent Psychiatry and American Psychiatric Association is that psychological treatments to 'suppress or revert gender diverse behaviours are unscientific and unethical'. The reports from these groups follow detailed review of the current literature.

Evans relies heavily on personal accounts and experiences reported by media organisations. Although each individual story deserves hearing, understanding and respect, there is an inherent danger to highlighting cherry-picked examples from blog posts or newspapers. These sources often have political standpoints or biases. The quoted Christian Institute, for instance, writes on their website that transgender ideology 'seeks to completely destroy the distinction between men and women that God in his wisdom has created', and the Sunday edition of the quoted *Times* has been forced to correct a number of inaccuracies in articles about the Tavistock after intervention from the press regulator.

The existence of a few examples of adverse outcomes does not lend support to the idea that affirming care is harmful. In any area of medicine or psychiatry there are always patients who regret treatment, but provided informed consent is obtained and the proportion remains low, that risk is deemed acceptable. What little legitimate research into detransition exists finds a miniscule rate,³ with the primary cause being lack of social support for the affirmed gender identity. By contrast, trans young people supported in their social transitions show radically reduced rates of internalising disorders compared with those that are unsupported.⁴ The claim that transition is predicated on a 'fantasy that the body can be rapidly sculpted as a way of being rid of profound psychological problems' is spurious; the body need not be altered at all for these effects of affirmation to occur (the Olson study included children receiving no medical interventions; instead,

inclusion criteria were that children should be affirmed in their identity by their families and healthcare professionals), and being trans is not a ‘profound psychological problem’ any more than homosexuality is.

It is also important not to conflate alleged failings of a specific institution or clinicians with that of an entire practice. Psychotherapists or psychiatrists not adhering to professional standards, such as those around informed consent, require a response of upholding good and agreed practices and laws, not stopping provision of care to those who seek it. It is also notable that not all consent violations are presented on an equal basis by Evans and those who share his viewpoint. Withholding access to care because a doctor personally disagrees with the informed choice of a patient for reasons based on speculation or ideology also violates informed consent, particularly where that decision has irreversible consequences for the patient, as in the case of withholding puberty blockade.

There is danger in not involving transgender perspectives on work that affects transgender individuals specifically. Work like this risks contributing to the known stigma and discrimination that the trans community already faces⁵ and allowing the credibility of peer-reviewed science to be misused by transphobic groups to promote a harmful ideology. Journals, editors and reviewers have a responsibility to ensure that published material meets a minimum standard of rigour. Evans makes claims including ‘there is considerable evidence that children are signing up to treatments with long-term implications, with very little real understanding of the consequences’ and ‘There is considerable evidence of children and adolescents changing their minds if given enough time and space to explore things’ without providing references to this ‘considerable’ body of work; we are aware of no such evidence for the former, and the latter claim has been thoroughly debunked.⁶ Similarly, the claim that ‘a new diagnostic category, ‘recent-onset gender dysphoria’ [sic], mak[es] up a substantial proportion’ of Gender Identity Development Service referrals is made without any citations to literature. ‘Rapid-onset gender dysphoria’ is a proposed diagnostic category, based on a single, flawed study.⁷ It is not currently recognised for use in clinical settings.

There are common but false comparisons between gender dysphoria and body dysmorphia or body image disturbance in anorexia. Body dysmorphia is a preoccupation with a perceived flaw in part of the body. Transgender individuals do not falsely perceive their body to be different to how others perceive it, only that it is perceived (by themselves and/or others) in a way that does not reflect their gender identity. We think this is an important distinction and failure to appreciate it could lead to attempts at ineffective or dangerous ‘treatments’, much like the unethical and pseudoscientific conversion therapy targeting homosexuality, which is now widely discredited. It is also a common mistake to try to define these complex issues through our own professional lenses – whether labelling as a psychiatric disorder or as a psychoanalytic defence mechanism that unfairly pathologises gender identities that do not fit our traditional western belief systems. Psychiatry has a history of falling into this trap, and we would hope the profession could learn from its mistakes.

We accept that this was a ‘special article’ rather than original research and not a research article, but we do not think that this excuses it from the high standards of evidence expected in an esteemed publication. We would echo the call for greater research into psychiatry’s role in ensuring transgender youth ‘fulfil their potential in comfort’ (https://www.repsych.ac.uk/pdf/PS02_18.pdf) and would recommend that this begins with the people most affected, listening to their concerns and values, and using scientific rigor rather than anecdote and ideology.

Declaration of interest

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1.2.50 Authors' reply

Lucy Griffin Katie Clyde Richard Byng Susan Bewley

date

2021-10

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pmc Thank you for publishing our article¹ and facilitating academic debate in this rapidly evolving area of healthcare. It is unsurprising to find disagreement over the interpretation of existing research, and we welcome this opportunity to respond to Ashley and review the many references supplied, including data published after our article was accepted. We happily address Ashley's points and respond to all individual references in Table 1 <https://doi.org/10.6084/m9.figshare.13626380.v3>.

We stated that the College sees the placement of barriers to seeking transition as a form of conversion therapy, and we shortened – but did not substantively change – the position statement quote.² We believe it accurately represents the meaning, and indeed the same abbreviation was used within the body of the position statement itself. If we are wrong about the College's stance, and we agree there is a lack of specificity about barriers, others too may be confused. Given moves to criminalise conversion therapies,³ the College should clarify what constitutes unacceptable practice⁴ and be clear that provision of psychological interventions to address existing mental health needs before referral for cross-sex hormones, or surgery, would not constitute a barrier or conversion therapy. This is of particular importance since the recent UK judicial review, which found that young people are unlikely to be able to provide informed consent for early medical intervention.

We agree we used some non-peer-reviewed literature. It is well established that dissenting voices can go unheard by invested clinicians and reports of harm take much longer to recognise.⁵ In a word-constrained, broad-based discussion, we could not analyse all the existing literature about natural history, persistence of gender incongruence in youth, rising referrals, or the age and sex switches, though these have been covered elsewhere.⁶ Similarly, other authors have noted that gender dysphoria is a common step in the developmental pathway of same-sex attraction.⁷

Proponents of affirmative care often claim that medical transition is well studied, with academic consensus on effectiveness. In reality, the literature is fraught with study design problems, including convenience sampling, lack of controls, small sample sizes, short study lengths and high drop-out rates among participants. Most of the studies cited in Ashley's letter were of cross-sectional observational design (Table 1) <https://doi.org/10.6084/m9.figshare.13626380.v3>. These low quality studies are unable to demonstrate causality and are susceptible to confounders. An important example of the shortcomings of such convenience sampling is the 2020 paper by Turban et al, which claims to demonstrate lower suicidal ideation in adults who had been prescribed GnRHa in adolescence.⁸ There are a number of methodological shortcomings associated with this biased sampling,⁹ the most worrying being the authors' failure to recognise that this single positive finding is inevitable as prescribers would only have offered puberty blockers to adolescents with stable mental health. Those adolescents with severe psychological problems would not have been eligible. Suicidal ideation is almost certainly related to poor mental health (both past and present) in this group rather than any lack of puberty blockade. This same fact also renders any retrospective desire for treatment invalid. The authors' recommendation that 'this treatment [should] be made available to transgender adolescents who want it' is unsupported.

Before-and-after studies and case-note reviews are similarly unreliable. Like first-hand accounts, they are mainly useful for raising, not answering, quantitative questions. Benefits will be bolstered by mutual belief systems, clinician charisma, powerful mood-altering drugs and body modifications, as well as the placebo effect. By their nature, these kinds of evidence are unconvincing to an ethical medical profession with a long history of causing harm.⁵

The problem of missing data distorts routinely quoted high levels of satisfaction and low regret rates in transgender healthcare. It is unknown whether large losses to follow-up in gender dysphoria research, often over 30%,¹⁰ mask

adverse effects, including death by suicide, cardiovascular disease or general morbidity associated with deteriorating mental and physical health. Thus, long-term cohort data, as well as appropriate randomised trials, are essential.¹¹

Publication bias in this area can be demonstrated by a key ‘positive’ published study¹² which was widely reported by media outlets. This population-based study initially reported a ‘longitudinal association between gender-affirming surgery and reduced likelihood of mental health treatment’ and declared that these findings ‘lend support to the decision to provide gender-affirming surgeries to transgender individuals who seek them’. However, when the authors were asked to address significant methodological limitations and reanalyse including a comparator group, any purported benefit disappeared.¹³ The journal editor stated that the original conclusion of the benefits of surgeries ‘was too strong’, and that the data ‘demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related health care visits or prescriptions or hospitalizations following suicide attempts’.¹⁴ The published correction garnered much less media interest than the initial flawed research.

We agree with Ashley that scientific literature must meet the highest standard for publication and that competent care depends on the integrity of the scientific process. We would add that gender healthcare deserves the same rigorous scientific underpinning as all other areas of medicine. However, in the absence of double-blind randomised controlled trials, there can be no analysis of metadata. The often cited ‘What we Know’ project does not meet even the minimum standard of a systematic review.¹⁵ Poor-quality publications are then recycled as ‘evidence’ and can form the basis of poor-quality guidelines,¹⁶ which in turn are cited as further evidence that this ‘treatment’ works.

Ashley calls for love, but this quality resides outside the consultation room and is not a medical intervention. We support the highest-quality compassionate and evidence-based care for all individuals, based on their own values and circumstances, and are only opposed to bad science^{17,18} which supports, promotes or sells medical interventions without reliably quantifying the outcomes. Present and future patients deserve better, unbiased, sound evidence. Higher-quality collaborative research and independent adjudication of the evidence¹⁹ are required to find out exactly what works, for whom, when and for how long.

Declaration of interest

None

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1.2.51 The article ‘Sex, gender and gender identity’ fails to adequately engage with the extant scientific literature

Florence Ashley

date

2021-10

Contents

- *The article ‘Sex, gender and gender identity’ fails to adequately engage with the extant scientific literature*

The recent paper titled ‘Sex, gender and gender identity: a re-evaluation of the evidence’, which appeared as a Special Article in the *BJPsych Bulletin*, contains concerning misrepresentations of the scholarly literature. The article selectively cites sources to make claims that are contrary to the available literature and best practices, which strongly support access to social, legal and medical transition. Using a direct quote, the authors claim that a Royal College of Psychiatrists position statement includes ‘placing barriers [to] medical transition’ within the meaning of conversion therapy. However, the document actually says ‘place barriers in the way of trans people who seek advice regarding medical and/or social transition’.¹ Raising barriers to transition and raising barriers to people seeking advice are two different things altogether, and the elision misrepresents the Royal College of Psychiatrists’ position statement. Substantively altering quotes in this way is contrary to ethical authorship practices and is difficult to explain. While I would agree that preventing transition is a form of conversion therapy, as expressed in a recent report by UN Independent Expert Victor Madrigal-Borloz,² this is not what the cited position statement says.

Despite discussing these topics, the authors fail to cite available data on the prevalence of anti-trans conversion therapy in the UK;³ fail to acknowledge strong methodological criticisms of studies suggesting that most transgender youth grow up to be cisgender;^{4,5} fail to refer to empirical evidence of the harmfulness of misgendering and deadnaming;⁶⁻⁹ fail to mention that youth referred to gender identity clinics are significantly similar to those in the past despite changes in gender ratios;¹⁰ fail to substantially engage with significant evidence of mental health benefits to transition by brushing it off as immaterial to youth;¹¹ fail to refer to evidence demonstrating that trans youth can be trusted about who they are and do not plausibly transition out of internalised homophobia;¹²⁻¹⁵ and fail to refer to a wealth of data showing transition and gender affirmation to have an important positive impact on mental health.¹⁶⁻²³ Many references used in the article in support of substantial and contentious points are of poor quality and include news reports, non-peer-reviewed blog posts and a Tumblr survey.

Scientific literature must meet a high standard for publication. The editorial and peer-review process is intended to screen for problems such as these, which gravely threaten the quality of published works and undermine the public’s ability to rely on scholarly publication as an indicium of reliability. Providing competent care for transgender youth depends upon the integrity of the scientific process, of which publication is an important part. The past few years have seen a concerning rise in articles opposing gender-affirming care being published in scientific journals despite failing to engage with the available literature and, at times, being directly contradicted by it. Transgender communities deserve high-quality research and scientific publications.

Gender-affirmative care remains the leading approach to care for transgender youth and is well supported by empirical evidence, clinical experience and ethical reasoning.^{24,25} Contrary to what the article’s authors imply, gender-affirmative care does not foreclose youth’s futures. Quite the contrary.²⁶ Attempts to unduly delay or prevent social, legal or medical transition among youth who desire them should be opposed. Children and adolescents deserve unconditional acceptance and love at all points in their lives, including in their gender.

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1.2.52 Effects of diet and fitness apps on eating disorder behaviours: qualitative study

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2021-09

Abstract

Background

Diet and fitness apps are often promoted in university and college settings and touted as a means to improve health with little attention given to unanticipated negative effects, especially among those at risk for or with eating disorders.

Aims

Few researchers have studied how these apps affect women with eating disorders in university and college settings. This research investigates the unintended negative consequences of engaging with these tools.

Method

Data collection sessions comprised three components conducted with 24 participants: survey (demographic and eating disorder symptoms), think-aloud exercise and semi-structured interview. Thematic analysis was used to analyse data.

Results

Participants reported that diet and fitness apps trigger and exacerbate symptoms by focusing heavily on quantification, promoting overuse and providing certain types of feedback. Eight themes of negative consequences emerged: fixation on numbers, rigid diet, obsession, app dependency, high sense of achievement, extreme negative emotions, motivation from 'negative' messages, and excess competition. Although these themes were common when users' focus was to lose weight or eat less, they were also prevalent when users wanted to focus explicitly on eating disorder recovery.

Conclusions

Unintended negative consequences are linked to the quantified self movement, conception of appropriate usage, and visual cues and feedback. This paper critically examines diet and fitness app design and discusses implications for designers, educators and clinicians. Ultimately, this research emphasises the need for a fundamental shift in how diet and fitness apps promote health, with mental health at the forefront.

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pmc Diet and fitness apps often are touted as a means to improve users' health. Most of these apps consist of nutrition, food, physical activity, weight and even sometimes body measurement tracking tools and connections to a community of users with similar goals. Although these apps are popular^{1,2} and can be helpful to some,³ they can have unintended adverse effects on others, such as university and college students.^{4–7} These apps often overwhelmingly focus on weight loss and normalise weight control methods. Using weight loss as a proxy for health is problematic because it may increase the risk of or exacerbate eating disorder behaviours in already susceptible groups, such as women attending university.⁸ Further, these apps tend to overlook the role of mental health in addressing physical health challenges. The emphasis on weight loss within these apps is consistent with and feeds into Western cultures' obsession with thinness and dieting. Diet and fitness apps also support and encourage dieting behaviours. This is an issue because dieting behaviours and unhealthy weight control methods are also risk factors for eating disorders.^{9,10} Additionally, when compared with, for instance, paper tracking, these apps are always on hand and more discreet because of the prevalence of and norms around smartphone use, making it easier to constantly engage with diet and fitness content. They also often provide users with a set plan based on how much weight they want to lose, and leverage features, such as progress visualisations to influence behaviour, colour choices to denote positive and negative behaviours, and reminders and streaks to encourage consistent tracking. Although disordered eating affects all genders, eating disorders and eating disorder-related behaviours are extremely prevalent among women, especially those in college and university settings.^{8,11–13} In fact, researchers have found that 13.5% of undergraduate women screen positive for eating disorders,⁸ and 40–49% of university women engage in eating disorder behaviours at least once a week.¹³

Only somewhat recently have researchers studied diet and fitness apps in the context of eating disorders.^{4–6} For example, Honary et al⁶ found that almost half of the young people who participated in their study had maladaptive eating and exercise behaviours from using diet and fitness apps. In their study of 493 college students, Simpson and Mazzeo⁴ found that those who reported using diet and fitness apps had higher levels of eating disorder symptoms. Similarly, but focusing on individuals with clinically diagnosed eating disorders, Levinson et al⁵ found that in their cohort, 73% of those who used MyFitnessPal perceived it as contributing to their eating disorder, and these perceptions were correlated with eating disorder symptoms. Although these studies are important to recognise the link between eating disorders and diet and fitness apps, they do not shed light on how these apps may unintentionally affect users and their eating disorder symptoms. To address this gap, a qualitative study was conducted to answer the following research question: what are

the unintended negative consequences of diet and fitness apps among women attending university who exhibit eating disorder-related behaviours? The term ‘unintended consequences’ refers to unforeseen or unpredicted results.⁴² This terminology is common when discussing technological impact, especially related to health information technology. These consequences can be positive, negative or neutral, but often refer to adverse effects.

The research question

This study takes an interpretivist perspective: knowledge is contextual and grounded in participants experiences.¹⁵ This paper reports on one portion of a study on the use, impact and perceptions of diet and fitness apps (and if they are used in conjunction with other technologies, such as social media). Eight themes emerged that highlight the unintended negative consequences of diet and fitness apps. Findings from this study can be used by app designers, educators and clinicians to more carefully consider how these apps affect users, especially young women to whom these apps are often marketed.

Eating disorder behaviours

For the purposes of this research, eating disorder behaviours are behaviours associated with anorexia and bulimia nervosa. These include excessive calorie or food restriction; intense fear of gaining weight; obsession with weight and consistent behaviour to prevent weight gain; self-esteem overly related to body image; bingeing; feeling of being out of control during bingeing; purging; dramatic weight loss; preoccupation with weight, food, calories, fat grams and dieting; refusal to eat certain foods; comments about feeling ‘fat’; hunger denial; excessive exercise regimen and development of food rituals.¹⁶ Because many women do not see a professional for their symptoms and thus never receive a diagnosis,⁸ eating disorder behaviours in this context may or may not indicate full clinical eating disorders or qualify to be categorised as other eating disorders, such as other specified feeding and eating disorder or unspecified feeding and eating disorder. The women in this study self-identify as having an eating disorder. Therefore, in the remainder of this paper, eating disorder behaviours and eating disorders are used interchangeably to emphasise women’s own perspectives and experiences with eating disorders, and the importance of studying eating disorders even in the absence of a clinical diagnosis.

Method

To capture rich information from individuals about how diet and fitness apps may affect eating disorder-related behaviours and perceptions, a primarily qualitative research approach was employed. This methodology allowed for users to share their stories and experiences in their own words and emergent themes unlikely to be discovered when using only quantitative approaches. Three data collection methods were used: surveys (demographic and eating disorder symptoms survey), think-aloud exercises and semi-structured interviews.

Recruitment

In total, 24 participants took part in the study. The focus of this research was university women with eating disorders who use or have used diet and fitness apps in the USA. Participants who were either formally or self-diagnosed were recruited. This was specifically done to include the portion of women who do not seek a professional diagnosis or treatment. Therefore, this study represents users whose needs are largely invisible. This population is important to study because anorexia nervosa, bulimia nervosa and related eating disorder behaviours tend to affect university women,⁸ and diet and fitness app users tend to be younger.¹ To recruit users, on-campus groups were asked to share information on a campus listserv and fliers were posted to social media. Additionally, paper fliers were posted on bulletin boards on and off campus, such as at local gas stations. Because eating disorders are stigmatised conditions, many people may be wary of being seen getting contact information from fliers. Posting paper fliers in discreet locations, such as on the backs of doors in public restroom stalls where participants could covertly obtain information for the study, was the most successful approach.

Measures

Demographic and eating disorder symptoms survey

The survey contained questions about age, gender, and race/ethnicity, as well as eating disorders and app use. A combination of three well-known measures for assessing the severity of disordered eating and exercise behaviours and attitudes was used, which is similar to Tan et al¹⁷ and described in *Table 1*: the Eating Attitudes Test (EAT-26),¹⁸ the Eating Disorder Examination Questionnaire (EDE-Q 6.0)¹⁹ and the Clinical Impairment Assessment Questionnaire (CIA 3.0).²³

Measure	Description	Interpretation
EAT-26	The EAT-26 is a 26-item self-report questionnaire that assesses symptoms and concerns characteristic of eating disorders on a six-point scale (always to never), using behavioural questions regarding the past 6 months. ¹⁸ It is often used as a first step in a multi-stage screening process and has been useful as a screening tool to assess eating disorder risk. It consists of three subscales – diet, bulimia and food preoccupation, and oral control – that make up an overall score. As part of the EAT-26, participants are also asked to self-report their height, current weight, ideal weight, lowest adult weight and highest adult weight. For those who score >19 and/or qualify for one or more of the behavioural questions, the recommendation is to see a qualified professional because they are exhibiting symptoms characteristic of eating disorders. Even without the cut-off score, this measurement can be used as a continuous measure of eating disorder symptoms.	
EDE-Q 6.0	The EDE-Q 6.0 is a 28-item self-report questionnaire that measures frequency and impact of eating disorder behaviours in the past 28 days that reflect severity of aspects of the psychopathology of eating disorders, using seven-point scales (no days to every day; not at all to markedly), and questions where respondents report the number of times or days they engaged in particular behaviours. ¹⁹ A highly reliable and validated tool, the EDE-Q 6.0 is the most commonly used assessment for eating disorders. ^{17,20} It consists of four subscales – restraint, eating concern, shape concern and weight concern – which make up the global score. Higher scores indicate greater levels of symptoms. Suggested cut-offs range from 2.30 with the occurrence of binge eating and/or excessive exercise in community samples of young women to indicate ‘probable’ eating disorders, ²¹ to 2.80 for clinical samples. ²²	
CIA 3.0	The CIA 3.0 measures the severity of psychosocial impairment from eating disorder features in the past 28 days, on a four-point scale (not at all to a lot). ²³ It is a 16-item measure that focuses on mood, self-perception, cognitive functioning and work performance, which is intended to be taken after a measurement of current eating disorder behaviours (such as the EDE-Q 6.0). It then provides values to assess the severity of psychosocial impairment secondary to eating disorders. Higher scores indicate greater psychosocial impairment. A score of 16 is suggested as a cut-point for predicting eating disorder case status. ¹	

Think-aloud exercise

The think-aloud is a method in which participants speak out loud thoughts that come to mind as they go through a task.²⁴ The objective with the think-aloud exercise was to explore participants’ perceptions linked to specific aspects of the app. Participants went through three tasks: setting goals, viewing progress visualisations and using social and community features of the app. As users went through these tasks, they were asked to speak aloud what they were thinking and feeling as they interacted with the app.

1

EAT-26, Eating Attitudes Test; EDE-Q 6.0, Eating Disorder Examination Questionnaire; CIA 3.0, Clinical Impairment Assessment Questionnaire.

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Semi-structured interview

The purpose of the interviews was to understand participants' general experience with and perceptions of diet and fitness apps. Participants answered questions regarding why they used diet and fitness apps, the role the app played in their eating disorder behaviours (both positive and negative), unanticipated effects and their reflection on their use over time. At approximately 14 interviews, repetitive themes in the participant responses were apparent and converged into the same points (i.e. data saturation).

Procedure

Although there were distinct methods of data collection, they occurred during the same session. All sessions began with the demographic and eating disorder symptoms survey. All participants took the demographic survey; five opted not to take the eating disorder symptom survey. Current app users ($n = 17$) then participated in the think-aloud followed by the interview. Former app users ($n = 7$), on the other hand, only participated in the interview after taking the survey. In those cases, participants discussed how they used the app and were asked to recall specific features. Participants were compensated \$25 each for approximately 1 h of their time. All but one data collection session took place in person (one was conducted via telephone).

Ethics

All procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees (Institutional Review Board approval number: STUDY00004634) on working with human participants. Institutional review board approval was obtained from Pennsylvania State University, and written informed consent was obtained from all participants. Materials were reviewed by a mental health professional. Resources were provided to every participant. Participants who currently did not use diet and fitness apps were not asked to interact with apps to avoid potential triggers. A plan was in place to work with participants in seeking support should they need it during or after a session; participants were reminded they could cease the session at any point. Because participants were students at one university, the university's Center for Counseling and Psychological Services was available to participants.

Data analysis

Excel for MacOS and JASP for MacOS (JASP Team, University of Amsterdam, the Netherlands; see <https://jasp-stats.org/>) were used to organise and analyse the quantitative data from the demographic survey and eating disorder symptoms measures. Body mass index (BMI) was derived from height and weight data. For those aged 20 years, BMI was computed with the United States National Institute of Health calculator (https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm), and for those aged <20 years, BMI was calculated with the Centers for Disease Control and Prevention calculator (<https://nccd.cdc.gov/dnpabmi/calculator.aspx>). Think-aloud exercises were video and audio recorded, and interviews were audio recorded. In total, the think-aloud exercises and semi-structured interviews were 21 h and 36 min. The think-aloud exercises and interviews were transcribed for a total of 436 pages, and analysed together. The data were analysed by the author, using Braun and Clark's thematic analysis approach,²⁵ which included becoming familiar with the data, systematically identifying codes and themes, and defining and naming the common themes found across the entire data-set. Similar discussions and answers were grouped together, and initial codes related to unintended negative consequences were developed. During data collection, the analysis was iteratively performed to refine the themes as more data was collected. The videos and still images were used to better understand specific app content and features to which participants were referring.

Results

Participant demographics

Participants were aged 18–23 years, with a mean of 20.63 years. The majority of participants identified as White (non-Hispanic) ($n = 18$), with one from Israel; three identified as Asian, Asian American or Pacific Islander; two identified as multi-racial and one identified as Native American or American Indian. Most participants had not been professionally diagnosed with an eating disorder ($n = 17$), and most reported being in recovery or recovered ($n = 20$). Participants estimated they had an eating disorder anywhere from 2 months to 7 years (mean 34.93 months, s.d. 26.78 months), and most ($n = 20$) felt that their eating disorder began before using diet and fitness apps. The most used app was MyFitnessPal ($n = 21$); however, many of the other apps used had similar features to MyFitnessPal. Participants reported using diet and fitness apps anywhere from 2 months to 8 years (mean 30.21 months, s.d. 30.05).

Participants reported current (mean 22.90, s.d. 3.58), high (mean 24.71, s.d. 3.84), low (mean 19.54, s.d. 3.40) and ideal BMI (mean 21.13, s.d. 2.26). At the time of data collection, most participants were in the healthy range ($n = 16$), followed by overweight ($n = 2$) and obese ($n = 1$). Highest reported BMI for participants was most often in the healthy range ($n = 14$), followed by overweight ($n = 3$) and obese ($n = 1$). Lowest reported BMI most often fell in the underweight ($n = 8$) or healthy range ($n = 8$), followed by overweight ($n = 2$). Most participants reported an ideal weight in the healthy range ($n = 17$), followed by underweight ($n = 1$) and overweight ($n = 1$). Seventeen out of nineteen participants reported their ideal weight as less than their current weight, and only two reported their ideal weight as higher or the same as their current weight.

Sixteen out of nineteen participants answered one or more of the eating disorder questionnaires in a way that suggested eating disorder symptoms. For the EAT-26, the overall mean score was 21.32 (s.d. 10.63), and 15 out of 19 participants exceeded the cut-off point. For the CIA 3.0, the overall mean of all 19 participants did not reach the cut-off point of 16 (mean 14.84, s.d. 10.39); however, nine participants exceeded this threshold. For the EDE-Q 6.0 global score, the overall mean of 2.70 (s.d. 1.04) was between suggested cut-off points.^{21,22} Scores were also compared with the norms of university women, which was computed by taking the norm mean (1.65) and adding 1 s.d. (1.30), to equal 2.95;²⁶ ten participants exceeded this threshold. Additional information can be found in Supplementary Table 1 available at <https://doi.org/10.1192/bjo.2021.1011>.

Themes

Eight types of unintended negative consequences from using diet and fitness apps emerged, which can be seen in *Table 2*. These themes focus on the interaction between the user, context and app, and how the design of apps affects attitudes and behaviours. These themes include fixation on numbers, rigid diet, obsession, app dependency, high sense of achievement, extreme negative emotions, motivation from ‘negative’ messages, and excess competition. Although these were common when users’ focus was to lose weight or eat less, these adverse effects were also prevalent when users wanted to gain weight, eat more or focus explicitly on eating disorder recovery. As a result of these unintended negative consequences, some participants reported secondary effects, such as interference with personal relationships, social outings, school and work, as well as increased health issues. *Table 2* Emergent themes, definitions and example quotations

Theme	Definition	Example quotations
Fixation on numbers	Developing a fixation on numbers associated with food and exercise, an acute awareness of calories, an altered relationship with food and/or a need for exactness from the quantifications within the app	‘I think it’s [logging food and exercise everyday] definitely very triggering because you look at food differently. Like now when I look at food, I see like that’s protein, that’s fat, that’s carbs instead of like that’s a chicken breast, that’s peanut butter, that’s a piece of bread... it’s definitely very, very triggering to be tracking it all the time. And especially back then [during my eating disorder], it was like, “Well, that’s 100 calories right there, like I need to eat broccoli instead, that’s like 35 calories”... It’s a number game basically...’ [U06] ‘I try to get exactly on [the number]... I like having it exactly on... It [the app] made me more OCD [obsessive compulsive disorder] ‘cause I’m like, “I have to hit this number”, basically... making sure I hit those numbers... There was one time my parents wanted to go out to dinner... So, I called the [restaurant] so I could already track it and have it as close as possible. And then my parents get here, and they’re like, “Oh, we’re going go to [this other restaurant] instead”. And I was literally having anxiety about going. I didn’t want to go to dinner. I was like, “No. I already had everything perfectly planned for my day”, and that was probably a bad moment... I feel like eating disorders stem from people

trying to be perfect, and with this, you're hitting numbers trying to be perfect, so I think that could be kind of bad' [U14]Rigid dietDeveloping a strict and rigid diet, including eating the same foods every day and/or developing safe and fear foods through the use of the app's food database, personalised prior meals or the barcode scanner'I think another kind of bad thing about it is I eat the same thing almost every single day except for dinner, but I think like just because in my head, I can kind of keep track of the points, and I think that's probably part of it. I'm not going to eat like a lot of new stuff if I have to like kind of go and do the work for it and see how much it is, so I think that kind of makes me eat the same thing every day' [U08]'I love how it could scan a label... That was my favourite thing in the world... It got to the point where I would never buy something that didn't have a label on it 'cause I couldn't track it... And I would be very secretive about just having a picture and being able to successfully find it on the app. If I couldn't find it on the app, I wasn't going to eat it 'cause... It wouldn't have been correct... You start to eat the same things... '[U17]ObsessionBecoming obsessed with logging and tracking, which can lead to the development of obsessive thoughts around food and exercise'I just think the entire app in general is harmful... For someone like me, it's extremely dangerous. Just everything. Being able to log your calories, 'cause you become obsessive over taking pictures of labels, you're measuring things, and getting the correct amounts becomes impulsive and just like obsessive. Exercise then, plays a same role in that... I got to be honest: before I started using the app, I felt like my logging wasn't that dangerous. It wasn't that compulsive or that obsessive, I should say...' [U17]'...I remember, I had that year at least five, six anxiety attacks because I was so anxious about what I'm eating, and I was so nervous about it. And the app said one thing and then the computer said something else, and I just lost my mind... So for me, it emotionally was a bad thing, the app... That's when I was really obsessing, and I would make sure everything is measured to the centimetre, to the ounce... I think it [the app] makes us overthink food, which can lead to obsessing about it... So I think the focus should be way more on health and way less of numbers... I think this [the app] just reinforces the wrong thing' [U12]App dependencyFeeling that one needs the app, feeling safe and in control with the app, developing anxiety when not using the app and/or not wanting to cease app use'In the moment, I didn't care. I knew it [the app] was harming my brain because I knew it was messing with my head mentally, but I just wanted to keep it because I felt like that was the one thing I could control. Because when you have an eating disorder, that's the one thing you want, is control. And I knew this app gave me control over what my parents wanted me to eat, just in that sense. I never really told them 'cause I didn't want to lose that control I had. Because being forced to eat a sandwich or being forced to eat, to go see a therapist, I had no control over those, but with the app, I felt like I had control over one part of my life that I really wanted to change' [U21]'Last summer, I had to delete it [the app]. I deleted it and had to get it back 'cause I was like, "Oh, my gosh, I need to know what I'm eating"... I literally got anxiety, so I had to get it back... I was like, "Maybe I should just stop tracking and just eat intuitively". So, that's why I tried deleting it. And then like a few days later, I had to get it back...' [U14]High sense of achievementFeeling extremely rewarded for eating under calorie and nutrient budget, engaging in compensatory behaviours and inputting them on the app, and losing weight; often occurs when receiving positive feedback on the app, such as via green visualisations'I definitely would say that if I got to the end of the day... like if on Tuesday, I was a little bit more in the green [on] Wednesday, I'd feel better about it. So it was almost like an accomplishment *per se*... Sustaining it [my eating disorder] would absolutely be seeing that when you're low or you're in the green... You don't even think about green being a good thing but just the colour cues that you associate with rewards... when you're starting to reinforce eating less, eating less, eating less... So I think it's [the app's] very much targeted towards the weight loss rather than fitness, *per se*' [U19]'I obviously like to be in the green for the calories remaining... This thing, progress bar, I mean, I kind of like, I mean, I used to like to see it really close to that like goal line or even like below, which sounds bad. But because that looked better to me if the bar's lower. So I mean, I guess, maybe that's kind of a problem, but I mean, it kind of made me feel that I was kind of like successful for the week if it was like mostly under the bar, obviously [laughs] even though that's under your calorie thing, which is probably not good... I just kind of wanted to see where I was in my calories for the day, and if I was like under what they allotted me, then I was happy... If I went to this bar and I saw everything was like below the goal, then that would kind of make feel like all right, that was good' [U04]Extreme negative emotionsFeeling extreme negative emotions, such as guilt, embarrassment and shame, especially when exceeding one's calorie or nutrient budget or gaining weight; often occurs when receiving negative feedback on the app, such as via red visualisations'At the end of the day, if I was still very hungry and I didn't have any calories left, that whole red number... That red number would scare me a lot because I'd be like, "Well, now I can't eat anything, and I'm really hungry, and I can't sleep with an empty stomach". Then if I ended up eating, I would wake up feeling guilt for going over my intake because I felt like it would get in the way of my goal of losing weight... Once it hit 200 or more, I would get really stressed out, even panic because... I would be ashamed because I felt like I wasted my whole day of when I was fasting 'cause when I was fasting, it would be a really low goal of calories... So it was just very stressful to deal with the red numbers... The red number would

come, and I'd be over my calories, and it just freaks me out all the time. I wouldn't even want to go to school if I knew I ate too much that night or that day before... I feel guilt for what I ate that day 'cause it's usually something that was high in calories, like a cookie or something. And then that caused that to become a fear food, like dietitians like to call it, a fear food that I try to exclude from my diet because that leads to a red number that embarrasses me' [U21]'I don't like the colour red. I feel like it's bad, and it would always be like a frowny face, like bad, like you didn't do what you're supposed to today, and I was like, "I know, I know I didn't"... I think they definitely need to be not as like strongly represented. Like if you're 1 calorie over, it's like, "Ok, like no big deal". It should be like a range, you know what I'm saying? One calorie over is different than being like 400 calories over, and I think it definitely gave me the wrong perception and made me kind of go like the other way especially like when all my things were red in [my] app, I was like, "Ok, well, then this makes me definitely not want to eat for like 3 days after seeing that" [U05]Motivation from 'negative' messagesFeeling motivated by 'warning' messages usually intended to curb unhealthy behaviours, such as feedback that states low weight or low calorie intake'...I was under-eating, so they [the app] would show me, you would be 90 pounds in a month or something if you kept on eating like this... I would just under-eat more to make that happen faster... So, I used to exercise 400 calories, then I would just skip lunch, I would eat dinner... Over here it would be 500 remaining or something. And at that point it would be, "Ok, so you're going to be 95 pounds if you kept on eating like this in 2 weeks". So that was more of a motivation, I think... Because you're trying to lose so much weight, and you're like, "If you keep on under-eating, you're going to be 98 pounds", which is exactly what you want to be at that point... It's not a warning...' [U22]'If you click this "Complete Diary"... So it tells you, "If every day were like today, you would weigh this amount", which [laughs] it's like I have such mixed feelings about it because like it can be motivating, but also it can be really triggering... like someone with an eating disorder is like, "Yeah, yeah, you're right; oh my god, I can weigh less than that in 5 weeks if I eat less"... When you're in the middle of your eating disorder, you think this is motivational, but when you look back on it, it's like, that's horrible [laughs], like that's really horrible' [U06]Excess competitionMaking calorie consumption, expenditure and weight loss a game by trying to beat the app or self; often achieved by netting fewer calories each day and/or being under budget'It was kind of like a game to beat the calories, kind of. So one day I had a 0, maybe it was like a negative calorie. I was like, "Oh, wow, like look at me, like that's cool!"... Just because like you can visualise what you're eating, so the more you don't eat, it's like, "Oh, I beat the app!"... I definitely wanted to beat the calories they gave me. I feel like that kind of does start an eating behaviour where you don't want to eat anything... Like especially 'cause they give you a calorie limit. I know when I was under the calorie limit, I was like, "Ok, I won today"... I was like, wait a second, the app kind of like made it a game for me to like not eat much' [U07]'It just became this weird competition thing with it [the app]... I would just be like, "I need to be lower than what it was before". [laughs] I don't know... It just always had to be less than the day before in the food and the weight and everything... Because then, if I wasn't, then I was like a failure 'cause that was what the eating disorder thoughts were telling me' [U13]

Participants discussed developing a fixation on numbers, fuelled heavily by the app's quantification, which worsened their eating disorder behaviours and changed their relationship with food. Having used the apps so much, many participants reported already knowing the calorie content of every food they ate before logging it. Participants also explained that they tended to eat the same foods each day because they knew the calorie content and could mitigate any unknowns about what they were consuming (even if they abandoned the app). The app also fed into the concept of fear foods and safe foods, where users would only buy and track foods if they were aware of their calorie content (e.g. in their personal app database or foods that had a barcode).

They described becoming obsessed with logging their food intake, and developing obsessive thoughts around food and exercise that sometimes interfered with schoolwork. For example, some participants used the app to log all their meals in advance, which acted to strictly control their consumption. Some also described developing a dependency on these apps. Many participants discussed how they needed the app and became very anxious when they stopped using it; they sometimes redownloaded the app to relieve their anxiety. One participant described how uncomfortable she was when she went to a clinician who wanted her to explore the idea of not using her physical activity tracker (Fitbit).

A number of participants described the role of green progress visualisations, which users see when they have remaining calories on MyFitnessPal and similar apps. Many expressed feeling rewarded when viewing this feedback, as it signalled they were consuming less than their allotted calories. On the other hand, participants felt guilt, embarrassment and shame over exceeding their calorie budget and being shown red visualisations in response. The extent to which they exceeded their budget affected participants differently. Some expressed that they felt badly regardless of how much they went over their budget, whereas others explained how they felt worse the higher their calorie number exceeded

their budget. Many participants also described being in an unhealthy competition with themselves and with the app to eat less and less each day, because the app ‘gamified’ eating, exercise and tracking.

Although there are some features in diet and fitness apps that attempt to curb maladaptive eating and exercise behaviours, participants explained that these did not work as intended. For example, MyFitnessPal has a feature called ‘Complete Diary,’ which is a button that allows users to tell the app they are finished logging food, exercise and weight for the day. Once clicked, either a warning message or weight projection appears. Many participants found both types of messages to be motivating to continue to lose weight regardless of the content or context of the message.

Discussion

Unintended negative consequences are prominent regardless of where users are in their journey (e.g. recovery or not). This is a result of the design of diet and fitness apps, the individual and their context. This section first discusses implications for educators and clinicians, and then critically examines the design of diet and fitness apps and offers suggestions for improvement.

Implications for clinicians and educators

Understanding the unintended consequences can be useful for psychiatrists, psychologists and other mental health experts, as well as general practice clinicians, to aid in the diagnosis and treatment of eating disorders. Especially in college and university settings, healthcare professionals should be aware of and engage in discussions about the use and potential downsides of diet and fitness apps. Educators should also be privy to possible unintended negative effects to prevent triggering or exacerbating maladaptive eating and exercise behaviours. By encouraging or even requiring the use of digital food and physical activity tracking as part of nutrition courses and ‘healthy’ university initiatives (e.g. <https://www.usatoday.com/story/college/2016/01/19/oklahoma-college-tracks-students-fitness-with-fitbits/37410983/>), educators may unknowingly exacerbate eating disorder-related issues, especially among university women. Therefore, great caution should be exercised when considering promoting diet and fitness apps, especially in these settings. As always, it is important to remember that app users and app use exist in a larger context, where societal norms and external pressures influence the effects of these tools.

Rethinking diet and fitness app design

The design of diet and fitness apps may partially contribute to unintended negative consequences, which are related to three major areas: the quantified self movement, our conception of appropriate usage, and visual cues and feedback.

Table 3 outlines how these findings relate to app design, to help us understand where we can make improvements to minimise unintended negative consequences and focus more on promoting healthy behaviours. However, it is important to note that although small changes may have some positive impact, this work highlights the need to change how we think about health promotion in digital tools by focusing on the mental health needs of users and the interplay between mental and physical health. A more holistic and personalised approach is consistent with prior literature on supporting the needs of people with eating disorders.²⁷ *Table 3* Summary of suggestions to address diet and fitness app issues

Area	Problem	Related unintended negative consequences	Suggestions
Quantified self movement	Overabundance of quantification despite the fact that not all aspects of health can easily be quantified	Some quantifications are not good health indicators	
	Too much of a number focus can trigger and exacerbate eating disorder behaviours	Fixation on numbers	
	Rigid diet		
	Obsession		
	App dependency		
	High sense of achievement		
	Extreme negative emotions		
	Motivation from negative messages		

Excess competition Work meaningfully with people with eating disorders during all phases of designing these tools
 Find new ways to acquire user needs and non-numeric yet quick and easy methods for tracking behaviours
 Consult expert recommendations about healthy eating and exercise during design process
 Support healthy eating patterns, food variety, portion control, shifting to better food choices and various eating contexts
 Change exercise tracking to focus on performance and enjoyment rather than calorie expenditure
 Incorporate qualitative components to assess other aspects of health Conception of appropriate usage Push users to log consistently over long periods of time
 Tend to view breaks and abandonment as negative
 Encouraging overuse can trigger and exacerbate eating disorder behaviours Obsession
 App dependency Reduce reminders to log daily
 Encourage breaks
 Rethink what app engagement is and reward users for engagement that is not actively logging or viewing numbers
 Visual cues and feedback Try to use visualisations to motivate users but do not fully understand their effects
 Visual cues do not always match users' goals
 Warnings have opposite of intended effect or are avoided
 Visualisations and messages can trigger and exacerbate eating disorder behaviours High sense of achievement
 Extreme negative emotions
 Motivation from negative messages
 Excess competition Study effects of design and warnings more thoroughly and on different users at different times
 Develop more nuanced design visualisations that better coincide with intended messages and users' goals
 Rethink unhealthy eating and exercise pattern thresholds for showing feedback

Quantified self movement: moving beyond numbers

The quantified self is reflected in diet and fitness apps' heavy focus on numbers. Although self-tracking numeric data has benefits,^{28–30} findings cast light on issues with the quantification and tracking of behaviours related to diet and exercise, especially for those with a history of eating disorders, which has been supported by other literature.^{6,31} Users with eating disorder behaviours develop a fixation on numbers and a rigid diet partly because of diet and fitness apps' heavy focus on numbers, as well as features such as barcode scanners, which are aimed at reducing user burden but actually encourage eating pre-packaged and fast foods,³² which often are not the healthiest options. Because food, exercise and weight are quantified and goals are numerically driven, users become overly preoccupied with numbers, and food begins to be viewed as its caloric and macronutrient content.

Although the quantified self movement has its merits, it is clear that using numbers as indicators of health has its limitations and feeds into the need for control, which is a hallmark of eating disorders. To begin to reduce unintended negative consequences, designers, developers and researchers need to focus less attention on quantifying food, weight and exercise. Instead, understanding what a healthy lifestyle is and finding ways to promote that with technology is imperative. For example, rather than focus mostly on calories, apps should be designed to help users develop a positive relationship with food and their body, as well as healthy eating patterns that include fruits, vegetables, protein, dairy, grains and oils; focus on food variety, nutrient density and amount/portion sizes; help limit added sugars and saturated fats, and reduce sodium intake; find ways to help people shift to healthier options and assist healthy eating in various settings (home, work, school, restaurants, etc).

For physical activity, the focus should be less on exercise's relationship to calories and more on how much exercise, what types, ability to perform, enjoyment and its relationship to positive mental health. Studies have shown that exercising for enjoyment rather than appearance is correlated with low self-objectification, low body dissatisfaction and less disordered eating.³³ By focusing on exercise as something enjoyable and healthy, the focus will be less on exercise as a means to lose weight or look 'better', and thus improve overall mental health. Apps should also adapt to users' personal contexts and needs around physical activity and healthy eating, as well as acknowledge systemic barriers and the role of trauma. Because customisation may be crucial for supporting users' needs, more sensor-based and passive

tracking are being explored.³⁴ However, caution must be exercised, as automated detection often reproduces biases and existing norms, exacerbating inequities, which can worsen mental health.

Other important aspects of health not easily captured in many current diet and fitness apps include positive body image, mental health and bodily functioning. For example, does a user feel good in their clothes? How is their self-esteem, emotion regulation, concentration, etc? Are they depressed, anxious, etc? Are they experiencing any pain or discomfort? Are they less tired throughout the day, and do they have improved sleep? All these things are important aspects of health. Even for users whose weight loss is a healthy goal, these factors may influence their needs and ability to lose weight, which means supporting these needs can positively affect all users.

Conception of appropriate usage: encouraging less logging (in some cases)

The quantified self movement coupled with our conception of appropriate app usage can lead to an obsession (about logging, food, weight and exercise) and the development of an app dependency, which is partly fuelled by how much and how often designers, developers and researchers think people should use these types of digital tools. To promote consistent and long-term use, many apps contain reminders to log and gamified aspects (e.g. streaks). This, coupled with the quantification, leads to users becoming obsessed with logging, which is in line with prior research.^{6,32} However, contrary to some research,³² users with eating disorder behaviours do not really ‘lose the habit’ of logging, because they feel the need to have control over their food and body. Despite numerous studies aiming to reduce app abandonment,^{32,35,36} abandonment is not always negative. In fact, for users with eating disorder behaviours, taking a break from apps can be beneficial.⁷ Taking time off from apps can help users learn to listen to their body’s signals of hunger and fullness and decrease their dependency on apps, which is important if we wish to promote health. Therefore, reducing logging reminders and encouraging breaks may be beneficial. Ways to reward users for engaging with apps without viewing quantified behaviours or actively logging (e.g. providing an alternative app view during break periods) could be explored.

Moreover, we need to ask ourselves: what role should these apps play in users’ lives? Are they meant to be used every day throughout a person’s life or are there more finite periods? How do we determine a success versus a failure (and should we impose a viewpoint of ‘success’ or allow users to choose)? We have to stop pushing an ideal, universal use and start understanding how people actually use these technologies ‘in the wild’, and how their needs change over time. Then we can design around their natural patterns of use, be more adaptive and flexible, and acknowledge different situations and contexts. Although app vendors want users to use their technology long term, we also must understand that this is not appropriate for all users and may even be harmful for some.

Visual cues and feedback: investigating effects more thoroughly

Findings show that app visualisations and feedback, such as coloured visualisations and messages, can unintentionally contribute to unhealthy behaviours. Instead of promoting healthy behaviour change, red and green visualisations in combination with the focus on numbers often result in users feeling a high sense of achievement when being under their calorie budget and extreme negative emotions when being over their budget, which has been seen in other research.⁶ These colours were likely chosen because of the connotations they already have in some societal contexts. However, these effects in the context of diet and fitness apps are not well studied. Studying these effects is crucial, given that the effects of colour choice can vary from context to context.^{37–39} Thus, we need to examine the effects of colours on users, and find ways to balance emotion response and behaviour change strategies.

The rewards and punishments users get from diet and fitness apps through these visualisations and the focus on the quantified self often promote excess competition. Although many apps want to encourage competition, users with eating disorder behaviours often develop unhealthy competitive behaviours. Not only do these visualisations instil a sense of reward in punishment in users, but they also tend to be very limited. For instance, at the time of this study, in MyFitnessPal, users see the red number regardless of whether they exceed their daily allotment by 1 or 1000 calories, which does not make sense if the focus of these apps is promoting health. Therefore, we need to develop more nuanced visualisations to motivate users without negatively affecting them.

Users also felt motivation from (what are intended to be) ‘negative’ messages and visual cues. For example, the ‘Complete Diary’ function in MyFitnessPal is meant to motivate users in the appropriate context and provide a warning to deter unhealthy habits. In many instances, users felt both messages motivated them to continue unhealthy behaviours regardless of the content, suggesting that more research is needed to understand how warnings and other feedback messages influence user perceptions and behaviours. One of the issues lies in the threshold that is used to determine with what feedback is presented. Although these algorithms are proprietary to MyFitnessPal, at the time of this study, MyFitnessPal seems to use a baseline of 1000 calories consumed to determine which message the app shows. If users do not hit this threshold, then they are shown the ‘Based on your total calories consumed for today, you are likely not eating enough’ message. If users consume over 1000 calories, then the app presents ‘If every day were like today, you would weigh X pounds in X weeks’ message. This occurs regardless of how many calories users have remaining. Thus, more research is needed to understand the appropriate thresholds to use to provide different feedback based on users’ needs.

Further, precautions such as warnings should not focus on taking away someone’s agency or labelling someone or their behaviours as ‘bad.’ There is a tendency to do this with eating disorder-related behaviours, which can increase stigma and reinforce negative emotions. Rather than adding these types of features, users and potential users from a variety of backgrounds should be more meaningfully involved in all aspects of the design process in a way that honours their lived experiences as expertise, and have the power to inform design decisions within these apps.

Limitations

First, the sample comprised a small subset of rather homogenous users. Thus, it is likely that not all consequences and perceptions are represented in this work. Future research should include more users from a variety of races, ethnicities, cultures, genders, ages and types of conditions. Second, BMI has a number of problems and limitations. It was used in this study as way to provide additional information only, not to advocate for its blanket use to denote health or diagnose/treat eating disorders. Third, unfortunately, normative clinical data that have similar contexts and participants are not easily available for all measures. In general, the means reported in clinical samples for the EDE-Q 6.0 and CIA 3.0, (e.g. Dahlgren et al⁴⁰) are higher than the present study; however, it is important to note that participants in this study were often recollecting past experiences with eating disorder behaviours, and many reported being in recovery currently. Thus, it is possible that eating disorder symptom scores at the time of the study were lower than they would have been if the study had occurred during what participants described as the worst points of their eating disorders. The findings suggest that specific design choices are problematic for some users. However, these design features and choices themselves were not tested. Research could benefit from experimental testing of these designs, as well as participatory and community-driven design of diet and fitness apps.

In conclusion, the use of diet and fitness apps by women with eating disorder behaviours is likely more common than many realise, given the rates of dieting and weight loss among healthy weight and underweight women.^{41,42} This work identifies problematic aspects of design and design suggestions, as well as implications for clinicians and educators. Although this study focuses on users with a history of eating disorders, redesigning apps to focus on health is beneficial to all users. Ultimately, this research emphasises the need for a fundamental shift toward a more holistic, personalised approach to health and how it is represented in digital tools.

I would like to thank participants for sharing their experiences and expertise. This research would not be possible without them.

Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjo.2021.1011>.

[click here to view supplementary material](#)

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Data availability

The data that support the findings of this study may be available upon reasonable request from the corresponding author, E.V.E. Participant privacy and consent is of utmost importance. The data are not publicly available due to their containing information that could compromise the privacy of research participants.

Declaration of interest

None

1.2.53 Mr Sluggish Schizophrenia

Robert van Voren

date

2021-08

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- *Mr Sluggish Schizophrenia*
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pmc r.t.l. Anatoly Smulevich, unknown, Marat Vartanyan, Aleksandre Tiganov. Photo Credit: Robert Van Voren

On 15 April 2021, the World Psychiatric Association (WPA) congratulated the Russian professor Anatoly Smulevich on his 90th birthday on its website. It wrote that ‘his work is highly regarded both in Russia and around the world . . . the WPA would like to wish Prof. A.B. Smulevich the happiest of birthdays and thank him for his long-standing contribution to the world of psychiatry’.

To most, the name Smulevich rings no bells. I have been involved in the fight against the political abuse of psychiatry for almost 45 years and know full well that he was one of the main researchers in the field of ‘sluggish schizophrenia’, the main diagnosis used against dissidents in the Soviet Union. He belonged to the small group of ‘nomenklatura psychiatrists’ who monopolised all contacts with the outside world and dominated psychiatry in the USSR. Their actions caused the forced hospitalisation of thousands of dissenters, who were subjected to torturous ‘treatment’, and established a repressive and abusive psychiatry that affected millions of people and disabled many for the rest of their lives. Like the Nazi euthanasia programme, this Soviet political abuse of psychiatry is among the worst violations of medical ethics. Professor Smulevich not only contributed significantly to the ‘scientific basis’ of this perversion of medicine, he also actively defended the position that criticism against Soviet psychiatry was a matter of politically inspired slanderous allegations. He was considered by the KGB to be a ‘trusted psychiatrist’.

In an interview on 29 September 1986, he claimed that in the USSR ‘a sane person cannot be sent to a psychiatric hospital’. In March 1989, during a meeting with an American delegation, he explained that 38.1% of all schizophrenics suffered from sluggish schizophrenia and described the symptoms, which included ‘anti-Soviet thinking’ and ‘delusions

of reformism'. He then argued that all dissidents could be diagnosed as suffering from sluggish schizophrenia. During the discussion of the case of an alleged victim, Smulevich continued: 'In the Soviet system this is a person who has overvalued ideas. Yes, one can fight for freedom in a thousand and one ways but it should not be to the neglect of other areas of his life. [He] fought for freedom and even wrote books about freedom, neglecting all other ideas in his life. His life became unbalanced, all of his interests were expressed in one area'. In the same year, he published an article in the *British Journal of Psychiatry*, actively defending the concept of sluggish schizophrenia.

In most of the biographies of Professor Smulevich that one can now find on the internet, most of his work on sluggish schizophrenia and his activities during the Soviet period are omitted, but those who were sent to psychiatric hospitals because of their convictions very well remember the man nicknamed 'Mr Sluggish Schizophrenia'.

Declaration of interest

None.

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1.2.54 The need for biodiversity champions in psychiatry: the entwined crises of climate change and ecological collapse

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Abstract

The past 20 years have seen the disappearance and degradation of biodiversity on earth at unprecedented rates. This phenomenon shares similar drivers to those behind climate change yet requires its own solutions. The twin catastrophes of climate change and biodiversity loss demonstrate how our health is bound up in the vitality of this planet. There has been an increasing effort on the part of healthcare professionals to appreciate this relationship, as evidenced by the growing influence of planetary health as a discipline. However, the health impacts of biodiversity loss have been less focused on than those brought on by climate change. Psychiatry's appreciation of the interface between environments and our health, alongside the evidence for the connection between nature and mental health specifically, prompt psychiatrists to ensure that the institution of healthcare throws its influence equally behind solutions to climate change as well as biodiversity loss.

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pmc This article is both a provocation and a call to action for psychiatry to champion biodiversity while raising awareness of the risk of ecological collapse. Although the connection may not at first be intuitive, our influence as healthcare professionals, appreciation for health as a concept defined by wellness rather than an absence of disease and understanding of how sick environments create illness, both seen and unseen, place responsibility firmly at our table to advance the cause of all life on earth.¹

These arguments are underscored as international organisations such as the World Health Organization (WHO) increasingly recognise the causal links between our health and biodiversity loss.² This is particularly important because framing the crisis through the lens of health may prove to be instrumental in shifting the tide towards the unified action needed.

In fact, new evidence is rapidly verifying that the loss of biodiversity in both quantity and quality has real impacts on our health, both mental and physical.^{2,3} This evidence is finally catching up with associations between nature and healthfulness that exist across many cultures, and the knowledge central to many indigenous cultures.⁴ While this is an important development we should respect that gaps in our knowledge and apprehension regarding specific correlations should not preclude action.

We have been slow to respond to climate change and must bear this in mind. At the same time, in the face of uncertainty we should allow ourselves to be compelled by a change to life on earth described as the sixth planetary extinction, marked by a rate of extinction nearly 1000 times pre-human levels.^{5,6} It therefore falls to healthcare professionals to mitigate not only the consequences of climate change but also the equally concerning trend of ecological destruction.

Climate change: one driver of biodiversity loss among many

The planetary crisis we are facing is more complicated and worse than was first imagined. For decades, scientists have understood that the planet is getting hotter.⁷ As the temperature rises, we are facing changes to the climate that are difficult to predict and harder to control. Climate change looks like rising water levels, protracted and intensified heat waves, changes to water composition and the degradation of ecosystems.⁷ These changes to the ‘weather’ are directly tied to increasing food and water scarcity, which in turn lead to displacement through forced migration and armed conflict.⁸

The consensus among those studying this phenomenon is that climate change is a product of changes to human behaviour since the industrial revolution.⁹ Through unregulated extraction and consumption of carbon-based fuels, the global temperature has steadily increased, long after this association was first suspected in 1896 by Swedish scientist Svante Arrhenius. The establishment of the Intergovernmental Panel on Climate Change (IPCC) by the United Nations in 1988 cemented a global commitment to better understand the development and implications of climate change.

As we grapple with the scale of the crisis, the need to unify climate change with social justice is increasingly underscored. People who have experienced and will continue to experience the greatest impacts of climate change on health are the least responsible for greenhouse gas emissions.¹⁰ To date, the vast proportion of total historical emissions has been produced by a proportionally small number of wealthy countries.¹⁰ However, in the past 20 years we are now coming to the sobering fact that climate change and its injustices are not all we must confront.

The year 2020 marked the end of a 10-year period designated the ‘UN decade on biodiversity’. The stated aim of the effort was to live in harmony with nature. This commitment was in part brought on by alarming reports such as the Millennium Ecosystem Assessment in 2005, which noted that humans had changed ecosystems more rapidly in the previous 50 years than at any point before.¹¹

Biodiversity is a contraction of biological diversity and simply put is the stuff of life itself. The 2005 report defines biodiversity as variability among living organisms from all sources, including terrestrial, marine and other aquatic ecosystems, and the ecological complexes of which they are part.¹¹ Biodiversity itself is the basis of the complex of plants, animals and microorganisms that make up an ecosystem.¹¹ The accumulation of all of our planet’s ecosystems is encapsulated by the biosphere.¹²

To help us understand our dependence on these systems the concept of ecosystem services was created. This model looks to explain all the ways in which we are connected in the web of life and outlines that ecosystems: (a) provide resources such as food, water, timber, medicines and fibre, (b) regulate climate, foods, disease, waste and water quality, (c) contribute to cultural experiences such as recreation, aesthetic enjoyment and spiritual fulfilment and (d) support soil formation, photosynthesis and nutrient cycling.¹¹ The truth has been plainly described by the environmental activist Satish Kumar in the following stark terms: ‘We are nature. What we do to nature, we do to ourselves’.¹³

Since the mid-2000s, global efforts to address the collapse of biodiversity have emerged, most notably with the establishment of the Intergovernmental Science-Policy Platform on Biodiversity and Ecosystem Services (IPBES). Its 2019 Global Assessment Report describes a biosphere transformed and degraded by human activity, whereby ‘seventy-five per cent of the land surface is significantly altered, 66 per cent of the ocean area is experiencing increasing cumulative impacts, and over 85 per cent of wetlands (area) has been lost’.¹⁴ It identifies climate change as just one among several drivers – albeit one with a multiplying effect – that have an impact on both nature and human well-being, alongside habitat change, invasive alien species, overexploitation and pollution.^{11,14} The thing that cannot be forgotten is that many of these losses, in particular of species and biodiversity, are irreversible.¹⁵

The pivotal importance of attending to the loss of biodiversity is reflected in its inclusion within the UN’s sustainable development goals and the UN’s choice to designate the 2020s as the ‘decade for eco-system restoration’.^{16,17} Biodiversity loss and climate change share human behaviour as their root cause, but while their solutions are mutually beneficial, they demand distinct strategies. The centrality of biodiversity to the survival of all life, coupled with its demand for solutions apart from ones that address sustainability or climate change per se, is why biodiversity loss specifically requires champions among healthcare professionals.

Planetary health: an opportunity for healthcare’s growing role

Why has change been so slow to come? Resistance has been in large part cultivated by corporations, politicians and the interests of the wealth that entwines them.¹⁸ In our own community, David Pencheon, a former head of the NHS Sustainable Development Unit, has referenced a kind of ‘moral offset’ that means health professionals feel less motivated to act on the climate crisis because their work already improves lives.¹⁹ Health services also prioritise acute illness over prevention, discounting future risk in favour of short-term medical responsibility.¹⁹

At the start of the millennium, the importance of an interdisciplinary approach to health and climate change was recognised. Institutions such as the *Lancet* sounded the need to frame the crisis in terms of its effects on health. Although not a new term at the time, the concept of planetary health was fully endorsed in 2015 by a joint effort between the *Lancet* and the Rockefeller Foundation, a sign that healthcare as an institution had begun to throw its weight behind a response to the planetary crisis.²⁰

Planetary health in the simplest sense makes the assertion that human health is inextricably linked to the health of the planet. It can be understood as a discipline that borrows from public and environmental health but is bold and explicitly

political. Richard Horton, editor-in-chief of the *Lancet*, described planetary health in 2018 as ‘an inquiry into our total world. The unity of life and the forces that shape those lives’.²¹

At the heart of planetary health lies a paradox that many of the gains to health have come from an untold exploitation of the environment.²² The field does not shy away from this uncomfortable fact and indeed is based on the belief that a more balanced relationship wherein both humans and the planet thrive is possible and essential. It suggests that acting as stewards of the biosphere, humans can move from an exploitive to a nurturing role.²² As a whole, the discipline and its advocates seek to bring the influence of healthcare, as an institution, into the centre of discussions and campaigning around the climate and ecological crises. Such aspirations are in line with the increasing anticipation that casting planetary change through the lens of our own health may be instrumental in helping to inspire the type of action urgently needed.²³

Alongside this developing approach, in October 2020 the National Health Service (NHS) made the impressive commitment to become the first carbon-neutral national health service.²⁴ Yet the report leaves the issue of biodiversity loss behind. This trend towards focusing on climate change is similarly reflected in the *Lancet*’s countdown on health and climate change,²⁵ and as of February 2021 four NHS trusts have declared climate emergencies since Newcastle upon Tyne Hospitals NHS Foundation Trust first did so in July 2019.

Although the field of planetary health is premised on a connection between health and nature, clinicians are only beginning to grapple with its implications. This may reflect the fact that the impacts of biodiversity loss on humans are dizzying in their scope but also, with respect to mental health particularly, can be harder to understand and therefore measure. Moreover, although the emphasis on climate change has created a focus point for action, it unintentionally creates a conceptual blind spot whereby the broader threat of ecological collapse can feel like an ‘add-on’ and therefore harder to address or even a distraction.

Biodiversity and human health

The concept of ecosystem services underlines how essential biodiversity is to life on earth. Without pollinators many plants cannot reproduce and without plants no oxygen is made. Links between health and biodiversity have been clearly drawn and are now continuously emerging in greater breadth and resolution.² In 2020, the COVID-19 pandemic highlighted the connection between biodiversity loss and infectious disease, while research elsewhere highlighted the role of ecosystems in sequestering carbon.^{26,27} Moreover, a growing evidence base recognises that our well-being and mental health are tied to the health of our ecosystems. Similarly, the destruction and loss of natural spaces is increasingly shown to affect our mental, emotional and spiritual health.

Carbon capture

The links between climate change and biodiversity are increasingly clear. Rising global temperatures degrade our richest ecosystems, yet these also represent essential storages of carbon. A recent paper by Dinerstein et al states that nearly all of the remaining native ecosystems will require preservation to keep the global average temperature rise below 1.5°C.²⁷ The paper brings together startling facts, including that intact forests sequester twice as much carbon as planted monocultures, and highlights that diverse systems from peatlands to mangroves are also important carbon storehouses. They make clear that it is the rich biodiversity of these natural spaces that allows carbon to be stored in such amounts. This understanding motions at the need to consider climate change and biodiversity loss in the same breath with efforts to ‘pair nature and climate deals which are mutually reinforcing’.²⁷ We are in a race against time where every piece of the puzzle is connected for better and worse.

Pandemics

Pandemics act on our physical and mental health through both direct and indirect mechanisms resulting in immediate but also far-reaching changes to individuals and societies. The origins of COVID-19 and its development into a global pandemic are closely tied to ecological destruction.²⁶ It is a double tragedy that the experience of lock-downs and quarantine have highlighted the importance of natural spaces for many.²⁸ Concerns about the impact of biodiversity loss were made as early as 2005, when Paul Epstein noted that ‘widening social inequalities and changes in biodiversity have apparently contributed to the resurgence of infectious diseases.’²⁹ The 2020 IPBES workshop on biodiversity and pandemics is clear about the drivers behind COVID-19, stating that ‘pandemics have their origins in diverse microbes carried by animal reservoirs, but their emergence is entirely driven by human activity [...] The underlying causes of pandemics are the same global environmental changes that drive biodiversity loss and climate change’.²⁶

More sobering is the warning that, without changing these underlying drivers, we can expect more frequent pandemics. Indeed, there are an estimated 1.7 million undiscovered viruses, 631 000–827 000 of which could have the ability to infect humans. Averting further pandemics rests on a reversal of the unsustainable exploitation of the environment driven by demand from wealthier countries and emerging economies.²⁶

Nature and well-being

There is a growing recognition of the impact of nature on well-being.³⁰ Exactly how exposure to nature benefits humans is not entirely clear. Theories such as that proposed by Kaplan & Kaplan in 1989 suggest that exposure to nature acts on well-being by modulating stress through restoration of our attention.³¹ Nature is also believed to enhance our well-being by supporting health-promoting activities such as physical activity and social interaction.^{30,32} Astonishingly, from the view of public health, green spaces have also been found to be equigenic, a term referring to interventions that disrupt the normal health disparities arising from socioeconomic inequality.³³ In urban environments, such spaces provide further mental health benefits as they mitigate heat islands, improve air quality and prevent floods, leading to longer-term and more holistic health benefits.³⁴

Crucially for psychiatrists, links have also been made between natural spaces of high value and improved mental well-being.^{3,32,34} A 2014 literature review by Lovell et al, however, offers caution about drawing definitive associations between increased biodiversity and health and encourages further research on this relationship.³⁵ Recently, a study of the impact of biodiversity across Europe added the finding that the diversity of birds in an ecosystem improved people’s life satisfaction.³⁶ Irvine et al, in a review of spirituality and biodiversity, offer that ‘there is suggestive evidence that biodiversity appears to contribute to spiritual outcomes’.³⁷ They note that these sorts of observation are critical in making clearer links between conservation of biodiversity and human well-being.

Eco-distress and solastalgia

During the 2019–2020 Australian bushfire season, it was estimated that 3 billion animals were affected.³⁸ This is an unspeakable tragedy for the life lost and those living in the areas affected by the fires. However, it was also witnessed by many abroad, eliciting feelings of helplessness, confusion, guilt, grief and anxiety. Much like the loss of these ecosystems, it is unclear how the growing presence of such emotions will affect people. An increasing interest in such questions has been seen with the emergence of concepts such as eco-distress and solastalgia.³⁹ For the moment, these constructs do not describe mental illness but rather proportional reactions to traumatic ecological events. The term solastalgia specifically describes the distress resulting from the transformation and degradation of one’s home environment. Although such concepts are relatively new, they underscore the role that mental health professionals play in raising awareness about ecological collapse and its psychological toll.

How to respond?

Recognising biodiversity loss, and ecological collapse more broadly, does not necessarily mean dividing attention from climate change. Indeed, one of the best ways healthcare systems can address ecological collapse is by mitigating their greenhouse gas output: if they were a nation, healthcare systems globally would constitute the fifth largest greenhouse gas emitter.⁴⁰ What is key is understanding the crisis holistically, so that psychiatrists work against the conceptual fragmentation that prevents bold systemic solutions.

Within mental health services, pharmaceuticals contribute around 20% of our total carbon footprint.⁴¹ The development and adoption of sustainably informed prescribing practices provide a concrete way for institutions and individual clinicians to play their part.⁴² Sustainable prescribing would need to take into account the environmental implications of common prescribing practices, including polypharmacy, unclear durations of treatment and exceeding recommended dose ranges.⁴³ Such considerations would create greater space to offer non-medication-based complementary therapies, including those that are nature-based.

Beyond the ethics of accurately representing the broader ecological crisis, this holistic approach also makes it more likely that policies that tackle greenhouse gas emissions alongside other drivers of ecological collapse will be found and implemented. For example, a green rooftop developed by a hospital to reduce air conditioning could also then be cultivated with plants favoured by local pollinating insects. If tended or enjoyed by psychiatric in-patients, this becomes an intervention in which climate change, biodiversity and therapeutic impacts are married.

Part of the difficulty in knowing how psychiatrists should most effectively lend their voices to the crisis of biodiversity loss is the immensity that the term implies. How do we go about saving the biosphere? The Global Deal for Nature proposes a firm target of protecting 30% of the earth by 2030, which lays the ground for global action.²⁷ This clearly stated goal, much like the limit of 1.5°C warming for climate change, helps us to believe that, in spite of overwhelming complexity, conceptually simple strategies such as conservation can work.

With this as a foundation, psychiatrists could focus on two kinds of strategic action. First, psychiatrists should support and initiate further research into the relationship between mental health and the natural world. In the UK, this effort could be advanced by innovative collaborations between mental health institutions and wildlife organisations such as Natural England and the Wildlife Trusts. Psychiatrists should also engage with knowledge and practices developed by colleagues in the field of ecopsychology, including giving consideration to concepts such as nature connectedness.⁴⁴ Supported by a more robust evidence base, psychiatrists will better identify ecology-related causal factors in mental illness, as well as potential avenues of support. This sensitivity, in turn, will increase patient awareness of how mental health is entwined with natural spaces.

In adopting the cause of biodiversity, new research would be complemented by expanded clinical experiences and opportunities for first-hand observation of the nature–mental health interface. Psychiatrists, for example, can help make more immediate changes to the environments of our health services. This includes championing public green spaces and supporting trusts and hospitals to tend their own natural spaces. NHS Forest, for example, is a programme that has promoted planting trees on NHS grounds.⁴⁵ The conservation of areas close to health services more easily allows for the integration of sustainable green care options within mental healthcare. A project such the Green Walking initiative, which has seen eight trusts introduce green walking programmes for psychiatric in-patients, shows how easily local green spaces can be integrated into clinical care and generates insights into best practice that complement ongoing research.⁴⁶

The second kind of action would see psychiatrists advocate, campaign and highlight the mental health implications of ecological collapse in their organisations and communities in a way that bridges people’s lived experiences with the aspirational scale of planetary health.

The American Psychological Association has made recommendations for how mental health professionals can highlight the relationship between health and climate change, identifying education, awareness, communication and motivating climate solutions as important areas of action.⁴⁷

Although these areas are humble it should be remembered that healthcare’s involvement in campaigning against climate change began with the premise that simply sharing information can lead to a change in perspective. Developments such as the NHS net-zero plan, the establishment of planetary health institutes around the world, publications focused on

planetary health, the *Lancet* countdown and the UK Health Alliance on Climate Change (UKHACC) all emerged as a result of passionate voices calling for action.

Speaking eloquently and listening carefully are skills that mental health professionals use every day. As leaders within mental health, psychiatrists should speak to the government and the health sector broadly to ensure that the relationship between biodiversity and health is heard. Advocating for the inclusion of instruments that take into consideration the impact on mental health of developments and changes to land usage, for example, would be a clear and effective demand. In summary, all of these suggested actions offer important steps in conceiving of a sustainable mental health service that champions a more preventive style of patient care.

Conclusions

At the heart of psychiatry is the appreciation that our health and experience are influenced by a complex web of interactions. Carrying this knowledge has allowed psychiatrists to make bold observations on the very real impact of social inequality on people's mental health.⁴⁸ This ability to understand how influenced people are by their environments is also why psychiatrists should see the growing threat to nature as entwined with climate change and ultimately with mental and physical well-being for everyone.

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Data availability is not applicable to this article as no new data were created or analysed in this study.

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Declaration of interest

J.K. is an Associate Registrar in Sustainability for the Royal College of Psychiatrists and an Associate of the Centre for Sustainable Healthcare.

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1.2.55 W. Alwyn Lishman, MD, FRCP, FRCPsych (Hon)

Maria RonEmail: m.ron@ucl.ac.uk

date

2021-08

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- *W. Alwyn Lishman, MD, FRCP, FRCPsych (Hon)*

pmc Emeritus Professor of Neuropsychiatry, Institute of Psychiatry, Psychology and Neuroscience, King's College, London, UK

Alwyn Lishman, who died on 24 January 2021, aged 89, was the first Professor of Neuropsychiatry to be appointed in the UK. He was the co-founder and Honorary Life President of the British Neuropsychiatry Association (BNPA). In 2016, when addressing the BNPA, Alwyn said that he wanted to be remembered for what he did, in terms 'expressed concisely', thus setting a challenge for those of us who now wish to celebrate his exceptional contribution to psychiatry. His famous book *Organic Psychiatry: The Psychological Consequences of Cerebral Disorder*,¹ first published in 1978, set an example of conciseness and clarity in medical writing while at the same time single-handedly defining the discipline of neuropsychiatry. Alwyn considered this book to be his most important legacy; two further single author editions followed in 1987 and 1997. At the time this book was published, neuropsychiatry was a small specialist interest. Now, thanks considerably to his influence, it is a major component of psychiatric research and practice.

Alwyn saw neuropsychiatry as much more than an admixture of neurology and psychiatry, as involving the understanding of brain mechanisms in relation to mental disorder, and benefiting from advances in neuropsychology, biochemistry, genetics, imaging and many other disciplines. For him, neuropsychiatry could equally apply to the study of schizophrenia, affective disorders or traumatic brain injury, in fact to the whole of psychiatry. By defining neuropsychiatry in this way, he was redressing the balance between brain and mind that had been polarised by the influence of psychoanalytic theory.²

His research was wide-ranging. Memory was one of his early interests. In what he called 'a crude approximation to testing Freud's theory of repression', he explored the effect of the hedonic tone of the material to be remembered, finding that, while normal people recalled pleasant material better, the pattern was reversed in depressed patients. Later his emphasis was to exploit brain imaging in relation to psychiatry, and studies of brain damage in alcoholism and psychosis of epilepsy followed.

Alwyn Lishman was born in Houghton-le-Spring, County Durham, on the 16 May 1931. His father, George Lishman, had been a prisoner during the First World War and, when his poor health prevented him from becoming a doctor, he ran the family business, a tallow chandlery that supplied candles for mining and shipbuilding. His mother Madge (née Young) was a teacher, described by Lishman as something of a dragon who locked him up with his sister Valerie until they finished their homework without any mistakes. Alwyn's innate perseverance and attention to detail must have been greatly enhanced by this strict upbringing.

For somebody who was a master of words it is perhaps surprising to know that he could read music before he could read words. He assiduously played the piano from the age of 5 and wanted to be a musician but pressure from his father finally persuaded him to go to Birmingham University to study medicine. His interest in the relationship between brain and behaviour was sparked by his time working with Solly Zuckerman while doing an intercalated degree in Anatomy and Physiology. He qualified in 1956.

After his house jobs, he spent his National Service practising neurology. He was posted to the Army head injury hospital outside Oxford, where he was mentored by Ritchie Russell. Neurology attracted Lishman for its clinical precision, but the lack of effective treatments and his wish to help his patients made him consider other options and he followed Bob Cawley, his great friend from medical school, to the Maudsley Hospital in London in 1960. He said that it took a certain degree of unworldliness to make the move to a much less prestigious discipline.

He described the Maudsley in the 1960s as extremely social and great fun and he built lifelong friendships there. Jim Birley, Griffith Edwards and Mike Rutter were contemporaries. He thrived under the abrasive but kind influence of Aubrey Lewis and his doubts about psychiatry quickly evaporated when he realised that thinking at the Maudsley was as rigorous as any. He wrote his doctoral thesis on 'Psychiatric disability in soldiers with penetrating head injuries', using the Oxford register set up by Ritchie Russell. At a time when there was little interest in brain injury, Lishman's insights into the behavioural and psychiatric consequences of frontal and left temporal injuries were stunning.

He was appointed to his first consultant job at the National Hospital (Queen Square) in London in 1966. His clinical work there fuelled his interest in neuropsychiatry, and he cherished his interactions with neuropsychologists such as Oliver Zangwill and Elizabeth Warrington, but the dismissive attitude of some neurologists towards psychiatry prompted him to return to the Maudsley in 1967 as consultant psychiatrist. In 1979 he was appointed to the first Chair of Neuropsychiatry in the UK, at the Institute of Psychiatry. In 1987, with Jonathan Bird, he co-founded the BNPA, the first, but not the last, neuropsychiatric association in the world and still a thriving forum that welcomes people from different disciplines. He was made an Honorary Fellow of the Royal College of Psychiatrists in 1999.

Alwyn was an exceptional mentor, and he was proud that several of his trainees went on to hold chairs of neuropsychiatry. For me, the debt of gratitude is immense. When I arrived at the Maudsley in 1971 we were assigned a 'moral tutor' and Alwyn Lishman was mine. This led to fruitful years of research and, more importantly, we became close friends and I became part of his family. Alwyn, an accomplished musician, was generous enough to be my accompanist when I, a tone-deaf late starter, misguidedly attempted to take my clarinet grades. To my surprise he was even more nervous than I was. We tacitly agreed not to repeat the experience.

In 1966 he married Marjorie Loud, a psychiatric social worker he met while training at the Maudsley, and they had two children, Victoria and William. He continued to play the piano and the organ and built his own harpsichord. He retired early in 1993 to look after Marjorie, who had developed a brain tumour. Marjorie died in 2000. Alwyn's last few years were marred by the ravages of dementia. He is survived by his two children and two grandchildren.

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1.2.56 Anthony Ng: the kids are alright

Claire McKenna¹

date

2021-08

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Claire McKenna talks to Anthony 'Tony' Ng, first chair of the American Psychiatric Association's Caucus on Climate Change and Mental Health, about his decades of work in disasters both natural and man-made

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- *Anthony Ng: the kids are alright*

Dr Anthony ‘Tony’ Ng is a general psychiatrist and medical director of community services at Northern Light Acadia Hospital in Bangor, Maine, USA. He has a long interest in disaster emergency psychiatry and climate psychiatry and in 2019 took up a year-long role as the first chair of the American Psychiatric Association’s (APA’s) Caucus on Climate Change and Mental Health. He is the former chair of the APA’s Committee on Psychiatric Dimensions of Disaster, with which he is still involved. In addition, he is a member of the Climate Psychiatry Alliance, an independent organisation (with members in the USA and UK), which works to lobby government and raise awareness of the links between climate change and mental health. Dr Ng is also a proud member of the Royal College of Psychiatrists.

Dr Ng has aided the psychological response to victims of disasters around the world and led a disaster response coalition, the New York City chapter of National Voluntary Organizations Active in Disaster (NYCVOAD), between 2001 and 2003. His work has involved him in atrocities such as the 9/11 terrorist attack in New York in 2001 and the Sandy Hook school shooting in Connecticut in 2012, as well as natural disasters such as Hurricane Katrina in 2005, among many others.

This interview took place via Zoom in September 2020 and has been edited for length and clarity.

How did you come to be interested in the area of disaster relief and, more recently, climate psychiatry?

Well, it began with an interest in trauma, because I realised so many of my patients in community mental health had some sort of trauma-related issues. I then became interested in humanitarian assistance for refugees and so forth. It was the 1990s and I think Bosnia, Croatia and Cambodia were pretty up there in the news. And I was mostly focused on the psychiatric piece, PTSD and so forth. As I’m doing this stuff, I realise that you can’t really appreciate it until you can look beyond just the trauma – you need to look at how these things happened in the first place. And that got me interested in things such as socioeconomic factors, political strife and also climate issues. Climate became a big issue for me about 5 years ago, but it was brewing before that because I responded to [Hurricane] Katrina and I saw the aftermath of it all. When you start looking at it, it is climate change that leads to some of the severe weather that we’ve seen.

In the past few years, the APA started to take a lot more interest in the relationship between climate change and natural disasters and that led to the connection I have with the Climate Psychiatry Alliance. We wanted to explore what climate change is doing to our patients and what are the long-term effects it could have on psychiatric well-being in terms of population-based models, as well as the individual-based model.

How have people in the USA been affected by disasters, both natural and man-made?

Almost every year we’re seeing increasing preparation for some sort of weather issue, whether its tornadoes or hurricanes or wildfires. Ice storms can also be a big problem in the winter, which take out a fair bit of the country if they happen.

What has been challenging is that disasters based on terrorist attacks are the media-driven events; they don’t happen often but they have high emotional content. And I think that’s what draws a lot of the attention. But every year, every US state is struggling with some sort of weather-related event – they’ve kind of gotten used to it. But what people are not seeing is how often these hurricanes are coming, how intense they’re coming and also why the risk of these events is going up. More people are migrating to the coasts for whatever reason. In essence, it puts them more at risk for trauma from natural disasters, which may be stemming from climate change. And so it’s kind of a ripple effect. But it’s a slow pain. People don’t appreciate the impact as much.

I wanted to hear a little bit more about your past work in disaster relief. Was there anything that stands out as a particular learning experience for you?

I honestly think the best learning experience was the work that I did for 3 years in New York City after 9/11. Now, granted, it wasn’t climate related, but what it really educated me on was the strong interface between disasters and mental health, along with the human service side. You really can’t appreciate disaster mental health until you really develop a good understanding of human service response to disasters.

As a psychiatrist you think about the PTSD, depression, anxiety and all those things. Certainly, you can work with those. But when you look at it more deeply – people are worrying about food, shelter, job stability, legal issues – those become bigger issues for them. So, it is not as much about the diagnostic arena, but how do people in distress behave? However, the focus in psychiatry has always been on that small diagnostic corner and the research money goes into that area.

The majority of people don't go on to develop PTSD, but they certainly have a lot of distress behaviours that can affect their overall well-being. For example, after a disaster, how do I find my loved ones? How do I get information about what's going on? How do I seek care? I just lost my job, so who will assist me with resources? How we intervene in these areas early on has an impact much later.

One of the pieces of feedback we often hear from people is that it's not the disaster that created the stress, it's the disaster *after* the disaster.

The Climate Psychiatry Alliance website alludes to the impact of climate change on 'the theoretical foundations and research priorities of psychiatry'. Can you elaborate a little bit on how you think climate change might have an on impact those areas?

With climate change, we have not had the investment to really look specifically at what some of the markers or correlations are that might impact on people's mental health. So, I think this is one of the charges of the Climate Psychiatry Alliance – to increase people's awareness of the need to fund research.

One of the biggest achievements it [the CPA] was able to do is to create a Climate Change Caucus within the American Psychiatric Association, which sits under the Disaster Committee. They were able to advocate for it to become a standing entity. The other thing about the entity is that it falls under the Council of Research within the APA, so that means it also gives them a little bit more face time in terms of encouraging a focus on further research. Certainly, we need a better research base for climate change and mental health. And people are slowly doing it.

But the challenge, of course, is that the return isn't as fast as some of the other psychiatric research. Climate change in general is a creeping disaster. It's a death by a thousand cuts kind of thing if you don't do anything about it. And the healing process also takes a long time. So, though your results may not be earth shattering within a year or two, certainly over time they could add to the overall resources we have to deal with climate change and better understand the resources that we need to help people with it.

So, you were the first chair of the Caucus on Climate Change?

I was very honoured to be asked to chair the first year to really kind of get it going a little bit. It's only about 3 years old now. And the other nice thing about it is that, because of the work of the Caucus, the disaster course which the APA gives to its members (basically teaching about basic principles of disaster psychiatry) has added a section on climate change impact and disaster psychiatry.

So, you can point to some tangible gains. It seems that you see the functions of the Caucus as raising the profile of climate change psychiatry and influencing research priorities. Are there any other areas you think are important for the Caucus or for the Climate Psychiatry Alliance?

We also worked on areas such as lobbying. One of our members, for example, she lives in DC [Washington DC] and she has significant knowledge about advocacy to legislators on climate change issues. She has become a resource for local politicians because Congress is right there.

One nice thing about the Climate Psychiatry Alliance that's different from the Climate Caucus is that the Climate Caucus sits with the APA. So, you kind of have to do things within what the APA can do within its lane. But the Climate Psychiatry Alliance allows many more opportunities to engage without representing official positions.

Do you think it's important for us as psychiatrists to take an interest in climate change?

I believe it is important to appreciate its impact. I think to be a better psychiatrist you do have to have some appreciation of climate change, especially perhaps climate change where you're working.

It may be a big task to try to understand climate change globally. But I think for every psychiatrist, I think there's some impact within our areas. So, if you work in a rural area, you should know what climate change is doing to your rural population, for example if there's a change to the crop cycle, if there's a change to the drought season. If you're in the

city as a psychiatrist, how does it affect your patients there? Does it increase the risk of allergies by affecting air quality for example?

In a city environment, you may have more people in the population who may appreciate climate change. Outside that, they may not have the same feeling, but your farmer may have just lost a job because of severe drought in your area. It's not that you're blatantly up front saying 'I want to talk about climate change', but you're saying 'I could see in the back of my mind how climate change may be impacting your life and what stresses you go through'.

One of the problems with addressing climate change is that it's sometimes hard to see the wood for the trees, so your suggestion that we focus on the small area that we can make a difference in sounds helpful. Do you have any advice for psychiatrists generally about what they could do on an individual level and at a system level to combat the climate crisis?

It's helpful if you can identify what local resources are available for you where you're living. Let's say, for example, using my wife's island (she is originally from the Isle of Man), you need to know what the Isle of Man initiatives are. One of the areas they're looking at is a reduction in the use of peat for heating.

The use of peat creates a significant amount of carbon emissions. How is that impacting your local community? And these are very easy things to look up. I think then you can appreciate the impact because, for example, yeah you can reduce peat use, but how does it affect your patient who is trying to get heat? Because peat may be the cheapest thing right now for them. You can help to at least frame the discussion with your patients.

And also, I think certainly it's helpful to encourage more like-minded advocacy. For example, could we have a similar Caucus on Climate Change in the UK for psychiatrists?

Would that be a good idea, do you think?

I think we should work closely. I think, first of all, such a group can encourage the Royal College [of Psychiatrists] to put more on the climate change agenda that will trickle down to what individual psychiatrists do, but that also can ripple down to the research that you and I were just talking about earlier. There's a lot on for the leadership and because there are so many things going on, they may not see this as a big priority for them.

And maybe the *local* psychiatric association can get together and say, 'OK, what is the impact of climate change in Northern Ireland?'. I know that by me doing something, I feel like I'm contributing to a solution rather than sitting there on the sideline.

Do you think climate change has a disproportionate effect on people with mental disorders?

I believe so for many reasons. For people who have mental illness in general, they are often already disadvantaged socioeconomically. I can move away to an area that's nicer so that it can be less impactful on me in terms of climate change. People with mental illness are often stuck. Their coping mechanisms are challenged because of mental illness. Whatever anxiety and stress they may deal with from other ripple effects, whether it is just higher heating bills and other related stresses, they don't have as many resources to help them navigate through those challenges. We might have the option to say, 'I do my part because I buy organic meat and can buy socially responsible groceries'. But if you live in a neighbourhood where organic options are not available you don't have that choice.

One of the things we're seeing is a spike in climate-related anxiety, particularly among children. Do you have any thoughts about how we can talk to kids about climate change without making them really anxious about it?

As much as we adults try to think about this, kids are much more concerned. They're much more savvy about what's going on than we are. And I think they are a very good barometer for us. In terms of talking to kids, I think it's a conversation that needs to happen. And it's OK if you don't have all the answers. I don't think kids expect you to have all the answers. I think the piece I would really instil in them is to understand what science is and what facts are. If I can ask my kids to do some critical thinking, I'm setting them up so that in 10, 15 years time, they would ask these same questions in the same way that we would like them to.

That brings us to 'alternative facts'! A lot of us in the UK have watched with dismay as Trump reneged on the Paris climate agreement, et cetera. Are you more pessimistic now than you were about the chances of the USA addressing climate change in a meaningful way?

I think, first of all, it is very hard for some folks to appreciate what climate change is. They live in, let's say, a small village. If you talk about corals, they never see corals. It doesn't affect them. It doesn't mean anything to them. I think one thing we fail at in terms of having those discussions about climate change is how climate change affects you *there*, where you are, versus climate change in general. And when people can't relate to it, it becomes harder for them to empathise and say, 'I have to do something about it'.

But this is not just us. I think everywhere is struggling with that, too. One interesting thing about the model of government we have here in the US is that there's a lot of state government versus federal government. So, yes, while the federal government pulled out of the Paris Agreement, there are a lot of governors who basically said, 'We're not – that's going to be our benchmark'. For example, in the state of Maine, the governor has created a task force on climate change. She wants to reduce emissions, wants to improve climate change and she wants to aim for the goals of the Paris Agreement. So, I think that's the little bit of hope that we have.

Which leads me neatly on to my final question. There is sometimes a lot of pessimism around climate change for people who do believe in it, that actually we're not moving fast enough to make meaningful change. How hopeful in general are you about whether humanity can turn away from climate disaster?

Maybe I'm too optimistic, but I think as the human race, we will move toward a better place. Are we going to have bumps along the way? I can guarantee you we will but I do think folks are increasingly seeing some of these critical issues. I think for a lot of reasons, economics will drive it. I mean, you can look at history. Climate change, yes, it's not easy, but I can still remember when I was growing up in the 1970s seeing Environmental Protection Agency commercials of people dumping toxic waste and trash in rivers and now we have made significant progress in those areas. So, I think it's going to happen slowly.

You clearly are an optimist.

Yes and no. To some degree, I am pragmatic. I think what really helped me personally is having a 10-year-old son. I tell him that sometimes he's the best teacher for me. He reminds me of certain things, because you know, we rationalise all kinds of reasons for why we do certain things, but the kids bring it down to core values. So, I think this is what we need to do.

As much as people feel frustrated that we can't make big changes right now, 5 years ago I didn't know about Greta [Thunberg], I didn't know about those kids. Now, I hear about kids taking legal action, asking for injunctions on certain initiatives that they feel may be damaging to the climate. That's a big deal. And as I said, over time, these kids vote. Over time these kids become leaders in whatever field they're going to and will have an impact. To change the culture, you need a couple of generations before you can move it through.

Climate change, it's unfortunate, but it's going to be a marathon, not a sprint, so we've got to be prepared for it.

1.2.57 Is climate change a mental health crisis?

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date

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Abstract

The Earth's climate is in a complex state of change as a result of human activity. The interface between climate change and physical health has received significant attention, but its effects on mental health and illness are less understood. This article provides an insight into the psychiatric sequelae of climate change, suggests strategies that psychiatrists can use to take action, and argues that it is their responsibility to do so.

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- *Is climate change a mental health crisis?*
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pmc Anthropogenic climate change is irrefutable and has become increasingly difficult to ignore. It is currently considered by experts to represent the largest existential threat to humanity, endangering life itself through environmental degradation, rising ambient temperatures and extreme weather events, among other mechanisms. Efforts to tackle this complex and unpredictable issue have assumed national and international priority, exemplified by the introduction of the 2008 Climate Change Act and the International Paris Agreement, respectively. A global youth movement calling for action on this matter has also received widespread media attention.

The World Health Organization regards climate change as this century's defining issue for health systems. The body of research connecting climate change with health has primarily focused on physical health. Of the literature investigating mental health, the majority either describes effects on vulnerable localities or presents qualitative data,¹ limiting the universal generalisability of such findings. Individuals with mental disorders are particularly susceptible to the effects of climate change. This is hardly surprising, given its widespread influence on physical, social and economic systems, all of which are key determinants of psychological well-being. It is already apparent that climate change is contributing to an impending and inevitable global mental health crisis.

There is a growing wealth of research examining extreme weather events, including hurricanes, floods and wildfires, in the context of mental health.¹ Climate experts anticipate an increased periodicity and intensity of such events in a collage of unfolding disasters, rendering these crises harder to predict and respond to. The Australian bushfires and Hurricane Eta are just two examples that caused mass devastation in 2020.

It is helpful to divide the mental health consequences of extreme weather events into direct and indirect.² Such events are associated with mass destruction, and expose the population to direct danger, physical injury and death. Immediate psychological responses include acute stress and grief reactions. The long-term psychopathological patterns that occur following trauma are well understood, and it is recognised that extreme weather events increase the prevalence of post-traumatic stress disorder, depression, anxiety, substance misuse and stress-related relationship difficulties.³

We must also consider the destructive impact of extreme weather events on infrastructure, specifically properties, transport services, social support networks and employment. They place additional strain on already overstretched health-care resources such as community and in-patient mental healthcare systems. In 2005, Hurricane Katrina resulted in a surge in neurotic and affective disorders that disproportionately affected women, young people and those of lower socioeconomic status.⁴ The identification of at-risk groups is essential in ensuring effective prevention and treatment of weather-related mental illness.

Associated with climate change are destructive, enduring and largely irreversible long-term environmental changes – desertification, deglaciation, thawing permafrost, rising sea levels, loss of biodiversity and species extinction, to name a few. Sadness, hopelessness, anxiety and grief reactions are recognised individual psychological responses to environmental degradation.² Societal sequelae include scarcity of resources and involuntary climate-related migration, both of which are likely to result in increased armed conflict and exacerbation of mental health issues. Much of the existing evidence of these responses to climate change come from vulnerable areas, such as coastal and circumpolar regions, which should be regarded as predictions of the future globally.

Global warming is an already demonstrable facet of climate change, and rising temperatures are known to have adverse effects on mental health outcomes. Associations between warmer temperatures and mania in older people, transient affective disorders, substance misuse and psychiatric hospital admissions have all been established empirically.⁵ Furthermore, those affected by mental illness are up to three times more likely to die from a heatwave than those unaffected.⁶ Factors that may explain this vulnerability include poorer baseline physical health, increased isolation and institutionalisation, maladaptive behaviours and the effects of psychotropic medications. Rates of suicide have consistently been found to rise during heatwaves.¹ Global warming thus represents a key factor influencing psychiatric morbidity and mortality.

Climate change has been shown to increase the risk, frequency and distribution of foodborne, waterborne, vector-borne

and zoonotic infectious diseases.² This is likely to be compounded by an uncontrollable surge in global antimicrobial resistance. The profound psychological burden of infectious diseases is plainly exemplified by the COVID-19 pandemic. Restrictive measures, including quarantine, isolation and social distancing, superimposed on vast economic setbacks and a widespread unemployment crisis, have undeniably contributed to a mental health emergency whose full extent is yet to be determined.

Individual psychological responses to COVID-19 are wide-ranging, from anxiety and low mood to insomnia, denial, fear and even anger. The phenomenon of ‘headline stress disorder’, a heightened emotional reaction to seemingly endless news reports that can induce somatic symptoms of anxiety, has been observed throughout the pandemic.⁷ Frontline healthcare workers were particularly susceptible to psychological symptoms during the initial stages of the outbreak,⁷ and this disproportionate impact on our future healthcare workforce will only inflate the magnitude of the crisis. It is probable that ongoing climate change will bring about further pandemics, and COVID-19 provides a means of predicting and mitigating the psychiatric ramifications of new infectious diseases.

The above phenomena are already influencing diagnostic frameworks in psychiatry. There is an advent of integrating new terminology for climate-specific mental disorders into the lexicon, highlighting the growing awareness of climate-driven psychological experiences. ‘Ecoanxiety’ relates to fears about environmental doom and uncertainty, and ‘solastalgia’, a contraction of nostalgia and solace, conceptualises psychological distress secondary to environmental degradation. A range of ‘psychoterratic’ syndromes have since been described, in an attempt to capture the diverse emotional disorders seen in response to climate change.⁸

At present, the DSM-5 and ICD-11 offer no specific references to mental disorders related to climate change, but it is likely that such phenomena will soon be incorporated. Psychiatric phenomenology has historically adapted to contemporary cultural issues, and climate change should be no exception. In 2008, Wolf and Salo described the first patient diagnosed with a putative ‘climate change delusion’.⁹ The patient in question was a 17-year-old boy with a depressive illness, who refused to drink and compulsively checked taps based on the belief that he would deprive others of water. Seasonal affective disorder, now widely regarded as valid and common just 40 years after its first description, is a further example of the evolution of psychiatric frameworks in response to environmental factors.

We have a moral and professional duty as mental healthcare professionals to act on the impending climate-driven health crisis. Every-Palmer et al identify the ‘CARM’ approach – collaborate, advocate, research and mitigate – as a useful tool for conceptualising our opportunities to do so.³

Interdisciplinary collaboration with policy makers, healthcare organisations and other stakeholders represents the most comprehensive and effective means of raising awareness of this emerging issue. The *BMJ*, *Lancet* and *PLOS Medicine* have conveyed the responsibility of mental health experts to provide clear information detailing the mental health sequelae of climate change.³

It is best practice to treat patients holistically by considering the environmental, social and economic determinants of health and illness. Climate change and its associated complications are a prominent example of such determinants. The literature consistently report a disproportionate impact of climate-related psychological consequences for those with pre-existing mental health issues. We must identify and advocate for vulnerable populations, to ensure equity of resource allocation.

Our understanding of the complex interactions within and between climate change and mental health is in its infancy. Future research in the field should be prioritised to attain a more concrete understanding of these interactions, and to inform the development of effective interventions for both prevention and treatment of climate-related mental health issues. It is crucial that mental healthcare professionals anticipate the inevitable psychological and psychiatric burden of climate change.

The future of global mental health and the planet is in our hands. We should therefore strive to reduce the environmental impact of our institutions and practices. As doctors, our carbon footprint from clinical practice is ten times greater than that from our personal lives.¹⁰ The Royal College of Psychiatrists’ Sustainability Committee has generated a summary of ten ways to reduce one’s footprint in the professional setting¹⁰ – a good starting point for those willing to make a difference. Mental health professionals take pride in providing individualised care, but we must acknowledge that continuing clinical practice that ignores this issue will contribute to an international mental health crisis. Our decisions will not be forgotten by the patients and psychiatrists of tomorrow.

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Declaration of interest

None.

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pmc Malawi, a south-eastern African country of approximately 20 million people, has only three consultant psychiatrists. As grim as this ratio is, it is not unique to Malawi; rather, it is a tendency within Africa that begs interventions.

The Malawi Quick Guide to Mental Health, by the Scotland–Malawi Mental Health Education project, is one such intervention. With Donncha S. Mullin and Robert C. Stewart as lead editors, this is a seven-part practical resource material adapted mostly from World Health Organization’s *mhGAP Intervention Guide Version 2.0* (2016) and the Royal College of Psychiatrists’ *Where There is No Psychiatrist* (2018).

The target reader is ‘the busy primary care provider working at first- and second-level healthcare facilities in Malawi’ and the 90-page guide is adapted to the practical realities of working in mental health, paying attention to the country’s official national language (Chichewa), social mores, current mental health legislation and local support institutions.

Written in accessible language and formatted in bullet-point presentation style, the first three parts provide guidance about mental health and the ongoing COVID-19 pandemic, mental health emergencies and the principles of assessment and management of mental illnesses. The other sections offer guidance about specific psychiatric disorders, including epilepsy, which is identified within the neurologist’s remit but may present to mental health services.

A chapter is dedicated to special populations (pregnant women, older adults, children and adolescents) and a final part contains information leaflets on specific mental disorders written in English and Chichewa, adapted from existing leaflets of the Royal College of Psychiatrists, Mind and National Centre for Mental Health.

This guide fulfils its aim in providing support for the non-specialist mental health worker in landlocked Malawi and neighbouring Anglophone countries, by virtue of its being written in English. Always signposting to other resource materials for additional information, this guide is a primer for the curious non-specialist health worker.

The curious specialist reader will be furnished with aspects of the Malawian world-view about mental illness and the country’s mental health legislation, the Malawi Mental Health Treatment Act 1948, a functional colonial relic, which is also not unique to Malawi. *The Malawi Quick Guide to Mental Health* is a pragmatic intervention addressing the dearth of mental health specialists in Malawi but this resource material will also serve other Anglophone low- and middle-income countries in similar predicaments.

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1.2.58 Klaus Bergmann, MD, FRCPsych

Robin Jacoby Robert Howard

date

2021-08

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- *Klaus Bergmann, MD, FRCPsych*

pmc Formerly Consultant Old Age Psychiatrist at the Bethlem Royal and Maudsley Joint Hospital, London, UK

Klaus Bergmann, who died following a stroke on 5 December 2020, was one of the towering figures in British old age psychiatry in its early years, playing a major role in bringing the specialty to maturity. In the 1960s and 1970s, he was based in the Department of Psychiatry at Newcastle University, headed by Martin Roth. Mentored by David Kay and in collaboration with Gary Blessed and Bernard Tomlinson, Klaus was deeply involved in one of the first community cohort studies of the prevalence and outcomes of old age mental disorders outside hospitals. The important findings of these studies have dictated policy ever since.^{1,2}

Although involved in research, Klaus was a superb clinician who cared more about his patients than he did about anything else at his work. His acumen in diagnosis and treatment was second to none. He was the reason many of his trainees went into old age psychiatry, some of those now occupying the highest levels in the profession.

He was born in 1930 in Dresden, younger brother to two older sisters, to Fritz and Alice Bergmann. Fritz owned a millinery firm that he was able to re-establish in Luton after emigration from Germany. In 1937, before the Second World War, his Jewish family moved via Palestine to England. He would often recount his childhood disappointment that he had not been allowed to wear the uniform and carry the dagger of the Hitler Youth, which he coveted.

Klaus was educated first at St George's School, Harpenden, following which he studied medicine at Sheffield University, where he met his wife Marie, a fellow student reading German. After National Service, he returned to Sheffield for psychiatric training under Erwin Stengel, also a refugee from the Nazis. This gave him a broad outlook based both on rigorous history-taking and mental state examination, but with psychoanalytic insights. He always maintained an affectionate respect for Stengel but, as was the case with others among his senior colleagues, he could never resist telling humorous stories about them. This characteristic betrayed both immense respect for those Klaus deemed worthy, combined with a refusal to adopt blinkered hero worship.

In 1964, Klaus moved from Sheffield to Newcastle, where the Department of Psychiatry was headed by Martin Roth, and it was here that he entered old age psychiatry. Klaus often said that he regarded Roth as the Kraepelin of old age psychiatry, i.e. a founding father in terms of classification and phenomenology. Once again, Klaus enjoyed poking fun at him without ever losing respect for his important contributions to the specialty. In 1966, Klaus took up a consultant post at St Francis Hospital, Haywards Heath, Sussex, where he was overworked and grossly under-resourced. So, in 1969, he returned to Newcastle, continuing to carry out research in the community.

At heart, Klaus was a clinician and a teacher and, in 1979, at the invitation of Raymond Levy, he moved down to London to the Bethlem Royal and Maudsley Hospital as a consultant old age psychiatrist, replacing Felix Post, who had retired. With typically wry humour he asked Raymond: 'Do you think they'll mind that I'm not a gentleman?'. As a matter of fact, they did not mind, and he settled in there very well. At the Maudsley he worked alongside Raymond Levy, who became Professor of Old Age Psychiatry. Later, they were joined by Robin Jacoby and Marisa Silverman (now Parrish).

Klaus inspired loyalty through his clinical skills and his courage. He was not frightened to offend people in defence of his patients. For example, if he saw something that he regarded as shocking, he would, himself, shock the perpetrator. One day, he arrived at a care home to be led into the day-room, where all the residents were sitting round the walls except for one old lady who was on a commode in the middle of the room, incompletely shielded by one or two movable screens. Klaus turned to the care-home manager and said: 'Oh, do you sh** in your sitting-room?'

He was often incredibly funny. Never completely shaking off his adolescent schoolboy personality, he was a fount of good and very non-PC jokes, designed on occasions to shock some of the more prudish people at the Maudsley. His office was a chaotic mess, with journals and committee papers all over the desk and the floor. His colleagues used to joke that he would not be able to retire but would have to be removed as a hoarder under a section of the Public Health Act. This delighted him, and he often boasted about it. In the end, he retired without recourse to the Public Health Act. Early on in his retirement he wrote reports for the General Nursing Council in connection with disciplinary action. He was rather fond of what he called his 'naughty nurses'.

Klaus enjoyed a long and happy marriage to Marie, who survives him with their son George, their daughter Caroline, and three grandchildren. Vicky, their elder daughter, died of cancer in 2014.

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1.2.59 Unequal effects of climate change and pre-existing inequalities on the mental health of global populations

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Abstract

Climate change is already having unequal effects on the mental health of individuals and communities and will increasingly compound pre-existing mental health inequalities globally. Psychiatrists have a vital part to play in improving both awareness and scientific understanding of structural mechanisms that perpetuate these inequalities, and in responding to global calls for action to promote climate justice and resilience, which are central foundations for good mental and physical health.

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pmc Climate change is affecting the physical and mental health of human populations through direct and indirect mechanisms including population displacement, forced migration, and economic and food system instability.¹ Global action and ‘a robust response [to climate change] ... will improve human health and wellbeing’² and reduce associated psychological consequences.³

We suggest that by addressing mental health inequalities, psychiatrists can contribute to addressing climate change and its health effects. We highlight the interconnectedness of inequality, climate and ecological destruction, and adverse mental health outcomes. We go on to propose a model for mental health practice and research that promotes climate justice and resilience in the context of increasingly complex geographical, economic and sociocultural factors.

Climate change and mental health: unequal effects, but not by chance

The COVID-19 pandemic has shown that minoritised and indigenous communities are at heightened risk from combined social and ecological shocks, including adverse weather events and pandemics, owing to vulnerability resulting from pre-existing factors such as discrimination, exclusion, poverty, land dispossession and malnutrition.⁴ There are also inequalities in exposure to ecological hazards. A study on associations between air pollution and neighbourhood characteristics in England and The Netherlands found higher concentrations in the most deprived 20% of neighbourhoods in England, with higher concentrations in both countries in neighbourhoods with >20% non-White populations, after adjustment for urbanisation and other variables.⁵

On a global scale, there is increasing recognition that climate change is compounding many health inequities and undermining pre-existing support structures which protect against poor mental health.⁶ The climate crisis has been called a racist crisis, reflecting both its disproportionate effects on Black communities and people of colour globally, as well as its evident unequal effects within countries.^{7,8} Following Hurricane Katrina, for example, Black New Orleanians faced greater stress than their White counterparts, even after adjustment for demographics, parental status, evacuation timing, home damage and job status; income had no clear effect.⁹ There was a similar pattern for post-traumatic stress disorder, which was partly but not fully explained by greater baseline mental distress.¹⁰

In recent years, campaigns for international action on climate change have highlighted how unjust social and economic systems, including legacies of colonialism, structural racism, and other exclusionary forces such as sexism and ableism at all levels shape vulnerability to the effects of climate change on mental and physical health. We contend, as argued by Leon Sealey-Huggins and colleagues (2018), that ‘we can only properly understand the harm being wrought by weather events and climate change by directly connecting it to broader social and political processes, of which structural racism is a central part’.⁷

Future research must further clarify the mechanisms as a result of which people with severe mental illness are more vulnerable to the adverse effects of climate change. This should include a recognition of closely interwoven vulnerabilities due to social exclusion, stigma and direct consequences of their illness or medications, as well as the effects of unequal distribution of resources at local, national and international levels, all of which affect people’s and communities’ capacities to cope and adapt.

Intersections between urban health inequalities and climate change effects

Cities are the places where most people live globally – 56% of the global population as of 2018¹¹ – and are the places where people are most exposed to the adverse effects of climate change. For example, the urban heat island effect means that higher temperatures are experienced in urban areas than in more rural ones nearby, and access to places for people to cool off in, such as shady green spaces or waterways, is often more limited. The health effects of rising exposure to high temperatures are not only physical but have also been associated with increased risks of mental ill health¹² and with suicide.¹³

Cities are also a key focus for research into mental health inequalities, particularly in relation to differences in urban versus rural rates of schizophrenia. The spatial distributions of other mental health outcomes such as suicide and self-injury are less clear cut, suggesting a greater need to further understand the influence of sociocultural and environmental characteristics of particular neighbourhoods.¹⁴ One example of this is how qualitative methods have begun to unpack the paradoxically low rates of direct self-harm in highly deprived areas in London.¹⁵

People in cities often experience the greatest exposure to some of the key contributors to climate change, including air pollution from fossil fuels and degradation of green space. Further, increased exposure to poor-quality air and green spaces often mirrors and compounds pre-existing socioeconomic inequalities. Evidence on the lifelong effects of air pollution on mental health outcomes such as depression continues to emerge.^{16,17} Exposure to air pollution and traffic noise are similarly unequal for different neighbourhoods with regard to both socioeconomic status and ethnicity, with those least likely to own a car often most likely to live in traffic-clogged and polluted areas.¹⁸ At the same time, good access to urban nature can help to partially mitigate the harmful effects of socioeconomic inequalities.¹⁹

Further, there has been greater awareness of the urgent need for more urban green space²⁰ and a recognition of strong disparities in access to green space in European cities.²¹ Access to green space has been linked with reduced depression risk,^{22,23} and there is increasing recognition that social factors affecting both availability²⁴ and levels of use²⁵ seem to mediate the mental health effects of green and blue spaces such as parks, forests, rivers and beaches.

There is increasing evidence of biologically plausible explanations of associations between urban environmental exposures and mental health. These include the effects of traffic and air pollution exposure on neurodevelopmental pathways in children,²⁶ neuroinflammation across the life course,¹⁷ and changes in arousal and stress responses associated with time spent in green space.²⁷ Proposed mechanisms through which the green space's benefits may be manifest include a shift in attention, promoting curiosity, social networks, group cooperation and physical activity. However, methodological and interpretation challenges remain, for example, in understanding the importance of confounding factors such as noise pollution and general neighbourhood deprivation.¹⁷ Limited studies have translated these observations into robust evidence for improved mental health.²⁸

There is also a lack of research from low- and middle-income countries (LMICs) on the effects of climate change on mental health. This is urgently needed to inform policy action in these contexts. In LMIC contexts, forced migration due to climate change – with the destination locations often being cities – is a significant challenge, and studies have highlighted that dislocation from one's home compromises emotional well-being related to happiness, life satisfaction, optimism for the future and spiritual contentment, even despite well-intentioned relocation programmes focused on material compensation and livelihood re-establishment.²⁹

Challenges in conceptualising complexity

For mental health, 'the risks and impacts of climate change ... are already rapidly accelerating, resulting in a number of direct, indirect, and overarching effects that disproportionately affect those who are most marginalised'.³⁰ Our ability to fully appreciate and act on these vulnerabilities has been constrained by complexity on multiple levels, from the geographic scale to the interrelated nature of the underlying causal mechanisms.

These constraints have limited research into the effects of climate change on mental health, to date. Quantitative approaches have tended to focus mostly on proximate causes, which can obscure important structural and political drivers of the distribution of mental health effects of climate-related heatwaves, floods, wildfires and droughts.³¹ Studies which have found associations between heat and mental health outcomes such as suicide have also cautioned about the difficulties of ascertaining causal effects using an ecological study design.¹³

Berry et al (2018) proposed that a systems approach that accounts for interrelated and interdependent factors, forming a complex whole, is important for future research thinking and leadership around climate change and mental health.³² We argue that this approach should also accommodate a structural and intersectional understanding of pre-existing inequalities in mental health. This may come from approaches which address broader inter-penetrative global socio-economic processes such as globalisation,³³ and the syndemics model of health that focuses on ‘interacting, co-present or sequential diseases and the social and environmental factors that promote and enhance the negative effects of disease interaction’.³⁴

The role of psychiatry in understanding and addressing climate change

In 2015, our Australasian colleagues³⁵ proposed the ‘CARM’ approach – to collaborate, advocate, research (and educate) and mitigate – as a framework for psychiatrists to join with a growing number of medical entities to act on climate change. We have proposed our recommendations within this same framework (*Box 1*), and with the emphasis that interventions need to be ‘coordinated and rooted in active hope’ to tackle the problem in a holistic and effective way.³⁰ Alongside growing recognition that we should practice psychiatry more sustainably,³⁶ we should acknowledge it as our professional and ethical responsibility to address the environmental, social and economic determinants of mental illness.³⁵ *Box 1* Framework for psychiatrists to act on climate change (adapted from the ‘CARM’ approach³²). Collaborate Work with disadvantaged communities so that their voices and priorities are better heard, and help them influence policy decisions Build on existing multidisciplinary work across specialties, and with patients and the public, to drive meaningful change on key issues relevant to climate and mental health Advocate For patients and communities’ mental health and well-being For actions that strengthen local community resilience and tackle global injustice For policies and funding for appropriate and evidence-based interventions to support and protect mental health following climate-related extreme events Research (and educate) To improve understanding of mental health in relation to the causes of inequalities, climate vulnerability and resilience Continue to build the evidence base for action, including through participatory and action research methods, and using mixed methods and systems approaches that recognise the interconnectedness and complexity of these subjects Advocate for increased funding for research to improve understanding of how both structural inequalities and climate change affect mental health, including when they intersect and how we can address them in tandem Mitigate Prioritise primary prevention for mental health across the life course Strengthen mental health systems and links between healthcare services and local communities Improve equity of access to quality care Act within local services to reduce carbon and improve mental healthcare

Collaborate

Psychiatry should work with disadvantaged communities to help them influence policies that may be linked to climate change, including empowering indigenous communities, implementing processes for equitable access to resources and ensuring inclusivity in long-term sustainable development policies. We should build on our multidisciplinary work with colleagues across specialties, with patients and the public, and with other health organisations. For example, psychiatrists can make use of the Royal College of Psychiatrists’ membership of the UK Climate and Health Alliance to collaboratively communicate the urgency of the situation and the case for action, and to influence policy makers, community organisations and other stakeholders to deliver meaningful change.

Advocate

Climate change is a global problem which needs global cooperation and local action. As advocates for patients’ and communities’ mental health and well-being, psychiatrists can help to drive these objectives forwards. There is already strong evidence that the psychiatric community can use in advocating for policies and interventions which can build local community resilience and tackle global injustice. These could include but are not limited to urban planning and regeneration; increased green space; cleaner air; community food growing; liveable streets; and high-quality, low-carbon housing. Importantly, they should also include national and international policies for urgent action on climate change and protection for those harmed or displaced by it, which may further exacerbate pre-existing mental health inequalities. With an already increasing frequency of adverse weather events, there is also an important role for the

psychiatric community in advocating for policies and funding support for appropriate mental health interventions in the wake of climate-driven events such as floods, major storms and wildfires, and to strengthen resilience to them.

Research (and educate)

A better understanding of the causes of inequalities, vulnerability and climate resilience as they relate to mental health is clearly needed, requiring changes to both research and education. Alongside more established quantitative epidemiological approaches, this is likely to benefit from qualitative and narrative methods, as well as systems approaches that recognise the complexity of these interlinked causal relationships and policy challenges.³² We should continue to build the evidence base for action, including through participatory and action research methods that emphasise the voices, needs and priorities of those who are most climate vulnerable and which seek to tackle structural injustices. We should also advocate for increased funding for research focused on understanding and addressing the effects of structural inequalities and climate change on mental health.

Mitigate

There are a number of areas where we can intervene early in addressing unequal climate change effects, for example, through prioritising primary prevention for mental health disorders across the life course and working upstream to address drivers of mental ill health and intervene early; strengthening mental health systems, particularly in areas of high deprivation; and strengthening links between clinical services and local communities. Against a backdrop of both national health service and governmental carbon reduction initiatives, psychiatric services must also both reduce their own emissions and improve mental healthcare, to avoid contributing further to the root causes of climate-related mental distress.

Conclusion

The time is now for concerted action to better understand and intervene in the structures and policies that create and perpetuate social and ethnic inequalities globally and harm planetary health. Working together to create the conditions for good mental health, such as enabling equitable access to resources, services and healthy environments, will also strengthen climate resilience and health equality across society. We can no longer overlook the interconnected ecological and social crises, and psychiatrists can play a critical part in defining the fairer and healthier society of tomorrow.

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Data availability

Data sharing not applicable to this article as no datasets were generated or analysed.

S.Z. conceived the initial idea for the article and wrote the first draft. I.B., V.B. and J.D. were involved in developing the outline and contributed to revisions of the draft. All authors were involved in finalising the final manuscript.

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Declaration of interest

S.Z. is on the sustainability committee of the Royal College of Psychiatrists. This is a voluntary role with no financial remuneration. I.B. is an active voluntary member of the grassroots advocacy group Health Declares Climate & Ecological Emergency (<https://healthdeclares.org/>).

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1.2.60 The Psychology of Climate Anxiety — ERRATUM

Joseph Dodds

date
2021-08

Contents

- *The Psychology of Climate Anxiety — ERRATUM*

pmc This article was originally published with an incorrect affiliation for Joseph Dodds. Dr Dodds is solely affiliated with Psychology Faculty, University of New York in Prague, Czech Republic.

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1.2.61 Green care in first-episode psychosis: short report of a mixed-methods evaluation of a ‘woodland group’ in an early intervention service

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Abstract

Aims and method

In the context of increasing recognition of the role of nature in well-being, but limited evidence for specific patient groups, we describe a mixed-methods evaluation of a 10-week green care intervention (a woodland group) for 18- to 30-year-olds who had experienced a first episode of psychosis. Data were collected using the Questionnaire on the Process of Recovery (QPR), semi-structured service evaluation questionnaires, the NHS Friends and Family Test (FFT), and focus group analysis.

Results

All participants present at week 10 ($n = 5$) would recommend this group to others; 4/8 participants showed reliable improvement on QPR outcome measures. Thematic analysis identified themes of connection with nature and others, development of a sense of well-being and ‘peacefulness’ and new perspectives on psychotic experience.

Clinical implications

This small retrospective evaluation describes patient-reported benefits, feasibility and acceptability of green care interventions within early intervention in psychosis services (EIS).

Contents

- *Green care in first-episode psychosis: short report of a mixed-methods evaluation of a ‘woodland group’ in an early intervention service*
 - *The intervention*
 - *Ethics and consent*
 - *Data collection and analysis*
 - *Results*
 - *Discussion and conclusions*
 - *Data availability*

– Declaration of interest

pmc Early intervention services (EIS) aim to reduce symptomatic periods and improve developmental and social trajectories for those who have experienced a first episode of psychosis (FEP).¹ Full recovery and therapeutic engagement may be difficult to achieve.^{2–4} Green care uses natural environments to facilitate improvements in well-being, with growing evidence to support effectiveness in the general population.^{5,6} Evaluations suggest that people with mental health problems may benefit proportionally more from such nature-based care.⁷ Accessing green space may mitigate health inequalities closely tied to severe and enduring mental illness (SMI),^{8,9} including for young people, among whom nature ‘connectedness’ is low.¹⁰ Groups in natural spaces may also confer potential advantages for therapeutic engagement and work.^{11–13} However, there is limited evidence for green care for those with SMI^{14,15} and, to our knowledge, none in FEP. Green care is a ‘complex intervention’, combining psychological work, physical activity and social interactions,¹⁶ so our study used a mixed-methods approach, as recommended by the Medical Research Council.¹⁷ This mixed-methods evaluation considers potential benefits and barriers encountered in a green care programme delivered in an EIS.

The intervention

The woodland group was facilitated by Circle of Life Rediscovery (CLR), commissioned by Sussex Partnership NHS Foundation Trust for 10 weekly half-day sessions. Two CLR staff prepared and attended groups, collaborating with EIS staff who facilitated transport and supported individuals (up to 15), with an overall staff:participant ratio of at least 1:3.

The group included a short walk, refreshments, contemplative time and activities such as learning about plants and habitats, maintaining the woodland area and cooking.

All participants were aged between 18–30 and had experienced FEP, some demonstrating active psychotic symptoms. Target problems included isolation, anxiety and depression.

Ethics and consent

This study was conducted as a service evaluation and did not require research ethics approval. All participants gave written consent for data to be collected and used within evaluations of the service.

Data collection and analysis

Participants completed the 15-item Questionnaire about the Process of Recovery (QPR) at weeks 1, 3, 6 and 10. The QPR has good internal consistency, high test–retest reliability and convergent validity.^{18,19} ‘Reliable change’, an estimate of statistical significance of change in outcome scores, was calculated using the Jacobson–Truax formula with published Cronbach’s alpha and standard deviation.^{20,21} Participants in the final session also completed a semi-structured service evaluation questionnaire and the NHS Friends and Family Test (FFT).²²

Qualitative data were invited through free-text portions of the evaluation questionnaire and through intervention summaries completed by participants and staff. A 20 min focus group ($n = 7$) was convened in the final session, facilitated by the group leader and transcribed by the first author. All three authors independently performed thematic analysis of the data.

Results

The QPR 5-point Likert scale ranges from 1 (disagree strongly) to 5 (agree strongly). Mean QPR scores increased from 3.4 ($n = 3$) at week 1 to 3.8 at week 10 ($n = 8$). Four patients showed reliable improvement and one showed reliable deterioration for those with data at two time points ($n = 8$).

All participants present at week 10 ($n = 5$) recommended the group on the FFT.²²

Results of the evaluation questionnaire (at week 10) are shown in *Table 1*. Table 1 Participants' ($n = 8$) scores on the service evaluation questionnaire (at week 10) Mean (median) *a*

Statement	Mean	Median
I feel more connected to the world around me	4.4	4
My emotional and psychological well-being has improved	4.3	4
My recovery has been helped	4.1	4
I have found ways to manage difficult emotions	3.5	3.5
I have found things that can help me in a crisis	3.8	4
I have connected with other people in a positive way	4.8	5
I have had some difficult social encounters	3.4	3
I have been more worried about the world around me	2.5	2.5
I feel more hopeful	3.9	4
I have felt more confident about going to new places	3.4	4
I have learnt new skills	4.3	4
I have felt more confident about meeting people	4	4
I have made friendships which may continue	4.1	4

All authors were concordant on two higher-order themes from the qualitative data. The first was connection with others and nature. Participants described reduced isolation and improved relationships: “‘It’s therapeutic to sit round a fire with other people [...] it’s nice to feel connected.’ ‘The difference [...] I’m not isolated [...] I can feel normal. You go to doctor’s appointments, you’re not part of the 9–5 but we are still here.’ ‘I feel [...] awe/curiosity for the natural world.’”

A second overarching theme was of positive change in self, including skills development and emotional change. This was expressed as feeling ‘confident to do things’ or ‘I enjoyed the cooking [...] it helped distract me more, and it’s skills I have used at home’. Participants appreciated creativity and the chance to ‘take something away’ – including physical objects, memories and new skills. They described feelings of calmness: ‘100% impact. I feel better about myself [...] I feel supported, I feel able. I have found stillness, calmness [...]. It is very healing’. Staff noted that participants appeared more relaxed in the woodland group than in other settings.

Particularly relevant to this group were repeated suggestions that the group enabled changed perspectives on psychosis. One participant wrote ‘[it] showed me what’s real in my [...] psychotic state’ and another ‘[it] helps me understand other people’s perception of psychosis’.

Barriers to participation included short sessions and poor weather. No adverse events, near misses or concerns regarding risky behaviour were reported.

1

Scores are on a 5-point Likert scale: 1, ‘strongly disagree’, 5 ‘strongly agree’.

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Discussion and conclusions

This evaluation offers promise for green care as an intervention in FEP. Unusually, group attendance improved over time and all participants recommended it. Sequential QPR measures showed positive trends across all recovery domains; additionally, attendees described increased insight and contextualisation of difficulties, alongside distraction from problematic symptoms. Participants spontaneously discussing their beliefs and experiences, potentially enabled by the attention-restoring and stress-reducing properties of the woodland environment, seems to have encouraged reflection and reality testing. The group was therapeutic, with features of universality, development of socialising skills and interpersonal learning.²³

Feedback for improvement was sparse. The location, with associated travelling costs, and the intensive EIS staff involvement were cited as barriers to re-commissioning. CLR staff reported that the 'scaffolding' provided by NHS support enabled them to facilitate the group. Without this early input, successful engagement of this patient group seems less likely. Full economic (and carbon) costings, including staff resource, should be part of future evaluations and commissioning for such groups, as within the wider social prescribing context.²⁴

The findings are limited by small sample size, areas of incomplete data and use of patient-reported outcome scales only. We have no data from those who chose not to attend the intervention. Although qualitative analysis allows themes to emerge from the data, defining components and aspects of the intervention which may be poorly understood,²⁵ thematic saturation was likely not reached, and participants may have felt constrained by facilitator presence in the focus group. Further exploration of the increased reflective ability on personal psychotic experiences that participants reported feeling within the grounding and supported woodland setting would be particularly helpful.

Initiatives to boost green prescribing are expanding.²⁶ This is a preliminary report, indicating promising features for green care as a sustainable intervention in EIS. As a community-based intervention it is empowering and there is potential benefit from developing nature connectedness, which is associated with increased conservation behaviours.²⁷ Although further exploration of the benefits of green care, including its influence on psychotic experience and longer-term outcomes, is needed, the experiences this group describe suggest that nurturing opportunities for patients to access nature could promote recovery and rebalance relationships with the environment.

Thanks to Marina Robb, Circle of Life Rediscovery, and to the Hailsham Early Intervention Service.

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Data availability

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available owing to potential compromise of the privacy of those who contributed.

S.C. gathered and analysed evaluation and focus group data and produced the first draft. H.S. and C.B. contributed to qualitative analysis and contributed to subsequent drafts. All authors meet ICJME criteria for authorship.

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Declaration of interest

None.

pmc Psychiatrists are now interesting to the general public. It was not always so. After years of meeting them only as cardboard cut-out figures in crime novels there is now curiosity about who they are and what they do. I have just finished reading Joanna Cannon's book *Breaking and Mending*, about the effect of psychiatry on the person. Written by someone exquisitely sensitive to every nuance in professional life, Joanna's book was an eye-opener for me with my more hardened exterior. Brian Barraclough's autobiography is very different. It satisfies the voyeur in the reader – what are the people psychiatrists treat really like and what do they get up to?

And there is much for the voyeur here. But this independently published book has a misleading title. Brian Barraclough does not come over as 'partly Anglicised'; he is a Kiwi through and through, and although his assiduous English wife Jennifer, also a well-known psychiatrist, has done some, possibly a great deal of, editing she cannot hide its craggy authenticity. Despite spending 38 years of his life in the soft underbelly of Sussex and Hampshire, Dr Barraclough has not acquired the veneer of many English sophisticates, who might write more smoothly. He has always lived in the marvellous upside down map of the world where New Zealand is securely on the top.

Here we read about the recent history of psychiatry. It is so odd that it is hard to believe it is recent and not ancient history. Barraclough fosters the old by giving an oral testimony, almost mediaeval in its bluntness, unapologetic and unadorned, thinking primarily not of the reader but of the need for accurate report. So, we are taken back to characters and experiences that some younger psychiatrists might find unbelievable. Dr Barraclough's mentor, Harold Bourne, bluntly tells a female medical student 'your vivid red lipstick represents a penis', and also, while maintaining he is primarily a psychoanalyst, practises long-term 'ECT maintenance' (i.e. giving courses of electroconvulsive therapy at intervals of a few weeks 'to avoid relapse'). We read about a woman who broke her teeth after unmodified ECT (she had osteogenesis imperfecta), another woman, a devout member of the Church of England who had severe obsessional disorder, who, after much deliberation, was recommended for a leucotomy. Afterwards she is observed by Barraclough to squat and defecate on the floor. She looks up and says, 'That is my shit, clean it up'. He also describes working for a psychiatrist who carried out 'behaviour change treatment' for homosexual men in a closed ward for 9 days, topped up with aversion therapy for others; there is no discussion of outcome.

You might think that these experiences might all come from New Zealand. No, half come from the Mecca of psychiatry in the 1960s, the Maudsley Hospital in London. This was the 'only decent place to study', according to Harold Bourne, where once trained, the inspired joined the diaspora to spread enlightenment to the hungry elsewhere. But this was a time when opinion, not evidence, guided clinical practice, even at the Maudsley. After all these experiences, it is not surprising that Dr Barraclough turned his attention to the dead, to the subject of suicide, where his contribution is widely praised and may be described more fully in a forthcoming volume.

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1.2.62 The psychology of climate anxiety

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2021-08

Abstract

This paper focuses on climate anxiety and its role in the psychology of climate change, compared with responses to the COVID-19 global pandemic. Four psychological hypotheses for why we do not act on climate change will be reviewed, and the role of anxiety for each, as well as potential solutions. Different types of climate anxiety both inside and outside the clinic will be explored, along with associated defence mechanisms and treatment.

Contents

- *The psychology of climate anxiety*
 - *Climate psychology and climate anxiety*
 - *Why do we not act? Four psychological hypotheses*
 - * *Faulty alarm hypothesis: cognitive bias in our evolved risk detection system*
 - * *Social dilemma: bystander effect*
 - * *Ecopsychology: the problem of disconnection from nature*
 - * *Psychoanalysis: climate denial and apathy as a defence against anxiety*
 - *Types of climate anxiety and defence*
 - *Working with climate anxiety*
 - *Declaration of interest*

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This article was originally published with a second, incorrect affiliation for Joseph Dodds. This has now been corrected and an erratum published at <https://doi.org/10.1192/bjb.2021.58>

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Climate psychology and climate anxiety

The past decade has seen the important development of climate psychology.^{1–7} Ursano and colleagues² describe climate change as one of the top threats to global health in the 21st century, and psychology has begun to respond. The American Psychological Association's 2010 report into climate change¹ identified six key areas for psychology, including risk perception, psychological and behavioural causes of climate change, psychosocial impacts of climate change, adaptation and coping strategies, psychosocial barriers to action and the role of psychologists. At the same time, psychotherapists and clinical psychologists are coming to terms with ecological loss, anxiety and guilt in their patients, and also among themselves, as they come to grips with the faltering biosphere.^{8,9}

This article focuses on climate anxiety and its role in climate psychology, while recognising that anxiety interacts with a range of other emotions such as grief and rage. The American Psychological Association¹⁰ refers to ecoanxiety as 'a chronic fear of environmental doom', ranging from mild stress to clinical disorders like depression, anxiety, post-traumatic stress disorder and suicide,^{11–13} and maladaptive coping strategies such as intimate partner violence^{14,15} and substance misuse.^{16–20} Cianconi et al²¹ found complex types of climate anxiety and trauma, including intergenerational effects, especially where environmental damage involves loss of a way of life or culture.

It is essential to differentiate between pathological and adaptive forms.²² *The Handbook of Climate Psychology*⁴ defines climate anxiety as a 'heightened emotional, mental or somatic distress in response to dangerous changes in the climate system', but suggests that 'paying heed to what is happening... is a healthier response than turning away in denial or disavowal'. Climate anxiety can lead to symptoms such as panic attacks, loss of appetite, irritability, weakness and sleeplessness,¹ yet given the increasing evidence about the impact of climate change on health, psychological professionals might ask if their patients feel too much anxiety, or whether they themselves feel too little. Climate anxiety is being felt much more powerfully among the young,^{23,24} by first responders to climate-related natural disasters^{25,26} and climate scientists and activists, who are exposed to information about the threat more than most and therefore may need psychological support.

When considering the effects of climate anxiety, it is necessary to focus on at-risk populations, including children, the elderly, the chronically ill, those with mental illnesses and those with mobility impairments.² Those from lower socioeconomic groups are disproportionately affected by climate change because of disparities in infrastructure and health resources. Severe weather events can also damage social support systems and mental health infrastructure, further isolating the most vulnerable.^{27–29} Clayton^{30,31} reports that anxiety, fatalism, hopelessness and fear have been increasing globally, and offers a clinical approach to understanding, measuring and treating climate anxiety, while emphasising the distinction between adaptive and maladaptive types, and the need to keep the society-level response required to combat climate change in mind.

Given our need to effectively mobilise in response to climate change, the Climate Psychology Alliance⁴ suggests that psychologists and psychotherapists should not aim to get rid of climate anxiety, but instead 'support individuals and communities to build strong containers that allow the expression and exploration of their emotions without collapsing under it or turning away'. Climate change is a psychological problem but that does not mean that it should be individualised or medicalised. As Lawton writes,³² if ecoanxiety is treated as pathology, 'the forces of denial will have won... what we are witnessing isn't a tsunami of mental illness, but a long-overdue outbreak of sanity'.

Why do we not act? Four psychological hypotheses

Climate anxiety is heightened in those that are aware of and *feel* the existential threat of climate change, by the fact that most of us, most of the time, act as if it does not exist. The poverty of collective responses to climate change is in stark contrast to its threat. Why do we not act? This section explores four psychological hypotheses, the role of anxiety for each, and comparisons with psychosocial responses to COVID-19.³³

Faulty alarm hypothesis: cognitive bias in our evolved risk detection system

This explanation suggests humans have evolved the ability to respond to certain types of threats optimally, especially those that are immediate, visible, fast (something happens so slowly that it slips our notice), with historical precedent, simple causality, clear and direct personal impacts or caused by an 'enemy' tribe or group.^{1,34,35} From this perspective, the problem with climate change is that we do not feel enough anxiety as it slips our notice by missing all of the characteristics above. The answer is to help us feel the anxiety, to motivate us to act, turning up the volume on the threat and our response. The lack of effective risk perception leads to behaviours that worsen climate change.³⁶ According to the 2018 American Psychological Association report, 'the perception of risk regarding climate change, belief in the ability to effect change, and the etiology attributed to extreme weather events are important factors impacting the decisions people make regarding climate change related behaviors'.²

Comparison with COVID-19

Both climate change and COVID-19 are environmental crises where human behaviour and psychology are important factors, yet the latter happens much faster, with clearer links between behaviour and consequence, leading to much more dramatic responses. International efforts to respond to COVID-19 may have the unintended benefit of shaking people out of climate lethargy, by showing that the global mobilisation required to confront climate change is possible, and allowing the public to see (and feel) that invisible environmental dangers are very real.³³ However, as with climate change, with the COVID-19 pandemic we also see huge levels of denial, anger and despair.

Social dilemma: bystander effect

Social dilemmas (or commons dilemmas) involve conflict between individual and collective self-interest.³⁷ For example, it is in every fisherman's interest for other fishermen to adopt quotas on how much fish can be caught every year to ensure fish stocks recover, but simultaneously, each would like to take what they can. Climate change is the ultimate commons dilemma.³⁸ How do we escape from this 'rational-disaster' model of human extinction? Games theory³⁹ studies such conflicts, most famously with the prisoners' dilemma. Anxiety here refers to not only the 'costs' of the game when played badly, but of predicting the behaviour of others. How can I trust that you will do the right thing? And how can I trust that you trust that I will do the right thing? Research in human and animal behaviour^{40,41} shows cooperative strategies can flourish in a wide range of contexts. The key is to focus on the structure of the game, to allow cooperative behaviour to flourish.

Comparison with COVID-19

Responses to both involve social dilemmas. When reviewing how successful different countries were/are in tackling the viral pandemic, it seems that a crucial factor was not the wealth of the nation, but its social cohesion and a collectivist versus individualistic orientation.⁴²⁻⁴⁴ To the extent that the measures were clearly enunciated, seemed fair and received widespread social support, systems of trust were established and each could play their part in the collective effort. Climate change is another order of complexity beyond COVID-19, but important lessons can be learned.

Ecopsychology: the problem of disconnection from nature

Since the 1990s, ecopsychology has emerged as a particular response within psychology to environmental problems, emphasising a holistic approach,⁴⁵⁻⁴⁸ suggesting that our modern lives are so disconnected from nature that we do not care enough to want to protect it, and fail to realise that we are threatened by damage to the natural world. Ecopsychology views disconnection from nature as also central to the current mental health epidemic.^{18,49} Reconnecting to nature is seen as a requirement for mental health that also provides the emotional link that will drive us to act (out of love, not just fear). Ecopsychologists emphasise that the anxiety, guilt, grief and anger we feel concerning collapsing ecosystems, our 'pain for the World', are appropriate and, although difficult, provides the starting point for action and a renewed relation to Earth.⁵⁰

Comparison with COVID-19

COVID-19 forces us to recognise that the 'split' between ourselves and nature is not real, and shows that our social systems are all too fragile in the face of environmental danger. On the other hand, ecopsychology tends to downplay that nature does at times try to kill us, and is not only a beneficial force that nurtures. For some, COVID-19 is a natural response of Earth to human degradation, as Gaia retaliates against a human civilisation getting too close to remaining wild spaces. In a sense, it has partially worked. COVID-19 has arguably done more than any climate treaty to reduce carbon emissions,³³ perhaps buying us a little more time. Some hope this is a moment for 'waking up', to take stock and give us a chance to change our futures.

Psychoanalysis: climate denial and apathy as a defence against anxiety

The psychoanalytic model of environmental problems^{5-7,51,52} focuses on the complex way humans deal with anxiety (see also terror management theory⁵³). In contrast to the faulty alarm hypothesis, the anxiety of climate change is seen as not too little, but too much, defended against through individual and socially structured defences.^{9,54} Defence mechanisms are strategies the ego uses to defend against anxiety, conflict and threats to self-esteem. From this perspective, as with the Faulty Alarm hypothesis, we need to be able to feel the anxiety (and other feelings) produced by climate change. However, merely amplifying messages of fear and guilt can backfire, by strengthening and rigidifying defences. Climate anxiety is therefore, in part, a realistic but painful response to our situation, and difficult to hold onto, especially in a social context of generalised denial.

Comparison with COVID-19

The psychoanalytic perspective helps explain certain factors the faulty alarm theory cannot account for, in particular, why responses to climate change include a substantial amount of anger and hostility. Climate scientists have been the recipients of death threats and abuse, and negative reactions in the context of COVID-19 are even more pronounced.

Types of climate anxiety and defence

Melanie Klein⁵⁵ identified two groups of anxieties. Paranoid–schizoid anxiety involves feelings of persecution and fears of annihilation and fragmentation, and is defended against by psychotic defences (denial of reality), projective identification and splitting. Depressive anxieties relate more to loss, guilt and fears of dependency, dealt with by neurotic defences. We can relate these to the findings of affective neuroscience,⁵⁶ which differentiates the FEAR system (involving the amygdala, medial and anterior hypothalamus, and the periaqueductal gray), which generates anxiety in response to external threats; and the PANIC system (centred on the anterior cingulate gyrus, with connections to thalamic, hypothalamic and other nuclei, such as ventral tegmental areas), which generates anxiety in response to the loss of attachment figures.

The psychoanalytic model suggests that the threat of climate change leads to two types of climate anxiety: first, the ‘apocalyptic’ fears (fears of death, annihilation and extinction); and second, complex feelings around loss, grief, dependency and guilt^{52,57} for losses that have already occurred and those that are to come (‘pre-traumatic stress’, ‘anticipatory mourning’, ‘solastalgia’^{58,59}). Responses to climate anxiety include proximal defences (pseudo-rational, threat-focused and more conscious), distal defences (functioning unconsciously and taking a symbolic form) and facing difficult feelings and generating adaptive responses.⁶⁰ Anxiety, guilt and loss become more manageable as they become more shared,⁶¹ and can be reflected upon in a safe space where realistic possibilities for action open up. All major defence mechanisms⁶² are clearly visible in relation to climate change, focused on the two emotional threats: denying the reality of climate change (it does not exist, it is a conspiracy), or denying our losses, dependency or responsibility (nature might die but we will be fine; it is caused by other humans or natural causes, the Chinese or the sun, not me).

There are many shades of variation: not only outright denial, but minimising the threat (it will not be that bad, it will happen in the future, or to other species or countries), by finding scapegoats through projection; intellectualisation (taking courses on climate change without allowing emotional responses or behavioural change); idealising charismatic leaders that support denial, repressing and suppressing awareness; reaction formation (denying the reality or the impulse while simultaneously giving expression to its opposite, e.g. those who ‘burn a tire for Earth day’ or participate in ‘coal-rolling’, becoming environmentally destructive to prove to themselves they either do not believe in climate change or do not care, as an attack against perceived group enemies, and a means of evacuating bad internal states); hopelessness (it is too late anyway); apocalypticism (the end of the world is exciting and allows for fantasies of the ‘bad’ being punished for their behaviours, and we can start again and better⁶³); or manic defence behaviours, such as seeking distraction through increasing addictive behaviours and consumption,^{18,19} to avoid thinking about the problem. A certain amount of climate activism is also of a manic reparation type, which can quickly lead to disillusion and burnout if the movement’s goals are not quickly met. These are just a few of the responses/defences that climate change evokes, with many reactions comparable with the COVID-19 pandemic.

Working with climate anxiety

Adams⁶⁴ asserts that treating climate anxiety needs to address the underlying dangers, and therefore requires meaningful collective responses, including ‘acknowledging loss collectively and publicly’ as ‘an important step in facing up to the reality of the Anthropocene and the impossibility of carrying on “as normal”’. Randall^{57,59} has emphasised the importance of experiencing and articulating difficult emotions, such as loss, grief and fear, in a shared context as a way of developing forms of mutual support. In addition to dealing with anxiety in their clinical practice, therapists can help support the development of social containers to express, contain and mobilise climate anxiety into positive social change.⁴ Ultimately, the results need to be measured in reduced carbon dioxide emissions rather than necessarily reduced expressions of fear.

By allowing feelings and thoughts we usually avoid to be brought into awareness, we can avoid more pathological unconscious acting-out. Bednarek⁶⁵ agrees that climate anxiety should not be seen ‘as a problem to be solved or a condition to be medicated’, but rather ‘an important encounter with our awareness of our impact on the world’. All of us need to wake up to climate anxiety, including mental health professionals. Those who are most informed about the current danger, such as scientists, journalists, students or activists, often express the most intense fears – an anxiety heightened by feeling isolated in a culture in denial.^{66,67} Instead of pathologizing their anxiety, which only worsens mental health, we can ask ‘what support do we collectively need in order not to freeze and anaesthetise ourselves against this context of so much loss?’⁶⁵

The answer lies not only from work in individual psychotherapy, but in developing strong social networks of supportive relationships, and a living relationship with the natural world.⁶⁸ Community is crucial for collective resilience, as we are seeing in the COVID-19 pandemic. Nature itself can function as one of these containing spaces.^{8,46,69} To conclude, the symptoms of climate anxiety are not necessarily feelings to be got rid of, but lessons to be learned, although only if they can be felt in a safe way, through developing meaningful action and positive social, psychological and ecological change.

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Declaration of interest

None.

1.2.63 Children and youth in the climate crisis

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date

2021-08

Abstract

This editorial is co-written by a developmental psychologist and a young climate activist. We start by showing how the climate crisis is imposing a heavy psychological burden on children and youth, both from experiencing climate-related disasters and from the knowledge that worse is to come. We then describe the global movement of youth demanding urgent climate action. We conclude that health professionals can support young people in many ways, but particularly by supporting their capacity to take action, raising awareness about the impact of the climate crisis on youth mental and physical health, and taking action themselves to work for a secure climate future.

Contents

- *Children and youth in the climate crisis*
 - *The climate crisis poses an existential threat*
 - *Impact of climate change on child and youth physical and mental health*
 - *Emotional responses to the climate crisis*
 - *Children and youth taking action*
 - *Action is the antidote to despair*
 - *Concluding comments*
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The climate crisis poses an existential threat

Climate change is well underway and poses a critical threat to the future. Although the Earth is currently only about 1.1°C above preindustrial levels,¹ it is clearly already too hot.

The Global South (also referred to as low- and middle-income countries or the majority world) is currently bearing the brunt of climate change effects, but they are rapidly becoming more common globally; for example, unprecedented wildfires in the Amazon, Australia and California, record-breaking hurricanes in North America and record-breaking heatwaves in the UK and Europe. Glaciers and icecaps are melting faster than predicted, rising sea levels have already forced coastal and island populations to relocate, and droughts and resource shortages have already contributed to conflict and refugee crises.² Global warming is contributing to the Earth's sixth mass extinction, with about 1 million animal and plant species under threat.³ All these serve to heighten young people's awareness of the reality of the climate crisis.

We are fast approaching irreversible tipping points and, without moving speedily to net zero emissions and draw down the excess greenhouse gases already in the atmosphere, we face an existential threat to the global ecosystem and human civilisation.⁴ The well-being and even survival of today's children are at risk. As Aran Cosentino (Italy, aged 18 years) said, 'I am worried about climate change because the future of us young people is in danger. If governments do not act quickly, we will not have a future where we can live in peace with our children'.

Impact of climate change on child and youth physical and mental health

Both the causes and consequences of climate change are inequitably distributed. It has been disproportionately caused by the Global North, also referred to as high-income countries, the minority world or the WEIRD nations (Western, educated, industrialised, rich democracies), comprising 12% of the world's population,⁵ However, it will most severely affect the Global South,⁶ where 85% of children live⁷ but the institutional capacity to respond is weaker.^{8,9} Further, although predominantly caused by the current generation of adults, the worst consequences will occur during the lifetimes of today's children and young people,¹⁰ as reflected by Emma Demarchi (Australia, aged 17 years): 'Young people are facing climate related inter-generational theft and its effects on us are astounding'. Also, climate change will also reinforce societal inequalities based on income, ethnicity, race and class. For example, the United Nations International Children's Emergency Fund (UNICEF)¹¹ vividly illustrates how climate change exacerbates pre-existing socioeconomic inequalities. When confronted with an extreme weather event, like a drought, a child from a wealthier family may experience temporary hardship, but can recover relatively fast – their family can safely relocate and stay together, purchase food even when prices escalate, access clean water even when scarce, access healthcare even when services are overstretched, and maintain the child's education and reduce other social stressors. None of these may apply for a child in poorer circumstances, who may find themselves on an escalating downward pathway through the accumulation of negative repercussions, to result in long-term, and sometimes lifelong, deprivation.

Climate change has both direct and indirect effects on the physical and mental health of children and youth. Because of their immature physiological systems, reliance on adults and likely repeated exposure to climate events over time, children are more vulnerable to the negative effects of climate change than adults.^{12,13} Both sudden extreme weather events and slower, longer-lasting climate effects (e.g. rising sea levels, droughts) are increasing in frequency and ferocity. These, in turn, directly cause deaths and injuries, physical ill health (e.g. through malnutrition, lack of clean water, infectious diseases) and mental health problems, including post-traumatic stress disorder, anxiety and depression, phobias and panic, sleep disorders, cognitive deficits and intellectual disabilities.^{14–16} As one example, after floods in Pakistan, 73% of 10- to 19-year-olds displayed high levels of post-traumatic stress disorder symptoms, with displaced girls affected most seriously.¹⁶ Reactions to climate disasters also include distress, grief, anger, feelings of helplessness and hopelessness, and increased aggression and violence.¹⁷

More broadly, climate change threatens the underlying social, economic and environmental determinants of children's health.¹⁸ By disrupting families and communities, climate change can have an indirect impact on children; for example by increases in rates of domestic violence and child abuse after hurricanes and wildfires.¹⁹ Climate change causes and exacerbates conflict²⁰, being described as a 'threat multiplier' for intra- and interstate conflict.²¹ There are already millions of so-called 'climate refugees', forced to seek new homes, where they are often met with hostility and

resistance.²² The resultant disrupted parenting, education and social connections all have long-term sequelae for children and youth.^{16,23} Particularly for Indigenous youth, breaking their connection with the land can lead to mental health problems, including depression, despair and suicide.²⁴

Emotional responses to the climate crisis

Although adults may wish to protect children from knowledge of the climate crisis, this is neither possible nor right: the United Nations Convention on the Rights of the Child²⁵ confirms their right to know about, and be involved in, issues that will affect their future. Research around the world shows that most children and youth know about the climate crisis and are worried about it. A 2013 survey of British 11- to 16-year-olds found that 74% were worried about its impact on their future.²⁶ A more recent study of Australians aged 7–24 years indicated that 96% considered climate change a serious problem, and 89% were worried about its effects.²⁷ Even more recently, 16 young people summarised the results of a survey of 1477 young Australians (aged 10–24 years) as thus: ‘We are aware of climate change, and we are worried about climate change. We are concerned about the repercussions of climate change globally, regionally and here at home. We are concerned about experiencing climate-related disasters due to a lack of action by those in power, and we are worried about what that means for us, our families, and our friends, in the present, and in the future’.²⁸ A recent survey by the Royal College of Psychiatrists²⁹ found that 57% of child and adolescent psychiatrists reported seeing children and young people distressed about the climate crisis and the state of the environment.

The emotional impact of knowing about the climate crisis is not limited to ‘worry’. Children and youth also experience anger, frustration, depression, sadness, grief, anxiety and a sense of powerlessness about its impact on their lives.^{26,30} Interviews with 10–12-year-olds in the USA found that strong feelings of fear, sadness and anger were expressed by 82% of the children.³¹ In a 2019 survey of over 15 000 Australians aged 14–23 years, one in five reported planning to have no children, or fewer children, because of their concerns about climate change,³² as illustrated by Alice Hardinge (Australia, aged 23 years): ‘My future feels dire, and my decision to have children has been impacted by the fear of food shortages, droughts, fires and floods’.

Burgeoning rates of ecoanxiety (severe and debilitating worry) and ecological grief (grief related to current or anticipated ecological loss) are commonly described.³³ However, despite these emotional reactions being uncomfortable and, in extreme cases, debilitating, it should be recognised that they are based on a rational understanding of the climate science, and hence should not be regarded as unreasonable, illogical or pathological.

Children and youth taking action

For decades, children and youth have been responding to their knowledge of, and fears about, the climate crisis by demanding climate action from older generations and those in power. In the past 2 years, Greta Thunberg has been the face for the millions who have mobilised across the world, but back in 1992, 12-year-old Severn Cullis-Suzuki gave a speech at the United Nations Rio de Janeiro Earth Summit that ‘silenced the world for 5 minutes’. Severn said to world leaders, ‘You grown-ups say you love us. But I challenge you, please, make your actions reflect your words’.³⁴ Almost three decades later, in 2018, Greta Thunberg made a very similar speech to world leaders at the 24th United Nations Framework Convention on Climate Change (COP24) in Katowice, Poland: ‘You say you love your children above all else, and yet you are stealing their future in front of their very eyes’.³⁵ The similarities between the two speeches, almost three decades apart, starkly show how little has changed and how children and young people are right to feel frustrated.

Greta Thunberg began striking from school on 20 August 2018, vowing to stay until the Swedish election 3 weeks later. Initially it was just Greta and her sign ‘Skolstrejk för klimatet’ (‘school strike for the climate’), but from the second day others started joining her. After this first strike, Greta began boycotting class every Friday, announcing the strikes as ‘Fridays For Future’, which quickly gained international attention.

Showing how her actions resonated with children around the world, just a few months after Greta’s first day of striking, school students across the world had coordinated national school strikes involving thousands of children and youth, such as in Australia, where over 150 000 students took action in November 2018. The first global day of action followed on 15 March 2019, with strikes in over 100 countries, and by 20 September, just 13 months from the first climate strike, an estimated 4–6 million people participated in >2500 events in over 163 countries. This is estimated to be the largest climate mobilisation in world history.³⁶

Despite these massive displays of child and youth fear, anger, frustration and determination, their demands have ‘not translated into action’ and emissions have continued to rise whilst ‘the changes required are still nowhere in sight’, as Greta Thunberg said to world leaders at 25th United Nations Framework Convention on Climate Change (COP25) in Madrid, Spain, on 11 December 2019.³⁷ Now, in a time of global unrest, with concurrent crises facing young people, they continue to organise mobilisations with demands centred in an understanding of the fundamental ways in which social and economic issues are interlinked with the climate catastrophe.

Action is the antidote to despair

Conversations with students who have engaged in school strikes or other forms of activism show how their activism has helped them manage their anxiety about the future and channel it into determination, courage and optimism. As Alice Hardinge said, ‘Climate despair is real and dangerous, the best cure is action ... [taking action] creates a sense of solidarity, of cooperation and productivity in the face of despair’. This idea that ‘the best antidote to anxiety and despair is action’ suggests that an important way to build young people’s resilience, self-efficacy and agency is by encouraging and supporting their involvement in activities to both mitigate and adapt to climate change.³⁸

Young people involved in climate activism appear to have learned many valuable positive skills and attributes through their involvement. The Melbourne School Strike organiser and volunteer for the Australian Youth Climate Coalition, Andeli Zuz (Australia, aged 20 years), said: ‘Without the skills I learned in activism I simply would not have been able to do this job, as simple as that. It has taught me far more about community organising and event management than school ever could’. Another Melbourne school strike organizer, Emma Demarchi said: ‘Taking action on climate change can be incredibly rewarding and fulfilling and has certainly built many of my skills up’.

It is interesting to note that these skills and capacities which young people report developing through taking action on the climate crisis match well with those describing positive youth and young adult development,^{39,40} including self-regulation of behaviour and emotions, ‘bigger-than-self’ values such as social justice, conflict resolution skills, teamwork skills and social and civic engagement skills. As Alice Hardinge said: ‘I’ve learnt how to ... talk to authority figures, recognise my rights, speak confidently in public ... not let keyboard warriors impact my self-worth ... communicate non-violently and how to work effectively in a non-hierarchical and consensus based collective’. These skills will stand them in good stead throughout their lives.

Yet, although taking climate action is highly rewarding and beneficial for young people, the burden and scale of the climate crisis is often overwhelming. For example, Emma Demarchi said: ‘Climate action can also very often feel just as lonely and full of despair and anxiety. Young people often feel like they are fighting a battle they need to win but know they might never and the impacts on mental health can be great’. Andeli Zuz commented: ‘Sometimes it [climate action/advocacy] makes me feel empowered, like I have some control, other times deflated as I feel like no matter what I do it won’t work’.

Young people who feel immense pressure and responsibility to do all they can to protect the future are thus at risk of burnout and mental strain. To sustain their mental health, engagement and empowerment, strong communities and support networks that are honest and hold space for their feelings are vital. Mental health professionals have an important role in validating such feelings, helping young people manage them and supporting their activism. It is encouraging to see some resources to support such work now being developed. For example, the Royal College of Psychiatrists has recently produced a resource to help young people cope with ecodistress.⁴¹ However, equally critical is to demonstrate to young people that they are not being asked to take the whole burden themselves; this entails mental health professionals themselves taking action, and using their influence and expertise to work for speedy and effective policy change to help secure a habitable planet and a safe future for the next generation.

There are other important roles for mental health professionals. For example, in response to the confusion that many parents express about how to talk to, and support, their children in the context of the climate crisis, parent-focused resources were developed by the Australian Psychological Society,^{42,43} and can be used in community workshops. Not all children and young people, nor all mental health professionals, are aware of the implications of the climate crisis for the next generation, creating an ongoing need for education in work places, practice and through written material. It also needs to be acknowledged that facing up to the reality of the climate crisis is challenging for mental health professionals themselves. In Australia, Psychology for a Safe Climate (<https://www.psychologyforasafeclimate.org>) has developed resources and methodologies for supporting activists, including health professionals, to manage their

climate grief. In advocating for policy change, strong position statements from our professional organisations can be a valuable tool.

Concluding comments

The climate crisis is already placing significant psychological burdens on children and young people, from both direct experience and simply knowing the dangers it poses for their future. Yet until recently, children's voices have been neglected in discussions of the climate crisis. But the courage and determination of Greta Thunberg acted as a catalyst for children in their millions to raise their voices and demand to be taken seriously, and to demand action.

Mental health professionals can help to protect the next generation and prepare them for the future. Clinicians need to be aware of how the climate crisis can cause emotional distress, and recognise and respond to the psychological consequences of exposure to the effects of climate change, especially in the Global South, where psychological help is scant.⁸ Supporting young people in speaking out and taking action, whether to protect their communities from the effects of climate change or to demand action by politicians and others, may be the most beneficial approach that mental health professionals can take. Such action builds beliefs in self-efficacy and collective efficacy, practical active citizenship skills, courage and hope,^{9,13} which is reinforced when young people can see that mental health professionals are also taking action. This editorial seeks to help give voice to youth and provide an example of intergenerational partnership.

However, without speedy action at a global scale to prevent catastrophic climate change, it will not be possible to protect young people's psychological well-being, or even their survival. Today's adults may be the last generation that can ensure a liveable world for future generations. They need to act as citizens to demand effective and speedy climate action, and not rely on young people to carry this burden alone. For mental health professionals who have responsibility for protecting human health and well-being, there is a particular moral imperative to use their status and expertise, individually and collectively, to speak out on behalf of the children and youth of today and tomorrow.

Ethics and consent

No ethical approval was required for this editorial. Young people provided quotes voluntarily and explicitly agreed to them being used. This paper includes quotes volunteered by young people aged 17–24 years, who were known to the second author through their joint engagement in the school strike movement. They were invited to provide responses to a series of questions for the purposes of this editorial, and gave their written consent to them being used herein.

Ann Sanson (PhD) is an Honorary Professorial Fellow at the Department of Paediatrics, University of Melbourne, Australia. **Marco Bellemo** is an organiser with School Strike For Climate in Australia.

Data availability

The quotes used in this editorial were provided specifically for this purpose. Access to them would require further consent from the participants. The corresponding author (A.S.) can be contacted for further information.

Both authors made substantial contributions to this editorial, jointly planning and co-writing it.

Declaration of interest

None.

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1.2.64 Crisis care: tackling the climate and ecological emergency

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Abstract

The climate crisis is a health crisis; it demands the urgent attention and action of healthcare professionals and organisations. In this issue of the *BJPsych Bulletin*, we consider what the destructive effects of the climate and ecological crisis entail for the mental health of populations, and what the response of psychiatrists, both individual and collective, must be. We also highlight the opportunities and benefits a more sustainable and preventative approach could offer individuals, communities and the planet.

Contents

- *Crisis care: tackling the climate and ecological emergency*
 - *The climate crisis is a health crisis*
 - *Healthy solutions*
 - *The role of doctors*
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pmc “‘We are perilously close to the collapse of civilization, we are all in danger, and only a mobilization of our entire economy and society can protect us’ – Margaret Klein Salamon, activist, psychologist and author.¹ ‘Undoubtedly climate change poses the most profound long-term threat to the health of the nation’ – Simon Stevens, Chief Executive, National Health Service in England.²”

Without question, human activity throughout the past century and more has led to the destruction of ecosystems on which we depend, and contributed to unprecedented levels of greenhouse gases in our environment. The results of these activities are a disrupted ecology: extreme weather, severe storms, floods, droughts and heatwaves at a frequency and intensity never before seen during the span of human existence. Changing patterns of land use, rising sea levels, destruction of habitats, biodiversity loss, deforestation, soil degradation, plastic waste and air pollution combine with climate change to create food shortages, forced migration, social upheaval and conflict, and increased vulnerability to infectious disease.³ The World Health Organization estimates that in the next 20 years, climate change alone will lead globally to 250 000 additional deaths per year.³

In this issue of the *BJPsych Bulletin*, we consider what the destructive effects of the climate and ecological crisis entail for the mental health of populations, and what the response of psychiatrists, both individual and collective, must be. We also highlight the opportunities and benefits that a more sustainable and preventative approach could offer individuals, communities and the planet.

The climate crisis is a health crisis

The climate crisis is a health crisis; it demands the urgent attention and action of healthcare professionals and organisations. We at the *BJPsych Bulletin* share this view with the authors of the *Lancet* Countdown on Health and Climate Change,⁴ editors of the *BMJ*^{5,6} and members of the UK Health Alliance on Climate Change (including the Royal Colleges of Nursing, Physicians, General Practitioners, Emergency Medicine and Surgeons; Faculty of Public Health; Royal Society of Medicine and Royal College of Psychiatrists (RCPsych)).⁷

While the RCPsych first appointed an Associate Registrar for Sustainability in 2015, supported by an active committee, it has recently prioritised its focus in this area. In a new position statement, the College declared a climate and ecological emergency that is impacting on the mental health of populations, including the amplification of existing inequalities.⁸ The position statement⁸ describes the intimate connections between health and the natural world; our species is one part of a complex inter-dependent ecosystem. Depression, anxiety and post-traumatic stress disorder are associated with floods.⁹ Suicide is linked to drought and hotter temperatures.¹⁰ People with severe mental illnesses are three times more likely to die in a heatwave.¹¹ Psychiatric medications such as antidepressants and antipsychotics affect heat-regulating functions.¹² Dehydration and sweating can contribute to lithium toxicity, which places those taking these treatments at increased risk during heatwaves.¹² Food insecurity affects childhood development.¹³ Air pollution is associated with anxiety and depression,¹⁴ and neurodevelopmental effects in children,¹⁵ and accounts for 6% of the modifiable risk for dementia.¹⁶ Climate change and ecological breakdown leads to poverty, precarity and social unrest, with associated psychological trauma.^{17,18} Extreme weather events are likely to make it increasingly difficult for us to deliver healthcare to communities. The secondary effects of the crisis include climate grief and anxiety, which are particularly noticeable in children and young people.¹⁹ Their anger, too, is understandable, as they face a future where leaders have delayed action and misinformation continues to permeate mainstream media. A burgeoning field of climate psychology aims to help us understand how we reached this state, face the losses that are already certain and deal with 'present traumas'.²⁰ In the face of such threats, denial of the crisis is a luxury we can no longer afford.

In this special issue, we will learn of the direct effects of extreme weather events and habitat loss, and the resulting social disintegration, on mental health, and the indirect effects of the climate emergency and the sense of insurmountable challenge on our mental well-being. Concepts such as eco-distress, climate grief and solastalgia²¹ (mourning for the degradation of one's home) are explored. We also consider the way forward, and the potential immediate and longer-term health and economic gains in urgent, collective action.

The climate and ecological crisis can trigger a complicated set of psychological reactions, including grief, guilt, fear, anxiety and a fluctuating awareness of our own destructiveness, resulting in varying forms of denial and disavowal.²² These responses have been extensively documented by activists and experts in the field of climate psychology. They can, in part, explain why so little action has been taken at the necessary scale and pace, despite repeated promises.^{20,23} Weintrobe describes how the neoliberal mindset of 'uncare' and narcissistic entitlement perpetuates ways of living that damage ourselves, our relationships to others and to the planet.²⁴ She argues that the more we are able to face the violence beneath our convenient lives, the better we can turn to a more moral path, but courage and kinship is required for facing these realities.²⁴

The consequences of ecological destruction fall first and worst on the most marginalised people, including those who are poor, those with severe mental illness, older people and children. Climate and environmental justice is linked to racial justice globally, as the most significant effects of the crisis are already being felt by indigenous peoples and by those in the Global South, who are disadvantaged by colonialism and exploitation. These populations are also least likely to have contributed to the root causes of the climate crisis.

Healthy solutions

Public health experts have clearly described what must be done to limit the damage. The United Nations Intergovernmental Panel on Climate Change has advised that greenhouse gas emissions need to drop drastically by 2030 to give us any chance of avoiding the most catastrophic effects of global warming.²⁵ The *Lancet* Countdown describes the pathway we are on, leading at its current trajectory to a possible 3°C warming, and the second pathway, which aims to keep warming ‘well below’ 2°C above pre-industrial levels.⁴ The reality of those targets is already being felt in all parts of the world. Facing the catastrophe of the climate emergency means putting in place a number of correctives to the way we live today.

At this point, individual action to manage emissions will not produce the rapid decarbonisation and restoration of our habitat that is needed to prevent further loss of life and livelihood. Although many of us will find solace in personal deeds, which are important, an overemphasis on individual behaviour distracts from the collective action that is necessary to face the challenge. We need governments to go beyond goal-setting and begin to deliver on ambitious targets, to take brave and bold steps. But they are unlikely to move far and fast enough without firm instruction, including from healthcare professionals and leaders.

Action to address the causes of the climate crisis improves the well-being of populations, prevents disease, reduces inequalities and is good for the economy.²⁶ By reducing use and switching to clean forms of renewable energy, and building active travel infrastructure and sustainable food networks, we create a low-carbon society with enormous health benefits.²⁷ Modelling of the potential effect of active travel in England and Wales suggests that increasing walking and cycling could reduce ischaemic heart disease, lung disease, dementia and cancer.²⁸ Preserving and increasing biodiverse, unpolluted green and blue spaces carries significant benefits for patients, families, staff and communities.

Embracing our connectedness to the natural world is not only about prevention, but also the potential for healing. Nature-based interventions show a wide range of benefits, including improved well-being and sense of coherence, and reduction of distress and anger in both clinical and non-clinical populations.²⁹ The RCPsych statement⁸ highlights the importance of services where staff and patients work together in ‘Choosing Wisley’,³⁰ which could reduce waste and replication, and improve sustainability and quality.

The role of doctors

As engaged and informed doctors have long argued, healthcare professionals need to be aware of, and able to articulate and engage in the politics of the climate and ecological crisis. We are trusted professionals, and as such have an opportunity and, furthermore, a duty to act as leaders in our own organisations and communities. We must be able to communicate the urgency of the problem and the immense benefits of action in preventing unnecessary mortality and morbidity. The National Health Service (NHS) is the single largest source of greenhouse gas emissions in the UK public sector, and 60% of the carbon footprint of the NHS relates to medication and medical equipment.²⁶ The Greener NHS report, which sets accelerated targets for a net zero NHS, makes reducing emissions a key responsibility of all NHS staff.²⁶ Drivers include professional and patient transport, energy use and consumption, use of natural resources, shifting to preventative practices and reducing unnecessary prescribing.²⁶

Increasingly, psychiatrists are raising awareness through direct and coordinated action. Whether through activist groups, such as Doctors for Extinction Rebellion and Psych Declares; through the RCPsych Sustainability Committee; internationally, through the Climate Psychiatry Alliance; or locally, through NHS Trust Green Plans, there are ways for everyone to get involved. Health professionals play an important role in drawing attention to the physical, mental, social and psychological effects of the crisis, and the opportunities offered by its solutions. Our ability to influence government decision-making and public perceptions through awareness is likely to be at least as important as action on reducing our own emissions.

The RCPsych’s response to the climate and ecological crisis has been robust and multifaceted. An important step was the February 2020 announcement of divestment from fossil fuels and signing up to the Principles of Responsible Investment supported by the United Nations.³¹ In 2020, a guide and podcast on eco-distress was produced for parents, carers and young people.¹⁹ A key aspect of these resources is the validation that climate anxiety is not in itself pathological, but an appropriate reaction to the peril we face.

Educating future generations of psychiatrists has been an important focus of the RCPsych's work, and 2020 saw the inclusion of sustainability as a core area of the new curriculum and the launch of a Continuing Professional Development module on sustainable healthcare.³²

It is, perhaps, younger psychiatrists who best understand the implications of today's climate and ecological crisis. In giving voice to future leaders, the *BJPsych Bulletin* celebrates the winner of the 2020 Praxis Editorial Award, Dr Daniel Romeu, whose entry eloquently argued the importance of action from psychiatrists. The competition received entries from medical students, foundation doctors, trainees, Specialty and Associate Specialist Doctors (SAS) responding to the question 'Is the climate a mental health crisis?' They responded with an emphatic 'yes'. We were impressed with their creativity, passion and hope for improving individual and planetary health and addressing inequalities. Congratulations also to the highly commended authors Dr Karyn Ayre, Mr James Street, Dr Fergus Brown and Dr Kris Roberts. We are grateful to our panel of judges: Anouchka Grose, Professor Alex Ford and Dr Katherine Kennet.

Conclusions

Psychiatrists are in a position to use their collective voice, medical expertise and understanding of both individual and systemic factors, to advocate for redressing inequalities and lead organisational change. The climate crisis amplifies existing health disparities, and disproportionately affects those already vulnerable owing to poverty or underlying conditions.

This special issue of the *BJPsych Bulletin* contributes to the compelling argument that the climate crisis is a mental health crisis, and that working to redress this should become core business for psychiatrists. Not only must this climate crisis issue induce alarm, but it should also generate hope, resolve and action.

Sally Weintrobe reflected in a recent paper, 'People, young and old, are at the point of beginning to find the collective courage to face the shock required to emerge from our retreat from reality'.²⁴ We trust these papers motivate and inspire you not only to face the reality of this emergency, but to engage creatively with action that improves the health of the populations you serve, and the environment in which you live and work.

We thank the editorial committee who commissioned and handled papers in this special issue: Dr Norman Poole, Dr Cate Bailey, Dr Anouchka Grose, Dr Neil Armstrong, Dr Harriet Stewart and Dr Nitin Gupta.

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C.B. devised and wrote first drafts of this article to frame a special issue of the *BJPsych Bulletin* on the Climate Crisis. N.P. and A.J. commented on these drafts and enhanced content on the potential benefits of sustainable practices for the health of communities and the action taken by the RCPsych.

Declaration of interest

C.B. is Trainees' Section Editor of the *BJPsych Bulletin*, and N.A.P. is Editor-in-Chief of the *BJPsych Bulletin*.

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1.2.65 What mental health professionals and organisations should do to address climate change

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2021-08

Abstract

Aims and method

The climate change emergency is also a mental healthcare emergency. We seek to provide a framework for what mental health professionals and organisations should do to make their practice more sustainable.

Results

There are ethical, legal and organisational imperatives to make mental healthcare more sustainable. Mental healthcare must be refocused with an emphasis on prevention, building social capital and community resilience. Patients must be empowered to manage their own mental health. Efficiencies should be found within the system. Low-carbon ways to deliver care must be found, measured and improved upon. Greater adaptability needs to be built into the system to mitigate the impact of climate change. Sustainability should be integrated into training programmes, and good examples of practice shared and celebrated.

Clinical implications

Mental health organisations and individuals must act now to prevent and adapt for the climate and ecological emergency. Sustainable practice is also good practice.

Contents

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Climate change will increase and alter the burden of poor mental health worldwide. Direct effects, such as floods and droughts, have been shown to worsen a variety of mental health disorders. Indirect effects, such as displacement of populations, are likely to compound this trend.¹ There are ethical, legal and organisational imperatives to make mental healthcare more sustainable. The climate emergency is also a health emergency, and clinicians have a duty to act as individuals and as part of organisations.² Sustainability is written into the constitution of the National Health Service (NHS),³ and the Climate Change Act of 2008 legislated for a reduction in NHS carbon emissions of 80% over 30 years.⁴ More recently, the NHS has made the formal commitment to become carbon neutral by 2040.⁵

Mental health services are estimated to emit 1.47 million tonnes of carbon dioxide annually.⁶ We must act now to reshape services, both to meet the ambitious targets set by the NHS, and to avoid runaway consequences.

The COVID-19 pandemic has required us to think differently about how we deliver mental healthcare, and provides an opportunity to enact changes now consistent with sustainable future.⁷

What should people and organisations do?

The Consensus Statement on Sustainability in Mental Health establishes four tenets of practicing mental healthcare sustainably (*Box 1*).⁸ These focus on reducing greenhouse gas emissions and enabling organisational, social and cultural factors that will help patients achieve better mental health in the future. A health service that targets its resources and empowers patients to take ownership of their health will become more efficient, resilient and less carbon-intensive. **Box 1** Tenets of sustainable mental healthcare. Prevent mental illness, build social capital and promote individual, social and community reliance and mental well-being. Empower patients, staff and carers to manage their mental health. Eliminate wasteful activity. Make use of low-carbon alternatives.

Focus on prevention, build social capital

Prevention protects resources, and hence saves carbon. Preventative healthcare is more cost-effective than a reactive approach. This is true in mental healthcare, where preventative programmes have shown to be effective in a wide range of common mental health problems such as depression, anxiety and first-episode psychosis.⁹ Prevention of conduct disorders could save £150 000 per case in lifetime costs.¹⁰ Early intervention programmes can delay or prevent transition to psychosis among participants,¹¹ and have significant cost-savings.¹² Some preventative measures are outside the purview of psychiatric services. Adverse childhood experiences increase the risk of depression by four times, and suicide attempts by 30 times,¹³ yet mental health services are not involved at the advent of these life events. Greater joint working between public service bodies would achieve better long-term mental health outcomes.

Addressing the social determinants of poor mental health can also achieve better outcomes. The Marmot Review established that ‘the lower one’s social and economic status, the poorer one’s health is likely to be’.¹⁴ Organisations should make targeted use of resources in areas such as housing, social isolation and employment, to work to improve social capital.

Housing

Homelessness and long-term mental illness are linked.¹⁵ Models such as Housing First have been shown to help individuals engage better with treatment programmes, doing this at around half the cost of traditional models.¹⁶ The Critical Time Intervention programme can also be effective in preventing homelessness on discharge from in-patient care.¹⁷

Isolation

People with mental ill-health are more likely to suffer adverse consequences of social isolation.¹⁸ Recent lockdown conditions have shown the impact of social isolation on previously well-managed mental health conditions.¹⁹ Befriending services can be effective in improving depression,²⁰ and is highly valued by patients. Social prescribing can also help address isolation, loneliness and inactivity.

Employment

Unemployment is associated with poor mental health,²¹ whereas being in employment or volunteering promotes better mental health.^{22,23} Individual Placement Support services have demonstrated successes, when used, by integrating employment specialists into community teams to support those with severe mental health problems into work.

Addressing social determinants of mental health will enable populations to become more resilient to the effects of climate change. Groups with less social capital are both more likely to experience poor mental health,¹⁴ and more vulnerable to the effects of climate change.²⁴ Conversely, a better housed, stably employed, socially connected population will require less mental healthcare as circumstances change.

Empower patients to manage their own mental health

A variety of opportunities exist to enable patients to take a leading role in the management of and recovery from their conditions (*Box 2*). *Box 2* Sustainability within a management plan. Dr Alvarez, has been reviewing John, a 57-year-old man with depression, who drinks alcohol regularly. John has been calling the ambulance service and police when intoxicated, resulting in frequent visits to his flat. Emergency services suspect that he is doing this in part because he is lonely and isolated. John has said he ‘doesn’t do much’ in the day, and his care coordinator confirms he goes to the shop twice a week but nothing else. Dr Alvarez asks what John has enjoyed before – he says he remembers helping his father in the garden but ‘of course, I don’t have a garden now’. John discussed him at the team meeting and hears from the occupational therapist about ‘Men in Sheds’, a local gardening group coordinated by peer-support workers. Dr Alvarez contacts John’s general practitioner to establish contact with a link worker from the local social prescribing initiative, who meets with John to enable him to attend. After 4 weeks of attending together, John feels ready to go himself and says it is the highlight of his week. Dr Alvarez asks John to monitor his symptoms via an online symptom tracker, and is able to demonstrate to John that he his mood has improved, and alcohol consumption reduced. He is no longer calling emergency services. Dr Alvarez and John discuss a keeping well plan, getting John to identify what has got him better. They agree to meet again in 3 months via video conferencing to review his progress.

Co-production

If done correctly, individual, jointly developed care planning forms an opportunity identify what works for patients correctly first time, and hence reduce wasted effort. This needs to be done in a non-tokenistic way that does not marginalise patients.²⁵ Co-production must also form an integral part of any service redevelopment.²⁶

Self-monitoring

Technology can empower patients to manage their own symptoms. Tracking their symptoms online or via smartphones has been shown to benefit a variety of disorders, including anxiety, stress, alcohol and sleep disorders, depression, suicidal behaviours and post-traumatic stress disorder.²⁷ Use of symptom monitoring is well developed in Improving Access to Psychological Therapies, and could be expanded to other services.

Peer support

Peer support provides excellent opportunities for patients to take ownership of their mental health. They can reduce in-patient admissions across a variety of diagnoses,²⁸ and can also link patients to a social support network.²⁹

Social prescribing

Social prescribing is a key component of personalised care,³⁰ and provides for an opportunity to tie together many aspects of sustainable healthcare practice. It has potential to lower the carbon footprint of healthcare by empowering people to pursue their own non-pharmacological solutions to their social, practical and emotional problems.

Green and blue space

Access to green and blue space can promote mental health and improve symptoms in a variety of mental and physical disorders.³¹ Green space and horticultural therapy projects should be part of any hospital build or redesign, and Trusts should identify areas where they could form part of their existing portfolios. Green walking groups³² and activities centred on blue space both have benefits.³³ Importantly, those with poor mental or physical health are least likely to have access to green and blue space,³⁴ and efforts will be needed to engage these groups.

Eliminate wasteful activity

Wasteful activity is a significant contributor to both the carbon footprint and financial cost of the NHS. A leaner, smarter service will deliver higher-value, more sustainable healthcare.

Medicine optimisation

Although the carbon impact of psychiatric prescription is currently poorly understood, some quick wins exist. Using long-acting injectable medications at the longest evidenced-based interval rarely occurs, but could reduce the cost of prescribing by £250 per patient per year, or a total of 170 000 kg carbon dioxide equivalent.³⁵ Psychiatry also has considerable influence over prescribing in primary care, and should routinely work with general practitioners to reduce pharmaceutical waste, polypharmacy and overprescribing. There should be greater use of structured medication reviews to work with patients to optimise their medications.³⁶ These form further opportunities for shared decision-making over treatment.

Concordance and treatment effectiveness

Half of all medicines dispensed are not taken as directed.³⁷ In mental healthcare, the figure is likely to be even higher. Better understanding the reasons for non-adherence, such as side-effects, personal beliefs or other barriers, may go some way to reducing waste. There may also be opportunities for patients to pursue treatment strategies that de-emphasise the role of medication, if circumstances permit. The open dialogue approach has been successful both in treating symptoms of psychosis and returning patients to work, largely in the absence of medication;³⁸ its efficacy in the UK is currently being evaluated. In some situations, it may be possible to continue to support people with severe mental illness who choose to not take medications at all; so called 'managed non-adherence'.

Reducing 'did not attend' rates

'Did not attend' rates in mental healthcare are estimated to be between 15 and 20% higher than other specialties.³⁹ Patients who miss appointments tend to be more unwell, and have a higher chance of relapse and hospital admission.⁴⁰ A reduction in missed appointments can be obtained by gaining a better understanding of their cause, and adapting to this in ways relevant to patients.⁴¹

Make use of low-carbon alternatives

Mental healthcare emissions are more evenly spread across a variety of these direct and indirect sources than in other specialities (*Fig. 1*).⁵ The lack of a quick fix reinforces the need for collective action by individuals across mental health organisational divisions. *Fig. 1* Mental healthcare carbon emissions compared with other healthcare sectors. Relative carbon emissions of healthcare sectors (kgCO₂e).

Low-carbon treatment choices

Clinicians need to be aware of the carbon impact of their treatment choices, and offer low-carbon treatment choices when possible. There is a need for a better understanding, and the NHS should work with pharmaceutical companies to make this readily available for clinicians. Meanwhile, evidence-based alternatives, such as electronic cognitive-behavioural therapy and other web-based psychology programmes, are available for disorders such as depression,⁴² anxiety⁴³ and insomnia.⁴⁴ These have as little as a fifth of the carbon emissions of face-to-face cognitive-behavioural therapy (230 kg v. 1100 kg), and a quarter of the carbon emissions of a course of antidepressant treatment with psychiatrist follow-up (900 kg).⁴⁵

Active transport and reduction in vehicle emissions

Staff and patient travel forms a significant component of mental healthcare carbon emissions. Clean and zero emissions fleet vehicles, cycling and other types of active travel are all part of the solution; mental health organisations must take steps to procure and promote these. The 2019 Royal College of Psychiatrists sustainability prize winners from Southern Health NHS Foundation Trust ran a project to reduce their transport emissions, using online meetings, cycling or walking, and car sharing, saving 22 216 kg carbon dioxide equivalent over a year.⁴⁶

Energy use

Mental health organisations should invest in smart energy systems, and to procure their energy from the greenest possible sources. By installing a piece of software that remotely shut down computers not in use overnight, NHS Oldham was expected to save over 800 000 kg carbon dioxide equivalent and £41 000 in the first year.⁴⁷ Clinicians can identify energy-saving schemes in their workplaces. The Centre for Sustainable Healthcare run the Green Ward competition, offering guidance and support for sustainable schemes, including energy use.

Waste and recycling

Although a relatively small component of the overall carbon impact of the NHS, interventions involving waste often are the most definable and easily engaged-with green programmes. The Royal Surrey Hospital's recycling programme grew from a group of nurses carrying home recyclable waste into a dedicated recycling centre for the Trust, and 60 'sustainability champions'.⁴⁸

Food and catering

Mental health organisations must work to offer their in-patients and staff members sustainable and healthy food options. North Bristol NHS Trust successfully worked with their wholesalers to source all of their ingredients within a 50-mile radius.⁴⁷ Clinical staff can do much via feedback to on-site catering options to include more sustainable options, or taking steps to change their own diet at work.

Plan, measure and improve

Transitioning toward sustainable models of care requires unprecedented coordination between and within mental health organisations and their local partners. Success depends on a structured, coordinated strategy and ways of measuring and improving changes.

Green Plans

All mental health Trusts are required to have a board-approved Green Plan, but their importance to organisations currently varies. Sustainability should be an integral part of mental health organisations' strategic approach and should have executive-level buy-in. An effective Green Plan will be led by a Board member and have wide representation. The Sustainable Development Unit and NHS England have published guidance on how to develop a Green Plan.⁴⁹

Carbon footprint

The Sustainable Development Unit has tools for NHS Trusts to measure and reduce their carbon footprint in procurement, and have forthcoming plans for other divisions. An 'ethical procurement' tool is also available. The Royal College of General Practitioners has produced a 'Green Impact for Health Toolkit', enabling general practices to audit their practice – a similar toolkit should exist for mental healthcare organisations.

Quality improvement

Quality improvement is an effective framework to achieve sustainability aims. One advantage of the quality improvement model is that it seeks to understand local systems first, making it more effective at solving local problems. It is also a 'bottom-up' approach, fostering a sense of ownership and ambition among staff. The Centre for Sustainable Healthcare have adapted the quality improvement model for sustainability, which can be used in mental healthcare settings (*Fig. 2*). *Fig. 2* Applying sustainable clinical practice principles in quality improvement. Published from the Centre for Sustainable Healthcare under creative commons licence CC BY-SA 4.0.

Adapt the system

Climate change will bring about longer-term shifts in patterns of need, mediated through changing populations, economic hardship, increased social division¹ and poorer physical health.⁵⁰ In the UK, climate change is leading to more flooding and heatwave events, which have adverse impacts on mental health.⁵¹⁻⁵³ In the global South and elsewhere, additional hazards such as wildfires, droughts, hurricanes and cyclones, are recognised drivers of poor mental health,⁵⁴ particularly for those with pre-existing difficulties.⁵⁵

Clinicians must prepare for this change and increase in mental disorder. There will need to be flexibility built into the system, as the full effects of climate change on the population are unknown.

Equipping psychiatrists to become sustainable practitioners, now and in the future

Organisations must play the central role in directing a shift in the organisation and delivery of clinical services. However, the normalisation of such practice through education, knowledge sharing via networks, and empowerment, is essential to allowing clinicians to play their part.

Training

There is broad interest among psychiatry trainees and medical students in becoming sustainable practitioners, but many do not see it as a core feature of their role as trainee doctors. Sustainability should be integrated into training and established as a central responsibility of a psychiatrist. Medical schools such as Lancaster Medical School are already embedding sustainability into their curriculum,⁵⁶ and sustainable practice should be made part of e-portfolio and annual review of competency progression commitments. There are also broader arguments to place sustainability at the heart of the General Medical Council's duty of a doctor Gold Guide.

Sharing good practice

Attendees at conferences and meetings should routinely expect to see a focus on sustainable healthcare, as has been the case at several regional conferences to date. Video conferencing opens up more opportunities to do this in a sustainable way. Networks such as PsySustnet provide an additional resource to exchange learning. Awards such as the Royal College of Psychiatrists' annual sustainability prize have successfully celebrated outstanding achievement in sustainable mental healthcare.

Empowering employees

Mental health organisations should enable their employees to engage with sustainable activities, and bring their knowledge and energy to their workplaces. The psychiatry higher training programme has integrated ‘special interest’ time, where trainees can pursue projects to the benefit of patients, Trusts and trainees alike. This could be widened to other mental health practitioners to allow all to engage in sustainability projects. A central part of empowerment should also support the growing understanding of supporting the well-being of clinicians.

Summary

Mental health organisations must act now to prevent and adapt for the climate and ecological emergency. Clinicians’ involvement is vital for developing effective and safe sustainable models of care. There is much work to be done, and there are significant changes to be made to the system to adapt to these needs. The good news is that much can be achieved through prevention of illness, choosing low-carbon treatment strategies, controlling waste and empowering patients to be more in control of their care and treatment. The best news is that sustainable practice is also good practice.

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Declaration of interest

None.

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1.2.66 Soaring seas, forest fires and deadly drought: climate change conspiracies and mental health

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Abstract

There is scientific consensus that anthropogenic climate change is real and that it provides an existential threat to humanity and the planet. In this article, we focus on climate change conspiracy theories and the impact of such beliefs on mental health. We discuss the psychiatric disorders that

might be relevant to conspiracy belief endorsement and we present the underlying psychological mechanisms. We note that there is little to no literature to associate beliefs about climate change with serious mental health conditions. However, we anticipate that such beliefs may manifest pathologically in psychiatric presentations as climate change becomes increasingly at the forefront of the global agenda.

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pmc There is a consensus among climate scientists that anthropogenic climate change is real, harmful to the environment and a threat to our futures.¹ Despite this, climate change denial and scepticism are prominent in social and political discourse, with support from influential public figures.² Conspiracy theories are bedfellows of climate denialism and scepticism and have been defined as ‘attempts to explain the ultimate causes of significant social and political events and circumstances with claims of secret plots by two or more powerful actors’.³ Climate change conspiracy theories are popular, with endorsement between 20%⁴ and 40%⁵ in the USA. In other Western countries, denial is less prevalent, though still present.⁶

Douglas & Sutton² noted climate change conspiracy theories to follow four main themes: scientists are faking climate change (a) for political reasons or (b) to secure research funding, or climate change is a hoax to (c) enable the ‘green agenda’ and (d) promote nuclear power. Notably, each theme implicates ‘scientists’ in perverse and deceptive actions. It would appear that this is required to undermine the consensus position among experts.

Why do people believe climate change conspiracy theories?

Douglas et al⁷ suggested that epistemic, existential and social motivations underpin conspiracy beliefs. Epistemic motivations relate to the extent to which individuals or groups hold knowledge of phenomena that affect their lives. Conspiracy beliefs are strengthened when events are significant and/or wide-reaching⁸ and mainstream explanations are simplistic or lacking emotional charge.⁹ Conspiracy beliefs can provide a sense of understanding in the face of contradiction and uncertainty, and may offer closure when mainstream narratives do not provide satisfactory explanations.¹⁰ Existential motivations relate to the experience of anxiety, threat or a perception of powerlessness in the face of danger. In such instances, conspiracy theories may provide safety.^{11,12} Finally, social motivations concern issues of power and hierarchy, with conspiracy theories more likely to emerge in those who have experienced oppression, victimisation or persecution.¹³ In such circumstances, groups can become insular and develop an ‘us versus them’ narrative.¹⁴ Safety is achieved through a narcissistic defence, whereby power is transferred from perceived ‘elites’ to the conspiracy belief holders.¹⁵ Of note, such groups are predominantly single and isolated ethnic-minority males with lower socioeconomic

status and educational achievement.¹⁶

Holding one conspiracy belief increases the likelihood of believing another¹⁷ and individuals predisposed to general conspiracy thinking are more likely to deny climate change.¹⁸ An underlying tendency to prioritise counter-narrative explanations and to distrust institutions may be apparent. The notion of political socialisation is important (e.g.¹³); climate change denial is part of the conservative rhetoric and conspiracy talk that is common among world leaders such as Trump¹⁹ and Bolsonaro.²⁰ Political polarisation of climate attitudes has been well-evidenced in the USA²¹ and Europe,⁶ among other regions. Climate change conspiracy theories might suggest allegiance to a particular conservative world view and be phenomenologically different from more emotionally charged beliefs such as the QAnon and COVID-19 conspiracy theories.

Conspiracy theories, overvalued beliefs and delusions: challenges with definitions

Psychiatrists work with symptoms and diagnoses that are based on criteria set out by manuals such as DSM-5 and ICD-10. When criteria are met, a diagnosis can be made and a treatment plan devised. When thinking about conspiracy theories, the psychiatric terms ‘overvalued ideas’ and ‘delusions’ are challenged. Psychiatry defines ‘overvalued ideas’ as an erroneous response to an idea – ‘an acceptable, comprehensible idea pursued by the patient beyond the bounds of reason. It is usually associated with abnormal personality’.²² The overvalued idea may be based on true evidence. The term was coined by Wernicke in 1906 and has further been explored by Jaspers and Fish, who made various suggestions of how to distinguish overvalued ideas from delusions.²³ A delusion is defined as a ‘false, unshakeable idea or belief that is out of keeping with the patient’s background; it is held with extraordinary conviction and subjective certainty’.²² Consequently, there can be a diagnostic dilemma as to which category climate change conspiracies – or any conspiracy theory beliefs – best align.

The evidence supporting climate change conspiracy theories

Conspiracy theory beliefs are widespread (e.g.^{24,25,26}). The internet is rife with ‘fake news’ and ‘misinformation’. Social media platforms, blogs and a whole range of other websites are dedicated to the mass propagation of ‘evidence-base-less’ theories that directly refute scientific findings.^{27,28} Bye Bye Blue Sky is one of many groups that promote and raise awareness of climate change conspiracy theories. For example, their mission statement describes ‘chem-trails’ and a government conspiracy to control the weather as ‘the toxic spraying of nano particulate metals which are further amplified by ionospheric heaters to steer, direct and control our weather for military purposes ... we seek to apply the wealth of our knowledge, passion and talents to end the illegal spraying of our planet’ (byebyebluesky.com/). Alarming, the internet content and group demonstrations can be very convincing. Furthermore, some theorists have mastered the ability to navigate through such forums and use them to their advantage to disseminate their views to a large population.²⁹

An interesting quality of conspiracy theories is that the counter-evidence is shunned by theorists who claim that the refutation of their ideas by powerful figures is further evidence of truth suppression. This introduces an ‘us versus them’ dynamic.¹⁴ It may also have a directly proportionate effect – the stronger the evidence against the conspiracy theory, the more vehemently the counter-narrative is held.³⁰ This is further reinforced by computer algorithms that provide a feed of confirmatory evidence and omit counter-narratives from view.³¹ Curiously, it is evident that the scientific community’s message on climate change does not have the same footing or far-reaching sustenance as the competing conspiracy theories.

Referring back to the traditional definitions of overvalued ideas and delusions, it seems that conspiracy theories about climate change could be categorised as either or neither. A diagnostic challenge is introduced when groups or ‘masses’ of believers share the same conspiracy theory and it almost has the constructs of a culture. Studies^{4,5} have found the existence of large populations that believe conspiracy theories, supporting the idea that such beliefs extend beyond the individual. This directly causes conflict with the definition of delusions. It emphasises the need for clinicians to consider the presence of additional psychopathology and/or functional impairment in order to make a diagnosis in an individual who is preoccupied with conspiracy beliefs. It could be postulated that this may divide psychiatrists. Some may consider that this group hold pathological beliefs, whereas others may frame the beliefs as in keeping with a ‘subculture’ and therefore not indicative of psychopathology.

Climate change conspiracies and mental disorders

Although there is an abundance of literature on climate change conspiracy theories in terms of their nature and spread, there appears to be very little on how such theories have had a clinical effect on mental health. In this section, the link between climate change conspiracy theories and mental disorders is discussed.

Personality disorders

Individuals with certain personality disorder diagnoses are likely to be more susceptible to preferring narratives engineered by conspiracy beliefs due to the nature of the definition in diagnostic manuals such as ICD-10. In particular, the cluster A personality disorders have the fitting profile. The description of paranoid personality disorder specifically makes reference to a 'preoccupation with unsubstantiated conspiratorial explanations of events both immediate to the patient and in the world at large'. Additional traits include recurrent suspicions without justification, general suspiciousness and a pervasive tendency to distort experience by misinterpreting neutral actions of others as hostile or malicious. Persons with a diagnosis of paranoid personality disorder may also have a rather rigid world view and an assertive sense of personal rights, which may not be proportionate to actual situations.³² It is apparent how this profile might cross over with characteristics identified in those who endorse conspiracy theories (e.g.⁷).

The ideas characteristic of paranoid personality disorder are typically persecutory and self-referential. Individuals diagnosed with this disorder are likely to be socially withdrawn and perceive that they are unduly victimised.³³ Imhoff & Lamberty³⁴ noted similar characteristics in relation to subclinical paranoia. However, instant access to widespread networks, facilitated by the internet, allows the formation of clusters of like-minded individuals who also hold similar persecutory, self-referential ideas. There is now a mechanism by which such individuals can indulge pathologically in misinformation to bolster their false beliefs together and 'connect'. Therefore, in this scenario, self-referential ideas become a collective experience.³⁵ This could further add opposition to the mainstream narrative and have an impact on individual presentation.

The criteria for schizoid personality disorder include traits such as an 'invariable preference for solitary activities', 'a lack of close friends or confiding relationships', 'poor acknowledgement of social norms and conventions' and, importantly, 'excessive preoccupation with fantasy and introspection'.³² A combination of such traits could underpin a tendency to believe conspiracy theories.

Schizotypy is also implicated in the conspiracy theory literature.³⁶ Schizotypy is captured in DSM-5 as a personality disorder and categorised with schizophrenia in ICD-10. March & Springer³⁷ explored whether the 'odd beliefs' and 'magical thinking' seen in schizotypy predicted belief in conspiracy theories and found a significant association between the two. The authors commented that the results indicated that individuals with 'unusual patterns of thinking and cognitions' and 'interpersonal and affective' deficits were more likely to hold conspiracy beliefs. There are indications that particular personality traits are risk factors for psychosis in an attenuated form.^{38,39}

Nihilistic and apocalyptic delusions in psychotic depression

Severe depressive disorders may have a psychotic component in which mood-congruent delusions are a feature. Nihilistic delusions, where the patient has abnormal conviction that they are dead, their organs are rotting or the world is dead around them, are not uncommon.⁴⁰ There is a possibility that this belief could extend to an individual believing that they are personally responsible for climate change or – in extreme cases – the destruction of the world.

Another type of delusion referred to in the literature is 'apocalyptic delusions' or 'end-of-the-world delusions'. The content of such delusions is thought to be influenced by contemporary culture and societal changes. Early content of such delusions included fears of the plague, famine and asteroids hitting the earth.⁴¹ Although these persist, the content has evolved in the present day, as would be expected, and includes despair over climate change. 'Climate apocalypse' and 'climate dystopia' are terms that encompass the idea that an apocalypse will occur as a result of climate change – severe weather changes, forest fires and a depletion of natural resources will render the earth uninhabitable and therefore bring about the inevitable impossibility of the survival of human life.⁴²

There is a single published case study to describe this phenomenon. Wolf & Salo⁴³ described a 17-year-old boy diagnosed with a depressive disorder, who developed a delusion that his consumption of water would lead to the deaths of millions of people, as water supplies would be depleted. This was associated with ‘visions’ of an apocalypse.

Overall, there is a lack of recorded clinical cases of severe depression related to climate change or climate change conspiracy theories. However, with heightened attention on and uncertainty about climate change in modern society, there may be an increase in manifestations of this in depressive disorders through the modes suggested.

Psychotic disorders

There are controversial terms such as ‘mass delusion’, ‘climate alarmists’ and ‘greenhouse sceptics’, which refer to various groups of people who hold certain beliefs about climate change.⁴⁴ There are conspiracy beliefs propagated by some ‘climate deniers’ to state that climate change is a hoax.⁴⁵ Counter-conspiracy beliefs also exist, which propose that the impact of climate change is understated, data are suppressed and governments are purposefully minimising the accelerating impact on the earth to fit with their political agendas.² In terms of psychiatric diagnosis there is no evidence to suggest that such beliefs have a delusional quality. The terms ‘mass delusion’ and ‘climate deniers’ do not have clinical connotations. Nonetheless, there is likely to be a minority with associated risk factors for psychiatric disorders within the groups who are prone to holding these beliefs with absolute conviction despite contrary scientific evidence. Such delusions may be considered part of an evolving clinical picture of a delusional disorder, or a psychotic disorder such as schizophrenia. Considering the nature of these disorders, if climate change delusions were present, they would be expected to have a bizarre quality; and it would not be unusual for extreme conspiracy theories to be the themes.

There is a small literature base – and accompanying anecdotal evidence – concerning the interplay between socio-cultural events and delusional content. For example, Cannon & Kramer⁴⁶ have noted that delusional content in the USA related to syphilis in the early 20th century, Nazis during Second World War, communists during the Cold War and technology in more recent years. The internet has become increasingly relevant to delusional content (e.g.^{47,48,49}). Curious case studies also exist. For example, Caseiro & Queiros⁵⁰ reported a case in which football was thematic, in the context of Portugal winning Euro 2016. Notably, psychosis is often triggered by real-world events and the nature of delusional content can reflect genuine concerns about the world, anxiety and existential threat.⁵¹

It is possible that concerns about climate change could exacerbate existing delusional beliefs, or extreme views could escalate above a delusional threshold. Consequently, such beliefs could become ‘diagnosable’ and meet criteria for a psychotic disorder.

A psychological adjunct

There is an association between the cognitive and affective processes that underpin conspiracy beliefs and those evidenced in delusional thinking. For example, the jumping-to-conclusions bias has been observed in psychotic-like thinking.⁵² This bias is associated with the overly rapid appraisal of stimuli to form a conclusion and has recently been evidenced in a sample of conspiracy theory believers.⁵³ Poorer analytical thinking is also implicated,⁵⁴ and cognitive distortions noted in depression could also be relevant.³⁵ Similarly, historical victimisation and a schematic view of the world as dangerous are risk factors for psychosis⁵⁵ and can provide a framework through which anomalous information is perceived. Individuals with schizotypal and paranoid personality disorder diagnoses are also likely to have experienced danger in their early lives^{56,57} and such threatening experiences are also precipitants to conspiracy beliefs.^{11,13} Distortions in human information processing are commonplace, adaptive and dimensional, with evidence to suggest that some individuals perceive ‘true’ information, whereas others omit, deny or delude as their environmental niche requires.⁵⁸ Events that elicit threat responses are particularly relevant. Additionally, the demographic profiles of those who endorse conspiracies¹⁶ are similar to those found within psychosis cohorts.⁵⁹

Many theorists and clinicians support the concept of dimensional psychosis with phenomenological continuity.^{60,61} Subclinical delusional thinking has been associated with conspiracy beliefs,⁶² as has paranoia.^{34,63} Conspiracy theorists may not be delusional or paranoid. However, it is plausible that they exhibit similar genetic, psychological and/or social characteristics to those who are vulnerable to psychosis. The proneness–persistence–impairment model⁶¹ and

extended psychosis phenotype⁶⁴ are helpful frameworks for exploring the relationship. For many, a belief in climate change conspiracies could simply concern loyalty to conservative values.¹³ However, some may have an underlying predisposition to psychosis, with a tendency towards conspiracy thinking. Potential migration towards clinical thresholds could occur in response to greater perceived threat from significant events and exposure to, and preoccupation with, conspiracies. Individuals with diagnoses of paranoid or schizotypal personality disorder may fall into this position. The notion of the extended phenotype could explain why individuals who hold one conspiracy belief are more prone to believing others (e.g.¹⁷); this has also been called ‘conspiracist ideation’.^{65,66}

Forecast

There is evidence to suggest that historical events have informed delusional content^{46,49} and there are some indications that the COVID-19 pandemic has had a recent effect.⁶⁷ Delusions can be triggered by real-world events and the content can reflect genuine concerns about the world, anxiety and existential threat.⁵¹ Notably, the conditions in respect to the above phenomena were opportune for the development of conspiracy theories. That is, these events generated real threat to individuals and communities (e.g.⁷).

It can be hypothesised that the global reluctance/opposition to impactful climate policy change is actually protective with regard to the pervasive development of conspiracy belief psychopathology. That is, conspiracy theories emerge when a way of life is threatened. At present, climate policy has not had a tangible impact on freedoms, rights or lifestyle. Nonetheless, we forecast that this will likely change in the coming decades (e.g. as governments fall in line with the Paris Agreement). To our knowledge, there is only a single case study⁴³ to describe the interplay between climate change conspiracy beliefs and severe psychopathology. It is hypothesised that climate change has not yet become a common feature of delusional beliefs.

For those who have a predisposition to psychopathology, such changes may trigger migration towards clinical disorder. It is possible that climate change and associated conspiracy beliefs may affect mental health in the following ways: (a) dramatic societal changes (e.g. energy conservation policies, restrictions on existing freedoms) might precipitate an increase in climate change conspiracy theories, and individuals predisposed to conspiracy thinking (including those with underlying paranoid, schizoid and schizotypal traits) might migrate to delusion; (b) the increasing presence of climate change discourse in public conversations could lead to such content appearing in the content of pre-existing delusional belief systems; and (c) concerns and guilt about climate change could lead to presentations of depressive psychosis with nihilistic and/or climate-related apocalyptic delusions.

Concluding remarks

As climate change becomes more present in public consciousness, conspiracy theories are likely to become increasingly prominent and to manifest in the presentation of several mental disorders. This article has hypothesised that there may be a potential commonality between pervasive conspiracy thinking and mental disorders, particularly psychosis and certain personality disorders. However, it is proposed that clinicians approach individuals who hold conspiracy beliefs with diagnostic caution, given that conspiracy beliefs are widely held within the general population. Careful assessment is needed to identify those who are psychologically vulnerable to developing mental health complications due to exposure to conspiracy beliefs.

Further research is recommended to investigate whether a proportion of climate change conspiracy theory advocates do have underlying psychological risk factors for the development of concerning psychopathology; and also how such theories have featured in mental disorders, particularly as symptoms of psychosis or personality disorder.

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None.

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1.2.67 Silver linings: how mental health activists can help us navigate wicked problems

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Abstract

This article explores how ‘wicked problems’ such as climate change might force psychiatry to rethink some of its fundamental ideas and ways of working, including clinical boundaries, understandings of psychopathology and ways of organising. We use ethnographic evidence to explore how mental health service ‘survivor’ activists are already rethinking some of these issues by therapeutically orienting themselves towards social problems and collective understandings of well-being, rejecting ‘treatment as usual’ approaches to distress. In this way we provide an example of the potential of activists to help psychiatry negotiate the climate crisis.

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- *Silver linings: how mental health activists can help us navigate wicked problems*
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pmc In *Hyperobjects: Philosophy and Ecology after the End of the World*, Timothy Morton suggests that the climate emergency is a ‘wicked problem.’¹ Problems might be described as wicked in cases where their complexity, our lack of knowledge or the absence of stable, defined goals make them extremely difficult (or even impossible) to solve. Wicked

problems are often highly entangled and interdependent, such that addressing one area leads to unwanted consequences in another. When dealing with a wicked problem, the answer does not lie in a single solution. Wicked problems require broad perspectives, which examine social processes and systems and are responsive to phenomena that may be marginal or poorly understood. Morton argues that the wicked problem of the climate crisis is placing an intense and transformative pressure on our patterns of reasoning and that it demands an overhaul of some of our key ideas and values. As Boulton notes, climate change ‘renders *vulnerability* [our italics] as the tangible human experience of environmental degradation and destabilizes our sense of existence’ to the extent that it challenges ‘human-scale understandings of personhood, planetary existence, and cognition in general’.²

We suggest that psychiatry cannot be left out of any overhaul of key ideas or values, not least when they pertain to vulnerability and our understanding of the person. There are at least two aspects to this. First, we suggest that the climate crisis disrupts ideas about psychopathology that draw on notions of autonomy, independence, functioning, goal orientation and economic activity. Second, we note how the crisis unsettles critical but unexamined assumptions about how individuals and institutions should be organised by questioning the values of orderliness, preparedness and managerial rationality often found within organisations such as the UK’s National Health Service (NHS) and Department for Work and Pensions. To investigate this we draw on ethnographic fieldwork with mental health service ‘survivor’ activist networks in London, who reject ‘treatment as usual’ and challenge some of the main premises of mental illness and what it means to live healthily. We explore interlocutors’ preferences for ‘dis-organisation’ and disorder in group meetings as a therapeutic act. We also present how activists reframe their inability to work and to receive sickness benefits as a means of community engagement, collective ethics and undertaking social ‘goods’. Ethical approval for the fieldwork cited in this article was approved by the University of Kent. Verbal informed consent was obtained from all participants.

Mental health service survivor activists: the Challenge Mental Health network

Mental health service survivor activists have iatrogenic and traumatic experiences of NHS mental healthcare. As a collective, they draw their alternative understanding of what it means to be a valuable member of society away from individual ‘functions’ and towards socioenvironmental concerns. Global phenomena such as the climate emergency are used by activists to think through how mental distress is conceptualised in mental health services. They find that it no longer makes sense to work within a framework and discourse of individual responsibility when the climate emergency shows how profoundly interconnected our lives really are. In this article, we provide ethnographic material to think these issues through, suggesting not solutions but ways that psychiatry might begin to respond to the climate crisis in a more inclusive and holistic manner.

Survivor groups such as Challenge Mental Health (CMH) network meet across London to campaign for better understandings of mental distress and improvement of local and national mental health services and treatments. One of CMH’s main premises is that psychiatry underestimates the social causes and treatments of ‘mental illness’ (or what they term ‘distress’). They argue that undervaluing social processes in this way contributes to poor mental health. As a group, CMH are opposed to thinking in terms of individual vulnerabilities or pathologies. Instead, they emphasise social attitudes, collective pathologies and systemic barriers that impede recovery. They concentrate on collectively alleviating social influences of distress and support one another by telling personal stories of distress and discussing ideas around illness beliefs and causes. They also allow individuals to experience distress in the presence of the group without intervention or treatment.

The way survivor groups organise themselves reflects an ambivalent relationship with bureaucratic working; this in part involves a conscious construction of a meeting space which is entirely ‘other’ from places such as the clinic or the hospital. At first glance, these preferences might appear at odds to those with training in goal-oriented therapeutic approaches. CMH have particular ways of approaching their meetings for example. They reject orderly, rule-governed practices and behaviours which are rooted in planning and preparedness and which might remind them of NHS ‘treatment as usual’. CMH meet according to consensus in spaces all over London – responding to members’ needs at the time. Meetings can last for hours and involve complete strangers. I have often witnessed people walking in off the street, or straight from a hospital discharge for example. The meetings are informal and are conducted without set procedures or agendas. Meetings are reactive – responsive to personal stories, events or news – and topics of discussion are changeable and unpredictable. Official leadership or facilitation in meetings is rare and they are typically initiated by whoever wants to speak at the time. All are welcome, but there are rarely introductions – it is up to individuals to

introduce themselves; sometimes members sit for hours together and never find out who one another are. There are no expectations of turn-taking, as in more conventional group therapy settings.

These arrangements have their difficulties – interlocutors sometimes express frustration about the lack of structure in meetings and, when there is a disagreement, there are no procedures in place to ask members to leave. But it is telling that these arrangements cannot just be read in the negative, as absences of positive qualities. Rather, they are consciously curated and challenge many assumptions about trusting therapeutic interactions needing to occur in contexts that are safe, ‘contained’, stable, orderly, predictable and familiar. Here, it is the very lack of order that is therapeutic, felt by participants to be empowering and healing, where rational institutional working had been found to be alienating, demoralising and stigmatising. Through certain ways of being-in-place, activists resist processes and relations that might in other contexts be seen as organisational virtues that define the gold standard of conventional healthcare – such as professionalism and expertise, impersonal institutionally defined roles and processes, and the standardised relationship, even the ‘routinised intimacy’, that characterises contemporary mental healthcare.³ Activists instead rely on spontaneity, mutual attentiveness, responsiveness and informal group working.

Interlocutors speak about medical procedures associated with bureaucratic rationality, planning and accountability as countertherapeutic. During a meeting, one newcomer asked members of CMH why there were no meeting minutes, because then others could contribute remotely. One reply was, ‘If we took minutes, everything we say would be documented, get out of context and we would feel scrutinised’. Many interlocutors expressed a specific dislike of documentation (and particularly, being ‘written about’), especially those with experiences of being detained under the Mental Health Act (‘sectioned’) and/or claiming benefits (something that the majority of activists experience). Interlocutors described how it felt alienating and disempowering to not know what is written (or spoken) about them (i.e. in medical notes), particularly being unable to read or understand what the notes say when shorthand or medical terminology is used. Thus, meetings do not run according to agendas and the group do not write manifestos; rather, they operate on the principle that to have any ‘rules’ evokes those systems and modes of behaviour they specifically reject.

How does this relate to the climate crisis?

For those for whom ‘therapeutic’ places provided by service providers are often harmful and exacerbate or elicit unwellness, making spaces according to these sensitivities requires flexibility. Therein lies Morton’s ‘overhaul’; this rejection might be understood by psychiatrists and service managers in negative terms as an absence of organisation, or an inability to generate efficient ways of working. Understanding recovery collectively as activists do may even be read as a sign of dependence. Yet the climate crisis might suggest a different frame. A distaste for planning, organising and preparing reflects an awareness that these forms of organising (and the values and sensibilities that drive them) are discredited because the ecological crisis is driven by them. The production of pollutants on such a scale that they threaten life on earth demands industriousness, discipline and rational organisation on a huge scale. But as Bouton reminds us, we are all interdependent and interconnected and ‘all vulnerable’.⁴ Not acting in accordance with conventional psychotherapeutic thinking concerning relationships and ways of behaving enables mental health activists to have more control and ownership over their recovery, as does questioning the logic underpinning certain clinical ‘goals’ pertaining to health and wellness. Recovery for many survivor activists is relational, flexible and agentic and creating meeting spaces to behave in ‘disorderly’ ways is part of this process.

Boundary objects

Psychiatric categories are an example of what Bowker & Star call ‘boundary objects’ – concepts that work across different institutional settings and contexts.⁵ Star & Griesemer define boundary objects as ‘objects which are both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites’.⁶ Boundary objects are terms that allow cooperation and communication between individuals (say, within an organisation) even if they do not necessarily agree with the precise meaning and definition of the terms. They have different meanings for different people. An example of such a term might be ‘recovery’: it is contested but also has a generalisable meaning in mental healthcare. Clinical terms designed to guide treatment decisions, for example, also guide access to benefits and relate to legal responsibility, capacity and disability.

In this way psychopathology is tied to conformity and deviance as conceptualised in the context of the welfare state. But we can only take deviance as a sign of ill health and conformity as a marker of health if we think that society is more or less healthy. The climate crisis challenges that. Our collective inability to respond to emerging climate science looks compulsive and irrational, perhaps even delusional. It is functional people who produce and consume and thereby drive the production of greenhouse gases and undermine food security, while the economically inactive have the lightest carbon footprint.

‘Unemployment’ as mental illness or an enabler of social ‘goods’?

Survivor activists can be sceptical that good ‘health’ is so easily mapped onto capacity, function and ability to find and keep work. Many of CMH’s campaigns revolve around the idea that people on benefits for mental illness are being pushed into work as part of new benefits changes and government targets related to financial management and (post)austerity measures and that this is harmful to claimants’ sense of autonomy and agency. CMH hosts film nights as opportunities to air concerns and grievances around such topics. One evening, Lissa, one of the founding members, stood in front of the small group of CMH members, therapy students and passers-by and announced that, ‘The government is trying to persuade us that unemployment is a mental illness. This driving force telling us we should all be in and doing productive work alters the sense of *who* and *what* we are’.

The discourse around ‘getting into work’ affects those in distress. Members discussed the connections between mental health services and the welfare system anxiously. Will, for example, a young activist in his 20s, feels guilty about his inability to work. He says he has never been in the position where ‘they thought enough of me to get to work’, even though he has tried. Will has spent most of his adult life living in supported accommodation and has been in hospital under various Mental Health Act sections. He was diagnosed with Asperger syndrome in school and had other mental health difficulties. He explains that he has undergone a work capability assessment and is waiting for the results. He feels as though he has to constantly justify why he has not worked and struggles with feeling illegitimate for never having had a job. At the job centre Will asked a receptionist whether he could just get ‘normal jobseeker’s allowance’ instead of sickness or disability benefits. She was surprised and told him that he would receive more money by accepting illness benefits. Yet Will insisted on claiming jobseeker’s allowance, lamenting that he ‘just wants to be like everyone else’.

At the film night, the group reflected on how people on benefits are treated with hostility and that they have the added disadvantage of having psychiatric diagnoses. ‘I don’t want to go around being seen as the victim’, remarks one, ‘especially when we already have a self-blaming culture’. Julie raises a recent comment made by George Osborne about people on benefits lying in bed with their curtains drawn while others go out to work and that they remain closed when workers come home again.⁷ ‘We are trying to change this narrative,’ she says. Lissa adds that she cannot stand the perception that people on benefits for mental illness do not do much all day because they don’t ‘work’. Her community psychiatric nurse (CPN) asked her what she ‘actually *does* all day’. So, she presented him with a list, ‘I get up early, check on my elderly mother, take my disabled sister to her hospital appointments, do her grocery shopping, call people up as part of my mental health support group mutual aid chats. Campaign for the end of workfare, write letters and articles. Lobby MPs, attend seminars in Westminster, draft responses and initiate public inquiries ...’. Lissa’s CPN was surprised, ‘It seems like you do more than me!’.

Julie explains that receiving benefits has meant that she gets to choose what she does with her life. She volunteers in the community, is a trained co-counsellor, runs literary events for mental health service survivors, supports benefit claimants with their claims and letters, and sanctions and lobbies Parliament to increase spending in mental health services in her free time. She supports as many friends and peers in mental distress as she can. She explains that, rather than running in ‘the rat race’, she has time to take action on behalf of those who are working. Employment caused her to have breakdowns. Implicit in her understanding is the idea that not working allows you to think, reflect, act collectively and undertake altruistic social ‘goods’; it gives you the time and energy to consider things that are bigger than you, to support others and gives you purpose and meaning.

Conclusions

Wicked problems such as the climate crisis force us to rethink our understandings of what mental health is, how mental healthcare should be organised and what its goals should be. What we have learned from mental health service survivors is that, for them, it is healthy to challenge ideas about individual functioning and social responsibility. Resisting the pressure of working employment or assuming the role of a ‘productive’ member of a society by resisting workfare can be healthier for recovery than what is desired according to the psychiatric model of mental health. For activists, recovery outcomes are not connected to gaining employment. In fact, the push towards function via work/employment can exacerbate stress, feelings of stigma and of low self-worth. Therapeutic activities for activists instead involve creating environments for exploration in group settings, where the unpredictability and uncertainty of distress is given space. By interrogating the social causes of distress but refraining from seeking solutions to it, activists avoid attempting to fix or resolve problems and instead allow for ‘not knowing’. Thus, they suggest that the model of mental illness needs to be more flexible – it needs to allow for debate around what is classified as ‘healthy’ behaviour, to make room for dialogue and the open exploration of wicked problems, and to be reactive and responsive to the moment we are living in.

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Data availability

The data are not publicly available because they contain information that could compromise the privacy of research participants.

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Declaration of interest

None.

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1.2.68 Freedom to think: the need for thorough assessment and treatment of gender dysphoric children

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Abstract

Referrals (particularly natal female) to gender identity clinics have increased significantly in recent years. Understanding the reasons for this increase, and how to respond, is hampered by a politically charged debate regarding gender identity. This article starts with a discussion of the so-called 'affirmative approach' to gender dysphoria and considers the implications of the Memorandum of Understanding on conversion therapy. I then say something about the relationship between gender dysphoria and the developmental problems that are characteristic of adolescence. Finally, I outline what changes to the current approach are needed to do our best to ensure these patients receive the appropriate treatment.

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- *Freedom to think: the need for thorough assessment and treatment of gender dysphoric children*
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 - *The Memorandum of Understanding on Conversion*
 - *Children with complex problems*
 - *Research*
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 - *Informed consent*
 - *Comprehensive assessment*
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 - *Political pressure on institutions and research*
 - *Conclusions*
 - *Recommendations*
 - *Supplementary material*

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The online version of this article has been updated since original publication. A notice detailing the changes has also been published at <https://doi.org/10.1192/bjb.2020.124>.

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– Declaration of interest

pmc There has been a 3264% rise in referrals to the national gender identity service at the Tavistock and Portman NHS Trust in London over the past 10 years (from 77 in 2009–2010 to 2590 in 2018–2019).¹ The profile of referrals has also undergone a major transformation: we have seen a reversal of the gender ratio from two-thirds male:female to two-thirds female:male, with a recently described clinical phenomenon of as yet uncertain diagnostic significance making up a substantial proportion. This gender dysphoria of recent onset among adolescents (sometimes termed ‘recent-onset gender dysphoria’ or ROGD, ‘rapid-onset adolescent dysphoria’² or ‘adolescent-onset transgender history’³) lacks an agreed name or established diagnostic criteria, but its emergence has been documented by a number of gender clinics worldwide.⁴ Bernadette Wren, the then associate director of the Tavistock and Portman NHS Foundation Trust’s Gender Identity Development Service (GIDS), gave evidence to a House of Commons select committee in which she summarised the GIDS intake in the following terms: ‘many of the young people, and increasing numbers of them, have had a gender-uncontentious childhood, if you like, and it is only when they come into puberty and post-puberty that they begin to question. That now represents a substantial proportion of our group’.⁵ We have very little understanding of what underlies these changes, and indeed of the understanding of this whole area is extremely limited and it is particularly important to examine it from different perspectives. This is very difficult in the current environment, as the necessary debate and discussion is continually being closed down, either through individuals being prevented from expressing their views or being self-censoring through fear of the accusation of ‘transphobia’.

The ‘affirmative approach’

The affirmative approach to gender dysphoria appears to have been adopted by the majority of NHS and privately provided children’s services in the UK. Again, Bernadette Wren stated in the House of Commons: ‘I work in a service where a lot of the young people – and anybody who wants it – have physical intervention. We have no record of turning people down for physical intervention’.⁵ This approach endorses the child’s belief that they were born in the wrong body and practitioners are required to support the child’s self-identification. Commenting on the decision of the American Academy of Paediatrics (AAP), Cantor says ‘Although almost all clinics and professional associations in the world use what’s called the “watchful waiting approach” to helping gender diverse children, the AAP statement instead rejected that consensus, endorsing gender affirmation as the only acceptable approach’.⁶ This is despite research findings which strongly suggest that most of these cases would eventually desist if left untreated.^{7,8} The ‘affirmative approach’ risks sending children down a path towards concrete and sometimes irreversible medical interventions for what is in very many cases a psychological problem. This approach, in my view, is driven by political ideology rather than clinical need and inhibits the clinician’s curiosity and freedom to explore a child’s underlying belief systems and motivations. The ‘affirmation approach’ looks narrowly at a problem in only one area of psychological functioning, as if one part of the individual could be isolated from other areas of the personality, so ignoring the complex relationship between the overt symptomatic picture and trauma, social anxieties and even the relatively normal turbulence of adolescence.

The Memorandum of Understanding on Conversion

The Memorandum of Understanding on Conversion, which many healthcare professionals have signed, purports to protect the patient from conversion therapy. The Royal College of Psychiatrists signed the first version of the Memorandum (in 2015)⁹ as it referred to homosexuality but declined to sign the second Memorandum (2017)¹⁰ as the definition had been expanded to include transgender individuals. The Memorandum is very often interpreted as obstructing the clinician’s freedom to examine and explore the various pathways that have led to gender dysphoria, but, somewhat surprisingly, when one reads the document one discovers an acknowledgment that the therapist or healthcare professionals’ job is to help the patient discover and come to terms with who they really are: “‘For people who are unhappy about their sexual orientation *or their transgender status* [my italics], there may be grounds for exploring therapeutic options to help them live more comfortably with it, reduce their distress and reach a greater degree of self-acceptance’.¹¹”

This Memorandum implies that there is a fixed category called ‘transgender’ which, like eye colour, is simply a given that need not be thought about or understood. Children’s sexual orientation and gender identity are formed out of a

complex developmental process that involves an interaction between their body, their mind and society at large. Sexual identity and gender identity are developmental processes that evolve as the individual goes through the different life stages.

The Memorandum is, in my view, symptomatic of the way that political agendas have influenced this area of clinical practice. We do not just accept/affirm a patient with anorexia when, although she weighs 45 kg, she thinks she is overweight and needs to diet more carefully. Instead, we take it as our duty to try to understand what it is that is driving that belief while persuading her that she needs to eat.

Children with complex problems

There is a growing body of knowledge that connects the development of gender dysphoria with psychological factors.^{12–17} A group of parents whose children were treated at the Tavistock and Portman NHS Foundation Trust's Gender Identity Development Service (GIDS) in London wrote to the trust's board. In their letter they express deep concern that children with no long history of gender dysphoria, who were on the autism spectrum or suffered from social anxiety adjustment disorders were, with very insufficient investigation, diagnosed as transgender. They believed that the GIDS adopted a superficial approach that was in danger of colluding with the child's belief that all their problems will be solved if only they could change gender.

The parents wrote to *The Guardian*, which reported on Saturday 3 November 2018 that children were 'fast-tracking' young people into life-altering decisions without fully assessing their personal histories. Their letter stated that:¹⁸ "the GIDS team is being asked to engage with and assess complex and difficult cases within a highly constrained time frame."

They also believed that their children had been indoctrinated as a result of online websites that recruited the child into membership of the trans community.

Research

One needs to be very cautious about recommending medical and surgical interventions that place a lifelong burden of treatment on patients. We know little about their effectiveness (there have been no long-term follow-up studies). Carl Heneghan, Oxford University's Professor of Evidence-Based Medicine and Editor-in-Chief of the journal *BMJ Evidence-Based Medicine*, has called the puberty blocker treatment an 'unregulated live experiment on children'.¹⁹ *Research Digest*, published by the British Psychological Society, reported on an Australian review which concluded that the current medical approach is based on extremely limited evidence.²⁰ The Royal Society of General Practitioners has drawn attention to 'the significant lack of evidence for treatments and interventions which [...] is a major issue facing this area'.²⁰ Professor Robert Winston (Lord Winston) of Imperial College London has expressed concern about medically transitioning young people without having 'really defined what is really wrong: what is the cause for people seeking gender reassignment? Until we define the problem, I think we're going to have a very blunderbuss problem'. Winston also highlights how often medical transition may not meet the expectations of patients: "He said 40 per cent of people who undergo vaginal reconstruction surgery experience complications as a result, and many need further surgery, and 23 per cent of people who have their breasts removed "feel uncomfortable with what they've done". He added: "What I've been seeing in a fertility clinic are the long-term results of often very unhappy people who now feel quite badly damaged. "One has to consider when you're doing any kind of medicine where you're trying to do good not harm, and looking at the long-term effects of what you might be doing, and for me that is really a very important warning sign." He added that the long-term effects of taking hormones "are likely to affect reproductive function".²¹

Even GIDS's own senior psychologist Bernadette Wren has mused: 'Of course, you have to think that in another generation we will have done something which is not regarded as having been wise.'²² Professor Donal O'Shea, an endocrinologist, has been highly critical of the World Professional Association for Transgender Health's (WPATH's) Standards of Care, which inform NHS England's guidelines: 'Aligning with them would result in significant harm accruing to those with gender confusion'. His colleague, psychiatrist Dr Paul Moran, considers that the WPATH guidelines 'are clinically unsafe, and unsuitable for use in a public healthcare gender clinic.'²³

Patients that regret treatment

An increasing number of ‘regretters’ or ‘detransitioners’ are speaking out on social media and at conferences to argue they have been let down by mental health services that have failed to assess their psychological problems before prescribing medical treatments such as puberty blockers and cross-sex hormones, or surgery as treatment for their gender dysphoria. A number of clinicians have called for research into desistance, detransition and regret among gender dysphoric adolescents. The US National Institutes of Health (NIH) Sexual & Gender Minority Research Office (SGMRO) recently named detransition in its report outlining scientific research gap areas in the field of sexual and gender minority health.²⁴ The 8th edition of WPATH’s Standards of Care will include a section on detransitioning.²⁵

Sky News reported on Saturday 5 October 2019 that Charlie Evans, who has detransitioned, has set up a charity to help others in a similar situation and has been contacted by hundreds of people seeking advice.²⁶

During the 1980s, I led a parasuicide service in King’s College Hospital, London, and treated a number of individuals who had self-harmed or attempted suicide after gender reassignment surgery. These patients had a history of serious and enduring mental illness and/or a personality disorder. Having developed a late-onset gender dysphoria, they were often angry at the loss of their biological sexual functioning and aggrieved with psychiatric services, which they felt had failed to examine their motivations for requesting reassignment surgery and/or to adequately investigate their psychological difficulties. A common theme in their presentations was a belief that physical treatments would remove or resolve aspects of themselves that caused them psychic pain. When the medical intervention failed to remove these psychological problems, the disappointment led to an escalation of self-harm and suicidal ideation, as resentment and hatred towards themselves were acted out in relation to their bodies.

Informed consent

David Bell was approached by a large number of clinicians who had very serious ethical concerns about the service. His report was presented to the Tavistock and Portman NHS Foundation Trust board. In his report he wrote: ‘This is a highly complex and difficult area which appears at times to be treated superficially’. *The Times* (8 April 2019) quotes an anonymous clinician from the GIDS as saying: ‘It was regarded as taboo to discuss the impact of medical intervention on later sexual functioning in such a young cohort’.²⁷

In the National Health Service (NHS), clinicians are usually required by law to discuss the potential negative effects of any treatment. However, for reasons that are not clear, the treatment for gender dysphoria has evolved operating outside the usual medical/professional practice. Children are signing up for treatments that permanently modify their bodies, but they may not fully understand the life-long consequences of their decision or acknowledge the potential risks and uncertainties of treatment. Their ability to provide informed consent has been questioned, including by some clinicians working in gender clinics.^{28–30} Are children of 12 and under really aware of what it will mean to become an infertile adult, who cannot have an orgasm and has to remain a patient dependent on hormones and medical care for the rest of their lives? Do girls know what it will mean in the future to have to undergo hysterectomy to avoid vaginal atrophy? It is also important to discuss openly that, although patients may decide in the long term to transition, they cannot eradicate the biological realities of their natal sex and will have to find some way of living with the losses involved. A full assessment and psychological engagement over a prolonged period can help the individual think through the social, psychological and biological implications of the medical interventions.

Comprehensive assessment

A thorough assessment process involves two parts. First, an extended open-minded psychotherapeutic approach has the capacity to create the conditions whereby the factors, conscious and less conscious, that have led to the presentation can be understood (it needs to be borne in mind that a large number of individuals present with ‘rapid-onset gender dysphoria’, suggesting underlying triggering factors). An understanding of the family and social context will, of course, be critical. This difficult psychological work needs to be carried out by experienced mature and sensitive clinicians, as it can easily be felt to be threatening, especially where the individual presents with strongly held convictions – for example many believe that only a change in physical sexual identity can bring them the relief they need. There is considerable evidence of children and adolescents changing their minds if given enough time and space to explore things. Second,

it is clearly vital that consent be fully explored. For example it will be important to gauge how much understanding the individual has of the implications of medical and surgical treatment. If an individual has no concern at all about the prospect and outcomes, this lack of concern should be thought of as *a symptom* that needs to be investigated and understood, rather than being treated superficially as a positive indication of their motivation. Unfortunately this kind of superficial approach is not uncommon. One needs to be able to empathise deeply with the individual's confusion, distress and mental pain, yet maintain adequate separation in order to be able to resist the pressure to join the patient in their view that active medical rather than psychological intervention is the only solution that can be even considered.

We must not forget our ordinary understanding of adolescence as a time of turmoil and considerable psychic pain as individuals have to come to terms with who they are, their strengths, weaknesses and limitations. Much of this, of course, centres on coming to terms with changes in the body and the new social roles that these changes demand. Gender services very often discuss only gender, with little mention of the relation with the changing sexual body. One young woman in my clinic, who was on a path to transitioning and then changed her mind, reported that there was no discussion of any biological realities in the pro-trans groups: 'Lots of talk about gender politics and none about the physical realities involved in transitioning'. The majority of children prescribed puberty blockers go on to take cross-sex hormones.

Gender conflicts are a normal part of development

We also need to bear in mind that adolescence is a time of experimentation that inevitably stirs up all sorts of conscious and unconscious confusions, doubts and conflicts which drive individuals to manage the anxiety and psychic pain through the use of powerful psychological defences such as denial, projection and splitting. When the child or adolescent is in danger of being overwhelmed there will be a tendency to focus on a fixed solution to deal with the most pressing concern, particularly the unbearable pain of confusion. The experience of being dislocated from one's body, which is changing rapidly in many ways, is not uncommon in adolescence. (This is perhaps one element of Kafka's classic tale *Metamorphosis* (1915) of a man who wakes up as a monstrous insect.) These feelings may be dealt with by premature foreclosure: 'I am not the gender of the biology I was born with; I am the other' – a statement that any experienced and mature clinician would resist through trying to create the conditions where confusion and psychic pain can be more tolerated. One of the central developmental tasks of adolescence is to come to terms with all sorts of realities, providing the basis for an integration of body and mind.

A political, rights-based approach to the treatment of children is at risk of forcing these complex psychological needs into the background. Pro-transitioning websites encourage children to view anyone who puts a different view, including parents, as suspect/the enemy; to self-diagnose and view the taking on of a trans identity as a wide-ranging solution to all their problems; to learn a script/obtain online tutoring so that the clinician who carries out the assessment will come to the 'right' conclusion, i.e. medical referral for transitioning. The so-called 'affirmative approach' persuades schools and others to accept unquestioningly the child's claims. Clinicians work in a take out zone where question is not welcomed. These various forces combine to ensure that these children very often get an assessment that is nowhere near adequate.

This radical disconnection of gender dysphoria from its potential roots in psychological disorder is fiercely promoted by pro-trans lobbies, who brand clinicians as 'transphobic' if they insist on a thorough psychological assessment of young people seeking to transgender/transition. That is, clinicians who are trying to protect the child from embarking prematurely on irreversible treatment are rebranded as a malign influence getting in the way of what the child 'needs'.

In 2019, Dagny, a young woman who later realised her mistake and seeks to live again as her natal sex (a 'de-transitioner') published an article about her experience of transitioning. She highlights the influence of the online site Tumblr and gives a very good description of the ways in which she internalised the ideals of the website:¹¹ "One of these unhealthy beliefs I held was the belief that if you have gender dysphoria, you must transition. And anyone that appeared to stand in my way was a transphobe – an alt-right bigot."

De-transitioners often describe being ostracised by the pro-trans group when they started to express doubts or question the treatment. Dagny writes that she became a different person when she started using Tumblr: "My online experience, having been affected by that level of groupthink, that level of moral policing and the constant implicit threats of social exposure and ostracisation made me an intensely internal and anxious person. It made me paranoid about the motives

of people around me – I saw my parents as bigots because Tumblr told me to; because they held out for so long to prevent me from starting hormones.’”

Children can also get online tutoring on how to get past the assessment process. *The Times* of 16 February 2019 also quoted David Bell as saying that they ‘have learnt through online resources [or] coaching from parents or peers exactly what to say in order to get the results they want’.²⁷

Many parents have expressed concern that school counsellors and child and adolescent mental health services are adopting an unquestioning gender-affirmative approach. They describe how, once children announced that they believed they were the wrong sex, practitioners immediately endorsed this belief, often after only one meeting. Politically driven proposals proclaim the right of the child to define their own identity. But this denies the fact that identity is developed in relation to internal and external realities, both of which remain outside the individual’s control. We do not control our biological inheritance and we cannot have complete control over the way we are seen by others.

Political pressure on institutions and research

The extraordinary grip of powerful trans lobbies is having the effect of silencing clinicians who fear them. Television producers and journalists continually report that, although clinicians at GIDS are willing to speak in confidence to them about their reservations of treatment in these areas, they shy away from being named for fear of the consequences – being branded a transphobic bigot. Some fear disciplinary action being taken against them by their trust. Kenneth Zucker, a well-known researcher and clinical lead of the Child, Youth and Family Gender Identity Clinic in Toronto, was sacked from his post after being accused of conducting ‘conversion therapy’. The centre had a policy of first trying to help the individuals deepen their understanding of themselves before recommending medical interventions. The investigation subsequently completely exonerated Zucker.³¹ James Caspian, a psychotherapist with considerable experience of working with transgender patients, has described his sudden realisation of the increasing number of patients who regretted the sexual reassignment they had undertaken. In 2019, he wrote that he had been contacted by more than 50 patients in the preceding 2 years. However, his proposal to carry out a formal research project to investigate this phenomenon was rejected by his university department for fear of a backlash.³² In 2018, Lisa Littman described the insights of parents whose adolescent children had recently adopted a transgender identity – a phenomenon she provisionally labelled ‘rapid-onset gender dysphoria’.³³ Littman’s paper prompted huge controversy: *The Guardian* called her work ‘a poisonous lie used to discredit trans people’ and the result was that the paper was withdrawn, only to be subsequently republished with only very modest revisions.³⁴

It is thus clear that this politically driven culture interferes with the freedom of thought necessary to work with these very troubled children and adolescents. It ceases to be possible for them to be assessed with an open mind, as individuals with their own unique difficulties and instead they become political symbols, actors in a wider ideological conflict – prejudice – and this is causing very serious damage.

Conclusions

The fantasy that the body can be rapidly sculpted as a way of being rid of profound psychological problems needs to come under much closer scrutiny. There is a great reluctance to even consider that the difficulties can be understood, at least sometimes, through the lens of body dysmorphia, where the individual becomes obsessed with a perceived physical flaw. Plastic surgeons are very familiar with patients who seek surgery to erase a psychological difficulty and refer these individuals accordingly. Medical and surgical interventions in those with gender dysphoria very often leave the underlying problems completely unaddressed. It is, of course, not the case that surgical interventions can remove all evidence of natal sex – which remains as a source of persecution, a constant reminder of the continued existence of an unwanted aspect of the self. Individuals need help and support in coming to terms with who they are, as part of the maturational process. However, patients often put enormous pressure on family, schools and clinical services to join with them in the belief that to transition to the ‘ideal’ body, i.e. to eradicate unwanted aspects of their body, is the only solution to their problems. Perelberg makes the point that, if the family or clinical service accepts this without sufficient question, then there is a ‘confusion of registers’, i.e. the patient acts as if they are convinced that a problem of self-representation existing in the mind can be cured by concretely treating the body. The cost is that the individual

is dissociated from their own body, treating it like a mannequin rather than a part of the self with anxieties, feelings and confusions.³⁵

Whatever decisions are made regarding medical treatment, a thorough psychotherapeutic and psychiatric assessment is essential to enable us to help these vulnerable young people, their families and their clinical teams make informed decisions. It is a process of opening up a dialogue with the individual about their motives, beliefs, the issues they are struggling with – and, crucially, trying to understand the complex role of gender identity in their more global functioning. A clinician has a duty to protect and this cannot be honoured without a thorough understanding of who the child is and how they arrived at the place they are.

Recommendations

Clinicians and patients need a service that is independent and protected from intrusions by pressure groups to force a rigid ‘one size fits all’ affirmative approach to gender dysphoria. NHS gender identity services have been functioning as if acting outside the ordinary requirement of good medical and psychiatric practice. The accusation of transphobia serves to shut down thoughtful enquiry and has been remarkably successful. As a result, the very thing that is most needed to protect children from harm is lost. This rapidly expanding and poorly understood phenomenon requires a new regulator tasked with appropriate oversight of gender identity services to ensure a more clinically rigorous, balanced and ethical approach to this complex area. Perhaps the Human Fertilisation and Embryology Authority (HFEA) developed to address ethical concerns in a rapidly expanding new field can provide the right kind of model.

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Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2020.72>.

[click here to view supplementary material](#)

Declaration of interest

M.E. and his wife Sue Evans have provided witness statements for a UK judicial review examining whether minors are able to provide informed consent for gender-affirming treatments. M.E. has previously raised concerns about such treatments with the Board of Governors and the CEO of the Tavistock Trust. Sue Evans administrates the online pages for a crowd justice fund, which will be used to pay the legal fees of the judicial review. Neither M.E. nor Sue Evans has received or will receive any financial reward for participation in the case.

An ICMJE form is in the supplementary material, available online at <https://doi.org/10.1192/bjb.2020.72>.

1.2.69 Sex, gender and gender identity: a re-evaluation of the evidence

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Abstract

In the past decade there has been a rapid increase in gender diversity, particularly in children and young people, with referrals to specialist gender clinics rising. In this article, the evolving terminology around transgender health is considered and the role of psychiatry is explored now that this

condition is no longer classified as a mental illness. The concept of conversion therapy with reference to alternative gender identities is examined critically and with reference to psychiatry's historical relationship with conversion therapy for homosexuality. The authors consider the uncertainties that clinicians face when dealing with something that is no longer a disorder nor a mental condition and yet for which medical interventions are frequently sought and in which mental health comorbidities are common.

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pmc In 2018 the Royal College of Psychiatrists (RCPsych) issued a position statement to promote good care when dealing with transgender and gender-diverse people that relates to 'conversion therapy'.¹ In this article we reappraise the phenomenology of gender identity, contrast 'treatments' for homosexuality with those for gender non-conformity, analyse the relationship between gender dysphoria and mental disorders with particular reference to the younger cohort of transgender patients, and ask how psychiatrists can address distress related to gender while upholding the central tenet of 'first do no harm'.

Homosexuality and conversion therapy

Male homosexuality was outlawed in the UK in 1865 until the Sexual Offences Act 1967 decriminalised sexual acts between men. During that time, homosexuality was shameful, stigmatised and conceptualised as a mental disorder. Psychiatry was instrumental in its treatment, which continued even after the legal change.²

Attempts to 'cure' same-sex desire included psychotherapy, hormone treatment and various behavioural interventions. These interventions are now considered 'conversion' or 'reparative' therapy.³ One high-profile failure for such 'treatments' was Alan Turing. After being found guilty of gross indecency in 1951, he was prescribed oestrogen, which rendered him impotent and caused gynaecomastia. He died by suicide in 1954.⁴

Conversion therapies lost popularity as evidence emerged of their ineffectiveness,⁵ coupled with more tolerant social attitudes. Homosexuality was removed from the World Health Organization (WHO) ICD-10 classification in 1992. In 2014, the RCPsych published a position statement explicitly rejecting conversion therapy and supporting a ban.⁶ Same-sex orientation is regarded as a normal, acceptable variation of human sexuality.

Enshrined in the Equality Act 2010, lesbians and gay men in the UK now enjoy the same civil rights as heterosexuals in terms of healthcare, marriage and raising of children, and equal employment. Although they enjoy equal status and

increased visibility in most Western societies, there remain countries and cultures where same-sex practice is taboo or criminal, and where people still seek treatment.

Beyond sexual orientation

In recent years, increasing links have been forged between lesbian and gay communities and those representing other gender identities. Stonewall describes ‘any person whose gender expression does not conform to conventional ideas of male or female’ as falling under the umbrella term ‘trans’.⁷

Definitions have evolved beyond those included in the 1992 ICD-10 under ‘gender identity disorders’, with which psychiatrists might be familiar.⁸ Transsexualism was widely understood to mean ‘a desire to live and be accepted as a member of the opposite sex, and an accompanied discomfort of one’s anatomic sex’.⁸ Underlying mechanisms are poorly understood, although there are similarities and overlaps with both body dysmorphia and body integrity identity disorder.^{9,10} Sufferers might embark on social and medical intervention to help them ‘pass’ as the opposite sex. Historically, a diagnosis of gender dysphoria would have been required for doctors to intervene in this group.¹¹

Transgender, however, has become a much broader category (*Fig. 1*). New terminology reflects a conceptual shift from clinical disorder to personal identity.¹² Crucially, gender dysphoria is no longer integral to the condition. The World Health Organization has renamed ‘gender identity disorder’ as ‘gender incongruence’ and reclassified it as a ‘condition related to sexual health’ rather than retaining it in the chapter pertaining to ‘mental and behavioural disorders’,¹³ a somewhat discrepant placement, reflecting a political rather than scientific decision-making process. *Fig. 1A* page from *The Gender Book*¹² (reproduced with permission of www.thegenderbook.com).

By contrast, DSM-5 has removed ‘gender identity disorder’, renaming it ‘gender dysphoria’. It is possible to meet the criteria for a diagnosis of gender dysphoria within DSM-5 without experiencing body dysphoria relating to primary or secondary sexual characteristics,¹⁴ and the American Psychiatric Association emphasises that ‘not all transgender people suffer from gender dysphoria’.¹⁵

The following is from the 2018 ICD-11:¹⁶ “‘Gender incongruence of childhood is characterized by a marked incongruence between an individual’s experienced/expressed gender and the assigned sex in prepubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child’s part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games or activities and playmates that are typical of the experienced gender rather than the assigned sex.’”

Definitions are inadequate in explaining how anyone experiences the gender of the opposite sex. Without further explanation of ‘toys, games or activities’ that are typical of each sex, this is left to parents, teachers and doctors to determine. The inference might be that gender-congruent behaviours have some objective existence and not fulfilling them might indicate a ‘trans’ identity. Children who do not conform to social norms and expectations come to dislike their sexual characteristics: that embodiment of their gender dissonance.

There is a lack of consensus demonstrated as to the exact nature of the condition. Questions remain for psychiatrists regarding whether gender dysphoria is a normal variation of gender expression, a social construct, a medical disease or a mental illness. If merely a natural variation, it becomes difficult to identify the purpose of or justification for medical intervention.

Conversion therapy relating to gender

The RCPsych gives a description within the position statement of ‘treatments for transgender people that aim to suppress or divert their gender identity – i.e. to make them exclusively identify with the sex assigned to them at birth’.¹ Conversion therapy is described as ‘any approach that aims to persuade trans people to accept their sex assigned at birth’. It goes on to include ‘placing barriers [to] medical transition’. Unfortunately, the statement does not define ‘approach’ beyond alluding to psychoanalytic or behavioural talking therapies. Thus, conversion therapy for transgender people appears conflated with that for homosexuality. Furthermore, there is little evidence that it is taking place in the UK.¹⁷ Historically, a diagnosis of gender dysphoria was required before medical intervention;¹⁰ this is a part of standard gatekeeping that is now being criticised as a ‘barrier’ instead of regular safe medical practice.² Now, a self-declaration of being ‘trans’ appears to be indication enough for a patient to expect their doctor provide a range of complex medical treatments, with no evidence of dysphoria being required.¹⁸

The position statement¹ could also be read as suggesting that full medical transition is an ultimate goal in gender-diverse patients, rather than considering a range of possible goals, which might include limited interventions or reconciliation with one’s own (sexed) body. With regard to conversion therapy in children, the statement does not refer to desistance; evidence suggests that the majority of children left alone reconcile their identity with their biological sex; the feelings of 60–80% of children with a formal diagnosis of gender dysphoria remit during adolescence.^{19–21}

Definitions of sex, gender and gender identity

Gender theorists propose that all people must have a gender identity; it is not waivable. For those people whose internal identity aligns with their sex, the word cisgender and ‘cis’ terminology are used. Those whose identity is wholly that of the opposite sex are described as transgender or ‘trans’. However, there are other identities for those whose internal sense lies somewhere between or outside a neat fit into either gender-binary category. Fluidity and fluctuation in gender identity is also recognised, with categories such as ‘non-binary’, ‘gender-fluid’, ‘genderqueer’, ‘pangender’ and ‘genderfuck’ all recorded by clinicians at the UK’s Gender Identity Development Service (GIDS) for under-18-year-olds.²² The social networking site Tumblr presently describes over 100 different genders.²³ Without a strong male or female identification, ‘agender’ becomes itself another gender identity.

Some consider gender identity to be fixed and absolute, with some neuroscientists asserting that it develops *in utero* in the second-trimester brain.^{24,25} However, there is little to no convincing evidence to support fundamental differences between the brains of females and males.²⁶ If one’s ‘internal sense of being a man or a woman’ no longer refers to a ‘man’ or ‘woman’ as defined by biological sex²⁷ then the definition of gender identity risks becoming circular.

Within current debates, if gender identity becomes uncoupled from both biological sex and gendered socialisation (*Box 1*), it develops an intangible soul-like quality or ‘essence’. As a pure subjective experience, it may be overwhelming and powerful but is also unverifiable and unfalsifiable. If this identity is held to be a person’s innermost core concept of self, then questioning the very existence of gender identity becomes equated with questioning that person’s entire sense of being, and consequently risks being considered a threat to the right to exist, or even as a threat to kill. Behaviours such as ‘misgendering’ or ‘dead-naming’ are understood by proponents of gender theory to be destructive, debasing and dehumanising.²⁸ This might explain why the prevailing discourse has become as sensitive and at times inflammatory as it has.

Box 1 Sex, gender and gender identity

Sex Humans are sexually dimorphic: there are only two viable gametes and two sexes, whose primary and secondary sexual characteristics determine what role they play in human reproduction. Sex is determined at fertilisation and revealed at birth or, increasingly, *in utero*. The existence of rare and well-described ‘disorders (differences) of sexual differentiation’ does not negate the fact that sex is binary. The term ‘assigned at birth’ suggests a possibly arbitrary allocation by a health professional, rather than the observed product of sexual reproduction.

Gender Gender describes a social system that varies over time and location and involves shaping of a set of behaviours deemed appropriate for one’s sex. It operates at an unconscious level via strong social norms, yet is also rigidly enforced by coercive controls and sometimes violence.¹⁸ The ‘rules’ exist regardless of how individuals feel about them. Gender can thus be perceived as oppressive and potentially painful to all people of both sexes within patriarchal societies, the dominant form of social structure across most, although not all, of the globe. Feminist theory holds that gender operates as a hierarchy, with men occupying the superior position and women the subordinate. As long as this hierarchy exists, all women are harmed to some extent, whether or not they conform to their sex stereotypes.¹⁹

Gender identity If sex refers to biology, and gender to socialisation and role, then gender identity may

be viewed as the psychological aspect. The American Psychological Association defines it as ‘someone’s internal sense of being a man or a woman’.²⁰ Gender identity is thus distinguished from biological sex and gendered socialisations.²¹

Nonetheless, notions of gender identity are still contested and raise some ethical questions for professionals working at the interface of physical and mental disorder. Most psychiatrists reject Cartesian dualism, whereby the mind is something imprisoned inside the body, or the ‘ghost in the machine’.²⁹ How should doctors consider the body? We are born as, and die as, a body; we *are* our bodies. How can someone be born in the wrong body? Many patients bring a ‘wrong’ or ‘wronged’ body to their doctor; these may be traumatised, wounded, diseased or disliked bodies. How should doctors react when someone informs them that, although they inhabit the body of a man, they are in all other respects female? We must deal with all our patients with compassion but also make safe medical decisions when demonstrable material reality is at odds with a patient’s subjectivity.

Children and adolescents

The Gender Identity Development Service (GIDS), Britain’s only specialised gender service for children and adolescents and based at the Tavistock Centre, London, has recorded a 25-fold rise in referrals since 2009, most marked in biological girls (‘assigned female at birth’), who make up the majority of referrals presently (*Fig. 2*).³⁰ *Fig. 2* Referral rates to the Gender Identity Development Service at the Tavistock Centre (Tavistock and Portman NHS Trust) in London between 2009 and 2019.³⁰

Despite gender dysphoria no longer falling within the remit of mental illness in ICD-11, there is a substantial body of evidence of increased levels of mental illness among adults, usually attributed to societal responses to gender non-conformity or ‘minority stress’.³¹ De Vries et al measured psychiatric comorbidity among those referred to a child and adolescent gender clinic in The Netherlands and also found increased rates of depression, anxiety and suicidal ideation in this younger group.³² However, a potentially worrying picture regarding causes and consequences emerges from more recent research in this young, increasingly natal-female population.

Kaltiala-Heino et al examined referrals to an adolescent gender identity clinic in Finland over a 2-year period, finding high rates of mental health problems, social isolation and bullying (*Fig. 3*).³³ Most bullying pre-dated the onset of gender dysphoria and was unrelated to gender incongruence. *Fig. 3* Referrals to an adolescent gender identity clinic in Finland over a 2-year period (from 2011–2013).³³

Similarly, in the UK, Holt et al³⁴ found that associated difficulties were common in children and adolescents referred to the GIDS in London (*Fig. 4*). Same-sex attraction was particularly common among natal females, with only 8.5% of those referred to the GIDS describing themselves as primarily attracted to boys. This raises important questions about current societal acceptance of young lesbians even within youth LGBTQ+ culture. It is possible that at least some gender-non-conforming girls come to believe themselves boys or ‘trans masculine non-binary’ as more acceptable or comfortable explanations for same-sex sexual attraction,³⁵ a kind of ‘internalised homophobia’. Autism spectrum disorders are consistently overrepresented in referred children and adolescents.³⁶ *Fig. 4* Referrals to the Gender Identity Development Service at the Tavistock Centre (Tavistock and Portman NHS Trust) in London between 1 January 2012 and 31 December 2012.³⁴ ASD, autism spectrum disorder.

The RCPsych’s position statement acknowledges these elevated rates of mental illness within the transgender population,¹ but appears to attribute them primarily to hostile external responses to those not adhering to gender norms (or sex-specific stereotypes).^{37,38} A deeper analysis of mental illness and alternative gender identities is not undertaken, and common causal factors and confounders are not explored. This is worrying, as attempts to explore, formulate and treat coexisting mental illness, including that relating to childhood trauma, might then be considered tantamount to ‘conversion therapy’. Although mental illness is overrepresented in the trans population it is important to note that gender non-conformity itself is not a mental illness or disorder. As there is evidence that many psychiatric disorders persist despite positive affirmation and medical transition, it is puzzling why transition would come to be seen as a key goal rather than other outcomes, such as improved quality of life and reduced morbidity. When the phenomena related to identity disorders and the evidence base are uncertain, it might be wiser for the profession to admit the uncertainties. Taking a supportive, exploratory approach with gender-questioning patients should not be considered conversion therapy.

Suicide, self-harm and current controversies

Transgender support groups have emphasised the risk of suicide. After controlling for coexisting mental health problems, studies show an increased risk of suicidal behaviour and self-harm in the transgender population, although underlying causality has not been convincingly demonstrated.³⁹ Then, expressed in the maxim ‘better a live daughter than a dead son’, parents, teachers and doctors are encouraged to affirm unquestioningly the alternative gender for fear of the implied consequences. There is a danger that poor-quality data are being used to support gender affirmation and transition without the strength of evidence that would normally determine pathways of care. One 20-year Swedish longitudinal cohort study showed persisting high levels of psychiatric morbidity, suicidal acts and completed suicide many years after medical transition.⁴⁰ These results are not reassuring and might suggest that more complex intrapsychic conflicts remain, unresolved by living as the opposite sex.

Established risk factors for self-harm and suicidal behaviour appear to be age related (younger trans patients are at higher risk) and include comorbid mental health problems, particularly depression, and a history of sexual abuse.³⁹ Thus, all new patients of any age warrant thorough assessment and formulation using a biopsychosocial model; the best evidence-informed interventions should be provided. If this is followed by an individual desisting it should not be considered conversion therapy. That term should perhaps be reserved for coercive treatments.

Best psychiatric practice avoids oversimplification of the causes and treatment of suicidal behaviour and self-harm. Preliminary data from a small ‘before and after’ pilot study of the use of puberty blockers at the Tavistock Centre in selected children found a reduction in body image problems in adolescents following a year of puberty suppression. However, positive effects were offset by increases in self-harm and suicidal thoughts.⁴¹ Surprisingly, this unpublished study was deemed a success such that prescribing of puberty blockers was introduced as standard practice and commissioned with scaling up of services. There was no development of alternative psychological approaches, nor were randomised controlled comparisons made.

Evidence suggests that almost 100% of children commencing puberty blockade go on to receive cross-sex hormones.⁴² This requires further interrogation to ascertain whether the high figures are due to robust, effective selection and gate-keeping or to a less palatable interpretation that preventing physical and sexual maturation crystallises gender dysphoria as a first step on a cascade of interventions.⁴³ The GIDS remains under intense scrutiny regarding research criticisms.⁴⁴ Although in the early 2000s it was criticised for being too conservative and not offering puberty blockers, there appears to have been a volte-face made in response to external pressure,⁴⁵ without the publishing of robust data showing that this intervention is effective and safe.

Puberty blockers are known to affect bone and, possibly, brain development. They put users at risk of developing osteoporosis⁴⁶ and are associated with reductions in expected IQ.⁴⁷ They are described as ‘buying time’ for adolescents to make up their mind about whether to proceed with transition. Long-term effects are not known, but infertility appears inevitable when cross-sex hormones are introduced shortly after puberty blockers.⁴⁸ Loss of sexual maturation will also be associated with lack of adult sexual function, although it is unlikely that a pre-pubertal child can truly understand this side-effect at the time of consent.

Those seeking transition are a vulnerable population who suffer from high levels of suicidality, psychiatric morbidity and associated difficulties. Medical and surgical transition is sought to relieve these psychiatric symptoms. Plausibly, there is an initial reduction in distress following transition, although no controlled trials exist. Therefore, the long-term outcome of medical and surgical transition in terms of mortality and quality of life remains unknown. No long-term comparative studies exist that satisfactorily demonstrate that hormonal and surgical interventions are superior to a biopsychosocial formulation with evidence-based therapy in reducing psychological distress, body dysphoria and underlying mental illness.

Clinical implications

It is unclear what the role of psychiatry is in the assessment and treatment of gender dysphoria, now that it is no longer considered a diagnosable mental illness, and whether there is still a place for a routine psychosocial assessment. It could be argued that patients should be deterred from gender intervention pathways while comorbid mental illness is treated (*Fig. 5*). Without long-term follow-up data, it is not possible to identify those who might reconcile with their sex and those who might come to deeply regret their medical and/or surgical transition. Moreover, it is not transparent where ultimate and legal responsibility for decision-making lies – with the patient, parents (if the patient is a child), psychologist, endocrinologist, surgeon or psychiatrist. *Fig. 5* Are these scenarios examples of good clinical practice or conversion therapy?

Psychiatrists understand that human development is necessary, but not always comfortable. Puberty, although a normal physiological process, is associated with particularly high levels of psychological and bodily discomfort. Psychiatrists' role is to journey with patients as change is navigated and to provide support through sharing uncertainty and difficult decision-making. But in the current climate, psychiatrists may be unsure whether addressing psychological and social antecedents will lead to accusations of conversion therapy. Attempts to reconcile a sufferer's discomfort with their actual body would be good practice in other conditions involving body image disturbance, such as anorexia nervosa.

The magnitude of any benefits of medical and surgical transition is not clear. Follow-up studies are sparse, and with the new cohort of adolescents, clinicians step even further into the unknown.⁴⁹ These young people are not comparable to adult, mainly male-to-female, research participants on whom existing empirical clinical guidelines were based. Doctors are now questioning the wisdom of gender-affirmation treatment of children and young people, citing poor diagnostic certainty and low-quality evidence.⁵⁰ A recent review of evidence for the use of gender-affirming hormones for children and adolescents states that these drugs 'can cause substantial harms, including death' and concludes 'the current evidence base does not support informed decision making and safe practice'.⁵¹

Among a plethora of online videos by teenagers proudly displaying their mastectomy scars a worrying increase in detransitioner testimonies can now be found⁵² (*Fig. 6*). These are mainly young women who have rejected their trans identities and are reconciling with their birth sex. *Fig. 6* Reasons given for detransitioning in a female detransition and re-identification survey run between 16 and 30 August 2016 and shared through online social networking sites.⁵²

Feminist concerns

In theory, universal human rights should not pit disadvantaged groups against one another, but in practice, disputes occur. Women's rights activists point to persistent global inequalities, sex discrimination and violence against women and girls. They are concerned that ignoring sex as a reality risks no longer being able to name, measure and ameliorate sex-based harms. Endorsing old sex and gender stereotypes in an attempt to validate young patients may inadvertently shore up outdated notions of how men and women should look and behave. There is no reason to believe that women have an innate love of pink and wearing high heels and find map-reading difficult, any more than men have a natural leaning towards blue and playing football and make excellent leaders.

Inherent in the notion of 'gender identity' is that there already exists a specific subjective experience of being a man or a woman. However, there cannot be a significant intrinsic experiential difference between male and female human beings when we cannot know what those differences are. One cannot possibly know how it feels to be anything other than oneself. Medicine may be in danger of reinforcing social norms and reifying a concept that is impossible to define over and above material biological reality. At present, many health, social, educational and legal policies are being adapted to give gender primacy over sex.^{53–57}

Conclusions

Language that confuses or conflates sex and gender identity, while appearing inclusive, might have the unintended consequence of closing down the means to understand complexity and respond appropriately to patients' emotional and material reality. The medical profession must be compassionate, accept differences and fight for those who are marginalised and discriminated against.

However, viewing transgender as a fixed or stable entity, rather than a state of mind with multiple causative factors, closes down opportunities for doctors and patients to explore the meaning of any discomfort. Being gender non-conforming, or wishing to opt out of gender altogether, is not only *not* indicative of mental disorder – it is, in many ways, an entirely rational response to present capitalist reliance on rigid gender norms and roles. However, when multiple medical interventions are required on an otherwise healthy body or doctors are expected to deny the concept of sex or the sexed body, the situation becomes less coherent. The notion of conversion therapy for those seeing themselves as transgender relies on another binary – that of 'cisgender' and 'transgender' – being set, closed, biologically anchored categories without overlap, rather than a more plausible hypothesis that one's gender identity is flexible, informed by one's culture, personality, personal preferences and social milieu.

The push for early bodily modification and hormones by some transgender patients is a cause for concern. New services, modelled on commissioning guidance from NHS England for adults of 17 years and above, will allow for self-referral, preclude psychological formulation or therapeutic intervention as standard practice, and recommend hormonal intervention after two appointments.⁵⁸ This will further scale up hormonal and surgical interventions in young patients, who will miss out on pubertal development and necessary mental health treatment in their quest for interventions that may harm and that they may later regret.

In the rapidly moving and politicised debate, psychiatrists look to the RCPsych for guidance. Those providing and interpreting the scanty evidence from published research need to be independent and impartial, using best-quality measures rather than ideology. It is confusing to liken open-minded working with young patients as they figure out who they are to conversion therapy. Holding an empathic neutral middle ground, which might or might not include medical transition, should not be equated with this. Psychiatrists need to feel empowered to explore the meaning of identity with their patients, treat coexisting mental illness and employ a trauma-informed model of care when appropriate.

The General Medical Council's Good Medical Practice demands of clinicians compassion, shared decision-making and safeguarding of young people's open futures.⁵⁹ The counterargument to unquestioning gender affirmation is that the process of medical transition may itself prove to be another form of conversion therapy, creating a new cohort of life-long patients dependent on medical services and turning at least some lesbian and gay young people into simulacra of straight members of the opposite sex. Psychiatry sits on this knife-edge: running the risk of being accused of transphobia or, alternatively, remaining silent throughout this uncontrolled experiment. Respectful debate, careful research and measurement of outcomes are always required.

We consulted a trans woman and a detransitioner for this article. We thank them for their input.

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L.G.: undertook a search and analysis of the literature, and conceived and wrote the paper. K.C.: undertook a search and analysis of the literature, and contributed to the drafting of the paper. R.B.: participated in the conception and evolution of the analysis, critically reviewing the paper and suggesting amendments incorporated into the final paper. S.B.: participated in the conception and evolution of the analysis, critically reviewing the paper and suggesting amendments incorporated into the final paper.

Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2020.73>.

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1.2.70 Response to Dr de Silva's letter

Gethin Morgan

date

2021-12

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- *Response to Dr de Silva's letter*

pmc 02 December 2020

Dr de Silva's wide-ranging review of suicide prediction strategies is very welcome: it includes a number of useful new ideas on how our predictive efforts can be taken forwards. I do not wish to take issue with any of them. My own paper, however, focuses more narrowly on two specific issues. The first highlights the way in which ongoing variation in severity of intent, usually due to the random and unpredictable occurrence of stress-related events, can confound our predictive efforts, and I suggest how we might circumvent this. The second aims to show that, in spite of attempts to dismiss its value, the assessment of suicidal ideation can have a useful role in the prediction process, provided it is applied correctly and used appropriately. My approach is in the nature of risk assessment, which has been criticised by some as being too dependent on negative issues. I hope I have shown that by helping to identify future hazards and so anticipate ways of dealing with them, this is not just a negative process. A capable clinician should surely be able to ensure that such assessment does not compromise the establishment of a good trusting relationship with the patient. My overall hope for the future of suicide prevention is that polarised views, in which different approaches are seen as either good or flawed, will not prevail. Good points from each and every approach can then be incorporated into an overall synthesis of preventive strategy that can be used in clinical practice.

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1.2.71 Expanding capacity in mental health research in intellectual disabilities

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Abstract

Although the research base on mental health in intellectual disabilities is advancing, there are long-standing barriers that hinder successful completion of funded studies. A variety of stakeholders hold the key to mitigating the challenges and arriving at sustainable solutions that involve researchers, experts by experience, clinicians and many others in the research pathway. Lessons learned during the COVID-19 pandemic can also contribute to improvements in the conduct of research in the medium to long term. People with an intellectual disability and mental health conditions deserve high standards of evidence-based care.

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pmc Research evidence is essential in supporting professional decision-making for the benefit of patients across health and social care. The benefits of participation in research include better outcomes and more efficient use of resources, with harmful or unhelpful treatments being phased out.

A major driver for funded applied health and social care research is the increase in research capacity and the completion of high-quality studies on priority topics that have been identified by stakeholders, including scientists and the public. In the UK, the substantial annual investment of more than £1 billion by the National Institute for Health Research (NIHR) supports both projects spanning the range of methodologies and the infrastructure to underpin the endeavour.

Recognising the challenges of investing and supporting research in health and social care organisations, NHS England and the NIHR published a joint report¹ that included 12 actions that would help to relieve the bottleneck many chief investigators encounter at the setting-up and recruitment phases. Two major stumbling blocks at the time were setting excess treatment costs with regard to treatment delivery, and research governance; the latter ranges from ethical approval to assessment of local capacity and capability in agreeing recruitment targets.

Although progress has been made, these issues, which are common in research activity across many different health and social care domains, have not completely resolved 3 years on. In this editorial we address a variety of both barriers to research and facilitators of research, with a specific focus on research in intellectual disability services. We argue that such problems may be relevant in research in other hard-to-reach populations who may or may not have cognitive impairment.

Since the launch of the NIHR in the UK in 2006, there has been an increase in the number of funded studies investigating a variety of research questions in intellectual disabilities, including developing, adapting and testing interventions in randomised controlled trials (RCTs). The majority of these are trials of psychosocial interventions. However, the portfolio of studies remains small compared with other fields of medicine, estimated at 1.4% of all NIHR-funded studies.²

People with intellectual disabilities (global developmental delay evident in childhood that affects adaptive functioning) account for approximately 2% of the population in the UK and are more likely to suffer health-related multimorbidity, higher and earlier mortality and face significant inequalities.³ Many lack capacity and therefore decisions about their participation in research depend on families' and paid carers' understanding and attitudes towards research projects and research processes. This is because they may be called on to act as consultees to enable participation of those most vulnerable. It is therefore essential that people lacking capacity should also be able to take part in and benefit from research specific to people with intellectual disabilities, with appropriate safeguards as mandated in the Mental Capacity Act 2005 or equivalent permissions internationally.

Barriers

Despite the amount of research conducted over time, many challenges that have been reported previously still remain and have an impact on the completion of studies. Lennox et al⁴ described identification of substantial numbers of participants, frequent need for substituted decision-making, occasional limited literacy of both person and carer, and organisational gate-keeping practices as significant barriers to recruitment in an RCT of health checks in Australia. More recently, a systematic review of 53 papers reporting RCTs in people with intellectual disabilities published between 2000 and 2017⁵ identified similar barriers in recruiting to target, participant treatment preferences, engaging with stakeholders, obtaining consent and staff turn-over. Optimistically the authors concluded, 'conducting RCTs with people with cognitive disabilities can be challenging, however, with reasonable adjustments, many of these barriers can be overcome'.

People with intellectual disabilities are excluded from research that may be relevant to their health vulnerabilities,² as well as being sceptical about the impact of it on their lives. This is illustrated by the Research Voices project,⁶ which revealed a number of serious concerns that parents of people with profound and multiple disabilities harbour about research, such as mistrust of health professionals seeking participants for studies, the emotional and time burden of research assessments, frustration with not knowing the findings or findings not translating to real improvements in practice.

Research infrastructure brings its own multifaceted challenges. The role of clinical research practitioners (CRPs) (who are National Health Service (NHS) based and able to recruit from services directly) is not fully understood by intellectual disability services and there is significant variation among the operations of clinical research networks across the different UK countries. Therefore, professionals in the services may be asked to undertake recruitment in addition to an already busy clinical role. Further, data guarantors are frequently local authorities, who are providers of social care services not directly connected to the NHS in England. Finally, intellectual disability services that are located outside NHS structures have fewer opportunities to be informed of ever-evolving research processes, thus remaining unable to utilise available resources to assist them in incorporating and supporting research in their day-to-day practice.

Clinician factors are also important in maintaining non-engagement in research activities, including older age, being male and working in the private sector.⁷ Oliver-Africano et al⁸ identified beliefs about drug efficacy, potential ethical conflicts in medication trials and multidisciplinary team processes as having adversely affected recruitment to a clinical trial of antipsychotics in adults with intellectual disabilities. Delays associated with any of these factors inevitably matter in completing studies that depend on time-sensitive research contracts and are likely to hamper the validity of the research findings if there is underrecruiting.

Finally, clinicians and scientists in general may not make sufficient effort to include participants from underrepresented groups in their studies, thus perpetuating the limited access of people with intellectual disabilities in research. This is particularly important for diseases where it has been demonstrated that there is excess morbidity and/or mortality in this population.⁹

Facilitators

Prioritisation of research is likely to confer benefits to both health and care organisations, as shown by views reported in a review of engagement in research:¹⁰ “The wider review demonstrated [...] how collaborative and action research can encourage some progress along the pathway from research engagement towards improved health-care performance. There is also evidence that organisations in which the research function is fully integrated into the organisational structure, out-perform other organisations that pay less formal heed to research and its outputs.” These lessons, although not specific to intellectual disabilities, are relevant in this context as presenting a justification for embracing research by the multitude of service configurations delivering care to this population.

In other changes to research governance, the new Health Research Authority has halved the time needed to obtain regulatory approvals,¹¹ although other milestones along the research pathway remain areas of concern.

Although the funding for research in intellectual disabilities may be lower than what is essential for investigating the increased morbidity, mortality and the health inequalities seen in this population group, there is an emerging cohort of completed high-quality studies. There are also many committed researchers, healthcare service professionals and other staff whose enthusiasm and problem-solving capacity signal their willingness to engage with the process. These may further promote interest in research by influencing national clinical practice and through targeted dissemination, including to people with intellectual disabilities and their carers. Clinician familiarity with academic work, peer support and support from management are also likely to increase positive attitudes towards research. Research that is seen as arising out of patient concerns and that could lead to tangible benefits in interventions and care improvements is also likely to be supported.⁶

Recently the NIHR Dissemination Centre published a themed review on intellectual disability research.¹² More than showcasing the funded projects, it highlighted the meaning of the findings for the care that people with intellectual disabilities and their family carers receive. In addition, the collection of studies included in the review demonstrate that funded research can be conducted successfully in the field of intellectual disabilities but that all the studies have had significant involvement of people with intellectual disabilities and their family carers throughout. These studies are examples of good practice that can be shared between researchers, people with intellectual disabilities, their carers and charities supporting them.

Solutions

A primary area for mitigation lies in health and social care professionals’ and people with intellectual disabilities’ conviction of the importance of research and its wider contribution to lives and well-being. A recent course¹³ devised to train people with intellectual disabilities in research methods suggests that learning about conducting research and driving the research process is feasible. Such courses could increase the number of suitably trained people with intellectual disabilities who could be recruited to work as researchers in various projects.

Incentives for encouraging donation of time to research activities by family and paid carers may improve uptake and retention, alongside other strategies. Increasingly, experts by experience are being asked to interpret and comment on research findings and this is a way of increasing familiarity with research processes, as well as consumer feedback.

The well-intended efforts of paid carers to protect vulnerable adults if they lack capacity, including the personal data protection regulations, often stifle participant recruitment. In England and Wales, this could be addressed by a revision of the Mental Capacity Act 2005. Heywood et al¹⁴ outlined how the Act is predominantly focuses on treatment and decision-making within a ‘best interests’ framework, rather than on research where decisions are not made using that framework. The sections of the Act governing research do not effectively balance protection and empowerment, and researchers may be reluctant to include participants who lack capacity in research projects.

The research community may also need to take some responsibility in providing solutions to the present challenges. Being clear about what the findings mean to the wider group of people with intellectual disabilities, proactive dissemination strategies and other activities in engaging the public with research are paramount in moving forward. Research aims to shape service delivery and to translate advances in science into measurable benefits for the population at large. It is questionable whether consumers consider research findings relevant to their health and whether those who commission services apply research findings to enhance clinical effectiveness and value for money.

An example of fostering closer links between clinicians, academics and people with lived experience of intellectual disability is the newly formed RADiANT consortium, a platform that works to increase health and social care staff's awareness of research and develop research skills and capacity. The consortium is focused on mental health and behavioural problems in intellectual disabilities, autism and other neurodevelopmental conditions (see radiant.nhs.uk for more information). So far it has produced guidance on how to manage the COVID-19 pandemic in different mental health settings and has delivered several educational activities. Its wider impact remains to be established.

Professional bodies across all professions must also promote research-related objectives in training curricula and on public-facing forums such as websites and newsletters.

Strengthening health and social care links is an area for further development, especially as social care is identified by NIHR as a domain for research investment. This means extension of the research infrastructure to reach the neglected care sector, which is central to accessing individuals to take part in research activities as proxy informants.

The coronavirus pandemic has shown that, while continuing to endorse ethically conducted research, it is possible to do so at pace.¹⁵ It will be important to remember those lessons as we are coming out of the pandemic and in the event of future public health emergencies. In particular, they can inform how to carry out remote research assessments and interviews with participants with intellectual disabilities and ensure that the voice of experts by experience remains central to research activity. During the pandemic, people with intellectual disabilities have been disproportionately affected in both their health and social care needs and require high standards of support in both. We must be able to reassure them and their families that being partners in research pays off in achieving those standards.

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Declaration of interest

None.

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1.2.72 Involving service users to identify research priorities in a UK forensic mental health service

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2021-12

Abstract

Aims and method

Patient and public involvement (PPI) is a priority for health research. PPI improves the relevance and quality of research. The study aimed to involve service users in identifying research priorities for the service. A two-phase adapted Delphi technique was used to generate a list of research topics from service users in secure in-patient mental health settings and on specialist mental health prison wings. Topic content analysis was undertaken. Service users were further consulted, and research themes were ranked in order of priority.

Results

Of the eight research themes identified, the three given the highest priority by service users were, in descending order, physical health, future plans and moving on, and causes of illness and crime.

Clinical implications

Service users are willing to be involved in setting research priorities for mental health services. Through non-tokenistic PPI, service users can uniquely shape the research agenda of mental health services.

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- *Supplementary material*
- *Data availability*
- *Declaration of interest*

pmc Patient and public involvement (PPI) is a strategic priority for the National Institute of Health Research,¹ enabling stakeholders to have roles other than as research participants throughout the research process.² Despite the barriers,³ challenges of time and methodological conflict, PPI can bring benefits to research.⁴ It improves the relevance and quality of research,¹ and increases recruitment success.⁵ Researchers in this field have evidenced the value that the PPI perspective can bring to research,⁶ but caution using tokenistic approaches. Utilising a devolved model of working with user-led organisations or groups can support effective involvement,⁷ as long as all parties clearly understand the underpinning philosophy. A related approach of using a reference group specifically established to guide and assist with the conduct of a research project is also recognised as valuable.⁸

The Tees Esk & Wear Valleys NHS Foundation Trust's forensic directorate aims to significantly increase research activity. Although forensic mental health priorities have been previously proposed, they have arisen from studies that did not include service users,^{9,10} focused on specialist areas outside of in-patient¹¹ or prison settings,¹² and sought consensus between service users and professionals.¹¹ This paper describes how non-tokenistic PPI through adapted Delphi methodology can be applied in a forensic service, to identify service user priorities for research.

Method

Setting

The forensic service has 18 in-patient clinical areas, offering 224 medium-secure, low-secure and locked rehabilitation beds to adult males and females with a range of mental disorders, intellectual disabilities (also known as learning disabilities in UK health services) and autism spectrum disorders. The service also provides mental healthcare to 11 prisons in the north of England and to patients in the community. Within the prison system, there are 29 beds across two specialist mental health wings (clinical areas). Each of the 20 clinical areas holds a regular service user-led community meeting with staff support. The meeting is used to share information, elicit views that may be passed on to service managers and discuss items of interest to the in-patient experience. Attendance and participation at these meetings is voluntary. There is also a community service that does not have equivalent service user community meetings.

Ethical approval and service user involvement

No identifiable participant data were collated, and all data were collected through existing service user meetings. Ethical approval was not required for this study, which was accountable throughout to the Forensic Speciality Development Group in Tees, Esk and Wear Valleys NHS Foundation Trust. The project proposal was approved by the hospital-wide service user group, whose suggestions shaped study design.

Design

The Delphi technique is an established methodology that has been used widely in psychiatry to consult with and build consensus among experts in the field.¹³ A two-phase modified Delphi exercise was undertaken in which service users were consulted as experts by experience of the forensic service. An iterative process was followed to obtain consensus on the most important research themes.

Participants

All users of services who were available and willing to attend an established community meeting in one of the clinical areas were eligible to participate in the exercise. Service users in prison who were not on a specialist mental health wing and users of forensic community mental health services were therefore not eligible to participate.

Delphi process: phase 1 – obtaining the initial views of service users

A consultation form was developed for use in community meetings. The form comprised three sections. In the first section, a succinct definition of research and examples of health research questions unrelated to mental health were given; for example, ‘what causes heart attacks?’, ‘what is the cure for cancer?’ and ‘which shampoo will make your hair grow faster?’ The second section provided information about the purpose of the exercise, rationale for consulting service users, the constitution of the project team, anonymisation of responses given and the extent to which the findings would be shared. In the final section, three prompt questions were listed to elicit relevant responses about research priorities: What questions should researchers in this service try to answer? What discovery would you most like researchers to make? What do you think we need to know more about in forensic services?

The consultation form was emailed to a senior nurse in each clinical area, with a cover letter explaining the background to the project and how to use the form to elicit and anonymously record service user views. Instructions were given to record the numbers of patients on the ward, at the meeting and contributing to the process. The importance of service user voluntariness in participating in the exercise was highlighted. The senior nurse was asked to present the form during a community meeting and invite service users to answer the three questions. Answers were written down on the form, which was returned to the project administrator.

Delphi process: phase 1 – analysing the initial views of service users

Two consultant psychiatrists and an in-patient nurse from the project team jointly undertook content analysis¹⁴ of all responses, by hand. Disagreements were resolved through consensus. An inductive–deductive approach was used to move from a large number of specific research questions and objectives provided by participants to a smaller number of general research topics.¹⁴ Each individual response was read and grouped into one category with similar responses. Each category was given a title that summarised the content of the associated responses. Then, responses in each category were reviewed in turn, to consider whether it would be more appropriate to place each response in an alternative category. This step ensured that each category accurately reflected the content of the respective responses. Next, categories that were considered similar were combined. Category titles were broadened to incorporate very small groups and single responses that could not be grouped elsewhere. Principles for the iterative analysis were to avoid single-response groups, to accurately represent service users’ responses and to identify between approximately five and

ten themes. This target number of themes was chosen to ensure the service user voice was not lost through excessive combining of responses, resulting in a small number of themes. Similarly, the aim was to avoid a very long list of themes, which would be less useful in identifying the specific areas of research that should be prioritised. The final categories represented an unranked list of research priorities.

Delphi process: phase 2 – obtaining prioritised views of service users

The results of the analysis were listed as themes on a follow-up consultation form, which defined research, explained the purpose of the project, described the first phase of the Delphi process and highlighted the voluntariness of participation. To avoid responder bias associated with the ordering of the themes, the themes were displayed in a circle on the follow-up consultation form. The form and a cover letter were sent to a qualified member of staff in each clinical area who had responsibility for disseminating research information (the Research Champion). The cover letter provided instructions on how to obtain anonymised responses from service users during the community meeting. Research Champions offered copies of the form to willing service users present at the community meeting, who were invited to circle their top three priority areas for research. The Research Champion returned completed forms to the project administrator.

Delphi process: phase 2 – analysing the prioritised views of service users

Two consultant psychiatrists, a ward-based staff nurse and a senior nurse working in the prison service met to analyse the completed follow-up consultation forms from phase 2. The themes identified in phase 1 were listed on a whiteboard. Each response form was considered in turn by the analysts, jointly. A mark was added alongside each theme on the whiteboard every time that theme was circled as a priority theme on a response form. After reviewing all responses, frequency counts were calculated for each theme. The themes were then ranked according to the number of service users who had considered each theme to be one of their top three research priorities. The overall top three research priorities were highlighted.

Results

Participation in the Delphi process

Service users from 20 clinical areas (18 wards and two prison wings) were eligible to participate in each phase of the Delphi process. Some clinical areas did not provide details of the number of service users who attended the community meeting or proposed priority research areas in phase 1. Therefore, the overall response rate in phase 1 was calculated with the number of participating clinical areas rather than individual service users.

Of the 20 clinical areas invited to participate in phase 1, responses were received from six clinical areas (five wards and one prison wing) (*Table 1*). In phase 2, five clinical areas, including one prison wing, returned completed follow-up consultation forms from 27 service users (*Table 1*). Based on the number of beds in the service ($n = 253$), this is equivalent to 10.7% of the total number of eligible service users. *Table 1* Participation of service user clinical areas in phases of the Delphi process

Participation in phase 1	Participation in phase 2	Participation in both phases	Participation in at least one phase	
Number of clinical areas responding	6 (30%)	5 (25%)	1 (5%)	10 (50%)
Number of clinical areas not responding	14 (70%)	15 (75%)	19 (95%)	10 (50%)
Number of clinical areas invited to participate	20 (100%)	20 (100%)	20 (100%)	20 (100%)

There was overlap of clinical areas participating in the two phases of the Delphi process, with service users from one (5%) of the 20 clinical areas participating in both consultation phases. Although most services users were not involved in both phases, service users from half ($n = 10$, 50%) of all clinical areas, including both prison wings, participated in at least one of phases of the Delphi process (*Table 1*).

Profile of service users participating in the Delphi process

Male and female service users from both prison and in-patients clinical areas participated in the study (*Table 2*). Input during at least one of the Delphi process phases was received from service users within hospital-based clinical areas of all three levels of security provided by the forensic service. However, females in the locked rehabilitation clinical area were not involved in the study. Services users with a mental disorder, as well as those with an intellectual disability or autism, participated in the Delphi process. *Table 2* Description of the clinical areas in which participating service users resided Clinical areas involved in the Delphi process of identifying research priorities Male Female Prison Yes Yes In-patient Medium security Yes Yes Low security Yes Yes Locked rehabilitation Yes No Mental disorders Yes Yes Intellectual disabilities and autism Yes Yes

Identification of research themes that are important to service users

Service users offered 63 suggestions for research in the first phase of the Delphi process (*Table 3*). The suggestions were written in a combination of questions and statements. Eight research themes were identified through thematic analysis (*Table 3*). The second phase of the Delphi process revealed how 10.7% of all service users across the forensic service prioritise these themes. The top three priorities for research are, in descending order, physical health, future plans and moving on, and causes of crime and illness. Other themes of importance are treatment and cures, length of stay, trust and attitudes, purpose of life and dealing with change. *Table 3* Research priorities as ranked by service users Examples of responses received in Phase 1 Themes identified in phase 2 Ranking in descending order of priority Best way to lose weight? Physical health! The correlation between medication and physical health well-being My metabolism has slowed, how do I get it going again? Best way to lose weight off the stomach? How does being in a forensic service affect your chances of getting a job? Future plans and moving on 2 Anxiety about leaving [prison mental health service] Will I always need medication? What causes offenders to reoffend? Causes of crime and illness 3 We need to know more about autism Information on eating disorders Is there a cure [for] self-harm? Treatment and cures 4 We should make treatment shorter (DBT [dialectical behaviour therapy] is too long) Could we cure LD [intellectual disability]? To have a tablet that cures everything We should try to make people's stay in hospital shorter, not waiting for treatment Length of stay 5 Discover the length of time you are going to be in hospital Attitudes of staff in prison Trust and attitudes 6 Trust issues with officers Attitudes of healthcare staff... they make me nervous More about what you want from life Purpose of life 7 What is the purpose of life? Why are you born to die? Changes in staff is destabilising Dealing with change 8 How to cope with change The impact of staff leaving [prison mental health service]... it's difficult to have staff change so frequently

Discussion

Research that is to have a meaningful impact on the care, experience and recovery of those who use forensic mental health services must involve service users from the start of the research cycle, at the point of setting research priorities. First, this study showed that PPI research methodology was effective in involving some, but not all, male and female service users in both prison and hospital settings who have a mental disorder, intellectual disability or autism. Second, through this adapted Delphi approach, services users identified eight research priorities for forensic mental health and intellectual disabilities.

It is notable that service users place a high value on health research with a holistic conceptualisation of health, including physical, mental and spiritual (existential/‘purpose of life’) domains. The list indicates that service users with a history of mental disorder and offending are interested not only in obvious aspects of forensic mental health, such as mental illness, crime and treatment, but also in staff relationships (‘trust and attitudes’) and the aetiology of their difficulties.

Contextualisation of findings

In the present study, physical health was ranked as the top priority, with a focus on weight loss. Surprisingly, this theme did not feature in the lists generated from earlier exercises to establish the research priorities in forensic mental health.^{9,11,12} The explanation for this notable difference may lie in the recent incentivised drive by commissioners of secure mental healthcare in England for providers to take demonstrable steps to improve physical health, particularly through achieving a healthy weight.^{15,16}

There was overlap with the findings of a previous study showing that service users, as well as professionals, prioritise epidemiological research into factors associated with crime and recidivism, and research oriented toward recovery topics such as the future use of mental health services and employment.¹¹ Further consistency was found in the high priority given by both clinicians and service users to research about effective treatments and interventions.¹⁰⁻¹²

This finding of common interest is not surprising, given the partnership nature of many treatments involving the professional, who delivers, prescribes or administers the treatment, and the service user, who accepts or refuses the treatment that may cause harm, benefit or no effect. However, although previous studies mentioned treatment as a research priority, service users in the present study clearly linked treatment to cure. Current understanding among mental health clinicians and academics about the nature of disorder, disease, disability and concepts of recovery, diversity, social inclusion, person-centred care and stigma may partly explain why research questions such as ‘could we cure LD [intellectual disability]?’ which are important to some service users, are less likely to be posed by professionals in a research priority-setting exercise.¹⁷

The advancement of risk assessment in forensic mental health is consistently reported as a research priority in studies based on literature review, professionals-only groups or mixed professional and service user groups.⁹⁻¹¹ Although it is not clear why risk assessment did not feature as an important research area in the present study, which involved only service users, it is proposed that this topic might be of lesser importance to service users and greater interest to professionals, whose roles involve assessing and managing risk.

It is also notable that in contrast to a larger international study of research priorities for mental health and justice, the present study of service users lawfully detained in either a prison or secure hospital under the Mental Health Act 1983 did not recommend research into legislation and policy.¹¹ Length of stay in hospital emerged as one of the new research priority areas in the present study. Although it may appear surprising that this was not a theme, given priority in previous studies, it may be that addressing other themes widely reported, such as treatment, may ultimately have an effect on overall length of stay.¹⁸

Strengths and limitations

It might appear that the responses of service users point to areas that have been extensively researched. For example, much is already known about effective weight loss interventions in the general population. Although such responses may reflect limitations of the phrasing of questions used to elicit the initial views of service users, they may also reveal a lack of evidence of context-specific effectiveness and acceptability of interventions in forensic services.¹⁵ This is evident by the aforementioned current emphasis on finding effective ways to achieve weight loss among service users in secure mental health settings.

The use of existing consultation structures is recommended for ascertaining the research priorities of service users within forensic mental health services.¹⁹ The community meeting was, therefore, an appropriate forum in which to obtain the research opinions, because service users were already accustomed to voluntarily making suggestions to improve the service in this group setting. In contrast, a formal panel meeting may have been less accessible to some in-patients and prisoners.¹⁹ Although the presence of staff and other service users might have influenced responses provided, the wide range of individual answers given, including criticism of staff attitudes, suggests that group bias was not significant.²⁰

There is little evidence to guide sampling approaches in PPI, although convenience sampling is most commonly used.²¹ The modest response during both phases of the study is a significant limitation, and may reveal lack of interest in or apathy toward research among the service user group. It is possible that such explanations may relate to psychopathology experienced by potential participants; for example, anhedonia in a depressive episode, or apathy as a negative symptom

of schizophrenia. Alternatively, some service users may have limited understanding of research and the value of service user involvement in research. Unknown factors relating to the level of research interest among staff responsible for presenting the study to service users at community meetings may have contributed to the low response rate. Although the final list of priorities generated from the views of a small proportion of service users is valuable, it may not reflect the views of those service users who did not respond.

A strength of the study is effectively reaching a wide range of service users, with differing risk and health needs. The methodology of involvement was successful in increasing research involvement access to service users who, (because of reasons relating to health or risk) may not have had the opportunity to leave the ward or wing to attend a formal group meeting of service user volunteers, without limiting involvement to a select sample of existing service user representatives.²¹

Consideration was given from the outset to the evidence-based approaches to avoid tokenism and collaborate with user-led groups in a way that clearly explained the philosophy of the project. However, a formal reference research group of service users did not exist at the time of the study, although the generic (non-research) service user group was already established. Consultation with this service user group helped to shape the study design; ongoing consultation with the group may have been valuable in finding ways to increase the response,⁵ and to reduce sample bias.²⁰ Although the involvement of professionals from in-patient and prison settings, as well as nursing and medical disciplines, ensured a healthy range of perspectives during the thematic analysis, service user involvement at this stage for collaborative data analysis would have further strengthened the study.²²

Implications and future directions

To our knowledge, this is the first study to use PPI principles and the Delphi technique to establish research priorities from the exclusive perspective of service users within a forensic service for mental health, intellectual disabilities and autism. The methods showed how a mental health service can overcome barriers³ and involve its users to identify priority areas of research. By contributing to research priority-setting exercises, service users demonstrated that they wish to express their views on the greatest research needs for forensic mental health services. It also revealed a willingness to be involved at the earliest stage of the research process, and a desire to influence the work of researchers in the field. Comparisons with similar studies highlighted the importance of understanding the service user perspective separately from that of professionals.

The eight research priorities were adopted immediately by the forensic service, serving as a checklist against which all proposed research is considered before service-level approval. Additional weight is given to proposed research in an area falling within one of the top three themes. Rarely should research be undertaken within the service that does not link directly or indirectly to this list. Embedding the service user perspective to this degree avoids tokenistic involvement,⁶ and allows service users, as experts by experience, to directly shape research strategy and influence future research. Findings have been shared with service users, senior managers and staff working across the forensic service. Although the scope of this study was limited to the service user perspective, further study is required to explore the extent to which the research priorities of clinicians working in this forensic service are aligned with those proposed by service users, and to understand any differences.

There is a lack of evidence to guide the best method of achieving engagement.²¹ There is benefit in exploring the enablers and barriers to PPI in research that involves service users in a forensic service. Early conversations should commence with representatives from community service users and carers/friends/families of service users, to develop appropriate methodologies for obtaining the views on research priorities from these two groups. The development of a carer research reference group may be an effective approach to carer involvement with this process.⁸

Further consultation with service users is required to develop a strategy to support ongoing involvement, ensuring that future research questions, methods and outcomes are acceptable and relevant to service users. The exercise of setting research priorities from the service user perspective could be repeated at 5-year intervals, to ensure that the service continues to prioritise research that is relevant to those who would benefit from the service. Given the expected benefits of PPI, the challenge is to evaluate the impact of this early service user involvement in setting research priorities, on subsequent phases of the research process and future service user involvement in, and engagement with, research.^{23,24}

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Supplementary material

For supplementary material accompanying this paper visit <http://doi.org/10.1192/bjb.2020.131>.

[click here to view supplementary material](#)

Data availability

The data that support the findings of this study are available from the corresponding author, A.A., upon reasonable request.

A.A. conceived the idea. B.F., H.B. and R.W. were involved in data acquisition. A.A., B.F., H.B. and R.W. contributed to the design, analysis and interpretation of the work, and were involved in producing the manuscript and approving the final version.

Declaration of interest

None.

ICMJE forms are in the supplementary material, available online at <https://doi.org/10.1192/bjb.2020.131>.

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1.2.73 Patients in mental healthcare should be referred to as patients and not service users

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Abstract

Over the past few years the term ‘service users’ has been increasingly used to describe patients in mental healthcare. This paper argues that the term ‘service user’ in this context should be avoided and outlines four reasons: the term is discriminating, cynical, patronising and detrimental. Of course, none of these effects is intentional, but that does not change them. The term ‘patient’, however, describes appropriately a temporary role in healthcare, provides parity of esteem with patients in physical healthcare and reflects the reasons why large parts of society are willing to fund healthcare, in solidarity with those who are sick.

Contents

- *Patients in mental healthcare should be referred to as patients and not service users*
 - *Discriminating*
 - *Cynical*
 - *Patronising*
 - *Detrimental*
 - *Conclusions*
 - *Declaration of interest*

pmc The terms with which we name similar objects and roles can change over time. One reason may be that a term is seen as devaluing or linked with connotations that one would like to change. Psychiatry has a long history of examples of this. Terms such as ‘madness’ have been replaced by more medical terms such as ‘mental disorders’ to emphasise that one is dealing with a health problem. Another example is seen in the former asylums, which tended to change their names to avoid the negative connotations associated with a previous name that had been built up in the population over time. For example, the Karl-Bonhoeffer-Nervenlinik (last of the changed names) in Berlin changed its name four times within a period of only 100 years.¹

Recently, there has been a shift in the National Health Service (NHS) towards calling patients in mental healthcare ‘service users’ instead of patients. The term is used in guidelines published by the National Institute for Health and Care Excellence (NICE),² in publications of voluntary organisations³ and in prestigious scientific journals.⁴ Of course, every individual should be entitled to be addressed in any way they like, but the question is whether the term service user should be generally used when referring to patients.

I will argue that the term service user should be avoided, for four reasons: because it is discriminating, cynical, patronising and detrimental. Of course, these effects are not intentional, but that does not prevent their ultimate harm.

Discriminating

The term patient describes a temporary and context-dependent role. When I see my general practitioner (GP) in their clinic, I am a patient. When I see the same person in a different context, we have different roles. I may be a neighbour, a fellow passenger on the same bus, a father of a child that goes to school with their child, or the GP may even be a patient in my clinic. There are endless possibilities. However, the term patient is a precise description of a temporary role in a professional health service, without any negative connotation. Health services have patients, whereas lawyers, insurance companies and restaurants have clients or customers or consumers, but never patients. The term patient applies to all types of health service and has only rarely been challenged outside mental health. If mental health services now diverge from other health services and decide to call their patients by another term, they turn their patients into something different. Parity of esteem – defined as ‘valuing mental health equally with physical health’⁵ – is undermined when mental health services use terms that distinguish their patients from patients in other services and, thus, discriminate against their own patients.

Cynical

Service user, as a term, suggests that the people in question either ‘use’ the services actively or that the service has been of ‘use’ to them. Neither of these assumptions necessarily applies. In England alone, more than 50 000 times a year patients are treated involuntarily, i.e. against their wishes and involving specific legislation that allows such coercion.⁶ One can hardly claim that those people ‘use’ the service, just as prisoners are not ‘prison users’. Also, although mental healthcare is hopefully beneficial to many patients, it would be grandiose of professionals and others to believe that mental healthcare helps everybody. Thus, it is not universally of ‘use’ and there is no question that in some cases – despite the best intentions of all people involved – it might even be harmful. Thus, both suggestions of the meaning of ‘use’ that are inherent in the term service user may be regarded as cynical.

Patronising

A number of surveys have asked patients in mental health services which term they prefer to be used. The results of these surveys are consistent. The majority of patients prefer the term patient, and this applies across studies that have been conducted at different times and in different settings.^{7–9} Insisting on a term that most of the patients explicitly do not want may be seen as patronising.

Detrimental

This may be the most complicated of the four points. Healthcare – at least in most European countries – is paid for through the solidarity of the population, either by sharing contributions and benefits through health insurances or in tax-funded healthcare systems. With respect to the NHS in the UK, most people in the population have little problem with paying their taxes so that people who suffer from illnesses can receive proper healthcare when they need it. This may be motivated by the expectation that each taxpayer will also receive tax-funded care when they need it, but is also based on cultural values (e.g. of Christianity and Enlightenment) and the compassion for those who suffer. As a society we accept that some people are sick and need professional – and potentially expensive – treatment for as long as they are sick. This is reflected in the term patient (originating from the Greek ‘pathos’ and Latin *patiens*, which denote suffering). When mental healthcare providers expect the population to fund their work, then the term service user is not helpful. It rather evokes the idea of a ‘service’ that someone decides to use or not to use, instead of the professional care that some people receive because they are so seriously distressed that they need that care.

Conclusions

I would therefore argue that the term patient should be re-established in mental healthcare in the NHS. In this brief paper, the argument focused on the alternative term service user. Similar arguments could be made about other terms, such as ‘client’ and ‘consumer’. Those arguments would overlap in parts with the ones put forward here (see ref.⁹).

I have personally experienced the strong views and feelings of present and former patients in NHS mental health services who prefer the term service user. As noted at the beginning, such views should be respected, as long as the requested terminology applies to those people themselves and not to everybody else. However, the general terminology that is used in mental health services should not be determined by the specific views of a minority of patients and/or professionals. Mental healthcare is based on shared values and scientific evidence. Both require precise thinking, and precise thinking requires an exact and consistent terminology.

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Declaration of interest

None.

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1.2.74 PsychStart: a novel mentoring scheme for supporting and valuing medical students interested in psychiatry

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Abstract

We describe the establishment and evaluation of a career-based mentoring scheme (PsychStart) for medical students interested in psychiatry. Medical students reported multiple benefits of mentoring, including enhanced personal and professional development, increased career and clinical knowledge, and broadened exposure to psychiatry. The mentoring scheme was also found to promote and sustain interest in the specialty. Further evaluation is required to determine the long-term effects of mentoring and how this may compare with other undergraduate enrichment activities. We conclude that mentoring in psychiatry could offer innovative solutions for improving recruitment and retention, and for supporting and valuing medical students who demonstrate an early interest in the specialty.

Contents

- *PsychStart: a novel mentoring scheme for supporting and valuing medical students interested in psychiatry*
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 - * *Effects of mentoring and the PsychStart scheme*

- * *Potential links to recruitment*
- * *Qualitative feedback*
- * *Leaving the scheme*
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 - * *Potential student gains from PsychStart*
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pmc Increasing the number of doctors choosing to enter and remain in psychiatry has been a key health policy priority in the UK over the past 3 years.^{1,2}

The proportion of graduates from each medical school entering immediately into psychiatry post-foundation training varies widely, from 0.1 to 0.4%.³ Overall, approximately 5% of foundation year 2 (F2) doctors who enter directly into specialty training are appointed to core psychiatry training each year.^{3,4} However, increasingly large numbers of junior doctors are delaying their progression into specialty training, for multiple complex reasons.^{3,4} Although recruitment to core training has improved more recently, almost 10% of core and consultant posts still remained unfilled in 2019.^{5,6}

Recruiting and retaining sufficient doctors to fill these gaps requires multifaceted, long-term approaches. As well as increasing the number of doctors entering medical school, policy has recently focused on improving the exposure and experience of psychiatry training at undergraduate level.⁷ Prior research has demonstrated that regular early undergraduate exposure to psychiatry (through the Psychiatry Early Experience Programme, PEEP) can sustain positive attitudes towards psychiatry and challenge preconceptions about the specialty.⁸ However, little is known about the value of mentorship for medical students interested in psychiatry, despite this demonstrating clear value for students and doctors in other specialties and the broader literature.^{9–12}

This paper describes and evaluates the establishment of an undergraduate enrichment programme that combines opportunities for mentorship with additional clinical exposure to psychiatry. To our knowledge, this is the first paper to explore the potential role of undergraduate mentorship in improving recruitment to the profession. We also evaluate the potential utility of mentoring for supporting, and promoting the development of, the future psychiatric workforce.

Method

PsychStart, a career-based mentoring scheme for medical students interested in psychiatry, was co-founded by two of the authors (T.H. and N.T.) at the University of Nottingham in January 2018.

Medical students from all year groups were recruited to the scheme via communication through the student-led psychiatry society Mind Matters, social media advertising (Facebook and Twitter) and signposting during lectures and psychiatry teaching.

There are approximately 280 students in undergraduate years 1 and 2 of the Nottingham medical course, and 100 students in graduate-entry years 1 and 2. The undergraduate and graduate students merge during year 3, with approximately 380 students in years 3–5 of the medical programme. The psychiatry module is taught in year 4, and approximately 45 students complete this module at any one time.

Mentors were recruited from three local healthcare trusts that provide clinical psychiatry placements, as well as from the University of Nottingham and the university's Institute of Mental Health, facilitating the involvement of both academic and clinical psychiatrists. Mentor recruitment was limited to registrars (specialty trainee year 4 and above, ST4+) and consultant psychiatrists across a wide range of psychiatric subspecialties.

Places on the scheme were allocated on a first-come-first-served basis when appropriate mentors became available. Medical students were matched 1:1 or 2:1 to registrar or consultant psychiatrist mentors according to three main criteria: subspecialty interests, geographical location of mentors' workplaces and students' placements locations, and other career interests (e.g. in research, management or education).

All mentors and mentees were invited to attend a 2 h training session, with scheduled time incorporated for the initial 'meet and greet' between mentors and mentees. The mentor training was led by a consultant psychiatrist with experience of medical education and the Nottingham psychiatry module (N.T.), with input from the Director of Student Wellbeing. Mentor training topics covered the role of a mentor, theories of mentoring, characteristics of positive and negative mentorship, the structure and scope of the PsychStart scheme, the context of psychiatry at Nottingham medical school, and student welfare and support. Mentee training was coordinated by a junior doctor (T.H.) and/or the President of the student-led PsychStart committee, with oversight from a consultant psychiatrist (N.T.). Mentee training topics included the role of a mentee, characteristics of positive and negative mentoring interactions, the structure and scope of the PsychStart scheme, and career pathways and opportunities in psychiatry.

No minimum or maximum restrictions were placed on the frequency of mentor–mentee contact, but monthly email contact was recommended initially to promote engagement.

A generic email account was created for general communication and administrative queries. A separate email account monitored by a consultant psychiatrist (N.T.) was used for communication of any mentoring difficulties or issues requiring senior input.

Regular surveys were distributed to mentees to evaluate the different mentoring relationships and identify any requiring extra support. Any failing or inactive mentoring relationships, as identified by survey data and communication with the scheme's co-founders, were discussed with the concerned mentors and mentees. Where appropriate, some mentoring relationships were subject to reallocation.

To celebrate successes on the scheme and support the network, annual awards evenings were established where mentoring achievements were formally recognised. Awards were selected using information from regular feedback surveys, and mentors and mentees were also given the opportunity to submit nominations.

The data presented in this paper are from the 12- and 18-month evaluation surveys in January and June 2019 (Appendix 1 in the supplementary material, available at <https://doi.org/10.1192/bjb.2020.107>) and other feedback, including nominations for the annual scheme awards. All participants gave informed consent for their anonymised data to be included in future research and promotional materials. As this was a service evaluation to help improve a novel mentoring scheme, ethical approval was not required.

Results

In mid-2020, there are currently 66 active mentoring relationships participating in the PsychStart scheme at Nottingham University. Of these, 36 are 1:1; the remaining 30 students are matched 2:1 to mentors. There are also 20 medical students on the reserve list awaiting mentor allocation.

Mentee demographics

Of the current mentees, in mid-2020, 50 (75.8%) are women and 16 (24.2%) are men. Just under half (29; 43.9%) are in the pre-clinical phase of the medical course, with the rest in years 3 and above (37; 56.1%) (*Table 1*). The scheme is most popular among fourth year students (14; 21.2%) (*Table 1*). *Table 1* Year groups of medical students on the PsychStart scheme across the East Midlands in mid-2020

Year group	n (%)
Undergraduate year 15	7 (7.6%)
Graduate-entry year 19	13 (13.6%)
Undergraduate year 28	12 (12.1%)
Graduate-entry year 27	10 (10.6%)
Year 3a12	18 (18.2%)
Year 414	21 (21.2%)
Year 510	15 (15.2%)
Foundation years1	1 (1.5%) ¹

1

The graduate-entry medicine (GEM) students merge with the undergraduate students from year 3 onwards.

Psychiatric subspecialties

In mid-2020, there are 51 registrar and consultant psychiatrists participating in the PsychStart scheme across the East Midlands. The mentors span a range of specialties, from forensic to perinatal psychiatry, with most mentors in general adult and child and adolescent mental health services (*Fig. 1*). *Fig. 1* Specialty distribution of mentors on the PsychStart scheme across the East Midlands in mid-2020.

Survey responses

We received responses from 31 out of 44 mentees (70.5%) in the 18-month survey and 47 out of 68 (69.1%) in the 1-year survey, creating a cumulative total of 78 responses from 68 mentees; 18 students completed both surveys.

Most students had participated in the PsychStart scheme for over a year at the time of survey completion (46; 59.0%); 14 students (17.9%) had participated in the scheme for 6–12 months; and 18 (23.1%) for less than 6 months.

Subjective ratings of scheme experiences and mentoring relationships

Including all 78 survey responses, over 90% of students described their overall scheme experience as ‘good’ or ‘excellent’ (*Table 2*). The organisation of, and support available on, the PsychStart scheme were also rated as ‘good’ or ‘excellent’ by 93.6 and 89.8% of mentees respectively, with no student rating these as ‘poor’ or ‘very poor’ (*Table 2*). *Table 2* Subjective mentee ratings of their experiences on the PsychStart scheme

Rating category	Proportion of mentees selecting each rating, %
Excellent	38.5
Good	52.6
Average	7.1
Poor	1.3
Very poor	0.3
Overall PsychStart experience	38.5
Organisation of PsychStart	56.4
Support available through PsychStart	46.2
Quality of individual mentoring relationship	34.6

Over 80% of students subjectively rated the quality of their mentoring relationships as ‘good’ or ‘excellent’ (*Table 2*). Only 6.1% of students reported poor mentoring relationships (*Table 2*).

Over 80% of mentees ‘agreed’ (48.2%) or ‘strongly agreed’ (35.7%) that they had been well-matched to their mentors; 14.3% of responses were neutral and 1.8% disagreed.

Frequency of mentee–mentor contact

Two-thirds of survey responses indicated a frequency of mentee–mentor contact of every 3 months or more often (52; 66.7%), of which just under a quarter (18; 23.1%) reported monthly contact with mentors (*Fig. 2*). Over 80% (66; 84.6%) were in contact with their mentors every 6 months or more often (*Fig. 2*). *Fig. 2* Frequency of mentor contact reported by mentees on the PsychStart scheme.

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Mentoring activities

Students reported a range of mentoring activities on the PsychStart scheme. The most popular activities were receiving careers or medical school advice, engaging in clinical shadowing, discussing psychiatry topics with mentors and being signposted to opportunities in the specialty (*Fig. 3*). Some students reported attending events, such as conferences, with their mentors, arranging clinical psychiatry electives, and engaging in audit or quality improvement projects and research (*Fig. 3*). *Fig. 3* Frequency of mentoring activities reported by mentees on the PsychStart scheme.

Effects of mentoring and the PsychStart scheme

A majority of mentees reported improved personal (71.4%) and professional (75%) development, clinical knowledge about psychiatry (60%) and knowledge about careers in the specialty (83.6%) (*Table 3*). *Table 3* Reported effects of the PsychStart mentoring scheme

Statement	Proportion of mentees selecting each response, %
Strongly agree	23.2
Agree	48.2
Neutral	28.6
Disagree	0.0
Strongly disagree	0.0

‘My mentor has supported my personal development’ 28.6
 ‘My mentor has supported my professional development’ 41.8
 ‘PsychStart has increased my clinical knowledge about psychiatry’ 29.1
 ‘PsychStart has created positive publicity for psychiatry within the medical school’ 52.7

Over 80% of mentees felt that PsychStart had created positive publicity for psychiatry within the medical school, with over half of students strongly agreeing with this statement (*Table 3*).

Potential links to recruitment

Approximately one-third of mentee responses (21; 32.3%) reported that PsychStart had increased their interest in psychiatry as a career. All but one of the remaining responses (43; 66.2%) reported that PsychStart had maintained their interest in a career in the specialty.

The one mentee who reported that PsychStart had decreased their interest in psychiatry as a career rated their overall scheme experience as excellent. On further clarification, this mentee had been deciding between careers in general practice and psychiatry, and through further experiences of both specialties had decided to pursue primary care. They claimed that PsychStart had helped them to make an ‘informed decision’ and that they were hoping to complete a foundation post in psychiatry.

Qualitative feedback

In total, 57 participants provided comments on their favourite aspects of the PsychStart scheme, from which 10 key themes were identified (*Table 4*). Most commonly, respondents cited their individual mentoring interactions and relationships as their favourite scheme component. *Table 4* Major themes identified from qualitative analysis of mentees’ reported favourite aspects of the PsychStart scheme

Theme	Example quote
Positive mentoring interactions	(My mentor is) ‘easy to contact and replies thoroughly and fast to my questions about psychiatry and medical school in general’
Self-development	‘I feel the personalised aspect of having a one to one mentor is very useful for self-directed learning and attaining personal outcomes’
Feeling supported	‘Feeling it’s a safe space to ask absolutely anything without being judged’
Early/enhanced clinical exposure	(I like) ‘how the scheme gives medics an early exposure to psychiatry’
Career planning	‘It has helped me feel like my decision to do psychiatry is well informed’
Extra-curricular opportunities	‘Gives me the opportunity to see areas I would not be able to see during my studies’
Scheme flexibility	‘I like the independence in choosing what I want to gain from the scheme’
Networking	‘A great way to make links with people within psychiatry’
Scheme organisation	‘The consistent follow-up from the committee to see how the relationship between mentors and mentees is going. I think that’s really important’
Annual awards evening	‘I loved the awards ceremony and hearing about what everyone was doing’

Six key themes were identified from the answers of 39 respondents who offered suggestions for scheme improvement (*Table 5*). The most popular suggestions included greater provision of locally available mentors, more scheme

publicity/advertisement and more communication prompts to mentors/mentees. Table 5 Major themes identified from qualitative analysis of mentees' suggested areas of improvement for the PsychStart scheme

Theme	Example quote	Distance
Distance from mentors	'My mentor is quite far away. I understand that not all mentors can be close but if I didn't have a car it would be hard to meet'	
Difficulty contacting mentors	'I haven't had much contact with my mentor due to my exams/my mentor not being contactable'	
More publicity	'More advertisement of research and conference opportunities'	
Regular communication prompts	'It might be useful to have a regular email prompt to give advice or ideas for activities and prompt mentees/mentors to reflect on what they have discussed/done together'	
More events	'There could be more events that are open to everyone on the scheme to aid networking opportunities'	
Structured activities	'More structured things for mentors and mentees to do together'	

Leaving the scheme

In total, 40 mentees have left the scheme since it began, most commonly because they graduated medical school or moved location (22; 55%). Other reasons have included other commitments 3 (7.5%), wanting to explore other specialties (2; 5%) and taking a year out of medical school (1; 2.5%); 7 mentees (17.5%) left the scheme without any specific reason and 5 (12.5%) left because of poor engagement.

Of the mentors, 9 have left the scheme since its inception for various reasons: moving geographical location (3; 33.3%), other commitments (3; 33.3%), difficulty meeting their mentees owing to travel distance (2; 22.2%) and retirement (1; 11.1%).

Discussion

The General Medical Council (GMC) mandates that all medical students must have access to educational and pastoral support and career guidance.¹³ Medical schools provide extensive educational networks for students to support academic progress, career development and well-being.

In the medical literature, the most frequently cited definition of mentoring is that provided by the Standing Committee on Postgraduate Medical and Dental Education (SCOPME), who describe it as: 'A process whereby an experienced, highly regarded, empathetic person (the mentor) guides another (usually younger) individual (the mentee) in the development and re-examination of their own ideas, learning, and personal and professional development'.¹⁴ The role of a mentor is sometimes confused, and occasionally overlaps, with that of several others, including a tutor, supervisor, counsellor, advisor and role model.¹⁵⁻¹⁷ The main distinctions are the highly personal and active nature of the mentoring interaction and the focus on the individual mentee's personal and career goals, instead of professional skills.¹⁵⁻¹⁸

Over 90% of medical students perceive mentoring to be important and are keen to engage in mentoring relationships.^{19,20} Despite this, only one-third of medical students report having a mentor.^{19,20} Furthermore, there is a lack of mentoring schemes in most countries' medical schools, including the UK.^{21,22} This lack is surprising given the evidenced widespread benefits,^{15,21} although it could be argued that there has been uneven support and guidance for potential mentors to enable them to adopt such roles.²³

Mentors provide strong role modelling for careers and can have a significant impact on specialty choice.^{21,24} In a study including over 9000 medical students, mentors and role models were identified as the most or second-most influential factor in determining specialty selection; for 'controllable lifestyle' specialties, of which psychiatry was included, their influence was exceeded only by 'lifestyle factors'.²⁵

Potential student gains from PsychStart

Our project has demonstrated that a mentoring scheme for medical students interested in psychiatry can be delivered alongside the standard curriculum and is popular among students at a large UK medical school. Participants reported several benefits from mentoring, including enhanced personal and professional development, improved careers and clinical knowledge, and feeling well supported. These benefits could apply to all students and to mentoring in other specialties, with the broader literature demonstrating similar benefits from other mentoring schemes.²¹

It is interesting that many of the qualitative comments by students highlighted generic aspects of the mentoring relationship, such as receiving personalised support, careers advice and assistance in their personal and professional development, as their favourite components of the PsychStart scheme. All students already have a personal tutor throughout the medical course, and clinical supervisors for each placement, who are also able to deliver these functions. It may be that students particularly enjoy receiving such support in the context of their desired specialty or accessing this from somebody to whom they have been closely matched on the basis of shared interests.

Many of the observed mentoring activities fulfil several selection criteria for core psychiatry training applications.³² For example, involvement in audit and quality improvement, completion of research, and demonstration of commitment to the specialty through arranging further clinical exposure and clinical electives with mentors. Hence, mentoring opportunities may increase employability and help students to maximise their chances of successful future training applications. This is likely to be an important attraction to the scheme as recruitment to core training becomes more competitive.

Potential specialty gains from PsychStart

Mentoring may also facilitate increased and broadened clinical exposure to a specialty, with many students arranging shadowing opportunities with their mentors and accessing subspecialties that are less established within the standard curriculum. This is particularly useful within psychiatry, where many subspecialties, such as forensic and perinatal psychiatry, are optional or seldom taught in medical school. The Psychiatry Early Experience Programme (PEEP) has previously demonstrated the benefits of increased psychiatry exposure for young medical students, including sustained positive attitudes towards the specialty.⁸ It is unclear whether such positive attitudes extend beyond those students who engage in psychiatry enrichment programmes, but over 80% of mentees felt that PsychStart had created positive publicity for the specialty within the wider medical school, suggesting that these may permeate throughout the student body. Ajaz et al previously reported that medical students often experience ‘badmouthing’ or ‘bashing’ of psychiatry,²⁶ which can deter them from entering the specialty; this highlights the importance of fostering positive attitudes and prompted the Ban the Bash campaign by the RCPsych, which aimed to identify and discourage disparaging comments about psychiatry.²⁷ More recently, the College has focused on emphasising positive ‘pull factors’ that promote selection of psychiatric careers.

The most common year for students to sign up to PsychStart is year 4, which coincides with the clinical psychiatry module; hence, clinical exposure to a specialty may prompt involvement in extra-curricular opportunities. The mentoring scheme was much more popular among women students, with 75.8% of mentees being women. This is considerably larger than the approximately 55% women on the Nottingham medical course (This information was obtained by T.H. through contact with Dr Pamela Hagan at the University of Nottingham Medical School. Permission was granted from the University of Nottingham Dean of Medical Education Professor Gill Doody). It is not clear why this discrepancy exists. Prior research has associated female gender with preferential selection of psychiatry at undergraduate level;²⁸ however, women have historically been less likely to receive mentorship, and to become mentors, in medical fields.^{29,30}

Our scheme data provide further evidence to support the utility of mentoring in improving specialty recruitment, with over one-third of students reporting an increased interest in psychiatric careers. Our data also suggest that mentoring may help to retain, as well as promote, students’ interests in particular specialties, with just under two-thirds of students reporting a sustained interest in psychiatry on the PsychStart scheme. This is particularly important given that 22% of medical students who exhibit an early interest in psychiatry lose this interest throughout their studies.²⁸ There is evidence that these benefits also exist outside of psychiatry; for example, Dorrance et al reported that a mentoring and research initiative showcasing a career as an internist in primary care settings resulted in a higher proportion of graduates opting for internal medicine training.³¹ Furthermore, mentoring has been found to increase interest in

academic careers.^{10,21} Holt et al reported no significant difference in specialty choice at baseline and at their 3-year follow-up for students participating in the Psychiatry Early Experience Programme;⁸ this may suggest that, although clinical shadowing may be useful, other opportunities provided by mentorship may have a greater influence on career selection. However, further follow-up and evaluation is required to determine the long-term effects of mentoring and early clinical exposure on decisions to pursue psychiatry.

Strengths and limitations

Our scheme data have several strengths. First, to our knowledge, this is the first published report to evaluate a formal mentoring scheme for UK medical students interested in psychiatry. Second, the high response rates to the two surveys (69.1 and 70.5%) assures us that we have gained a representative sample of students on the PsychStart programme. Third, the broad range of survey responses covering all year groups at Nottingham medical school gives strength to the generalisability of our findings.

However, we recognise that these data have the following limitations. First, they are subjective, based on students' written reports and ratings of their mentoring relationships. The nature of the design of the evaluation did not allow for further probing about the students' perceptions and experiences of the scheme. Furthermore, students' stated interests may not necessarily predict future actions and result in core psychiatry training applications. Second, our data were derived from a self-selecting sample of students participating in the PsychStart scheme. We were therefore unable to draw any comparisons between students who do and do not receive mentoring in psychiatry and determine whether the scheme 'adds value' for those already interested in a career in the specialty. Finally, the maximum duration of mentoring relationships at the time of survey completion was just over 18 months; hence, we are unable to comment on the long-term effects of mentoring for this cohort.

Research recommendations

We recommend that future research should examine the long-term effects of mentoring and its impact on the quantity and quality of applications to core psychiatry training. Given prior research associating mentoring with improved medical school performance and training outcomes,^{21,33} it would additionally be useful to examine the effects of mentoring in psychiatry on exam performance in the specialty. Delineating what motivates students who do and do not sign up to such mentoring schemes, and potential logistical barriers to taking part, could provide useful insights into factors both promoting and hindering engagement with psychiatry and mentoring. Further attention should be given to the experience of mentors, especially given that the concept of 'reverse-mentoring' is becoming increasingly recognised in the medical literature; this describes a process whereby junior medical professionals can mentor their senior colleagues, providing benefits such as enhanced understanding of digital technologies and online platforms, and improved workplace culture.³⁴ Critically, it is important to understand whether receiving mentoring from a psychiatrist rather than other doctors positively influences later career choice. Comparison of the impact of mentoring with other medical student enrichment activities, such as shadowing⁸ or participating in Balint groups³⁵ or medical student psychotherapy schemes,³⁶ needs further evaluation.

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Supplementary material

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[click here to view supplementary material](#)

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Declaration of interest

None.

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1.2.75 Analysing *Joker*: an attempt to establish diagnosis for a film icon

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Abstract

Todd Phillips's film *Joker*, a 2019 psychological thriller, has stirred up strong reactions to the portrayal of the lead character's mental disorder, which is never specified. I used DSM-5 criteria to study whether Joker/Arthur Fleck showed signs of a real mental disorder. The psychopathology Arthur exhibits is unclear, preventing diagnosis of psychotic disorder or schizophrenia; the unusual combination of symptoms suggests a complex mix of features of certain personality traits, namely psychopathy and narcissism (he meets DSM-5 criteria for narcissistic personality disorder). He also shows the symptoms of pseudobulbar affect due to traumatic brain injury. This apparent co-occurrence of both mental disorder and a neurological condition may be confusing for audiences trying to understand mental illness.

Contents

- *Analysing Joker: an attempt to establish diagnosis for a film icon*
 - *Todd Phillips's Joker*
 - *Diagnosing Joker's mental conditions*
 - * *Pseudobulbar affect*
 - * *Personality disorders*
 - *From flawed man to cartoon supervillain*
 - *Declaration of interest*

* *Supplementary material*

pmc The Joker is considered one of the most recognisable and iconic fictional characters in popular culture and one of the best comic villains.¹ Since his debut, the Joker has appeared in countless comics, TV shows and films. Like most enduringly popular fictional creations, the Joker has repeatedly morphed his mannerisms, appearance and *raison d'être* to meet the styles and trends of the time.¹ He has been adapted to serve as Batman's antagonist in various incarnations, including the 1960s television series *Batman* and 1966 film of the same name, in which he was played by Cesar Romero, and in subsequent films played by Jack Nicholson (*Batman*, 1989), Heath Ledger (*The Dark Knight*, 2008), Jared Leto (*Suicide Squad*, 2016) and Joaquin Phoenix (*Joker*, 2019). Over his 80 years of existence, the Joker's character has gone through numerous significant changes in interpretation, taking a ride between the forces of goofy and evil.

Cesar Romero's slapstick Joker is far from his modern incarnation as an intimidating mass murderer, but Joaquin Phoenix's version has almost the same aesthetic, clearly a deliberate homage to Romero.² Jack Nicholson's Joker shares a similar backstory to Phoenix's, both being normal men with real names (Jack Napier and Arthur Fleck respectively), who, after a formative traumatic incident, come to inhabit the twisted clown persona. Nicholson's Joker was a criminal who was physically and mentally altered after falling into a vat of hazardous chemicals. Heath Ledger's iconic take reinvented the character for a new age, permanently imbuing the clown with angst. Ledger described his character as a 'psychopathic, mass-murdering, schizophrenic clown with zero empathy', and Paul Levitz, president of DC Comics in 2002–2009, said, 'I keep coming back to the way he physically incarnates madness'.³ Ledger's incarnation seems to inspire Phoenix's Joker, who is also a social outcast, building on that concept to see the Joker inspire some kind of protest movement.² Jared Leto's take marks the first time that the Joker was almost universally derided, but despite controversial aesthetic choices this incarnation embodies a quintessential component of the Joker's psychology: his 'super-sanity' (as stated by Grant Morrison, it refers to the particular state of mind amalgamating elements of Carl Jung's archetypal trickster figure from mythology, and the corrupting hyper-intellectualism of the dark feminine figures in tragedies (*Lady Macbeth*, etc.), into Joker's possession of a higher realm of brain function which we perceive as irrationality; sometimes Joker is even aware that he is a fictional character). Anyway, the differences between different actors and performances should not be overemphasised. In all of his incarnations, the Joker has been a trickster figure who thrives on thwarting expectations and hovering in the uncomfortable, yet mesmerising zone beyond what description can encapsulate.¹

Todd Phillips's *Joker*

Todd Phillips's *Joker*, a 2019 psychological thriller film starring Joaquin Phoenix, is a far cry from the previous incarnations, which is stirring up a fierce debate about the portrayal of the character's mental disorder.^{4–6} The director turned a comic icon into a neuropsychological study drama that reflects on how society views and treats the mental health problems of certain individuals. According to some critics, *Joker* runs the risk of being perceived as a glorification of what one angry and disturbed loner is able to accomplish and raises debate over whether the film turns an archetype of a violent man into a heroic figure (intentionally or not).⁷ Andrew A. Nierenberg concluded that 'Sadly, the movie will increase stigma for those with psychiatric disorders and make people afraid. It will take great efforts to combat this setback in the battle against stigma'.⁸ Furthermore, doctors Annabel Driscoll and Mina Husain wrote in an opinion piece for *The Guardian* soon after the film's release, 'Severe mental health conditions, such as psychotic illnesses, remain shrouded in stigma and are consistently misrepresented and misunderstood [...] Portrayals of mental illness in film can perpetuate unfounded stereotypes and spread misinformation'.⁹ Meanwhile, British neurocriminologist Adrian Raine was impressed by how accurate the film's depiction of the psychology of a murderer was. In an interview with *Vanity Fair*, he described it as 'a great educational tool' and stated that he planned to present film clips during his classes.¹⁰

In general, *Joker* is closer to an art-house film than a typical comic book film, since it shows less explosive action but more social commentary. Unlike other interpretations, we discover a lonely, timid and uncharismatic man. The plot of the film centres on Arthur Fleck, a socially inept party clown and aspiring stand-up comedian living with his ailing mother Penny in Gotham City. Gotham is struggling with crime, unemployment and poverty. Arthur is a middle-aged, underweight and pale-faced man suffering from a medical disorder that causes him to laugh uncontrollably at inappropriate times and he depends on social services for medication. His communication skills are generally poor; he stares at people for too long, uses abnormal facial expressions and misses important interpersonal cues, making others feel discomfort. In the evenings Arthur and his mother watch a TV show with host Murray Franklin, and Fleck imagines himself being on the show and getting everyone's attention. Arthur experiences a romantic feeling towards

his neighbour Sophie, but later the film reveals that he was actually imagining all of their dates. During the film, a series of events in close succession ultimately tips him over the edge: Arthur guns down three men on the subway train ride home after he was mocked; his therapy sessions are terminated, he stops taking his medications and later he reveals that Penny adopted him after he was found abandoned. Penny had a mental disorder and her case history records at the mental health clinic mention Arthur having a head injury after she abused him, tied him to a radiator and beat him alongside her abusive boyfriend. Then the dream of the character comes true: he becomes a guest on Murray Franklin's show and asks the host to introduce him as Joker. While it initially seems that Arthur intends to kill himself live on air, he shoots Franklin instead. In the end, we find Joker in a therapy session at the mental health clinic. He is then seen running, dancing and leaving bloodied footprints in the hospital's corridors, implying the psychiatrist's death.

Diagnosing Joker's mental conditions

Although Arthur's disease remains unspecified throughout the film, we can make some conclusions if we take a look at Joker's symptoms and mental condition throughout the film. During the therapy sessions, Arthur describes his complaints as loneliness, isolation and 'constant negative thoughts'. An entry in his notebook states that 'the worst part of having a mental illness is that people expect you to behave as if you don't'. We know that the character attends therapy sessions for a long time and that he is prescribed several psychotropic medications. He even had sufficient insight to say, 'I need my medication to be increased'. Unfortunately, we have very little information on his family history since he was abandoned as a child. His foster mother has delusional disorder and probably a personality disorder and she underwent in-patient therapy. Arthur was brought up by a foster mother and did not have a father figure. The foster mother herself describes him growing up as a fun and kind boy, but later he was abused and beaten by his adoptive parents and even had a severe head injury. Thus, we can find a number of risk factors for mental disorders in our fictional patient's case history.

Pseudobulbar affect

In addition, we can assume that Arthur suffers from pseudobulbar affect, or emotional incontinence, which is a disorder of regulation of emotional expression, caused by neurological disease or injury affecting the brain.¹¹ Pseudobulbar affect is characterised by sudden, uncontrollable episodes of crying, laughing or both. These episodes are excessive, inconsistent with or disproportionate to circumstances or the patient's underlying mood at the time.¹² In Joker's case, pseudobulbar affect probably occurred secondary to severe traumatic brain injury (TBI). A number of studies have established that TBI increases the risk of mood disorders, personality changes and substance use disorders.¹³⁻¹⁵ A study by Tateno et al revealed that the prevalence of pathological laughing and crying (PLC) during the first year after TBI was 10.9%, and that compared with patients without PLC, patients with PLC had significantly more depressive, anxious and aggressive behaviours and had poorer social functioning.¹⁶ This conclusion is consistent with a recently published article that considers neurological aspects of Joker's disease and assumes that he suffers from neuropsychiatric sequelae related to childhood TBI involving the frontotemporal regions and, in particular, the lateral aspect of the left frontal lobe.¹⁷

Personality disorders

In general, Arthur appears to have a complex mix of features of certain personality traits, namely narcissism (since he craves attention by any means) and psychopathy (since he demonstrates no empathy for his victims). He also displays some traits of depression, but at the same time, he demonstrates excellent self-control. We can see no evident symptoms of thought disorder; Arthur is a highly motivated lucid thinker, he never tells his therapist about any hallucinations or delusions regarding the neighbour who is the subject of his affections, so their romantic relations and dates may be just his conscious imagination. Such diagnostic vagueness does not allow a diagnosis of psychotic disorder or schizophrenia, although to the viewer's untrained eye Joker may appear a hysterically laughing supervillain who is stereotypically 'insane'. We also have no evidence to establish a diagnosis of major depressive disorder or bipolar disorder.

Narcissistic personality disorder

DSM-5 describes 301.81 Narcissistic Personality Disorder as ‘a pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts’ characterised by at least five of nine criteria.¹⁸

According to criterion 1, such patients routinely overestimate their abilities and inflate their accomplishments, often appearing boastful and pretentious. They may blithely assume that others attribute the same value to their efforts and may be surprised when the praise they expect and feel they deserve is not forthcoming. Really, Arthur Fleck’s life is dominated by his aspiring stand-up career, he craves public attention and likes to imagine himself being on the TV show. Individuals with narcissistic personality disorder are often preoccupied with fantasies of unlimited success, power, brilliance, beauty or ideal love (criterion 2). Throughout the film, Arthur is infatuated with his neighbour, single mother Sophie, and later we recognise that all of their dates were just his fantasies. Individuals with this disorder generally require excessive admiration (criterion 4). Their self-esteem is almost invariably very fragile. They may be preoccupied with how well they are doing and how favourably they are regarded by others. This often takes the form of a need for constant attention and admiration. As we can see throughout the film, Arthur meets this criterion. A sense of entitlement is evident in such individuals’ unreasonable expectation of especially favourable treatment (criterion 5). They expect to be catered to and are puzzled or furious when this does not happen. In his fantasies, Arthur charms the audience of the TV show, but when he becomes a guest on the show, he awkwardly tells Murray a joke that he finds funny for its dark humour though nobody else does. After being confronted about this, Arthur grows angrier, resulting in a murder. Finally, our character meets criterion 7, which states that individuals with narcissistic personality disorder generally have a lack of empathy and have difficulty recognising the desires, subjective experiences and feelings of others. Really, Arthur feels no empathy towards his victims. Thus, as we can see, Arthur meets five of the nine criteria, which is enough to establish a diagnosis of 301.81 Narcissistic Personality Disorder.

Antisocial personality disorder

At the same time, as I have stated, Arthur has the symptoms of psychopathy. Although psychopathy is not among the ten official personality disorders listed in DSM-5, it is well recognised as a variant of antisocial personality disorder (301.7, according to DSM-5). Indeed, Joker meets a few of the criterion A group of symptoms: he fails to conform to social norms with respect to lawful behaviour, as indicated by repeatedly performing acts that are grounds for arrest; he demonstrates irritability, aggressiveness and disregard for the safety of others, as well as lack of remorse. For this diagnosis to be given, the individual must be at least age 18 years (criterion B) and must have had a history of some symptoms of conduct disorder before age 15 years (criterion C). Arthur is definitely over 18 years of age, but he has no history of symptoms before the age of 15 (or we do not have information about that). For this reason, we cannot establish a diagnosis of 301.7 Antisocial Personality Disorder, according to DSM-5.

From flawed man to cartoon supervillain

Although the film provides the audience with identifiable components of real mental disorders, in general, the psychopathology that Arthur exhibits is foggy and the combination of his symptoms is unusual. Such diagnostic vagueness helps to create a more relatable character who reflects the burden of any mental disorder; but for the mental health professional it can be confusing and leave the impression that different neurological and mental disorders have been mixed. Actually, the plot moves from a portrait of an individual who is struggling with mental disorder and striving to make a life for himself into pure supervillain caricature. Joker as a character makes it incumbent on the film to drop its pretence at serious character development to enter the comic book mode. Arthur Fleck ceases to be a human being for whom we might feel empathy and descends into a one-dimensional stereotype. The film uses Arthur’s childhood trauma as well as his struggle with mental disorder as a means to earn sympathy from the audience, rather than disgust at his actions. It is an age-old cinema psychology cliché: the character hasn’t had enough love. Thus, as a character, Arthur appeals deeply to the human tendency towards self-pity. From this point of view, the character’s mental illness just happened to be one of the stressors that are the true cause of Arthur becoming the Joker. His mental illness was

only important to the overall plot as a way of connecting all the other stressors together. Therefore, to reduce all of Arthur's actions down to his mental health problems is extremely simplistic.

In conclusion, it would be worthwhile to recall an episode from the film. When Arthur's diatribe is booted on the Murray Franklin Show, he tells the audience that 'humour is subjective'. Likewise, any considered response to divergent interpretations of Arthur Fleck's diagnosis forces specialists to acknowledge their own subjectivity.

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Declaration of interest

None.

Supplementary material

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1.2.76 Fluctuation of suicide intent and other matters in psychosocial assessment post self-harm

Prasanna de Silva

date

2021-12

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- *Fluctuation of suicide intent and other matters in psychosocial assessment post self-harm*

pmc Professor Morgan's article rightly focuses on the fluctuations in suicidal intent among mentally ill people undergoing the various crises and vicissitudes of life. He emphasises the importance of repeated assessments, rather than relying on the initial one, to accommodate these fluctuations in intent.

He appears to have given up on prospects of predicting longer-term suicide risk but has not commented on the emerging body of evidence suggesting the effectiveness of combining an app-based questionnaire with inflammatory biomarkers such as interleukin subtypes, SAT1 and Toll-like receptor subtypes.¹ These biomarkers probably reflect the degree of underlying stress which Professor Morgan describes, with some quantitative features provided in addition. These types of hybrid assessments should cover both the short- and longer-term risks but will not predict when (or under what circumstances) the lethal behaviour could take place. Consequently, mitigation needs simple strategies such as Dr

Cole-King's suicide safety plan, a brief document co-produced with the patient, held by the patient and carer, describing what to do and who to contact if suicidal intent reaches a climax.²

Brief hybrid assessments might also be less intrusive and distressing to patients compared with the standard 'psychosocial assessment' carried out in emergency room settings, typically by junior psychiatric liaison staff and often under time pressure (including the 4 h wait and expectations of prompt bed clearance and discharge as the person is deemed 'medically fit'). Often both the assessor and patient are aware that this is likely to be the only contact between them, further reducing the likelihood of frank disclosure of trauma and abuse; this is strongly associated with invalid assessments and completed suicide in the future.³

Patients also find repeated disclosures of personal details to multiple mental health staff frustrating and traumatic,⁴ along the lines of 'why don't you look up the notes before speaking to me?'. Similar to the experience of repeated police interviews under implied caution ('anything you say might be used for a future Mental Health Act assessment'), patients are (perhaps rightly) suspicious that the assessors are looking for discrepancies in the history to undermine the reliability of the person's account leading to suicidal thinking and/or self-harming behaviour, thereby making it easier to discharge (or dismiss) the patient seeking help.

Professor Morgan touches on in-patient ('never event') suicides,^{5,6} mainly involving patients who have either absconded or been given planned home leave, as major improvements to ward design (including shaving off door edges and securing windows, door handles and toilet equipment) have now taken place. He does not, however, suggest practical changes in ward policy, for example, the potential benefit of a face-to-face review within 24 h of being placed on home leave in order to check on basic needs (elegantly summarised by Maslow), as well as potential toxic relationships with close family members, who might be either over-controlling or otherwise pessimistic on the prospects of the patient moving from being a burden (a variation on therapeutic nihilism and malignant alienation, not often discussed in the literature).

Finally, the issue that I, as a clinician, struggle most with when debriefing assessors or looking at longer-term suicide mitigation is that suicide risk assessment is used primarily as a defensive tool by the assessor, possibly aided by the patient, who does not wish to upset the assessor or get him/her into trouble in the future. So, the 'protective factors' often highlighted in the assessment are documented without due diligence on how stable or permanent these are.

On occasion, a suicidal person will 'blurt out' a suicide plan he/she has been considering. Often, this communication is with a staff member of low rank, for example, a ward domestic or student nurse, simply based on their compassionate nature and their not being part of the 'assessment brigade'. Typically, these patients will subsequently deny that they will carry out this plan, and at times they will deny ever having disclosed such a plan, but, given the circumstance or opportunity, they may use the plan. Alternatively, a person who has failed with a plan will deny wanting to repeat the action (for example, an overdose) but could use this as a learning experience to organise a variation or plan more violent methods such as jumping or hanging.

As Professor Morgan rightly states, an assessor needs to compassionately (and non-judgementally) ask whether alternative means have been considered following a failed suicide attempt. This is genuinely hard work and especially emotionally draining. Therefore, it is essential for staff assessing suicidal patients to be debriefed supportively and given sufficient time off (at least undertaking other duties) to regain their emotional composure.

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1.2.77 Managing suicide risk in primary care

Ann Maria Albert Hannah Gallen Misha Gaur

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- *Managing suicide risk in primary care*

pmc 05 June 2021

We read with interest Professor Morgan's special article on predicting short-term suicide risk.¹ We are grateful for the mention of the extensive body of evidence suggesting the futility of suicide risk assessments and alleged risk factors including suicidal thoughts and behaviours in predicting suicide risk. We appreciate the statements 'To base assessment of ongoing risk on the individual's mental state during a single interview is clearly likely to be highly unreliable' and 'An important trigger for relapse is stress, particularly stress that has previously been present and has not been resolved'. It is important that the above facts are conveyed to the patient's general practitioner (GP) via the suggested correspondence. However, we wonder about the purpose of the proposed 123-word paragraph ending with the sentence 'Overall, however, the predicted level of suicide risk must still be regarded as significant, requiring vigilance until I next see him/her'. What action is required of the GP when they receive similar letters about almost every patient seen by the mental health services? If the patient requires vigilance for their mental health, would this not best be provided by secondary care mental health services with their array of highly specialist teams and army of experts? What aspects of suicide prevention are the GPs better equipped for than the secondary care mental health services? It is important to acknowledge that it is not possible to reliably predict suicide risk from single consultations. However, it appears the suggested correspondence is unrealistically asking an already overstretched primary care service to pick up responsibility in a specialist area. Furthermore, we would be grateful for any guidance on how to better assess and manage suicide risk during a 10 min GP consultation than during the 30–60 min assessment by specialists.

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1.2.78 Peggy Seriès: Bayesian on a bike

Claire McKenna¹

date

2021-12

Contents

- *Peggy Seriès: Bayesian on a bike*

pmc Born near Bordeaux in 1974, Dr Peggy Seriès is a senior lecturer and principal investigator in the computational psychiatry laboratory at the Institute for Adaptive and Neural Computation (ANC), University of Edinburgh. Her career to date has included spells in prestigious computational neuroscience labs in France, New York and University College London.

Her move into computational psychiatry was motivated, she says, partly by her own experience of anxiety, but also by witnessing the suffering due to mental illness of her students and the death by suicide of two of them.

Essentially, the Bayesian brain hypothesis suggests that brains use probability calculations to make *predictions* about what we experience, based on sensory inputs and our prior experiences. Seriès's research work focuses on using mathematical and computer models to understand how our expectations and prior beliefs about the world modulate our perception. In particular she is interested in differences in prior beliefs and learning in disorders such as schizophrenia, autism, depression and anxiety.

Seriès edited and contributed to the first accessible textbook on the emerging field of computational psychiatry.¹ For any clinicians feeling jaded, read it for an overview of computational approaches in your psychiatric field of interest and to get excited about psychiatry all over again.

Seriès only started cycling competitively at the age of 39. Since then she has won multiple track cycling championships nationally and internationally, completed three half ironmans and is in training for a full ironman. In 2013 she cycled the full route of the Tour de France, considered one of the most gruelling endurance competitions in the world.

This interview took place via Zoom in June 2021 and has been edited for length and clarity.

I want to hear more about your cycling achievements! Is there a connection between your love of cycling and your interest in maths and neuroscience?

Thanks for asking! I'm actually very proud of my cycling achievements, mostly because I started competing so late in life and it was never something I thought I could do. Racing bikes has been such a blast!

I'm not sure there is a clear connection, though maybe the pleasure I get from both is the pleasure of feeling like an explorer, which is what I wanted to be when I grew up. On the bike, what I like best is putting my panniers on, carrying a tent and going for an adventure.

You diverged from an undergraduate degree in maths and physics into computational neuroscience – was that always your plan?

¹

Claire McKenna talks to Peggy Seriès, editor of the first primer on computational psychiatry, about a field that sometimes seems wilfully inscrutable. Seriès also speaks about her alter ego as an elite cyclist and ironwoman and is frank on the barriers faced by women in academia.

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No, it's been a tortuous path, via electronic engineering and artificial intelligence, but I'm very happy about where I landed.

I think the deciding factor was that my father suffered an encephalitis when I was 19. For a while he had short-term memory loss, olfactory hallucinations and prosopagnosia. For me, it was a shocking awareness of how delicate and complex the brain is and how a lot of our self-identity is related to our memories: who are we if/when we lose our memories? Initially, memory was what I wanted to study.

Did anyone else inspire you?

My mother was a neurologist but has always been fascinated by psychiatry, so she'd have to be on the list. Otherwise, in the people I've worked with, I'd have to say Peter Dayan for his pioneering and very inspiring work in computational psychiatry and Eero Simoncelli, who has been a role model as a researcher and mentor.

What gets you out of bed in the morning?

Mostly porridge! After breakfast though, I think I am fascinated by understanding how one's experience of life is shaped. How free are we about how we feel, how happy we are? This is something I am working on in my private life, having more control over my own experience, and I see it related to my work as well, both my work on Bayesian perception and on mental illness: how much are we shaped by our previous beliefs? Where do those beliefs come from? How can we change them?

What keeps you awake at night?

That the causes of mental illness may lie more in how our society pressures us and lets the vulnerable down than in how our brain might become 'chemically unbalanced'. That all the neuroscience understanding in the world can't compensate for a society that makes people feel stressed and miserable.

What do you love most about what you do?

I'd have to say interacting with students, seeing my PhD students develop. In my teaching, having an honest discussion about mental illness, when they are at an age when it starts to be relevant – an age at which I certainly would have liked to be more informed about it.

Computational neuroscience still seems to be a field dominated by men – have you had any difficulties as a woman in this field?

This year a woman has been recruited [to the ANC] but until now I have been the only woman in my Institute out of 20 people. I think it's at the current stage of my career that I see how male-dominated things are in academia and when I feel that progression is harder. Or maybe I was more naive before. There's a perception that women don't put themselves forward as much as men do, and I think this was definitely true of me, and it came at a cost.

I also think it is undeniable that it is hard for women to succeed in academia while at the same time managing to settle down in one place and with one person to build a family.

You asked me about the connection between my work in neuroscience and my passion for cycling. I think the cycling gave me a lot of confidence. I am more confident now in this world of men knowing that on a bike I can actually beat them! It's as if I got on their kind of field and I am actually competitive.

Do you think things are any different now for young female academics than they were for you?

Yes, I think things are different now. Women were very clearly treated differently from men when I was young. It was so ingrained in our society that we (women) were not even aware of it.

A very long time ago during my studies, I was supposed to be supervised for a small research project by a supervisor who, in the first meeting with me, invited me for a drink and asked if I had a boyfriend. On our second meeting, he was sitting topless in his office, feet on the table and when I came through the door, commented that I was short. I never went back but also never thought to tell anyone about this – I just did my project alone.

It is now covert and more subtle and probably takes different forms – I'd like to think that behaviours like this don't happen anymore, but as in the rest of society, I think in academia women still feel they are playing a game where the rules have been written mostly by, and for, men.

Thank you for sharing that. I was reminded of the BalanceTonPorc movement in France, the equivalent of the MeToo movement. Did you ever consider denouncing your aggressor?

No. You know back then I just felt happy that I could work by myself and I didn't realise what it was. But now I think about it as a supervisor myself. If I imagine behaving like this with a student of mine, it's very difficult to understand.

You've clearly done a lot to recruit, do research with and nurture PhD students. You've also written about the importance of 'scientific humility' and making science more accessible. Perhaps this humility doesn't serve women well in a field dominated by men. You have though used your skills of collaboration to pull together international leaders in the field of computational psychiatry for your new book. Why did you think there was a need for a primer?

The field has been growing steadily in the past few years, but it is not often taught formally yet. I wanted to offer a book that could be accessible to a broad audience. I had my students in mind but it is hopefully also accessible to students coming from psychology or medicine. The book is not perfect, but I think it's a start and hopefully it will help to consolidate the field and lead to better things.

I came from a background where people often like to explain things in a very complicated way with very complicated vocabulary. I have been inspired by researchers like Eero Simoncelli, who instead would say 'it needs to be clear to your grandmother'. That was the contrary of arrogance in how you present your work – the need to aim for accessibility. For me, it was very inspiring.

Why did you use that Einstein quotation at the start of the chapter you wrote:1 'One thing I have learned in a long life is that all our science, measured against reality is primitive and childlike – and yet it is the most precious thing we have'?

What I meant is that the models we have at the moment are most certainly oversimplified and naive, but we have to start somewhere and from there we can grow and improve.

I want you to give me a bit of an 'idiot's guide' to computational psychiatry! How are computational theories of the mind linked to computers – is it anything to do with computer (hardware/software) metaphors of the mind?

In some sense – the computational theory of mind views the mind as an information processing system, and perception and cognition as a form of computation that is realised by neural activity in the brain. The software would be cognition and the hardware, the neurons.

The work we do operates at both levels: how can we describe cognitive processes and how are those cognitive processes realised by the neural substrate?

Language is a limited and imprecise way to describe how our brain and mind works. Is computation a tool to extend our own mental capacity and escape the imprecision of words?

Yes, verbal theories can only make general and somewhat vague predictions. Mathematical descriptions offer a way to formalise theories precisely and quantitatively so they can be tested, compared with data and extended.

Computational psychiatry has been called a 'Rosetta stone' linking levels of explanation in mental illness – do you agree?

I don't think it will lead to an overnight understanding of mental illness. But I think computational neuroscience tools are very good at exploring and providing links between different levels of description, for example linking the description of individual neurons and the dynamics of networks of neurons, then linking networks of neurons and behaviour etc. In that sense they can provide links between neurobiological elements and descriptions related to symptoms.

Why is Bayes' rule important in understanding the mind?

Bayes' theorem tells us how to optimally calculate the probability of an event based on new information that is, or may be, related to that event, as well as prior information.

It is important in understanding how the mind works because the mind has to do something like that: figure out at each moment in time what is in the environment and what is the best action to take. It has to combine uncertain bits of information and try to make sense of that information in view of previous knowledge. Bayesian inference can thus

offer a benchmark of how the brain (I notice you say the mind and I say the brain!) should do that if it were functioning optimally. It is often found that this benchmark comes close to what the brain does in practice.

What is the difference between Bayesian inference and predictive processing?

Predictive processing, or predictive coding, is a theory of brain function in which the brain is constantly generating and updating an internal model of the environment. The model is used to generate predictions of sensory input that are compared with actual sensory input. This comparison results in prediction errors that are then used to update and revise the mental model.

Bayesian inference is a method of statistical inference in which Bayes' theorem is used to update the probability for a hypothesis as more evidence or information becomes available.

Although the neuroscience literature often confuses the two, as both theories are related to building an internal model of the environment to generate predictions, they are distinct. Predictive processing can implement Bayesian inference, but it does not necessarily do so, nor would it be the only way to implement Bayesian inference.

What is machine learning and how is this used in computational psychiatry?

Machine learning is a branch of artificial intelligence based on the idea that systems can learn from data, identify patterns in the data and make decisions with minimal human intervention.

We distinguish two types of computational psychiatry: theory-driven and data-driven.

The first kind uses mostly models coming from computational neuroscience, that formalise psychological or neural hypotheses about how the brain learns or makes decisions and produces behaviour (such as reinforcement learning models and Bayesian models). This is the type I am mostly involved in.

The second kind uses machine learning to try to 'blindly' detect patterns in psychiatric data or do prediction or classification (without making assumptions about the underlying mechanisms).

Both types of work are complementary and can also be combined.

What translational benefit has computational psychiatry had?

There are already indications that machine learning can help predict trajectories of mental illness or predict response to treatment. There is for example a seminal study by Chekroud et al,² showing that it is possible to predict (somewhat significantly above chance) response to treatment (citalopram) for people suffering from depression. But overall, the field is really in its infancy.

You pointed out that you tend to talk about 'the brain' and I tend to say 'the mind'. Is computational psychiatry more concerned with the computational representation of cognition, as opposed to the qualia of consciousness?

Yes, we computational neuroscientists commonly like to avoid talking about qualia or even consciousness, we often feel uncomfortable around those concepts and like to leave those to philosophers of the mind! I think it's a shame that it's not a literature we often read and we are not enough exposed to it. Philosophers of mind read us, but we don't really read them.

I think, though, it will be very important to address the notion of suffering and mental pain. At the end of the day it is not really the content of the experience that makes a person feel 'ill' – some people have hallucinations they are perfectly comfortable with – but that feeling of suffering, that something is 'very wrong' or overwhelming, that is perhaps difficult to measure or model quantitatively.

What projects are you currently working on?

One of my main projects is about clarifying the differences between Bayesian theories in relation to autism and schizophrenia: the theories are quite similar at the moment for the two disorders, while the symptoms are very different.

As far as I understand it, the similarities are related to the idea that in both autism and schizophrenia there are 'weak priors', so that the influence of prior expectations on perception is weaker?

Yes, exactly. The ideas are very similar, that you'd have a weak influence of perceptual priors in both autism and schizophrenia, but perhaps at a more cognitive level you would have stronger (possibly maladaptive and overwhelming) priors in schizophrenia. But in reality the pathologies have very rarely been compared using computational methods.

I'm really interested in actually testing these theories. And what's interesting is that in our work we found differences [between autism, schizophrenia and controls], but they are very subtle. And I find that quite fascinating as well.

In reality, even between schizophrenia, autism, depression and anxiety, it's very hard to find behavioural tasks that lead to very robust differences that we can actually quantify and model. So at the moment, there is some indication that these theories are somewhat promising, but there's also data coming in that are against those theories. It's quite hard to know how much progress we have really made, I think, with these Bayesian theories and part of my work tries to assess that.

The Bayesian framework for understanding the mind seems intuitively appealing, and can be retrofitted to lots of psychological theories. However, it is often applied very liberally, in a speculative kind of way that seems unfalsifiable. The more I read about predictive processing, the more I can apply it to just about anything! Is there a risk of the Bayesian bandwagon running away with us?

As a framework, the Bayesian approach is indeed unfalsifiable; there will always be a Bayesian model that can fit the data. However, individual models are falsifiable. I think the trick is not to use Bayesian or predictive ideas in the vague sense, but to formalise these ideas as much as possible in the form of mathematical models and simulations and compare a family of different individual Bayesian models and other types of model. Only then can we test quantitatively our hypotheses, confront the data and really evaluate whether/which Bayesian descriptions really correspond to the data.

We may be able to understand the neural mechanisms behind the distress related to psychiatric disorders, but do computational approaches to understanding mental illness tell us at what level we should intervene to relieve this distress? It may still be best to intervene at the level of people's socioeconomic circumstances or preventing their trauma or challenging their negative thought patterns.

I agree, but I don't think these levels of explanation are incompatible. A computational approach (such as machine learning) can be informative in identifying what environmental factors are critical in triggering mental illness, for example.

Work looking at reinforcement learning and Bayesian inference can also hopefully ultimately inform learning-based psychotherapies, as researchers like Michael Moutoussis³ have shown.

If computational psychiatry were the Tour de France, which stage are we currently at? What would represent the Champs-Élysées in computational psychiatry for you?

We're probably at the Prologue [the time trial which starts the Tour] even if it feels like the Alps! The Champs-Élysées, for me, would be to better understand the root causes of mental illness, either at a biological or environmental level, and inform new therapies, in particular psychotherapies.

1.2.79 Author's reply:

Gethin Morgan

date

2021-12

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- *Author's reply:*

pmc 17 June

I am grateful to Drs Albert, Gallen and Gaur for their interest in my paper. Unfortunately they appear to have misunderstood some major points which I make. I certainly do not suggest that the assessment of suicidal thoughts is futile

in short-term prediction of suicide. I argue exactly the opposite, presenting evidence that provided this is carried out correctly and appropriately, it should have significant predictive value.

What is more, I do not in any way suggest that ongoing care of suicidal patients should be handed back to the general practitioner (GP), certainly not before their problems have been resolved. My suggested letters are meant as clinical summaries which should be sent routinely to GPs by any psychiatric team as part of good ongoing clinical care. They do not mean, in any way, that the secondary service thereby should relinquish ongoing clinical care of their patients before treatment is complete.

How to maintain good ongoing supportive care of patients who have experienced a suicidal crisis is an important clinical challenge. My paper considers how the psychiatrist might attempt to achieve this, by emphasising concern to provide the form of help which would be most acceptable to the patient, and to which he/she would readily turn should the crisis recur.

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1.2.80 To travel is to live: embracing the emerging field of travel psychiatry

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date

2021-06

Abstract

For a person with mental illness, travelling abroad can be challenging but it can be easier when the traveller and healthcare practitioner have a clear understanding of the likely impact of travel on the illness and of the illness on the travel experience. Travel may also precipitate first presentations of mental illness or unmask previously undiagnosed mental disorders. We propose that mental health problems should receive greater recognition in travel medicine and that psychiatrists should collaborate more closely with travel medicine clinicians to ensure that their patients benefit from the opportunities afforded by international travel.

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 - *Is travel advisable for people with mental illness?*
 - *Travel mental health recommendations*
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pmc “‘To move, to breathe, to fly, to float, to gain all while you give, to roam the roads of lands remote, to travel is to live.’ Hans Christian Anderson, *The Fairy Tale of My Life: An Autobiography* (1847)”

The psychological benefits of international travel, especially for tourism purposes, have been largely ignored until relatively recently in the travel medicine literature, whose focus to date has been on the mitigation of travel health risks through vaccination and pre-travel physical health counselling. The unique challenges faced by travellers with diagnosed mental illness are rarely addressed in the pre-travel medical consultation. Furthermore, travel may precipitate first clinical episodes of mental illness in an unfamiliar environment. Travel medicine physicians without basic knowledge of psychiatry are often poorly prepared to anticipate the likelihood of decompensation of mental illness in this cohort of travellers. We propose travel psychiatry as an emerging area of both research and clinical interest. This article draws on the sparse available literature and over 40 years of combined clinical experience in psychiatry (B.H.) and travel medicine (G.F.) to describe the effects of international travel, both positive and negative, on people with mental illness, with the aim of advocating for an integrated approach to supporting individuals with mental illness when travelling abroad.

Mental health challenges of international travel

Travel, even with a recreational motivation, is inherently stressful and the perceived stressful impact is likely a product of the travel itinerary, destination, activities and individual traveller susceptibility. Felkai & Kurimay reported that 11.3% of travellers experience some symptoms of mental illness during travel, with 0.3% of travellers experiencing an acute psychotic episode.¹

Indeed, incidence data reveal that acute psychotic episodes account for one-fifth of travel-related mental illnesses. Travellers who are deemed medically fit to travel and who have no history of mental disorder may develop acute *de novo* psychosis during their trip. The cumulative effects of travel-induced stress, culture shock, inappropriate alcohol intake and/or recreational substance use, circadian rhythm disruption, underlying brain pathology and physical illness have been implicated as contributing factors in the development of first-time psychosis during travel.¹⁻³ Another subgroup of travel-related psychosis occurs during travel to destinations with high religious, cultural and aesthetic value, so-called high-valence venues.³ However, many of these episodes occur against a background of a pre-existing psychotic illness. Airault & Valk describe a number of specific destination syndromes, including Jerusalem syndrome, Stendhal syndrome and Paris syndrome.³ In addition, travel to high-altitude destinations is increasingly regarded as an additional risk factor for the development of acute psychotic episodes and an increased risk of both suicidal ideation and completed suicide.⁴

Misuse of alcohol and/or psychoactive substances among international travellers may be associated with an exacerbation of existing mental illness and could precipitate an acute psychotic episode.^{1,5} Physicians should consequently be mindful about their patients travelling abroad for the purpose of seeking therapeutic or recreational drugs. Drug tourism, whereby tourists cross international borders for the purpose of obtaining or using psychoactive substances, is associated with significant adverse health effects, including drug-induced psychosis, unintentional physical injury, risky sexual behaviour and criminal acts.⁵ In addition to drugs of misuse, medications used in travel medicine (such as mefloquine for malaria chemoprophylaxis) can potentially trigger acute psychotic episodes in people with a previous or undiagnosed mental illness.^{1,5}

Anxiety symptoms are common in individuals engaging in travel. The sense of uncontrollability and inherent unpredictability presented by travel may cause travellers to develop anxiety symptoms or worsen an existing anxiety disorder. Culture shock is a travel phenomenon that exposes travellers to the risk of anxiety symptoms, in addition to confusion, a sense of isolation, rejection and deprivation due to cultural differences experienced while abroad. Patients may feel overwhelmed when immersed in an unfamiliar destination and struggle to make the necessary adaptations to acclimatise to local customs and cultural norms. Moreover, travelling abroad inevitably leads to a lack of daily structural routine, separation from social supports in some cases and a lack of support, which can precipitate poor adherence to prescribed psychotropic medications. Furthermore, there is evidence that jet lag can exert a debilitating effect on travellers with mental illness, with sleep loss being demonstrated to increase the risk of episodes of (hypo)mania in

individuals diagnosed with bipolar disorder.² This may be significant in international travel if the patient encounters circadian rhythm disruption and other stressors that result in sleep disturbance.

Where an individual develops an acute episode of mental illness, receiving appropriate intervention in a timely fashion can be challenging for a number of reasons, including problems communicating health difficulties to clinicians, cultural differences, poorly established diagnoses and lack of clarity in relation to the psychiatric history of the traveller. Furthermore, difficulties may arise if there is delay in the diagnosis of physical illness, such as hypoglycaemia, epileptic aura or hypothyroidism, which may initially present with alterations in mental health. Repatriation to the home country where patients can receive specialised treatment from their multidisciplinary mental health team in a familiar environment may be the most appropriate intervention.¹ However, repatriation for psychiatric reasons can be a particularly complex undertaking requiring, in many cases, medical escort by a suitably trained mental health professional(s) and stabilisation of the person's mental health before costly aeromedical evacuation that may not be covered by travel health insurance.⁶

Is travel advisable for people with mental illness?

Although it is reasonable to postulate that leisure activities abroad may be beneficial for people with mental illness, research is lacking in this area. One qualitative study from The Netherlands explored how engaging in travel contributes positively to the mental rehabilitation of psychiatric patients.⁷ Material was collected from participant observation involving eleven travellers with severe and enduring chronic mental illness who were accompanied by four psychiatric nurses during two trips. Many positive experiences were reported, including maintenance of social contact; the opportunity to develop foreign language skills; enrichment of life resulting from enjoyment and cherishable memories; positive influence on self-esteem; and a departure from the monotonies of daily routine life.⁷ The research also provided a learning environment outside of psychiatric institutions for the nurses involved. Some travellers required the nurses' support in managing psychotropic medications and some activities of daily living. We have recently reported similar positive findings from semi-structured interviews conducted with a series of patients with chronic psychotic illnesses who engaged in travel independently, on their own or with friends.⁸ The putative mental health benefits of 'prescribed travel' should be balanced against the risks in less-supported, lone travellers of developing suicidal ideation or experiencing exacerbation of mental illness. This may potentially arise from unexpected travel-related stressors, including, for example, confrontations at airport security stations.

Travel mental health recommendations

Travel psychiatry has a promising future as an integrated subspecialty of both psychiatry and travel medicine. Novel research will help to establish a stronger evidence base for clinical recommendations aimed at promoting mental health during travel.⁹ We recommend that clinicians be aware of the psychological stress and exacerbating factors that patients encounter during foreign travel and encourage patients to attend a pre-travel medical consultation in order to agree on preventive strategies (*Box 1*). **Box 1** Preventive strategies in travel psychiatry: mental health recommendations for patients and clinicians

Pre-travel

- Attend a pre-travel medical consultation, where stressful events that might be encountered during travel can be considered
- Identify significant risk factors (e.g. psychiatric history, purpose of travel, destination of travel, prescribed medications)
- Obtain comprehensive travel health insurance
- Carry a brief letter from healthcare provider about psychiatric history
- Research the destination and health facilities available locally
- Schedule a pre-travel psychiatric assessment
- Reconsider daily dosages of existing psychotropic medications

During travel

- Educate traveller about jet lag effects
- Ideally, travel with family or friends
- Prescribe a psychotropic drug with anxiolytic properties during the flight, e.g. a low-dose antipsychotic or hypnotic, but avoid benzodiazepines
- Remain in contact with medical practitioner through email or web call
- Encourage treatment adherence with support from travelling companion

Have a regular, well-planned schedule

- Avoid 'triggers' of mental illness
- Avoid psychoactive substance use and caution with use of alcohol
- Seek medical help if a deterioration in mental health occurs

Post-travel

- Follow up with healthcare professional
- Post-travel psychiatric assessment

Suicide tourism, be it planned or unplanned suicide, is one of the leading causes of mortality among international travellers.¹⁰ Research, including psychological autopsies, should focus on investigating risk factors for suicidal ideation during international travel in an effort to increase the detection of such motivations in intending travellers, who may not consult a travel clinic or psychiatrist in advance of travel.

Post-travel psychiatric assessment may be indicated for certain vulnerable traveller groups, such as volunteers and humanitarian aid workers exposed to hostile and psychologically challenging environments, to counter the effects of post-traumatic stress disorder.¹¹ Consideration should also be given to the possibility of reverse culture shock, where travellers experience depressive symptoms and disorientation on returning to their home country.

Routine coverage of psychiatric disorders in travel insurance policies should be ensured in order to provide financial security to people with mental illness travelling abroad. Unfortunately, travellers with pre-existing mental illness often find themselves excluded from such policies and this greatly complicates efforts at their repatriation.

Conclusions

The lack of research and clinical attention given to travel-related mental health benefits and risks merits the development of an integrated subspecialty of travel psychiatry. This would advance our understanding of the interaction of travel and mental illness in a variety of traveller groups and travel settings. Travel psychiatry should involve close cooperation between mental health professionals and travel medicine practitioners, with ample scope for collaborative patient-centred research. Travel medicine practitioners should receive enhanced training on the psychiatric aspects of travel: travel-related psychological stressors, the impact of travel on pre-existing disorders and the potential for first-time episodes of mental illness during travel, as well as the importance of timely consultation with a travel psychiatrist.

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G.F. was responsible for conception of the work. He contributed substantially to acquisition, analysis and interpretation of the literature, drafting the work, revising it critically for important intellectual content and giving final approval to the manuscript to be published. He agrees to be accountable for all aspects of the work. S.Y.C. contributed substantially to acquisition, analysis and interpretation of the literature, drafting the work, revising it critically for important intellectual content and giving final approval to the manuscript to be published. He agrees to be accountable for all aspects of the work. B.H. contributed substantially to analysis and interpretation of the literature, revising the draft critically for important intellectual content and giving final approval to the manuscript to be published. He agrees to be accountable for all aspects of the work.

Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <http://doi.org/10.1192/bjb.2020.32>.

[click here to view supplementary material](#)

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1.2.81 Root causes of deaths by suicide among patients under the care of a mental health trust: thematic analysis

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date

2021-06

Abstract

Aims and method

This study explored the root causes of deaths by suicide among patients under the care of a mental health trust. Thematic analysis was carried out to identify themes from the serious incident reports for patients between 1 January 2017 and 31 July 2018.

Results

In total, 48 cases were reviewed. Three main themes emerged from this study: patient-, professional- and organisation-related factors. The majority of the deaths were caused by patient-related factors, particularly exacerbation of the patient's mental health condition.

Clinical implications

This study provides insight into perceived causes of death by suicide among mental health patients. It is hoped that this will, in turn, influence the manner in which decisions, policies and resource allocation are carried out to further prevent and reduce the incidence of suicide, particularly among mental health patients.

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– Declaration of interest

* Supplementary material

pmc Suicide is a global health problem. It is estimated that every year about 800 000 people die by suicide worldwide.¹ Previously, the UK has reported a significant reduction in the rate of suicide. However, a report in 2018 indicated a marked increase.² Furthermore, 28% of people who died by suicide in the UK were under the care of a mental health service 12 months prior to their death.³ This implies that more than one-quarter of patients who die by suicide have an underlying mental illness and were known to services prior to their death. Perhaps, if timely intervention had been in place, the risk of suicide might have been reduced.

Serious incident reports represent a record of events deemed to have had untoward consequences for patients, families and/or carers, and the organisation.⁴ The reports are produced to identify areas for improvement in order to avoid a recurrence of such events, and not to apportion blame.⁴ Any case of unexplained death is classed as a serious incident and is referred to the coroner for inquest. Following an inquest, the coroner will make a verdict of accident, natural causes, suicide, industrial disease, narrative or open.^{5,6} A suicide verdict is only given by the coroner following evidence from the suicide report indicating that ‘on the balance of probabilities’ the deceased performed and intended an act of suicide that would result in the end of life.⁷ This new standard for the coroner’s ruling has been in place since May 2019.⁷

Predictors of suicide

In most cases, identifying why patients die by suicide is challenging. In fact, the Samaritans⁸ supported this notion, making it clear that the causes of suicide are not straightforward but sometimes could be preventable. In the clinical setting, the SAD PERSONS scale is the risk assessment tool used to predict the possibility of suicide among patients.⁹ However, there remains insufficient evidence of its ability to predict suicide, because it fails to provide a comprehensive understanding of the underlying causes of suicide; however, it continues to be used globally.^{10,11} Thus, an understanding of possible underlying causes of suicide is imperative.

The root cause analysis within a serious incident report provides details about possible or perceived causes of suicide. The root cause is based on systematic investigation of what led to the serious incident. Root causes of suicide can be multifactorial but are generally classed as: individual, quality and safety process, organisational, situational and care-related factors.^{12,13} However, in the light of the complexities associated with suicides, understanding the root causes of suicide may be a step in the right direction to prevent suicide globally.

This study aims to explore common themes emerging from root cause analysis of serious incident reports for mental health patients who died by suicide under the care of a mental health trust. The research question is: what are the root causes of suicide among mental health patients? It is hoped that study will give an indication of the perceived underlying causes of suicides among mental health patients and therefore help service providers, researchers and policy makers to implement policies and strategies to further prevent and reduce the incidence of suicide, particularly among mental health patients.

Method

This study took place in a National Health Service trust in the UK’s Midlands. Data were collected as part of a service evaluation within the trust. The process of reporting a serious incident within the trust is detailed in *Fig. 1*. In the trust, serious incident reports are based on evidence gathered independently. Serious incident reports for patients who died by suicide provide details about the individual, the intent, and the event leading up to the suicide, with the hope of learning about the cause(s) of suicide. *Fig. 1* Serious incident report process.⁴

Serious incident reports are written by a senior clinician within the trust who was not involved in the care of the patient. The serious incident investigations are done soon after the incident to avoid issues about recollection of events. However, the report is not published until the coroner’s verdict has been established. The aim is for a serious incident report to be instigated and completed within 3 months of the event, although the coroner’s verdict may take longer

to be established. The serious incident report is based on semi-structured interviews with the clinicians, the patient's relatives and loved ones, and examination of the case notes.

The root cause is established by the serious incident review team group, following the investigation by the senior clinician. A typical root cause may be about a paragraph consisting of a few sentences and is very specific about the definitive cause of suicide. The root cause section is not based on a predefined category, and details reported vary among patients. Furthermore, in some cases, a root cause may not be identified, whereas other reports contain more than one root cause. The root causes and other findings such as shortfalls in service and delivery within the serious incident report are later disseminated in team meetings. Actions are then taken based on the recommendations suggested for the learning process and service changes.

In this study, serious incident reports for patients who died by suicide while under the care of the trust between 1 January 2017 and 31 July 2018 were reviewed. There were 71 deaths during this period, of which 36 were ruled as suicide by the coroner. It should be noted that the coroner's rulings of suicide in the serious incident reports reviewed in this study were based on the old standard of 'beyond all reasonable doubt'. A further 16 serious incident reports with a narrative verdict were considered by the service evaluation team as possible suicides and were therefore included to increase the scope of learning. This review was therefore based on 48 cases.

Thematic analysis was carried out inductively by the authors to identify themes emerging only from the root causes of the serious incident reports.¹⁴ Thematic analysis was selected owing to its ability to generate trustworthy and insightful rich data about the root causes of suicide among mental health patients.¹⁴ Moreover, the use of an inductive approach helped to create themes directed by the content and not by preconceived ideas or theory. Braun and Clarke's¹⁴ six-step procedure was used to identify themes. Familiarisation, coding, theme development, revision, naming and writing up were carried out by the main researcher and agreed by two other authors. Any disagreements were resolved by discussion.

Trustworthiness and rigour were established using Lincoln and Guba's¹⁵ criteria: credibility, transferability, dependability and confirmability. Credibility was ensured by member checking and triangulation. Member checking was carried out by the review team, who validated the findings of the serious incident reports. Triangulation was ensured by the main researcher discussing the findings with two other authors. If there were disagreements, they were resolved by discussions. Transferability was achieved by providing a detailed description of the research by all authors such that it could be easily applied in other contexts. Dependability was attained by clearly documenting the research process. Confirmability was achieved by ensuring that the interpretations and findings were derived from the data, with themes and subthemes supported by quotes.

Ethical considerations

This study was scrutinised and approved by the Research and Innovation Department of the trust. Information from serious incident reports was only disclosed to the review team. Data were protected by storing electronic data on an encrypted USB drive and password-locked computers, and paper files were stored in a locked cabinet. All materials relating to this service evaluation will be stored for at least 3 years from the end of the study in accordance with the trust's research policy.

Results

There were nearly twice as many deaths in males ($n = 31$) as in females ($n = 17$). The age range was 15–86 years. The most common method of suicide was hanging. Two-thirds of the death took place at home ($n = 32$), and only one death occurred in the hospital on an in-patient ward. It should be noted that one-sixth ($n = 6$) of the reports had no identified root cause. Three main themes emerged, each of which had a number of subthemes. Quotes only from the root cause sections of the serious incident reports were used to support the subthemes and themes emerging in this study. Quotes from each serious incident report were assigned a code. The serious incident reports were labelled in chronological order (1–48). The three main themes emerging from this study were: patient-, professional- and organisation-related factors.

Patient-related factors

The thematic analysis identified three main patient-related factors that contributed to deaths by suicide: exacerbated mental health conditions, lack of engagement with services and non-adherence to medications. An exacerbated mental health crisis was the most common patient-related factor and also the most frequently recurring subtheme emerging from the serious incident reports. The exacerbated mental health condition was often secondary to physical health problems, social and relationship difficulties, an underlying criminal offence, alcohol and substance misuse, or sexual offences, especially child pornography.

Furthermore, in some cases where lack of engagement and non-adherence to medication were identified as root causes, patients also had an exacerbated mental health condition. This is because these factors could have a bi-directional effect. For instance, lack of engagement and non-adherence to medication could result in exacerbated mental illness and *vice versa*. *“Patient had a history of being reluctant to come into hospital. Deterioration in mental health was triggered in response to an argument with his family; the patient had an argument with a family member, several days prior to his death” – Report 24* *The patient suffered from paranoid schizophrenia, discontinued depot medication and thereafter appears to have complied poorly with oral medication. There was a two month period during which no medication were taken’ – Report 16”*

Professional-related factors

These are factors related to the manner in which care and services are delivered by mental health professionals (usually doctors and nurses). Five main factors emerged: issues around risk assessment and management, inadequate clinical enquiries, non-adherence or poor adherence to policies and procedures, no interprofessional communication and collaboration, and lack of consultation of carers by clinicians.

Among these five factors, issues around patient assessment and management were the most common and represented the second most frequently recurring subtheme in this study. This was an interesting finding, as most mental health professionals are trained and are aware of the protocols and practices within the trust. Further exploration revealed that poor practice, especially improper documentation, was a major cause. This was noticed more in cases where the patient frequently presented and the health professional did not update the risk assessment and management documentation. *“Early warning signs were not documented, so it is unclear whether these were identified, known and shared. Clinical documentation provided wrong information (details were not updated) about patient current state. It was anticipated that patient would make a full recovery having presented frequently previously’ – Report 21”*

Further exploration into cases where professionals did not carry out enough detailed clinical enquiries shows that clinicians had misperceptions regarding the seriousness of the patient’s presentation. This clinical enquiry includes patient history and collateral information from carers and other professionals managing the patient. *“The patient superficially appeared to be making some progress and was fully compliant with care plan and activity schedule and was engaging well with staff and patients. There was no indication that progress would not continue. It was anticipated that the patient would make a full recovery’ – Report 15”*

Consulting carers may help clinicians to corroborate or contradict patients’ claims about their mental health. Carers may be family, friends or any loved ones that look after patients in a non-professional capacity. In this study, one report indicated that the root cause was the clinician not carrying out detailed clinical enquiries and not consulting the patient’s carer. *“Patient concealed information and gave assurance of not being suicidal. This was taken on face values, despite family expressing concerns and partners assertion that patient was concealing information’ – Report 43”*

Clinicians mostly did not adhere to the trust’s follow-up review standards. Follow-up is very important as it ensures that a patient receives continued support whether they are in crisis or not. *“Patient was discharged from mental health treatment with no follow-up or aftercare arrangements despite agreement to liaise with Hospital X, and despite further episode of self-harm and having been pending transfer from hospital Y to a mental health bed’ – Report 11”*

Likewise, a lack of interprofessional communication and collaboration may result in the patient not having the necessary support. This is particularly important for patients who have comorbid physical and mental health problems. *“Given*

the patient consistently gave differing accounts of history to a multitude of practitioners, the trust should have engaged with other agencies involved in patient care and this will have helped deliver holistic care' – Report 20"

Organisation-related factors

Factors within the organisation identified as root causes included inadequate psychiatric accommodation, a lack of additional support for mental health patients (such as drug and alcohol services) and unsafe wards. At the time this study was conducted, the trust did not have a drug and alcohol service, although patients were often referred to local available services. Nevertheless, patients and their carers often indicated that they were not satisfied with the referred drug and alcohol services and would prefer one within the trust. *"Patient indicated not finding the drugs and alcohol services helpful but was still signposted. It is highly unlikely patient will make self-referral and engage with the services' – Report 9"*

Psychiatric ward bed shortages in the trust can be attributed to high demand, which may be a result of the trust's location in one of the main cities within the West Midlands. It should also be noted that in some cases where psychiatric beds were not immediately available, alternatives such as daily visits within the community or a short stay in a general hospital ward or mental health supported accommodation in the community were provided to patients. Providing such alternatives may be a safe alternative in the absence of the ideal psychiatric ward admission; however, the care and support provided in such an environment may not be suited to the patient's needs. This does not exclude the fact that suicide occurs in in-patient wards. *"The patient had a complex history and had taken overdoses previously, The last contact with the Trust, patient was expressing concerns about sleep again and was on the bed list and daily review with HTT but perhaps would have benefited more as inpatient on the ward' – Report 36"*

In this study, there were two cases of unsafe wards, one an in-patient ward within the trust and the other in prison accommodation. It was further observed that the in-patient death occurred as a result of not adhering to the trust's observation policy. *"Patient had serious mental illness, personality disorder and substance use disorder, There was no observation in last 24 hour before death and no evidence of psychiatric and psychological input' – Report 41"*

Thus, in-patient wards may be a safer option for reducing deaths by suicide; however, if no other patient- and professional-related factors are taken into consideration, in-patient wards may not provide the necessary prevention of suicide among mental health patients.

Discussion

This study confirms views about suicide being a complex problem, with aetiology and predictors that are difficult to identify.^{13,16,17} The root causes considered in this study will provide a more comprehensive understanding of possible underlying causes of suicide than the SAD PERSONS scale. This is because the SAD PERSONS scale appears to focus more on certain patient-related factors,^{9,10} whereas this study identified that underlying professional- and organisation-related factors can also influence suicide rates.

The findings are consistent with those of previous studies regarding acute crisis having a strong association with suicide among mental health patients.^{13,18} Thus, there is a need for continued assessment and support in mental health services. Often, a patient who died by suicide deliberately did not give essential information or denied plans for suicide when assessed by health professionals.^{16,19} This can be particularly difficult, as those patients are very likely to be frequent attendees with a history of self-harm, suicide ideation and multiple suicide attempts. Meanwhile, health professionals want to respect and listen to patients; hence, they work with the details provided by the patient, which might not give a true picture of the extent of their symptoms.

A particularly significant finding of this study is the need for processes, procedures and training that help health professionals to increase their ability to carry out detailed clinical enquiries while assessing and managing patients. Also emerging from this study is the need for an approach to patient and carer involvement that promotes active participation of patients and their carers (family, friends or loved ones) in assessment and management of patients. The National Confidential Inquiry into Suicide and safety in Mental Health (NCISH)³ report also supports this view, stating that clinicians should conduct a robust patient assessment which is person centred and takes into consideration the stressors, support and perspectives of family and carers.

Furthermore, involving family members is particularly useful in corroborating or contradicting the symptoms expressed by patients,²⁰ especially when patients do not willingly divulge information or deny the extent of their mental health crisis. However, confidentiality and carer rights are two factors that can swerve professionals in their decision about the extent to which family members should be involved. Also, clinicians should explore whether family member involvement in patient assessment and management is a potential protective or risk factor.¹⁶

Shortage of beds was not a major reason for deaths by suicide in this study. Since the closure of asylums in the UK in the 1950s, more mental service provision now occurs in the community than on in-patient psychiatric wards.²¹ Thus, it can be presumed that community and outreach services are equally effective in managing mental health patients and reducing avoidable admissions. It can be argued that patients in crisis will receive more effective care and support in a psychiatric unit than at home.²² Nevertheless, each patient should be evaluated based on their risk and triggers, and a decision should be made regarding whether intervention services should be delivered in the community or in a psychiatric unit.

Adherence by health professionals to policies and procedures is a crucial aspect of reducing deaths by suicide. For example, where handover and referral procedures are not adhered to, insufficient details will be passed on, affecting interprofessional communication and collaboration. Ultimately, this may result in patient assessment not being holistic, with a spiral effect on the management of the patient. Perhaps the reason the discharge and handover policies were not adhered to was poor clinical documentation. Fowler¹⁶ emphasises the importance of proper clinical documentation in providing comprehensive and practical patient assessment and management. Thus, this study indicates that clinical documentation can have a spiral effect on the assessment and continuity of care of patients and on suicide prevention.

The NCISH³ report recommends safe wards and early follow-up as key ways of reducing suicide incidence. Considering that hanging is the most common method of suicide in the UK, having safer wards is an essential priority to reduce incidence on the wards. This view is also consistent with the study of Meehan *et al*,²³ who suggested that in-patient wards should be redesigned to ensure safety. However, it appears that more suicides take place at home than elsewhere, as revealed in this study. Although it might not be practical to design or redesign all mental health patients' homes to be safe, other measures need to be put in place. For instance, studies have shown that there is higher risk of suicide in the first 7 days after discharge.^{3,23,24} Thus, carrying out early follow-up should become a priority in suicide prevention.

Summary

Suicide prevention remains a priority globally. Investigating root causes is a step in the right direction in developing strategies that may be effective in reducing the current suicide rate. It is acknowledged that root causes are not conclusive evidence of the reason suicide occurs; nevertheless, they provide an indication of the underlying causes of suicide.

The three major root causes identified in this study are interwoven, and the goal should be for suicide prevention strategies to take into cognisance all three factors. However, it is also recognised that in the present economic situation, resources are scarce. This study adds new knowledge about suicide prevention by highlighting root causes of suicide among mental health patients. It provides insight into the two most likely root causes, which are exacerbated mental health conditions and issues around patient assessment and management.

Moreover, this study indicates that using a robust person-centred approach with involvement of carers (family, friends or loved ones) in assessment and management, especially among frequent attendees, may help to prevent suicide in mental health patients. Furthermore, this study highlights the need to carry out a risk assessment each time a patient presents, in order to have an updated and relevant patient safety plan. Even in scenarios where patients present on several occasions and no new risks or triggers are identified, health professionals should document this, and a rationale for not giving an update should be provided in the patient record.

A limitation of this study was that it was conducted in one hospital trust in the West Midlands region of the UK. Therefore, the findings may not be generalisable to all other mental health services. Nevertheless, the findings are transferrable and could be applicable to other mental health services. Another limitation was the flexibility of the thematic analysis, which allows researchers to use what is deemed applicable to their research aims and objectives. To minimise this limitation, the research team have provided justifications for the choice of this methodology and details of the data analysis, and explained the measures taken to ensure trustworthiness and rigour.

A suggestion for further research is to identify factors that make patients more vulnerable to suicide in non-hospital settings and provide evidence-based strategies to reduce these. Overall, this study provides insight into perceived causes of death by suicide among mental health patients. It is hoped that this will in turn influence the manner in which service providers, researchers and policy makers carry out decisions, policies and resource allocation and implement strategies to further prevent and reduce the incidence of suicide, particularly among mental health patients.

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Data availability

All data generated or analysed during this study are available on request.

O.O., K.W., D.B. and G.T. were responsible for writing the protocol. O.O., K.W. and D.B. were involved in the conceptualisation of the study. O.O. was responsible for the literature search. All authors read and approved the final manuscript.

Declaration of interest

Supplementary material

For supplementary material accompanying this paper visit <http://doi.org/10.1192/bjb.2020.106>.

[click here to view supplementary material](#)

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1.2.82 Matthew Large

Abdi Sanati¹

date

2021-06

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- *Matthew Large*

¹ **Abdi Sanati meets Professor Matthew Large**. Conjoint Professor in the School of Psychiatry, University of New South Wales, and Clinical Director of Mental Health in the Eastern Suburbs Mental Health Service, Prince of Wales Hospitals, Sydney, Australia

pmc As psychiatrists, we engage with risk assessment on a daily basis. I personally have seen an increased emphasis on risk assessment since I started training two decades ago. The question for me has always been how accurate our risk assessments are. I then read the works of Professor Matthew Large and was heartened by his common-sense approach to risk. We met a few years ago in a Maudsley debate on risk. Professor Large has written extensively on risk assessment in psychiatry. Although he holds an academic title, he works in emergency departments and acute wards. He knows the reality of working as a psychiatrist. He lives and works in Sydney, Australia.

Thank you very much for your time, Professor Large. I wanted to start by asking what do you think the place of risk assessment is in psychiatry?

Before answering, I should say a few things. People who read my papers sometimes think of me as a cloistered academic, but in Australia I am a full-time clinician. I mostly work in emergency rooms and observation wards. In the past 2 days I have seen 21 hospital patients, quite a few of whom were new to me. In the Maudsley debate I was criticised for being detached from the reality of day-to-day work, but the opposite is the truth. Perhaps the most fundamental criticism of risk assessment relates to the very nature of day-to-day psychiatric practice. I don't think any of us really work with low-risk patients – I am at a loss to think who these patients even are. Therefore, in our work, risk assessment must have a modest role. Nevertheless, I acknowledge that we can moderately differentiate between people at higher risk and lower risk. My main criticism of risk assessment is not that it gives you no information, but that the amount of information it provides is so slight. The vast majority of people classified as higher risk don't engage in seriously harmful behaviour and in most studies about half of the seriously harmful events occurred in lower-risk people. Taking this one step forward, if you can imagine an intervention that is effective, benign and acceptable to high-risk patients (the vast majority of whom will never experience serious harm), how can such an intervention be rationally denied to lower-risk patients, among whom half of all serious harm events occur?

I remember reading about a paper by Frank Knight published in 1922, where he distinguishes risk from uncertainty, the former being quantifiable, the latter not. The paper was in the context of insurance, but don't you think it has a relevance in the practice of risk assessment in psychiatry?

Uncertainty is a huge driver of medical diagnostics but we do not think about it enough. As a concept uncertainty is more fruitful than risk in psychiatry. Consider the following scenario. A 16-year-old smoker may or may not develop lung cancer. Here the uncertainty is mostly due to chance and more information cannot really help you. Aged 50 the same smoker might develop haemoptysis. Whether or not the person has lung cancer is now a matter of discernible knowledge. These two types of uncertainty, sometimes called aleatory and epistemic uncertainty, are often confused. For example, while we might establish with some degree of certainty that a patient has suicidal ideas, this means surprisingly little about the chance of later suicide. More bluntly, while our risk assessments can tell us something about the patient in front of us, they are not a meaningful prediction. Unfortunately, this is not always understood and can and does have bad consequences for patients. I started thinking about this in relation to mental health law. When a group of patients are detained on the basis of a perceived risk, all higher-risk patients, including the majority false-positive group, share the burden of the resulting interventions. This is actually very old-fashioned collectivism and most of us would much prefer to carry our own risk if we were ever in this situation.

Interesting that you mentioned mental health law. I remember you wrote about the role of the dangerousness criterion. Could this criterion be useful in people like a patient who attacks his mother when he is unwell?

Sadly, we are stuck with the term dangerousness. To answer your question, if you had a patient who you knew attacks his mother when he is unwell this could be considered to be an epistemic dimension for him and might contribute to a treatment decision. However, I think he could be treated when he is so unwell as to attack his mother and because of a lack of mental capacity to refuse treatment. No recourse to risk is actually required. Further, this sort of specific knowledge about one patient is hard to generalise to others. Research invariably shows that if you do generalise a violence risk factor this will only modestly differentiate between higher- and lower-risk patients. Even when risk factors are combined, risk assessment does not work very well – a recent meta-analysis by Seena Fazel's group found that the odds ratio (OR) for violence among higher-risk patients compared with lower-risk patients was 6 under optimal research conditions and 3 under more ordinary circumstances. An OR of 6 sounds high but remember that being male is associated with an OR for homicide of about 10 and an OR for suicide of 4 in most countries. What differentiates maleness from psychiatric risk factors is the negative value or stigma associated with mental illness.

You recently co-authored a study on the relationship between suicidal ideation and later suicide. What intrigued

me was that there was not much difference between the predictive power of risk assessment based on clinical examination and risk assessment based on actuarial tools.

I accept the work of Paul Meehl that found that actuarial assessments are generally a bit more accurate than clinical assessments. What this does not mean is that actuarial assessments are sufficiently good to be a basis for clinical decisions. At least a clinical risk assessment opens some possibility for engagement with the patient and consideration of their unique qualities and needs. If used sensibly, a clinical assessment might even lead to a meaningful or helpful dialogue. A tick-box approach demeans the assessed person's human agency and decision-making and likely does much the same to the risk assessor. Patients have every bit as much human agency as we do. I always try to assess the extent to which my patients are risk assessing me as someone who can harm them by depriving them of their liberty and by enforcing treatments. I am eager to see game theory applied to risk assessment – I think there might be some fruitful work to be done in this area.

One striking feature of risk assessment tools is their poor positive predictive value (PPV). I wonder how you think tests with such a low PPV could help clinical decisions?

Well, I don't think they can. Any test with such a high number of false positives is pretty useless in medicine. I try to focus on clinical needs. Sometimes needs converge with risk but risk rarely tips my decisions. An excessive focus on risk can contribute to unnecessary hospitalisation. Psychiatrists and the media (particularly in the UK) often focus on the very rare event of a homicide by a patient with schizophrenia. My colleagues and I did a couple of studies some years ago and that found that 35 000 patients would need to be detained to prevent one such stranger homicide. Tangentially to this, what we worry about is largely a question of our value systems. I have recently been focusing on the relative risks of suicide and vascular death after discharge from psychiatric hospital: in reality, the risk of vascular death exceeds suicide within months of discharge, yet worries us much less.

There is also the role of politics. A few years ago, the UK deputy prime minister spoke of zero suicide and the focus was mainly on mental health services. Could it be that by putting all the responsibility of suicide prevention on mental health services, the politicians avoid the social changes that are necessary for reducing suicide? Changes such as reducing inequality, helping families, providing meaningful employment, among others.

Let's look at this objectively. The prevalence of mental illnesses does not vary that much between countries but the incidence of suicide varies dramatically. We have made a rod for our own backs by believing that 90% of suicides are *because* of mental illness. While mental illness is associated with suicide, this is not always causal and mental illness and suicide have many common underlying causes, for example social disadvantage, stigma and substance use. Even if we assume a big role for mental illness in suicide, where does this lead us? With the possible exceptions of lithium and clozapine, there is pretty much no evidence that psychopharmacological treatments reduce suicide, and suicide rates in hospital and aftercare are very high, suggesting we are not good at protecting our patients.

In my own experience, I have witnessed some divergence between academics and clinicians. I remember once in a debate an academic quoting research, which I add was not designed to investigate suicidality, to say all suicide was because of mental illness and no one can rationally contemplate suicide.

There is a divide. The question I have is who is a 'suicidal patient'? It is almost insulting to think that the process of listening to patients and observing their unique or idiographic characteristics can be reduced to a few common or nomothetic risk factors. I think risk assessment should be replaced by risk communication – a communication that we must have with patients and their families. We should be open about the uncertainties and the low power of our predictive tools. We need to be honest about our limitations.

One problem that we face is that the inaccuracy of risk assessment tools has to be communicated to the courts, judges and coroners. How do you think we can do it?

The courts can get this very wrong. In the case of Melanie Rabone² the Supreme Court heard expert psychiatric

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In an important judgment in 2012 concerning the suicide of Melanie Rabone, a 24-year-old woman who was an informal patient, the UK Supreme Court ruled that the state has a duty to all patients under Article 2 of the European Convention on Human Rights. For further information see: <https://www.supremecourt.uk/cases/docs/uksc-2010-0140-judgment.pdf>.

evidence that overestimated suicide risk by two orders of magnitude. We need to explain to the courts that the presence of multiple and statistically valid risk factors does not equal useful knowledge about the future and that we are doctors and not soothsayers.

1.2.83 Gender equality in academic psychiatry in the UK in 2019

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Abstract

Aims and method

To investigate whether gender balance in academic psychiatry in the UK has improved since a 2005 initiative to encourage career progression for female academics in UK universities. We surveyed the gender of academic psychiatrists across the UK and compared our findings with our previous 2003 London-wide survey and with the Royal College of Psychiatrists' 2001 workforce census.

Results

The percentage of women in academic psychiatry posts in the UK more than doubled, from 20% in 2001 to 40% in 2019, with increases at senior lecturer (from 25 to 50%), reader/associate professor (from 29 to 48%) and professor level (from 11 to 21%). Outside London, men occupy 72% of all posts and 89% of professorial posts. Within London, men occupy 45% of all posts and 74% of professorial posts.

Clinical implications

The representation of women in academic psychiatry has improved but men continue to dominate at professorial level. Gender equality appears worse outside London. The situation is exacerbated by the diminishing availability of posts across the UK.

Contents

- *Gender equality in academic psychiatry in the UK in 2019*
 - *Method*
 - * *Analysis*
 - *Results*

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- *Discussion*
 - * *London compared with the rest of the UK*
 - * *Barriers to career progression and the Athena SWAN initiative*
 - * *Reasons for the continued inequality*
- *Data availability*
- *Declaration of interest*
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pmc The percentage of female medical students in the UK in 1963 (the first year that data were reported) was 29%. It had increased to around 40% by 1980 and, since the mid-1990s, it has been consistently greater than 50%.¹ In 2018–2019, 59% of medical and dental students were female.² However, NHS Digital reported that women made up only 45% of qualified doctors in the UK in 2018 and 64% of consultant posts were held by men.³ This suggests that women are more likely to leave medicine or fail to progress to consultant grade than their male counterparts. Gender balance also varies between medical specialties: in psychiatry women held 45% of substantive consultant posts in 2019,⁴ reflecting a gradual increase from the 34% reported in the Royal College of Psychiatrists' workforce survey in 2004.

Gender balance is worse in clinical academia. A survey published in 2018 by the Medical Schools Council identified 3465 clinical academic posts in the UK,⁵ comprising approximately 2% of the NHS medical workforce.⁶ One-third (31%) of these posts were in London. Most (41%) were in medicine, followed by surgery (9.1%), psychiatry (7.3%) and general practice (7.2%). Men held 72% of all clinical academic posts. Gender imbalance increased with academic seniority, with women occupying 41% of lecturer grade, 34% of senior lecturer/reader grade and 18% of professor grade posts.⁵ In 2003, we conducted a survey of academic psychiatrists employed in substantive posts in London universities and found that only 24% were women, comprising 62% of lecturers, 25% of senior lecturers, 29% of readers and 11% of professors.⁷

Since 2005, higher education institutions in the UK have been encouraged to participate in the Athena Scientific Women's Academic Network (SWAN) charter,⁸ which promotes good practice in addressing inequalities in career progression in fields that have tended to have poorer gender balance – science, technology, engineering, mathematics and medicine ('STEMM' subjects). The programme has been incentivised by awarding academic departments, institutions and universities three grades of charter mark (bronze, silver and gold), with the suggestion that only those that achieve silver will be eligible to apply for certain national research funding streams.

The UK Royal College of Psychiatrists' workforce census of 2019 reported that women held 29% of clinical academic posts in psychiatry.⁴ However, these data were limited by possible double counting of clinical and clinical academic posts, missing data and lack of breakdown by academic grade. We therefore contacted all UK universities known to undertake research in psychiatry to request information about the gender balance of their substantive academic psychiatrists. We aimed to investigate the situation within and outside London universities and to compare our data with our previous London-wide survey results from 2003 and with data from the Royal College of Psychiatrists' 2001 UK-wide workforce census published in our original survey⁷ to investigate whether, in the context of initiatives such as Athena SWAN, there had been any improvement in gender balance in academic psychiatry.

Method

We contacted the relevant heads of departments of all 15 UK universities known to employ psychiatrists in substantive academic or clinical academic posts (Imperial College London, King's College London, Queen Mary University London, University College London, the Universities of Bangor, Cambridge, Cardiff, Edinburgh, Liverpool, Manchester, Nottingham, Oxford, Swansea and Warwick, and Queen's University Belfast). We requested data on the number and gender of academic psychiatrists by grade (professor; associate professor/reader; senior lecturer; lecturer; research fellow). No other data were requested, no individually identifiable data were gathered and data were collated across institutions; therefore no ethical approval was required. Departments that did not respond to the first email received two further reminders.

Analysis

Data were collated using IBM SPSS version 25.0 for Windows. We present descriptive statistics (frequencies and percentages) on the number and gender of academic psychiatrists in the UK and within and outside London. Chi-squared tests were conducted to compare the percentage of women by grade within and outside London, and the change in percentage of women by grade across the UK using the Royal College of Psychiatrists' workforce census data from 2001, and within London using the data from our previous survey of London academic psychiatrists conducted in 2003.⁷

Results

We received responses from 12 of the 15 (80%) universities, including all those in London. The gender of academic psychiatrists by grade is shown in *Table 1*. Overall, 49% of posts were held by women. Although there was equal gender balance at senior lecturer and reader/associate professor level, men occupied 79% of professorial posts. *Table 1* Gender balance among UK academic psychiatrists, 2019

Academic grade	Female, n (%)	Male, n (%)	Total, n
Research fellow	60 (70)	26 (30)	86
Lecturer	34 (64)	19 (36)	53
Senior lecturer	36 (50)	36 (50)	72
Reader/associate professor	11 (48)	12 (52)	23
Professor	21 (21)	79 (79)	100
Total	162 (49)	172 (51)	334

Figure 1 shows the gender balance by grade of UK academic psychiatrists in 2001 and 2019. Research fellow posts are not included as data on these were not reported in 2001. The percentage of female academic psychiatrists has increased from 20 to 40% overall, with the largest increase seen at the level of senior lecturer (from 25 to 50%), a statistically significant increase. Of note, the total number of posts has fallen from 366 to 248 since 2001. *Fig. 1* Percentage of UK female academic psychiatrists, 2001 and 2019.

Table 2 shows the gender of academic psychiatrists by grade in universities inside and outside London, including research fellows. Around three-quarters of all UK posts (252/334) were in London. Women held the majority of more junior posts (research fellow and lecturer) within London, whereas the reverse was true outside London (although the total number of these posts outside London was small). These differences in junior posts within and outside the capital were statistically significant. There was equal gender balance within and outside London at senior lecturer grade, but most professorial posts were held by men (89% outside London, 74% within London). Women occupied 63% of reader/associate professor posts outside London and 40% within London, but, again, the number of these posts was relatively small and thus we need to be cautious in interpreting this difference. There were no statistically significant differences in the percentage of women at these higher grades within and outside London. *Table 2* Gender balance among academic psychiatrists within and outside London, 2019

Academic grade	Female, n (%)	Male, n (%)	Total, n	Female, n (%)	Male, n (%)	Total, n	Chi-squared	P
Research fellow	57 (76)	18 (24)	75	3 (8)	7 (21)	10	110.79	0.001
Lecturer	32 (74)	11 (26)	43	2 (8)	10 (80)	12	101.45	0.001
Senior lecturer	27 (50)	27 (50)	54	9 (50)	9 (50)	18	>1	
Reader/associate professor	6 (40)	9 (60)	15	3 (37)	8 (81)	11	0.60	0.303
Professor	17 (26)	48 (74)	65	4 (11)	31 (89)	35	180.07	4
Total	139 (55)	113 (45)	252	23 (28)	59 (72)	82	18.20	<0.001

Figure 2 shows the gender balance by grade within London universities in 2003 and 2019. Research fellow posts are not included as data on these were not gathered in 2003. The percentage of academic psychiatrist posts in London occupied by men fell from 74% in 2003 to 54% in 2019, with increases in the percentage of women at every grade: a 41% increase at lecturer level, 21% at senior lecturer, 9% at reader/associate professor, and 8% at professor level. However, only the increases in the percentage of women at lecturer and senior lecturer level were statistically significant. *Fig. 2* Percentage of female academic psychiatrists, London universities, 2003 and 2019.

Discussion

We found 49% of all clinical academic posts in psychiatry to be occupied by women, compared with the 29% reported in the Royal College of Psychiatrists' 2019 census.⁴ The disparity may be explained by the limitations of the census noted previously (double counting and missing data). Although we did not achieve 100% response from universities outside London, given that three-quarters of posts were within London, this finding appears robust as well as encouraging. Our results also compare favourably with the figure of 28% reported by the Medical Schools Council for all medical specialties.⁵

Our data suggest that gender equality in academic psychiatry across the UK has improved since 2001, with increases in the percentage of women at all grades and a statistically significant increase at senior lecturer level, where women now hold 50% of posts. This is in keeping with the gradual increase in women achieving substantive consultant posts (an equivalent grade to senior lecturer) in psychiatry over a similar period.⁴ However, there has been a comparatively small rise of only 10% in women at professor grade, with four-fifths of these posts occupied by men. This is particularly disappointing when comparing these figures with other medical specialties, where women still only comprise one-third of senior lecturer and readers/associate professors and 18% of professors.⁵ In other words, the progress made in gender equality at the lower grades of academic psychiatry has not had the same rate of impact on the highest grade. This could be due to the fact that people tend to occupy a professorial post for much longer than lower grade posts and thus vacancies do not arise as often. It might therefore be expected to take longer for gender equality to be achieved at this level than at senior lecturer and reader/associate professor level. Nevertheless, 18 years is surely long enough to infer that this is not simply a 'pipeline' problem that will correct itself over time.

London compared with the rest of the UK

We also found that the situation within and outside London differed, with somewhat better gender equality in the capital, where women held 55% of academic psychiatry posts, compared with 28% elsewhere. Outside London, the majority of more junior posts were occupied by men and, although there were equal numbers of men and women at senior lecturer grade and more women than men at reader/associate professor level, there were very few of these posts. At professor level, men held 31 of the 35 available positions. Within London, although research fellow and lecturer posts were in greater supply and women held the majority of these, the '*pinch point*' in career progression came above senior lecturer level, with women representing only a quarter of all professors. Comparing our results with our 2003 survey of London universities,⁷ we found that the percentage of women at all grades had increased, but statistically significant increases were only evident at lecturer and senior lecturer level. It therefore seems that, although the opportunity for progression in academic psychiatry is improving for women overall across the UK, it remains very challenging to achieve the highest level of promotion, and the situation may be even harder for women pursuing their career outside London.

Barriers to career progression and the Athena SWAN initiative

The barriers to career progression for women in academia have been described previously,⁹ and helpfully summarised by Howard¹⁰ as including 'few visible role models and mentors, the short-term contracts used for relatively senior academic positions, lack of transparency for pay and promotion procedures, gender imbalance in the decision-making processes of promotion and organisational policies, slow setting up and take-up of work life-balance policies and, particularly challengingly, the intangible cultural factors that seem to exclude women from the corridors of power'. Others have also emphasised the importance of unconscious bias as a driver of inequality within academic institutions.¹¹

The Athena SWAN charter established guiding principles to assist higher education institutions in addressing the many barriers to gender equality, with the aim of improving the recruitment, retention and career progression of female academics.⁸ Its bronze, silver and gold accreditation awards provide an incentive to establish and develop key actions and policies to overcome the specific barriers in a particular setting, with the aim of changing cultures and processes that disadvantage female staff. The charter has since been extended to non-STEMM specialties and been broadened to include other aspects of diversity as well as gender.

The implementation of the Athena SWAN initiative was evaluated in five departments of one UK medical school using

a qualitative approach.¹² Although it was felt to have introduced a welcome mechanism to raise the issue of gender equality within the organisation, it was also reported to create considerable additional work for female staff. This included completing the lengthy SWAN application itself, as well as coordinating actions to address specific barriers, and the increased burden on the small number of senior women, who had to take on more committee work to improve gender representation. The authors concluded that the aims of the initiative were undermined by the negative impact on female staff.¹² A separate evaluation found no difference in the career progression of female academics in the 12 UK medical schools that had been participating in the Athena SWAN programme from its inception compared with those that joined after the announcement in 2011 that the award of National Institute of Health Research (NIHR) funding would be contingent on achieving a silver award.¹³

The financial incentivising of the Athena SWAN initiative by the NIHR represents a ‘carrot and stick’ approach which has certainly raised the consciousness of higher education institutions to the pervasive gender inequality they harbour. All the universities we surveyed had joined the Athena SWAN programme and 12 of the 15 held a silver award at the time of our 2019 survey. Our results suggest that in academic psychiatry there has been clear improvement in the representation of women at all grades of academic post since 2001. Nevertheless, even with the support of a national accreditation process and a financial ‘sword of Damocles’ suspended over these institutions, women in academic psychiatry remain disadvantaged in their career progression within them, particularly with regard to the achievement of a professorial post. The ongoing male dominance at the highest academic grade is, put simply, dispiriting.

Reasons for the continued inequality

One possible reason for this continued disparity is that women are not achieving the key metrics that most universities take into account for promotion to professor. Women tend to hold more teaching and pastoral support roles than their male colleagues, areas of responsibility that tend to be valued less than research activities when considering senior promotions.¹⁴ As well as research grant income, publications are a common metric for academic promotion. However, no data are available allowing us to compare the academic credentials of applicants for promotion to professor by gender in psychiatry.

Our data raise a further important issue. The Royal College of Psychiatrists’ workforce census of 2001 identified 218 academic psychiatrists at senior lecturer grade and above, but only 153 in the 2019 census. Our survey identified 195 at these grades, of whom 134 were based in London, and in 2003 we identified 165 London-based academic psychiatrists at the same grades. All these data suggest that the number of academic posts in psychiatry is shrinking. Across the UK we identified 248 posts at any grade, representing a total reduction of one-third since 2001. Although this problem is not limited to psychiatry, it seems to have been particularly badly affected. The Medical Schools Council reported a reduction in all senior lecturer and reader posts of between 25 and 33% across the four countries of the UK since 2004 and highlighted that psychiatry had seen major losses – 84.4 full-time equivalent (FTE) senior lecturer/reader posts between 2007 and 2017.⁵ This clearly adds further pressure and challenge for those hoping to enter and progress a career in academic psychiatry.

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Data availability

The data that support the findings of this study are available on request from the corresponding author.

All the authors were involved in the design of the study. S.Dh. and H.K. collected and analysed the data. S.Dh. drafted the manuscript, which was revised by H.K. and S.Do.; all authors agreed the final version before submission.

Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <http://doi.org/10.1192/bjb.2020.116>.

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1.2.84 A qualitative exploration of the barriers to and facilitators of clozapine monitoring in a secure psychiatric setting

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Abstract

Aims and method

To explore the beliefs and understanding of staff and patients at a secure mental health unit regarding clozapine monitoring, and to identify barriers to and facilitators of monitoring. Qualitative semi-structured interviews and focus groups were conducted with 17 staff members and six patients.

Results

Six key themes were identified. The key facilitator of effective monitoring was the motivation of staff to help patients to become independent and facilitate recovery. An important barrier was a lack of clarity around the roles of different staff groups in monitoring. Staff and patients widely supported the establishment of an in-patient clozapine clinic and perceived that it would prepare patients for discharge.

Clinical implications

An in-patient clozapine clinic is a robust mechanism for clozapine monitoring in secure settings. The barriers and facilitators identified here could be applied to other secure units to guide their systems of clozapine monitoring.

Contents

- *A qualitative exploration of the barriers to and facilitators of clozapine monitoring in a secure psychiatric setting*
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pmc Clozapine is the only antipsychotic medication with established efficacy in adults with treatment-resistant schizophrenia and is an important treatment option in forensic psychiatric settings.¹ However, it must be used with caution owing to its considerable side-effect profile.¹ Most prominently, this includes a risk of neutropenia and fatal agranulocytosis, cardiac complications and bowel obstruction.¹ Development of the metabolic syndrome, consisting of obesity, insulin resistance (often resulting in type 2 diabetes) and lipid derangements, is common.¹ Consequently, alongside psychiatric monitoring, close monitoring of several physical health parameters is required for patients, as stipulated in the British National Formulary and by manufacturers (*Table 1*). *Table 1* Minimum physical health monitoring required for patients taking clozapine (source: BNF, Lancashire and South Cumbria NHS Foundation Trust¹)

Monitoring for neutropenia	Weeks 1–18	Weeks 19–52	Ongoing monitoring
Full blood			

count Weekly a Every 2 weeks a Every 4 weeks a Other physical health parameters Baseline 1 month 3 months 6 months 9 months 12 months/annually Weight, BMI, waist circumference e b ✓ ✓ ✓ ✓ ✓ Pulse and blood pressure c ✓ ✓ HbA1C or fasting glucose ✓ ✓ ✓ ✓ Prolactin ✓ ✓ Lipids ✓ ✓ ✓ ✓ ✓ ECG d ✓ Liver and renal function Where there are concerns¹²³⁴

Despite being an important line of treatment, it is consistently reported in the literature that challenges remain around the use of clozapine. Previous audits have demonstrated incomplete adherence to physical health monitoring, particularly during the first year of monitoring when the risk of side-effects is greatest.²⁻⁵ Even where abnormalities are identified, this often does not translate into results being communicated or acted upon.^{2,5,6} A previous evaluation of shared-care clozapine monitoring found that implementing a different model of monitoring could feel process-driven and generate anxiety for staff, with a recommendation to identify facilitators and barriers to ensure that change is successful and sustained.⁷ Therefore, in this study, we aimed to explore the beliefs and understanding of staff and patients at a secure mental health unit regarding clozapine monitoring, and to use this information to identify barriers to and facilitators of monitoring.

Methods

Setting

The study setting was a secure mental health unit in north-west England. At the time of the study, approximately 30% of all patients were prescribed clozapine, with an average age of 36 years. This project was nested within a larger service evaluation of clozapine monitoring at the unit, which resulted in a clozapine clinic being recommended.

Data collection

Staff

Semi-structured interviews and focus groups were conducted with 17 staff members. Purposive sampling was conducted in order to represent the different staff groups involved in clozapine monitoring.

First, all junior doctors based at the unit were invited by S.B. to participate in a focus group; all five agreed to participate. The physical health team, encompassing two general nurses and two healthcare support workers, also agreed to participate in a focus group. With regard to mental health ward staff, S.B. attended a selection of in-patient wards and opportunistically asked mental health staff (nurses and support workers) to take part in semi-structured interviews, which were conducted in a private room at the time of recruitment. Eight interviews were conducted. Interviews instead of focus groups were used for ward staff owing to the practical difficulties of multiple staff being simultaneously removed from clinical duties.

¹ More frequent monitoring will be required if abnormal results are obtained.

² Weight should be measured regularly during the first 3 months of clozapine treatment.

³ Blood pressure and pulse must be checked regularly during titration of clozapine.

⁴

If there are clear cardiac risk factors or an established cardiac comorbidity, troponin and C-reactive protein (CRP) should also be checked at baseline prior to initiation.

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Patients

Semi-structured interviews were conducted with six patients. Again, purposive recruitment was performed to recruit patients from medium-secure, low-secure and step-down wards. Patients were approached by a mental health nurse, who introduced the project to the patients and accompanied S.B. during interviews. Only those patients that ward staff deemed clinically stable and able to provide informed consent were approached.

In all cases, the project's purpose and voluntary nature were explained, and verbal consent was obtained. As the primary purpose of the project was service evaluation, written consent was not deemed to be required when planning data collection with senior colleagues at the unit. Verbal consent was witnessed and formally recorded. It was required that participants spoke English and could provide verbal consent. Topic guides were used for interviews and focus groups and encompassed clozapine monitoring in general, with a possible clinic discussed at the end (see Appendices 1 and 2). The length of interviews ranged from 5 to 20 min, and focus groups lasted approximately 30 min.

Epistemology

The research was underpinned by an interpretivist approach, which recognises the subjective nature of knowledge and the need to understand situations from the perspective of those involved.^{8,9}

Analysis

The focus group with doctors was audio-recorded and transcribed verbatim. All other data collection took place in clinical areas where it was not permitted to use audio-recording devices. Therefore, extensive field notes were made, and several quotes from each interviewee were transcribed verbatim to ensure data capture. Subsequently, based on field notes, quotes and transcripts, thematic analysis was utilised in the format described by Braun and Clarke.⁸ Thematic analysis is based on finding and interpreting patterns (themes) within the data.⁸ Following data familiarisation and immersion, a list of codes was generated by S.B. Next, themes were searched for, and an analytical framework was constructed by S.B. Where this framework did not fit the data, themes were further refined and alternative explanations sought until a final framework was agreed by S.B., J.B. and M.L. As well as following standardised topic guides, robust and transparent analysis was critical to ensuring reflexivity and minimising the researcher's influence on emerging themes.

Ethics

Formal ethical approval was not required as the project formed part of a clinical service evaluation. Approval for this was provided by the senior leadership team at the unit.

Results

The analytical framework is shown in *Table 2* and discussed below. Themes are divided into those that facilitate effective clozapine monitoring, those that act as barriers and those acting as both facilitators and barriers. Pseudonyms are used throughout. *Table 2* Analytical framework to emerge from qualitative data collection with staff and patients
 Theme
 Barrier
 Facilitator
 Clozapine monitoring as a means of promoting responsibility and independence among patients ✓
 Staff are highly motivated to help patients and to promote recovery, despite competing priorities ✓
 The roles and responsibilities of different staff groups are not well defined around clozapine monitoring ✓
 Knowledge about clozapine among staff is sometimes lacking ✓
 There is a lack of formal pathways for clozapine physical health monitoring ✓
 Patients have varied understanding and engagement around clozapine ✓ ✓

Facilitators

Clozapine monitoring as a means of promoting responsibility and independence among patients

Clozapine care was seen by staff as more than just the therapeutic compound, and about supporting the holistic recovery of an individual. Staff believed that a clozapine clinic would increase patients' knowledge and emphasise the importance of monitoring. Utilising a clinic arrangement was perceived by staff and stepdown patients as more equivalent to the community, helping patients to adapt upon discharge. *“Service users would feel that clozapine was being taken seriously and be reassured by this rather than a random person coming to take their bloods at random time points. It would help them to understand about clozapine” (Jim, Mental Health Support Worker)* *“I think it's a really good idea, it'll be like what happens in the community” (Matt, stepdown patient)*

Staff believed that patients would respond to the routine of a clinic. Although there might be some pushback initially, it was perceived that it would quickly become the norm. *“There may be stumbling blocks at the start, as there is for any new thing, but once it becomes more routine, part of every ward's day, it'll just become normal for everyone” (Geoff, Mental Health Support Worker)*

Staff are highly motivated to help patients and to promote recovery, despite competing priorities

Although all staff groups faced competing pressures on their time and worked in sometimes challenging situations, they mutually perceived each other as well trained, highly competent and motivated. Although ward staff would be required to facilitate clinic attendance, the benefits to patients of an organised system and to the wards of being able to reliably get bloods done were felt to outweigh this. In addition, a clinic was perceived to have benefits for staff development in terms of phlebotomy training, where staff struggled to get supervised experience. *“It means the right people will be doing it... it'll be a separate department doing it and will stop the communication problems” (Lucy, Mental Health Nurse)*

Barriers

The roles and responsibilities of different staff groups are not well defined around clozapine monitoring

All staff groups perceived that the roles and responsibilities of different teams involved in clozapine were not well defined. The exception to this was pharmacy, who were seen to have a clear role in delivering patient education at clozapine initiation and coordinating full blood counts (FBCs) thereafter. No staff group saw themselves as responsible for cardiometabolic monitoring and were not able to identify who was. The main barrier to defining responsibilities was that clozapine monitoring spans mental and physical health. As an antipsychotic, the physical health team saw clozapine as a psychiatric responsibility. By contrast, ward staff believed that it was outside the scope of psychiatry, owing to the physical health monitoring and extensive side-effects. *“It's a mental health medication and the responsibility of RMNs. I was always taught that if you're prescribing and administering a medication then it was your responsibility to monitor it” (Sharon, Physical Health Team)*

Going forward, it was believed that any potential clozapine clinic should be staffed by mental and physical health colleagues.

Knowledge about clozapine among staff is sometimes lacking

It was perceived by some staff that certain staff groups lacked understanding about areas not viewed to be their responsibility, particularly cardiometabolic monitoring among ward staff. There was concern about this among experienced staff, who believed that undergraduate training around clozapine had declined. They suggested that robust training was needed for forensic staff, given the widespread use of clozapine. “*It was drilled in when I was training that you had to ask everyone on clozapine about their bowel habit every morning but I’m not sure they’re doing it now*’ (Steve, Mental Health Nurse) *The experienced nurses do this very well. They’re well informed about the importance of monitoring clozapine. The new nurses really struggle, they don’t know the side effects*’ (Kristina, Doctor)”

There are a lack of formal pathways for clozapine physical health monitoring

Just as it was not clear who was responsible, it was also believed that pathways for testing and acting upon abnormal physical health results were lacking. Different wards sometimes had different systems, which made it difficult to keep track of how and whether things were done. Staff widely acknowledged that there was a need to organise monitoring, supported by electronic systems. It was believed that it would be difficult to train all staff to do this, and that a clinic model would create a discrete group competent in this. “*There’s not any formalised process and I think that is probably one of the problems as to why the clinic would be useful I guess*’ (Tom, Doctor) *The same people would be doing it all the time and would know what they were doing*’ (Carly, Mental Health Nurse)”

Both facilitators and barriers

Patients have varied understanding and engagement around clozapine

Although most patients were aware that some form of monitoring was required for clozapine, their understanding varied. This was apparent when discussing the reasons for the regular FBCs. “*It’s for cholesterol isn’t it*’ (Kyle, low-secure patient) *It’s for the white cell isn’t it*’ (Warren, low-secure patient) *It’s for the green light isn’t it?*’ (Elaine, medium-secure patient)”

Aside from regular FBCs, patients had minimal awareness of any other monitoring and were usually only aware of side-effects if they had experienced them. “*I can’t go to the toilet*’ (Colin, medium-secure patient)”

Nevertheless, patients understood why they took clozapine and perceived it favourably for psychiatric symptoms. “*Within a few weeks I was more stable and they [hallucinations] disappeared, I sometimes miss them though. Some of them were my mates*’ (William, stepdown patients)”

Patients were used to a model of care that required little effort, and staff felt that it could be a struggle to engage some. Likewise, some patients described the convenience of the current system. “*We struggle to get patients to go and see the GP. It’s a challenge just to get people out of bed and to come to the ward clinic room*’ (Steve, Mental Health Nurse) *I’m quite happy with how it is at the moment... more convenient*’ (Kyle, low-secure patient)”

Discussion

Effective monitoring of physical health parameters and side-effects is a must-do aspect of clozapine care to prevent serious incidents in the short term, as well as the long-term health effects of cardiometabolic complications. Despite this, studies repeatedly report that adherence to the required monitoring, in both in-patient and community settings, is incomplete.^{2-6,10,11} Although clozapine is widely used in forensic settings, there is very little published literature relating to its use here. This qualitative study has provided valuable insight into clozapine monitoring in a secure unit and has identified facilitators and barriers to effective monitoring. These are displayed in *Fig. 1* in the format of Lewin’s force field analysis, which depicts change as a state of imbalance between driving and resisting forces, with change achieved by increasing the facilitators, reducing the barriers, or both.^{12,13} *Fig. 1* Force field analysis of forces driving and resisting change in relation to clozapine monitoring.^{12,13}

The key facilitator was the motivation of staff to facilitate recovery and prepare patients for discharge. Staff understood the risks of not effectively monitoring clozapine and were keen to implement a more efficient model. This mirrors the findings of a previous evaluation of community shared-care clozapine monitoring, where forensic healthcare professionals were motivated by enabling patients to develop skills for independence.⁷ Both staff and patients believed that physical and mental healthcare were equally important for people taking clozapine.⁷ In our study, there was a range of understanding among patients, with stepdown patients having greater understanding of the associated benefits of monitoring. Their engagement is a further key facilitator to be harnessed. Linked to this, staff noted that patients responded favourably to routine, and that consistency should be a core component of clozapine monitoring.

In terms of barriers, an important finding was that roles and responsibilities for monitoring were not clearly defined and inter-team communication was sometimes lacking. Spanning mental and physical health, clozapine monitoring was widely perceived to be outside the scope of practice of the different teams involved. These factors have previously been identified as key determinants of psychiatrists' practice in relation to clozapine, and major contributors to low rates and inconsistency of follow-up.¹¹ Likewise, there was sometimes a lack of knowledge about clozapine monitoring, particularly aspects that staff did not perceive as their responsibility. Although the FBC component was widely understood, as results must be available to enable clozapine dispensing, some staff perceived understanding of cardiometabolic monitoring to be limited among ward staff, despite the widespread prevalence of these complications. Defined roles and responsibilities must be supported by robust pathways for clozapine monitoring. Inconsistent documentation, limited knowledge about clozapine and a lack of communication between teams have previously been shown to limit improvements when abnormalities are detected.^{4,6} Logistically, access to phlebotomy-trained staff was a key barrier to on-schedule monitoring, which has been highlighted in previous audits of clozapine monitoring.^{2,3} From a patient perspective, monitoring was passive, and many had little insight into the monitoring requirements. Although there were more barriers than facilitators with respect to changing the clozapine monitoring system, the facilitators were strong motivators, so it is anticipated that they will drive the proposed change and allow the barriers identified to be overcome.

Although not widely explored in the academic literature, there is some consensus as to what gold-standard clozapine monitoring encompasses, and this study adds to this. First, it is essential that staff and patients perceive clozapine monitoring as a tool for facilitating patient recovery, independence and safety, and not simply as the process for supplying a medication.⁷ Patient education should not be a one-off event but should be repeated throughout treatment, especially as patients may be unwell at the time of clozapine initiation and have low health literacy.¹⁴ Clozapine monitoring must be supported by care pathways and effective interventions to ensure that, first, monitoring takes place and, second, that abnormal findings are actioned.⁶ Pathways should be standardised so that they can be easily followed by busy staff working across wards. Any system of monitoring must be supported by electronic tools to keep track of monitoring.⁶ An in-patient clozapine clinic is an effective system for clozapine monitoring that is widely supported by staff and patients. This provides FBC monitoring, along with monitoring of other physical health parameters and side-effects. In terms of staffing, multidisciplinary representation is likely to be effective, with mental and physical health co-staffing supported in this study. Several senior staff members in our study raised concerns about undergraduate training around clozapine. Given the complex monitoring and severe side-effects, robust training on clozapine should be encompassed by undergraduate mental health nursing degrees and a mandatory workplace training module. Where establishment of a clozapine clinic is not feasible, it is recommended that, as a minimum, a clozapine pathway is established that defines the roles and responsibilities of different staff groups and triggers appropriate communication and actions where abnormal results are identified. This should be underpinned by an electronic system that simplifies the process and is accessible by the relevant staff.

Limitations

As with much qualitative work, there were small numbers of participants, and they were interviewed in a single location. This restricts the transferability of results, as some may be specific to the individual setting. However, the findings reinforce those from the wider literature, and beliefs and challenges have been identified that are widely applicable to mental health settings.

A further limitation is the possibility that the results were influenced by recall and social desirability bias. Furthermore, as patients were approached by a senior nurse, it is possible that patients with a favourable attitude towards clozapine or a good relationship with staff were recruited.

Summary

Clozapine is widely used in forensic settings, yet considerable challenges remain around its use, particularly ensuring on-schedule monitoring of physical health parameters. The reasons underlying this have not previously been widely explored, and this qualitative study adds to the evidence base by identifying facilitators of and barriers to monitoring. Forensic healthcare staff are highly motivated to promote skills for independence and recovery among patients, and understand the role of clozapine care in this. This motivation and enthusiasm is a core facilitator of positive change and increases the likelihood that change will be sustained. Formal procedures and pathways must be in place to underlie clozapine monitoring, supported by electronic systems and tools. A clozapine clinic is a robust mechanism for providing in-patient clozapine monitoring in secure settings that is widely supported by staff and patients, and prepares patients for transition to the community. These findings can be applied to other mental health units to optimise their systems of clozapine monitoring.

We thank all of the staff who facilitated this project. Most importantly, we thank all of the patients and staff who participated.

Data availability

The data that support the findings of this study are available upon reasonable request from the corresponding author, S.B. The data are not publicly available due to their containing information that could compromise the privacy of participants.

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S.B., J.B., N.A. and S.N. were involved in the conception and design of the study. S.B. was responsible for the acquisition of data. S.B., J.B. and M.L. were involved in the analysis and interpretation of data. S.B. initially drafted the manuscript, and all authors were involved in revising it critically and approving the final version.

Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <http://doi.org/10.1192/bjb.2020.100>.

[click here to view supplementary material](#)

Clozapine monitoring – staff topic guide (interviews and focus groups) Can you tell me about your role? Can you tell what you understand about clozapine monitoring? Prompts: Why do you think clozapine monitoring is important? What are the risks to patients if monitoring is not done correctly? Can you tell me about your role with regards to clozapine? What is your understanding of how clozapine is currently monitored here? Prompts: Full blood counts Physical health parameters, side-effects Patient education Do you think the current system of monitoring works well? Who do you think should be responsible for clozapine monitoring here? Prompts: Full blood counts Physical health parameters Side-effects What do you think is the role of the ward staff, physical health team, pharmacy, consultant and medical staff? What do you think is the role of the service user in monitoring their clozapine? Prompts: Do many patients self-medicate? How are patients on clozapine prepared for discharge? Do you think service users should be more involved in monitoring their clozapine? Do you think service users are given sufficient education about clozapine when they are initiated on it and throughout their treatment? What do you understand about how clozapine is electronically monitored? Prompts: FBCs Physical health bloods, clozapine levels, ECGs etc Side-effects How do you think this could be improved? Are there any aspects of clozapine monitoring that you think work particularly well here? Are there any aspects of clozapine monitoring that you think would benefit from improvement? What barriers do you think there are to clozapine monitoring here? Can you think of anything that could be done to improve the system of clozapine monitoring here? What do you think about the idea of a clozapine clinic that service users attend for all aspects of clozapine monitoring? Prompts: Where do you think this should be? Who do you think should run this? Would this work for all service users? Is there anything else with regards to clozapine that we haven't discussed and that you would like to mention?

Can you tell me what you understand about clozapine? Prompts: Why do you think you take clozapine? How long have you been taking clozapine for? Has clozapine worked well for your symptoms? Did you start clozapine during this admission or previously? When you started on clozapine, what information was given to you about it? Prompts: Who gave you this information? Was this spoken or written information? Can you tell me what you understand about the side-effects of clozapine? Prompts: Were you given information about side-effects before you started taking clozapine? Were you given information about how to prevent any side-effects? Have you experienced any side-effects from taking clozapine? Tell me about this Can you tell me about the monitoring that you have to have for clozapine? Prompts: How often does this happen? Do you understand what they're monitoring for? Do you receive the results of your blood tests? Who do you think is responsible for monitoring your clozapine? Aside from the regular blood tests for the green, amber, red result, do you have any other monitoring for clozapine? Prompts: Do staff on the ward measure your weight and ask about your bowels? Do you have blood tests for other things as part of your clozapine monitoring? (blood sugar, cholesterol etc) Low secure and step-down only – can you tell me what you understand about how your clozapine will be monitored and dispensed in the community when you leave hospital? What do you think about the idea of having a clinic on the hospital site where you'd go to have your clozapine monitoring done? Is there anything else about clozapine that we haven't mentioned and that you'd like to discuss?

1.2.85 More research needed into long-term medical student mental health during COVID-19 pandemic and beyond

Anusha Mahesh Prabhu Intishar Rashad

date

2021-06

Contents

- *More research needed into long-term medical student mental health during COVID-19 pandemic and beyond*
 - *Declaration of interest*

pmc The mental health of healthcare professionals has been significantly affected by the COVID-19 pandemic.¹ We believe that more research focusing specifically on the long-term mental health of medical students is required. Medical students are an at-risk group, with a greater incidence of anxiety² than the general population, and a higher prevalence of suicidal ideation than physicians and nurses.³ The risk is further compounded by being young,¹ having higher awareness of disease severity, and possessing common personality traits such as maladaptive perfectionism and difficulty adapting to disruption in routine.²

Medical students often face a sense of duty to volunteer in hospitals in times of global health emergencies such as the current pandemic, which can bring particular emotional challenges. The subsequent higher risk of transmitting COVID-19 may cause increased social isolation. Uncertainty around medical education due to cancelled exams and placements also increases stress.⁴

Although a recent meta-analysis showed no difference in anxiety during COVID-19 in medical students,² isolated studies worldwide have shown increased anxiety in those whose loved ones had contracted COVID-19 and who had interacted with COVID-19 patients.⁴

Higher levels of baseline stress and depression are negative predictors of poor mental health,¹ so more research must be done to identify those especially at risk. Those with pre-existing mental health issues have reported decreased access to the usual support services during the pandemic.¹ To our knowledge, there is no available literature exploring the impact of COVID-19 on medical students with pre-existing mental illness. Experiences in previous pandemics such as SARS show that long-term mental health issues such as alcohol misuse and post-traumatic stress symptoms can persist for several years in healthcare workers who have been quarantined or have worked in high-risk areas.⁵

The majority of current studies of mental health in COVID-19 have been cross-sectional, and few have focused on medical students. Longitudinal, large-scale, multi-country studies focusing on medical students of all age groups and investigating more variables, such as pre-existing mental illness, are required to identify those most at risk and the long-term effects on this population. The results of these studies could be used to improve future implementation of targeted medical student-specific mental healthcare interventions.¹

Both authors have contributed equally in preparing this article.

Declaration of interest

None

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1.2.86 Evaluation of radically open dialectical behaviour therapy in an adult community mental health team: effectiveness in people with autism spectrum disorders

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2021-06

Abstract

Aims and method

Radically open dialectical behaviour therapy (RO DBT) is a transdiagnostic treatment designed to address disorders associated with overcontrol, including autism spectrum disorders (ASD). To date, no studies have reported on the effectiveness of RO DBT for people with ASD. Forty-eight patients were referred to a RO DBT programme, of whom 23 had a diagnosis of ASD. Outcome was measured using the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE) and the Questionnaire about the Process of Recovery.

Results

The intervention was effective, with a medium effect size of 0.53 for improvement in CORE global distress. End-point CORE global distress score was predicted from initial severity and a diagnosis of ASD. Participants with a diagnosis of ASD who completed the therapy had significantly better outcomes than completing participants without an ASD diagnosis.

Clinical implications

These findings provide preliminary support for RO DBT as an effective intervention for ASD in routine settings.

Contents

- *Evaluation of radically open dialectical behaviour therapy in an adult community mental health team: effectiveness in people with autism spectrum disorders*
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pmc Society generally holds self-control in high esteem and it can lead to better health outcomes.¹ Consequently, high self-control has not commonly been a focus for psychological intervention. However, too much self-control, or maladaptive overcontrol, is associated with a range of problems, including social isolation, poor interpersonal functioning and mental illnesses such as chronic depression, anorexia nervosa and obsessive-compulsive disorder.² Radically open dialectical behaviour therapy (RO DBT) has been developed as an adapted form of dialectical behaviour therapy to directly target overcontrol, and is now supported by several controlled clinical trials.³ The therapy introduces strategies to improve social connectedness and intimacy and to reduce social isolation by improving emotional expression and the ability to respond more flexibly. The primary mechanism of change is through social signalling.⁴ In RO DBT, what matters most is how a person communicates or socially signals their inner experiences to others and the impact that social signalling has on their experience of social connectedness. RO DBT has been delivered in a variety of clinical settings, but there are no published studies of the effectiveness of RO DBT delivered in an adult community mental health team (CMHT).

Autism spectrum disorders (ASD) have also been recognised as disorders of maladaptive overcontrol, but ASD have

not been recorded as comorbid conditions in the studies of RO DBT to date.⁴ In the UK, the Autism Act 2009 requires National Health Service (NHS) trusts to provide access to services for the diagnosis of autism in adults and this has resulted in a large increase in referrals of individuals seeking this diagnosis to explain their difficulties.⁵ However, the National Institute for Health and Care Excellence (NICE) guideline on the management of ASD in adults indicates very limited evidence for psychosocial interventions.⁶

This study reports on the effectiveness of RO DBT for people with maladaptive overcontrol in an NHS adult CMHT setting, with a specific focus on the outcomes of a subsample of these individuals who are diagnosed with ASD.

Method

Setting

The study was undertaken in an NHS secondary care CMHT in northern England providing care and treatment for patients with mainly non-psychotic disorders. The RO DBT programme was open to other adult patients in the trust because it was the only service offering RO DBT, but the vast majority of patients came from the local team. The study used data collected routinely for all patients receiving group therapy in the service and so did not constitute research requiring ethical approval or informed consent from participants. The study was approved by Tees, Esk and Wear Valleys NHS Foundation Trust.

Sample

Patients were considered eligible if their lead clinician considered that they were presenting with maladaptive overcontrol in the context of their mental health problems or following a team case formulation meeting. Patients were identified as meeting criteria for overcontrol using a clinical interview and a range of tools, including the Assessing Styles of Coping: Word-Pair Checklist, the OC Trait Rating Scale, and the Brief Overcontrol Scale.^{2,7,8} We only accepted patients who acknowledged that they had a coping style characterised by overcontrol and that they wanted to change it. Patient diagnosis was identified from the patient electronic record.

Intervention

The typical RO DBT out-patient format is a 30-week programme and involves a 1 h weekly individual session and a 2.5 h weekly skills training session. The primary goal is to decrease behavioural overcontrol and aloofness, rather than decrease behavioural dyscontrol and mood-dependent responding, as in standard DBT.⁹ Patients are encouraged to practice disinhibition, participate without planning and to be more emotionally expressive.^{2,4} In this study, regular individual sessions were not possible because of the limited staffing resource in the CMHT. Occasionally, participants received additional individual sessions, for example, if they started late in the programme as a means of catching up. Delivering a group-only programme is a recognised variation to the standard approach.¹⁰⁻¹²

Five cohorts of patients over the course of 3 years participated in a RO DBT programme consisting of 30 weekly skills training classes. Some started the programme halfway through a cohort and so continued into the next cohort. The fifth cohort programme was cut short by the COVID-19 pandemic, when all group therapy programmes were suspended.

Therapists

Four psychological therapists trained in RO DBT delivered the programme (three psychiatric nurses and one occupational therapist) and they were supported by one psychiatric nurse in co-facilitating some of the skills classes. Clinical supervision was provided during weekly consultation meetings using the model of standard DBT.⁹

Measures

In the first skills class, participants completed the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE)¹³ and the Questionnaire about the Process of Recovery (QPR).¹⁴ These measures were repeated at mid-point (week 15) and end-point (week 30).

The CORE is a 34-item self-report questionnaire measuring the level of global distress the person has experienced in the previous week, measured on a five-point scale ranging from 0 to 4, and reported as a mean score per item. The measure contains four subdomains: subjective well-being, problems or symptoms, social and life functioning, and risk of harm to self and others. It has become a standard tool for measuring outcome in psychological therapy studies and has good psychometric properties.^{13,15} The recommended clinical cut-off for CORE global distress is a mean item score of 1.0, with scores above this threshold considered to represent ‘clinical caseness’. A mean item score of 2.0 represents moderately severe distress. Reliable change is indicated by a global distress score change of at least 0.5, whereas clinical recovery is indicated by a reduction in the mean global distress score to <1.0.¹⁶

The QPR is a 25-item self-report measure designed to evaluate the achievement of recovery goals in severe mental illness. It was designed collaboratively by clinicians and patients and has been recommended as a tool to promote engagement and a collaborative clinical approach, but also as a method of detecting change in recovery in CMHTs.^{14,17,18} As such, it can measure whether the service is meeting the perceived needs of patients irrespective of their clinical outcome.

Data analysis

Data analysis was undertaken using Real Statistics for Excel 365 for Windows.¹⁹ Baseline characteristics were described comparing differences between those completing the programme to 30 weeks (the per-protocol sample) and those dropping out early or not attending at all (the ITT sample). For the intention-to-treat (ITT) analyses we used the last observation carried forward (LOCF) method. Improvement in outcome measures at 15 and 30 weeks was examined for per-protocol ($n = 21$) and ITT ($n = 35$) samples using analysis of variance (ANOVA). Effect sizes were calculated using Cohen’s d with 95% confidence intervals.²⁰ Predictors of outcome at 30 weeks were examined for per-protocol and ITT samples using stepwise multiple linear regression. As a *post hoc* analysis, we compared the ASD and non-ASD participants for per-protocol and ITT samples for continuous outcomes using the t -test and categorical outcomes using the χ^2 -test.

Results

Sample characteristics

Of the 48 eligible participants, 23 had a confirmed or working diagnosis of ASD, either as the only identified problem ($n = 3$) or as a comorbid condition ($n = 20$). This was the single most common diagnosis among the participants. Thirteen patients from this group had the diagnosis confirmed by the local specialist autism service; the other ten were on the waiting list for specialist assessment, but the working diagnosis was an autism spectrum condition. The primary diagnoses were depressive disorder ($n = 14$), generalised anxiety disorder ($n = 8$), bipolar disorder ($n = 6$), personality disorder ($n = 5$), post-traumatic stress disorder ($n = 4$), schizophrenia and related disorders ($n = 4$), anorexia nervosa ($n = 3$), ASD ($n = 3$) and attention-deficit hyperactivity disorder ($n = 1$).

Participant flow

The flow of participants through the study is shown in *Fig. 1*. In total, 21 participants completed the programme with outcome data recorded at mid-point (week 15) and at end-point (week 30). Participants in the fifth cohort were able to complete only 15 sessions before the sessions were stopped because of the COVID-19 pandemic and so their data are included in the ITT analysis but not the per-protocol analysis. *Fig. 1* CONSORT flow diagram. RO DBT, radically open dialectical behaviour therapy.

Non-attenders and those who dropped out did not differ from completers with respect to age, gender, ASD diagnosis or global severity of problems but reported a higher level of risk and a lower QPR score at baseline (*Table 1*). The sample reflected the CMHT's case-load, with more women than men and overwhelmingly White British in ethnic origin. *Table 1* Participant characteristics according to treatment completion

Treatment completers ($n = 21$)	Treatment non-completers ($n = 27$)	$n\%/n\%$	Comparison between groups
Female	13	61	$1.85^2 = 0.31$, d.f. = 1, $P = 0.58$
White British	21	100	$0.00P = 1.00$
Autism diagnosis	11	52	$1.44^2 = 0.13$, d.f. = 1, $P = 0.72$
Age, years	Mean (s.d.)	Mean (s.d.)	$t = 0.71$, d.f. = 47, $P = 0.24$
Sessions attended	Mean (s.d.)	Mean (s.d.)	$t = 14.98$, d.f. = 47, $P < 0.001$
Baseline CORE global distress score	2.06 (0.68)	2.48 (0.76)	$t = 1.13$, d.f. = 34, $P = 0.10$
Baseline CORE well-being score	2.44 (0.50)	3.02 (1.00)	$t = 1.62$, d.f. = 34, $P = 0.06$
Baseline CORE problems score	2.52 (0.75)	2.93 (1.00)	$t = 0.97$, d.f. = 34, $P = 0.17$
Baseline CORE functioning score	2.19 (1.00)	2.46 (0.75)	$t = 0.53$, d.f. = 34, $P = 0.30$
Baseline CORE risk score	0.64 (0.00)	1.27 (0.23)	$t = 2.16$, d.f. = 34, $P = 0.02$
Baseline QPR score	24.67 (9.91)	15.27 (11.86)	$t = 2.06$, d.f. = 31, $P = 0.02$ ¹²³

The mean CORE global distress score at baseline was >2.0 for both groups, indicating that participants had moderately severe mental health problems. The lower score on the QPR measure in treatment non-completers suggests that this group was less well engaged with their care and treatment at the outset.

The reasons for drop out are reported in *Fig. 1*. External circumstances included starting a new job and taking on childcare responsibilities. Illness/therapy factors included feeling too unwell to continue participation and not being able to grasp the concepts discussed in the sessions.

Participants with a diagnosis of ASD did not differ from those without an ASD diagnosis with respect to mean age (35.6 v. 40.2 years, $t = 0.69$, d.f. = 47, $P = 0.30$), female gender (52 v. 60%, $\chi^2 = 0.30$, d.f. = 1, $P = 0.59$), mean baseline CORE global distress score (2.39 v. 2.06, $t = 0.97$, d.f. = 34, $P = 0.18$) or mean baseline QPR score (21.73 v. 21.18, $t = 1.27$, d.f. = 31, $P = 0.89$).

Outcomes at 30-week end-point for per-protocol and ITT samples

The intervention was effective in both the per-protocol ($n = 21$) and the ITT ($n = 35$) samples (*Table 2*). In the per-protocol sample, five participants (24%) achieved a CORE global distress score indicative of clinical recovery (score <1.0) and nine (43%) made a reliable improvement (reduction in score >0.5). The effect size for change in CORE global distress was medium to large (Cohen's $d = 0.59$). The mean improvement at the 30-week end-point was 0.43 (95% CI 0.09–0.78) for the CORE global distress and the mean increase in QPR score was 8.29 (95% CI 3.00–13.57). *Table 2* Per-protocol and intention-to-treat (ITT) analyses of outcomes

mean (s.d.)Mid-point,

mean (s.d.)Final,

mean (s.d.)	F	d.f.	P	Effect size (95% CI for d)	
Per-protocol sample ($n = 21$)					
CORE global distress score	2.06 (0.66)	1.78 (0.78)	1.63 (0.81)	6.02	$2.20 < 0.010$
CORE well-being score	2.44 (0.75)	2.12 (1.05)	1.92 (1.00)	4.74	$2.00 < 0.010$
CORE problems score	2.52 (0.86)	2.15 (0.96)	2.00 (0.97)	6.55	$2.00 < 0.010$
CORE functioning score	2.19 (0.67)	1.85 (0.71)	1.74 (0.83)	5.62	$2.00 < 0.010$
CORE risk score	0.64 (0.65)	0.68 (0.77)	0.46 (0.68)	2.48	$2.00 < 0.010$
QPR score	24.67 (9.91)	29.68 (11.83)	32.95		

¹ CORE, Clinical Outcomes in Routine Evaluation – Outcome Measure; QPR, Questionnaire about the Process of Recovery.

² ² for frequency variables, t -test for continuous variables.

³ Bold denotes significance at $P < 0.05$.

(11.59)11.6120<**0.001**0.77 (0.75–0.79)ITT sample ($n = 35$)CORE global distress score2.23 (0.74)1.98 (0.83)1.85 (0.93)8.2634<**0.001**0.46 (0.45–0.48)CORE well-being score2.67 (0.88)2.46 (1.11)2.23 (1.18)4.3534**0.02**0.40 (0.39–0.42)CORE problems score2.69 (0.87)2.36 (1.01)2.21 (1.12)9.3234<**0.001**0.47 (0.45–0.48)CORE functioning2.30 (0.74)2.00 (0.76)1.93 (0.87)8.6534<**0.001**0.47 (0.46–0.49)CORE risk score0.90 (0.80)0.86 (0.80)0.68 (0.79)3.3134**0.04**0.27 (0.26–0.29)QPR score21.44 (11.37)25.59 (13.67)28.23 (14.86)14.8631<**0.001**0.52 (0.50–0.53)⁴⁵

In the ITT sample, 9 participants (26%) achieved a CORE global distress score indicative of clinical recovery and 13 (37%) made a reliable improvement. The effect size for change in CORE global distress was small to medium (Cohen's $d = 0.46$). The mean improvement at the 30-week end-point was 0.38 (95% CI 0.02–0.74) and the mean increase in QPR was 6.69 (95% CI 0.33–13.05).

Seven participants (five with an ASD diagnosis) continued in the therapy group beyond 30 weeks for clinical reasons. The mean improvement for all participants ($n = 28$) with outcome at the end of their intervention was 0.53 (95% CI 0.24–0.82) on the CORE global distress score, which represents a clinically reliable improvement overall.

Predictors of outcome

We used stepwise regression to examine which factors predicted the outcome score at 30 weeks in participants completing the programme to 30 weeks (per-protocol, $n = 21$) and the intention-to-treat sample (ITT, $n = 35$). We entered the following variables into the analysis: age, gender, initial severity (CORE global distress score at baseline), diagnosis of ASD, cohort and number of sessions attended.

Initial severity and diagnosis of ASD were entered into the model in both per-protocol and ITT samples and accounted for a highly significant amount of the variation in the final outcome score – 60% in the per-protocol sample and 55% in the ITT sample (Table 3). Participants with lower baseline CORE global distress scores and a diagnosis of autism were significantly more likely to have a better final outcome score. Table 3 Predictors of final Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE) global distress score Model P Per-protocol sample ($n = 21$) $r^2 = 0.64$ adj. $r^2 = 0.60$ $F = 15.76$ <**0.001** Variables e.95% CI r Constant 0.270.39 Initial severity 0.850.180.54–1.154.81 <**0.001** Autism 0.750.230.34–1.133.27 <**0.01** Intention-to-treat sample ($n = 35$) $r^2 = 0.57$ adj. $r^2 = 0.55$ $F = 21.65$ <**0.001** Variables e.95% CI r Constant 0.080.33 Initial severity 0.950.140.70–1.196.58 <**0.001** Autism 0.370.210.01–0.731.760.09⁶

Comparison between ASD and non-ASD participants at the end of treatment for continuous and categorical outcomes

Participants with a confirmed or working diagnosis of ASD showed clinically reliable improvement and showed better outcomes than non-ASD participants with respect to functioning and perception of recovery (Table 4). Table 4 Comparison of change in continuous outcomes between participants with and without a diagnosis of autism spectrum disorder (ASD) Change in ASD (s.d.) Change in non-ASD (s.d.) T d.f. P Per-protocol sample a CORE global distress score 0.79 (0.61) 0.04 (0.37) 3.0420 <**0.01** CORE well-being score 0.89 (0.90) 0.13 (0.58) 1.9320 **0.03** CORE problems score 0.94 (0.60) 0.06 (0.52) 3.2820 <**0.01** CORE functioning score 0.83 (0.79) 0.03 (0.43) 2.4720 **0.01** CORE risk score 0.38 (0.45) 0.03 (0.36) 1.9620 **0.03** QPR score 12.18 (6.97) 4.00 (7.29) 2.2920 **0.02** ITT sample b CORE global distress score 0.57 (0.57) 0.18 (0.62) 1.5734 0.06 CORE well-being score 0.54 (0.84) 0.28 (0.97) 0.2634 0.40 CORE problems score 0.67 (0.61) 0.24 (0.77) 1.4634 0.08 CORE functioning score 0.62 (0.69) 0.12 (0.55) 2.0034 **0.03** CORE risk score 0.31 (0.38) 0.12 (0.59) 0.6234 0.27 QPR score 9.53 (7.73) 4.18 (8.74) 1.4631 0.08⁷⁸⁹¹⁰

⁴ CORE, Clinical Outcomes in Routine Evaluation – Outcome Measure; QPR, Questionnaire about the Process of Recovery.

⁵ Bold denotes significance at $P < 0.05$.

⁶ Bold denotes significance at $P < 0.05$.

⁷ CORE, Clinical Outcomes in Routine Evaluation – Outcome Measure; QPR, Questionnaire about the Process of Recovery.

⁸ Per-protocol sample: ASD, $n = 11$; non-ASD, $n = 10$.

⁹ Intention-to-treat (ITT) sample: ASD, $n = 18$; non-ASD, $n = 17$.

¹⁰

At the end of treatment the ASD and non-ASD participants ($n = 28$) did not differ significantly in the number who met the clinical recovery threshold (CORE global distress score <1.0) ($\chi^2 = 2.01$, d.f. = 1, $P = 0.16$). However, participants with ASD were significantly more likely to have a reliable improvement in CORE global distress score in the per-protocol but not the ITT sample. In the per-protocol sample, 73% of participants with ASD showed reliable improvement, compared with 10% of non-ASD participants ($\chi^2 = 8.21$, d.f. = 3, $P = 0.04$). In the ITT sample, the figures were 56% for those with ASD and 18% for non-ASD participants ($\chi^2 = 4.58$, d.f. = 3, $P = 0.21$).

Among the male participants completing the programme, 4/8 (50%) achieved clinical recovery (a CORE global distress score <1.0) compared with 2/13 (15.4%) of the female participants. However, the difference between men and women was not statistically significant ($\chi^2 = 2.41$, d.f. = 1, $P = 0.12$).

Discussion

The findings from this study provide preliminary evidence for the effectiveness of RO DBT for mental disorders in routine clinical practice, and in particular for adults with ASD without intellectual disability. RO DBT is a treatment for maladaptive overcontrol, which characterises many individuals with autism, and demonstrating that RO DBT is a potentially effective treatment for this population is therefore an important step forward.

There have been three randomised controlled trials of RO DBT for refractory depression^{21–23} and two open trials for anorexia nervosa.^{24,25} The only published study in a mixed diagnostic group is a non-randomised controlled trial in adults with mental health problems related to overcontrol referred to a specialist psychological therapy service.¹⁰ RO DBT has been delivered in a variety of clinical settings, including psychological therapy services, US military veterans services, eating disorder services and forensic in-patient care.¹²

In psychiatric settings, ASD is almost certainly underdiagnosed as a comorbid difficulty or misdiagnosed as a psychotic disorder, personality disorder or obsessive–compulsive disorder,^{26,27} and adults with ASD have high levels of psychiatric comorbidity and dysfunction.^{28,29} ASD is also a significant risk factor for suicidal behaviour.³⁰ Previous studies on treatment for ASD have generally looked at adapting established psychological therapies to treat comorbid conditions in people with ASD as a way of improving their mental health and well-being.^{31,32} There have been very few studies designed to improve functioning in autism itself,^{33,34} and the current NICE recommendations are largely extrapolated from work in adolescent and intellectual disability populations.⁶

Our results can best be compared with two open trials that also used the CORE as a primary outcome measure. A study of modified individual CBT for people with ASD in a specialist psychological therapy service had a larger sample ($n = 81$), but with milder baseline severity (mean CORE global distress 1.79).³⁵ Of the participants completing the therapy in that study, 37% showed reliable improvement and 19% achieved clinical recovery on the CORE global distress score, compared with 73 and 36% respectively for the participants with ASD in our study. A study of RO DBT in in-patients with anorexia nervosa had a sample size of 47 and a baseline severity of 2.21 for CORE global distress, very similar to our study.²⁴ The mean change in CORE global distress in the ITT sample was 0.46, with an effect size of 0.71, thereby showing a more positive outcome overall compared with the current study.

Social signalling, such as social smiling and prosocial body language, has been regarded as a core deficit in ASD that is not readily amenable to change. Our anecdotal impression was that many participants with ASD were able to learn social signalling, and several gave positive feedback. For example one anonymous participant commented, ‘I cannot believe how much it has helped me understand myself, ASD and how to approach the problems I face with the condition’. Given that the treatment is designed to treat overcontrol irrespective of ASD diagnosis, our finding that participants with ASD gained greater benefit requires further exploration.

Bold denotes significance at $P < 0.05$.

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Strengths and limitations

For any treatment of ASD to be delivered, it must be feasible within the current clinical practice of mental health service delivery. One of the strengths of this study is that it was implemented in a government-funded community treatment team, alongside the routine delivery of care and treatment for a wide range of mental health conditions, and without any additional resources. It is also important to note that the participants treated had an illness of at least moderate severity and were not selected for the likelihood of responding to the treatment.

There are several limitations that we recognise. This was an uncontrolled study and we did not gather data on what other treatment participants might have received. The study sample was entirely White British, so the findings may not be translatable to multi-ethnic populations. The sample size is small, and a large proportion of participants did not complete the 30 weeks of the RO DBT programme. This high attrition rate can at least partly be explained by an apparent lack of motivation and engagement at baseline among the treatment non-completers, as demonstrated by their lower QPR scores. In addition, we did not measure the fidelity of the programme to the RO DBT manual. However, despite the fact that participants in this study received a more limited version of the recommended RO DBT standard of one-to-one therapy in addition to weekly skills classes, positive findings were found in both the per-protocol and the intention-to-treat samples. This in itself is important to note, as most government-funded community treatment centres, like the one in this study, would not have the resources to provide the full programme of RO DBT. Our outcome measures were limited to self-report questionnaires, which might have been biased in favour of the treatment received, and we do not know whether the positive outcomes experienced by the participants were sustained beyond the 30-week therapy programme. We did not record the severity of overcontrol at baseline, which is one possible explanation for the better outcome in participants with an ASD diagnosis.

Implications for future research

Future research needs to examine RO DBT in ASD using a randomised controlled trial methodology and it would be important to record any additional psychological and pharmacological treatments that participants receive for comorbid conditions. Follow-up beyond the end of the therapy programme should also be measured. There are already modified versions of RO DBT being delivered¹¹ and so studies need to carefully describe the content of the therapeutic intervention and compare more and less intensive models of RO DBT. Studies using RO DBT need to report the number of participants with ASD where the treatment is directed at other disorders, as ASD is likely to be a comorbid condition in many disorders of overcontrol.

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Data availability

The data that support the findings of this study are available from the corresponding author, [PLC], upon reasonable request.

P.L.C. designed the study, analysed the data and wrote the article. S.S. helped design the study, delivered the treatment, gathered the data and helped revise the article. C.G. and V.M. delivered the treatment, gathered the data and helped revise the article.

Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <http://doi.org/10.1192/bjb.2020.113>.

[click here to view supplementary material](#)

1.2.87 Impact of homicide by a psychiatric patient on forensic psychiatrists: national survey

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2021-06

Abstract**Aims and method**

To explore the experiences and support needs of consultant forensic psychiatrists, whose patients had committed homicide while under their care. We circulated a survey to all forensic psychiatrists in the UK, through the Royal College of Psychiatrists, asking about their experiences of a homicide by a patient under their care. Respondents were invited to discuss their experiences further in a structured telephone interview and themes were identified from these discussions. Data were analysed quantitatively and qualitatively.

Results

One-third of the 86 respondents had had at least one patient who had committed a homicide while under their care. Of these, over three-quarters (78%) reported that the homicide had a significant impact on their personal life, professional life and/or mental/physical health. For some respondents, the impact was severe and long term. Respondents generally felt that they would have been helped by receiving more support in the aftermath of the homicide.

Clinical implications

Greater recognition is needed of the impact on treating psychiatrists of homicide by a patient and more support is needed for affected clinicians. Further research is necessary, including the effects of such events on colleagues in other specialties and examination of the costs versus the benefits of mandatory inquiries after homicides.

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pmc Homicide by patients receiving psychiatric care is a rare event. Between 2006 and 2016, 11% of all homicide convictions in the UK, a total of 785 homicides, were by mental health patients. This is in stark contrast to the high rate of suicide by individuals under psychiatric care: during the same time period, 17 931 mental health patients died by suicide, representing 28% of all suicides in the UK.¹

A recent study by Gibbons et al² found that the death of a psychiatric patient by suicide can have a serious impact on the treating psychiatrist's psychological health, clinical practice and attitude towards their work. Concerns have been expressed about some of the unintended and adverse consequences of a patient-perpetrated homicide, both for the individual clinician and for the organisation,³ but there have been no studies examining these effects directly. In the UK, there have been several cases of psychiatrists being referred to the General Medical Council (GMC) for allegedly failing to prevent a homicide, although as far as we know, no referral has yet resulted in GMC sanction. In France, however, there has been at least one prosecution of a psychiatrist as a result of their failure to anticipate and prevent a patient-committed homicide. The psychiatrist was subsequently convicted of manslaughter, for which she received a suspended custodial sentence.⁴

A mandatory independent inquiry (which refer as the inquiry) into the care of any individual who kills and who has been under the care of psychiatric services at the material time, or the preceding 6–12 month period, was introduced in the UK in the 1990s, following a number of high-profile homicides by psychiatric patients⁵. Concerns have been expressed over the intervening years, about the potential that such inquiries have for bias and errors of judgement, including the shifting of responsibility from the system onto the individual clinician, while failing either to improve patient safety or to reduce risk.^{6–9} Despite this and the acknowledged limitations of accurately predicting risk in psychiatry,^{10–12} the practice of carrying out internal and external (if the circumstances are sufficiently serious) inquiries has continued.

This survey set out to examine the impact on their treating psychiatrist of a patient committing a homicide. Forensic psychiatrists were targeted, as they work with particularly high-risk patients, who have a history of serious violence and who are therefore considered to be at high risk of future violence, including lethal violence.

Method

In 2017 we conducted a national online survey of consultant forensic psychiatrists, asking them whether any of their patients had committed homicide whilst under their care and, if so, how the experience had affected them. An invitation to participate appeared on the Royal College of Psychiatrists website. The survey covered the following areas: impact on personal and professional life, mental and physical health; support sought or received; experience of the mandatory inquiry and associated processes and coping strategies. Everyone who completed the survey was subsequently invited to discuss their experiences further in a structured telephone interview with one of the three authors. The telephone discussion was led by a topic guide, at least in part informed by the areas covered in the quantitative survey. The discussion was recorded contemporaneously by the interviewer and themes and subthemes were identified and then discussed and refined by the three authors, until a consensus was reached. Data from the survey and transcripts are presented quantitatively and qualitatively, in terms of the main themes emerging from the interviews.

Results

In total, 86 consultants completed the survey, of whom 26 had experienced at least one patient-perpetrated homicide.

Quantitative data

The results of the survey for the 26 respondents are summarised in *Table 1*. Where a respondent had experienced more than one homicide, they were asked to comment on their worst experience. Table 1

Survey data for the 26 respondents who had experienced patient-perpetrated homicide and their patients	Respondents	Consultant gender, <i>n</i> (%)
Male	19	(74)
Female	7	(26)
Consultant experience at time of homicide (first homicide if more than one), <i>n</i> (%)	15	
years	13	(50)
Between 2 and 15 years	11	(42)
2 years	2	(8)
Homicides (26 respondents)		
Number of patient homicides, <i>n</i> (%)	20	(70)
One	4	(16)
Two	3	(12)
Three		
Gender of perpetrators, <i>n</i> (%)	23	(92)
Male	3	(8)
Female		
Perpetrator location at time of homicide, <i>n</i> (%)	6	(23)
In-patient	20	(77)
Out-patient		
Time since homicide, range (mean)	4 weeks to 30 years	(7 years)
Relationship with victim, <i>n</i> (%)	13	(50)
Family member/acquaintance	4	(15)
Stranger	9	(36)
Other		
Consequences of homicide cases, <i>n</i> (%)	2	(8)
Referral to General Medical Council	16	(63)
Local media	14	(53)
National media	3	(11)
Psychiatrist named in the media	9	(34)
Required to give evidence in court, <i>n</i> (%)	17	(65)
Required to give evidence to an external inquiry, <i>n</i> (%)	10	(38)
Adverse impact on career, <i>n</i> (%)	10	(38)
Adverse impact on mental health, <i>n</i> (%)	21	(81)
Adverse impact on physical health, <i>n</i> (%)	11	(42)
Adverse impact on personal life, <i>n</i> (%)	20	(77) ¹

The majority of the 26 respondents ($n = 18$; 69%) had experienced one patient-perpetrated homicide; however, just over one in four reported more than one homicide. Half of the 26 consultants had been in post for more than 15 years at the time of the homicide. The homicides had taken place between 4 weeks and 30 years earlier (mean 7 years). The majority of perpetrator patients were male and were living in the community at the time. Half the victims were family members; in only 15% of cases was the victim a stranger.

Just over three-quarters ($n = 21$; 81%) of the respondents reported that the homicide and its consequences had affected their mental health, and around one in four psychiatrists described these effects as having been ‘very significant’. Almost a half ($n = 11$; 42%) experienced physical health effects and just over three-quarters ($n = 20$; 77%) reported a negative impact on their personal life. Half the cases had been reported in the local and/or national media and three of the

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Data (for both consultants and patient-perpetrators) relate to the homicide with the worst impacts on the respondents, if respondents experienced more than one.

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psychiatrists were named in the media. Two individuals were also subsequently referred to the GMC. Ten psychiatrists (38%) reported that their career had been adversely affected as a result of the homicide.

Qualitative data

Eight of the twenty-six psychiatrists who had experienced a patient-perpetrated homicide participated in a further qualitative telephone interview.

The following themes emerged from an analysis of interview transcripts. Themes were identified through independent coding and discussion among the three authors, until consensus was reached.

Homicide as a traumatic event

All consultants recalled the moment they were informed of the killing and the emotional and psychological impact this had on them at the time. Recall of this event remained vivid and painful, despite the homicides having taken place, for the most part, years or decades earlier. Respondents clearly recalled where they were, what they were doing and what they had felt on first hearing the news. In most cases, they had been informed about the homicide through a telephone call. Some consultants had received the news at work, others while they were at home or away on holiday: “‘It happened 18 years ago ... but I still remember clearly how it made me feel.’ ‘My blood ran cold ... it was the most devastating experience of my career ... everyone’s worst nightmare.’ ‘It was harrowing, horrible, the worst experience of my life.’”

Impact on mental health

Following the homicide, consultants described a range of emotional and psychological problems, including: depression, anxiety, anger; confusion; sleep and appetite disturbance; loss of interest and enjoyment, poor concentration, social isolation and constant ruminations about what had happened. For some respondents the emotional and psychological impact of the homicide had persisted for years: “‘I became suicidal, low mood, more alcohol, anxiety, high arousal, poor sleep, anxious.’ ‘I still feel a strong sense of injustice ... bitterness and resentment.’ ‘Looking back, I got quite depressed ... not knowing what was going to happen next ... assuming the worst ... assuming my career was over, before it had even started ... I kept thinking I should have done more ... it was a potentially career-ending event.’”

Symptoms of post-traumatic stress disorder, including reliving and re-experiencing symptoms, avoidance and hyper-arousal, were common: “‘Even now if my mobile phone goes off if I’m at home, relaxing with the children/family ... my heart misses a beat ... in case someone telling me that a patient has killed ... committed suicide ... or escaped.’ ‘I thought about this case a lot and for years afterwards ... I still have images in my head of the photos of [the victims] who were killed.’”

Despite very significant distress, none of the doctors interviewed had sought medical help for their symptoms or been formally diagnosed as suffering from a mental illness. Few of them had even previously admitted to themselves the personal toll that the experience had taken on them.

Impact on relationships and family life

Respondents described feelings of personal as well as professional isolation, following the homicide. Most of them had not discussed what had happened with family members or friends, because of feelings of shame, or because they feared that they might be blamed or seen as a failure. Some doctors did not talk about what had happened, out of a wish to protect their family from such a frightening and distressing experience and to retain their home as a safe and protected space, uncontaminated by their work.

Some respondents actively avoided talking or thinking about what had happened, because it only intensified feelings of distress and helplessness. However, this avoidance also resulted in them feeling more isolated and cut off and, in some cases, misunderstood by friends and family members: “‘The killing ... had a more profound effect than I would have admitted at the time ... I only realised what a personal and professional toll it took on me, my home life and relationship with colleagues years later.’ ‘I couldn’t really talk to family, I kept to myself for months.’ ‘I coped by switching off emotionally ... It had a terrible impact on my relationship with my partner.’”

Increased use of alcohol was also reported in the months following the homicide, largely as a strategy to block distressing thoughts and to manage anxiety levels and insomnia: “‘I started drinking too much ... and it got a bit out of control.’”

Impact on clinical practice and career

Some of the direct professional consequences of the homicide included: being suspended; being referred to the GMC; being named in the local or national media; repeated appearances at internal and external inquiries and in court; change of job; and loss of income.

All respondents felt that the homicide had posed a specific challenge to their professional identity and role, including their clinical judgement, competence and confidence: “‘I felt isolated and frightened ... but I put on a good show as I had been trained to do.’”

Most consultants considered that their clinical practice, as well as the way they thought about their work, changed following the homicide. In most cases these changes were felt to be negative. The most commonly described changes were: feeling more anxious about and avoidant of risk; increased caution and lack of confidence in clinical decision-making; reduced willingness to rely on and trust colleagues; and increased cynicism about the concepts of multidisciplinary team working and collective responsibility: “‘It gave me a heightened sense of just how risky this work is ... made me less tolerant of risk.’ ‘It made me more twitchy about patients and risk averse.’ ‘I now cannot delegate and I am picky about documentation.’”

Respondents frequently expressed a sense of bewilderment about the fact that they alone, rather than any other member of the multidisciplinary team, had been held responsible for what had happened: “‘No other member of the team was singled out for similar treatment ... it was me on my own ... nurses claimed to have been frightened, intimidated, claimed no role.’ ‘I felt exposed ... and responsible ... worried I would be blamed ... that this would affect my career. I felt very alone and vulnerable.’ ‘As doctors – we think we ought to be unbreakable ... I ended up professionally isolated.’”

Despite feeling professionally and personally vulnerable and isolated, all respondents had carried on working and supporting their teams as usual in the aftermath of the homicide.

Scapegoating and professional isolation

Although some respondents felt that colleagues had been supportive, others felt that they had been treated like pariahs following the homicide, which reinforced feelings of shame and stigma. It was not uncommon for colleagues and managers to decline to discuss the case with them, ostensibly on the grounds that they might end up a witness in any future inquiry process or legal action.

Inquiries and hearings

One of the most traumatic consequences of the homicide were the lengthy, complex and often obscure inquiry processes that followed. These included not only the internal and external disciplinary processes and the mandatory inquiry process at trust level, but also frequently a public inquiry, criminal proceedings or coroners' courts in which the respondents were witnesses. Inquiries were experienced as being highly adversarial and potentially career-ending ordeals, with hidden agendas and obscure rules of engagement, over which they had no control.

Regardless of the outcome, the various internal and external reviews and the inquiry process were emotionally and physically draining. Moreover, the fact that the inquiry processes were commonly extremely prolonged, with lengthy delays between the hearings and the outcome, made it more difficult to begin to recover and move on following the experience: "I learned the meaning of the term Kafka-esque ... being prosecuted for something but you don't know what, and ... things around you keep changing in an inexplicable way." "The internal inquiry blamed everyone and was poorly managed. The interview was very traumatic ... a panel of 8 people, arguing with each other ... I physically collapsed afterwards ... I had no solicitor, no support." "It was like a big dysfunctional family ... a bird's nest of bad relationships ... where the abused children turn on each other."

A number of consultants described how they had been being expected to express remorse and contrition for the homicide, even where there appeared to be a consensus that the homicide could not have been prevented or predicted: "You had to throw yourself on your sword and go quietly, rather than whinge or complain ... even if you feel you have been treated unfairly." "The whole experience was negative, humiliating, criticising." "Ultimately you are on your own ... you need to be prepared to defend yourself ... whatever you think, you have got to say you're sorry."

None of the consultants was able to identify any positive aspects of the inquiry, in terms of learning for themselves, answers being provided to the victim's family, righting wrongs, or driving improvements in patient care and safety: "I don't think it changed practice ... it was unpredictable, there was not much more I could have done ... I didn't learn lessons at all, just made me very anxious." "... other people picking over the bones ... it was all hindsight bias." "I saw them as biased and unfair ... it was not until many years later that I could look at ... what had happened ... and think about whether there was something to learn."

Respondents frequently referred to the outcome of the inquiry being entirely and arbitrarily dependent on the individual panel members, over which they had no say or control. One consultant felt they had been lucky in having had two psychiatrist members of their panel, whose input had been helpful and constructive: "The saving grace of the independent inquiry was that there were two psychiatrists on the panel who were well disposed ... the psychiatrist on the panel was a life saver ... however, the outcome could have gone either way."

Another consultant, however, described the psychiatric input in a much more negative way: "I was very struck by the medical member's punitive approach and the rush to judgement. I also thought that there was some sadistic pleasure in shafting another colleague."

The psychiatrist member of the inquiry panel was often well known to the respondent, thereby increasing unease about the lack of impartiality. A number of consultants expressed a wish for greater transparency and clarity about how psychiatric and lay members of homicide inquiries are appointed and what training they receive prior to performing this role: "There is a need for panel members to have appropriate training for the role ... lack of due process in the homicide inquiry."

Respondents who considered the homicide and subsequent inquiry to have had no significant effect on their clinical practice or approach described this as being a matter of luck, rather than due to anything that they personally had done,

or had felt able to influence: “It had no effect on my career ... but I missed a bullet ... it could so easily have destroyed everything.”

Support sought, offered and received

Although a couple of consultants felt that they had been reasonably well supported by their NHS trust in the aftermath of the homicide, most felt that that their trust had been more concerned about protecting the reputation of the organisation, even when this meant blaming the doctor. Expressions that were frequently employed by respondents were being ‘scapegoated’ or ‘thrown to the lions’ by their employers following the homicide: “employers gave no support ... just worried about bad publicity for the Trust.’ ‘Some people contacted me spontaneously and offered commiseration, including unexpected folk ... But ... managers were defending the organisation.’ ‘There was no support of any kind or advice from colleagues or the employer ... I was made to feel like a pariah ... the Trust saw me as a threat ... I was not provided with any information about the Trust response to the SUI [serious untoward incident] or the inquiry, although ... later informed that an inquiry had reported.”

In general, consultants were left to work out for themselves who to talk to and where to seek help: “My organisation turned on me ... The College’s psychiatrists support network ... listened but was not really supportive ... I just had one phone call ... no debrief or support within the team ... I just carried on.”

Only one of the respondents reported being offered time off or counselling following the homicide.

Coping and how to survive

When asked ‘What helped you get through this?’, most respondents cited support from friends, family and close colleagues. However, feelings of shame and an understandable desire not to have to dwell on distressing events often stopped consultants from asking for help even where this might have been on offer: “I only got through because I was resilient and tough ... but I also did not talk to anyone about how I was feeling, and that had negative effects.”

Most respondents attributed their ‘survival’ to their own personal resilience and luck: “[Psychiatrists] are so tough emotionally – you have to be very resistant to stress to survive.’ ‘I learned that how you are finally dealt with depends on what you do afterwards, how you conduct yourself in the aftermath. People like a survivor.”

As regards support during the inquiry processes, good legal representation was felt to be essential, as well as access to a sympathetic colleague, who had gone through a similar experience. Several respondents suggested that it would have been helpful to have been provided with a ‘road map’ of possible outcomes, to help prepare them for what was to come: “It would help to know what to expect, what about GMC referral, what do I do to prepare?’ ‘Need to instruct a barrister – best you can get.’ ‘Need for a mentor – someone who has gone through a similar experience ... who will understand what a doctor might be feeling and give practical advice as well as emotional support.”

Suggestions were also made about the need to reconsider how homicides by psychiatric patients are perceived, reported and responded to in the UK: “The [Royal College of Psychiatrists] needs to stand up against a mob rule mentality ... needs to make sure the public understands that psychiatrists sometimes make mistakes, they do not get it right all the time and are not infallible ... just to understand how complex these issues are.”

Discussion

The psychiatrists who completed this survey described feelings of depression, anxiety, guilt and responsibility, shame and self-doubt following patient-perpetrated homicide. Professional and personal isolation, including scapegoating, were common.

Although some of these responses and experiences are similar to those described by psychiatrists following a patient suicide,^{2,13} there appear to be some important differences in the way that psychiatrists react following a patient-perpetrated homicide compared with a patient suicide. These differences may reflect the way in which society views the killing of a third and 'innocent' party, as opposed to self-inflicted harm; the relative rarity of homicide compared with suicide; and the organisational, societal and legal repercussions following homicide.

The homicide itself represented a psychological trauma similar to that following a traumatic bereavement.¹⁴ For many consultants, it led to a shattering of basic assumptions¹⁵ about the world as benevolent, meaningful and controllable and about the self as worthy. Consultants who had previously thought of themselves as being 'good doctors' found themselves defined, judged and found wanting by this single event. They were transformed overnight from confident and effective clinical team leaders to negligent, reckless and incompetent, and clinical liabilities.

As with many victims of trauma, a sense of actual or threatened loss – loss of job, loss of career prospects, loss of reputation, loss of sense of professional competence and identity – featured prominently.

The parallels with victims of psychological trauma are stark, and yet doctors who found themselves in this position were extremely reluctant to present themselves as vulnerable or distressed. The narrative commonly adopted was that the only people deserving of sympathy were the victim and their family members. Any attempt to usurp that role was felt to be both self-indulgent and distasteful. Moreover, as clinical team leaders, there was often a sense that they needed to be able to support and shield their team and to lead from the front.

Many respondents described a disconnect between the widely proclaimed mantra of multidisciplinary teamwork and collective responsibility and the way in which, in the aftermath of a homicide, they had been held responsible, above all others, for what had happened. They frequently found themselves depicted in the aftermath as dictators and autocrats, which led to feelings of disillusionment and betrayal.

For our respondents, the homicide represented just the start of what was experienced as a long, confusing and painful journey of recovery and redemption, for them as much for the patient perpetrator. Chief among the post-homicide hurdles to be negotiated and survived were the numerous legal and quasi-legal proceedings, such as coroner's courts, perpetrators' trials, GMC referral, disciplinary hearings and the inquiry.

The inquiry process and associated processes were generally experienced as frightening, confusing, punitive and humiliating. Although the process is understood to be inquisitorial in nature, it was in reality experienced as highly adversarial, with the outcome appearing to be entirely and arbitrarily dependent on the experience and beneficence, or otherwise, of individual panel members.

The way forward

The value of post-homicide Inquiries, as currently constituted, has been repeatedly questioned over the years.⁶⁻⁹ However, the social imperative to identify a cause and to be able to hold someone responsible appears to outweigh any objections on the basis of lack of fairness or transparency or even due process.

The experience of our respondents suggests that it may be time for NHS England to carry out a cost-benefit analysis of such inquiries and to review the mandatory inquiry policy. It is clearly important for the families of victims to be able to express feelings of grief and anger and to understand why the killing has occurred and what, if anything, could have been done to prevent it. However, it is also important to convey the message that such tragic events are, thankfully, exceptionally rare,^{16,17} that not all of them can be predicted or prevented^{1,7} and that there is rarely any single cause or individual responsible for them. More consideration could also be given to alternative ways to help victims' families, for example using mediation or restorative justice approaches,¹⁸ although it should also always be remembered, when thinking about who does the 'restoration', that the offender in this case is the patient who killed, rather than the doctor who was looking after them.

As with psychiatrists whose patients kill themselves, the psychiatrists in this survey had been offered no or little support following the homicide.² Trusts may need to be reminded that they have a duty of care to their employees, who require support following an event of this nature. There needs to be more open discussion about how to weigh up the doctor's duty of care towards their patient with their responsibility to protect the public, including the acknowledgement that the two may sometimes appear to be in opposition.¹⁹ The Royal College of Psychiatrists could also play a more active role in supporting its members following a patient-perpetrated homicide, such as by providing confidential telephone support and advice about where to get help and identifying colleague 'buddies' who have been through similar experiences and can provide guidance and support through the process. Early advice from defence unions and identification of senior legal experts are also clearly essential for survival.

The strength of this study is that we were able to elicit qualitative as well as quantitative responses from forensic psychiatrists. Although we focused on forensic psychiatrists, the majority of homicides by psychiatric patients are carried out by patients who are under the care of general adult psychiatrists. It is not clear whether responses of general psychiatrists following a homicide would be any different, and this survey would be worth repeating with a larger sample of psychiatrists from all disciplines to explore potential similarities and differences.

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Data availability

The data that support the findings of this study are available from the corresponding author, G.M., upon reasonable request.

The contribution of all three authors is compliant with ICMJE requirements. All three authors devised the survey, conducted interviews, carried out the analysis of data and contributed to the writing of the paper.

Declaration of interest

R.R. and G.M. have both had experience of a patient committing a homicide while under their care. Neither of them completed the survey and their experiences do not constitute part of the results.

Supplementary material

For supplementary material accompanying this paper visit <http://doi.org/10.1192/bjb.2020.96>.

[click here to view supplementary material](#)

1.2.88 Sentience and transcendence: personal reflections on physical and mental adaptation from a near-death event and life-limiting surgery

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Abstract

In this article I reflect on my experience of adapting physically, mentally and spiritually to a medical trauma that had life-changing consequences. I consider how, over 7 years to the time of writing, mental difficulties were inseparable from the physical; and how, for me, both are aspects of a form of understanding knowable only as mystery. Writing from a position of religious faith, I try to convey my experiences in a way that will be of interest to others regardless of their views. At the end, I reflect on aspects of my care that might be particularly relevant for a holistic, person-centred therapeutic approach.

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pmc In 2012, while working as a vicar in Newham, East London, I suffered an ‘abdominal catastrophe’ necessitating emergency resection of most of my small bowel and a portion of colon. I now live on intravenous nutrition (TPN, total parenteral nutrition, fluids and chemicals pumped direct into the bloodstream through a tube – in my case a Hickman line – permanently inserted into a central vein, thus bypassing the digestive system). The crisis occurred out of the blue. I was 60 years old and in good health.

On the way from Accident and Emergency to be prepared for theatre I had a cardiac arrest, triggered, it was subsequently concluded, by disruptive electrical impulses owing to bowel ischaemia. I was revived after 6 minutes of cardiopulmonary resuscitation (for days after the operation I was puzzled why, in addition to the pain in my abdomen, my chest hurt so much). From a side room, as she was being warned of a not very hopeful outcome, my wife Celia saw me being wheeled in an oxygen tent for a second computed tomography scan.

The operation was completely successful, and physical existence felt near-miraculous as I came out of the crisis. Over the following months and years, however, as TPN became normality, my memory of the trauma lost much of its emotional resonance and life began to feel as mundane as if nothing had happened. Faith sustained me through physical challenges and depressive periods, return to work and early retirement, but I found myself asking age-old questions: Is there meaning to all this? What is it to ‘live’ rather than merely ‘exist’? How can life be at once so cruel, so tedious, so

beautiful? Far from abstract, this questioning was visceral: gut experience (recognising the irony of the image) striving for conceptualisation. Pre-catastrophe faith had to engage with both a new wilderness of meaninglessness within myself and a baffling sense of transcendent blessedness – experiential encounter with the teaching (e.g. *Mark 8.35*) that we must lose our life to find it, a maxim I return to later in this article.

The anaesthetist and the chaplain

As I was being prepared for theatre, consciousness was a floating state anchored to a locus of morphine-dulled pain I knew to be my body. ‘I’ was an internal voice observing, joking about signing (scrawling, on my back) the consent form in such circumstances, and instructing Celia where the church wardens would find the service sheets I had prepared for Christmas in 4 days’ time.

The anaesthetist chatted to put me at my ease. “‘What do you do?’ she asked. ‘Your job?’ ‘I’m a vicar.’ ‘That’s nice.’ ‘Not everyone thinks so.’ ‘Well, I do! I’m Orthodox.’”

I tried to sit up, but movement was no longer possible. It was the beauty of the Eastern Orthodox Liturgy that, years before, had attracted me back to Christian faith.

My next recollection is of the anaesthetist saying, close beside me, “‘I’m very worried.’ ‘I know.’ From the outset she had voiced anxiety about the situation. ‘They’ve told you this is a major operation. But I don’t think they have really ... You do realise, don’t you? It is ... very serious.’”

The rhetorical question and understated comment were exactly what I needed: they enabled my instinctive knowledge that I might die to surface fully into consciousness. Our earlier exchange had (I think) permitted her to follow her hunch that, although ‘the patient’ must not be distressed, ‘the priest’ would wish to be alerted to the prospect of dying. “‘Can I see a chaplain?’ I asked.”

The on-call chaplain was Brother Julian, a Franciscan who ran a local hostel for homeless people, and whom I knew well. His usual beaming smile brought into the room the whole universe of faith – in which pain, fear and death are embraced within an infinitely vaster continuum of grace, compassion and joy. There was neither time nor need for words beyond thanks, prayer and a blessing. Having come straight to the preparation room, Brother Julian offered to fetch the oil of anointing from the multifaith room the other end of the hospital, but I heard Celia say, ‘Can we get on?’ and I was happy with this. Were we not ‘one flesh’? Everyone then withdrew for Celia and me to say our maybe/maybe-not goodbyes. I entered sedation in a state of great peace and awareness of love, confident that whichever way the operation went, it was toward life.

Religious experience, faith and spiritual context

A conventional English private education had ensured I knew my Bible and Book of Common Prayer. At home, however, although there was no active hostility to faith, religion had not been part of life. At university I became gripped by theology, but almost as if ‘I’ were another person: real spiritual life was art, music and pleasure, with a lazy inclination toward Taoism. Then, at 27 years of age, I had an overwhelming inner experience that rid me of suicidal fantasies I had entertained since adolescence. Although disliking the phrase ‘born again’, which I associated with people who seemed stuck in their conversion experience, this event felt indeed like re-birth, in line with Jesus’s dictum: ‘I tell you, unless someone is born from above, he cannot see the Kingdom of God.’ (*John 3.3, The New Testament, A Translation* [David Bentley Hart]).

Spiritually I felt most at home in the mystical tradition of patristic and Orthodox writers, The Cloud of Unknowing and St John of the Cross. The theology of the Vedas and traditions of contemplative prayer in all faiths brought spiritual enrichment. Denominational Christianity seemed cramping. But hearing my default Anglicanism described somewhere as ‘the most spacious mansion in Christendom’, that is where I committed myself.

Ordained at 34 years of age, I had served most of my ministry in institutionally marginal parishes with wider community commitments: in Newham, these included work with refugees; and when I was in Accident and Emergency, stories of people elsewhere in the world suffering atrociously without medical support played in my mind like a kind of mantra, sustaining me in my own lesser experience of pain and powerlessness.

Short bowel syndrome, TPN and therapeutic context

It transpired my abdominal catastrophe had been caused by a section of small bowel becoming trapped in a caecal hernia, of which I had been unaware, starving my whole gut of oxygen. Yet this functionally useful explanation (no further investigations needed) did not satisfy my hunger for an explanation at a holistic rather than instrumentalist level.

Through parish work and ministerial training, I was acquainted with the National Health Service at every grade and had visited nearly every kind of hospital ward. A patient's view is radically different. Nevertheless the Gospel imperative to visit the sick had prepared me in the sense that, through empathy and compassion, however partial, I brought better informed awareness to the experience.

It took time to get the hang of TPN. I now infuse 6 days a week, for 14 hours each infusion. The aseptic procedure for connecting and disconnecting is fiddly and time-consuming. Of several side-effects, the most immediately disagreeable and socially awkward is constant diarrhoea – despite having virtually no appetite, I have to eat to maintain other organ functions (my surgeon had expressed pleasure that, with still just enough jejunum to connect to my colon, I did not need a colostomy).

Thankfully I can walk about with pump and fluids in a backpack during infusions. However, with the functions of physical existence taking up so much time, every day I face the question of what makes existence *meaningful*. In that confrontation faith is a compass and map, as well as emotional sustenance, toward an answer that (as, since my conversion, I no longer give credence to the existentialist Absurd) must necessarily be greater than existence: God, obviously. Yet the word 'God' has become so commodified it is ever more incapable of bearing the weight of its own meaning.

From theological college I had gained outline familiarity with psychotherapeutic theories and praxis, and over the years had myself undergone two periods of counselling in relation to stresses present and past. I also regularly talked with a spiritual director. In the parish I offered a listening ear to people going through difficult times, some of whom found the feelings stirred up in clinical therapy sessions hard to handle (my role being to support a parishioner, not intrude upon therapeutic ground). However, in the aftermath of abdominal catastrophe I needed first and foremost to recover a sense of myself simply as a human being, rather than an *object* of surgical, therapeutic, caring or technological intervention.

Only gradually did I come to recognise this feeling of being less than fully human. Poor communications across the National Health Service, management muddles and homecare company inefficiency compounded mental stress. Lacking strength to 'think positive', however, I rediscovered a sense of agency through silent, often wordless prayer. Acknowledging Christ in all I met, from consultants to cleaners and names at the bottom of emails, I regained a sense of humanity and joy. Holding prayerfully in mind the millions around the world enduring infinitely worse, I outfaced the petty humiliations of dependency.

Curiosity about my condition helped combat spiritual stasis and temptation to self-pity. Although not disabled, I have lost an essential organ. A plastic tube sprouts from my chest. I receive artificial nutrition. Certain activities are now problematic or impossible: risk management is self-conscious, psychological nervousness or cavalier overcompensation hard to avoid. After two bouts of septicaemia (the second time, going into septic shock within hours), I agonise about carelessness. Having also suffered nerve damage in my right hand and developed atrial fibrillation and low thyroid on top of normal ageing problems like arthritis, my body clamours for attention. Yet all remind me ... I am ALIVE!

The body as a spiritual organism

Bodily demands are depressing; at the same time, off the flint of faith, so to speak, they spark amazement (as in 'amazing!', 'wow!' or religious 'Amazing Grace'; but also an inner maze of numinous darkness, struggle and trust, wilderness and promise). Christianity proclaims 'the Word' – the cohering principle of the cosmos – revealed in the uniqueness of an individual historically existent human being. Incarnation, sometimes termed 'the scandal of particularity', defining Jesus as both human and divine, makes for a faith in which at one level the spiritual is set aside. In the mystical tradition particularly, the body can become the entire focus of the transcendent.

Vital to my progress was and is contemplative prayer: a spirituality, sharing similarities of practice with other faith traditions, in which the body is not merely a transient vehicle for spirit but, in its very mortality, a 'temple' (*I Corinthians*

3.16) of glory, of the eternal nature and identity of the divine indwelling time. Jesus tells his disciples that to find life they must lose their lives for his sake and for the sake of the 'good tidings'. The Greek word translated as 'life' here is *psyche*: meaning not only body (*soma*), but also intelligence, imagination, feeling, intuition, consciousness, all that constitutes personal identity – soul (somewhat like Hebrew *nephesh*, not disembodied Neo-Platonic soul).

My catastrophe made me experientially aware of my disposability. However, survival brought an intimation, equally intense, of the transcendent *soma pneumatikon*, the resurrection body of divine 'breath' or spirit, *pneuma* (*I Corinthians 15*). Insofar as faith is an owned creaturely experience, diverting one, at the level of will, from unconditional openness to the love of God, I realised that losing one's *psyche* entails losing faith itself.

Near-death experience and sentience

My cardiac arrest was accompanied by no near-death experience in the normal sense of extraordinary feeling or vision. Such experiences inspire considerable popular and research interest. However, any near-death event (most people who recover from a near death event do not report a near-death experience) raises important questions about human *being* at a liminal juncture.

At a brain-conscious level there may be nothing; yet our being in its wholeness is more than consciousness: the fact of existence is inseparable from individual and communal *identity*. As a priest, I find it significant that a body before burial or cremation is (to relatives and friends) still 'her' or 'him' rather than 'it'. This reflects the subjective emotions of the living; yet at the same time, disposal of human remains has archetypal cultural significance, suggesting that a human corpse cannot be totally reified without violation of some quality essential to human being. Can that quality be pinned down?

My 6-minute outage from normal existence is a blank to me. However, my sense of who I am also has an unconscious relational, narrative dimension. My consultant tells me that the physiological effects of cardiac arrest are not easily identifiable, and personal realisation of what I had been through had a psychological effect on me. The event of which arrest was part had, in its wholeness, a drama incommunicable through empirical analysis. Comprehension ('grasping together') requires comprehensive assimilation: epistemic integration of experience at every level, including that of the basic organic matrix of existence, the fundamental conditionality of experience.

I had not been dead for 6 minutes, but what had I been? 'Near death' sounded banally quantitative, avoiding qualitative definition. 'Clinical death' was portentous, but did not help me understand. 'Understanding' would require, I felt, not merely an empirical cognitive account, but some sapiential *event* at the level of my whole being, resonant of the all-affecting nature of a personal crisis.

It was in remembering back to recovery of consciousness in intensive care that I came to the notion of sentience. That moment also represented final return to consciousness from the cardiac arrest: realisation that I was, indeed, alive.

I had gone into theatre knowing that I might not come out alive. At the moment of reactivating consciousness, I simply remember a sensory experience of whiteness, whether from something external or from within, like a screen coming to life, making me wonder, 'Where am I?' Then I recalled being told, as I was being wheeled into theatre, that after the operation I would be taken to intensive care. So ... that must be where I was. Which meant I must be alive. 'That's nice', I thought.

The trite words reflected a two-dimensional state of awareness: the cognitive intensity of the moment precluding reflective consciousness. Meanwhile, the felt question 'Where am I?' presupposed, at a purely sentient level, trust in the fact of my own existence.

Can there be any form of consciousness without that fundamental level of existential trust? How does simple animate matter relate to the phenomenon of consciousness? From a position of faith, philosophical discussions of the nature of mind and consciousness in relation to matter, in particular the brain, are reminiscent of pre-scientific attempts to locate the seat of the soul. Confidence in one's own existence seems to me now, at a distance from intensive care, the pre-condition of any capacity for ideation; a synergy of different aspects of being that, if it can be conceptualised at all, would require so to speak quantum rather than Newtonian understanding.

The body and mystery

Jesus wept. This manifestation of divine vulnerability precedes the raising of Lazarus from the dead (*John 11.1–44*). In hospital, more than once in emotional shock I pulled the bedding over my head and cried. When the Muslim chaplain, whom I knew through interfaith work in Newham, visited, I cried – and apologised. What is the power and shame of tears? This purely physical ‘welling up’, a universal human experience, brings what is highest and deepest within us unavoidably to consciousness.

For over a year after leaving hospital, several times a day, without warning, with no conscious emotional desire to weep, I experienced a kind of hyperventilation like a child sobbing. Initially these spasms felt consistent with an underlying emotional state; but as they continued even after my emotional condition had stabilised, it occurred to me my body held memories that consciousness had either successfully processed or, as a result of the anaesthetic, never directly experienced. My sentient being had suffered more trauma than my ‘self’.

Although I had no near-death experience during cardiac arrest, my ‘conversion’ over 30 years previous had been precipitated – the details are beyond the scope of this article – by a frightening out-of-body experience in which I saw my body as a *thing* separate from me. The thing was discarded and I felt (as I articulated it at the time) that I had ‘jumped into my own body’, a new body, the true me.

Sentience may affect us in ways we cannot be conscious of, rather as cancer or medication are already at work before symptoms manifest. It may at some point become empirically explorable. Yet, more significantly for whole-person understanding, we already know it as mystery. Mystery can become glib, just as certainty, incurious about its own nature, can foreclose on open-minded experience; but as the liminal zone of our being, it transcends apprehension, interfaces with the transcendent ... guiding the anaesthetist’s hunch, informing the chaplain’s smile.

In hospital after my operation a young doctor appeared one day: ‘You’ve been given a second life’, he said, hurrying off. I suspect it was he who had resuscitated me. The distinction between a second life (of extended mortality) and new life (qualitatively changed spiritual life) in Christ became crucial for me. Lazarus was not raised to immortality, and my bodily survival was a medical success story. So what?

My first near-death event was, in terms of *life*, more significant than the second; yet the quasi-miracle of physical survival years later brought life alive to me again. A vehicle of agony and abuse, delight and wonder, even at its most basic level of sentience the body is to the eyes of faith a sign (theologically, a sacrament) of a quite other order of being: a new mortality that is eternal, in tune with angelic intelligence (the substantiality of inexpressible communications), and destined for glory (the holistic experiential, philosophical and ethical ground of dignity of every human life).

In physically ingesting the body of Christ in the bread of the Eucharist we participate in the Body that is the Church – a communion of minds and affections, vision and hope, compassion and concelebration, transcending its own fatal debilities. TPN sustains my second life, but it is the *mystery* of the body, new life, that makes that life worth living.

Concluding reflections on care

In risking crossing the clinical boundary to address me personally, the anaesthetist transformed the crisis for me. The prayer with Brother Julian meant that I went into a dangerous operation with a sense of complete preparedness. But had I not myself known about chaplaincy, this care would not have been offered.

As a patient I was also conscious of the emotions and energy levels of carers – professionalism cannot eradicate human relationship. I was touched and intrigued by the young doctor’s visit, and longed for a chance to thank him properly.

Patients are the *objects* of medical professionals’ care. We are in their power: most of the time I experienced this as beneficent objectivity. Equally, however, I felt both we and they were caught in an under-resourced system that claims too much, creating depersonalising reification. COVID-19-era precautions will presumably make it even harder to maintain the personal relational care I found, and still find, so vital to well-being.

James Ramsay is a Priest with permission to officiate within the Diocese of Norwich, Church of England, UK.

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Declaration of interest

The author is an ordained Anglican priest, but has no interest to declare.

Supplementary material

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1.2.89 The sociocultural and behavioural characteristics that patients want in psychiatrists: cross-sectional survey of patients' views

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Abstract

Aims and method

There appears to be no research to date investigating patients' preferences for sociocultural characteristics or behavioural qualities of psychiatrists. We aimed to assess which are most important to patients. Patients (132) in community mental health teams across two sites (East Cornwall, East London) completed a questionnaire ranking the importance of different sociocultural characteristics and behaviours of psychiatrists.

Results

Patients cared more about age and gender than other characteristics. Four preferences (from a choice of ten) regarding behavioural qualities were clearly identified as important: explaining things clearly, dedication to personal treatment, being friendly and polite, and being up to date with medical knowledge.

Clinical implications

Patients are fairly unconcerned about the age, gender, religion and social background of psychiatrists. Characteristics they care about most include communication skills, competence, dedication to personal treatment and friendliness. Explaining things clearly is particularly important. This indicates specific areas of improvement for training and further research.

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pmc Patient preference is a central principle in healthcare. Both patient views and satisfaction are recognised as important as expectations of standards of care rise.¹ Studies on patient satisfaction with care have shown that the therapeutic relationship between patient and doctor and the interpersonal relationship with staff are important to patients.²

The evolution of patient-centred care means that patient involvement is increasingly integral to health services research and development, demonstrated by a rapidly growing literature base of patient views. However, there is still a dearth of literature examining patient involvement for improving professional performance in medicine.³ The literature that does exist largely focuses on communication skills during consultations. This scarcity means that we cannot yet state whether patient feedback can affect performance and what the influential factors are.⁴

We know that judgements are made on the basis of initial perceptions;⁵⁻⁷ these perceptions are based on easily identifiable features such as gender or age, and on traits judged to be important by each individual, such as standing within

society. Gledhill et al found that psychiatric in-patients prefer psychiatrists to wear smart attire and to call them by their first name, although this research was conducted in 1997.⁸ However, the smart attire may also lead to patients viewing their psychiatrist as less friendly and approachable.

Patient preference regarding a doctor's gender is an obvious and better explored example of consideration of patients' attitudes. It has been found that significant gender preference is low but trends for same-sex doctors are seen in specific scenarios, including choosing a primary care doctor.⁹

A study undertaken in The Netherlands in 1993 by Kerssens et al used a general household survey to investigate gender preference for 13 different medical specialties and explored possible reasons for any preferences arising. They found that gender preference was stronger in specialties more likely to be engaged in intimate and psychosocial health problems, such as general practitioners (GPs) and gynaecologists. They found that individuals who indicated a preference for a female physician did so on the basis that they found it easier to talk to a female and felt more comfortable being examined by a female and the same reasons were cited by those indicating a preference for a male doctor. For women, 81% had no gender preference for psychiatrists, 4% preferred a male and 15% a female psychiatrist. For men, 91% had no preference, with 3% preferring a female and 6% a male psychiatrist. This was a population, not a patient, survey.¹⁰

More recently it has been suggested that gender is likely to continue to influence the doctor–patient relationship more in psychiatry than in most other specialties. This may be due to the many entrenched social perceptions and stereotypes that we are still too unaware of.¹¹ It has also been found that female psychiatrists are still at an advantage when it comes to developing a working relationship with their patients.¹²

Patients are also likely to have strong views on how important various behaviours and skills of clinicians are. When examining communication, there is clear evidence that modifiable human behaviours can have positive or negative effects in consultations. Yet even when specifically examining empathy, Derksen et al found that, although widely promoted as a fundamental skill in clinical practice, evidence is scarce for the effect of greater empathy.¹³ A commonly identified negative characteristic of healthcare professionals is paternalism. The desire for an equal power dynamic is one theme that frequently arises in studies examining the patient–medical professional relationship.¹⁴

Evidence suggests that patients attending out-patient psychiatric services are generally satisfied with the care they receive from their psychiatrists.^{1,12} There is some evidence exploring patient satisfaction pertaining to particular qualities in their psychiatrists, such as whether they are attentive, caring in demeanour, knowledgeable about an individual's illness and able to explain conditions well.^{15–17}

There is little literature on any aspect of how the patients' role is integrated.⁴ Even when patient involvement is promoted, many assumptions are made as to the scope, such as how, when and on what they can give feedback. Indeed, it has been seen that there is sometimes a misalignment between patient priorities and changes put into effect.¹⁸ For example, as part of the revalidation cycle in the UK's National Health Service (NHS), doctors are mandated to submit and evaluate patient feedback. This has been found to have a positive influence overall although its exact purpose and use remain a point of contention for many.³

It is also important to question why patient involvement in the development of professional performance has been lacking. Recent analyses have found that negative attitudes of doctors may in fact be a key barrier preventing systems development, thus hindering performance improvement.³ It is still important to generate the evidence, as clinical outcomes are likely to be affected.

There is also some indication that a therapist's perception of the patient's priorities can be incorrect. When there is a developing relationship, this failure can strongly affect the patient's confidence in their therapist.¹⁹ However, there appears to be no research to date specifically investigating patients' preferences for the sociocultural characteristics of their psychiatrists.

It can take up to 17 years for research to translate into practice in the UK health service; by developing and improving patient involvement we may be able to improve this implementation process and decrease the time frame.²⁰

Aims

This study aimed to explore the characteristics and qualities of psychiatrists that are most important to patients. We asked the following research questions: What sociocultural characteristics about psychiatrists are important to patients? What behaviours are most important to patients in their psychiatrist?

In addition, we hoped the data would be able to shed light on the following gender-based question: Are female patients more likely to want a female psychiatrist?

Method

Setting

The study took place in community mental health teams (CMHTs) across two UK NHS foundation trusts. The sites were a general CMHT and a complex care and dementia team in East Cornwall and a CMHT in East London. We therefore approached patients across very different environments – a deprived rural area in south-east Cornwall, which is predominantly White in ethnicity, and a deprived urban area in London, which is significantly ethnically diverse.

Design

This was an exploratory cross-sectional survey of patients' views.

Participants

Patients were identified from the team case-loads. They were included if they were over the age of 18 years, had contact with a psychiatrist within secondary mental health services and were classified as having a severe and enduring mental illness, which included patients with a psychotic illness (for example schizophrenia or bipolar affective disorder), a severe depressive disorder, a personality disorder or dementia. Patients were excluded if they were acutely unwell and therefore lacked capacity to give consent and if they were unable to speak English.

Data collection

In East Cornwall, patients were initially approached via their care coordinator during a pre-existing appointment or following an appointment with their psychiatrist. This initial approach resulted in a fairly low response rate, so an amendment to the study's ethical approval was sought and patients were also approached by a mail shot. In East London, patients were approached via a mail shot after they had been identified by a researcher in conjunction with their care coordinator.

Participants completed a brief questionnaire which asked them about several non-modifiable sociocultural characteristics of psychiatrists, including age, gender, religion, social background and marital status. They were asked to state whether or not they had a preference with regard to the gender, age or level of experience of their psychiatrist. Then the participant was asked to state how important each characteristic was. Finally, they were asked about modifiable characteristics. The participant was asked to select and rank the three qualities/behaviours most important to them from a list of ten: the psychiatrist is friendly and polite in manner, the psychiatrist is recommended as good by other patients, the psychiatrist is recommended as good by my GP, the psychiatrist is actively involved in scientific research, the psychiatrist is up to date with medical knowledge, the psychiatrist has a professional appearance and is well dressed, the psychiatrist is dedicated to my personal treatment, the psychiatrist is positive and optimistic, the psychiatrist explains things to me, the psychiatrist has a similar social and cultural background to me. This list of behaviours was generated from discussions within the research team and consideration of the literature.^{1,13,15}

Researchers then collected sociodemographic details about the patients from computerised medical records, including their age and gender.

All data collected were strictly anonymised to prevent patient identification.

Data analysis

The overall results were compiled to reveal: preference for genderpreference for agepreference for experienceimportance of the sociocultural characteristicsranking in importance for the ten characteristics.Comparison was then made to see whether female patients had a preference for seeing a female psychiatrist.

Ethical approval

The study received research ethical approval (REC reference number 13/EE/0230) from the National Research Ethics Committee East of England.

Gratuity

Participants were offered £5 (cash in East Cornwall and a voucher in East London) as a token of appreciation for their time. This was not advertised in the patient information leaflet, to reduce potential response bias.

Results

We received 132 returns of the questionnaire across all sites (76 from the East Cornwall CMHT, 28 from the East Cornwall complex care and dementia team and 28 from the East London CMHT). Participants were aged over 18 years, treated in secondary mental healthcare and were diagnosed with a severe and enduring mental illness.

The sociocultural characteristics important to patients

Participants cared more about the age and gender of their psychiatrist than their religion, background and marital status, but the majority of participants were not concerned about any of these factors (*Fig. 1*). With regard to age, 28% of the total sample expressed a preference regarding the age of their psychiatrist: 16% preferred a psychiatrist under 40 years old, 73% a psychiatrist 40–55 years and 11% a psychiatrist over 55 years. A larger proportion of the total sample (61%) expressed a preference regarding the level of experience of their psychiatrist, with 79% of them stating a preference for a psychiatrist who had been qualified for some time. *Fig. 1*Participants' rating of the importance of their psychiatrist's sociocultural characteristics.

Behaviours most important to patients

When asked to rank the three most important qualities/behaviours from the list of ten, there were four clear preferences (*Fig. 2*): the psychiatrist explains things to me (more than two-thirds had this in their top three rankings)the psychiatrist is dedicated to my personal treatmentthe psychiatrist is up to date with medical knowledgethe psychiatrist is friendly and polite. *Fig. 2*Participants' ranking of the top three (out of ten) preferred qualities/behaviours shown by their psychiatrist.

Additional results regarding gender preference

In total 73 women completed the questionnaire; 73% expressed no preference regarding the gender of their psychiatrist (*Fig. 3*). A similar percentage was observed among the 59 men who completed the questionnaire: 75% expressed no preference with regard to the gender of their psychiatrist. There was no significant difference between genders at the 5% level on statistical analysis (chi-squared test of independence, 5% confidence value). *Fig. 3* Female participants' preference for the gender of their psychiatrist.

Discussion

Main findings

In this study the characteristics of psychiatrists that patients cared most about included communication skills, competence, dedication to personal treatment and friendliness. Being able to explain things to patients was particularly important. Of note, being recommended by GPs and other patients was not as important, nor was appearance or being positive and optimistic. The importance of 'dedication to personal treatment' supports early findings by Johansson & Eklund that a common priority of psychiatric patients is the development of a therapeutic relationship.¹⁹

Participants did not express strong preferences about the age, gender, religion, social background or marital status of their psychiatrist.

As regards the modifiable characteristics analysed, participants did not identify optimism as being important. This aspect of the therapeutic relationship is a quality assessed in some consultant 360-degree appraisal systems. Our finding may be due to a desire for the clinician to be realistic and a feeling that being unduly optimistic can give false hope. As the survey population was patients in secondary care, there may be contributing factors that were not taken into account. These might include the chronicity of specific conditions and the amount of time that the participants have been receiving care.

Another postulation is that the questionnaire asked about a psychiatrist being positive and optimistic; patients might construe a combination of positivity and optimism as lacking in empathy and not understanding their suffering or recognising the impact their presentation/illness is having on their life.

In terms of non-modifiable characteristics, none were found to have significant importance. The preference for age and experience was of note, as it suggests that more senior clinicians have characteristics desired by patients.

With gender preference, the female participants did not show an overall preference to see a female psychiatrist. This is a comparable finding to the population survey undertaken in The Netherlands in which the majority of both women and men expressed no preference about the gender of the psychiatrist seen.¹⁰ The conflict with more recent studies into gender bias among psychiatric patients may be due to the disparity between preconceptions and outcomes with male/female psychiatrists. This warrants a focused analysis that could be instrumental to professional improvement.

Limitations

We must consider the potential limitations of the study, in particular response bias. One of the factors specifically commented on by the researcher based in East London was the fact that patients were more likely to return a questionnaire if they had previously met her in an earlier role running therapeutic groups in a hospital setting. In conjunction with patient-experience surveys generally having low response rates, this bias may be notable.²¹

The study was also limited to people who spoke English: although this may not have had a significant impact on the results in the East Cornwall sites (nobody on the East Cornwall CMHT case-load required the use of an interpreter or did not speak English as a first or second language at the time of the study), there is a considerably more culturally diverse population in East London who could not then be approached.

In terms of study design, there is no validated questionnaire specific enough to the aims of this survey and applicable to the setting. The behavioural qualities listed in the study were determined through discussion among clinician-researchers. The list might have been strengthened with input from patients.

We did not use a mixed-methods approach owing to limited study resources. Analysing the data by patient characteristics, including experience of services and diagnosed disorder, would have given more insight from a patient perspective, and may be an opportunity for future research.

Implications

Although we may worry about a patient's perception of us based on physical, usually unchangeable characteristics, our focus should be on how we communicate with our patients, as this appears to have more importance for patients. We should not underestimate the significance of being friendly in our clinical work, but also remember that patients value the time-honoured importance of up-to-date knowledge and being dedicated to their personal care.

This research focused on patients in secondary care, many of whom are already experienced with regard to psychiatric treatment. With this in mind, consideration should be given to repeating the research with newly referred patients.

It should also be considered that, in circumstances where the relationship between a patient and their psychiatrist has broken down and a new psychiatrist is to be allocated, attention to matching the psychiatrist and patient on the basis of sociodemographic characteristics is not merited by the evidence.

Some of the behaviours that were identified as important can be trained and regulating authorities such as the General Medical Council and the Care Quality Commission may wish to consider greater encouragement in developing these skills. Psychiatrists are already expected to update their knowledge through continuing professional development, but there is limited systematic training or supervision on how psychiatrists should explain treatments to patients. These communication skills are important to patients.

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Data availability

Data is available from the corresponding author.

Conception and design: S.P., R.L.. Collection and assembly of data: R.L., A.C., C.P., A.O'K., G.R.. Manuscript writing: all authors. Final approval of manuscript: all authors.

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Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <http://doi.org/10.1192/bjb.2020.115>.

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1.2.90 Being positive on disability in medical education

Elliott Carthy

date

2021-06

Contents

- *Being positive on disability in medical education*
 - *Declaration of interest*

pmc The world is a diverse place. The patients we treat are a diverse group. The same can't be said for the medical profession that represents them. I would argue that positivity regarding disabilities in medicine starts with us as educators. My favourite aspect of being a medical educator is what I as a teacher learn from my students. I, like most doctors and medical students, do not have a disability. However, I communicate with and advocate for people with intellectual disabilities, autism and learning difficulties such as dyspraxia and teach about these topics as routine practice to students and the wider multidisciplinary team. This is not just about reducing discrimination and promoting equality but also about appreciating the value that such people add to society.

General community estimates within the UK suggest the prevalence of disability in working age adults to be 19% in the UK,¹ yet in medical schools, it is estimated that only 4.1% of students have a disability.² Even accounting for potential non-disclosure, these numbers show substantial underrepresentation. The British Medical Association recently published a report titled *Disability in the Medical Profession*³ that highlighted the paucity of doctors and medical students with disabilities who felt safe to disclose their condition or felt supported by their institution or colleagues. Despite widening participation programmes, medicine can still be discriminatory towards those with disabilities. It would not be unreasonable to suppose that such reluctance to seek support or have the need for this recognised could be extrapolated to our patients.

The term disability is broad, both in nature and degree. This is often poorly reflected in medical guidelines, whereby our lack of understanding can contribute to the pre-existing stigma. The title of the General Medical Council's *Welcomed and Valued*⁴ guidance for those with disabilities in the medical profession gives the impression of framing inclusivity in a positive light. However, the persistent use of terms like 'support', 'student needs' or educators and institutions applying their 'duties' means the focus is on reducing discrimination and making reasonable adjustments to allow for

an assessment of competence. The presumption is that disability may be a threat to competence and to patient safety. In fact, disability may give lived experience that improves competency through empathy and understanding. We need to start focusing on what such students, doctors, educators and, crucially, patients can add, not simply what they need.

If we provide a safe space for those with lived experience of disabilities to share their experiences and the impact on their life, then each one of us can improve our understanding. Indeed, more doctors being open about their visible and invisible disabilities mean more positive role models for students. Widening participation can then move from just implementing anti-discrimination legislation to appreciating the value that diversity adds and the grassroots barriers to entering and thriving in the profession of medicine. Every medical educator can contribute by providing a safe space for disclosure and a willingness to learn and be educated by our patients and students.

Declaration of interest

None

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1.2.91 Difficulties in interpreting patient-reported outcome measures in the absence of a gold standard: the meaning of Clinical Global Impressions scores in liaison psychiatry

Rajalakshmi Valaiyapathi Kezia Smith Ksenia Marjanovic-Deverill

date

2021-06

Contents

- *Difficulties in interpreting patient-reported outcome measures in the absence of a gold standard: the meaning of Clinical Global Impressions scores in liaison psychiatry*

pmc As a part of routine clinical care, the Ealing Liaison Psychiatry Service (ELPS) uses the Clinical Global Impressions (CGI) scale to assess patient-reported outcomes. We would like to share our findings and the challenges in interpreting CGI ratings.

CGI scales in psychiatry were initially used to assess efficacy in clinical drug trials¹ and have since been adapted for use in liaison psychiatry as a part of a nationwide evaluation. The Framework for Routine Outcome Measurement in Liaison Psychiatry² proposed that all liaison psychiatry services use CGI scales for consistent data collection and national reporting of outcomes, although there is no guidance on a standard to aim for.

Our methodology involved patients and their ELPS clinicians providing a CGI rating on whether the patient's mental health had improved, not changed or become worse after ELPS contact. This study looked at all 205 patients between January 2018 and November 2019 who had filled out a CGI questionnaire, and the following analyses were made: percentages of patients reporting changes in their mental health and potential reasons for this; concordance between patient and clinician ratings. Fifty-nine per cent of patients reported an improvement in their mental health, although the reasons for this were unclear, given that the CGI questionnaire has no section for patients to justify their rating. A

variety of factors may be involved, including having a focused consultation with a clinician, a decrease in symptom severity, and improvements in physical or social symptoms during the hospital stay, as these are often inextricably linked with mental health.

Forty per cent felt there was no change after ELPS intervention, and 1% (three patients) indicated feeling worse. Of the latter, two patients had to be admitted to an in-patient psychiatric unit, which could suggest that their lack of improvement was due to the severity of their mental health condition itself. There was 91% concordance between patient and clinician ratings, suggesting that subjective ratings from patients may not be needed if clinicians' objective ratings are so closely tallied.

The CGI scale has been correlated with more time-consuming rating scales used in psychiatry,³ and its advantages lie in its ease of understanding by both professionals and lay people, its ability to track progress across time and its swiftness of application. On reflection of our findings, we are unable to comment on our performance given the dearth of literature discussing what constitutes the gold standard. However, encouragingly, most patients reported improvement while only a very small minority reported deterioration, indicating that liaison psychiatry interventions are effective and largely beneficial.

By nature, the liaison psychiatry population comprises patients with both physical and mental health conditions, causing relative difficulty in teasing out which of the two issues is better manifested in the desirable outcome. In addition, the heterogeneity of the liaison psychiatry population makes it difficult to make direct comparisons of validity between different psychiatric conditions.

This simple service evaluation suggests that ELPS improves patients' well-being according to CGI scales. Nevertheless, wider-scale studies should be performed to elucidate how liaison psychiatry interventions are beneficial and to inform what the standard of care should be.

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1.2.92 A portrait of anorexia nervosa

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2022-04

Abstract

The author draws comparisons between the subjectivity of interpreting a work of art and that of

¹

See commentary, this issue.

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experiencing anorexia nervosa. She explores her own experiences of anorexia through a portrait depicting the duality of the disorder.

Contents

- *A portrait of anorexia nervosa*
 - *‘It’s all inside your head’*
 - *Unlocking the chain*
 - *The journey of creation and the journey of recovery*
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pmc What I like most about art is that it enables me to express complicated thoughts and emotions that often feel impossible to communicate verbally. Not only is it expressive, it is also fluid and its effect on others is completely subjective. It has no concrete rules, methods or regulations. It is completely versatile, and for a sufferer of anorexia nervosa, that freedom is certainly relieving. Defining my disorder for others has often been difficult for me as I find it cannot be categorised by a standardised list of reasons or symptoms. I believe it parallels art in that it is subjective to an individual, it has so many loop-holes and complexities. And so with that, my disorder will be different to the girl who sits opposite me in class or the boy who goes to my gym. We are all dealing with our own specialised disorder and that is something I wanted to express in my artwork.

‘It’s all inside your head’

Since finishing this piece (*Fig. 1*) I have listened to a lot of people’s interpretations of it and I love how everyone came up with a different approach to what it represents. The two sides of the portrait are meant to represent what is visible of an individual with anorexia and then the complexities that lie below the surface. While creating ideas for the visible side of the portrait I thought about what a typical sufferer of anorexia is perceived to look like. As a society we automatically assume the individual to be underweight, malnourished, pale and quite frankly on the cusp between life and death. Unfortunately, statistical research will show that in a lot of cases these features are disturbingly common. But I have always held on to the belief that these visible symptoms are not the determining aspects that separate a sufferer from a non-sufferer. When I asked my Mum about the time I was in the deep throes of anorexia she said something that has stayed with me throughout my recovery. She simply told me ‘there was no one there’. That idea of an absence of self being a major symptom of anorexia is definitely something I believe fellow sufferers will identify with. The defensive remarks, spiteful comments and the extreme memory loss are all evidence that the person I knew I was, was no longer present. A lot of sufferers will personify their illness to detach it from who they are as an individual. In the case of anorexia, this person is commonly referred to as ‘Ana’ and this double identity was an important idea that I wanted to feature in my artwork. *Fig. 1 It’s all inside your head* (2020). Lily Aston.

My personal interpretation of the piece is that the black and white side represents this ‘absence of self’. The lack of colour and detail establishes the loss of personality, it is what others may see when they face an anorexia sufferer. The coloured side then represents what lies below the surface, the complexity of emotions: confusion, anger, sadness, resentment. These all combine to create this explosion of chaotic colour. They are the emotions that sufferers will tend to hide from the outside world in order to remain ‘undercover’. That is why many victims of anorexia will go through a major period of denial, convincing others and quite often themselves that they are ‘fine’, ‘I couldn’t be happier’, ‘I feel so much healthier now’, ‘oh no thank you, I’m not hungry’. Humans are emotionally complex beings and expression of these emotions is necessary to maintain our sanity. So in the case of an anorexia victim going through denial, it is only a matter of time before this wall is broken and these emotions come flooding out, quite often with a vengeance. I remember very clearly when my wall broke down. I came home from school and went straight to my room to lie on my bed. I had eaten about 600 calories worth of food in the span of three days and by that point my body was too weak to feel the hunger pains. I lay there for a couple of hours until my Mum called me down to say ‘We’re going to order

a takeaway’. And I was – furious. My perfect utopian façade had loosened at the seams and all this hate, fury and fear came bursting out in all directions as I screamed at these people who I loved more than anything in the world. I am ashamed to admit that in that moment I cursed their existence and wished they would disappear.

Unlocking the chain

That evening was a turning point for me, it was as if my double identity had begun to reveal itself to those around me, including myself. And it was important for me to convey this duality in my portrait. I considered doing two different faces as I hated the idea of anorexia being a part of me. But the harsh reality is that it doesn’t become a part of you – it overcomes you. Recovering from an eating disorder is like peeling a hundred layers of your skin from your body. It is extremely painful, both physically and mentally. But this shedding of skin is absolutely essential in order to detach yourself from the grip of anorexia. Throughout recovery, it is so important to realise that an eating disorder does not become a permanent part of your skin. I view it as a locked chain that is wrapped around your body, constricting your movements. It feels impossible to escape and your situation feels hopeless for quite a long time. But it is through deep inner strength and the support of others that we are made to realise that we had the key in our back pockets all along. However, recovery is not as brief and straightforward as unlocking a chain. Our chains are quite often tangled and complicated. It takes a lot of time and patience. But I say from experience, it is a challenge worth taking.

The journey of creation and the journey of recovery

The process of making this piece of art was a long and tough journey but I hope others who are currently battling with their own demons will be able to identify with it. I welcome and encourage people to interpret it however they like. For all our journeys are different in their many complexities, but I hope we will all end up at the same destination. Content and healthy.

I must also mention an incredible artist called Shawn Coss, whose interpretations of mental disorders truly touched and inspired me to create this piece. The haunting figures that are scattered around the portrait are features of his work. His talent for expressing such complex emotions encouraged me to express my own, and I hope that others will be inspired to do the same.

Lily Aston is a student currently on a gap year. Due to study Psychology at Bristol University in 2022 but currently resides in Eastbourne, UK.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in its writing.

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Declaration of interest

None.

1.2.93 Art and psychiatry in the 21st century: here's to more messy – and magical – entanglements

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date

2022-04

Abstract

In a volatile world, during a time of multiple crises and amid a projected upsurge in mental illnesses as an aftermath of the COVID-19 pandemic, now is a critical time to consider how art and psychiatry can entangle with each other. Submissions like that of Lily Aston can create new spaces for conversation, reflection and constructive collisions. This can help disrupt and extend the state of psychiatry, management of psychiatric services, and education and training in mental healthcare, and advance how we understand other bodies and minds around us, and how knowledge can be created.

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- *Art and psychiatry in the 21st century: here's to more messy – and magical – entanglements*
 - *What can anorexia (actually) look like?*
 - *Fluidity and freedom*
 - *Beyond art therapy, inspiration porn and 'public engagement'?*
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pmc .. _sec1:

What can anorexia (actually) look like?

It has been more than 150 years since 'anorexia nervosa' was first termed.¹ But what do we *know* about what anorexia is, and in what ways could art related to anorexia confirm, complicate and/or extend this discussion?

For instance, how will someone with anorexia express what anorexia (actually) feels and looks like in a painting (or poem, rap song, film, tango dance, etc.)? What do our observations about artworks say about us? As importantly, what does that which is not depicted and omitted reveal? How does one's subjective lived experience inform the artwork? How does this relate to (their and/or the viewers') learned (mis-)conception of what 'anorexia' *should* be and that of another person with anorexia or those with other 'non-standard' relationships with food? How does the narrative compare with that created by their healthcare provider and that which is described/prescribed within textbooks, papers

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Commentary on ... A portrait of anorexia nervosa. See this issue.

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and policies? What new insights and indeed new knowledges – including the tacit and embodied – can art that entangles with psychiatry create?

Art – like culture or baldness² – escapes easy definition. But can art help to raise the visibility of mental processes – literally and metaphorically – and reveal new insights into them? Can art open up new spaces for the patient and psychiatrist to engage with each other beyond the clinical and/or pharmaceutical? How does this irritate the patient–doctor dynamics and divide? What sort of productive antagonisms can arise when psychiatry engages with artistic practice and research? How can this disrupt dominant narratives around (dis-)order and (ab-)normality? To what extent does artistic quality come into play?

And how can the new culture section in an established platform accessed by researchers and practitioners in psychiatry entangle with some of the above-described tensions, to challenge, *and indeed advance*, ‘the state of psychiatry, management of psychiatric services, and education and training’³ in mental healthcare?

Fluidity and freedom

The above are some of the questions that Lily Aston’s submission can evoke. Alongside the submitted drawing/painting is a written commentary. The latter provides a level of contextualisation and what Aston has described as ‘my own interpretation’ of the painting as a ‘sufferer’ of anorexia nervosa.

So what can we see, and what does Aston say about what we are looking at (or looking for)? The artwork is dominated by a face which is divided diagonally. This illustrates what Aston has described as her ‘duality’. One side of her face and paper is in an ‘explosion of colours’, in paint, to depict ‘what lies beneath’ (flowers, pills). The other is in black and white, drawn in pencil, to depict an ‘absence of self’ and ‘loss of identity’. Yet, this isn’t a hard binary the way Descartes reduces the human body and mind. Instead, like how many understand gender today, the division is ‘fluid’. Perhaps like the *yin-yang* symbol, we are looking at complementary, not contrary forces at play. There are figures in black and white in the side that is colourful, while butterflies – coloured, in black and white, and some both coloured and in black and white – punctuate the entire composition.

Indeed, Aston’s work is one of contradictions. While ‘surrealistic’ (skeletal figures hovering around the skies), it is enthusiastic about realism (meticulous facial make-up and follicular luxuriance). It is not saying much (the subject glances nonchalantly into the distance). At the same time, it seems overtly literal, as if an illustration, a confession or a plea to be heard/seen (the words on the wings of butterflies read ‘It’s all inside your head’, and words on figures in the foreground say ‘trapped’ and ‘I’m sorry’).

The commentary also includes Aston’s thoughts about the role of art. While the process of making the piece was a ‘long and tough journey’ for her, what Aston likes most is how art allows her to ‘express complicated thoughts and emotions’ that ‘lie below the surface’, which are ‘impossible to communicate verbally’. At the same time, she seeks to be non-prescriptive: ‘I love how everyone came up with a different approach [to the piece]’. It is the ‘completely subjective’ nature of art, absence of ‘concrete rules, methods or regulations’, that opens up a space of ‘freedom’ for Aston.

Beyond art therapy, inspiration porn and ‘public engagement’?

There *are* rules and regulations in art – but of course. Like those in psychiatry – and any other facet of human endeavour – these rules and regulations are above and below the surface, written and unwritten. Fortunately, like they are elsewhere too, and especially given the year of reckoning that was 2020 (with the COVID-19 pandemic exposing endemic structural inequalities), these rules and regulations are not stagnant. Instead, they are evolving, questioned and get rewritten, as we learn, unlearn and grow, as individuals and with others, within and across disciplines, communities, societies, cultures, species and so on.

More than 170 years have passed since the *BJPsych* dropped ‘Asylum’ from its title. Fewer years have passed since it introduced artworks for its covers. Still, a lot has happened in the practice and discourse around the messy – and magical – entanglements of art and mind.

Tropes such as the ‘hysterical female’ – unsurprisingly, anorexia nervosa was previously known as ‘anorexia hysterica’ among other terms¹ – and ‘mad artist’ have been popularised, then troubled. Once mocked and ostracised – as reflected in its name – ‘outsider’ art is now the *lingua franca* alongside double kisses of arts royalty (Grayson Perry is but one prominent example), institutionalised (with Headway East London, a charity for people with brain injury, shown at London’s Barbican, and Project Art Works, a collective of neurodiverse artists, nominated for the 2021 Turner Prize).

Gone were the days when the only kids on the block were ‘art therapy’ and ‘artistic expression by patients’ and the often-associated charitable, curative and voyeuristic aspects reminiscent of freak shows of world expos and circuses of the old world (the late Stella Young’s Ted Talk on ‘inspiration porn’ is a good start for the curious on the objectification of alterity⁴). Instead, we can now turn to burgeoning discourses and practice in inter- and transdisciplinary fields, especially following the All Party Parliamentary Group on Arts, Health and Wellbeing report proposing ‘creative health’.⁵ They include: visual medical humanities⁶ and medical humanities,⁷ disability arts (such as the extensive multidisciplinary artistic practices of The Vacuum Cleaner⁸ and Dolly Sen⁹). There is also the blockbuster that is ‘arts in health’ (led by Daisy Fancourt, as reflected in her extraordinary ascent¹⁰) and critics pointing out its fatal flaws and blind spots (read the review by Stephen Clift, Emeritus Professor for the Sidney De Haan Research Centre for Arts and Health¹¹ and arts and activism veteran Frances Williams’s sharp comparative analysis across Greater Manchester and North Wales¹²).

To bring in perspectives that lie beneath, between and behind the surface, new generations of psychiatrists are increasingly emboldened to ‘out’ their own stories about their mental illnesses and to advocate new, bold ways of doing psychiatry using art (such as in PsychArt¹³). Those with hybrid backgrounds are also finding ways to converge ideas across boundaries (such as artist-psychotherapist Patricia Townsend’s study¹⁴ of the creative process through psychoanalysis and psychiatry-trained philosopher Mohammed Abouelleil Rashed on mad activism, anti-psychiatry and *avant garde* cinema¹⁵).

Arguments are being made for the need to use art to make attention-deficit hyperactivity disorder (ADHD) and other processes ‘more visible, that is, more seen, more heard, more talked about, not avoided, not dismissed, not spoken about in hushed tones, not just a specialist subject discussed by experts, and not only spoken ill of, because there is always more than one side to any story’.¹⁶ So too are proposals to foreground quality, ‘lofty’ art to build cultural intelligence and fuel quality conversations.¹⁷ Artists are increasingly infiltrating mental health research groups and professional bodies (such as the UK Adult ADHD Network¹⁸). Artists are also using artistic and creative research to engage in critical discourse with psychiatry on the cultural and medical constructs and pursuits of ‘normativity’,¹⁹ and not just as vehicles of communication or public engagement to make ‘serious’ research accessible.

Terms have been reclaimed (such as ‘sick’, for Sick! and Sick of the Fringe festivals). Others have been given new breaths of life, key of which is ‘neurodiversity’, which will be significant and exciting moving forward. First proposed by Australian sociologist Judy Singer in the 1990s,²⁰ the term has, over the years, been contested, protected, discussed, fought over and championed (including by researchers of autism²¹). The term is gaining attention as it is increasingly co-opted and objectified by the global elite as a ‘next business advantage’ and more.^{22–25} Fortunately – and as testament to the inclusive nature of the term – yet other counter-narratives are surfacing. These include the alignment of ‘neurodiversity’ with ‘biodiversity’.^{26,27} There are also countless new narratives and new creative research methods (such as ‘dyspraxic dysco’ and ‘neurodivergent leadership’) by some 300 researchers and artists worldwide who themselves have ‘non-standard’ cognitive modes, in the Neurodiversity In/And Creative Research Network (of which Singer and several psychiatrists such as ADHD expert Philip Asherson are also members).²⁸ With openly neurodivergent artists increasingly sharing their visions for social change,^{29,30} it is no wonder that those who had studied neurodevelopmental processes as medical deficits are increasingly interested in engaging in the positive aspects.^{31,32} In a recent keynote presentation, a well-respected leading clinical psychologist in ADHD even coaxed his audience of nearly 900 mental health researchers and professionals to no longer ignore but actively engage in the discourse on neurodiversity.³³

Cultural and academic institutions – historically conservative and slow-moving – are starting to catch up with some of these developments too. Collections (such as Wellcome and Thackery) are being updated with ‘woke’, more inclusive and decolonised frameworks, and are foregrounding voices previously deemed to be without agency. Increasingly, there are arts programmes in medical settings (such as in University College London Hospital), arts in health enterprises (such as Aesop) and galleries (such as artist-led Bethlem Gallery, which supports and exhibits artists who are current or former patients of the South London and Maudsley NHS Foundation Trust³⁴). Universities are training the next generations of ‘boundary spanners’, through new interdisciplinary arts–(mental) health programmes (such as at King’s

College London, Queen Mary University of London, Birkbeck and St George's University of London; artist Deborah Padfield's health humanities programme at St George's, for instance, was developed from her award-winning doctoral and post-doctoral interventions in the clinical space³⁵).

Widening the conversation and extending the possibilities

We are at an exciting juncture of multiplicity, fluidity and new possibilities with regard to culture, art and psychiatry. *BJPsych Bulletin's* entry into the conversation with a new culture section² is belated. This will be critical, particularly amid a volatile world in a period of multiple crises, and amid a projected upsurge in mental illnesses globally as an aftermath of the COVID-19 pandemic.^{36,37} There aren't any magic bullets – not even art¹⁷ or psychiatry! – for our challenges, which aren't described as 'wicked' for no reason. Works of art that have continued to intrigue are not those that provide or claim to provide answers, but those that problematise, interrogate and provoke.³⁸ Submissions like Aston's can thus open up spaces for reflection, connection and constructive collision to challenge and extend the state of psychiatry, management of psychiatric services, and education and training in mental healthcare. This can advance how we think about and relate to other bodies and minds around us, as well as advance how we understand how knowledge can be created.

Kai Syng Tan, PhD, FRSA, SFHEA, is a hyperactive award-winning artist, curator, academic and consultant. She is founder and co-chair of the Global Neurodiversity in/and Creative Research Network.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in its writing.

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Declaration of interest

None.

1.2.94 Religion and mental health: a narrative review with a focus on Muslims in English-speaking countries

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Abstract

Numerous commentators have noted a historic ambivalence between religion and psychiatry. However, a growing body of evidence indicates an association between mental health and various religious activities, both private and public. As such, there are growing calls for greater religious sensitivity among mental health clinicians, to help unlock the potentially healing aspects of religiosity. So far, most literature from English-speaking countries has focused on Christianity and mental health, with little attention paid to Muslim mental health. This is the fastest growing religion in English-speaking countries, and the mental health of Muslims in these countries is under-researched. As such, the present paper summarises new directions in the mental health and religion literature, with a focus on the mental health of Muslims in English-speaking countries.

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 - *Integrating religion into clinical care*
 - *Conclusion*
 - *Declaration of interest*

pmc Numerous commentators have noted a historic ambivalence between religion and psychiatry.^{1–4} This can be traced back to the writings of formative figures in the early decades of psychiatry; for example, Freud argued that religion was a delusional infantilism that could be disabused through therapy.⁵ Other magisterial figures such as Ellis and Skinner also considered some aspects of religion to be antithetical to positive mental health.^{6,7}

More recent studies indicate that this ambivalence continues to the present day. For example, one study found low levels of religiosity among psychiatrists compared with other physicians,⁸ while another study found a lack of integration of religious variables into psychiatric research.⁹ This may signify a continued uneasiness within psychiatry about incorporating aspects of religion into psychiatric research and practice.

Religion and mental health

That said, a growing body of research suggests a positive association between mental health and religious activities, known in the social sciences as ‘religiosity’.¹⁰ This literature indicates that religiosity is positively associated with prevention and recovery.^{1,11} For example, a large corpus of research indicates that religiosity is moderately associated with greater well-being, lower rates of depression and anxiety, and lower rates of suicide.^{12–14} Similarly, other studies suggest that both public and private religiosity is associated with recovery from a range of mental illnesses, including depression, schizophrenia and substance use disorder.^{15–17} Of note, many of the studies examining religiosity and mental health are cross-sectional, meaning that reverse causation is possible. However, the consistency of the findings has led researchers to further investigate religiosity to examine specific factors that may be associated with mental health.

Public and private religiosity

Some scholars divide religious practice into private (interiorised) or public (exteriorised) religiosity.^{12,13} Private religiosity refers to factors occurring alone or in the family home, for example, reading scripture or private prayer. Public religiosity refers to communal religious activities such as attending a place of worship or group study of a sacred text. Some religious activities are transversal across both those domains. For example, adherence to a moral code or a deep religious faith could manifest in both public and private domains.

Research indicates that these aspects of religiosity are associated with better mental health. For example, some anthropological literature indicates that participation in rituals can influence mental health through release of positive emotions.¹⁸ Moreover, public religiosity provides a community of believers, which can reduce loneliness and bring beneficial social support.¹² Private religiosity can help solidify family cohesion and provide ontological security during difficult life situations and transitions.¹⁷ All this can provide a sense of meaning and purpose, as well as a hopeful yet realistic view of life, which can be an ongoing resource for resilience, recovery and positive mental health.^{19,20}

Negative aspects of religiosity

In acknowledging these positive aspects of religiosity, it is important to consider other research indicating the potential harmful aspects of religiosity. For example, some research indicates that religiosity can lead to excessive feelings of guilt, fear, shame and death anxiety.^{21,22} Similarly, high levels of religiosity may lead some people to consult religious leaders in lieu of seeking help from a mental health professional in the presence of mental distress.²³

Some religious leaders may encourage such consultation, believing themselves to be better placed than clinicians in the process of ‘diagnosing’ distress and facilitating mental healing. For example, some faith leaders may impute mental illness to a spiritual weakness or insufficient religiosity. Likewise, mental illnesses may be attributed by these leaders to supernatural forces such as the ‘evil eye’ or ‘spirit possession’. This can lead to religiously inspired actions such as exorcism and the discouragement of mental health service utilisation.^{23,24} Research on Muslim chaplains in the USA, for instance, found a low rate of referral of congregants to mental health professionals among chaplains.^{25–28} This indicates the need for increased understanding in order to build better bridges between Muslims and mental health services. The next section thus focuses on Islam, Muslims and mental health.

Islam and mental health

As English-speaking countries become more diverse, with increasing proportions of the population following non-Christian faiths, the relationship between mental health and religion becomes more complex. Most notably, the Muslim population of many English-speaking countries is rising, with Muslims now making up 3.2% of Canada’s population,²⁹ compared with 5% in the UK.³⁰ According to the Pew Research Center, there were about 3.5 million Muslims living in the USA in 2017, making up around 1% of the population. By 2040, Muslims will replace Jews as the second largest religious group in the USA.³¹

There may be a differential effect on mental health according to religious affiliation, belief and practice; however, this has been understudied. For example, religions have many commonalities but also many differences.³² These differences manifest themselves in a variety of ways, including notions of morality, theodicy and supernatural intervention.

These differences may have a direct influence on seeking professional mental healthcare, for instance, by channelling people towards religious solutions to the exclusion of seeking psychiatric help. One broad difference between religions relates to the notion of spirit possession.³³ Possession refers to the belief that an individual has been entered by an alien spirit that controls or alters their actions, manifesting as an altered state of consciousness.³³ It is often found among Muslims but less so among Jews or Christians in English-speaking countries. Possession is frequently used as an explanatory model in some religious communities and among religious individuals to interpret illnesses such as epilepsy, panic and depression.^{33,34}

In Islam, supernatural beings that can take possession of humans are known as jinn, who are conceived as a race of intelligent beings that possess rational faculties. They marry, reproduce and die. According to Islamic doctrine, unlike humans, they have extraordinary powers. They can take different shapes, such as birds, animals and humans, and can move instantly from one place to another.³⁵ Jinn are discussed in Islam’s scripture, the Qur’an, as well as in the hadith literature.

Although the majority of Muslims believe in the presence of jinn, there is heterogeneity of belief regarding how much they can influence the human world.³⁵ Conducting ethnographic interviews with East London Bangladeshis, one study found that the community was split into two main groups. The older generation believed in the power of jinn and often attributed sickness to jinn, whereas the younger second- and third-generation Bangladeshis considered their parents’ beliefs to be superstitious and ‘non-Islamic’. Despite the younger generation’s sceptical comments about the older members of their community, almost all informants cited instances related to jinn’s malevolent power.³⁵

The aforementioned study of Bangladeshi Muslims in East London^{35,36} also indicated that some sufferers of ‘jinn’ and their families are likely to seek help from their religious leaders rather than mental health clinicians, even though the latter may be better placed to diagnose and treat any underlying mental health issues. This could be because people commonly perceive religious solutions as the answer to what they perceive to be religious problems.¹⁷ As such, Littlewood advises psychiatrists to be sensitive to such cultural beliefs by not contradicting any statements made by the patient and their family about jinn or spirit possession.³³ Instead, he recommends involving ‘culture brokers’ such

as an imam from the culture in question to provide contextual information on local beliefs and practices. This could positively affect the therapeutic alliance when authorised by the patient.¹⁵

It is important to recognise that broad religious traditions such as Islam contain much internal heterogeneity. Anthropologists have tried to capture this heterogeneity by devising the concepts of Great and Little Tradition. The Great Tradition in Islam is the textual, intellectual tradition of the towns, whereas the Little Tradition is the traditional, ritualistic religion of the countryside.³⁷ Beliefs in exorcism and jinn tend to be more prevalent within the Little Tradition.³⁸ Importantly, both these traditions may exist among immigrant and minority communities in English-speaking countries.

This example of belief in Jinn indicates how religious variables can influence explanatory models and mental health service utilisation. These religious beliefs and explanatory models often traverse time and geography. This brings us to the second part of this paper, which examines practices that can integrate religious variables into clinical care.

Integrating religion into clinical care

Clinicians can harness helpful aspects of religiosity to foster recovery in patients where appropriate. Moreover, clinicians and clergy can collaborate in the holistic care of patients. However, many clinicians are understandably wary of engaging in such activities, perhaps owing to the aforesaid complexities, as well as unfamiliarity with the diversity of religious experience.³⁹

Existing examples of positive collaboration tend to stem from cooperation between clinicians and Christian clergy. This is not necessarily because of anything inherently conducive to this form of cooperation within Christian theology or praxis; it may simply be due to strength of numbers in English-speaking countries. One example of clergy–clinician collaboration is Hope Haven, a private agency in Iowa that has been providing psychosocial rehabilitation services for many years.¹¹ The agency combines spirituality with mental health services in various ways. For example, the Religious Services department at Hope Haven seeks to engage area churches in welcoming and including people with psychiatric disabilities into the life of the church.⁴⁰ The agency offers daily devotions for patients, as well as spiritual support and prayer for those going through difficult situations. In a similar vein, Muslims in the USA and UK have established small-scale centres of psychotherapy such as the Khalil Centre and Ihsan Centre, where Islamic spirituality is integrated into care.⁴¹ However, such initiatives remain isolated examples.

This raises the question of what can be done to better equip everyday clinicians in routine practice to deal with religious patients and religious issues, especially those from minority faiths such as Islam. Some researchers have speculated whether mental health practitioners should receive training in the spiritual and religious beliefs of major religions so that they can better distinguish religious beliefs from psychopathology.^{42,43} This may be impractical, given the heterogeneity and diversity within and between religions previously described.

An alternative approach is the adoption of a set of attitudes and processes that facilitate the integration of spirituality and religion into clinical care. This could involve working with ‘culture brokers’ such as chaplains or community-based key informants in the treatment of religious patients, depending on the spiritual profile and wishes of the patient in question. This is the approach taken by the Cultural Consultation Service in Montreal, which has a bank of culture brokers that can be accessed by clinicians facing complex religious issues in the treatment of patients.⁴⁴ These culture brokers can offer perspectives and interpretations based on their locally grounded community experience, which may be especially effective if the culture broker is recommended by the patient and involved in their follow-up care. This approach can be a useful adjunct to standard clinical care; however, the provision and training of culture brokers can be a difficult task, meaning that more practical approaches are often necessary.

Instead of relying on abstract nomothetic knowledge or the intervention of third parties, a more practical approach may involve clinicians making conscious efforts to gain an idiographic understanding of the patient’s religious worldview during the clinical consultation. Importantly, researchers have developed a number of simple and generic tools and procedures that clinicians can use to elicit information about patient religiosity (or lack thereof), sometimes known as a ‘spiritual assessment’. These tools can be used by psychiatrists in clinical settings to enhance understandings and decision-making, and can be applied to Muslims as well as others.

This includes the Outline for Cultural Formulation and the Cultural Formulation Interview (CFI) contained in the DSM-5.⁴⁵ Supplementary modules to the core CFI include the ‘Spirituality, Religion, and Moral Traditions’ module, which provides 16 useful questions for the deep and meaningful probing of religious issues where appropriate.⁴⁶

Another of these well-known tools is known as the Faith, Importance, Community, and Address (FICA) instrument.⁴⁷ The FICA inquires into the following four domains: (a) *Faith and belief*, ‘Do you have spiritual beliefs that help you cope with stress?’; (b) *Importance*, ‘What role do your beliefs have in regaining health?’; (c) *Community*, ‘Are you part of a religious or spiritual community? If so, is this of support to you and how?’; and (d) *Address in care*, ‘How would you like me as your healthcare provider to address these issues in care?’.

Importantly, the short and neutrally posed questions allow atheists and non-religious people to quickly express a lack of interest in these issues and move onto other topics. Of note, there has been little research on the use and effectiveness of such tools and instruments among Muslim patients. This is an important area for future research.

Interestingly, some researchers have proposed specific procedures for clinicians working with Muslim patients. Abu Raiya and Pargament⁴⁸ proposed a series of recommendations including: (a) asking about the place of religion in patients’ lives; (b) educating themselves about basic Islamic beliefs and practices; (c) helping patients draw on Islamic religious coping methods; (d) referring to a clergy member if appropriate; and (e) participating in educating Muslims about mental health. These recommendations overlap with the above-described generic advice for clinicians dealing with religious patients and could be a useful tool for working with Muslim patients.

All these tools have the potential to foster what has been termed ‘existential recovery’, defined as ‘having a sense of hope, empowerment, agency, and spiritual well-being’.⁴⁹ For example, clinicians may refer an isolated patient of faith to a sympathetic chaplain for spiritual and social support, who may in turn link the patient to a community of believers. However, such actions must be tailored to individual need and preferences, and may be more difficult for patients who are members of minority faiths such as Islam, where access to Muslim chaplains is more limited.

Indeed, research shows that Muslim chaplains are underutilised in English-speaking countries such as the USA.^{25–27} In Britain, one study of the provision of spiritual and pastoral care facilities in a high-security hospital revealed that demand for pastoral care could be significantly higher among Muslim patients compared to Christian patients. With one Muslim chaplain employed part-time, the authors argued that the allocation of chaplaincy resources should be re-examined in light of the multi-faith nature of modern Britain.⁵⁰ This is an area in need of further discussion and research.

In addition, clergy–clinician collaboration could be better attained by giving mental health training to clergy and other religious leaders. In fact, there are now a number of pastoral counselling programmes training clergy and others to help people with mental health issues, using evidence-based psychotherapies nested within a religious framework. Such programmes can be found at prestigious US universities including New York University and Northwestern University. Again, such initiatives have predominantly involved Christian clergy; training of Muslim religious leaders is lacking.²⁷ Likewise, counselling courses are offered to the clergy by the Association of Christian Counsellors in the UK, among others, but not for Muslim clergy *per se*.

Despite these efforts, there is a need for further research and action in this regard. For example, a study of British clergy representing Christianity, Judaism and Islam revealed that most members of the clergy had received little or no training in mental health as part of their ministry training.⁴ The clergy members interviewed seldom differentiated between psychotic illness and common mental disorders such as depression and anxiety. Some members of the clergy interpreted unusual or disturbing behaviour as a religious problem provoked by a curse, witchcraft or spirit possession. In these cases, prayers and exorcism were considered an appropriate response.⁵¹

It is unlikely that mental health training for the clergy will cause these religious interpretations to disappear, because people may draw upon more than one explanatory model at a time to explain distress. However, training may give a more holistic understanding, and research indicates that people often hold coexisting religious and psychiatric explanatory models of mental illness, which can lead them to use various modalities of healing in cases of mental distress.^{17,52}

Indeed, it is important to communicate to clinicians and clergy that religious and psychiatric intervention is not an ‘either-or’ scenario; both deployed simultaneously could produce effective results. For example, anthropological research indicates that certain rituals such as prayer may be beneficial to the healing and recovery of some individuals.¹⁸ Thus, it is not advisable to reject such practices out of hand without learning about the preferences and worldviews of individual patients. This is where ‘spiritual assessment’ tools can be useful, even necessary.

Conclusion

There is growing evidence that the influence of religion on mental health is largely positive. This research supersedes outdated notions perpetuated by figures such as Freud about the negative effects of religion on mental health. Moreover, this growing evidence gives impetus to new models of cooperation between religious leaders and mental health professionals.

In an ideal world, this would involve a bidirectional system of cooperation and education. On the one hand, clergy could receive basic training and education in mental health. This could improve understanding of mental illness and increase referrals from clergy to mental health professionals. Similarly, educational and public outreach campaigns could be targeted at religious and minority communities, with cooperation and participation from the communities themselves. On the other hand, there is still a need for better education of mental health professionals in religious matters. This includes training in areas such as taking a spiritual history and working with culture brokers and community religious leaders. Such training could be co-delivered by clinical experts and religious leaders.

At the policy level, administrators may reconsider their chaplaincy resource allocation to ensure that minority faiths, whose adherents tend to have greater religious counselling needs, are proportionately resourced. Importantly, new action and research that responds to the growing religious diversity of English-speaking societies is necessary, with particular focus on the growing and heterogeneous Muslim community to ensure that policy and practice are based on evidence rather than stereotypes. This could ultimately lead to more supportive and tailored treatment options that harness, rather than ignore, patient religiosity and spirituality, thereby promoting a holistic recovery in religious patients.

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Declaration of interest

None.

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1.2.95 Psychiatrists should investigate their patients less

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date

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Abstract

Psychiatrists often order investigations such as blood tests, neuroimaging and electroencephalograms for their patients. Rationales include ruling out ‘organic’ causes of psychiatric presentations, providing baseline parameters before starting psychotropic medications, and screening for general cardiometabolic health. Hospital protocols often recommend an extensive panel of blood tests on admission to a psychiatric ward. In this *Against the Stream* article, we argue that many of these investigations are at best useless and at worst harmful: the yield of positive findings that change clinical management is extremely low; special investigations are a poor substitute for a targeted history and examination; and incidental findings may cause anxiety and further unwarranted investigation. Cognitive and cultural reasons why over-investigation continues are discussed. We conclude by encouraging a more targeted approach guided by a thorough bedside clinical assessment.

Contents

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pmc The Royal College of Psychiatrists’ *Standards for Inpatient Mental Health Services* require a ‘comprehensive physical review’ to be initiated within four hours of admission to a psychiatric inpatient unit, which is to be completed within one week.¹ In practice, this means that inpatients are often subjected to a battery of admission blood tests that are directed without regard for the presentation. Routine blood tests on admission remain a requirement in local trust policies,² and clinical evaluations indicate that the majority of patients receive them.³ In addition, selected psychiatric patients may have further investigations, such as a magnetic resonance imaging (MRI) of the brain for those with a first psychotic episode, or an electroencephalogram (EEG) to rule out seizures.

In this article, we consider some of the reasons why investigations might be requested by psychiatrists and why they are often inappropriate, and suggest an alternative approach.

The case for investigating

There are several (non-exhaustive) reasons why investigations might be requested for psychiatric patients: to screen for contributing physical factors in the acute presentation, including concern that rare but serious causes are not missed to provide baseline levels that may be relevant when starting particular psychotropic medication to screen for a range of chronic physical illnesses that might otherwise be missed because psychiatric patients may not present as often to healthcare professionals or are treated differently when they do to screen for health problems that are more common in those with severe mental illness, such as diabetes and liver disease.

Here, a distinction should be made between screening tests and diagnostic tests. Screening tests are those performed at population or subpopulation level to detect presymptomatic disease with the aim of early intervention. An example of this may be routine prediabetes screening in a patient on chronic antipsychotic treatment. Screening tests have been used in medicine since the middle of the 20th century (an early example being the successful screening and treatment of

syphilis) and have undoubtedly improved diagnosis rates for medical and psychiatric patients.⁴ Despite this, there are a number of strict criteria that a screening test must meet before it is acceptable for use, including prior implementation of cost-effective primary prevention, a validated test, agreement on further investigation, good evidence for intervention at the presymptomatic phase, and evidence that benefits outweigh harms.⁵

Screening tests are distinct from diagnostic tests, which aim to accurately diagnose a condition for which there is clinical suspicion. An example of this may be positive antineuronal antibodies in the cerebrospinal fluid of a patient with clinically suspected autoimmune psychosis.

Although there are undoubtedly many cases where screening and diagnostic tests are entirely justified, we believe that investigations are often inappropriate because they have a low yield, poor sensitivity and specificity, limited interpretability without clinical correlation, and the potential to cause serious harm.

The case for not investigating

Tests may miss what they are looking for or not alter management

For an investigation to be useful, it should have high sensitivity (the ability to correctly identify patients with a given disease) and specificity (the ability to correctly identify patients without said disease). Distinct but related clinically useful concepts are those of positive predictive value (the probability that someone with a positive test has the disease) and negative predictive value (the probability that someone with a negative test does not have the disease). It is of note that even when tests do have high reported sensitivity and specificity, there may be additional complexities in real-world settings. This is in part because when developing tests, figures of diagnostic accuracy are calculated in a specific context, which is often obviously symptomatic individuals compared with obviously healthy controls.

Many diagnostic investigations used by psychiatrists fail to meet these criteria, and many have such a low probability of a clinically relevant result that it is hard to justify their routine clinical use. Systematic reviews have found that routine blood tests rarely alter the management of patients due for admission to psychiatric hospital, even when abnormal results are found.^{6,7} In one of the included studies of 500 patients, only one individual had an abnormal result that mandated urgent medical intervention. Notably, this patient was obviously symptomatic.⁸

Imaging and physiological investigations may not fare better. EEGs show interictal epileptiform discharges (IEDs) in only 29–55% of people with epilepsy,⁹ so it is inappropriate as a rule-out test for complex partial seizures presenting with psychotic symptoms. In contrast, EEG abnormalities (broader than just IEDs) occur in 19% of those treated with antipsychotics, so an abnormal EEG is not specific to a neurological cause of psychiatric symptoms.¹⁰ Similarly, one study found that 6% of healthy controls have at least one abnormality on an MRI of the brain, so the presence of an abnormality *per se* has a poor specificity for determining a neurological cause for psychiatric symptoms. This same research also concluded that none of 349 individuals with first-episode psychosis had MRI findings that necessitated a change in clinical management.¹¹

Investigations are no substitute for history taking and physical examination

Psychiatric patients invariably present in complex and myriad ways. In a minority, there is a recognisable physical cause for the psychiatric symptoms. For a physical illness to lead to psychiatric symptoms, there must either be a pathophysiological process (e.g. neoplastic, endocrine, autoimmune, metabolic, epileptiform, infective, neurodegenerative or metabolic) that is affecting the central nervous system and/or psychosocial mechanisms resulting from the physical illness. In each of these cases, it is very unlikely that a patient would present as entirely physically asymptomatic to an appropriately curious and observant clinician.

To put it another way, we might be surprised to see such physical illnesses presenting ‘occultly’, in the sense that a case would be missed after a thorough history and examination but picked up on a routine blood test or other untargeted investigation. Where psychosocial mechanisms predominate, these generally occur via experience of symptoms or via knowledge of a diagnosis, both of which can be elicited through an appropriate history or examination. In the specific

case of functional disorders (such as functional neurological disorders), these are diagnosed through eliciting positive clinical signs, rather than being ‘diagnoses of exclusion’ which require investigation to exclude other causes.¹²

Even for tests with extraordinarily high sensitivity and specificity, there are further interpretative difficulties that arise in the absence of clinical suspicion. If a condition is very rare, then an abnormal investigation result may not be as diagnostic as is intuitively suspected. This is known as the ‘false-positive paradox’, or the ‘base rate paradox’, and occurs when the prevalence of a condition is lower than the test’s false-positive rate (in these cases, the test will give more false positives than true positives). Crucially, the calculation is entirely different in populations who are already suspected to have the disease based on history and examination. In these cases, the pre-test probability (and thus the post-test probability after a positive test) would be much higher, and a resulting abnormal test much more clinically useful.

Take hypothetical blood test A which has a specificity of 99% for condition X. If condition X has a population prevalence of 1% and there are no additional features to increase the clinical suspicion of the condition (e.g. the patient has not been examined), we can assume the pre-test probability is 1%. In this case, an abnormal result from blood test A translates to a chance of having the condition (i.e. post-test probability) of only 50%. Most physicians, including us authors, would probably overestimate the post-test probability following a positive result on blood test A.

Investigations can be harmful

Investigations often have attendant risks, which are seldom adequately considered. In some circumstances, taking blood can be painful or uncomfortable (particularly in a distressed, paranoid or disoriented patient), risking injury for patient and clinician. The noise and enclosed environment of an MRI scanner can be frightening for an anxious patient. Over-investigation may also contribute to the development or perpetuation of health anxiety, as it can serve to confirm a patient’s fears about a serious undiagnosed illness.¹³ This may be particularly pertinent for individuals with somatoform or hypochondriacal disorders, who psychiatrists may encounter more often than might clinicians in other specialties.

A further important consideration is the impact of false positives. When tests are ordered in the absence of a clinical suspicion or hypothesis, a positive result inevitably returns the question: what next? In many cases, this might be further investigation, leading to a non-negligible potential of harm. Take the case of creatine kinase (CK), which is sometimes recommended as an admission blood test for psychiatric in-patients,² despite being incidentally and benignly raised in many patients, and even being a poor discriminator for neuroleptic malignant syndrome.¹⁴ When faced with a raised CK in an asymptomatic patient, most of us feel that we should do something, so patients are frequently subjected to further blood tests and sometimes intravenous fluids for a test that should never have been done. More dramatically, if ten people are treated with endovascular coiling for an incidental unruptured intracranial aneurysm detected on MRI, one will end up disabled or dead within one year, all for a lesion that probably would not have caused any harm.¹⁵

Readers may be familiar with ‘incidentalomas’, an all-encompassing term for non-specific lesions seen on medical imaging. Incidentalomas have dubious clinical relevance, but often prompt further investigations and cause anxiety to patients and professionals alike. Relatedly, the phenomenon of non-specific abnormal results also occurs with blood tests. One study of healthy adults receiving a routine battery of blood tests found that over one-third had at least one abnormal result, of which only 7% were deemed to require a medical review (none of them urgently).¹⁶

Finally, in the context of limited healthcare funding, expensive investigations divert resources from more worthwhile causes. Discounting the cost of staff time, a simple routine battery of blood tests is likely to cost in the region of £15–20.¹⁷ The number of psychiatric admissions needed to screen to find a positive serum free thyroxine (FT4) is in the region of 127, which corresponds to a cost of around £400 per abnormal result.¹⁸ MRI brain scans cost in the region of £200. Cost-wise, there is likely more benefit from a five minute clinical history and examination.

Cultural and psychological factors

Psychiatry is a medical discipline and there are, without any doubt, physical causes of psychiatric presentations. In addition, patients with severe mental illness are far more likely to die early, in part owing to huge over-representation of physical comorbidities such as cardiovascular disease. Psychiatrists should be attuned to physical health problems in in-patients as much as mental health problems, and we should feel confident in routinely performing thorough physical health histories and examinations.

The historical and ongoing divide between mental and physical healthcare is also likely to be a factor in over-investigation of psychiatric patients. Psychiatrists do not always have easy access to opinions from other specialties, and it is unusual for a physician to be integrated into psychiatric services. Psychiatrists may utilise unnecessary investigations when they are worried about patients, instead of being able to access a clinical opinion from specialist physicians. If physical and mental health services were better integrated, this could be avoided.

However, the overuse of investigations is a common theme in much of medicine and often functions more as a ‘psychological comfort blanket for clinicians’ rather than providing any tangible benefit to our patients.¹⁹ It may also stem from ‘addition bias’, the human tendency to try to solve challenging problems by adding something in rather than taking something away.²⁰ Ordering an investigation may make us feel as though we have addressed the problem we were trying to solve, when in fact we might not have. For instance, if the problem is poor physical health outcomes in people with severe mental illness, admission blood tests are unlikely to be an answer. Focusing on this superficial attempt at joined-up healthcare perhaps distracts from other solutions, such as addressing stigma and reducing inequalities.

Furthermore, the familiar feeling that we must ‘do something rather than nothing’ may stem from a human tendency towards action, which is also known as intervention bias.²¹ Of course, as we have seen, there are scenarios where doing nothing is just as good, or even better, than doing something. The Hippocratic oath reminds us that our primary role as doctors is to first do no harm.

Overuse of investigations in psychiatry may also represent part of a wider risk-averse culture in medicine, which is sometimes referred to as ‘defensive medicine’. Defensive medicine is costly to healthcare institutions.²² Many doctors, including ourselves and three-quarters of all psychiatrists, admit to defensive medicine to some degree, including the ordering of clinically useless investigations.²³ The reasons why clinicians may practise defensive medicine are myriad; however, the most commonly cited reason is fear of litigation resulting from malpractice hearings, particularly as the majority of cases of litigation stem from doctors missing diagnoses, rather than actively causing harm through the use of treatments.²² There are some (albeit incomplete) data that some aspects of defensive medicine may stem from physicians struggling to tolerate uncertainty in patient diagnosis and care.²⁴

Concluding remarks

We suggest six points to keep in mind when considering an investigation for our patients.

Limitations of tests: Have we examined the patient and taken a history? Without a thorough examination, performing an investigation may not provide any useful information. Is the disease common enough that this test will be useful? If the disease or condition is rare, there is a high probability of false positives. How would we need to act if the test were to return an abnormal result? Additional interventions or investigations that may result could be harmful.

Limitations of human psychology: Am I doing this test to resolve my own anxieties, or will it benefit the patient? Sometimes doing nothing rather than something is in the patient’s best interests. Can I tolerate the uncertainty of not knowing? Reaching after false certainty is not in anyone’s interest. Is there any chance the test or the results could lead to negative outcomes for the patient? First, do no harm.

We support attempts to integrate the body into mental health and illness. We believe that a good means of helping to achieve this is to ensure that we conduct thorough histories and examinations. This allows us both to request the appropriate investigations and to know how to interpret them once we have the results. This approach is supported by the American Psychiatric Association, which discourages routine laboratory testing,²⁵ and by the National Institute for Health and Care Excellence (NICE), which does not recommend neuroimaging in first-episode psychosis.²⁶ However, too often doctors are still faced with incidental findings on tests that should never have been requested. Psychiatrists should investigate their patients less and examine them more.

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Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

M.B., F.S. and J.R. co-conceptualised the paper. M.B. wrote the first draft, amended subsequent drafts and reviewed the final submission. F.S. and J.R. reviewed and amended subsequent drafts, and reviewed final submission. B.S. reviewed and amended drafts and reviewed the final submission.

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1.3 2020

1.3.1 Anouchka Grose: Apocalypse now

Claire Mckenna¹

¹

Claire Mckenna talks to psychoanalyst Anouchka Grose about the twin terrors of eco-anxiety and Coronavirus panic.

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The apocalypse is trending. Climate catastrophe looms, end-times movie scenes spool out in real life all around us, and like a portent of our worst fears the COVID-19 pandemic is now upon us. As the scions of Big Bog Roll count their lucre, I've one pressing question for psychoanalyst Anouchka Grose – why toilet paper?! 'It's like the last thing between us and barbarism' she laughs, 'once that's gone and you have to touch your own shit, it's like the whole of culture's collapsed then'!

Grose is refreshingly unguarded and swears liberally (a sign of her honesty and intelligence I think, as well as her Antipodean roots). She came to London from Sydney in the 1970s, aged 2, to live in 'an Australian ghetto' as she puts it. Her new book, *A Guide to Eco-Anxiety: How to Protect the Planet and Your Mental Health*, is to be published in May 2020, and she does worry a bit about how her irreverent tone will be received.¹ It has tongue-in-cheek chapter titles like 'Anxiety: freaking the fuck out' and 'Pleasure yourself: you know you want to'. She wrote it like that partly so the act of writing wasn't unbearable, 'There's the question of how do you talk about something that's intolerable? And the climate thing *is* intolerable'. I think she's struck the balance in tone, which mitigates the nagging sense of fear.

Grose describes herself as a Lacanian psychoanalyst, who also lectures on Freud. She writes novels, non-fiction books, and journalism. Her new book originated from a piece she wrote in *The Guardian* in 2019, on the ecological crisis making Greenlanders depressed. However, she has long been an eco-warrior. She's been *mostly* vegetarian since 1985 and is a supporter of XR (Extinction Rebellion), the environmental movement that encourages 'non-violent civil disobedience'.

The movie *Apocalypse Now* is based on the novel *Heart of Darkness*, Joseph Conrad's racist fever dream. His tale of rapacious Belgian colonialism in the Congo seems a fitting allegory for Grose's left-leaning world view. Like many, she links our rapacious consumerist culture both to the climate and COVID-19 crises, 'Everyone seems as if they've seen behind the scenes of capitalism suddenly, like this window's open and you can see that it's just a stage'.

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Thoughts on humans and other animals

The parallels between climate-change anxiety and that related to COVID-19 have triggered a glut of hot-takes. I discuss with Grose that these crises induce an existential kind of dread. In the language we use about them, we hear the echo of primitive fears. Take the phrase ‘herd immunity’, for example. Grose says, ‘The word [herd] was shocking because it was dehumanizing. I mean, the idea that we’re just a herd and some of us will be lost and that’s fine. Like watching a nature documentary’.

In the language of scientists, however, she thinks there is a disconnect between their cautious approach and epoch-ending events like the climate crisis. She’d like them to be a little *more* alarmist, ‘I suppose they’re trained not to, because of the idea of the impartiality of science, but it turns out that science is political’.

She lauds the approach of people like Professor Jem Bendell, a sustainability academic. His viral essay² on climate-induced societal collapse didn’t pull any punches. He writes, ‘With the power down, soon you wouldn’t have water coming out of your tap... You will become malnourished... You will fear being violently killed before starving to death’.

The struggle is real

I’m Skyping Grose at her home in London on a beautiful, clear, sunny Spring morning. I can hear birds chattering and see daffodils in bloom from my window beside the river in Belfast. It’s hard to believe there’s a deadly virus out there.

Grose recounts the story of a fellow analyst, who continues to see patients face to face (despite social distancing advice) because ‘he didn’t want to get sucked into the hysteria’. Philosophical abstraction, Grose admits, can be unhelpful in dealing with concrete problems. This sometimes makes it difficult not to treat *all* prophets of doom as Cassandras, she thinks.

Do we have a duty as clinicians and therapists to protest the climate emergency? She thinks we do, ‘You know, if you’re going to have subtle arguments, you need to have a world in which to have them. And so protecting that world, you know, it is absolutely primary’.

No man is an island, and this is where the COVID-19 crisis diverges sharply from the environmental one. XR, for example, is conspicuously a mass enterprise. ‘That’s been one of the big things with the climate movement, that we have to collectivize’ she says, ‘we love each other, we have to be there for each other, touch each other. That’s one of the pillars of the advice - to be communal. And suddenly that’s been really, really problematized’.

The social isolation and poverty induced by the COVID-19 ‘lockdown’ may not bode well for our mental well-being. However, for some of Grose’s patients, their anxiety has gone right down: “‘They don’t have to make choices. They don’t have to think they need to have a better job, look for a boyfriend, you know, all these sort of horrible choice making things have gone. ... They’re just thinking, well, whatever it is, you know at least it’s interesting.’”

No pills for the pain

In her book on eco-anxiety, Grose says fear is a rational response to environmental Armageddon. ‘It’s the people who aren’t worried who are crazy’ she writes. The trick, she says, is to manage our anxiety so that we’re on the helpful side of the Yerkes–Dodson stress curve. Her take-home message is to ‘... be anxious, be very anxious, because your anxiety can be a brilliant resource’.

She recognizes the paralysis that often comes with eco-anxiety, as we feel stuck between a compulsion to act and the futility of our individual efforts. She suggests a piecemeal approach to tackling climate change and also gives us permission to breathe. ‘It’s vital to accept that there isn’t a correct level of activity with regard to the climate’ she writes, ‘each person has to gauge what they can bear’.

In her book, she blends practical tips on environmentalism and personal anecdote, with strategies to soothe mind and body. As you would expect, she has some difficulty with cognitive–behavioural therapy framing real-life problems as something you can think yourself out of. About psychoanalysis, she says: “‘It’s not that I think psychoanalysis has

brilliant answers to everything. But I suppose the anti-normative thing and the idea that a cure doesn't have to be a quick fix, that you have these very open-ended speculative treatments, seems to me quite a good way to approach this stuff [eco-anxiety]. And it's counterintuitive because you think just calming people down would be a good thing to do. But actually sometimes opening up questions or sort of encouraging people to tolerate the possibility of pain and the possibility of not knowing, yes, that might be a good way to come at it."

Man's search for meaning

The tectonic plates of our civilization are shifting uneasily against each other, fault lines exposed. Although there is nothing unique about this pandemic in the course of human history, Grose thinks humans need to tell stories to impose meaning on the chaos. Narratives abound of an anthropomorphized wilderness striking back, to punish us for our destruction of the world.

Grose hates some climate activist's actions that feed into this narrative, '[They] were putting up posters saying "human beings are the virus", and I just thought that was such a nasty way to treat people'. She says, 'It seems to have been some people in the Midlands trolling XR' and is upset about how so-called 'eco-fascists' use the well-intentioned movement with nefarious intent.

She suggests some alternative narratives: "'We could say we don't know why it's [the pandemic] happening, but there are ways we could soften the blow. By treating each other well and seeing what we can do and being much more tolerant of each other and prepared to share, less self-interested.'" Extreme messaging may be crude, but it certainly gets people's attention. I ask what is better to inspire behavioural change: appeal to people's desire to protect themselves or to protect others? Grose thinks there are two different types of people, who need different messages. On vegetarianism, she says 'It's like, you know, meat will give you bowel cancer for one lot. Meat will bring about the apocalypse for the other lot'.

Like many, Grose sees opportunities for our civilization in the 'Coronapocalypse', 'I mean, I just don't see how the world could just slip back to before... Like what is big enough to make people see?'

'An emissary of pity and science and progress, and devil knows what else'

Kurtz, as portrayed by Joseph Conrad, exposes the myth of the Western man's 'progress'. Grose says that in today's world, we have fooled ourselves into thinking that our technology makes us gods, so that we are estranged from our own mortality. We defend ourselves with material and mind-numbing things. She says: "'None of these defences are, in themselves, necessarily all bad, but they become a problem when the fantasy solution is opted for so enthusiastically that fashion and cars start clogging up the planet, causing people to feel anxious, and then to vote for yet more of the sorts of leaders who promise an endless supply of fashion and cars.'"

She asks that we wean ourselves off 'these pacifying myths, in order to pave the way to ask proper, difficult questions about life, death and the ethics of coexistence'. She does stress, however, that, 'It's absolutely vital that environmentalism doesn't equate with miserabilism'.

Grose agrees with the view that eco-anxiety can be a luxury, for those who don't have to worry about their basic survival needs being met. She is clear-eyed about the XR movement being predicated on privilege, in that '... being arrested if you're a black person is not the same thing'.

Racism in the discourse around climate change and COVID-19 has been inescapable, Grose agrees. Does our tendency to 'other' people, to deny reality until it happens to people like us, betray something about our society? Our tolerance of institutionalized racism shows we have a huge capacity for denial of the 'other', Grose thinks: "'But you're haunted by the fact that your defence isn't working and you know that those people are human. You know that they suffer... And actually, what I hear from people is that the better defended you are in material terms, the more haunted you are.'" Grose looks to Freud to understand why COVID-19 has triggered a retreat into isolationism and jingoism in some countries. The insularity he saw in Germany after World War One represented 'a state of mourning for what has been lost', he wrote. She proposes that instead of saying xenophobes and climate change deniers are 'simply idiots... we could say their minds are somehow in revolt... they don't know what to do about the things they risk losing, or have already lost'.

Suffer the little children

Babies, says Grose, are ‘the main reason I wanted to write this [eco-anxiety] book’. As a psychotherapist, she has been ‘...dealing for years with people who think it’s too risky to have children because the world’s going to end’. She has a 19-year-old daughter, so admits that she is biased.

David Attenborough gets some polite digs in her book for his arguments about slowing population growth. It’s not poor people in Africa we need to worry about, she says, ‘It’s careful, rich people with 1.87 children (or fewer) who constantly upgrade their iPhones...and go on yoga retreats in the Himalayas... An Australian Aboriginal baby has quite a different carbon footprint from, say, a middle-class British one... It’s consumerism, not babies, that we need to place the limits on’.

Which brings us to children in general, who are particularly vulnerable to the apocalyptic messaging around us. In her typically frank manner, Grose says there’s no easy way to tell children about the climate crisis, just like sex and death: “‘If we’re sort of busy pretending it isn’t happening and the information’s arriving from elsewhere, which it is, then that’s not helpful to children...but things that are awful you can only get it wrong. I mean I grew up in a sort of seventies, cool family where sex was completely out there, where, you know there was arty porn around the house. There was the idea that you’d be less traumatized if it was more out in the open. But obviously, it was horrible!’”

She thinks we can smooth the conversation by showing it’s not completely hopeless but, ‘You can’t not get it wrong. Don’t be upset if your kids clock you as a worrier – that’s just part of being a real parent, rather than one in an advert’.

Not with a bang but a whimper

It’s helpful when overwhelmed, to contemplate your own insignificance, Grose says. ‘When terrestrial life gets too much for you’ she writes, ‘let your mind drift up to the stars. It’s so easy to forget they’re there’.

I suggest to her that the danger in this is nihilism. Thinking we are unimportant and transient might lead to thinking nothing really matters.

Freud’s theory of ‘pre-emptive mourning’ can protect us against this, she says. We are prevented from enjoying the world if we are preoccupied with being ‘fated to extinction’, he observed. Grose offers comfort that ‘...the inevitability of loss and death needn’t make us value things any less’. She quotes Freud, ‘A flower that blossoms for a single night does not seem to us on that account less lovely’.

In the rush of COVID-19 think pieces, it’s customary to end on a note of optimism, which alleviates the discomfort of our fear. But let’s not. Grose reminds us that anxiety is a powerful adaptive force when used productively. ‘The horror, the horror’, Kurtz whispered at the last. Let’s sit with that horror and channel it, in the best way that we can.

1.3.2 Mild cognitive impairment: narrative review of taxonomies and systematic review of their prediction of incident Alzheimer’s disease dementia

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Abstract

Early detection of Alzheimer’s disease is vital for developing novel treatments. Attempts to identify the intermediate state between normal cognition and dementia have evolved over the past 50 years.

¹ **Declaration of interest:** D.A. reports personal fees from the Howard Florey institute sponsored by Eli Lilly, outside the submitted work.

Current taxonomies of mild cognitive impairment (MCI) may be criticised for their imprecise operationalisation. With the advent of biomarkers such as amyloid-beta positron emission tomography imaging in established Alzheimer's disease, much research has focused on establishing which factors predict progression from MCI to Alzheimer's disease dementia. In this review, we discuss the historical context of MCI before reviewing the literature of MCI subtypes and their risk of progression to Alzheimer's disease dementia. Finally, we summarise the literature and discuss limitations and weaknesses of how the construct is operationalised and implemented, before offering suggestions for development of the concept of MCI. We conclude that MCI must be empirically defined for the sake of its predictive validity to identify Alzheimer's disease before dementia develops.

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Dementia (in this review, we will use the term dementia because of its ubiquity, the fact that it is still used by ICD-10 and historically many studies have used the term dementia), now also known as major neurocognitive disorder,¹ is a common clinical syndrome that is characterised by progressive cognitive impairment that is severe enough significantly to impair daily functioning.² Much research effort has been directed towards Alzheimer's disease, which is the most common cause of dementia.^{3,4} Despite its tremendous burden, no disease modifying treatments for Alzheimer's disease are available.^{5,6}

The dominant theory of Alzheimer's disease pathophysiology implies that amyloid-beta (A) is central to the upstream mechanism of disease.⁷ Recent trials with monoclonal antibodies against A, such as solanezumab, have proved unsuccessful in mild to moderate Alzheimer's disease dementia⁸ and in mild Alzheimer's disease dementia,⁹ although the negative results may relate to the late disease stage at which the treatment was applied. With A deposited in the brain for over 20 years before the development of the clinical syndrome of Alzheimer's disease dementia,¹⁰ early recognition will be key to developing potential disease-modifying therapies and secondary prevention, as well as making lifestyle and medico-legal decisions while cognitive faculties are still sufficiently intact.

Efforts to identify early or even pre-dementia patients with some very mild degree of impairment have been underway for over 50 years,¹¹ and this thinking has evolved through several iterations to arrive at the current term of mild cognitive impairment (MCI).¹² The concept of MCI has several similar but importantly different definitions and taxonomies,

which will now be discussed systematically.

The review begins with a background consideration of Alzheimer's disease and an historical overview of MCI. This will be followed by a systematic review of the literature comparing the various taxonomies in their usefulness in predicting progression from MCI to Alzheimer's disease dementia. Finally, we discuss the state of the current literature and its limitations with a view to early identification of Alzheimer's disease to allow the testing of novel putative disease-modifying treatments.

Alzheimer's disease

Alzheimer's disease is a progressive neurodegenerative condition that is the most common cause of dementia, accounting for approximately 50–70% of cases.^{13–17} Its clinical hallmark is impairment of memory and new learning with rapid forgetting of newly learned information.¹⁸ Diagnostic criteria emphasise impairment of memory with insidious onset and gradual progression, as well as impairment of at least one other cognitive domain, which are severe enough to impair functional abilities significantly.^{1,18–21} The most recent iteration of the DSM has adopted the term 'major neurocognitive disorder due to Alzheimer's disease', while retaining the essential diagnostic criteria.¹

Mild cognitive impairment

MCI is an intermediate state between cognitively intact persons and those with dementia. This concept has evolved over time with various taxonomies, nomenclatures and definitions, which are summarised in *Table 1* and described in an historical context below. *Table 1* Various definitions of cognitive impairment that is not dementia

Term	BSF	ICDR	QD	34AAMI	24AACD	31CIND	41Petersen MCI	39Winblad MCI	12NIA-AA	43mNCD	1 Cognitive complaint																
	Self- or carer- complaint about memory	Self- or carer- complaint about cognition	Self-complaint about memory	Self- or carer- complaint about cognition	Self- or carer- complaint about cognition	Self-complaint about cognition	Psychometric impairment	—1 s.d. below healthy young adults	1 s.d. below age-matched sample	Battery of neuro-psychological tests	1.5 s.d. below age- and edu- matched sample	No cut-off specified															
	Typically 1–1.5 s.d. below age- and edu-matched sample	Modest impairment; typically 1–2 s.d. below age- and edu- matched sample	ADL—Slight or mild change	—Normal	Minimal impairment in complex instrumental ADL	Mild change, but still independently functioning	Independent, but possibly with greater effort or strategies	Dementia	No	No	No	No	No	No	No	No	No	No	No	No	Notes	Mild dementia may have CDR = 0.5	At least 6 months duration	Does not exclude non-dementia causes	AKA Mayo criteria	AKA Revised Mayo criteria or revised Petersen criteria	Biomarker criteria not presented here ²

2

AACD, aging-associated cognitive decline; AAMI, aging-associated memory impairment; ADL, activities of daily living; AKA, also known as; BSF, benign senescent forgetfulness; CDR, Clinical Dementia Rating scale; CIND, cognitive impairment not dementia; edu, education; MCI, mild cognitive impairment; mNCD, mild neurocognitive disorder; NIA-AA, National Institute on Aging and the Alzheimer's Association; QD, questionable dementia.

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Historical development

The concept of pre-dementia causing subsyndromal symptoms was described as early as 1962, when Kral¹¹ described 'benign senescent forgetfulness'. This encompassed mild fluctuating retrieval-based memory impairment, which he speculated could be a mild early form of senile atrophy that spared the Papez²² circuit. A shortcoming of Kral's description was that it lacked operational criteria, which can impede diagnostic reliability.²³

Over 20 years later, Kral's concept was extended and operationalised by Crook and colleagues; they labelled their concept age-associated memory impairment (AAMI), which they defined as subjective memory complaint and objective memory impairment on a memory test at least one standard deviation below the mean for young adults.²⁴ By using healthy young adults as a reference sample, this definition lacked specificity, given that performance on psychometric tasks of memory declines with healthy ageing²⁵⁻²⁷ and up to 90% of elderly individuals would fulfil this criterion.²⁸ A further criticism was that AAMI exclusively focused on memory, although other cognitive domains, such as visuospatial abilities, language or executive functions, may be affected principally early in Alzheimer's disease.^{29,30}

Addressing both of these criticisms, the International Psychogeriatric Association broadened the concept to include other cognitive domains and also defined objective impairment with reference to an age-matched sample.³¹ They labelled this age-associated cognitive decline (AACD), defined as subjective cognitive decline as observed by the individual or an informant; gradual decline over at least 6 months; and impairment in a cognitive domain with performance one standard deviation below the mean of an age- and education-matched normative sample.³¹ AAMI and AACD appear to be distinct clinical entities with only approximately 50% overlap in concordant diagnosis and AACD participants showing more extensive cognitive impairment.³²

The term 'MCI' was first described by Reisberg and colleagues with the development of the Global Deterioration Scale.³³ This was a seven-point ordinal scale from 'no cognitive decline' to 'severe dementia' that defined MCI as one or more of several examples of cognitive lapse such as becoming lost in an unfamiliar location, word-finding difficulty, forgetting names or misplacing objects, or as concentration deficit with clinical testing.³³

Concurrently, the clinical dementia rating (CDR) scale was developed,³⁴ which was also an ordinal scale ranging from 'no impairment' to 'severe dementia'. Although not directly referring to MCI, the CDR introduced the importance of daily functioning into the concept. A person scoring 0.5 or 'questionable impairment' on the CDR may have slight impairment of community affairs or home life but would be fully independent with self-care.³⁴ Flicker and colleagues used the term 'MCI' when they showed that psychometric impairment at baseline could predict subsequent decline in elderly patients after 2 years.³⁵

Ronald Petersen, a major developer of the concept of MCI through the Mayo clinic, developed his original definition of MCI based on patients recruited from a community-based medical clinic.³⁶ They identified people who were themselves concerned about their cognition, or whose carers or physicians were concerned. These patients then had an extensive battery of physical examination, cognitive assessment, investigations and neuroimaging to rule out dementia as determined by expert panel consensus. These patients by definition had 'normal' scores on the Mini-Mental State Examination³⁷ and Short Test of Mental Status.³⁸ Petersen and colleagues (1995) observed that this cohort tended to perform 1.5 standard deviations below the age-matched mean performance on memory tasks such as auditory verbal learning tests, and activities of daily living (ADL) were generally preserved, corresponding to a CDR rating of 0.5. By employing age-corrected, but not education-corrected, normative data, it introduced confounding difficulties with patients with low education or low IQ.

These criteria were more formally proposed and became known as the Mayo Clinic core criteria or the Petersen criteria.³⁹ The criteria were restricted to memory impairment rather than impairment of other cognitive domains, and thus were subject to similar criticism to that of AAMI; that Alzheimer's disease may principally affect other cognitive domains.²⁹ In 2003, a key symposium of experts revised the Mayo Clinic criteria to include domains other than memory.¹² Referred to as the Winblad criteria, these defined MCI as: (a) the person is neither normal nor demented; (b) there is evidence of cognitive deterioration shown by either objectively measured decline over time and/or subjective report of decline by self and/or informant in conjunction with objective cognitive deficits; and (3) ADL are preserved and complex instrumental functions are either intact or minimally impaired.¹² Subcategories of MCI were established based on the pattern of cognitive domains affected: amnesic single-domain, amnesic multiple-domain, non-amnesic single-domain and non-amnesic multiple-domain.⁴⁰

The concept of ‘cognitive impairment, no dementia’ (CIND) was introduced in the context of the need for early recognition of dementia.⁴¹ CIND was identified on the basis of a consensus conference of physician, nurse and neuropsychologist, integrating all available information from clinical and psychometric assessment.⁴² It includes individuals with non-dementia-related aetiologies such as delirium, chronic alcohol and drug use, depression, psychiatric illness, intellectual disability and circumscribed memory impairment; this results in high prevalence estimates⁴¹ and many CIND individuals will not develop dementia. A criticism of CIND is that it does not provide operational criteria, which may jeopardise its reliability.

Recent definitions and developments

In the context of emerging biomarkers, the National Institute on Aging and the Alzheimer’s Association (NIA-AA) convened a workgroup to revise the diagnostic criteria for pre-dementia Alzheimer’s disease.⁴³ Not long thereafter, the DSM-5¹ abandoned the term ‘dementia’ and replaced it with ‘major neurocognitive disorder’, while adding the term ‘mild neurocognitive disorder’ (mNCD), which has similarities to MCI including cognitive complaint, psychometric impairment and relative preservation of ADL.

The NIA-AA and DSM-5 mNCD both refrained from offering a strict cut-off score for psychometric impairment, instead suggesting that typical levels of impairment would be 1–2 or 1–1.5 standard deviations below the mean, respectively, for age- and education-matched normative data. Instead of arbitrary cut-offs, these criteria advocated for an individualised assessment that incorporated all available evidence.

The NIA-AA criteria⁴³ combined core clinical criteria with clinical research criteria, which incorporated biomarker evidence of disease. In doing so, these criteria moved beyond MCI as a pre-clinical definition incorporating history and examination findings to a prodromal state with biological evidence of incipient disease. The NIA-AA workgroup explicitly focused on MCI due to Alzheimer’s disease and used biomarkers to stratify the likelihood that the cognitive change is due to Alzheimer’s disease. Biomarkers indicating a high likelihood that MCI is due to Alzheimer’s disease are an abnormal A marker (e.g. positive PiB (Pittsburgh compound B) scan or cerebrospinal fluid (CSF) A₄₂) and a positive biomarker of neuronal injury (e.g. CSF tau, FDG-PET (Fluorodeoxyglucose Positron Emission Tomography) or structural magnetic resonance imaging). MCI unlikely to be due to Alzheimer’s disease is determined when A markers and markers of neuronal injury are both negative. MCI due to Alzheimer’s disease with intermediate likelihood has either A markers or neuronal injury markers as abnormal, while the other is untested. Recent studies suggest this taxonomy is useful in predicting Alzheimer’s disease.^{44,45} However, the invasiveness, cost and availability of these biomarkers may limit their widespread implementation in clinical settings.

Subjective cognitive decline is incorporated into modern definitions of MCI.^{1,12,24,31,36,43} MCI may be preceded by a state in which the individual experiences subjective cognitive decline that is too subtle to be detected on psychometric testing.⁴⁶ The Subjective Cognitive Decline Initiative working party have conceptualised this as a pre-MCI state on the same spectrum towards Alzheimer’s disease dementia and provided definitions⁴⁶ that have been operationalised for research purposes.⁴⁷

Prevalence of MCI

Since their publication, the revised Mayo clinic criteria¹² have been commonly adopted in the literature, and studies reported in this section used these criteria unless otherwise stated.

Prospective population-based studies show that the prevalence of MCI ranges from 15 to 22% in elderly individuals.^{48,49} Prevalence increases with age, decreases with education, and is more common in males, unmarried people and carriers of the APOE-4 allele.^{49,50} Prospective population-based studies have estimated incidence rates of around 6% per year, although the rate in men (over 7%) was slightly higher than that in women (under 6%).⁵¹

Progression of MCI to dementia

Estimates of progression rates to dementia or Alzheimer's disease dementia are important for advising patients about prognosis and have implications for conducting research in this population. Individuals with MCI have a higher risk of developing dementia compared with the general older population incidence of 1–2% per year,⁵² although estimates vary depending on the definition or subtype of MCI, study design and follow-up period.^{52–55} Earlier definitions using the Petersen amnesic-only MCI criteria estimated rates of progression to Alzheimer's disease dementia to be 10–15% per year.⁵² A randomised controlled trial reported a progression rate of 16% per year.⁵⁵ A meta-analysis of studies using Mayo clinic criteria for MCI suggested that over 10 years, 33.6% will cumulatively progress to Alzheimer's disease dementia in specialist settings versus 28.9% in population settings, which translated to an annual progression rate of 8.1% in specialist settings and 6.8% in community studies.⁵⁶

There is some criticism of the utility of MCI as a diagnosis given its heterogeneous nosology,⁵⁷ variable prognostic significance^{58–60} and the various ethical issues it raises.⁵⁷ We would counterargue that these issues provide impetus to refine the definition of MCI, as doing so will allow identification of a group that could be identified for treatment of modifiable risk factors that may decrease the risk of developing dementia, such as diet, diabetes mellitus, hypertension and hypercholesterolemia.^{61,62}

The present study aimed to review the evidence with regards to which taxonomy of MCI was more useful in predicting incident Alzheimer's disease dementia. We hypothesised that amnesic MCI (aMCI) and multiple-domain MCI would be more likely than non-MCI controls to progress to Alzheimer's disease dementia.

Methods

Search method

Medline was searched via PubMed on 28 February 2017 using the search terms 'MCI or Mild Cognitive Impairment' and 'Alzheimer's disease' and 'progression or conversion', identifying 2583 studies. The search was restricted to articles in the English language and studies conducted on humans aged 65 years and over, resulting in 1674 studies. See *Fig. 1* for the PRISMA diagram.⁶³ *Fig. 1* PRISMA diagram of study selection.

Selection criteria

Studies were selected if they performed longitudinal follow-up of at least 3 years, reported on the incident development of Alzheimer's disease dementia using established criteria, and explicitly compared two definitions of MCI. The 3-year duration was selected because of the lower specificity associated with shorter follow-up.⁶⁴

Data extraction

All titles were reviewed and the abstracts of all potentially relevant studies were assessed. The identified full papers were assessed for eligibility and data were extracted. Study quality was assessed using the Newcastle-Ottawa Quality Assessment Scale.⁶⁵

Results

There were 15 studies included in the final analysis, all of which were classified as ‘good’ according to the Newcastle-Ottawa Quality Assessment Scale.⁶⁵

MCI subtype and progression to Alzheimer’s disease dementia

Only a single study explicitly examined differences between various classification systems of MCI and progression to Alzheimer’s disease dementia. In a large population-based study of 4057 individuals with 4.5 years follow-up, DSM-5 criteria gave a higher annual progression rate than Petersen criteria for progression to Alzheimer’s disease dementia and to all-cause dementia.⁶⁶ However, the majority of people who developed Alzheimer’s disease dementia were classified as normal controls at baseline. The DSM-5 criteria were more restrictive, with only 139 cases meeting criteria, whereas 303 cases met criteria for Petersen aMCI. The authors do not stipulate why, but a possible contributing factor to this is that the DSM-5 criteria explicitly exclude people with severe depression, psychosis or delirium, whereas the Petersen criteria do not. Marcos and colleagues (2016) noted that most of the MCI cases did not progress to Alzheimer’s disease dementia or dementia during the 4.5-year follow-up; indeed, only 15% of the DSM-5 defined MCI cases progressed to dementia.

Twelve studies explicitly examined differences between various subtypes of MCI, usually within the Winblad taxonomy.¹² The most consistent finding was that aMCI is associated with an increased risk of progression to Alzheimer’s disease dementia.^{53,67–77} Individuals with aMCI are more likely (18–19% per year) to progress to Alzheimer’s disease dementia than non-amnesic MCI participants (10–11%) in community-⁵³ and healthcare-based cohorts.⁷⁸

Ten studies compared progression rates between various subtypes within the Winblad taxonomy. Seven of these studies show that multiple-domain aMCI has the best predictive accuracy for progression to Alzheimer’s disease dementia,^{54,67–69,73,74,76} with annual progression rates ranging from 4 to 25%. However, two studies found that single-domain aMCI was associated with the highest risk of progression to dementia due to Alzheimer’s disease,^{70,77} and one found no difference between single- and multiple-domain aMCI.⁷¹ A challenge to the discriminative validity of the Winblad taxonomy is that multiple-domain aMCI was also the best predictor of progression to vascular dementia.⁷³

Although all studies purported to employ the revised Mayo criteria, these were operationalised in different ways, for example, using hierarchical cluster analysis of neuropsychological data rather than clinical judgement⁷⁰ or not including information about subjective memory complaint.⁶⁷ Moreover, psychometric impairment was defined in one study as at least 1.5 standard deviations below the mean for an age- and education-matched sample on a neuropsychological battery⁷⁷ or as at least 1.0 standard deviations below the mean for an age- and education-matched sample on indices derived from the Montreal Cognitive Assessment.⁶⁸

Discussion

The concept of MCI has evolved from a vague clinical observation to a diagnosis that can incorporate disease biomarkers to predict the likelihood of developing Alzheimer’s disease dementia. There have been at least nine different attempts to define the intermediate state between cognitive health and dementia. However, only a single study has explicitly compared different taxonomies in terms of their usefulness in predicting incident Alzheimer’s disease dementia.⁶⁶ This study showed that DSM-5-defined mNCD had better positive predictive value than did Petersen criteria, although the majority of people who developed Alzheimer’s disease dementia were classified as normal controls at baseline. Of the studies comparing various subtypes of MCI within the Winblad taxonomy, aMCI better predicts progression to Alzheimer’s disease dementia than does non-amnesic MCI.^{53,78} This is consistent with the observation that memory impairment is the hallmark clinical feature of Alzheimer’s disease.¹⁸

Although there was not consensus, 7 of 10 studies found that multiple-domain aMCI was better than single domain aMCI in predicting progression,^{54,67–69,73,74,76} two showed the opposite^{70,77} and one showed no difference.⁷¹ A possible reason for the discrepant findings regarding single-domain aMCI and multiple-domain aMCI in the prediction of

Alzheimer's disease dementia is differing definitions of the subtypes. The inconsistent findings within this area highlight the variable implementation of the criteria. Although all studies purported to employ the revised Mayo criteria, these were operationalised in different ways, such as not including subjective memory complaint,⁶⁷ different psychometric cut-off z-scores ranging from 1.0⁶⁸ to 1.5,⁷⁷ different psychometric tests^{68,77} or even hierarchical cluster analysis of neuropsychological data.⁷⁰

This review suggests that aMCI is superior to non-amnesic MCI and that multiple domain aMCI is probably superior to single domain aMCI in predicting progression to Alzheimer's disease dementia. It may be that involvement of cognitive domains in addition to memory in MCI implies more severe or advanced disease that is closer to the emergence of dementia. Despite these findings, the predictive validity of MCI is limited, as up to 60% of MCI individuals will not develop dementia in the following 10 years.⁵⁶

We suggest that the concept of MCI may be improved in three ways. First, criteria should be operationally defined. Second, criteria should be empirically defined. Finally, the MCI group should be stratified for likelihood of progression to Alzheimer's disease dementia. These will now be discussed in turn.

Several taxonomies of MCI have suggested explicit cut-off scores on cognitive measures. Despite this, more recent taxonomies from the DSM-V and NIA-AA have dispensed with cut-offs for cognitive impairment. Although this approach has the merit of tailoring assessment to the individual, it may introduce issues with interrater reliability, which may further undermine the reliability of MCI in the research literature. We suggest that criteria for subjective and objective memory impairment should be operationalised to ensure reliability of the concept.

This raises the question of which cut-off should be adopted. We suggest that the utility of MCI may be improved by providing operational criteria that are empirically defined by their prediction of Alzheimer's disease dementia. There have been only a few attempts to use such data-driven definitions of MCI. For example, MCI subtypes identified with latent profile analysis outperformed Winblad criteria⁷⁹. Other studies have shown that the severity of memory impairment^{80,81} and the base rate of memory impairment⁸² offer an advantage over the common taxonomies. We propose that cognitive impairment used to identify MCI should be empirically defined, whether it be in terms of the lowest performance,^{80,81} base rate of impairment,⁸² or possibly average memory score or some other method.

These same factors may then be used to stratify the severity or grade of MCI. All current taxonomies treat MCI as a categorical entity, which is not consistent with a longitudinal model of Alzheimer's disease pathophysiology. Although the clinical manifestation of Alzheimer's disease exists on a spectrum from asymptomatic to severe dementia, MCI is not staged as such. We propose that MCI should be stratified by factors such as severity^{80,81} or base rate of impairment⁸² to indicate increased risk of progression to Alzheimer's disease dementia. This may allow individuals to be selected for more intensive monitoring, for secondary prevention techniques such as control of diet and cardiovascular risk factors,^{61,62} and for recruitment into clinical trials of putative treatments for Alzheimer's disease.

Conclusion

The current literature suggests that MCI individuals with memory impairment and impairment of multiple domains are at increased risk of progression to Alzheimer's disease dementia. We suggest that the concept of MCI should be improved by offering operational criteria of memory or cognitive impairment that are empirically defined. Furthermore, we propose that MCI should be developed from a singular categorical diagnosis to a graded diagnosis that indicates increased risk for progression to Alzheimer's disease dementia. In this way, MCI may become a more reliable construct with better predictive validity that will be more useful in understanding the natural history of Alzheimer's disease. This in turn will allow better targeted selection of individuals with pre-symptomatic Alzheimer's disease to allow early implementation of therapeutic strategies to modify the course of this common and burdensome disease.

N.I.B. drafted the manuscript. D.A. assisted in revising the manuscript.

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As interest in psychedelic research continues to increase, it is clear that a new conceptual framework is needed to investigate phenomena associated with altered states of consciousness. While research has focused primarily on their psychotherapeutic and entheogenic uses, few studies have dared to consider psychedelics as potent tools for enhancing cognition, conducting conceptual research and improving complex problem-solving. Sensing an opportunity to kick-start an intellectual revolution, Roberts introduces ‘multistate theory’ as a potential framework to guide new exploration of altered states of consciousness.

A core tenant of multistate theory is the rejection of the ‘singlestate fallacy’, which Roberts defines as the erroneous assumption that all worthwhile skills, abilities and knowledge reside in our default waking state. He argues that our default state is simply one of many possible states of consciousness (or ‘mindbody states’) that the mind can produce and operationalise. Directly criticising mainstream science and philosophy’s understanding of intelligence and consciousness, Roberts provides ample evidence that cognitive processes qualifying as intelligence reside in other mindbody states.

MindApps explores a simple analogy – as apps are to smart devices, ‘mindapps’ are to the brain–mind complex. Therefore, any agent of psychological change (both drug and non-drug) that produces a mindbody state can be considered a mindapp. Different kinds of mindapp, of which psychedelics are perhaps the most potent, ultimately produce disparate mindbody states. Consequently, Roberts challenges the reader to consider a new age of ‘mind design’, where mindapps are used in combinations to investigate mindbody states, create new ones and uncover the full extent of the human mind. As transhumanist and transpersonal perspectives begin to intersect, could it be possible to design minds that far surpass the functions and capabilities of our current ones?

Multistate theory is a novel conceptual framework that sits at the crossroads of science, philosophy, spirituality, humanities and the arts. Considering the evidence illustrating the efficacy of psychedelics and other mindapps as catalysts for substantive psychological change, multistate theory can serve as a guide not only for systematically investigating mindapps and the cognitive processes that characterise mindbody states, but also for conducting conceptual research.

While he is clearly optimistic about the future, Roberts is quick to highlight that *MindApps* is merely the start of a new conversation about what it means to have a mind. However, given his contributions to psychedelic research and education over the past 30 years, Roberts’s conclusions are deserving of a wider audience. As we shift from the age of information to the age of experience, his clarion call for bold innovation should be heard by all who wish to pioneer the development of new research questions, creative methodologies and engaging education for future generations of mind-designers.

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1.3.3 Rethinking self-injury recovery: a commentary and conceptual reframing

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Declaration of interest: None.

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Abstract

A growing body of research has focused on understanding what may contribute to cessation of self-injury. Although these efforts are of value, cessation represents just one component of self-injury recovery. Exclusive or primary focus on cessation may foster unrealistic expectations for those with lived experience of non-suicidal self-injury (NSSI). Accordingly, this commentary discusses the importance of expanding the concept of NSSI recovery beyond cessation in both research and clinical domains. We conclude by presenting a person-centred and non-stigmatising conceptual reframing of recovery.

Contents

- *Rethinking self-injury recovery: a commentary and conceptual reframing*
 - *Recent trends in NSSI recovery research*
 - *Moving beyond cessation*
 - *Reframing recovery*
 - *Summary*

Non-suicidal self-injury (NSSI), deliberate damage to one's body tissue in the absence of conscious suicidal intent,¹ is a behaviour that is most often used to regulate intense or unwanted emotions.^{2,3} In community samples, 18% of adolescents, 13% of young adults and 5% of adults (aged 25+) report a history of NSSI,⁴ with approximately one-third persisting with the behaviour for longer than 1 year.⁵ Associated with psychological distress, mental health difficulties (e.g. depression, anxiety, eating disorders),^{2,3} interpersonal difficulties^{2,3} and subsequent suicide risk,⁶ NSSI can also leave physical scars that can represent both resilience and a source of shame for people who have self-injured.⁷

Given its many adverse consequences, researchers have recently focused on identifying factors that facilitate cessation of NSSI. In particular, researchers have sought to delineate individuals who currently engage in NSSI and those who report having stopped, with the aim of identifying targets for intervention.^{5,8-12} Clearly, there is merit in these efforts. Yet, this approach may inadvertently emphasise NSSI cessation, without equal attention to the many concerns those with lived NSSI experience report in the broader context of recovery. In keeping with a recent trend in the NSSI literature to offer more person-centred views of NSSI,¹³⁻¹⁵ the present commentary discusses issues inherent in limiting focus to NSSI cessation and offers a person-centred, non-stigmatising framing of recovery.

Recent trends in NSSI recovery research

Notwithstanding the value of examining NSSI recovery, focus is often circumscribed to desistance of the behaviour. Indeed, this is typically the primary outcome measure in research.^{5,8-12} From a theoretical standpoint, NSSI has been situated within the context of recovery-based models in which desistance of a behaviour is the primary aim.¹⁶ For example, NSSI has been viewed in the context of the transtheoretical stages of change model, which considers individuals as 'recovered' (from the target behaviour) following a 6-month period of abstinence from that behaviour.¹⁶⁻¹⁸

In contrast to these views are those of individuals with lived NSSI experience, who have expressed concern that salient NSSI experiences may be neglected if the primary focus is on the behaviour.¹⁹ Indeed, individuals discuss a range of concerns (e.g. scarring, disclosure, coping) that extend well beyond NSSI disengagement.^{6,7,20-23} Taken together, the

totality of experiences expressed by individuals with lived experience of NSSI may not consistently be represented in the extant literature. Moreover, emphasis on cessation of behaviour may inadvertently place NSSI in disease-based conceptualisations of ‘illness’. In particular, there has been a recent and growing movement away from pathologising behaviour, including NSSI.²⁴ Notwithstanding the psychological and medical consequences of NSSI (e.g. distress, scarring), using disease-based language to describe NSSI can conflate illness with a behaviour, and exacerbate the already strong stigma associated with NSSI.¹⁴ Specifically, the tendency to conceptualise NSSI within models of infectious disease, including borrowing language from this domain (e.g. contagion), can have an ‘othering’ effect in distancing people who self-injure from those who are not ‘diseased’.¹⁴ This is reflected in recent research eliciting views from individuals with lived NSSI experience.¹⁹ Consistent with an emerging trend in the field, researchers and clinicians may find it more helpful to adopt a strengths-based and person-centred (rather than deficit- or disease-based) conceptualisation of NSSI and recovery.

Moving beyond cessation

Cessation of NSSI represents just one element of an ongoing and multifaceted recovery process. Although many would not disagree that recovery is broader in scope, researchers typically focus on cessation of the behaviour,^{5,9–12} with the implicit argument that this is the desired outcome of any intervention effort. However, it is not uncommon for people with lived NSSI experience to mention ongoing NSSI thoughts or urges,^{7,20} learning new ways to cope with difficult emotions,^{8,20,23} disclosure-related concerns²² and coming to terms with scarring^{7,21} – even long after ceasing to self-injure.

Attenuated focus on complete NSSI cessation may result in people perceiving their own recovery as all-or-nothing. As ongoing NSSI thoughts and urges are common, beliefs that people can be ‘cured’ or fully removed from NSSI are unrealistic. Likewise, equating recovery with a single outcome and viewing cessation as the sole indication of success are unhelpful. Ultimately, considering cessation as ‘successful recovery’ detracts from the multifarious paths people inevitably have. Left with the impression that recovery is a linear path to cessation, individuals are prone to become discouraged (even when progress is made) or may view their own efforts as futile.

A more realistic expectation would be that many individuals *will* continue to experience thoughts and even urges to self-injure in the future. However, over time, these occurrences will abate in magnitude and frequency. Moreover, as individuals begin to find and utilise alternative strategies in lieu of NSSI, the pairing of NSSI with painful emotions should correspondingly dissipate. By acknowledging and ultimately adopting more realistic and holistic expectations, individuals are apt to feel encouraged over the course of their NSSI journeys.

Reframing recovery

Following the above, we would encourage researchers and clinicians to adopt a broad, multipronged conception of recovery to account for a range of variables, including but not limited to NSSI cessation. Hence, we propose that consideration be given to how: people respond to difficult emotions and thoughts of NSSI (including coping responses); individuals adapt to and live with having NSSI scars; the process is non-linear and may involve setbacks (e.g. instances of NSSI); recovery may be an enduring (at times life-long) process; and other factors (e.g. disclosure, future coping, mental health difficulties) are germane. By virtue of expanding beyond NSSI cessation, more realistic expectations can be fostered. This not only acknowledges the multitude of experiences people may have but stands to foster more resilience.

In keeping with the above, when working with people with lived NSSI experience, it might be more helpful for researchers and clinicians to strive to adopt and reflect back the precise language these individuals use when referring to recovery. As the lexis of recovery is commonplace in NSSI discourses,^{17,18,25} the term ‘recovery’ is bound to be used. Yet, alternative referents (e.g. journey, overcoming self-injury) may also be employed. Some people may even be resistant to using the term ‘recovery’ as it may position NSSI within disease-based (as opposed to behavioural) frameworks. As noted above, such framings have been rendered stigmatising by those with lived experience.¹⁹ Others may view the term recovery as conceptually ill-suited, as recovery is defined as a return to a normal or healthy state.²⁶ Indeed, individuals may not view their experience as a return but more an experience in which they view themselves in a new light

(e.g. more resilient);^{7,23} additionally, some may view this definition as inferring that people who self-injure are somehow ‘abnormal’. Ultimately, by using individuals’ own language researchers and clinicians can avoid unnecessarily ‘correcting’ those who are arguably experts in *their* experience; further, this approach coheres with recommendations for discussing NSSI in assessment and related contexts.^{3,27}

Nevertheless, irrespective of the phrasings used, it would be helpful if conversations could underscore and foster realistic expectations extending beyond NSSI cessation. This may necessitate ascertaining what individuals mean by the particular term they use. Doing so can help determine whether an individual’s primary focus is on desistance of NSSI. Although desistance may have value for some people (e.g. acknowledging progress by the time elapsed since they last self-injured), it would be important to ensure that individuals view their trajectory realistically, cognisant of the manifold complexion of recovery (e.g. persistent urges, set-backs).

Summary

Recent trends in the NSSI literature have seen the emergence of research on NSSI recovery, with a particular focus on factors related to cessation of the behaviour. Hopefully, it is apparent from our commentary that a primary focus on cessation in the context of self-injury could detract from the myriad experiences people have and may inadvertently lead to a sense of failure, as thoughts and urges (among other features) are apt to continue long after a person no longer self-injures. Instead, we call on researchers and clinicians to focus on how people respond to intense or unwanted emotions and whether the chosen strategies are meeting the desired aims. In this way, focus centres on individuals and their experiences, with realistic expectations about their own progress, while allowing the requisite space to adopt alternative strategies that will best serve the functions needed.

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1.3.4 Kevin Mitchell

Claire McKenna¹

date

2020-04

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Claire McKenna talks to neurogeneticist Kevin Mitchell about ‘neuro-hype’, psychiatric genomics and a unifying theory for neuroscience.

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- *Innate*
- *Psychiatric genomics*
- *Towards a unifying theory for neuroscience*

Professor Kevin Mitchell has a few pet peeves with the way neuroscience is represented in the media. To start, he highlights the siren call of fMRI scans that often adorn any remotely psychological article: ‘People demonstrably find that same article more convincing if it has a glowing brain in one corner of it than if it doesn’t. So people are a bit susceptible, I think, to what we affectionately term “neuro-bollocks”’.

Mitchell is Associate Professor in Developmental Neurobiology and Genetics at Trinity College Dublin, where he is also Dean of Undergraduate Studies. His mission is to make complex neuroscience more accessible while resisting the temptations of neuro-reductionism. In his blog ‘Wiring the Brain’ (www.wiringthebrain.com), he writes spirited and forensic take-downs of overly hyped neuroscience research, as well as thoughtful philosophical explorations of the nature of the brain and mind. Blog titles include: ‘Is your future income written in your DNA?’ and ‘The murderous brain – can neuroimaging really distinguish murderers?’.

In 2018 he published *Innate*, an engaging popular science book exploring ‘how the wiring of our brains shapes who we are’, which has been praised by Stephen Pinker as a ‘new landmark’ in the old nature versus nurture debate.

Any other neuromyths he’d like to bust? He laughs, ‘There are so many!’. He is a critic of ‘blobology’ generally (the tendency to use blurry pictures of the brain to illustrate articles of little scientific value, such as ‘Your brain reacts to love like cocaine’), in part because it reflects a modular understanding of the way the brain works that bears no resemblance to reality.

One of his key messages is that nature is not obliged to make biology simple enough for us to understand. He does, though, think that public engagement by neuroscientists is vital, as ‘we see the effects of scientific illiteracy in lots of public policy’. He has several popular public talks on YouTube (including a TED talk titled ‘Who’s in charge? You or your brain?’).

Mitchell fizzes with infectious enthusiasm for his subject. Two and a half hours later we’re still talking and I feel I’ve just skimmed the surface. The themes of outdated traditions in neuroscience that try to localise brain functions (telling us nothing about the connectivity of the brain) and the lack of an underpinning philosophy of neuroscience are ones he continually comes back to. The way that neuroscience is taught explains the appeal of things like the decorative fMRI to professionals and public alike, he thinks. He emphasises that these scans are very indirect measures of neural activity on a background of constant endogenous activity. There is also the intuitive appeal of finding a ‘biomarker’ for mental illness.

Biomarker research

Mitchell dismisses the idea that we have biomarkers for any neurodevelopmental or psychiatric conditions: ‘All that literature [on biomarkers] is polluted with false positives’. Small samples, lack of replication, statistical ‘fishing’ in an exploratory fashion are all major problems that undermine the validity of biomarker research. And, he says, ‘it gets worse if you add in the dimension of genomics to that, because now you have the enormous genomics space in which to search for covariates of neural activity or structure’.

So, no scans as diagnostic tests for mental illnesses then? He is bracingly sceptical: “‘There’s not going to be a blood test. There’s not going to be a brain scan. There’s not going to be any other biomarker that captures those things, because they’re looking at the wrong level. [Those conditions] are defined at the level of human behaviour [...] Even if there’s a dynamic neural state that underpins some aspect of psychosis that we both share, the way that that state looks in your brain may be very different from the way it looks in my brain because our brains are not the same. So I don’t hold out much hope for, you know, getting to diagnostic biomarkers from that kind of imaging.’”

The neuro-hype of epigenetics

We turn next to epigenetics, a mechanism in molecular biology by which genes are ‘switched’ on and off and which is at risk of becoming ‘neuro-hype’. Epigenetics as a mode of intergenerational trauma transmission is very much a buzzword at present. Mitchell cautions against invoking sciency-sounding mechanisms to lend credibility to ‘nurture’ as a cause of psychological distress: ‘So people look at two fields – neuroplasticity/brain plasticity and now epigenetics – as some kind of a “get out of genetics free card”. I think people don’t like the idea, some people anyway, that we are born with certain predispositions that are hard to change’.

Mitchell finds the concept of trauma transmission through epigenetic mechanisms implausible primarily because it suggests an overly simplistic relationship between genes and our psychological traits. Our experiences, he says, are expressed through changes in our neuroanatomy, not in our patterns of gene expression.

He sees in such flimsy claims a cautionary tale about the need for a different approach in science publishing: ‘There is a hype industry around science, which I think is corrosive. And I think scientists are willing participants in it in a way that I find more and more distasteful the older I get, because it does a massive disservice cumulatively to how science is understood by the general public because we have this constant hype’. He thinks his cynicism reflects a growing awareness in the research community of the need to focus on replicability and reproducibility and is hopeful things are changing for the better.

‘Biology is not just complicated physics’

Mitchell is most passionate when discussing the need to bring about a sea-change in the way neuroscience is taught and thought about. At this stage in his career he sees this as the biggest contribution he can make to his field.

By and large, he says, biological research is conducted in a theoretical vacuum, which means that a mechanistic understanding of how brains and minds work has become entrenched. Much neuroscience research is, he feels, linear and reductionist as a result: “‘We have one theory, which is the theory of evolution, which is great. And it does underpin everything. But it doesn’t really explain how biological systems work and what they do [...] There are lots of engineering principles and dynamic systems principles that we could be applying from those fields [from engineering and physics] that most biologists don’t think about. It’s just not the way that we approach things.’”

He emphasises the need to get away from a modular understanding of how the brain works – the old ‘find the lesion’ trope – which works in neurology but not in psychiatry. ‘The connectivity across circuits is what’s really important’, he says.

He thinks an understanding of neuroscience *is* important for psychiatrists but needs to be taught alongside complexity theory (understanding the dynamics of change in systems) so that we don’t see brains as ‘passive stimulus–response machines’. He has a gift for the memorable tagline: ‘Biology is not just complicated physics!’, he quips.

Undergraduates

Mitchell’s genetics background influences his approach to his role as undergraduate dean. He says, ‘IQ scores, for example, are I think a measure not of potential but of achievement’. So two people with the same biological potential will perform differently depending on whether their environment allows them to thrive. He talks about the so-called ‘Matthew effect’ – the positive feedback loop between socioeconomic privilege, exam success and later career success that gets amplified across generations. Trinity College Dublin has pioneered novel approaches to making admissions criteria more equitable by accounting for social factors that affect a student’s exam grades.

He is critical of commentators in the British press who use the partial heritability of intelligence to suggest that we live in a meritocracy and even to lend credence to eugenics: ‘It’s a very Ayn Randian kind of idea that. Most of the people who’ve done well may have had some genetic capital in terms of talents and natural abilities but, of course, many of them also had lots of social capital and cultural capital’.

Innate

In his book *Innate*, Mitchell argues strongly against the idea of the mind as a *tabula rasa* but he distinguishes his book from the work of people such as Robert Plomin, who also writes about the influence of DNA on our psychological traits. He agrees with Plomin that our traits are partly heritable but differs in how predictive he thinks that is.

He explains that the precise statistical meaning of ‘heritability’ is commonly misunderstood. It refers to the variance in a particular trait being due to genetic differences. This variance or ‘heritability’ is meaningful at a population level, but less useful when it comes to individuals. If, for example, intelligence is 50% heritable, it does not mean that 50% of your intelligence comes from your genes.

He is sceptical of the idea that genomic analysis or ‘polygenic risk scores’ in individuals can be used as a prediction of, for example, how intelligent that person will be, because of the massive spread in distribution of a particular trait across people with the same polygenic score.

Polygenic scores also have poor predictive value because of the nature of genetic variation. They capture a background of common mutations, each with a tiny effect on a trait, which account for about half of genetic effects, but ‘the rest will be from really rare newer mutations that have bigger effects but that kind of wink in and out of existence in a population because they get selected against’.

Another key theme in his work is that our DNA has distal and very indirect effects on the development of our brain. It is the multitudinous ‘noisy’ developmental processes between the transcription of the program encoded in our genome and the ‘wiring’ of our brain that are responsible for much of the variation in our traits. He says: “‘So one of the main points, I guess, of *Innate* that I was trying to make was that there’s this source of variation in our psychological make-up that has gone largely unappreciated. It’s not just genes and environment. There’s this third source, third component of variation, this developmental variation that isn’t due either to genetics or to environment. It’s just the way that the development plays out during embryogenesis, during gestation and the way that it continues to play out over life.’”

Psychiatric genomics

All of this ‘noise’ in developmental variation is one of the reasons that Mitchell is guarded about the potential for genomics research to directly influence psychiatry. He points out that schizophrenia risk is only about 50% heritable but that doesn’t necessarily mean that the other 50% of the variation is environmental: ‘A lot of the outcome may just be the random chance actually during development’.

Mitchell mistrusts much of the early work in psychiatric genetics, in particular the candidate gene association studies, in which researchers studied one or two genes at a time. He describes the statistical acrobatics in data analysis and publication bias towards positive results that threw up spurious associations between individual genes and psychological distress. Genome-wide association studies (GWAS) have shown candidate gene studies to be unreliable. The effects of genes implicated in the development of mental illness are mediated by the sum of interactions between probably thousands of different genes with different biochemical pathways.

So, has genetic research added to our understanding of the causes of mental illness? Mitchell thinks it has, but not in the way we’d hoped for. He cites the example that 80–90% of the variance in who develops autism is down to genetics, but most of the contributing variants are not inherited – so-called *de novo* variants.

Another key finding is that genetic risk factors overlap and are shared between multiple psychiatric and neurodevelopmental morbidities: ‘One of the things we’ve learned is that those sorts of [*de novo*] mutations can give rise in different people to autism or ADHD or epilepsy or intellectual disability or schizophrenia or bipolar disorder, depression or a whole range of things. So, they don’t respect the diagnostic boundaries that we have’.

He feels that genetics research adds weight to the need to think about psychiatric disorders in dimensional terms but also in developmental terms: ‘You have two identical twins. As their brain is developing, what is the trajectory that leads one to develop schizophrenia and the other not? We can’t just look at the genes and say these are genes for psychosis because that’s not what the genes are doing’.

So far, so gloomy for a brave new world of psychiatric genomics leading to personalised medicine and new therapeutic targets. Genetics research will be useful for psychiatry in a probabilistic kind of way but he finds it difficult to see how it could be used to predict outcomes or therapies with certainty in individuals.

Towards a unifying theory for neuroscience

Where then does the future lie for genetics research into psychiatric disorders? Mitchell stresses that genes are algorithms for making proteins. Human behaviour is not directly resultant from the activities of proteins; instead we perceive and think and feel with our neural circuits: ‘So, the way the neural circuits are organised is, for me, the proximal biological underpinning of the conditions. The genetic variations that led to those things being organised in that way are extremely distal causes [...] So I think what we need to do is hand off to the neuroscientists’. Basically, he sees the biological causes of psychiatric disorders as a neuroscience problem: ‘I’m more optimistic about the idea of using genetic findings as a starting point to get at the neuroscience’.

He is particularly excited by the new field of optogenetics to help us study how discrete neural circuits work to influence animal behaviour in real time. He also hopes that the field of computational psychiatry will develop ‘so that we can develop a kind of a mature theory of what these circuits are doing in a complex dynamical systems kind of framework’.

He seems to bristle slightly at my suggestion that his approach to understanding the mind could be criticised as epiphenomenalism, and the associated problems with rooting thoughts, feelings and behaviours in biology. He appeals to holism: ‘I wouldn’t use the word epiphenomena because that sounds a bit dismissive actually, but I would say emergent phenomena’. He emphasises that our cognitive and social development are crucial in understanding these phenomena: ‘We shouldn’t think of nature and nurture as independent from each other, but highly interactive’.

He thinks neuroscience may be in the midst of a paradigm shift due to new technologies and mathematical tools that let us model the brain in a way that reflects its complexity.

So, I ask him, how long before the fruits of this new approach to neuroscience will benefit patients in psychiatry clinics? ‘Maybe if you ask me again in 5 years I’d be giving you, I think, a much more positive view of the importance of that. And if you ask me in 10 years, I’d be, I hope, pointing to areas where that understanding has led to some difference in the clinic’. He pauses. ‘Maybe 10 years is still too optimistic. Give me 20 years. Give us 20 years’. Not quite a headline that plays well to the gallery but a tonic in our era of spin.

1.3.5 Basic safety first: trauma-informed care in a hostile environment

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¹ **Declaration of interest** None.

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Abstract

This editorial introduces and reflects on a Praxis article in the trainees' section of this issue. The article, 'Assessing asylum seekers, refugees and undocumented migrants' by Waterman *et al*, begins with a clinical scenario describing an emergency presentation at a 'place of safety'. The authors are to be congratulated for navigating a compassionate path through the complexities of law, health and new diagnostic categories. The resources found in the article, drawing on the principles of trauma-informed care and the work of Judith Herman, can help trainees to be more confident in promoting the basic rights of survivors of trauma, which might form a first step in the re-establishment of trust and empowerment.

Contents

- *Basic safety first: trauma-informed care in a hostile environment*
 - *Individual and societal responses to trauma*
 - *Facing a culture of disbelief*
 - *Trauma-informed and human rights-based care*

There has never been a more timely moment to highlight the needs and rights of asylum seekers and refugees, as so comprehensively described in this month's Praxis article 'Assessing asylum seekers, refugees and undocumented migrants', by Waterman *et al*.¹ This population and those who care for them face many challenges. Not least of these is the ongoing hostile environment. In the UK, immigration checks are embedded in everyday interactions and accessing healthcare may result in sharing of personal data with the Home Office, leading to deportation or detention.² Frequently changing funding arrangements related to Brexit threaten numerous charities that support migrants.³ However, Waterman *et al*'s article can empower us to be hopeful and compassionate and, importantly, well-versed in relevant law. In so doing it embraces some of the core values of a psychiatrist as outlined by the Royal College of Psychiatrists, including advocacy, empowerment and a person-centred biopsychosocial approach.⁴

The article introduces a fictitious but sadly all too familiar case, which begins with a presentation in crisis at an inner-city 'place of safety'. What I have learned in reviewing this article has already helped me to advocate for two patients under my care to receive National Health Service (NHS) treatment and eligibility for housing that was called into question owing to legal uncertainties. Both had been the victims of torture and were at varying stages in asylum claims. The securing of such basic rights is the first step for survivors of trauma beginning to find safety and regain control over their lives, what Judith Herman describes as a primary stage in her book *Trauma and Recovery* (p. 326).⁵ However, it would seem that I was not alone in my ignorance of the complexities of law. A recent survey of a 514 health professionals found that only 26% were aware that all migrants were entitled to free general practitioner (GP) services.⁶ Just 39% were able to identify which groups of migrants were entitled to non-emergency NHS care.⁶

Individual and societal responses to trauma

In words that still hold true today, Herman wrote in the introduction to her powerful work: 'The ordinary response to atrocities is to banish them from consciousness'.⁵ Psychiatry and trauma have a long and complicated relationship. Trauma has had an often 'underground' history, resurfacing and then disappearing at various points depending on the sociopolitical climate.⁷ As far back as 1919 Janet recognised that the survivors of trauma 'are unable to make the recital which we call narrative memory, and yet they remain confronted by [the] difficult situation' (Janet 1919: see van der Kolk *et al*⁸). Years later Kardiner built on Janet's studies of 'hysteria' in women to formulate the outlines of traumatic syndromes in male combat veterans (Kardiner 1941: see van der Kolk *et al*⁸). Contemporary psychiatrists such as Herman and van der Kolk have formulated and communicated clearly and conclusively how traumatic life experiences have far-reaching effects on the mind and body. This has paved the way for an understanding of the neurobiological effects of trauma on the brain, endocrine and immune systems, including dysregulation of the hypothalamic–pituitary–adrenal axis and sympathetic nervous hyperarousal.⁹ Thanks to Felitti and colleagues' large and important study on adverse childhood experiences (ACEs), there are now robust and undeniable links between exposure to trauma and cardiovas-

cular and respiratory disease, cancer, obesity, chronic pain and gastrointestinal illness.^{9,10} The intergenerational effects of trauma are also being increasingly understood. It has recently been found that the children of mothers who were Holocaust survivors and suffered post-traumatic stress disorder (PTSD) have increased glucocorticoid sensitivity.¹¹

Herman, more than 20 years ago, identified the syndrome of complex post-traumatic stress disorder (CPTSD).¹² Yet it has taken tireless work and campaigning from clinicians, researchers and people with lived experience for it to now be included in ICD-11.¹³ The operationalisation and recognition of the diagnosis is a significant step towards research and treatments which acknowledge that prolonged and repeated trauma profoundly affects the sense of self, affective stability and relationships. Indeed, some studies have shown that CPTSD may be even more common than PTSD,¹³ and deserves specialist attention, both within services and also in the educational curricula for future psychiatrists.

Facing a culture of disbelief

The article by Waterman and colleagues avoids the scapegoating of refugees¹⁴ and the ‘denial, repression and dissociation’ of trauma that Herman identified operating on both societal and individual levels.⁵ Refugees and asylum seekers who are survivors of trauma encounter multiple challenges, which are described in the article. First, there is the trauma itself, which is known to cause ‘disintegration of experience’ and loss of narrative.⁸ Echoing Janet’s work, Herman describes how ‘people who have survived atrocities often tell their stories in a highly emotional, contradictory and fragmented manner’.⁵ Yet the processes of accessing healthcare or asylum demand that survivors tell their story repeatedly, and they are received by a ‘culture of disbelief’ and face both testimonial and hermeneutical injustice.^{2,15} Individuals who are already hypervigilant to threat must navigate health services that may share information with the Home Office, mistakenly charge them for treatment and inadvertently re-victimise them with unjust, uneducated and sometimes perverse decisions.² Psychiatrist Sandra Bloom states: ‘because of complex interactions between traumatized clients, stressed staff, pressured organizations, and a social and economic environment that is frequently hostile to the aims of recovery, our systems frequently recapitulate the very experiences that have proven to be so toxic for the people we are supposed to treat’.¹⁶

Trauma-informed and human rights-based care

Trauma-informed care can provide some framework for individuals and health services and is premised on a fundamental shift from thinking ‘What’s wrong with you?’ to ‘What happened to you?’.¹⁷ Such approaches seek to rebuild trust, create safe environments, empower and to avoid re-traumatisation.¹⁷

After reading this Praxis article I would urge trainees to familiarise themselves with the principles of trauma-informed care and to think how these might be applied in their organisations. Sweeney and colleagues’ article in *BJPsych Advances* is an extremely helpful summary.¹⁷ We must also remember that trauma does not occur only in wars or in other countries; experiences of torture and childhood adversity are all too common, as highlighted by the original study of ACEs in the USA.¹⁰ Research in the UK has found a similarly high frequency, with 47% of almost 4000 participants reporting having experienced at least one ACE.¹⁸ The pivotal works of Herman⁵ and van der Kolk¹⁹ provide a compelling, compassionate and eloquent narrative on a subject that is so often unspeakable. Practical resources and links to specialist agencies for asylum seekers and refugees can be found as an online supplement to the Praxis article.¹ Trainees may be interested to explore the various communities of healthcare professionals who advocate for human rights-based approaches to healthcare such as Medact (www.medact.org/project/migration-health), Docs Not Cops (www.docsnotcops.co.uk) and the Twitter hashtag #patientsnotpassports. Poetry and storytelling can also communicate and transform, with the potential to both educate and liberate from shame and secrecy.

British-Somali poet Warsan Shire writes in her poem ‘Home’: ‘no one leaves home unless home is the mouth of a shark. You only run for the border when you see the whole city running as well.’²⁰ I hope that Waterman and colleagues’ article offers trainees a framework for thinking about providing safe and compassionate care to asylum seekers, refugees and undocumented migrants. I thank the authors for their perseverance in bringing together complex legislation and issues of mental and physical healthcare in such a fine example of what we are seeking in Praxis articles. The article and the work of Herman, van der Kolk and the principles of trauma-informed care demand us as clinicians, as fellow humans, to bear witness and to empower survivors. We must strive to avoid re-traumatisation and rejection, despite the current hostile environment in which we live and practice.

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1.3.6 Online psychotherapy: trailblazing digital healthcare

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Abstract

Advances in digital technology have a profound impact on conventional healthcare systems. We examine the trailblazing use of online interventions to enable autonomous psychological care which can greatly enhance individual- and population-level access to services. There is strong evidence supporting online cognitive-behavioural therapy and more engaging programmes are now appearing so as to reduce user 'attrition'. The next generation of autonomous psychotherapy programmes will implement adaptive and personalised responses, moving beyond impersonalised advice on cognitive and behavioural techniques. This will be a more authentic form of psychotherapy that integrates therapy with the actual relationship experiences of the individual user.

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- *Online psychotherapy: trailblazing digital healthcare*
 - *Advantages associated with an online medium for psychotherapy*
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 - *Forms of additional support for online therapy*
 - *Online therapy: strengths, weaknesses and potential concerns*
 - *The next generation*
 - *Future directions*

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As in many other countries, the UK is looking to expand digital technology to control burgeoning healthcare costs. These plans are articulated in recent government publications such as *The NHS Long Term Plan*.¹ The top level of this ambitious scheme refers to a system that might offer seamless care across all aspects of the National Health Service (NHS) and associated services. A second level proposes enhancing access to clinicians through digital platforms such as video conferencing channels. A third level is the ambition for broad implementation of technological monitoring services for patients in their homes, enhancing care in the community through high-quality information. However, this long-term plan also illustrates that, particularly in general medicine, the implementation of autonomous computerised treatment remains a distant goal. In mental health, by way of contrast, psychotherapy is trailblazing this field. The recent Royal College of Psychiatry recommendations accompanying the NHS long-term plan² recognise the value of extending therapist-led psychotherapies through technology, for instance by using avatars to explore client identity. However, even here there is limited recognition of progress toward autonomous psychotherapy treatments where digital treatment programmes are established NHS-approved referral options. Examples of such programmes include *FearFighter* (UK),³ *MoodGYM* (Australia; <https://moodgym.com.au/>) and *SPARX* (New Zealand; <https://www.sparx.org.nz/>). We refer to these programmes in our appraisal of current digital psychotherapy services, which we then compare with the next generation of autonomous therapies that will offer a truly individualised form of therapy, informed by the user's personal profile and experience.

Advantages associated with an online medium for psychotherapy

Online therapy offers a number of potential advantages compared with other therapies. Perhaps the most obvious are broad accessibility and low treatment cost; however therapists also refer to the fact that patients often find it a less inhibiting medium, enabling greater disclosure and interaction.⁴ There is, in addition, a belief that young patients are generally more willing to engage with digital interfaces, as explicitly noted by the team working on a gaming application in New Zealand (*SPARX*).

Accessibility

Specific groups may particularly benefit from the improved accessibility of psychotherapy when offered through an online medium. These include those in low- and middle-income countries, the financially disadvantaged individuals without access to a free health service, full-time employees, people who cannot physically visit therapists and those who are not deemed 'ill enough' to meet a threshold to be offered services. Nevertheless, accessibility would not be augmented for those who are unable to engage with a digital service due to a lack of equipment, physical constraints or poor online confidence. Such individuals are over-represented in psychologically vulnerable groups.

In low- to middle-income countries, the responses to psychotherapy for depression are high, and there does not appear to be a requirement for the therapy to be adapted to local situations.⁵ These effects appear larger than in the high-income countries; this may partly reflect less-efficacious 'standard treatments', resulting in limited improvement in comparison control groups. There is ample scope to access the online-therapy format as ownership of mobile phones has high priority in these communities: 67% of African people owned a mobile phone in 2018.⁶

In high-income countries, free provision of psychotherapy is by no means universal. Psychotherapy is a relatively expensive service, often provided on an individual basis in predefined sessions typically totalling 6–20 h. Financial costs limit access to those who can afford treatment but, even where free-to-user services exist, access tends to be rationed according to symptom severity and degree of functional impact. Thus, individuals who are functioning reasonably well, in particular those who are working, are rarely eligible for psychotherapy even if quality of life is low. An online service could reach many of those individuals who cannot afford high therapy costs, and those individuals judged to be below the arbitrary threshold of clinical severity for access to standard delivery of psychotherapy.

Physical constraints compromise engagement with multisession therapies and may have medical, social or psychological origins (e.g. physical disability, imprisonment or agoraphobia). Among mental health symptoms, Community

Mental Health Teams in the UK recognise agoraphobia and social anxiety as a common barrier to accessing and delivering therapy. However, community patients can also struggle to access psychotherapy if they are perceived as having anger problems and are implicitly judged a risk as emotionally challenging issues are explored during therapy. Large geographical areas with sparse populations can limit access to specialised psychotherapy. In Australia and New Zealand, geographical access has motivated the priority development of online psychotherapy.

Financial costs

Online psychotherapy encompasses multiple modalities and approaches, including online contact – either through a video service or texting – with a therapist. Clearly the cost of this type of treatment is broadly comparable to face-to-face therapy in well-populated areas where travel is not a major factor but it can support service access. There are also systems that offer a limited amount of personal contact with a guiding therapist while the patient works through online modules. This can take the form of ‘check-up’ phone calls through to full therapy sessions interspersed between the computerised modules. However, ‘unguided’ therapy, where the patient uses a programme autonomously without any direct or personalised therapist support, has the most potential to save significant costs. Autonomous digital psychotherapy can nevertheless incorporate automated text messages and even user forums, while retaining minimal therapist costs. This type of therapy may represent a viable ‘first-level’ care strategy, with patients progressing to therapy with personal contact if required thereafter.³ Many programmes have been shown to be effective; however sustaining patient engagement in the therapy, which can be as low as 20% by the end of a treatment programme,⁷ remains a problem. However, because such a large number of people could be treated very cheaply, the potential gain in care is still enormous, provided the online therapy does not discourage or prejudice the efficacy of any future personalised therapy.

Current online therapies

The aim of early pioneering work on online therapy was to overcome access problems caused by population dispersal. Leading developments have thus originated in Australia (e.g. *MoodGYM* and *BluePages* [<https://bluepages.anu.edu.au/>]). Similarly, in New Zealand the development of *SPARX* was driven by poor mental health across widely dispersed young people. These therapies are offered on three financial bases: charged, access paid by health services and free to access. Australian services approve the use of *MoodGYM* (free) and *MyCompass*.⁸ New Zealand nationals can use *SPARX* for free. The UK’s NHS partly funds the use of two computerised cognitive–behavioural therapy (CBT) programmes, *Beating the Blues* (<http://www.beatingtheblues.co.uk/>) and *FearFighter* (<https://magellanascent.com/Content/View/2526>), as part of their ‘stepped model’ of treatment for depression and anxiety, respectively.³

The evolution of online psychotherapy is shown in *Fig. 1*. The earliest autonomous treatments, primarily based on CBT, are interactive programmes where users complete questionnaires and white-space areas with their own information so as to develop their insight and encourage internal reflection about habitual behaviour. This is combined with examples of characters with extreme forms of behaviour to help the user recognise their own thinking and behaviour patterns. *MoodGYM* is an illustrative example of this form of online therapy. Extensive evaluation suggests *MoodGYM* promotes significant improvements in users’ mental states.^{9–13} *MoodGYM* and related programmes generally consist of five to ten CBT modules that consider key aspects such as negative thinking and activation. The path through the programme is not modified according to earlier information provided by the user. This genre has now been extended to programmes that engage the user in mindfulness and meditation. *Headspace* (<https://www.headspace.com/>) is a well-known commercial example. Here the user participates in meditation exercises, including breathing and focusing, accompanied by calming graphics. Programmes within this general category, including those based on both CBT and mindfulness, may send automated texts to the user, often as reminders to engage with the programme. There is also a subgenre that combines online therapy with intermittent therapist contact through the use of phone calls, messages or emails. *Fig. 1* Evolution of online autonomous psychotherapy (may include access to a user forum). a. https://business.talkspace.com/?_ga=2.6168373.769027487.1553093877-2135218530.1553093877 b. <https://www.helloself.com/> c. <https://www.italk.org.uk/1-2-1-treatments-groups/computerised-therapy-c-cbt/> d. https://www.online-therapy.com/about_us.php e. <https://moodgym.com.au/> f. <https://www.headspace.com/> g. <http://ccbmain.cbtprogram.com/products/fearfighter/> h. <https://www.sparx.org.nz/> i. <http://www.celestegame.com/> j. <https://www.wysa.io/meet-wysa> k. <https://www.youper.ai/about-us> CBT, cognitive–behavioural therapy.

These early forms of online psychotherapy treatment require a high level of motivation that may be challenging for people with mental health problems. Concerns about engagement have prompted the introduction of ‘gamified’ CBT resources such as *SPARX* and *Celeste* (<http://www.celestegame.com/>), where CBT techniques are embedded within an intrinsically entertaining experience. *SPARX* offers self-help for young New Zealanders by being set within such a video-gaming framework. The user selects an avatar to fulfil a number of tasks, which include challenges such as bursting floating bubbles called GNATS (gloomy negative automatic thoughts) with a staff, while receiving CBT-based wisdom from a guiding character who draws links to behaviour in the user’s own life. *Celeste* is an even more traditional game which has drawn acclaim from video-game forums. *Celeste* centres on a nervous character who ‘learns’ to modify anxiety through CBT techniques that include breathing- and meditation-style tasks. These programmes may herald a new genre in which online virtual worlds combine gaming with the mutual support of internet forums.¹⁴ *Autcraft* (<https://www.autcraft.com/>) is another notable example of an early development of this format; it is packaged as a ‘limited edition’ of Minecraft which offers a kinder and more protected environment for autistic users to build confidence and practice social interaction. There is, however, a tension within such gamified applications in balancing the need to provide therapy while maintaining the unbroken flow of a game.

Not unrelated to interactive gamified therapy is the increasing presence of ‘chatbot’ forms of therapy. The programme is set within a machine-messaging environment and so is able to ‘chat’ to the user. These programmes, of which *Wysa* (<https://www.wysa.io/meet-wysa>) is a very good example, tend to deliver CBT, mindfulness and meditation. User are free to move between the encouraging and supportive online machine ‘conversations’ and subunits engaging them in direct psychotherapy. These programmes store information about the user, including their current state of mind, and use this information within the ongoing conversation. An example of this would be a comment such as ‘You said that you felt low yesterday, are you feeling a bit better today?’

The next stage in the evolution of autonomous online therapy is likely to involve a significant extension of the collection of user information and increased ‘tailoring’ of programme responses to the user’s behaviour and relationship experiences (*Fig. 1*). This would move online care beyond CBT-style interventions and start to offer a relational form of therapy, through which the user can develop a deeper insight into his/her own relationship styles, their aetiology and potential means of escaping negative patterns of behaviour.

Existing internet forums can offer mutual support for those with psychological distress or more specific mental health problems. They are sometimes suggested or offered as adjuncts to the types of digital therapy programmes described above. The use of such forums may or may not be free and are generally moderated. Examples include *Mood Garden* (<http://www.moodgarden.org/>) and *Big White Wall* (<https://www.bigwhitewall.com/v2/Home.aspx?ReturnUrl=%2f>), the latter of which has trained staff online on a 24-h basis.

Evidence base for online therapies

Research into online therapies reveals two important aspects: (1) improvement of psychological state, and (2) the degree of engagement demonstrated by users (Supplementary Table 1 available at <https://doi.org/10.1192/bjb.2019.66>). Perhaps unsurprisingly in view of the heterogeneity of studies, a wide range of results are shown for both of these measures across the different online programmes. The selection of participants is also a factor, which may depend upon unsolicited clicks on a website through to targeted selection of a specific patient group. Many studies include brief phone or text contact to encourage engagement.

Online CBT programmes have been the main source of evidence for efficacy of digital therapies. However, examination of bias-modification programmes for anxiety reveals weak effects of borderline significance (observed effect sizes, 0.07–0.42).⁸ In contrast, for a mindfulness programme aimed at patients with established bipolar disorder, a significant change is observed with an effect size of 0.52 on an intention-to-treat basis. Nevertheless, the attrition rate was 38%.¹⁵

There is a paucity of published evidence on those users who begin online CBT therapy independently through search engines or clinical recommendations. One informative exception is data on the use of the modular CBT programme *MoodGYM*. Only around 25% of arrivals proceeded from the initial introductory module through to a second module. Moreover, the maximum observed pre-post effect size was 0.4.^{7,9} Notably, around 50% of those enrolling on such programmes fulfil clinical criteria for depression.

Thus the majority of research into effectiveness examines the effects of CBT programmes on preselected clinical populations. Here, the typical pre-post effect size is 0.5–0.8^{8,13,16,17} with variation between individual studies. The effect size drops when a comparison group – typically a treatment-as-usual or waiting-list group – is included, negating statistical group differences in a subset of studies. On average, the effect size is typically reduced to around 0.4,^{13,17,18} which represents a low to moderate treatment effect. This suggests that part of the pre-post effect is a natural recovery cycle from psychological distress, a view also supported by mixed findings as to whether recovery is enhanced by an increased engagement with the digital programme. No association was found between reliable clinical improvement and either the (extended) duration of engagement with an online programme¹⁸ or the number of therapy modules offered,⁷ although other studies do report increasing therapeutic benefit in association with longer therapy engagement.¹⁹

Engagement is generally poor, with high rates of attrition among user of online therapies. A true meta-analysis of these data is impossible given the range of measures across studies (including full programme completion, minimum ‘adequate’ number of therapy sessions, average percentage of completed modules, percentage of participants progressing to second module or percentage completing half of the modules). However, data for full completion or adequate engagement show a wide range, e.g. 16–82% for completion. A ‘typical’ value appears to be around 50% for the completion of half of the modules.^{12,13,17,18,20–25}

The degree of engagement with online therapy is likely to reflect the variety of programmes, the range of indications or whether users were contacted (e.g. brief emails or text) to encourage adherence. Some of the factors that affect therapy engagement have been studied; for example observed higher levels of therapy adherence are reported in people with lower baseline symptoms.¹⁹ Although other studies have not found associations between engagement and symptom severity or improvement.¹⁸ Among social factors, adherence is reported to be higher among users who are white and older.²³ A meta-analysis also found engagement is better in females, individuals with higher educational attainment and in older users. Comorbid anxiety symptoms appear to introduce an additional challenge to adherence.²⁶

Forms of additional support for online therapy

A number of ‘add-ons’ have been introduced to stand-alone online therapy programmes, generally with the aim of reducing attrition. These include brief contact with therapists or allied health staff by phone or text. The use of weekly phone calls seems to be a particularly popular approach during treatment trials with the aim of increasing engagement. The number of therapy modules, out of ten, that were completed increases from when a user has no contact, to a weekly email to a weekly phone call (3.7, 5.5 and 7.3 modules, respectively).²⁴ A related approach is the use of automated reminder emails. Interestingly, better results appear to be achieved when the automated email informs the user about new site content, rather than simply reminding them to return to the programme. Moreover, email reminders are more effective when sent after 2 weeks of absence than when the user had been absent for 4 or 6 weeks.²⁷

An alternative add-on is membership of a social forum with other users, noted above to be a potentially valuable adjunct to a bipolar disorder mindfulness programme.¹⁵ Although the addition of a forum generally requires staffing in the form of moderation, peer support can improve adherence to psychoeducation modules.²⁸ Forum membership is reported to provide an impetus to ‘keep going’ in a qualitative study of a CBT sleep improvement programme. Here, users offered each other support during difficult parts of the programme.²⁹ Reported reasons for involvement with the forum were a desire to connect with peers, receive personalised advice, curiosity, being invited and wanting to use all sleep improvement tools. Reasons given for not joining the forum include design problems, negative self-comparisons, excessive time commitment, data privacy concerns and the uncertain quality of user-generated content. A user forum linked to an online CBT programme for individuals receiving prostate cancer treatment failed to show any improvement in CBT programme completion.³⁰

Online therapy: strengths, weaknesses and potential concerns

As previously discussed, there are concerns about the high attrition rate in the use of online therapy programmes and the small-to-moderate effect size when compared with other groups such as those on the waiting list or receiving treatment as usual. Expectation management should thus form an integral part of such programmes.³¹ One potentially compensating effect at the service level is the low cost of massive open online interventions. When the cost of minor improvement is minimal and the number of patients receiving treatment is so large, there is a large resulting gain in psychological health. Related to this is the advantage, highlighted above, afforded by an increased accessibility of treatments that no longer need to be time limited.

Online therapy is likely to be most appropriate as an early phase in a stepped treatment plan.^{3,13} A potentially worrying aspect of online therapy is whether it might have a negative impact on acceptance/receptivity to face-to-face therapy. Interestingly, enthusiasm for personal CBT may be increased among individuals receiving online treatment when compared with the provision of only psychoeducational information about depression,³² or there may be no observable effect on face-to-face treatment.³³ Some users of course may become ‘well enough’ that they do not feel in need of the further improvement that could occur through subsequent face-to-face therapy.³⁴ This is an odd reversal of the potential gain of online therapy improving the condition of those not considered ill enough to require face-to-face therapy.

It is also important to consider whether other harmful effects might result from engaging in online psychotherapy. Higher rates of clinical deterioration occur in patients receiving watchful waiting (7.2%) than those receiving online CBT (5.8%).³⁵ Feedback from those who completed a mindfulness programme saw 15 users denying any issues whereas 1 had been uncomfortable during a 30-min exercise (body scan) as it reawakened a traumatic memory.¹⁵ This potentially supports the concern that re-traumatisation might occur with increased vulnerability due to the reduction of psychological defences. A less direct form of harm to a user might occur if online responses could be subject to subpoena.³⁴

There are potential concerns that high-risk individuals may not be identified during online therapy. Questions have been raised as to whether it should be possible, or ethical, to trace individuals directly if worrying information is declared while using the programme. Coupled telephone help services are provided for users of some programmes such as *SPARX*. Other programmes rely on the presentation of emergency contact details in a more generic form, for example advising users to contact local mental health services or helplines. Similar issues have long been recognised with respect to self-help manuals, whether they are presented as literature or online. Online therapies have more opportunity to provide support through ‘help’ buttons or facilities to put the user in immediate contact with personal support by phone, email or messaging. An as-yet-unresolved issue relates to the international nature of the internet that makes it difficult to establish the jurisdiction under which the programme is being operated,³⁴ and consequently how users might seek redress for grievances.

The next generation

All of the psychotherapy programmes discussed above share a critical limitation. They do not adapt to the behaviour and relationship styles of the individual user. They set out to treat a ‘typical psychology patient’ and supply information that is known to be widely helpful in developing a healthier self-narrative. Thus *MoodGYM* encourages the user to understand the concept of ‘warpy thoughts’, which are related to automatic negative assumptions. *MoodGYM* illustrates this principal with tales of the experiences of programme characters with varying mental states. The user is then invited to reflect on circumstances in their own life when they react in this automatic negative manner. There is no feedback or onward development of these personal experiences by the programme. Similarly, *SPARX* encourages the user’s avatar to destroy pictorial bubbles or GNATs, then further expands on how these types of thoughts are expressed in ‘real life’. But again, the information is not specific to the user’s experiences in any manner. The chatbot programmes provide generic information for problems suggested during the chat conversation.

The limited dynamic personalisation makes it very difficult to move beyond meditation- and CBT-type programmes toward more relational forms of psychotherapy that are critically dependent on personal interactions both inside and outside the therapy room. Nevertheless, there is no inherent reason why such relationships cannot be explored online with personalised responses. The programming of such a functionality within a digital therapy is inherently more complex, requiring a wider range of outcomes, depending on the user’s inputs. The implementation of such levels

of complexity within online psychotherapy programmes is ongoing and is anticipated to lead to truly personalised therapies. This key development will presage the arrival of the next generation of autonomous online psychotherapy programmes.

Future directions

We are at an exciting phase in the development of autonomous online psychotherapy services. Increasingly, programmes are aiming to move from being informative to entertaining. The advent of programmes such as *SPARX* and *Celeste* as well as the protected virtual reality of *Autcraft* show how developers now attempt to offer integral enjoyment to facilitate the therapeutic process. This is a promising solution to the problem of high attrition observed in today's more 'instructional' programmes, despite their excellent therapeutic value for those individuals motivated enough to work through the programme. We now anticipate another generation of autonomous online psychotherapy where programmes will become responsive to the circumstances of the individual user and offer an agile, adaptive environment in which the user should feel more personally engaged with the process.

It might be intuitively strange to think about psychotherapy, a highly relational form of medical treatment, being in the forefront of autonomous digital care. Perhaps this can be explained by the fact that we are often seeking to treat the unfortunate effects of earlier interactions with others. Themed interaction with another's mind, through an internet programme, offers a fresh framework through which earlier negative experiences might be reconsidered, reappraised and restructured for future well-being. Ultimately, the future of autonomous digital psychotherapy is not about communication with a computer, but with the body of knowledge established through evidence-based practice and its dynamic tailoring to personal need.

Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2019.66>.

[click here to view supplementary material](#)

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1.3.7 Assessing asylum seekers, refugees and undocumented migrants

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Abstract

Identifying the causes of psychiatric and physical symptoms in asylum seekers, refugees and other migrants and making definitive diagnoses can be challenging. Ethical and legal challenges in the UK include the likely deterrent effects of upfront charging for National Health Service (NHS) services. This paper focuses on the fictitious case of an asylum seeker presenting to a mental health service in England, highlighting some of the difficulties in assessing and treating this patient group and providing advice to clinicians on clinical and practical management. Current NHS entitlements for migrants are summarised and a list is presented in the online supplement of non-governmental organisations that can provide further support.

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Clinical scenario

You are a psychiatry trainee at an inner-city ‘place of safety’ unit in England. You have been called to see Mr S.T., a 30-year-old Tamil asylum seeker from Sri Lanka, who has been brought in at 22.00 h by police. He is reported to be ‘responding to voices’ and to have collapsed twice, apparently losing consciousness. S.T. speaks minimal English and the Tamil telephone interpreter does not appear to be translating everything he is saying. Furthermore, S.T.’s ability to use the telephone service is limited owing to his distractibility and apparent guardedness towards the interpreter.

S.T. had claimed asylum on arrival at the UK border in 2015. He describes having fled Sri Lanka, where he had been detained and tortured for many months. However, his asylum claim was refused a month ago because of inconsistencies in his account. He was then evicted from accommodation provided by the Home Office and has since been street homeless. The timeline is difficult to establish and his story is not fully coherent.

S.T. states that since his traumatic experiences he has been experiencing frequent visual and auditory hallucinations, mood swings and ‘jumpiness’ whenever there is a loud noise. He avoids being close to anyone wearing a uniform and prefers being alone. He has not had a physical health check since arrival in the UK 4 years ago. He explains that initially he was unaware of how the medical services worked or what he was entitled to. Since his asylum refusal he has been feeling intermittently dizzy and has experienced several episodes of collapse, about which he can remember little. He recently tried to register with a general practitioner (GP); however, the GP practice refused to take him on because he had no proof of address. S.T. stopped trying as he became fearful that the GP would forward his whereabouts to the Home Office and that he would then be sent back to Sri Lanka, where he believes his life would be in danger.

After carrying out an initial assessment, you are uncertain whether there might be an underlying organic cause to S.T.’s presentation, as he has not had any previous medical investigations in the UK. You also feel that he would benefit from a period of in-patient assessment to further clarify the diagnosis and risk. Furthermore, because he is street homeless there is no safe place to discharge him to. He is consenting to in-patient admission but has no funds to pay for National Health Service (NHS) secondary care and you are unsure what NHS care he would be eligible for. The key questions raised by this case are presented in *Box 1*. **Box 1** Key questions •What is this person’s most likely diagnosis?•What are the possible causes of his physical symptoms?•What NHS treatment is he eligible for?•What management would you provide?•What political and social issues may you need to consider?

Assessment, differential diagnosis and formulation

Could there be a non-psychiatric cause for S.T.’s physical symptoms?

Many migrants are not registered with a GP, for reasons described below. It is therefore common to encounter someone such as S.T. who, despite being at high risk for physical and mental illness, has not previously accessed healthcare since arrival in the UK and may have multiple undiagnosed and untreated illnesses. This adds significant complexity to the diagnostic assessment as, although asylum seekers are more likely to have physical symptoms as a result of psychological trauma, they may also have undiagnosed physical illnesses and physical injuries as a result of torture. It is therefore vital to complete a full physical health workup, including screening for tuberculosis and sexually transmitted infections where indicated, in order to identify and treat medical conditions. Extra care should be taken during physical examinations to avoid retraumatizing the patient.

Dizziness and collapse are important features of S.T.’s presentation. Not only does he find these episodes distressing but his lack of awareness during the episodes renders him vulnerable to injury, exploitation and violence. When assessing patients who are in severe distress it is important to be mindful of the potential for diagnostic overshadowing and vital to identify possible medical causes for these episodes. These could include epilepsy, non-epileptic attack disorder, hypoglycaemia, dehydration and vasovagal syncope (fainting), and potentially substance misuse. If a neurological cause is suspected, referral to neurology may be indicated. Epilepsy is often difficult to distinguish from non-epileptic seizures and the two may both occur in the same individual. Important causes of non-epileptic seizures (particularly in people who have been severely traumatised) include panic attacks and dissociative episodes.¹ Panic attacks are usually rapid but not immediate in onset and are associated with prominent autonomic symptoms such as palpitations, shortness of breath and tingling in the extremities. Dissociation is a psychological defence mechanism manifested as a perceived detachment of the mind from the emotional state and the body. It often occurs in the aftermath of severe trauma and

may be triggered by reminders of the trauma. In our clinical experience, episodes of dissociative ‘unconsciousness’ are particularly common in people who have been subjected to sexual trauma and who have an overwhelming sense of shame and revulsion about what has been done to them.

A detailed history, including a collateral history (where possible), neurological examination and simple investigations (such as blood sugar and blood pressure, both during and after the episode) can be helpful to distinguish between these causes.

Psychotic phenomena in PTSD: a diagnostic challenge

S.T. was reported to be ‘responding to voices’. This might initially be thought to indicate a primary psychotic illness such as schizophrenia. However, it is also important to consider whether the voices might be a manifestation of post-traumatic stress disorder (PTSD). In PTSD, individuals may hear voices as part of a flashback to past traumatic events. Flashbacks may be triggered by reminders of the trauma or stressful situations and could therefore be intensified when the person encounters uniformed officers or is placed in a confined space (such as in hospital). Victims may find it difficult to distinguish these vivid phenomena from reality and may respond to them.

Ways in which flashbacks can be differentiated from primary psychotic experiences include: by their close relationship to the past traumatic experiences; by their transience; and by the preservation of some degree of insight. However, many experts believe that some people with PTSD also have more generalised psychotic experiences which are best understood as part of the PTSD process. This has been termed ‘PTSD with secondary psychotic features’.² A history of trauma is also common in people with psychosis. Therefore, it can be challenging to make a differential diagnosis of a psychotic illness in someone with comorbid symptoms of PTSD and it is common for clinicians to disagree on the primary diagnosis.

Distinguishing complex PTSD from PTSD and emotionally unstable personality disorder

Complex post-traumatic stress disorder (complex PTSD) is a new diagnosis included in the forthcoming ICD-11.³ Complex PTSD is more likely to develop following exposure to prolonged or repeated traumatic events from which escape is difficult (such as torture, slavery, human trafficking, prolonged domestic violence and repeated childhood abuse), whereas PTSD tends to develop following isolated traumatic events.⁴ Complex PTSD is also more likely to develop following interpersonal trauma than following events such as a road-traffic accident.⁴ Complex PTSD shares the same core features of PTSD (exposure to a threatening or horrific event, re-experiencing of the traumatic event, avoidance of traumatic reminders, sense of current threat and interference with functioning) but includes three additional features, all of which must be present for the diagnosis to be made. These are: interpersonal disturbances, affect dysregulation and a persistent negative self-concept. These additional features are believed to result from the degradation of the person’s self-identity and autonomy. Functional impairment tends to be worse in complex PTSD than in PTSD, and standard PTSD treatment may be less effective.⁴

It can sometimes be challenging to distinguish between complex PTSD and PTSD with comorbid emotionally unstable personality disorder (EUPD), since complex PTSD and EUPD may both stem from trauma in early life and share disturbances in affect regulation, self-image and interpersonal relationships. Although a pertinent feature of personality disorders is that, by definition, they develop in childhood, it can be particularly difficult to differentiate the disorders in someone who has experienced traumas at an early age or for whom we know little about their premorbid personality, like our patient S.T. However, there are some key differences: in EUPD, the person’s self-image and interpersonal relationships tend to be unstable, whereas in complex PTSD the person is more likely to avoid relationships and have a persistently negative self-image.⁵

Cultural idioms of distress

It is important to consider cultural idioms of distress when assessing patients from different backgrounds. For example, perceptual disturbances such as hearing voices might have a different significance or meaning to that assumed in a Western medical model. As with any symptom, asking the patient what it means to them is often illuminating. The section on cultural formulation in DSM-5 has some useful questions in this regard.⁶

A challenge for assessment: memory deficits are common following trauma

Trauma and its associated disorders, including PTSD and depression, are associated with relative deficits in autobiographical memory retrieval,^{7,8} and there is evidence that other aspects of memory may also be affected.⁹ As a result, asylum seekers who have experienced trauma may tell a story that is convoluted and has an inconsistent timeline, which can make eliciting a clear history challenging. It is often helpful to check back frequently with the patient to make sure that you have understood correctly and to reflect with the patient on elements of the account that you find inconsistent or incomprehensible. The process of recounting may be distressing for the patient; thus, breaks may need to be taken and it is often not feasible to elicit a full account in a single session.

Of note, it is therefore possible that S.T.'s poor memory had affected his asylum claim, since an inconsistent story or inability to recall specific memories is often considered by immigration systems to indicate poor credibility, despite this link between trauma and memory deficit.¹⁰

Decompensation since refusal of the asylum claim

S.T.'s mental health worsened following the refusal of his asylum claim. This is not surprising, since such refusals are often associated with being discredited and disbelieved and with the threat of imminent removal to a place where the individual believes themselves to be unsafe. Refusal of an asylum claim is also often associated with loss of accommodation and financial support. Even for those who are currently awaiting a decision, the research evidence indicates that prolonged immigration uncertainty is associated with a deterioration in mental health.¹¹

Many asylum seekers' claims are refused because of inadequate legal representation and/or lack of evidence to support their claim. These individuals may present in crisis and healthcare professionals are often unsure how to help people with such a precarious socio-legal situation. A number of useful charities that provide psychological, social and/or legal support are listed in online supplement 1 (available at <https://doi.org/10.1192/bjb.2019.67>).

Eligibility for treatment from NHS primary care, in-patient and community mental health services, and common access barriers

Is it important to note that it is not your job as a clinician to make decisions about who should receive NHS treatment free of charge. This responsibility lies with the NHS trust. According to General Medical Council guidance, the clinician's primary duty is to treat the patient. However, you may be asked by your NHS trust about the clinical urgency of providing treatment for patients who the trust has deemed otherwise 'ineligible' for free treatment (as highlighted below). Additionally, it is important to be aware of the eligibility for NHS services of different migrant groups so that, in making your management plan, you have an idea of potential barriers to access for these patients and can advocate for them as necessary.

Access and barriers to treatment in general practice

Eligibility for primary healthcare

According to guidance issued by NHS England in November 2015, anyone in England can register with a GP and receive GP services without charge and ‘GP practices are not required to request any proof of identity or of immigration status from patients wishing to register’.¹²

Barriers to registering with a GP

GP practices often mistakenly believe that prospective patients need to provide proof of address and residency, even though that is not legally required. This can result in vulnerable migrants being turned away. For example, of 1717 migrants who approached a charity following difficulties registering with a GP, 20% were still wrongly refused GP access even when supported by a charity case worker.¹³ Some GP practices register migrants as temporary patients,¹⁴ even though they are eligible to be registered as permanent. Migrants such as S.T. may not have a fixed address or may not have access to identity documents or proof of address.

Data protection and confidentiality issues

An additional barrier is that refused asylum seekers and undocumented migrants may be afraid to give personal details to a GP practice in case these details are accessed by the Home Office, which could in turn lead them to be arrested, detained and/or deported. Some try to get around this by registering using an alias.¹⁵ Their fears are well-founded. Non-clinical information about patients may be disclosed to the Home Office by NHS services in certain situations, such as if a patient who is ineligible for free treatment does not pay their treatment bill within 2 months. Their debt to the NHS may also affect their future immigration applications.¹² Previously, a memorandum of understanding (MoU) stated that NHS Digital could also disclose confidential patient information to the Home Office for the purpose of assisting immigration enforcement.¹⁶ However, this MoU was withdrawn for amendment in May 2018 and it has not yet been re-released.¹² At the time of writing, it is unclear how confidential information will be shared with the Home Office in the near future.

Access and barriers to treatment in secondary care (including community mental healthcare) and in-patient services

Asylum seekers, refugees and victims of torture are exempt from NHS charges across all services

All NHS services in England are currently free of charge for asylum seekers (those who have claimed asylum in the UK and are awaiting a decision from the Home Office), those with a rejected asylum/human rights application but who have officially appealed their rejected claim, refugees (those whose asylum claim has been approved) and suspected victims of human trafficking, among a number of other categories.¹² Also, refused asylum seekers can continue, free of charge, with any course of treatment already underway before their application was refused.¹² Additionally, a category of NHS services that is currently free of charge irrespective of immigration status is ‘services for the treatment of a physical or mental condition caused by torture, female genital mutilation, domestic violence, or sexual violence’,¹² which would apply to S.T., whose reported history of undergoing torture may have contributed to his current illness.

However, for those belonging to these exempt categories, the lack of clarity and misinformation about who is eligible for free care has had a deterrent effect and made many vulnerable individuals reluctant to present to services. These individuals often have complex legal situations or are unable to provide the documents requested. Furthermore, administrative staff rarely receive sufficient training in immigration law to adequately determine eligibility for care.¹⁷

New upfront eligibility checks and upfront charging regulations

Following new government regulations introduced in October 2017, all hospital departments in England are legally required to check patients' eligibility for free NHS healthcare. If a patient is unable to prove that they are exempt from charges, they are required to pay upfront in full before receiving any treatment.¹⁸ This requirement has now been extended to all NHS community health organisations, including community mental health services.¹⁹ If a patient cannot prove that they are entitled to free care, they have to pay the estimated price for their treatment upfront, unless it is considered 'urgent' or 'immediately necessary'. Doctors will have to review each case to decide whether care is 'immediately necessary' or 'urgent': if it is deemed immediately necessary/urgent, treatment can be offered and the patient will be charged later; however, any treatment deemed non-urgent can be refused until the patient is able to pay upfront.²⁰ However, this does not apply to GP care, which is currently free to all, as described above.

The effects of upfront charging

Even though the treatment needed is often deemed immediately necessary or urgent, the worry about being charged upfront can deter vulnerable patients from seeking help. A recent analysis of case notes from a Doctors of the World clinic found that 46 patients (over a third of all chargeable cases) had delayed seeking necessary healthcare owing to concerns related to charging, including concerns that their information would be shared with the Home Office.²⁰ A number of the UK's medical Royal Colleges have released statements about the upfront charging policy, warning of its risks.²¹

What is 'urgent' or 'immediately necessary' treatment?

There is a lack of clarity from NHS England about what constitutes 'immediately necessary' or 'urgent' treatment, resulting in confusion and inconsistency between and within services. 'Immediately necessary' is usually taken to signify treatment that is life-saving or is needed immediately to prevent a condition from becoming either damaging to the person or life-threatening. Urgent treatment is usually taken to signify treatment that, owing to pain, disability or the risk of the condition worsening without treatment, cannot wait until the person returns to their country of residence (it is usually expected that an undocumented migrant will not return to their home country for at least 6 months).²² Treatment is deemed 'non-urgent' if 'it can wait until the patient can reasonably be expected to return to their country of residence'.¹² Many clinicians and healthcare providers believe that the vast majority of healthcare treatment can be legitimately considered to be at least 'urgent', given that most physical and mental health conditions could deteriorate without timely treatment.

Treatment under the Mental Health Act and Mental Capacity Act

Those who are detained and/or treated under the Mental Health Act 1983 or Mental Capacity Act 2005 are also exempt from charges for treatment.¹² Therefore, S.T. would not be charged for his treatment if we decide to detain him.

What treatment would S.T. be eligible for without charge?

S.T. is consenting to an informal admission and would not be appropriate for community treatment (as he is street homeless). However, would he be eligible for an informal in-patient admission without charge?

S.T. is not currently legally classified as an asylum seeker as his asylum claim has been rejected and he has not yet launched an appeal. However, it could be argued that he still would be eligible for free voluntary psychiatric treatment, both as an in-patient and in the community, as a victim of torture.

Regardless, he should be eligible for voluntary psychiatric treatment (as an in-patient and in the community) without being charged upfront, on the grounds that the medical team consider his treatment to be 'immediately necessary' or 'urgent'. If he does receive treatment on this basis, it is important to note that he would still get a bill for this after his

treatment and, if he is unable to pay that bill, his details could be shared with the Home Office, putting him at risk of being detained or deported.

It is vital that this eligibility is clearly explained to him so that he does not become confused and frightened when the hospital conducts its compulsory eligibility checks.

How about if he were in Scotland, Wales or Northern Ireland?

The above guidelines only apply to NHS England. Separate guidelines apply to Scotland²³, Wales²⁴ and Northern Ireland.²⁵ In Northern Ireland, the eligibility guidelines are similar to in the UK. Key differences are that in Northern Ireland not all migrants are eligible for free GP care, and refused asylum seekers who have had their asylum claim refused since 2015 have the same entitlements as any other ordinary resident. Undocumented migrants (who do not meet the other exception criteria, such as being a victim of human trafficking) are liable to be charged for GP, inpatient and secondary care, but are not charged for A&E treatment, compulsory detention in hospital or treatment for some infectious diseases and HIV.²⁵ In Scotland and Wales, asylum seekers and refused asylum seekers are entitled to free primary and secondary healthcare on the same terms as any other ordinary resident.^{23,24} Please see the relevant guidance for further information.

Management of S.T.'s case

Which treatments are effective for someone in such a precarious social situation?

In an acute situation such as S.T.'s, the priority should be to allow the patient to feel as safe and comfortable as possible. Measures should be taken to provide a quiet and private space in which to talk to the patient. Short-term use of benzodiazepines should be (cautiously) considered if the patient is acutely agitated or anxious. If in-patient admission is thought to be indicated, clinicians should be mindful of how an acute in-patient psychiatric ward could be distressing for someone with a history of trauma.

Regarding longer-term management options for S.T., psychological treatments appear to have the greatest benefit in reducing PTSD symptoms.²⁶ For example, there is robust evidence supporting the use of narrative exposure therapy (NET).²⁷ Although a sense of safety is often considered to be a prerequisite for psychological therapies to be effective, NET (which was developed for use in conflict zones) may be beneficial even for patients whose immigration status and social circumstances remain unstable. The humanising effect of having someone trusted to talk to regularly, in a safe space and without judgement, can be an especially helpful aspect of talking therapies. There is emerging evidence to suggest that arts-based therapies can be effective for those who find it more difficult to express themselves verbally about their trauma.²⁸

Psychotropic medication can also be used to treat PTSD-related symptoms. Antidepressants can be helpful in treating depressive symptoms in people who have been severely traumatised: mirtazapine is often used because of its hypnotic effect. Antipsychotic medication (such as quetiapine, which is widely used) can be of benefit, particularly in the context of vivid flashbacks or hallucinations or in the management of persistent anxiety and agitation.²⁹

Practicalities and primary needs

S.T. has been made street homeless since the refusal of his asylum claim. This will also have implications for discharge planning if he is admitted to a psychiatric hospital for treatment. It is important to carry out a comprehensive needs and risks assessment as soon as possible and to generate a care plan in which these needs are prioritised appropriately.

If S.T. launches an appeal against his asylum application rejection, he would become eligible for support such as accommodation and certain other benefits; therefore, providing him with information on non-governmental organisations (NGOs) that provide legal advice may be a priority. A number of NGOs also support asylum seekers by providing therapeutic services, English language courses, social inclusion projects, housing and general ad-

vice. For example, NACCOM provides a useful list of charities/services that help destitute migrants across the UK (<https://naccom.org.uk/projects/>). Further information on some of these NGOs is given in online supplement 1.

Online supplement 2 gives advice on working with and assessing capacity via interpreters, which might help in further assessment of S.T.

It is also important to consider that, even if S.T. has a telephone, he might not have credit with which to make outgoing calls.

Suggested management plan for S.T.

- Informal psychiatric admission for further assessment and formulation
- Obtain collateral history from friends or relatives if possible (and if S.T. consents to this)
- Thorough physical assessment to identify and treat any non-psychiatric illnesses
- Early and proactive assessment of spectrum of needs: including prioritising housing, finances and referral to relevant charities for psychosocial and legal support
- Consideration of short-term use of benzodiazepines if highly agitated
- Consideration of anti-depressant and/or antipsychotic medication
- Referral for talking therapy with a trauma focus (if available locally or via a charity)

Conclusions

Diagnosing the causes of psychiatric and physical symptoms in asylum seekers and torture victims and making definitive diagnoses can be challenging. It is often difficult to determine whether psychotic symptoms in this group of patients relate to a primary psychotic disorder or to PTSD; and a new diagnosis of complex PTSD in ICD-11 adds to the pool of diagnostic options. Psychological distress is a common aetiological factor in physical symptoms such as dizziness and chronic pain. However, medical causes should not be excluded without sufficient physical health assessment as migrants may also have undiagnosed and untreated physical illness because of difficulty in accessing medical care.

S.T., the patient discussed in this paper, is fictitious and his case study was constructed to depict a realistic scenario based on our clinical experience of working with refugees and asylum seekers. Although his case may appear to be a particularly complex one, it is very common for migrants to encounter many of the barriers to accessing healthcare highlighted here. This can be very stressful for the healthcare team involved, especially if they are unclear about the frequently changing healthcare access requirements. Charities such as the Health Foundation, Doctors of the World, Medical Justice, Freedom from Torture, Medact and the Helen Bamber Foundation regularly release updated guidance that can be helpful.

There remain many ethical and legal issues that need addressing nationally, including the sharing of patient data between NHS services and the Home Office and the likely deterrent effects of upfront charging for NHS services. An urgent assessment is needed into the impact on vulnerable groups of extending charging into NHS community services. There is often confusion for both patients and healthcare staff about eligibility for free NHS care. This can result in patients who are eligible for free healthcare being denied this care, disengaging from healthcare services or not seeking care in the first place.

We thank R.M., our patient contributor, for her useful reflections on this case. She particularly emphasised how difficult it is for asylum seekers to tell an autobiographical story and the effects of prolonged immigration uncertainty on mental health.

Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2019.67>.

[click here to view supplementary material](#)

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1.3.8 The clinical fellows project: emergence of the FY3 year?

Anirban Raha Robert Heminway

date

2020-04

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- *The clinical fellows project: emergence of the FY3 year?*

Since August 2017, Sheffield Health and Social Care have begun providing a new non-training post in psychiatry. This was done with multiple aims, including attempting to increase the uptake of core psychiatry training jobs in South Yorkshire by giving a positive experience of working in a psychiatric setting and improving local clinical care with an increase in the number of doctors working at SHO/CT1 level. The non-training posts were described as clinical fellowships and were open to doctors who had not yet undertaken higher training in psychiatry.

We, Drs Raha and Heminway, were among the first people to take up these clinical fellowship posts and were therefore in a prime position to review how the project is being received and some of its outcomes. Since August 2017, 15 clinical fellows have been recruited, largely in the 'FY3 gap' but with some coming from general practitioner (GP) training. Dr Raha entered after having been a GP trainee and Dr Heminway from a post-foundation training break.

The clinical fellowship consists of a non-training junior doctor post, working at FY2/CT1-equivalent level in psychiatry. A number of rotational placements were created, including those based in general adult, older adult and addiction psychiatry, across both community and in-patient settings. A key benefit that was felt by the clinical fellows was that there were additional training opportunities given – a split of 80% clinical to 20% non-clinical time allowance, access to weekly continuing professional development (CPD) sessions, weekly supervision with a consultant psychiatrist and attending the core psychiatry training course for MRCPsych examinations. Clinical fellows have also since set up their own peer group to improve CPD and training opportunities for future clinical fellows.

The experience has been invaluable, not just for ourselves but also for other clinical fellows involved in the project; this has been borne out by the increasing uptake of core psychiatry training posts by the clinical fellows. Of the 2017–2018 cohort, half entered core psychiatry training, one entered GP training and one left owing to long-term sickness. Half the 2018–2019 cohort were also considering entering psychiatric training at the end of the clinical fellowship posting.

The culmination of this experience was the opportunity to present this project at the Choose Psychiatry meeting of the Royal College of Psychiatrists earlier this year. It was well received, owing to the fact that it was both improving access to psychiatry and improving junior doctors' opinion of psychiatric training and work (including those leaving the post to take up GP jobs). It was also highlighted that many junior doctors are no longer entering core training directly after foundation training. This clinical fellowship has therefore been an excellent way to accommodate this trend and provide a springboard for increasing access to and awareness of psychiatric training.

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1.3.9 Authors' reply

Rachel Gibbons Fiona Brand Anne Carbonnier Alison Croft Karen Lascelles Gislene Wolfart Keith Hawton

date

2020-04

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- *Authors' reply*

Authors' reply: We are grateful for Professor Morgan's engagement with our paper,¹ and that we have stimulated debate in this important area. We do, however, feel it necessary to respond to two fundamental misinterpretations of our discussion about the predictability and preventability of suicide.

First, the letter states that we were asserting there is 'no evidence that suicide risk assessment in clinical practice can usefully guide clinical decision-making', whereas we actually said that our ability to predict patients at the highest level of risk is limited and that despite the ubiquity of advice to use suicide risk assessment in clinical practice, the positive predictive value is low and there is no evidence that these assessments can usefully guide decision-making.

Second, Prof. Morgan asserts that we were advocating 'ignoring the value of suicide ideation', which was not indicated at any point in the paper.

Suicidal thoughts are very common; however, completed suicide is rare. The process that leads any individual to take their life is often poorly understood. Given this, identifying the specific individuals most likely to die by suicide is a very a challenging task. An overly high personal and systemic expectation of a clinician's capacity to predict suicide in any individual case is unreasonable and can lead to increased feelings of distress and blame following a death. The distorted focus on psychiatrists' role to prevent suicide obfuscates their important role in working to alleviate mental pain, encourage recovery and improve quality of life.

We strongly advocate dynamic formulation of risk as part of clinical care but question an over-reliance on risk assessment tools that have little or no face validity. There is now a general consensus^{3,4,5} that these tools do not predict likelihood of suicide. Indeed, the National Institute for Health and Care Excellence guideline on self-harm from 2011, based on reviewing evidence, states: 'Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm', nor 'to determine who should and should not be offered treatment or who should be discharged'.⁶

We agree with Prof. Morgan that there is much to affirm the important role of assessing suicidal ideation in guiding clinical decision-making. Suicidal ideation is important not only as an indicator of potential suicide but also as a clear sign of mental distress. Self-destructive thoughts are a key symptom in various types of mental disorder, including depression and personality disorders. These thoughts need to be assessed in the context of other factors, as recommended by various agencies, including the National Confidential Inquiry into Suicide and Homicide,⁷ such as previous self-harm, social circumstances, patients' relationship with their mental health team, access to means and early follow-up. We also endorse the current move away from primarily focusing on trying to identify patients at most risk to individualised safety planning for all patients.

We thank Dr Calcia for her supportive letter.⁸ We particularly agree with her focus on the need to prepare trainees for the experience of a patient death by suicide. In this respect, we include the following quotes from psychiatrists in our survey.

‘Start training the trainees early on suicide and suicide prevention. Do not neglect the impact it will have on level of functioning and on career choices. Building resilience is essential to help doctors sustain the possibly repeated events of patient suicide.’

‘I think the training on this subject should be part of core and higher training and higher trainees should have some mentoring and exposure to this process.’

While the above comments may seem counter to the current focus on a zero suicide policy, in our opinion they do reflect the reality of psychiatric practice. Preparation for this often painful event is likely to decrease personal trauma and reduce the risk of losing valuable staff from our profession.

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1.3.10 A brief history of the evolution of the Parliamentary Scholar Scheme

Keir Jones Asit Biswas

date

2020-04

Contents

- *A brief history of the evolution of the Parliamentary Scholar Scheme*

We were really pleased to read about the Parliamentary Scholar Scheme and how successful it has become – thank you for your thorough overview of this invaluable opportunity for speciality trainees in psychiatry.¹ The scheme can trace its origins back to a pilot scheme set up by Baroness Hollins in 2012, when KJ was one of three trainees at higher speciality trainee level in Psychiatry of Intellectual Disability or Child and Adolescent Psychiatry. He joined her team at the House of Lords one day a week for four months as a special interest session in Parliamentary affairs.

Similar to the current scheme, the role was to assist in the research and preparation of Parliamentary business, including speeches and written questions delivered by Baroness Hollins in the House of Lords. A wide range of new skills were developed by trainees, including understanding Parliamentary processes; developing communication skills beyond the usual boundaries of medicine; and making alliances with individuals and organisations from different professional and lay backgrounds in order to accomplish shared goals for the benefit of the vulnerable groups we support.

The work Baroness Hollins and her team did to represent the voice of people with an intellectual disability and/or mental illness at a Parliamentary level was truly inspiring, and the opportunity to be part of this team, advocating for our patient groups at a national level, was extremely rewarding and a great privilege. As you mentioned in your article, the opportunity opened our eyes to the substantial influence that medically trained professionals can have in contributing to political and managerial discourse and decision-making, in the widest sense.

AB, who was the Speciality Advisory Committee Chair, Intellectual Disability Faculty, Royal College of Psychiatrists, at the time, believes that this unparalleled and unique training opportunity and experience had a long-lasting effect on

the careers and overall personal development of trainees who were successful in the selection process and then went on to train, refine their skills, and learn about Parliamentary processes and how to influence policy-making, supervised by Baroness Hollins.

KJ feels it has influenced his subsequent decisions to pursue dual training in Intellectual Disability (after a first CCT in Child and Adolescent Psychiatry), act as trainee representative in the Royal College Faculty Executive and more recently join the Royal College of Psychiatrists Leadership and Management Scheme. Another colleague from this early form of the scheme went on to join the Royal College of Psychiatrists Westminster Parliamentary Committee.

We would like to take this opportunity to sincerely thank Baroness Hollins for setting up this scheme and encourage all trainees with an interest in this area to consider the scheme as a unique and invaluable opportunity. We believe this pioneering scheme in all its iterations has already left an important legacy within our generation of psychiatrists and beyond.

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1.3.11 The place of free will and agency in psychiatric practice

: Commentary on ... William James and British thought: then and now

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date

2020-04

Abstract

In psychiatric practice, professionals tend to split patients into those who are responsible for their actions, and those who are not. This approach does a disservice to both groups. Patients assumed to retain agency may be blamed, and those assumed to lack agency are disempowered. Professionals should adopt a more nuanced approach to agency and control, recognising that it is impaired in most psychiatric disorders, but absent in very few. This is possible without making stigma worse.

Contents

- *The place of free will and agency in psychiatric practice*
 - : *Commentary on ... William James and British thought: then and now*
 - * *William James' views on free will*
 - * *Agency as an all-or-nothing concept*

¹ Declaration of interest: None.

² See this issue.

- * *Agency in psychiatry*
- * *The place of agency in recovery*
- * *The wedge model of responsible agency*
- * *Could retaining the idea of agency, and thus choice, invite stigma?*
- * *Ways of avoiding stigma when a degree of agency is retained*
- * *What are the practical implications of this approach?*
- * *Conclusion*

William James' views on free will

The article by Leary¹ encourages a reappraisal of William James's contribution to the early study of psychology. He is best known for his interest in, and lectures on, the psychology of religious experience,² but Leary notes another central interest, in free will. He notes James's doubts in his early writings that even 'a wiggle of the will' is possible. James writes, for example, that addicts ('dipsomaniacs') experience a compulsion³ unlike anything experienced by other people, an impulse that is irresistible (James 1890, quoted in Pickard³). The presence or absence of responsible agency, meaning the ability to make choices and act upon them (thus an expression of free will), is central to modern psychiatric practice, and one of the ways in which James' interests continue to be relevant.

Agency as an all-or-nothing concept

Interest in agency by mental health professionals has fluctuated. Ideas such as locus of control and generalised self-efficacy have been the subject of research, but refer to the person's beliefs about their ability to choose and act, rather than their ability to make choices and carry through the actions associated with them (agency). In psychiatry, agency itself has been neglected as a subject for study,⁴ although in practice it is generally assumed either to be present or absent. In other words mental health workers, like their peers in the rest of society, have a tendency to split patients into those who have agency – who have the freedom to choose to act differently – and those who do not, and are powerless to control their behaviour.

The tendency to dichotomise agency in this way is not restricted to psychiatry. The legal system treats people as either responsible for their actions (having *mens rea*) or not, a dichotomy echoed in the choice between two possible verdicts.⁵ Addiction provides a recent example of the way agency is dichotomised in mental health. Before the 20th century addictions were generally considered character flaws, consisting of unwise choices freely made. The adoption of the illness model of addiction (a movement with a long history of which James was a part, crystallising in 1939 with the birth of Alcoholics Anonymous⁶) alters the formulation to that of someone who is unable to resist their impulses to use, latterly formulated as owing to changes in brain chemistry.⁷ Thus agency is either retained, along with fault, or lost, which allows for compassionate treatment. For a discussion of the debate as it pertains to addictions, see Pickard³ and Pickard and Pearce.⁸

3

The term compulsion is used here in its general usage, meaning that a person is compelled to act, having no freedom to do otherwise. In psychiatric use, such as in obsessive-compulsive disorder, a compulsion can sometimes be resisted.

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Agency in psychiatry

The tendency to dichotomise agency in psychiatry leads to patients being split into two groups. One consists of those who are thought to lack agency (at least when suffering from an episode of illness), who cannot recover by their own efforts, and who are unlikely to be able to contribute significantly to their recovery. The other contains those who retain agency, could act differently, but choose not to. For example, patients with personality disorder are usually thought to retain agency (they could choose to do things differently), whereas those ill with affective disorders and psychoses are thought not to. Although, if asked, mental health professionals may agree that the situation is more nuanced, this 'rule of thumb' approach is widespread, and has negative consequences. Control, or agency, when assumed to be fully present, can make it difficult for professionals not to blame patients, since if you are responsible for your actions, and some of those actions harm yourself or others, you deserve to be blamed. This can lead to poor treatment and stigma from the belief that the unpleasant and harmful behaviours by the patient are a conscious choice. **Box 1** Dichotomising agency in the clinical situation Helen has a family history of depression and self-harm. She has become more suicidal following the break-up of her marriage. She disclosed to her care coordinator that she had a rope and is intending to kill herself on her wedding anniversary. She is diagnosed with an exacerbation of chronic treatment resistant depression. She is admitted and placed on general observations. Over the course of the next few weeks she ties ligatures around her neck and cuts herself with smuggled razors. As the perceived riskiness of her behaviour escalates, her level of observations are gradually increased. Staff find it difficult to tolerate her levels of distress and aggression. Staff become split. Some feel she is severely depressed, and that she cannot help acting in this way. They spend increasing amounts of time with her. Others feel her problems are 'behavioural', by which they mean they are under her control; they wonder if she has a personality disorder, and advocate discharge.

The place of agency in recovery

An all-or-nothing approach to agency also has an adverse effect on those deemed unable to exercise choice and control. The assumption is that change is beyond the power of the patient, and is in the hands of professionals, or in some cases down to chance. But symptoms (when they are behaviours, as they often are in psychiatry) and maintaining factors of a range of common psychiatric conditions include actions and omissions. Examples include addictions, eating disorders, depression and anxiety disorders, and the list could be expanded to include all conditions for which there is treatment which requires concordance as, if the patient decides not to take their medication, say, the omission will affect their condition and act as a maintaining factor. Actions and omissions that are either core features or maintaining factors of psychiatric disorders involve a degree of control, and thus recovery from these conditions requires the patient to have the motivation and will to change their behavior.⁹ An anxious patient who finds it difficult to leave the house may eventually recover simply by taking a selective serotonin reuptake inhibitor, but at some point they will have to take the difficult decision to go out of the front door, and the sooner they do (for example, as part of a treatment programme) the sooner they will recover. Telling a patient, or implying, that they have no control over their behaviours undermines their contribution to their recovery, and, if they conclude from this that they should cease their own efforts, may prevent recovery altogether.

The wedge model of responsible agency

What is the alternative to the idea that patients are either subject to compulsion, and therefore entirely lacking in agency, or easily able to change their behaviours, but refusing to do so? It is the idea that control comes in degrees. This is a concept with which we are familiar when applied to ourselves, but have a tendency to forget in the clinical situation. Thus we find it easier not to shout at the kids when we are well rested and happy, more difficult when tired and stressed. The ability to exercise control (responsible agency) may be reduced by physical states like fatigue and pain, and emotional states like fear, anger and anxiety. In other words, it bears some relation to motivational and epistemic context;⁸ the ability to exercise control may vary with motivation, and with one's understanding of the situation and consequences – a smoker may stop when she becomes pregnant despite having previously attempted to do so without success.

Agency might also be impaired, to an extent, in a range of psychiatric disorders. Henderson lists ways in which this

might happen ‘through a defect in consciousness, a change in mood, in perception, in the ability to think or the content of thought’.⁴ It may be more difficult for an agoraphobic to leave their house than it would be for you or me, for these reasons, but the impairment is one of degree, and although leaving the house may be difficult, it is not impossible. This understanding forms the basis of the behavioural treatment of agoraphobia.

The tendency to think of behaviour in some psychiatric disorders as compulsive (wholly without choice) is unsustainable also in view of the way people suffering from these disorders behave in practice. People with these problems quite commonly do change their behaviour. Some interventions bolster the ability to choose; for example, buprenorphine reduces the euphoric effects of opiates, and behavioural experimentation improves the ability to tolerate phobic stimuli. Psychiatric treatments change behaviours across a range of disorders and interventions.^{10,11}

It also appears to be the case that behavioural changes become progressively easier as agency gradually increases. For example, the theory of behavioural activation for depression suggests that completing easier tasks leads to an improved ability to undertake more difficult tasks, possibly related to the impact of increasing self-efficacy on agency. This rationale is also seen in the graded exposure hierarchies used in the behavioural treatment of anxiety. In addition, experiments indicate that effortful practice appears to bolster willpower, the so-called ‘muscle model’ of the will.¹²

Could retaining the idea of agency, and thus choice, invite stigma?

It is possible that widening the arena in which choice is considered a factor could subject those who suffer conditions that may be less subject to agency-related stigma, such as depression, to the additional stigma that those suffering disorders thought to be more choice-based, such as personality disorder, are subject to. Might professionals, and the public, have more difficulty feeling compassion if we reconsider the contribution made to mental disorders from patient choices?

This is possible, but is not a reason to retain an inaccurate approach to agency. Maintaining that a person has no control over a situation, when they appear to in fact retain some control, is not a viable solution to stigma, and the folk are probably not convinced by this anyway. Although people are generally willing to allow some slack to people who are ill, they are also sensitive to when the sick person appears to be ‘overstepping the mark’.¹³

Ways of avoiding stigma when a degree of agency is retained

How might we mitigate any negative effect of acknowledging the place of will in the maintenance of mental disorder? ‘Responsibility without blame’ is a concept observed by a philosopher when visiting democratic therapeutic communities.¹⁴ Blame used in this context refers to affective blame, the negative feelings and attitudes that arise in another when someone is responsible for an action with a negative consequence. Pickard noticed that the staff of the therapeutic communities were able to retain the idea that patients with personality disorder were responsible for their decisions and actions – that they retained agency – while not engaging in blaming behaviours, or adopting a blaming attitude, that would be normal when those decisions and actions have negative consequences. She concluded that responsibility and blame can be separated, and should be for the purposes of good clinical care. Blame is usually countertherapeutic, and makes providing compassionate care more difficult, whereas the attribution of responsibility is essential both in motivating change, and in maintaining a mutually respectful therapeutic relationship (if your patient is not responsible for their apparent choices, you should treat them not as an equal moral being, but more like a child). Pickard thought that paying attention to the patient’s personal history was one of the elements that make it possible to avoid blame, as this evokes compassion and empathy, which make affective blame less likely.

The acknowledgement of choice and control should not be allowed to affect treatment. This is already a problem, for example, when patients who have self-harmed are treated poorly in emergency departments.¹⁵ The solution to this is not to maintain the fiction that such behaviours are outside the patient’s control, but to train professionals to act with compassion and care no matter the cause of the patient’s distress.

What are the practical implications of this approach?

If the exercise of free will is essential to recovery from mental disorders, we should treat people in such a way as to encourage the development of agency, to improve their capacity for control. It is possible to support patients through the difficult process of change, without moving to a paternalistic position in which change and recovery depends on us rather than the patient.⁹ Our approach to patients should thus be to acknowledge and bolster their power and agency in relation to their condition. In practical terms, when a patient tells us they cannot exercise control, such as to get out of bed when feeling depressed, it is helpful to regard them as able to exercise control, but to explore with them the degree to which this may be reduced, and the reasons for this. We should also work to avoid demoralising self-blame; for example, by emphasising that it is common for someone in their position to have these problems, that there are strategies for addressing it, and that it is okay to find it hard. It will be important to be circumspect in how this conceptualisation is used with regard to carers and relatives; the public is no less likely to dichotomise agency than professionals, and may react to the idea that agency is retained to a degree, by assuming that the patient is acting this way 'on purpose', a perennial problem in psychiatric disorder.

There is an additional point to note. As conditions such as obesity and addiction increasingly come to be seen as illnesses, or even diseases, people see themselves as less responsible and less able to change, with consequent increasing reliance on the efforts of professionals rather than themselves.

Conclusion

Most mental disorders probably affect agency, making it more difficult to implement good choices. The extent to which this affects the patient will depend on both the nature and the severity of the disorder. Although it is probably true that people with even severe personality disorders retain agency much of the time to a greater degree than people with severe affective and psychotic disorders, agency is likely to be retained to some degree in all but a small proportion of patients with psychiatric disorders. Most psychiatric patients are able to contribute to their recovery through the exercise of their will. For this reason, treatment should emphasise the bolstering of control and willpower, which should include working to improve patients' understanding of their problems, and morale. In this way, we can avoid the twin mistakes of disempowering the patient by assuming they have no meaningful power to make choices that affect the course of their illness, and adopting a blaming attitude, which can allow the correct attribution of agency to detract from compassionate and energetic care.

Thank you to Richard Gipps for very helpful comments on the draft of this paper.

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1.3.12 Online mood monitoring in treatment-resistant depression: qualitative study of patients' perspectives in the NHS

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¹ **Declaration of interest:** In the past 3 years, A.J.C. has received honoraria for speaking from Astra Zeneca and Lundbeck; honoraria for consulting from Allergan, Janssen, Livanova and Lundbeck; support for conference attendance from Janssen and research grant support from the Medical Research Council (MRC), Wellcome and National Institute for Health Research (NIHR). S.L.H. has received grant support from Wellcome Trust, NIHR, Department of Health and Social Care, MRC, Guy's and St Thomas' Charity, and the Economic and Social Research Council. J.R.G. led the conception of True Colours and has overseen its implementation in routine clinical practice and research studies. He is an NIHR senior investigator and has received research funding from MRC, Wellcome and NIHR. No other authors report any conflicts of interest, although E.I. conducted some of the interviews as part of her master's dissertation project.

² These authors contributed equally to this work.

date

2020-04

Abstract**Aims and method**

True Colours is an automated symptom monitoring programme used by National Health Service psychiatric services. This study explored whether patients with unipolar treatment-resistant depression (TRD) found this a useful addition to their treatment regimes. Semi-structured qualitative interviews were conducted with 21 patients with TRD, who had engaged in True Colours monitoring as part of the Lithium versus Quetiapine in Depression study. A thematic analysis was used to assess participant experiences of the system.

Results

Six main themes emerged from the data, the most notable indicating that mood monitoring increased patients' insight into their disorder, but that subsequent behaviour change was absent.

Clinical implications

Patients with TRD can benefit from mood monitoring via True Colours, making it a worthwhile addition to treatment. Further development of such systems and additional support may be required for patients with TRD to experience further benefits as reported by other patient groups.

Contents

- *Online mood monitoring in treatment-resistant depression: qualitative study of patients' perspectives in the NHS*
 - *Method*
 - * *Participants*
 - * *Interview procedures*
 - * *Data analysis*
 - *Results*
 - * *Insight*
 - * *Absence of behaviour change*
 - * *Improved clinical care*
 - * *Prioritisation*
 - * *Categorisation concerns*
 - * *Interface features*
 - *Discussion*
 - *Supplementary material*

Patients with treatment-resistant depression (TRD) can experience a more chronic and severe course of illness.¹ These outcomes could be improved by online mood monitoring to facilitate treatment personalisation, and the evaluation of

treatment efficacy.²⁻⁴ True Colours is an automated monitoring system developed by clinicians and currently used by psychiatric services in Oxford Health National Health Service (NHS) Foundation Trust, as well as by clinical trials across the country. Patients in Oxford Health are provided with access to True Colours by their clinical team at their or their clinicians request, whereas clinical trial teams can use the system to monitor participants and collect relevant outcome data. True Colours is also available via the Bipolar Disorder Research Network to patients with a diagnosis of bipolar disorder living in the UK.⁵ The system allows patients to self-monitor and self-manage symptoms⁶ by prompting them to complete personalised questionnaire assessments according to the time, frequency and mode of interaction selected. Patient responses are stored and displayed graphically through the interface, and are also made available to the patient's clinician or research team.

Adherence rates in patients with bipolar disorder are between 75 and 100%,^{7,8} and qualitative assessments indicated that patients with bipolar disorder find the system easy to use and a positive contributor to their clinical care and self-management.⁹ Comments on the flexibility of the system led to the development of a personalised questionnaire feature, which allows patients to add questions to their schedule.¹⁰ However, although the system is routinely used by patients with unipolar TRD, it is not clear whether they similarly benefit. Establishing the experience of this patient group is essential to maximising the clinical utility of this and other mood monitoring systems. This study aimed to qualitatively assess the perspectives of patients with unipolar TRD who used True Colours as part of the Lithium versus Quetiapine in Depression (LQD) study.¹¹

Method

Ethical approval was obtained from Cambridge South Research Ethics Committee (approval number 16/EE/0318). All participants provided written informed consent. This study has been carried out in accordance with the Declaration of Helsinki.

Participants

LQD participants were invited to take part in this study between March 2017 and March 2018. This was a convenience sample, meaning that LQD participants attending an 8, 26 or 52 week follow-up assessment in that period were given the opportunity to participate in this additional study at the relevant follow-up assessment, conducted at a clinical research facility. Repeat interviews were not conducted. The full methodology of LQD has been reported.¹¹ In brief, adult patients meeting the criteria for TRD were randomised to receive lithium or quetiapine augmentation and followed up over 12 months. As part of the study, participants were asked to complete two questionnaires weekly via True Colours to collect primary outcome data: the Quick Inventory of Depressive Symptomatology (QIDS-SR)¹² and Work and Social Adjustment Scale (WSAS).¹³ Study-specific questions regarding medication were included to track dosage and adherence.

Interview procedures

Participants took part in semi-structured interviews conducted by a researcher (full interview schedule is in the supplementary material, available at <https://doi.org/10.1192/bjb.2019.92>). Researchers were predominantly female and held a relevant undergraduate or master's degree. L.M. conducted training with all interviewers. Typically, the researchers had an existing relationship with the interviewees having conducted their prior LQD assessments. Interviews ceased once data saturation was reached, meaning no new emergent themes were being identified by the collection of additional data.¹⁴

Data analysis

Interviews were audio-recorded, transcribed verbatim and checked by another researcher. All identifiable information was removed, and participants were assigned a code for reference.

A thematic analysis was conducted – a widely used method for identifying, analysing and reporting patterns within data – with steps recommended by Braun and Clarke.¹⁵ This included actively reading the entire data-set several times, systematically identifying and coding for key features, analysing codes and combining them to form broader themes. Themes were then reviewed and refined to ensure that they were appropriate in relation to the coded extracts, as well as the entire data-set. This led to the removal of some themes (e.g. owing to lack of supporting data), and the collapsing of others into one, with additional subthemes. Finally, themes were appropriately named, and evidence included for each in the present report. This approach is inductive (bottom-up), meaning the themes identified were data driven.¹⁶ Two researchers (E.I. and B.V.) conducted analyses independently, and discrepancies in the identified themes were discussed with L.M. and R.W.T. until resolved by consensus. The second rater (B.V.) did not conduct any qualitative interviews, minimising any potential bias.

Results

A total of 26 individuals were invited to take part; 21 participated and five declined, primarily owing to fatigue (see *Tables 1* and *2* for demographics and clinical characteristics). We generated 81 initial codes from the qualitative data and combined them to form six themes (see *Table 3*). Duration of interviews ranged from 3 to 17 min (mean 6.9 ± 3.3). *Table 1* Demographic characteristics of participants ($n = 21$)

Characteristic	n	(%)
Age (years), mean (s.d.)	41.5	(15.2)
Gender		
Female	8	(38)
Male	13	(62)
Employment status		
Employed	10	(48)
Unemployed	7	(33)
Students	2	(10)
Retired	2	(10)
Education level		
Primary education or less	1	(5)
Secondary education	3	(14)
College-level education or equivalent	5	(23)
Degree-level education/diploma	5	(23)
Postgraduate degree	7	(32)
NHS trust		
South London & Maudsley NHS Foundation Trust	13	(62)
Northumberland, Tyne and Wear NHS Foundation Trust	3	(14)
Oxford Health NHS Foundation Trust	5	(24)

Table 2 Clinical characteristics of participants ($n = 21$)

Characteristic	Total	HRSD score, ^a mean (s.d.)	Number of past episodes of depression, mean (s.d.)	Number of antidepressant treatment failures in current episode, n (%)	Length of current episode in years, mean (s.d.)	Number of axis 1 comorbidities, n (%)	Overall mean % adherence to weekly True Colours data submission (s.d.)
Total HRSD score, ^a mean (s.d.)	22.3	(5.8)	4.1	4.1	8.4	(11.2)	72
Number of past episodes of depression, mean (s.d.)	4.1		4.1	4.1	8.4	(11.2)	72
Number of antidepressant treatment failures in current episode, n (%)	21		33	(14)	44	(19)	51
Length of current episode in years, mean (s.d.)	8.4	(11.2)	04	(19)	15	(24)	>112
Number of axis 1 comorbidities, n (%)	04	(19)	15	(24)	>112	(57)	

Table 3 Themes and subthemes

Theme	Subthemes
Insight	Anticipated insight (before using True Colours)
Experienced insight	Envisaged insight (gained through continued use of True Colours)
Absence of behaviour change	Not applicable
Improved clinical care	Using feedback during clinical appointments
Valuing access to human support	Prioritisation
Organising time	Motivation
Categorisation concerns	Discrepancy between experience and questionnaire response options
Ambiguity and repetitiveness of questions	Interface features
Positive experiences	Challenges
Suggestions for improvement	

³ Percentages may not add up to 100 owing to rounding.

⁴

HRSD, Hamilton Rating Scale for Depression.

a. Hamilton M. A rating scale for depression. *J Neurol Neurosurg Psychiatry* 1960; **23**: 56–62.

Percentages may not add up to 100 owing to rounding.

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Insight

Anticipated insight (before using True Colours)

Participants frequently described how True Colours enabled greater understanding of illness. This outcome was anticipated by almost half of the participants upon hearing about the system. “I thought that, you know, it would give us something to go by, some kind of guideline, on, you know, where I am with my moods, or my behaviour and my sleeping and so forth’ (P6). ‘I had an expectation that it may be useful that you would have some form of er. . . information that you know, whether you’re progressing or whether you’re not in relation to your treatment, and in relation to how your illness is affecting you’ (P7).”

Experienced insight

Regardless of whether it had been anticipated, 18 participants found that symptom monitoring enabled reflection. For some, viewing changes over time helped put their mood into perspective, particularly when feeling low. The process of completing questionnaire(s) appeared to play a key role in increasing awareness, and how mood linked to symptoms such as increased weight. Although many participants viewed this awareness positively, and one person reported a positive effect on their mood, a small number did not find it beneficial. “It’s allowed me to monitor things ‘cause obviously certain weeks can be worse than others or better than others. . . so yeah it’s been quite useful’ (P1) ‘Rather than thinking “I’m really depressed, I’m really depressed, I’m really depressed”, I’m able to kind of say “the score’s the same” and actually, it’s. . . your mood is the same. . . it’s, you know, in your head that things are worse’ (P10). ‘You’re looking at that [graphs] saying “Eee God I’m depressed” and it makes you feel even worse’ (P7).”

Envisioned insight

This subtheme refers to insight that could be gained through continued use of True Colours. Six participants felt this could be possible, several of whom had not experienced significant mood fluctuations when using True Colours, but felt the graphs could help detect future changes. Others, who had not used the graphs discussed how they could offer future insight into mood patterns. “I would have thought that if I did use it [graphs], yes it would be useful. . .” cause it would, you know, be able to tell me where the fluctuations are. With this said, I will make, um. . . endeavour to have a look in the next couple of weeks’ (P6). ‘I don’t think it was originally that it would be particularly useful until I actually see how the changes are mapped on the graphs and stuff like that. So, the more interested I am, I think the more useful it’ll be’ (P8). ‘I mean its early days but umm. . . but I think it [the graphs] will be useful in the future’ (P20).”

Absence of behaviour change

True Colours did not appear to affect the way in which most participants ($n = 19$) managed their depression. Because of the lack of changes reported, no subthemes were identified for this category. Participants recognised that the system could provide them with information, but did not see how this could translate to illness management. “Probably er. . . not err. . . not as much as manage it but be aware of it’ (P21). ‘No. Just. . . just it’s informative. It doesn’t change my lifestyle’ (P18).”

Improved clinical care

Using feedback during clinical appointments

Seven participants suggested the feedback provided via True Colours (i.e. graphs) could improve the efficiency of time spent with healthcare providers. “‘True Colours would be a way of keeping track of everything and also it would give me a visual representation to show medical professionals as opposed to just going well... I had a bad week 2 weeks ago. I can actually show them what happened as opposed to trying to remember it’ (P1). ‘I think for a professional that is dealing with your, or supporting you, I think that information I think may be useful’ (P7).”

Valuing access to human support

For four participants, the awareness that they could be monitored by a professional who would understand their difficulties was a source of reassurance. “‘When I had a bad week then I emailed Tr...the...the link on True Colours...to say look, this is happening and...and it did help to know that somebody else understood what I was going through rather than me saying to somebody I’m feeling a bit...crap this week and they’re just - oh...pooh poohing it really’ (P4). ‘Knowing that there is somebody out there that’s monitoring me... which is nice’ (P3).”

Prioritisation

Organising time

Seven participants admitted that they struggled to schedule time for True Colours and often forgot to complete questionnaires. “‘There just isn’t enough time in my day to do it’ (P5). ‘Sometimes I’ll be working or something and I’ll forget to do it’ (P1). ‘The only times I’ve kind of not done it is when I’ve kind of been really busy throughout the day’ (P10).”

Motivation

Even setting aside the issue of time, over half of participants indicated that because of a lack of interest, not prioritising or viewing True Colours as useful and/or an inertia (related to their illness), it was difficult to engage consistently. “‘It depends where I am mentally on that particular day. Um... sometimes, do you know, I won’t, I won’t, won’t be able to get out of bed to brush my teeth. And to be able, do you know, look onto your phone and fill out questionnaires, it’s nigh on impossible’ (P6). ‘While I was sat there trying to psychoanalyse myself through True Colours I feel as though I could be doing something, achieving something that will possibly help me through this journey I am on’ (P5). ‘I think that you can spend too much time thinking about like erm being depressed, or the causes of depression, or how you’re feeling, rather than living your life’ (P8).”

Categorisation concerns

Discrepancy between experience and questionnaire response options

Seven participants raised concerns regarding their ability to accurately summarise symptoms over the past week when there had been significant variability. They also felt there were not sufficient options to express experiences. “‘I couldn’t categorise myself because my days are so... at the moment so mixed up’ (P5). ‘Umm... sometimes it’s hard to put how you’ve been feeling or... kind of... getting an average... having a discrete box can be hard when you kind of want to do “well it’s that point 5 or...”... ideally I’d say “it’s just one between two points” rather than... a specific number’ (P15).”

Ambiguity and repetitiveness of questions

Comments were also made regarding the wording of some questions, and how they were either difficult to understand, or similar to others. This left a small number of participants feeling unsure about how to respond. “‘There was one question on there which... um... seemed a bit... could be misconstrued’ (P2). ‘Yeah, yeah, like it’s sometimes you feel it’s getting rep... uh... repeating itself all the time’ (P3).”

Interface features

Positive experiences

Positive features relating to the interface were identified. Just over half of participants described the ease of logging on and completing questionnaire(s), and five participants commented on the usefulness of personalised weekly prompts. “‘Yeah... it’s really easy... it’s all... it’s all laid out there for you so you just umm you know... tick whatever it is’ (P20). ‘I’ve had experienced nothing technical wise about it, nah, it’s always been quite problem free’ (P7). ‘I think like it’s good that there’s a reminder... and that I could choose when it was. Umm... because it’s like quite a convenient time for me just like in the evening to go on my phone, and it’s quite quick to do the questionnaires... and like you can choose when that comes which I think’s really good’ (P19).”

Challenges

A variety of challenges relating to True Colours were similarly identified. Although participants were aware they could access response graphs, not all were using this feature. Four found the graphs difficult to interpret, and therefore not useful, and one commented on the lack of graphs for personalised questions. Further, 13 participants reported technical and interface issues, which affected their ability to complete questionnaire(s) and/or access feedback. “‘Like the symptom graph I don’t quite get, and I don’t quite understand how it works... erm... ’cause I just see it as a load of blobs’ (P10). ‘I’d added like other questions just like for myself on there, but I wasn’t able to see those on the graph, I could only see the study ones’ (P19). ‘It’s not as good on the phone ’cause you can’t see it as properly as well as you can on the computer’ (P3). ‘I can’t log in, I don’t try anymore’ (P14).”

Finally, two participants felt that human contact, rather than a technology-based approach, would more likely facilitate an open and honest sharing of information and aid recovery. “‘I think the only way you get to know things is by talking... I know that’s not um... possible... but for people like me with my problem at my age we are not used to... um... baring our soul on a computer’ (P5). ‘I could fill a questionnaire and I could lie through my teeth, but I think you soon get caught out if you’re sitting with a human being’ (P8).”

Suggestions for improvement

Six participants volunteered information about ways in which the interface could be improved, including simplification of the questionnaire(s), and further personalisation options such as adding notes to questionnaire responses. “‘I still feel it can be simplified, to make it, make it a bit more user friendly. Realising that, you know, people using it may have various mental health issues, that might require, a bit more basis yes or no’ (P7). ‘Maybe if you could like... I don’t know, like write notes at bottom or something, or like just for your own reference’ (P20). ‘Perhaps some way of changing the size of the text very easily would help, especially for people who aren’t very computer literate’ (P15).”

Discussion

This study explored whether patients with unipolar TRD found True Colours, an online mood monitoring system used by NHS services, a useful addition to their treatment regimens. Our key findings were that mood monitoring enabled participants to feel that they had greater insight into their disorder, regardless of whether this was anticipated before use, but participants felt that their use of True Colours did not result in behaviour change. Many participants viewed their increased insight positively; but for some, spending time evaluating their symptoms was thought to contribute to a deterioration in mood. This aligns with the suggestion that the ability to identify and characterise one's mood state can predict positive affect, but a tendency to frequently scrutinise one's mood can predict negative affect and rumination.¹⁷

For most participants the perceived increase in insight was not associated with subsequent behaviour change. Neither completing the questionnaire(s) nor viewing the online graphs, which depicted their responses over time, led participants to make connections between patterns in their illness and their lifestyle choices. This is in contrast with research in patients with bipolar disorder, whereby monitoring via True Colours and other automated systems was associated with change in behaviour/improved self-management.^{8,9} This may be owing to the differing nature of TRD, which is not characterised by the same cyclic mood changes, and patients with unipolar TRD may require additional support for mood monitoring to inform behaviour change. It may be that patients with TRD who are undertaking therapies such as behavioural activation could benefit in this regard. The potentially unique needs of this patient group highlighted here would clearly benefit from further qualitative and quantitative research to fully understand how patients with TRD can benefit from this and other mood monitoring systems.

Although participants did not use True Colours for self-management, their responses suggested confidence that the system could improve clinical care by reducing reliance on their ability to accurately recall symptoms over time. The prospect of obtaining more contemporaneous data via this and other mood monitoring systems may improve our understanding of the course of major depressive disorder/TRD, and support the improvement of outcomes. Another key contributor to the enhanced clinical care theme was the belief that True Colours would give patients access to human support. This perception appeared to provide participants with a sense of support and reassurance, although this may have been inflated because of participants' awareness that their adherence was monitored by the LQD study team. However, True Colours does facilitate real-time data sharing with clinicians in standard clinical practice, although this may not be the case with other mood monitoring systems, and whether or not data is monitored by a clinician should therefore be made clear to those who use any online mood monitoring platform.

Three key barriers to mood monitoring via True Colours were identified. First, participants indicated that it was difficult to find the time and/or motivation to engage consistently with the system. However, as discussed, LQD participants were required to complete two questionnaires each week as well as study-specific questions.¹¹ In standard clinical practice, a manageable amount and frequency of use could be agreed between patient and clinician. Balancing the need to collect sufficient data while minimising the burden placed on patients is an important consideration and likely to be relevant to other online platforms.

Second, participants raised concerns about their ability to categorise experiences on standardised questionnaire(s). For some, there were clear discrepancies between what they had experienced and available response options. Others felt uncertain about question wording, reporting that they were difficult to understand or repetitive. Although these difficulties relate to the QIDS-SR and WSAS, and not the monitoring system itself, they indicate a need for the continued development of simplified self-report questionnaires to maximise the utility of online mood monitoring systems while maintaining the validity and reliability of assessments.

Finally, although participants had a positive experience with features of the interface (e.g. weekly prompts), a variety of issues were reported. Several participants chose not to view the graphs, and the majority of those who did had difficulty accessing or interpreting feedback. In addition, technical issues limited the ability of some to interact with the system. Although these graphical and technical concerns can be addressed, the finding that a small number of participants simply preferred human contact indicates that applications such as True Colours will not be acceptable to all, as is the case with any intervention.

There are limitations to this study. Convenience sampling was used, and although this is a widely used method of sampling in qualitative work, it may limit the transferability of the results to other settings, particularly as all participants were selected from a single clinical trial.¹⁸ Participants also varied in how long and to what extent they had used True Colours, making it difficult for some to comment on certain features (e.g. the graphs). The content and frequency of

questionnaires was also protocolised according to the design of the wider clinical trial, although patients did have the flexibility to add additional questionnaires to their schedule. Therefore the experience of participants in the present study may therefore differ from those of patients using the system to support their usual care, and future investigation of online mood monitoring in a purely clinical setting would be of benefit. However, it is noted that the protocolised questionnaires included in this study are routinely used in clinical practice.

To our knowledge, this is the first study to explore the experiences of patients with TRD who use the True Colours mood monitoring system. Our findings are encouraging and suggest the system is reasonably well adhered to and provides an effective way of capturing outcomes. However further development is needed to improve the participant–system interface, and maximise the clinical utility of True Colours for this group. Another important step should be the examination of True Colours use in relation to treatment outcomes, to assess not only whether patients perceive the system to be beneficial, but also whether this translates to an improvement in empirical outcomes.

Although this qualitative study was conducted in a single sample taken from a clinical trial, the differences between the experiences of patients with unipolar TRD reported here and those of patients with bipolar disorder⁹ may have wider implications across settings and mood monitoring platforms. It is clear that online tools developed to support patient care are not ‘one size fits all’, and the experiences and preferences of individual patient groups must be accounted for during development if such tools are to provide the benefits intended.

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Supplementary material

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[click here to view supplementary material](#)

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1.3.13 William James and British thought: then and now

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Abstract

The American psychologist and philosopher William James drew inspiration from British evolutionary theory, neurology, psychiatry, psychology and philosophy. Trained in anatomy, physiology and medicine, he developed a physiological psychology that offered acute analyses of consciousness and of the relations between mind and brain, habit and thought, cognition and emotion and other aspects of psychology. One of his insights, regarding the relation between attention and will, was based upon his own experience of panic anxiety, which was resolved through his reading of several British authors. The story of his psychiatric experience, practical response and later theoretical conclusion offers a potential contribution to contemporary therapeutic practice.

Contents

- *William James and British thought: then and now*

William James (1842–1910) was and remains one of the leading academic and public intellectuals in American history. A founder of modern scientific psychology, he was also instrumental in orienting contemporary clinical psychology. While establishing the pragmatic tradition in American philosophy, he became an inspiring and popular public lecturer, addressing topics like the will to believe and what makes life worth living. Although a psychologist and philosopher, he had a much broader background that included other fields in the sciences and humanities, but for all of that, the only degree he ever received was an MD from Harvard Medical School. His first job at Harvard, before transferring to its Department of Philosophy, was as an Instructor of Anatomy and Physiology.

James's significant contributions to the history of psychology and philosophy depended upon his knowledge of German philosophy and experimental psychology as well as his familiarity with French philosophy and clinical psychiatry, but just as important was his intimate connection with British philosophy and psychology, and his earlier study of British physiology, medical psychology and psychiatry. Beyond that, Charles Darwin provided the larger conceptual framework for his work, British neurologists helped him understand the workings of the brain and many other British thinkers, including literary authors, contributed insights that he integrated into his monumental *Principles of Psychology* (1890)¹ as well as into his later philosophical work. Indeed, he explicitly stated that his psychology represented a continuation, albeit with important revisions, of the tradition that began with John Locke's empirical psychology, and he dedicated his ground-breaking philosophical work, *Pragmatism* (1907),² to 'the Memory of John Stuart Mill', from whom he had learned 'pragmatic openness of mind'.

It was from Britain, too, that James received an invitation to deliver lectures, in Edinburgh, that led to his *Varieties*

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Declaration of interest: None.

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of *Religious Experience* (1902),³ which is still the starting point for empirical studies of the subjective aspects of religious belief, feeling and action. And just a few years later, Oxford invited him to deliver the lectures on *A Pluralistic Universe* (1909)⁴ in which he called for respectful awareness and acceptance of the diverse array of people, phenomena, perspectives and persuasions that compose this world of ours. (He had earlier denounced ‘blindness’ to the valuable distinctiveness of those unlike ourselves, citing Robert Louis Stevenson as well as Wordsworth to bolster his argument.)

Bringing together German, French and British sources was not the only act of integration that made James’s *Principles of Psychology* such a landmark achievement. He also joined the scientific with the humanistic dimensions of psychology. His central argument was that the human mind depends upon, but is not reducible to, its physiological and neurological conditions. To the contrary, it is an essential factor in the evolution and operation of those conditions, a proposition that is once again being entertained by many, after decades of neglect. Ironically, James’s conjoining of physiology and neurology with a careful and precise phenomenology of consciousness drew innumerable readers to his work, but also set the scene for the future dismemberment of what he had brought together. For he was so successful in drawing attention to the significance of the nervous system for an understanding of psychological phenomena that he helped to generate a thriving tradition of neuropsychological research that, until recently, overlooked the reciprocal influence of consciousness on the human organism, which was equally important to James. Similarly, James’s acute analysis of habit helped to inspire generations of behaviourists who proceeded, until the past quarter-century, to ignore the essential role of thought in the development and modification of habits, which James had strongly emphasised. And, on the other side of the coin, those who loved his masterful descriptions of consciousness, thinking, emotion and self came to neglect topics, this time neurophysiology and habituation, which James had shown to be intimately related to them. In addition, with ever-increasing specialisation within psychology, researchers came to ignore the relations among consciousness, thinking, emotion and self, which James had highlighted. As a result, it is only in the past few decades, with the advent of ‘interdisciplinary studies’, that cognition and emotion have been studied once again in terms of their significant overlap, as they were by James more than 100 years ago. And after a similarly long lapse, the role of attention is again a vital topic of research, even leading to explorations of its relation to will, which was a central interest of James.

In this context, returning to James’s work can yield dividends, for there are many other insights that James has to offer; this is also true with regard to James’s philosophical work, but that is beyond the scope of this essay. Because those insights often entail connections between different subfields of psychology, my own recent book on James’s *Principles of Psychology* focused intentionally on some of the more important relations within his thought: between his treatments of mind and body, habit and thought, perception and conception, imagination and memory, cognition and emotion, consciousness and subconsciousness, attention and will, and self and others, not to mention psychology and philosophy, all of which make his work so timely to explore.

The revisions James made in traditional empirical psychology involved changing the Lockean model of the mind from the passive mode, as exemplified in Herbert Spencer’s work, to the active mode, as accomplished by the introduction of subjective interest and individual choice into psychological dynamics, a crucial addition that James traced to insights from the British philosopher Shadworth Hodgson as well as to his own American mentor Chauncey Wright. James’s subsequent radical empiricism, which included subjective experience as its leavening element, placed James at odds with the kind of mechanistic psychology that was later advanced by John B. Watson and all those who banished subjectivity from psychology.

With this in mind, we can consider one possible contribution that James’s non-mechanistic psychology could make to current understanding of the relations between psychiatric conditions – in particular, depression, anxiety and panic of the sort suffered by James himself in a critical period of his life – and consciousness. To do so, we need to be aware of some additional facts, the relevant episode in James’s life and the role played by two additional British people, the 17th century writer John Bunyan and the mid-19th century physiologist William B. Carpenter. Bunyan, as we shall see, suggested to James a practice that changed his life for the better – in fact, a practice that saved his life, as far as he was concerned – and Carpenter proposed an idea that helped James explain the efficacy of that practice, thus influencing his construction of a psychology that began with a focus on brain processes but ended with an affirmation of consciousness, indeterminacy and free will: not a radically free will independent of natural conditions, but a will possessing sufficient personal agency to make life worth living, for James and many others. James’s notion of will, of voluntarism, of being able to make a difference in the world by virtue of his own capacities for resistance, participation and collaborative creation, was grounded upon his conviction that we live in a moral universe in which human action, however limited and pressed upon, can still have some sway, with each of us potentially ‘in the game’, as he put it. For

if human life is truly the struggle that it feels like, as James remarked, it is vitally important for us to believe that the results of that struggle are not foreordained. The difference each of us makes may be small, but it nonetheless makes all the difference for us.

James struggled in his 20s and 30s with poor health, depression, neurasthenia, suicidal thoughts and other related conditions, both before and during the first years of his commitment to the development of psychology. His reading of the French philosopher Charles Renouvier, along with his reading of Wordsworth and Browning, helped him survive and intermittently to emerge from his depressive state. (Less well known, but also significant, is the role that his meditations on Shakespeare's *Hamlet* played in the alleviation of his condition.) Not surprisingly, the variety of causes that fed his depression and ill health are somewhat less understood. He himself feared that inherited physiological factors were at the root of his problems. This generated an understandably fatalistic anxiety, exacerbated by his inclination to accept the deterministic assumptions that undergirded modern science. This nexus of anxiety and supposition led him to the unhappy conclusion that 'we are nature through and through' and that 'not even a wiggle of our will' occurs without some cause outside of our control. This threw into jeopardy his earlier hope to 'leave a trace' in human history, one that only he (through his own self-determination) could leave. And it made him question the very possibility of what he called 'the moral business' by which he had hoped to make his 'nick', thereby contributing his small but real 'mite' to the common good. As he agonised about all of this, he realised that what was at stake was the thought of 'my having a will'. Renouvier had offered an argument, effective for James only on an off-and-on-again basis, that no one can prove or disprove free will, but if free will does exist, its verification would lie in the personal act of freely willing to believe in it. Knowing that he was miserable when he did not believe in it, James committed himself to believe for a year and observe whether that belief made a positive difference in his life.

This is all background to an experience of massive anxiety and panic that was a turning point in James's life, almost certainly in 1870. This momentous incident was described, as if drawn from someone else's experience, in his *Varieties of Religious Experience*. It occurred, according to this 'anonymous report', during a period of 'the worst kind of melancholy' that took 'the form of panic fear'. It consisted of 'a horrible fear of my own existence' that 'came out of the darkness', accompanied by 'the image of an epileptic patient whom I had seen in the asylum, a black-haired youth with greenish skin, entirely idiotic, who used to sit all day on one of the benches... with his knees drawn up against his chin', moving 'nothing but his black eyes and looking absolutely non-human'. And here was the barb at the centre of his panic: 'This image and my fear entered into a species of combination with each other. *That shape am I*, I felt, potentially. Nothing that I possess can defend me against that fate, if the hour for it should strike for me as it struck for him'. The horror of him and the fear for himself – and the sense of his own 'merely momentary discrepancy from him' – left James 'a mass of quivering fear... with a horrible dread at the pit of my stomach' that he managed to escape only by clinging to scripture texts like 'The eternal God is my refuge', 'Come unto me, all ye that labor and are heavy-laden', 'I am the resurrection and the life', and so forth. At the end of his description of this harrowing incident, James asserted: 'Without clinging to these phrases rather than submit to the image of the idiotic patient, I think I should have grown really insane'.

I have written two articles about this episode, one providing new information about its immediately precipitating cause (namely, James's reading of the philosophy of Arthur Schopenhauer, with its pessimistic message about the illusion of individual personhood and of the associated belief in the indeterminacy of individual will) and the other identifying the source of its resolution. How James came to this resolution and how he came to understand and integrate its significance into his psychology is an interesting and relevant story.

In the months preceding the probable date of his fearful encounter with the idiotic, green-skinned phantom, James was not only depressed, but also reading John Bunyan's *Pilgrim's Progress* (1678–1684).⁵ As discovered fairly recently, his mother had given him a copy of this book (in a revised and simplified edition) in late January 1870. She did so purposefully, one assumes, since James was then in the midst of the same bout of suffering that eventually led to his 'touching bottom' during his hallucinatory panic attack. But in any case, James had clearly read the chapter entitled 'The Fight' in this revised version of Bunyan's work, as evinced by a dog-eared page within an extended passage that begins with Christian being 'full of fear' as he is confronted by the 'foul fiend' Apollyon, and then suffers even greater fear as he approaches the Valley of the Shadow of Death. At this point, Christian has a dream, not unlike James's own apparition, in which he comes to the edge of the 'dark as pitch' Shadow of Death. There he sees 'ghosts and imps and fiends of the pit', and hears 'howls and yells as of men in great pain, who sat bound in woe and chains'. Despite his terror, Christian trudges on, seeing and hearing 'dread things' until 'at last' he hears 'a band of fiends' coming to torment him. In trembling fear, he considers 'what he had best do'. And here, on that dog-eared page in James's

recently discovered personal copy, is where Christian's tale touches James's life: "At times he had half a thought he would go back; but then he knew that he might be half way through the vale. He thought, too, of all that he had gone through, and that it might be worse to go back than to go on. So he made up his mind to go on, but the fiends drew near. But when they had come at him, as it were, he cried out with all his might, 'I will walk in the strength of the Lord God'. (pp. 94–95)"

Then, as Christian went on with his mind riveted on the strength of God, he was comforted by a voice saying, 'Though I walk through the Valley-of-the-Shadow-of-Death, I will fear no ill, for thou art with me'. And with that, shrouded by these protective verses from Psalms 71 and 23, Christian 'came to the end of the vale'.

It is not difficult to connect Christian's experience with James's. Similarly full of fear, James confronted his own nightmarish apparition and escaped his own spectre of damnation through the recitation of biblical verses, just like Christian. Although his fear of impending insanity was different from Christian's fear of punishment by 'fiends of the pit', the analogy is easy to see. And James himself, always a perceptive and thoughtful reader, would have seen it. Indeed, in a letter to his brother Henry on 7 May 1870, he wrote that 'I have I think at last begun to rise out of the slough of the past 3 months'. Slough is, of course, a clear reference to the 'Slough of Despond' in *The Pilgrim's Progress*.

We can now consider how James translated this experience into a usable psychological proposition: how, in psychological terms, repeating biblical phrases helped James endure his journey through the Valley of the Shadow of Death without utterly breaking down. This is where the work of William B. Carpenter enters the story. Four years after his devastating experience, as he was beginning to formulate his own psychology, James read Carpenter's *Principles of Mental Physiology* (1874).⁶ In a published review, he specifically noted Carpenter's notion of 'ideo-motor action', which applied to some 'curiosities of our mental life', instances in which a dominating (we would say obsessive) idea gives rise to repetitive motor (behavioural) actions. What James came to realise was that ideo-motor action is, in fact, a more general principle of mental life, not confined to idiosyncratic clinical cases. Indeed, he concluded that the evolutionary function of all ideas is precisely to serve as intermediaries between sensory stimulation and behavioural movement, all of which occur without the intervention of the will. Ideas are naturally 'impulsive', as James put it. So the question is not why ideas lead to action (sensation-ideation-action being the normal course of events), but rather, why some ideas do not.

This is where James's Bunyan-related experience melded with his Carpenter-inspired realisation. Why had the image of the idiotic patient not led to a breakdown in his sanity as James had fully expected? He came to believe that the impulsive efficacy of the image was thwarted when his mind was distracted by more powerful ideas: when images associated with the biblical phrases became more dominant in his consciousness by means of his wilfully attending (or 'clinging') to them. James was well aware that the mind sometimes entertains multiple ideas, with the strongest taking precedence over the weaker ones. Now he added that selective attention could change the relative strength of an idea, bringing it to greater intensity in the centre of consciousness, while other ideas recede as a consequence to the margins of awareness. In short, James made Carpenter's observation about occasional ideo-motor action into a full-blown ideo-motor theory, with an important codicil about how ideas come to be, or not to be, in the centre of one's consciousness. This is precisely where subjective interest and wilful attention come into play, James concluded. Will, in this rendition, is equivalent to enhanced selective attention, which is directed by our interests. (James later clarified that our interests can be aesthetic and moral as well as intellectual and practical.) Will creates nothing; it does not directly affect action, it can only do so indirectly by increasing the prominence of one idea over others, thereby 'loading the dice' for one action over others. (Another way to say this is that we cannot will a movement independently of thinking about it.) In this way only do dominant ideas bring about 'voluntary action' as opposed to involuntary, instinctive or habituated responses.

This psychological explanation, giving a restricted yet significant role to personal interest and selective attention, provides the essential framework for James's chapter on 'The Will' in his *Principles of Psychology*. In that chapter, he explains and defends his ideo-motor theory and outlines 'Five Types of Decision' according to the prominence, conflict or absence of competing ideas. He also discusses extreme cases of 'The Explosive Will,' in which the impulsive power of ideas is not sufficiently repressed by countervailing ideas, and 'The Obstructed Will,' in which the repression of ideas is excessive. Clearly, what James offered was primarily a phenomenological description of the experience of will. Simple though it is, it bears consideration as contemporary research re-opens the matter of selective attention and its relation to will or willpower. The proof of its theoretical adequacy will depend, of course, upon the accumulation of scientific evidence, but its practical utility will be judged best by psychotherapeutic outcomes. Can a focus

on certain ideas or images facilitate behavioural change, whether immediately or after repeated occurrence, whatever might be going on ‘behind the scenes’ in terms of biochemical transformations and neurological processes? Research on meditation suggests that it can. What about therapeutic success? More should be made of this, especially among those who typically emphasise biomedical factors in treatment settings. More particularly, it might be useful to explore James’s claim that, although individuals cannot directly will a change in their psychiatric condition, they can and should maintain a focus on the idea of an alternative, keeping that idea forcefully in mind during the course of whatever kind of therapy might be taking place. It cannot hurt, and it might well prove to be beneficial. A good deal of research, after all, has shown that the mind is much more powerful, in a variety of ways, than was once assumed.

This is all reminiscent of Viktor Frankl’s comment, very possibly made with James’s views in mind, that even when all other means of changing a situation are blocked, as in a concentration camp or a severe psychiatric condition, one can at least posit one’s own attitude toward what is happening in one’s life.⁷ That attitude, expressing a firmly held idea or wish for another state of affairs, may well contribute, along with other remedies, to a positive change. William James, the grateful recipient of many British ideas, certainly thought so.

Interested persons can find additional information about James and his work, relevant to this essay, in references⁸⁻⁹⁻¹⁰⁻¹¹. The title of the last reference, ‘A moralist in an age of scientific analysis and skepticism’, is used to describe James, but it comes, in fact, from James’s own description of the British novelist George Eliot, indicating yet another link between James and British authors.

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One of the most difficult things about writing a book for general readers on mental health (and, more particularly, psychiatry) is knowing how to structure it – and where to begin. The authors of this very comprehensive book, a liaison psychiatrist (Ellen) and a writer–comedian (Deveny), have both experienced depression and they share their tales with considerable frankness and humility. However, instead of beginning with these engaging stories, they choose to start with a section on diagnosis and classification – which might unfortunately deter some from continuing.

There are really useful sections on how to talk to friends who you think might need help and what happens when you go to see a mental health professional. However, my particular favourite has to be ‘clues your shrink is a dud’, which warns against those who claim excessive certainty, have a guru mentality and are excessively expensive. And therein lie clues that this book doesn’t originate in the UK, but hails instead from Australia. The text has clearly been edited for the UK edition, with reference to clinical commissioning groups, mental health trusts and a list of UK organisations from which further help can be sought. However, there is, for example, no reference to the problems faced by those from UK ethnic minorities, the section on drugs mentions neither ‘skunk’ or ‘legal highs’ and the classification system is, of course, DSM.

Readers of this book would learn a great deal about mental health and illness from a biopsychosocial perspective. They might, however, be left with an idea that there is considerably more choice of professional and therapist in the National Health Service than in reality – although this may of course be true if they can pay. Personally, I don’t see any problem in asking your GP if they are good at mental health, and I wish it was easier to ask for second opinions. The authors tell us ‘remember you are in charge!’ but for many people seeking help it rarely feels that way.

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1.3.14 Hanafy Ahmed Youssef, DM, MRCS, FRCPsych

Omar Youssef

date

2020-04

Contents

- *Hanafy Ahmed Youssef, DM, MRCS, FRCPsych*

Formerly Consultant Psychiatrist, St Davnet's Hospital, Monaghan, Ireland

Hanafy Youssef, who died at the age of 80 on 21 January 2019, was a leading figure in Irish psychiatry. With his colleague John Owens, he set up the first community-based psychiatric service in Ireland. He was able to show that this pattern of service led to better outcomes for patients and their families. As a result, a number of other community-based services in Ireland and the UK were established.

Over a 20-year period in the 1980s and 1990s, he developed a highly productive research relationship with Professor John Waddington of the Royal College of Surgeons, Ireland. Together they published many papers on aspects of psychotic illness occurring in patients referred to the Cavan/Monaghan psychiatric services. Hanafy Youssef contributed to over 60 publications in the fields of psychotic illness, neurodevelopmental psychiatry and psychopharmacology. The relationship between the Cavan/Monaghan psychiatric services and the Department of Psychopharmacology at the Royal College of Surgeons, Ireland, continues to this day.

Hanafy had a strong interest in postgraduate psychiatric education. He was clinical tutor at St Davnet's Hospital and a member of the Irish Psychiatric Training Committee. He had a great capacity for explaining difficult concepts to medical and nursing staff. Indeed, as an educator, he was at the forefront of psychiatric education in Ireland. He was also a mentor to many overseas doctors who worked with him. He was an inspiration to them as they saw him become a leader in his specialty. He was a particularly strong supporter of women in medicine at a time when women doctors were still finding it difficult to climb the career ladder.

He had a great interest in the development of psychiatric services in less economically developed countries. In the 1970s he spent time in Zambia, developing clinics in rural areas and helping to confront the stigma often attached to psychiatric illnesses. From 1994, he spent 2 years in a professorial post in Trinidad and Tobago, where he helped improve the quality and prominence of undergraduate psychiatry training. He felt this was crucial if the finest doctors were to be recruited into the specialty. He then returned to take up a consultant post in liaison and general psychiatry at Addenbrooke's, a teaching hospital within Cambridge University Hospitals NHS Foundation Trust. In addition, he carried out voluntary work with charities in Yemen and Libya, providing both general medical and psychiatric care in areas where there was a shortage of doctors.

Hanafy was also a philanthropist, fiercely passionate about social justice, who took seriously the welfare of the less privileged. Together with his siblings he established Latifa's Orphanage House and a mosque in the suburbs of Alexandria. He worked tirelessly for the underprivileged and would offer free medical care to any in need.

Whether they spoke to him in person, heard him speak at international conferences or were his patients, Hanafy Youssef left a lasting impression on all he met. His knowledge, dedication to his field and commitment to his patients were widely appreciated.

He came from humble beginnings. He was born on 14 January 1939 in Alexandria, Egypt, to Ahmed Mahmoud and Latifa (née Taher). His father ran a hunting and tackle store there. Hanafy studied medicine at Alexandria University and undertook postgraduate training in the Department of Psychiatry at the University of Cairo. At university, he led an extremely active life, both in cultural pursuits and in sport. He authored several published novellas in Arabic, won a national poetry award and was the arts reviewer for the university paper. At the same time, he was a member of the university football and wrestling teams. He took an interest in science and politics, and became multilingual, adding French and Russian to the Arabic and English he spoke before entering university. After qualifying as a doctor, he spent 2 years as a medical officer in the Egyptian Army, including service during the Arab–Israeli Six-Day War.

He moved to Derry in 1971 to obtain further training in psychiatry and fell in love with Ireland and its people. This is where he met his wife Ann. He obtained a consultant psychiatrist's post at St Davnet's Hospital, Monaghan, in 1975 and spent most of his career there.

Hanafy retired in 2001 and enjoyed his retirement years in Armagh. He remained highly active, interested in medicine and writing about and closely following the struggle of his Egyptian compatriots for freedom and progress. He published several papers on the history of psychiatry, reviewed books on psychiatry and had several letters published in national broadsheets on a wide range of subjects. He was very proud of his family and their achievements.

He passed away peacefully surrounded by his family. He leaves Ann, his wife of 46 years, five children (Emma, Mahmoud, Latifa, Zahra and Omar) and three grandchildren.

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1.3.15 A visual step-by-step guide for clinicians to use video consultations in mental health services: NHS examples of real-time practice in times of normal and pandemic healthcare delivery

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Abstract

Despite the increasingly widespread use of video consultations, there are very few documented descriptions of how to set up and implement video consultations in real-time practice. This step-by-step guide will describe the set-up process based on the authors' experience of two real-time National Health Service (NHS) examples: a single health board use (delivered in normal time), and an All-Wales National Video Consultation Service roll-out (delivered during an emergency pandemic as part of the COVID-19 response). This paper provides a simple visual step-by-step guide for using telepsychiatry via the remote use of video consultations in mental health services, and outlines the mandatory steps to achieving a safe, successful and sustainable use of video consultations in the NHS by ensuring that video consultations fit into existing and new NHS workflow systems and adhere to legal and ethical guidelines.

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There is a large and growing evidence base of published data that demonstrates an overall consensus of suitability, acceptability and satisfaction regarding the use of digital technology,¹⁻⁶ particularly video consultations for the purpose of remote assessments and appointments in mental health, known as ‘telepsychiatry’.⁷⁻¹⁵ Telepsychiatry is widely reported to be at least as efficient and effective as traditional face-to-face care, providing improved clinical and quality of life outcomes across a wide range of population groups and settings.⁷⁻²⁰ Studies have compared video consultations with standard in-person care and concluded that video consultations might be superior to in-person consultations for some forms of treatment and population groups.^{2,7} The evidence base for telepsychiatry remains strong and consistent across mental health studies for both adult and child services.⁷⁻²⁰ It is commonly argued that mental health and psychiatry are particularly well suited to video consultations and that the psychiatric interaction translates exceptionally well to the technological world. This is because many treatments are based on interpersonal ‘talking therapies’ and medication management, which typically do not require any other medical devices for clinical use, perhaps in contrast to other specialties.²¹ Video consultations have the potential to offer many additional benefits to patients, families and clinicians besides treatment. They are reported to improve and widen patient and family access to healthcare, support co-production and self-management, increase efficiency and improve clinical outcomes, as well as significantly reducing clinical time and patient and family travel.^{2,22,23}

Local evidence to support this step-by-step guide

The CWTCH quality improvement project

In 2019, the Health Foundation²⁴ funded Aneurin Bevan University Health Board (ABUHB) for 1 year to establish a telepsychiatry programme with the objective of providing mental health appointments to children and adolescents within Gwent mental health services. This ABUHB programme is called Connecting with Telehealth to Children in Hospital and Healthcare (CWTCH). It is a National Health Service (NHS) quality improvement project that provides faster and more efficient appointments in child and adolescent mental health services (CAMHS) using a communication platform called Attend Anywhere (<https://www.attendanywhere.com>). The programme tested the suitability and acceptability of telepsychiatry and measured satisfaction across a wide range of settings and uses, including paediatric wards for emergency assessments, out-patient appointments, medication reviews, autism assessments, school post-vention clinics for pupil suicides, virtual groups and more. It demonstrated that telepsychiatry in CAMHS is a highly suitable adjunct to routine ways of working; once people became familiar with this way of holding appointments, it was rated as acceptable and satisfactory by patients, families and clinicians.^{25,26}

Rebranding of CWTCH and Royal College of Psychiatry endorsement

CWTCH has now been rebranded and is called CWTCH Cymru. It has received local and national recognition for its success and is now considered an exemplar of good practice across Wales. CWTCH Cymru and its guiding principles²⁶ have also been endorsed by the Welsh Royal College of Psychiatrists.²⁷

Partnership and development of the national roll-out of video consultations

In March 2020, in response to the COVID-19 emergency, CWTCH Cymru went into partnership with Technology Enabled Care (TEC; <https://digitalhealth.wales/tec-cymru>) and the Welsh Government to form a National Video Consultation Service.²⁸ This service is currently rapidly scaling up the routine use of video consultations across Wales, using the Attend Anywhere communication platform, to all appropriate primary, secondary and community care services, including mental healthcare for all ages. The National Video Consultation Service has a fully resourced website, with helpful guides, videos and toolkits, which can be accessed and used in addition to this paper.^{28,29}

Video consultation experience and lessons learned

The experience gained from working on two very different sized projects (small versus large scale) and in two very different contexts (normal versus pandemic) has demonstrated that regardless of the scale and rate of adoption, there are distinct challenges in introducing video consultations as a new way of working in the NHS for clinicians. Clinician acceptance and use of video as an accepted alternative to established ways of working were found to be rate-limiting factors with respect to adoption and spread. This challenge is defined by the authors as ‘clinician need versus clinical need’. This definition suggests that video consultations are more likely to be adopted and accepted as a feasible approach to healthcare delivery when the ‘need’ for this way of working is defined and accepted by the clinician or service, compared with when they are defined and accepted as a clinical need. In other words, video consultations are generally more successful and sustainable when a clinician or service perceives the need themselves and requests the service, rather when they are motivated by the projection of need or want from their patient population. It is therefore essential to establish and define this ‘need’ within a service, seeing clinician/service ‘pull’ for video consultation as an essential criterion for successful adoption. When the perceived need for video consultations by clinicians and services increased in the pandemic context, there was greater willingness to test new ways of working and overcome perceived or internal barriers to change. This has significant implications for how video consultations should be introduced into services and organisations, highlighting the need to focus on both the technical and the cultural aspects of the adoption process. These findings mirror the work of Greenhalgh et al and their ‘NASSS’ (non-adoption, abandonment and barriers to spread, scale-up and sustainability) framework.³⁰

Rationale and objectives

Despite the increasingly widespread use of video consultations, there are very few visual and fully documented descriptions of how to set up and implement such consultations in real-time practice with specific attention to features such as fitting into existing systems and the legal and ethical requirements of video consultations. This step-by-step guide will describe the process based on two examples: a single health board project (delivered in normal time), and an All-Wales National Video Consultation service roll-out (delivered during the COVID-19 pandemic emergency).

Methods

This paper was designed to be a simple and visual step-by-step guide describing how to set up and use video consultations for mental health services, including a range of ‘technical’ skills and knowledge that clinicians and services may find helpful for the adoption of video consultations. This paper will describe the various steps that have been taken by the authors in their real-time experience to initiate and implement a new video consultation programme in an existing NHS systems. The visuals used on the TEC website and in this paper are adaptations and syntheses of work from other recent video consultation reports in the UK.³¹⁻³³ Note that the visual diagrams and infographics used in this paper are examples based on the communication platform Attend Anywhere (<https://www.attendanywhere.com>); therefore, descriptions and instructions may differ slightly depending on the type of platform used in your health service.

Ethical approval was obtained from all seven Welsh research and development departments. Consent was obtained from all participants in both CWTCH and the National Video Consulting Service.

Results

Step-by-step guide

This section of the paper will provide a step-by-step guide that is divided up into three distinct sections. The first section demonstrates how to set up video consultations in an existing healthcare workflow. The second section provides the appropriate steps regarding ethical and legal principles. The third section discusses how to use video consultations in a secondary care health service, with the help of an infographic diagram.

A guide to setting up video consultations in existing systems

Managing the video consultation service

Within your healthcare service, you will need to identify a lead clinician who will decide how best to set up, use and manage the video consultations (*Fig. 1*). This person will be the ‘point of call’ for your service and its use of video consultations. *Fig. 1* Workflow visual guide. Diagram from the Welsh National Video Consultation Service Toolkit.²⁹

Setting clinical criteria

Your healthcare service will need to define and agree on clinical criteria for video consultations and the suitability and appropriateness of appointment types. Following this agreement, a template for triage or suitability would need to be developed and provided to the person(s) in charge of making video appointments, e.g. a receptionist.

Making and managing appointments:

Your service will need to identify how video consultations will be made, and who will make and deliver these appointments. Your service will also need to identify how appointment links and information will be sent to patients – for example, via a letter, verbally or via an SMS text or email – and how appointment slots will be offered, documented and given to the delivering clinician. In addition, your service will need to decide how the video consultation will be managed, how clinical templates and coding will be used for video consultations, and how these will be matched to existing systems. Your service will need to have a contingency plan for possible scenarios or problems (for both technical and clinical possibilities). Finally, your service will need to consider how clinical information is later documented, for example, similarly to the hand-written notes used in usual practice.

Setting up the clinical space

Your health service will need to identify how video consultations will be set up. For example, you will need to think about factors such as the room layout, e.g. whether it is well-lit and well-positioned, confidentiality issues and clinical appropriateness. More about this can be found in the following sections.

Additional considerations

Your service will need to decide how to deal with providing additional information; for instance, if the picture definition obtained via a video consultation is not good enough to allow accurate visualisation and identification of skin lesions, your service needs to decide how to obtain this additional information. It is important that patients are able to receive patient information leaflets as they would in a standard consultation. Your service needs to decide the best mechanism for communicating this information to them. For example, you could email them. Your service would also need to consider additional plans for in-person contact, such as for collection of prescriptions.

A guide to risk, safeguarding and ethical guidelines

Key considerations in the use of video consultations include legal and ethical issues, such as defining and documenting patient suitability and the role of the clinician, risk assessments and contingency planning, privacy, confidentiality, security and consent (*Fig. 2*). Appropriate strategies covering ethical issues will be necessary, such as taking informed consent and ensuring confidentiality and security while using technology, and procedures for conducting risk assessments. *Fig. 2* Legal and ethical visual guide. Diagram from the Welsh National Video Consultation Service Toolkit.²⁹ VC, video consultation.

Define and document clinical suitability and appropriateness

Your healthcare service will need to define and agree to clinical criteria for video consultations and the suitability and appropriateness of appointment types. This defining and documentation process would need to include the roles and responsibilities of clinical staff.

Risk, safeguarding and ethical considerations

All types of mental health services using video consultations, regardless of their level of risk, should consider conducting risk assessments, and abide by safeguarding principles and ethical guidelines.

To start thinking about the population your service will deliver a video consultation to, and the risk exposure that may arise, it is advised to conduct an initial ‘process mapping’ of your service. Process mapping will help your team to define video consultations in the context of your service, understand who is responsible for what and where, and to flag up any potential concerns or risk exposures. Process mapping and risk assessment will help your service to start thinking about and understanding what types of risks may arise in specific situations, and possibly how to avoid them.

You would need to think about the following. •Would using video consultations instead of in-person care increase risk in any way?•If so, what are these risks, and can they be resolved?•Is the risk of using video consultations greater than not seeing the patient at all?•Would these risks be the same if the service was delivered in person?•What other types of risks might there be – such as the setting, environment and clinical outcome?

On completion of process mapping and initial risk assessments, the next step would be to start thinking about – and formally agreeing to and documenting – clear and concise safeguarding contingency plans for your video consultation service. This would involve a ‘what to do’ plan in the event of an emergency or concern arising during a virtual appointment. It is advised to list a wide range of scenarios, ranging from low- to high-risk possibilities. Make it as specific to your service as possible, to make potential scenarios relatable to your staff. When developing the contingency plan, think about who is best suited to develop it and who will be following it, and consider a wide range of opinions and possibilities. Develop a list of all possible scenarios and all levels of risk exposure, and make them specific, applicable and relatable to your service.

Ethical guidelines

Video consultations, like any other form of healthcare delivery, will need to be treated exactly the same way as in-person care with regards to ethical guidelines and procedures. However, owing to the obvious remoteness of a virtual appointment, there are additional ethical considerations which need to be considered and applied, such as confidentiality, privacy and security issues.

It is essential that a video consultation service replicates an in-person appointment or assessment as much as possible. For example, the setting of an appointment room would ideally need to be the same as an in-person appointment room, e.g. if your service would normally use a private room for an in-person appointment, then a virtual appointment would also need this. It is also important to ensure that the platform used for video consultations is safe and secure, and that it meets your existing health systems standards, including software encryption. Many popular video chat platforms such as FaceTime and WhatsApp are not compliant with healthcare standards; therefore, you would need to seek out a safe and secure platform such as Attend Anywhere (<https://www.attendanywhere.com>).

Informed consent is the process of seeking agreement from a person before taking a course of action that requires consent. Informed consent is required from any person who is receiving a video consultation. There are two types of consent. •Implied consent (or tacit consent), which is signalled by the behaviour of an informed person in agreement. This type of consent is typically used in the delivery of ‘in-person’ healthcare.•Explicit consent is when a person actively agrees, either verbally or in writing. This type of consent is highly recommended for video consultations, as signalled (implied) behaviour may be more difficult to capture remotely.

To obtain consent, the person giving it would need to be considered to fully understand the process and to have full capacity to do so. A person with incapacity, such as a child or vulnerable adult, may not be able to give informed consent; therefore, parental or guardian consent (known as assent) would be required.

A guide to conducting the video consultation

The final step of this guide describes how to use video consultations in a secondary healthcare service (*Fig. 3*). *Fig. 3* How to use video consultations visual guide. Diagram from the Welsh National Video Consultation Service Toolkit.²⁹

Define and document clinical suitability and appropriateness

As shown in the above *Figs 1* and *2*, your healthcare service will need to define and agree to clinical criteria and patient suitability for video consultations. This is considered the most important step for video consultations.

Contact the patient and send instructions and video call link

Depending on the type of communication platform (e.g. Attend Anywhere) you will be using, the patient will need to be offered the video appointment; they will then need to agree to it, after which they will need to be sent the patient information sheet and URL link to access the video call.

Set up video call and start consultation

Again, depending on the type of communication platform you will be using, there will need to be clear steps set out to determine how best to use video consultations in your service.

Evaluation component

To ensure that the use of video consultations is properly integrated into your health service, it is important to capture feedback on use, acceptability, suitability and satisfaction. It is therefore advisable to establish an evaluation framework to capture this. An example of this may include attaching a basic satisfaction survey to the end of the video consultation, asking a few ‘how did it go’ questions.

For additional information, please see the TEC website (<https://digitalhealth.wales/tec-cymru>), which provides a detailed step-by-step guide on setting up a video consultation (*Fig. 4*), healthcare-specific toolkits, including examples of information sheets, suggested scripting for clinicians, technical guides to the Attend Anywhere communication platform and much more. *Fig. 4* Infographic visual guide: video consultations in secondary care. Diagram from the Welsh National Video Consultation Service Toolkit.²⁹

Conclusions

This paper outlines a simple visual step-by-step guide to help clinicians to set up and use video consultations in mental health services. This resource has been used to support clinicians to gain the technical skills and knowledge required to routinely use video consultations in practice. In addition, we found that there is an important ‘cultural’ aspect to successful adoption of video consultations, where the rate-limiting factor for successful adoption is the ‘need’ and ‘pull’ for this way of working to be defined and accepted by the clinician or service.

When the perceived need for video consultations by clinicians and services increased in the pandemic context, there was greater willingness to test new ways of working and overcome perceived or internal barriers to change. It will be interesting to see whether having made the change to this new way working in the pandemic context, clinicians and services actively choose to maintain these newly gained technical skills – and also whether patients and carers, having experienced video consultations for the first time, increase their demand for this to become a new ‘routine’ way of working. As use of video consultations increases, we will also undoubtedly learn how to titrate this offer according to need, circumstance and demographics, and discover which healthcare treatments can best be deployed or augmented through the use of video consultations.

This paper provides a guide to using video consultations in the NHS, based on personal experience of the authors and feedback from their evaluation. However, it is still early days for video consultations in Wales, and more research is needed to understand more about their use, particularly what can and can't be done using video consultation, as this is still unspeculative and unproven.

Gemma Johns is Research & Evaluation Lead of CWTCH and TEC Cymru ABUHB, Wales, UK. Gemma worked on both the CWTCH and National Video Consultation project and led the evaluation for both. **Jacinta Tan** is a Child and Adolescent Mental Health Consultant Psychiatrist and Project Manager of CWTCH, ABUHB. **Anna Burhouse** is the Health Foundation QI Adviser for CWTCH and supported the evaluation of the National VC programme, Northumbria Healthcare NHS Foundation Trust. **Mike Ogonovsky** is Assistant Director of Informatics ABUHB and Senior Responsible Officer of TEC Cymru. **Catrin Rees** is at Life Sciences Hub, Welsh Government, and is a Graphics & Web Designer for TEC Cymru. **Alka Ahuja** is a Child and Adolescent Mental Health Consultant Psychiatrist, Clinical Lead for TEC Cymru, Chief Investigator for CWTCH.

G.J. contributed to the main write up and development of the paper; she developed the manuscript draft, designed the template of the visual and infographics, and was involved in the overall structure and design, and in making amendments to the final manuscript. J.T. helped structure the manuscript and contributed clinical understanding to the guidelines, visuals and infographics. A.B. contributed some of the written text in the paper and wrote up the conclusion, and also helped structure the final manuscript and helped with amendments. M.O. contributed to the development, structure and reading of the manuscript (draft and final), and provided a technical and overall National Programme perspective on the paper and its guidelines. C.R. redesigned the draft templates into the final graphics for this paper, including the four visuals and the infographic, and also contributed to the structure and reading of the manuscript. A.A. was responsible for overseeing the entire development of the paper, helped structure the manuscript (draft and final), developed and shaped the clinical and technical perspective on the clinical guidelines provided in the paper, and helped develop the visuals and infographic.

The CWTCH project was funded by the Health Foundation as a quality improvement project in Aneurin Bevan University Health Board in Wales. The National Video Consultation Programme is currently being funded by the Welsh Government to test video consultation across all of Wales.

Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2020.71>.

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1.3.16 Defining what a ‘carer’ is and the role they play in in-patient mental health-care: A focus group study with patients, carers and clinicians

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Abstract

Background

The value of carer involvement has been extensively researched and promoted. However, the field lacks exploration of conceptual issues, which might help to explain why there are widespread difficulties in putting policy into practice in this area, as implementation rates remain low internationally.

Aims

This qualitative study explored patients’, carers’ and clinicians’ perspectives on the role of carers in mental healthcare, particularly with regards to in-patient settings.

Method

Sixteen focus groups were conducted with patients, carers and clinicians who have current or previous experience of in-patient settings. A thematic analysis was conducted on the transcripts, exploring two key domains: (a) what a ‘carer’ is, and (b) how the ‘carer’ role is described within the context of the hospital environment.

Results

Participants diverged in their opinions of what the ‘carer’ role entails, and the perceived helpfulness of it. Issues unique to the in-patient setting were identified, such as the role of the hospital environment in enabling or being a barrier to carer involvement. These differing perspectives and contextual factors had an impact on the position of carers in the hospital setting, as they could be viewed as helpful, a hindrance or as passive visitors, depending on the perspectives of clinicians.

Conclusions

More clarity and agreement is needed between patients, carers and clinicians in terms of how the ‘carer’ role is defined. This has the potential to improve carers’ experience of involvement in hospital settings.

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Background

In the field of mental healthcare, the involvement of family and friends, often referred to as ‘caregivers’ or ‘carers’, has been demonstrated to be useful for a variety of outcomes for patients. This includes a decrease in relapse and rates of readmission to hospital.¹ The efficacy and implementation of carer involvement has therefore received much attention in research and carer involvement policies and guidelines are widely promoted in mental healthcare internationally (for example from the UK National Collaborating Centre for Mental Health² and UK Department of Health and Social Care³). However, the literature lacks an examination of fundamental conceptual issues,⁴ the exploration of which might help us to better understand why carer involvement is so widely promoted in theory yet so poorly or inconsistently implemented in practice, both in the UK and internationally.^{5,6}

‘Carer’ is a policy-derived term, which aims to value the contribution that family members and friends make to patients’ care. However, there is a need to explore how the ‘carer’ role is actually understood by patients, their family members and friends and front-line clinicians. This is especially pertinent in hospital settings, as patients may be admitted to hospital following the deterioration of relationships or as a result of a breakdown in their usual social support networks.⁷ There is therefore value in exploring this topic to better understand how ‘carers’ are viewed in the context of mental healthcare, and how this might have an impact on the nature of their involvement in patients’ care.

Research question

How do patients, carers and clinicians conceptualise the role of carers in the context of mental healthcare and in-patient settings?

Method

Design

Focus groups were conducted with patients, carers and clinicians to explore their opinions and experiences of carer involvement in in-patient mental healthcare. The groups were conducted as part of a larger study of stakeholders' views on what carer involvement in in-patient mental healthcare should entail, and the methodology is described in further detail in a separate article.⁸ For the present part of the study, the topic guide contained questions and prompts pertaining to participants' conceptualisations of what the carer role entails, and the use of the term 'carer'.

Participants

Purposive sampling was used to recruit patients and carers through the East London NHS Foundation Trust in-patient and out-patient mental health services as well as local service user and carer organisations located in the London Boroughs of Hackney, Newham and Tower Hamlets. Advertisements were put on social media (Twitter and Facebook). All clinicians who participated in the study worked in in-patient services at the East London NHS Foundation Trust.

Maximum variation sampling was used to ensure a diverse sample of participants across mental health settings (acute in-patient units, triage wards, community settings), local boroughs and, in the case of staff, job positions. Patient and carer participants were recruited both from settings where a patient was currently in hospital, and from those who had been admitted to hospital within the past 5 years. Additionally, carers were recruited from both settings where an individual might already self-identify as a 'carer' (for example carer organisations) and settings where they might not do so (for example by being approached by a clinician when they visit a relative in hospital). Carers could also self-refer by responding to adverts shared widely via email lists, Twitter and bulletin boards. The advert did not use the word 'carer' but instead asked 'have you or someone you support ever been admitted to hospital for mental health reasons?'. This was to attract participants with potentially wide-ranging views on the 'carer' role, as well as those who were not familiar with the term 'carer'.

Sample size was initially planned on the basis of aiming for 6–8 participants per focus group, and 6–12 groups in total, as recommended by Finch, Lewis & Turley (cited in Ritchie et al).⁹ This was envisaged to allow for active participation for all members while giving individuals opportunities for more detailed discussion. However, adjustments were made for each group type, for example carers and clinicians were invited in higher numbers, to allow for the possibility that a proportion would cancel because of caring or working responsibilities.

Patients over 18 years old who were able to provide informed consent, had experience of admission to psychiatric hospital (within 5 years) and sufficient command of English were eligible for the study. Carers were eligible if they were over 18 years old, had experience of supporting someone who was admitted to psychiatric hospital (within 5 years) and sufficient command of English. Clinicians had to have current experience of working in acute in-patient settings.

Potentially eligible patients who were identified by clinicians were asked permission to receive further information from researchers about the study. Patients, carers and clinicians who self-referred were also given the opportunity to discuss details of the study with the researcher, before arranging to attend a focus group.

Ethics statement

All procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees and with the Helsinki Declaration of 1975, as revised in 2008. Ethical and institutional approvals were provided by the East London NHS Foundation Trust and the East of England – Essex NHS Research Ethics Committee (ref:15/EE/0456). All participants provided their written informed consent to take part in the study, as well as providing verbal consent to begin recording.

Procedures

Focus groups were facilitated by two researchers, with at least one clinically experienced and able to provide support if any of the participants became distressed or agitated. Except for one mixed patient–carer group, separate focus groups were conducted with carers, patients and clinicians to account for possible counterproductive dynamics between the groups and ensure that each group could express their views freely. Although up to ten participants were sought for most of the focus groups, smaller groups of three to five participants were arranged with patients who were currently in hospital, to minimise overstimulation and allow each participant to share their opinions comfortably.

A topic guide was developed based on guidance in Ritchie et al⁹ and was designed to facilitate up to 90 minutes of discussion. Each of the three participant groups had a slightly amended version of the same topic guide, so that the questions were relevant to them as patients, carers or clinicians. The initial aim of the guide was to gather opinions to develop a carer involvement intervention to be used in in-patient settings. After introductions and ground-rule setting, two main topics were introduced, each with a set of questions, probes and prompts to encourage active participation of all members. The discussion topics began (a) generally, asking participants about their views on carer involvement in mental healthcare, and (b) developed into specific questions about how to involve carers in hospital settings, including a discussion of barriers and facilitators to involvement in different clinical procedures. The topic guide was amended after five focus groups, as the questions on hospital procedures and potential interventions were refined following discussions in the initial groups.

The guide was applied flexibly to enable open discussions within each group. Consequently, although the whole topic guide was covered in each group, different groups discussed some topics more in-depth than others. Participants were asked open-ended questions to stimulate discussions, and all questions were posed as neutrally as possible to encourage them to express their honest opinions. For example, they were asked what they think about the term ‘carer’ and following this, they were asked to discuss what the helpful and unhelpful aspects might be of involving carers in in-patient treatment.

Analysis

The focus groups were audio recorded and transcribed using intelligent verbatim and omission of identifiable information, such as names. The analysis was conducted independently of the linked study,⁸ which had focused on the practicalities of barriers and facilitators to carer involvement in in-patient treatment. NVivo software was used for coding and organising data during the analysis. Interim analysis was conducted by J.K. and A.D. after nine focus groups and a decision was made to continue with recruitment. After 16 focus groups, J.K., A.D. and D.G. had a reflective discussion about whether saturation of themes had been reached, and it was decided to cease recruitment.

Inductive thematic analysis¹⁰ was used to analyse the transcripts. This involved looking for common themes and exploring whether there are any similarities and differences between the participant groups. The stages included initial familiarisation with the data corpus by reading all transcripts. Initial coding of the transcripts was then conducted for all transcripts with the research question in mind. Distinct areas of exploration were then identified through the initial coding, and further analysis was conducted within the framework of two domains: (a) what a ‘carer’ is, and (b) how the ‘carer’ role is described within the context of the hospital environment.

An iterative process of identifying subthemes through reflective discussions was conducted throughout the analysis. Labels were attached to each quote during the coding process to identify whether it came from a patient, carer or clinician. Comparisons between the three participant groups were then made at later stages of analysis, once initial

themes had been formed. Clusters of related subthemes were converted to overarching themes, with transcripts and quotes being re-checked to ensure consistency of the themes. For example, initial coding of quotes describing ‘battles’ were further analysed to understand which aspect of the hospital context and/or procedures was resulting in this perception, and what this meant in terms of being a ‘carer’. Largely, these quotes described how carers were perceived by professionals as being ‘difficult’ and there were several examples from different participant groups to support this view. These quotes were placed into themes after the transcripts were checked for alternative views. After finalising the themes, quotes were extracted for the article for transparency and to illustrate the findings, although some demographic information was changed to preserve anonymity.

All transcripts were independently coded and analysed by A.D., a researcher with a primary interest in patient perspectives on family involvement and J.K., a researcher with interests in sociocultural perspectives on mental health. The findings were discussed and agreed with a third researcher (D.G.), an academic and clinical psychiatrist who had also conducted some of the focus groups and was familiar with the transcripts. These backgrounds may have influenced each author’s personal interpretation of the themes. However, efforts were made to maximise the rigour and trustworthiness of the analysis process by analysing the transcripts separately and then having multiple reflective discussions on the development of the themes. Any points of disagreement were discussed and the transcripts were re-checked throughout the analysis process before deciding on the final themes.

Results

Participants

Eighty-six participants attended 16 focus groups held between 2014 and 2016. This included 31 patients, 22 carers and 33 clinicians. Four focus groups were held with carers, five with patients, six with clinicians. Clinician focus groups were broadly separated by profession: ward managers, nurses, psychologists, psychiatrists and support workers. One mixed group was held with both patients and carers. Smaller groups were held for participants currently in acute treatment to support their participation; the size of all groups varied from three to ten participants. Sociodemographic characteristics of the participants have been provided in *Table 1*. All participants had experience of voluntary or involuntary admission to a psychiatric hospital within the past 5 years, either as a patient, carer or staff member. Further demographic details about the participants are available in the linked study.⁸

Table 1 Sociodemographic characteristics of participants											
Patients	Carers	Clinicians									
Gender, n	Men 16	21	Women 15	20	17						
Age Mean (s.d.)	43 (12.3)	51 (15.8)	40 (10.4)	Undisclosed n	8						
Role, n	Patient 31	Parent 14	Partner 3	Sibling 2	Son/daughter 2	Sibling and daughter 1					
Psychiatrist	6	Psychologist	4	Nurse	10	Ward manager	6	Support worker	6	Activity coordinator	1

Thematic analysis

The thematic analysis was divided into two domains: exploring participants’ understanding of the ‘carer’ role and how they describe the role they play in hospital settings. Unless otherwise specified, the themes appeared in all three participant types: patients, carers and clinicians. The Appendix contains a summary of the themes and subthemes within these two domains.

Domain one: who or what is a carer?

It was difficult to find a universally acceptable term for a ‘carer’, as there was diversity in participants’ perceptions of what a ‘carer’ does. To some extent, caring could be seen as an every day part of human relationships. Some carers felt it did not need a label or further recognition, and so they preferred to use everyday terms such as ‘mother’ or ‘father’ instead. However, some carers viewed the caring role as something that is defined by going beyond what a family member would already do. The term ‘carer’ therefore was seen as a title that recognises this. Some clinicians saw it as more of a service term, used between staff only: “‘Like, I would never say, “This is so-and-so’s carer” in front of the person.’ (Clinician 32) ‘No, of course not.’ (Clinician 31)”

Caring in mental health is distinct from physical health

Participants noted how ‘with mental health patients... every bit counts, no matter how small or big’ (Clinician 22) and often, the support was not always clearly defined, but involved ‘being with’ the person. Carers used words like ‘sitting’ ‘minding’ and ‘monitoring’. Through this they said how there was an element of ‘experiencing with’ the person when one is a carer. This was seen as unique to mental health. Participants also described how carers do what staff cannot or do not do. Many participants felt that carers should be rewarded for reducing the pressure on services and for providing the support that nobody else could.

Furthermore, caring in mental health was described as different to physical health in terms of how it ‘crept up’ on people, and one became a carer ‘gradually’, ‘without noticing’. It was a ‘job with no end date’ because the unique nature of the support meant that there was so much uncertainty in the process. It was also felt that carers had little choice in the process. One patient felt that their family being forced to care was akin to a ‘form of slavery’ (Patient 21). “‘Sometimes you could be caring for somebody for such a long time, you don’t even know when you started, or when you stopped so to say, “now you’re a carer”, it doesn’t work like that.’ (Carer 14) ‘Some people don’t want to care and they’re in a carer role. They’re just angry with them, resentful and I’ve met people who resent being positioned in the family, in the genogram. So location-wise they’ve got that role and they’ve got no choice and [Clinician 12: ‘mm’] and others do it because obviously they want to...’ (Clinician 13)”

Disagreement on when caring begins and ends

Participant groups differed most strikingly in their definitions of when someone can be called a ‘carer’. Clinicians discussed at length the idea that the term ‘carer’ had ‘the idea of some sort of chronicity’ (Clinician 1) and was frequently unnecessary or inappropriate to use it in acute mental health settings. “‘You would use it if you have been yeah, in in mental health services for, you know, quite some time or your relative had an illness that was prolonged for months and months or years then you become a carer but it’s not really something in an acute setting.’ (Clinician 5)”

Similarly, patients often felt they only had a ‘carer’ when they were unwell, as their fluctuating mental and emotional states meant they experienced fluctuating levels of need. This left carers in the position of always needing to be available but not knowing when their involvement would be welcomed or rejected. “‘Well “carer” is to me like ... you’re still not well. You’re still being cared for. I mean I’m at a stage within my recovery where, I’m not being cared for. I’m caring for myself. So I’m my care – they’re just people who are there to help me when I do start falling back and so to me they’re not carers, they’re support.’ (Patient 24) ‘He [previously] referred to me as a carer, yes, but now where he feels that he’s on the road of recovery, he feels that I’m not caring for him as much. But, I am caring for him in what I’m doing for him. I do care for him ... I’m having to be the one that has to access the services. I’m the one that has to attend all the meetings [Carer 19: ‘hmm-hmm’] ...’ (Carer 18)” Although some family members felt the term ‘carer’ was ‘a bit patronising’ as it implied the patient needed care all the time, many others described the ‘24/7’ nature of caring as all-encompassing and requiring constant monitoring in case the person’s symptoms return. One referred to their role as a ‘mind-minder’. Some clinicians also described how they felt carers were the ones who had to ‘deal with it 24/7’ and ‘day in, day out’. “‘We care for them overall... is not just physical or mental. It’s everything. [Carer 17: ‘everything’, Carer 18: ‘yeah’] ... I think the trouble is that there may be people who think, “It’s only when I’m ill in hospital that you have become a carer,” but you are 24/7 worried about it. Worried about when it is going to happen again. [Carer 18: ‘yeah’] ... “Has he eaten?” So it’s all the time care.’ (Carer 19)”

Discomfort with dependency

Participants differed in how they conceptualised dependency. Many clinicians and some patients expressed discomfort with the idea of a patient being dependent on a carer. “‘Err it’s yeah it kind of implies a bit of feebleness about someone who needs the one cared for long time which isn’t necessarily the case and isn’t what we’re aiming for.’ (Clinician 16) ‘A lot of us have evolved from ... I mean, there are probably nurses that do, but most people have moved away from that kind of ... You’ve got a mental health problem, so you are obviously rubbish, you can’t do anything, so you must have a carer, kind of thing.’ (Clinician 28) ‘But then I think there’s also the other side maybe “carer” like you can’t do anything for yourself ... you’re helpless.’ (Patient 7)” Others viewed dependency differently. They were comfortable with the idea that there might be a temporary period where someone has lost their independence and needs support to look after themselves again. This was often described as a major point of contention with staff. “‘Yeah, a carer is ... you know the family, someone you rely on when you can’t cook or clean?’ (Patient 27) ‘It’s like we have to retrain our loved ones what they used to love to do, what they used to do, we we’re teaching them all over again it’s like [Carer 7: ‘baby’]. It’s like they’re babies again [Carer 7: ‘yeah yeah’] but while we’re talking to the doctors and people they don’t get it [Carer 7: ‘no’] because they just think “he’s a big geezer ... a big bloke” [Carer 7: ‘mm’].’ (Carer 8)” Although (as above) some clinicians expressed discomfort about disempowering overtones, many carers saw irony in this, as the nature of an involuntary hospital admission itself was viewed as paternalistic by some. “‘They’re saying, “They [will] do what they want to do.” Then why do they restrain them? Why do they pin them down? You know?’ (Carer 19)”

Not all ‘carers’ are caring

A difficult issue specific to mental health was that ‘the one group of people who could be their carers are the problems in some way’ (Clinician 13). This jarred with the idea of calling someone a ‘carer’, as they might be implicated in the person’s mental health problems by ‘adding to the stress’ (Clinician 2). Staff did not always know how to work with this contradiction. “‘... we use it in a quite generic way without really thinking about it but a lot of the time they’re not really carers err ... a lot of time they don’t know enough about the condition to be considered a carer and sometimes they do more harm than good.’ (Clinician 16)”

Patients described harm as being misunderstood and being put under pressure to stop ‘playing up’ or ‘attention-seeking’ and that they felt pressure from family members who were pushing for their progress to be ‘two steps further than what it should be’ (Patient 26). They felt strongly that it was their families’ ‘lack of understanding’ that made them feel worse. “‘I don’t think they should have any [involvement]. My family they don’t understand my illness [Patient 8: ‘mm-hmm’] so I’d rather they don’t know anything you know. They don’t understand the illness at all.’ (Patient 9) ‘... It’s helpful for them to be involved because if they weren’t there, we’d have nobody else to help you but at the same time it’s hard as well because they don’t have the knowledge that they need ...’ (Patient 26)”

Domain two: what is a carer’s role in hospital?

The role of the hospital environment

The hospital environment itself was seen as an important contextual factor that overshadowed all aspects of the patient and carer experience. As described next, participants spoke of the atmosphere and procedures as pertinent factors in determining the role of carers.

Frightening atmosphere

All three participant groups' descriptions of the hospital environment mentioned elements that were unwelcoming and frightening, with one stating it was 'scary for the relative, just as scary it is for the patients' (Clinician 17). This was especially the case during the admission process, which was described as 'a traumatic and chaotic experience for all the involved' (Clinician 10). During this time, family and friends could be an 'invaluable' source of comfort for patients, although this was also a time when both patients and carers were more likely to feel traumatised and in need of information to alleviate concerns. Clinicians described how carers might find it 'distressing' to view their relative being restrained or very heavily medicated. For this reason, they sometimes preferred to keep carers away to prevent them from witnessing upsetting scenes. Carers recounted the reassuring impact of 'very calm staff' during these times. "I was terrified.' (Patient 25)'You're scared of the whole situation, so you don't really talk to anyone, you – you don't wanna talk to staff, 'cause it's a frightening experience and it takes a while before you can actually feel settled enough to talk to people and... if your carer is someone that's spent a lot of time with you, they know how you are, so you're possibly gonna open up more to them.' (Patient 24)'Especially when it's your first time. I remember my first time [Carer 1: 'first time'] was a nightmare [Carer 1: 'nightmare'] [Carer 2: 'yeah'] yeah nightmare, bad memories.' (Carer 3)"

Inflexible systems: wards rounds and the medical model

Moreover, the structure of the hospital system itself was seen as an indirect barrier to the meaningful involvement of carers. Ward rounds were viewed by many participants as the main way families can be involved but also the greatest source of difficulty. Carers described them as inflexible and a source of uncertainty and stress. As most important decisions were made there, carers considered consultant psychiatrists to be the most important people to work with. However, clinicians noted that it is the consultants that often have little time to spend with individual patients and carers. "And it can be quite intimidating as well [Carer 11: 'completely']. You walk in and everyone's kind of all eyes on me.' (Carer 3)'it's like a panel [Carer 11: 'yeah'] isn't it?... I still can't get my head round what care co-ordinator, a social worker and somebody else does [Carer 11: 'mhm']' (Carer 14)'... other than the psychiatrist, who else needs to be in the room?... I don't actually know why so many people have to be in the room if they don't have actual involvement in the patient's care? 'Cause otherwise it looks like they're just ... it's one of their team's meetings and we're part of the entertainment.' (Carer 15)"

Clinicians in the focus groups were able to critically reflect on the system that they work in, recognising that it was very rigid, with medication frequently at the forefront of discussions. This placed carers' role on the periphery, as they were often not seen as a core part of the patient's care or the clinical team's routine procedures. Working with carers was seen as a resource-intensive add-on service that was difficult to provide. "The service itself doesn't lend itself for you to implement –.' (Clinician 28)'Yes, it's not flexible enough.' (Clinician 29)' – It's not flexible enough for a carer to access help.' (Clinician 28)' – Because, we work to a medical model. So the focus is we've got this ward round, we've changed the meds and that's... we'll all sit here, you can walk in, your back is against the wall and you've got 15 min, off you go. If that. Because we've got to talk about meds and everything else... It's chaired by a medic. It's their set time and you suit that.' (Clinician 26)' – And we call ourselves a client-led service –' (Clinician 29)' – Yeah, exactly [laughs].' (Clinician 28)"

Patients and clinicians as gatekeepers

Carers were not perceived as having any rights to involvement – the decision was seen as one that either the patient or clinician had to make. Admission was a particularly difficult time as the patient might not have capacity or might feel 'hostile to family'. Clinicians described how this period was a 'struggle' and how difficult it was to 'balance both needs' in these situations. "It's about them [the patients], exactly.' (Clinician 32)'Yes, so it's their choice and their rights.' (Clinician 33)"

Participants from all three stakeholder groups felt it important to override the patient's wishes in order to act in their 'best interests', as carers were seen as a source of contextual information that could facilitate the admission process and as a source of support for patients. Some patients expressed regret that they had excluded carers. However, many still

felt strongly that they should always be the ones to decide the level of involvement. “‘That’s where the carers come in, doesn’t it? Initially the first, second, third day, that’s where the carer’s voice should be heard more than being pushed aside.’ (Carer 17) ‘I think they – they should be involved even if you’re paranoid. If it’s in your best interests that these people know then I think they should be... should be informed.’ (Patient 30) ‘I want them brought in, then I would bring them in but in ten years I’ve only brought them in once. I tell them not everything but I tell them ... um which stuff’s safer.’ (Patient 8)”

The roles allocated to carers

Within this context, the way carers were described could be broadly allocated to one of three roles: (a) a useful resource, sometimes in need of support themselves; (b) troublemakers, creating a hindrance to everyday clinical procedures or (c) invisibles, having no clear role and not being central to anything. The allocated role largely depended on how clinicians conceptualised the role of carers, as the same carers described being included and valued in some settings and excluded in others.

A useful resource, that requires care

Carers could be seen as a useful resource for the healthcare team. One source of their knowledge came from knowing the patient intimately when they were ‘well’ and were able to contrast this with their current mental state. “‘They’ve gone through the process of you going from being well to getting unwell, so they they’re kind of experts around your care and they need to be involved fully with the psychiatrist, the team.’ (Patient 7)”

Carers were then able to advocate for the patient during a time that they had difficulty expressing their needs. They were also seen as supporters of symptom monitoring and treatment adherence. Staff described examples of the involvement of carers resulting in a positive impact on patients’ outcomes, and speedier recovery.

Some saw the carer’s role as a person who is in need of support themselves. Clinicians described how they saw it as their responsibility to support carers individually, while maintaining the patient’s confidentiality. However, often patients’ and clinicians’ descriptions of how to support carers was limited in nature, required consent from the patient, and was largely aimed at supporting the carer to continue caring. “‘I think that calling your family members or a friend or a relative a “carer” is quite good but then there should be a little bit more input in terms of you know supporting them to care for the patient.’ (Patient 20) ‘I think in the case of acute mental health treatment, I think family ... need the most reassurance and the most education as well about what’s going wrong. They need to have their life – have their mental health right so they can care for someone [else].’ (Patient 1)”

Troublemakers

Conversely, carers in the groups described how they could just as easily be seen as ‘busybodies’ and ‘troublemakers’ who were ‘overinvolved’ and presented a hindrance to services. Related to this, many carers described the hospital as a place of ‘battle’ that was ‘daunting’ and where they had to ‘fight’ and be ‘pushy’ to be included. This subtheme was particularly pronounced, and discussed at length in the focus groups. “‘Who we care for, our loved ones, they don’t realise what we have to go through when confronting professionals. [...] you get seen as the trouble maker ... So it is a massive battle. Until this day I still get missed off the list for CPA [Care Programme Approach] meetings. Recently, I’ve just got told the day before, and that was not even from the [team].’ (Carer 18) ‘I used to go each week and ask to go to the ward round and I wasn’t allowed to go... ’til one day I broke in to one of them.’ (Carer 11)”

This notion was supported by patient and clinician examples, who described clinicians intentionally excluding carers with the aim of ‘facilitating procedures’ and protecting patients and themselves from ‘overwhelm’ due to ‘overinvolvement’. “‘In our ward rounds, we don’t have family involved at all. We used to but I don’t think the consultant liked it. I think it was too much.’ (Clinician 32) ‘... they [carers] intervene too much [Patient 8: ‘mm-hmm’].’ (Patient 9) ‘... there’s a cooling off period before the patients settle down. If there’s a relationship problem ... we will keep them away for a while until such tempers settle down and perhaps they [patients] can explore [if] their presence or involvement will be of any benefit ... That is [a] clinical decision, team decision, yes.’ (Clinician 4)”

However, some patients viewed the solution to these problems as an increase in involvement and education for carers, so they could more appropriately support their needs. Clinicians and carers also felt that carers would participate with ‘better understanding and less interference’ (Clinician 17) when given information and reassurance. “‘My father was displaced as my nearest relative and I think instead of displacing him they should have given him more education and information and raised awareness about my condition so that maybe he could have come to an understanding make a more informed decision, ‘cause he was saying he doesn’t want me to be detained and they said, “okay, we are just gonna displace your nearest relative”, which I found very unhelpful very, very horrible.’ (Patient 7) ‘Yeah, [this time] I was invited to every ward round ... everything was explained and that calms your anxiety, if you’re given the information.’ (Patient 7)”

Invisibles

Finally, a less direct type of exclusion was commonly described. Carers often felt ‘invisible’ on the ward and excluded from ward procedures through omission. Unlike the previous theme, not engaging with carers was not necessarily because of intentional exclusion, but because clinicians were unable to see how their role could support carers. This also related to the non-systemic nature of many hospitals, where the main focus of treatment decisions were regarding the patient’s symptoms and their medication. Carers were described as having at most a peripheral role in these procedures. “‘I was invisible. You know, I was totally invisible. [...] There was never a chance that you could go into there and say, “How was my daughter today?” Because there’s no one person to ask. So I’m lost. So I’m just like a visitor, really, when I go to visit. And I was there all the time.’ (Carer 19) ‘When we come to the hospital ward rounds and this and that, they don’t really wanna to talk to me sometimes. I’m just sitting there like a dummy [Carer 5: ‘yeah’]. I can’t say nothing.’ (Carer 3) ‘You know when you see a mother crying? [Clinician 32: ‘yeah’] It’s more emotive than seeing the service user really unwell...’ (Clinician 30) ‘ – I think it’s because you know that they’re unwell, and there’s a reason that they’re presenting like that. But then – ’ (Clinician 32) ‘ – And you can do something to help.’ (Clinician 31) ‘Yes. You feel you’re actually working to make them feel better. But with the carer, it’s like, what can I do to...?’ (Clinician 32)”

Discussion

Main findings

This was a focus group study exploring patient, carer and clinician views of the role of carers in in-patient mental healthcare. We found some agreement on the types of support carers provide for patients. However, there were differences in opinion between the different stakeholder groups about when someone can be said to be providing care and the point at which someone can ‘justifiably’ be called a carer. Additionally, the hospital setting was seen as both directly and indirectly precluding the involvement of carers. The set-up of the service placed carers in one of three positions: supportive experts that provide collateral information, ‘troublemakers’ who get in the way of ward procedures and, perhaps the most difficult, ‘invisibles’, people who may spend substantial time on the ward but whom staff do not always know how to include in their routine procedures.

There were also multiple differences in opinion regarding the carer role, which might explain why carers often fell into these allocated roles. There was clear disagreement about what constitutes caring and unhelpful behaviour, as was demonstrated in the varying attitudes toward dependency. What some saw as providing essential care, others saw as an impediment to recovery. What emerged was that discomfort with the idea of dependency is not necessarily a universal. Although staff wanted to protect patients from ‘overwhelm’, many patients saw the solution to poor relationships with carers as increased involvement, so they have a better understanding of mental health and can support them more appropriately.

Additionally, although formal definitions of ‘carer’ exist, in reality, there were vast differences in labelling. Family members felt their caring role was all-encompassing in nature, whereas patients and clinicians did not often share this view, and had various personal definitions for when someone can rightly be called a ‘carer’. The disagreement about whether being a ‘carer’ is a constant state, or if it has to be ‘earned’ through caring for someone chronically unwell was linked to mismatched expectations in the clinical setting. It was not always clear if the existence of a ‘carer’ would

be acknowledged or accepted, and if this person would be entitled to inclusion, information and support. However, family members themselves reported a lack of choice about their caring role: it felt simultaneously imposed on them and denied from them.

Another major complicating factor were the fluctuations of mental and emotional state in patients in acute treatment. Carers were often left unsure as to how welcome they were as patients changed their minds between wanting to include them and not. This was combined with a range of positive and negative reactions from different staff members towards carers, which compounded the uncertain and stressful nature of the overall experience. Many people were left with the impression that hospital is a 'frightening' place or a 'battleground'.

Strengths and limitations

The study sample enabled us to explore and compare the views of patients, carers and clinicians from a variety of roles and settings. The diversity in demographics and experiences helped us to identify common experiences across different settings. One potential limitation was the inclusion of people who self-define as a 'carer', as they might represent a small proportion of family and friends who are providing support in clinical settings. However, our recruitment strategy included people from a variety of settings beyond carer organisations, such as asking clinicians to share study details with the visitors of people currently in hospital. This ensured that there was diversity among participants in terms of their understanding of the 'carer' role.

Overall, while focus groups are a good method for generating ideas, they are not ideal for the in-depth exploration of topics. This study may be viewed as a starting point into more in-depth qualitative enquiry into this area, particularly as this field has a lack of patient perspectives. Finally, this study mainly focused on in-patient treatment, and there might be other complicating factors that have an impact on peoples' experiences in other settings. Further discussion of strengths and limitations may be found in our linked article.⁸

Interpretation and comparison with literature

Previous literature highlights the difficulties experienced by families in the clinical setting. Jankovic and colleagues mapped out carers' experiences and found that difficulties begin to arise long before reaching the hospital admission stage.⁷ This might explain some of the discrepancies in participant views on when someone can be called a 'carer'. For carers, the less visible process of monitoring to prevent relapse might be experienced as a constant state, not just confined to when the person is unwell. Furthermore, the process leading to admission is often described as traumatic for the family members themselves, resulting in them needing higher levels of information and reassurance, but being unsure if they will receive this, or face exclusion or invisibility.

Studies of carer perspectives describe how they feel that confidentiality is used by clinicians as a reason to exclude them in in-patient settings.¹¹ Wilkinson & McAndrew describe families' feelings of powerlessness that can arise from being excluded and feeling invisible in in-patient settings.¹² By including clinicians and patients themselves in these focus groups, we demonstrate some of the reasons why carers might be excluded beyond the desire to protect patient confidentiality. In some cases, there appears to be a fundamental clash of values in terms of what is best for the patient. The patient voice itself, however, is not always included in these decisions, as illustrated by examples of family members being excluded to protect patients from overwhelm or because the carer disagrees with the treatment plan.

Each type of exclusion requires a different approach to address it. Intentional exclusion might be avoided through increased communication at the outset. This might include efforts to find common goals and values during the treatment process, or by addressing families' underlying needs for acknowledgement and reassurance. However, unintentionally leaving families out due to not considering them as central to ward procedures might be a more difficult, systemic issue to address.

The hospital setting being a barrier in itself is usually discussed in terms of the individualistic, non-systemic nature of the setting.^{13,14} Our study specifies some of the most difficult aspects, and why it may be such a challenge to overcome them. The centrality and time-limited nature of ward rounds, for example, emerged as a frustration for all stakeholders. Our linked studies specify some of the practicalities of what could be done to overcome some of these organisational

barriers.^{6,8} Frameworks such as the Triangle of Care¹⁵ or intervention models such as SYMPA (systems therapy in acute psychiatry)¹⁶ or Family Intervention¹⁷ can also provide some structure and guidance to this process.

Finally, Landeweer and colleagues highlight differences in what patients, carers and clinicians view to be barriers to family involvement. They suggest these discrepancies are the result of differences in their underlying beliefs and values.¹⁸ This study illustrates that indeed, even the definition of 'carer' is not necessarily agreed among all stakeholders. The reasons for this might be because of different motivations and belief systems about what mental health is and what treatment should entail.⁴ While all parties might view the patient's independence as the ultimate aim, the route to this and the speed at which it happens might not be universally agreed, resulting in conflict in the acute setting.

Implications for practice

The role of families in hospital settings is not universally agreed. They can present a variety of needs ranging from basic information, emotional support or collaboration to support the patient's treatment. This can pose difficulties for clinicians, who describe the conflict of having to attend to the individual patient while trying to best manage the needs of carers. This is dealt with in different ways, as some choose to work more closely with families and others exclude them from ward procedures. Families therefore face strong uncertainty in the in-patient process, not knowing if they will be welcomed, supported, ignored or excluded.

A further complicating factor emerged that not all clinicians viewed family members as carers and did not see it as their role to include them in clinical procedures. This may be related to what the fundamental purpose of a hospital is perceived to be. If it is solely to attend to the presenting symptoms of a patient, the presence of additional family members will indeed be seen as a hindrance to ward procedures. If a broader, systemic view is taken, those same family members might be conceptualised as major members of the patient's social network, whose presence can be beneficial, whether they are 'carers' or not. In reality, many clinicians placed themselves somewhere between both of these views, depending on the 'ideal' and 'realistic' service they could provide on a given day. However, this inconsistent approach might compound the high level of uncertainty already present in this setting. Structured procedures to routinely identify and support carers might alleviate some of the difficulties described above.

Additionally, as acknowledged by all three participant groups, patient choice is important, but it does not preclude meaningful interactions with carers. Although it must be acknowledged that many ward procedures and confidentiality rules are not set-up to favour carer involvement, positive examples of other ways of engaging carers demonstrated that it is still possible to improve upon patient, carer and clinician experiences in the in-patient setting.

Overall, this study highlights the importance of clarity when considering the 'carer' role, as misunderstandings can have the potential to have a negative impact on patient, family and staff experiences. As demonstrated by participant examples, excluding carers might appear to help clinical procedures in the short term, but could create more divisions between patients, carers and clinicians in the long term. Establishing wishes and expectations at the beginning of admission might be one way of opening up the potential for communication and reducing the likelihood that a patient or carer feels they have not been listened to. Finally, giving clinicians the space to have open conversations and critically reflect on core fundamentals such as the role of carers in their work might help them to problem-solve, and decide how to adapt their approach to carer involvement within their own local context.

In conclusion, there is no single agreed definition of 'carer'. This conflict in how a carer is viewed has the potential to have a major impact on their experience in in-patient settings. The implementation of carer involvement initiatives should incorporate addressing this fundamental aspect. Overall, it could be concluded that there needs to be clearer agreement about the role of carers in hospital settings, as they fluctuate between being perceived of as important resources, passive visitors or adversaries.

Data availability

All authors had access to the study data for the duration of data collection and analysis. A.D. and S.P. have ongoing access to the transcripts.

D.G., S.P. and A.D. designed the study. A.D. and J.K. carried out focus groups and data analysis under D.G.'s supervision. A.D. and J.K. prepared the first draft of the manuscript. All the authors critically reviewed the paper and approved the final draft. All authors read and approved the final manuscript.

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Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjo.2020.70>.

[click here to view supplementary material](#)

Domains, themes and subthemes

DomainThemeSubthemeWho or what is a carer?Caring in mental health is distinct from physical healthDisagreement on when caring begins and endsDiscomfort with dependencyNot all 'carers' are caringWhat is a carer's role in hospital?The role of the hospital environmentFrightening atmosphereInflexible systems: wards rounds and the medical modelPatients and clinicians as gatekeepersThe roles allocated to carersA useful resource, that requires careTroublemakersInvisibles

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1.3.17 Understanding increasing rates of psychiatric hospital detentions in England: development and preliminary testing of an explanatory model

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Abstract**Background**

The steep rise in the rate of psychiatric hospital detentions in England is poorly understood.

Aims

To identify explanations for the rise in detentions in England since 1983; to test their plausibility and support from evidence; to develop an explanatory model for the rise in detentions.

Method

Hypotheses to explain the rise in detentions were identified from previous literature and stakeholder consultation. We explored associations between national indicators for potential explanatory variables and detention rates in an ecological study. Relevant research was scoped and the plausibility of each hypothesis was rated. Finally, a logic model was developed to illustrate likely contributory factors and pathways to the increase in detentions.

Results

Seventeen hypotheses related to social, service, legal and data-quality factors. Hypotheses supported by available evidence were: changes in legal approaches to patients without decision-making capacity but not actively objecting to admission; demographic changes; increasing psychiatric morbidity. Reductions in the availability or quality of community mental health services and changes in police practice may have contributed to the rise in detentions. Hypothesised factors not supported by evidence were: changes in community crisis care, compulsory community treatment and prescribing practice. Evidence was ambiguous or lacking for other explanations, including the impact of austerity measures and reductions in National Health Service in-patient bed numbers.

Conclusions

Better data are needed about the characteristics and service contexts of those detained. Our logic model highlights likely contributory factors to the rise in detentions in England, priorities for future research and potential policy targets for reducing detentions.

Contents

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Rates of detention in psychiatric hospital have more than doubled in England since 1983 and risen faster than almost anywhere else in Europe during the past decade.¹ Detention in hospital is inherently coercive: it is experienced by most patients as such,^{2,3} and 3 months after detention many patients still disagree with the decision to detain them.⁴ Involuntary hospital admissions are typically longer and more costly than voluntary admissions. Patients experience only limited improvements in health and social circumstances following detention.⁵ Understanding and addressing the rising rate of detentions is therefore a priority for mental healthcare in England, which prompted the recent Independent Review of the Mental Health Act (MHA Review), which reported in December 2018.⁶ To support the review, an expert topic group was convened, supported by the National Institute for Health Research (NIHR) Mental Health Policy Research Unit (MHPRU). This group was tasked with exploring why rates of detentions in psychiatric hospital in England have risen since the introduction of the Mental Health Act 1983 (MHA), and most rapidly over the past decade. This work is reported here.

We sought to identify hypotheses for the rise in detentions in England, test their plausibility in relation to available evidence, and then develop an explanatory logic model for the rise in detentions in England between 1983 and 2016. The term ‘detentions’ is used here to include compulsory admissions to psychiatric hospital and detentions of people in psychiatric hospital following a voluntary admission, including civil and forensic MHA detentions, for people of all ages. We excluded uses of the MHA that direct conveyance to a place of safety or to permit short-term detention (72 h or less) for the purpose of assessment only.

Method

The study comprised: (a) generating hypotheses to explain the rising rate of detentions; (b) rapid scoping for evidence relevant to each hypothesis; (c) testing each hypothesis (in so far as data permitted) and rating its plausibility as an explanation for rising rates of detention; and (d) developing an explanatory model of the rising rate of detentions in England.

Hypothesis generation

A list of potential explanatory factors for the rising rate of detentions was generated from three sources. Reports and literature, chiefly the recent report from the Care Quality Commission⁷ and the evidence submitted to the MHA Review,⁶ which included over 50 focus groups with patients and carers, evidence submissions from over 200 mental health organisations, practitioners, patients and carers, and seven public workshops across England. Consultation with an expert topic group convened for the MHA Review. This comprised eight academics, six of whom were psychiatrists, one a social worker and one a researcher with lived experience. The group included two women and two members of Black, Asian and minority ethnic (BAME) communities, one of whom co-chaired the Mental Health Act Review African and Caribbean Group (MHARAC), which supported the MHA Review. Consultation with 14 members of the Lived Experience Working Group of the Mental Health Policy Research Unit (MHPRU), all with lived experience as a mental health patient or family carer. All members of this group were adults; the group was demographically varied with respect to age, gender and ethnicity.

Through discussion in the MHA Review topic group, all proposed explanations were considered and clarified into hypotheses where necessary, describing how proposed explanatory factors might contribute to an increase in detentions. Types of information that could support or contradict each hypothesis were agreed.

Evidence gathering

Relevant data sources were sought for variables relating to each hypothesis, with advice from academics with epidemiology, health economic and health services research expertise. We investigated the relationship of each variable to the rising rate of detentions in England through the following process.

First, an ecological study explored the associations over time between national population-level indicators for a range of explanatory variables and the rate of detentions. Where more than one relevant data source was identified for a proposed explanatory variable, the most appropriate variable was selected through discussion in the study team, with priority given to well-established measures used in previous research or national reports, and variables with the most years of data available. Annual data for all explanatory variables were collected from 1983 onwards, where available. Descriptive data from each variable were reviewed to assess whether exposure to the explanatory variable appeared to have changed over time (in the direction compatible with contributing to a rise in detentions). The association between each indicator variable and rates of involuntary hospital admission was assessed using regression analyses. Following guidance,^{8,9} only indicator variables with at least 10 years of annual data were included in the analyses, to avoid reporting imprecise statistical results based on limited data. Breusch–Godfrey tests were used to identify the presence of serial correlation (in which the model residuals are correlated over time). Such correlation can be present in time series data and can result in biased estimates if inappropriate regression methods are used. When there was evidence of serial correlation, Prais–Winsten regression¹⁰ was used; otherwise simple linear regression was used. Analyses were performed using Stata version 15 for Windows. The outcome variable in all analyses was annual number of detentions per 100 000 population, derived from publicly available English KP90 detentions data.¹¹ If prevalence of exposure to an explanatory variable was unchanged or was not associated with detention rates in the expected direction, it was considered less plausible as a contributory factor for the rise in compulsory admissions.

Second, available research was scoped by MHPRU researchers (L.S.R., N.L., L.M.) for additional evidence relevant to our hypotheses, including: studies exploring predictors of detention at individual patient, local area or international level, and qualitative literature regarding perceived changes in explanatory factors over time. Relevant literature was identified through: (a) a programme of systematic reviews and data analysis conducted for the MHA Review by the

MHPRU.⁶ These provided a range of types of evidence from quantitative and qualitative research, and included systematic reviews of social and clinical predictors of detention, interventions to reduce detention, qualitative literature on patients' and carers' experience of detention, an international comparison of detention rates and factors associated with detention rates, and an analysis of routine health records data regarding the nature of changes over time in patterns of detention in two London National Health Service (NHS) trusts; (b) keyword searching for relevant terms in electronic databases (MEDLINE and PsycInfo); and (c) asking subject experts in the MHA Review topic group, authors of this paper and others (acknowledged at the end of this paper) to identify other relevant literature.

Assessing the plausibility of hypotheses

Findings for each hypothesis were synthesised and summarised. The likelihood of any hypothesised or observed ecological relationship between explanatory variables and rates of detentions being causal in nature was assessed, where applicable and as far as evidence was available, with regard to established criteria for causality,¹² including the strength and consistency of associations, their perceived plausibility as causal mechanisms and, where possible, the specificity of relationships to populations at increased risk of detention, and temporality, i.e. evidence that rises in explanatory factors preceded rises in detentions. Hypotheses were then graded by the study team for plausibility as a contributory factor to the rising rate of detentions in England: 0, contradicted by available evidence; 1, lack of evidence or available evidence is ambiguous or mixed; 2, supported by the balance of available evidence. Two factors were considered in grading each hypothesis: evidence for change over time in the direction expected; and evidence, or self-evident face validity, that the hypothesised factor was causally related to risk of detention. Ratings were made initially by the lead authors of this paper (L.S.R, B.L.-E.), then reviewed by all authors and revised if necessary following discussion.

Logic model development

Following guidance,¹³ we developed a visual logic model to show how plausible proposed contributory factors (i.e. hypotheses rated as 1 or 2 for plausibility) might contribute to the rising rate of detentions in England and might interrelate. In developing the model, we worked backwards from the final outcome to be explained (the rising rate of detentions) to identify proximal outcomes, mental health service activities, inputs and contextual factors. We differentiated elements of this explanatory model that were supported by available evidence from hypothesised elements with ambiguous or absent evidence. Proposed causal pathways and mechanisms of change in the rate of detentions were illustrated in the model with arrows. An initial draft of the logic model was developed by B.L.-E., informed by a preliminary draft of relevant data tables and evidence reviews (supplementary Appendices 1 and 2, available at <https://doi.org/10.1192/bjo.2020.64>). This was then discussed with the study co-authors and revised with feedback and reference to additional retrieved evidence in five iterative stages.

Results

Rates of detention in England

Data for the number of detentions in England were not available from NHS Digital before 1988. National detention data collection methods changed from April 2016,¹¹ so data after this point are not comparable with previous data.

The annual rates of detentions per 100 000 population in England from 1988 to 2016 are shown in *Fig. 1*. Detention rates more than doubled during this period, from 52 to 114 per 100 000 population. A 1-day census of the number of people per 100 000 population detained at year-end each year also rose, from 26.0 in 1998 (the first year for which data are available) to 36.5 in 2016. The rise in the rate of detentions was steepest in the periods 1988–1996 and 2011–2016, plateauing in between. Increases in detentions were greatest at the point of admission. Overall detention rates, and detentions for assessment (section 2 of the Mental Health Act 1983, MHA), rose significantly during the study period. Rates of detention for treatment (s.3 MHA) and use of forensic detentions did not change significantly (supplementary Appendix 1). Use of legal powers by the police to bring people to a hospital-based place of safety (s.135 or s.136 MHA) for assessment – which were not included in our overall detention rate variable – also increased significantly

during the study period. Individual patients are not distinguished in government KP90 detentions data, which therefore cannot distinguish to what extent the rise in detentions reflects more people being detained, or the same number of people being detained more frequently. The data also cannot identify in which clinical or demographic groups the rise in detentions occurred. Fig. 1 Rates of involuntary detentions per 100 000 population in England 1988–2016. Inv hosp, involuntary hospital admissions; s., section of the Mental Health Act 1983; CTO, community treatment order; MHA, Mental Health Act 1983; NHS, National Health Service.

Proposed explanations for the rising rate of detentions in England

Seventeen hypotheses for the rising rate of detentions in England were generated. These are presented in the Appendix (immediately preceding the References), with a brief description of the proposed mechanisms of effect on detention rates. Consistent with previous work⁷ we have grouped the hypotheses as: social factors, service provision, legal factors and data recording problems.

Available data relevant to each hypothesis are summarised in *Table 1*, along with results of statistical tests of association with detention rate, where undertaken. Serial correlation was present for all but one indicator variable, so Prais–Winsten regressions were used. Full descriptive data and illustrative graphs showing change over time for each explanatory variable are provided in supplementary Appendix 1. Research evidence regarding the nature of the relationship of each of these factors to detention rates is summarised below and reported fully in supplementary Appendix 2. *Table 1* The relationship of potential explanatory factors to detention rates: exploration of available national data

Hypothesis number	Potential explanatory variable (measure)	Data source	Data points, years	Mean annual increase, variable units	Mean annual change, standardised units	Relationship to detention rate, coefficient (95% CI), <i>P</i>	Significant association corroborates hypothesis?		
1	Relative poverty UK (% people earning <50% median national income)	OECD ¹⁴	200.100.120.36	(1.55 to 2.26), 0.695	Not significant	Income inequality (Gini coefficient)	ONS ¹⁵ 280.050.040.38 (1.88 to 1.12), 0.605	Not significant	
1	Rate of evictions per 100 000 population	Mortgage and landlord possession statistics ¹⁶	183.440.120.02	(0.04 to 0.08), 0.512	Not significant	Unemployment rate (over 16 years old and seasonally adjusted)	Labour force survey ¹⁷ 290.100.061.56 (3.74 to 0.62), 0.153	Not significant	
1	Number of racial hate crimes recorded by the police per 1000 population	GOV.UK hate crime statistics ¹⁸	60.080.42n.a.	1	Number of reported racist incidents per 1000 population (England and Wales)	40.040.53n.a.	1	Proportion of people in England and Wales reporting experience of racial prejudice	
1	British social attitudes survey ¹⁹	200.240.060.13	(0.07 to 0.33), 0.192	Not significant	Fear and exclusion of people with mental illness, 1994–2014	Time to Change Attitudes to Mental Illness Research Report (2014) ²⁰	140.230.081.38	(2.70 to 0.07), 0.04	
1	Understanding and tolerance of mental illness, 1994–2014	140.010.010.47	(2.30 to 1.35), 0.58	Not significant	Integrating people with mental illness into the community, 1994–2014	140.210.080.06	(1.50 to 1.61), 0.94	Not significant	
1	Causes of mental illness and the need for special services, 1994–2014	140.050.0280.37	(1.95 to 1.20), 0.62	Not significant	Any drug use (proportion of population)	Crime survey for England and Wales ²¹	220.120.08 0.02	(2.77 to 2.81), 0.99	
2	Alcohol use in general population (proportion using alcohol in past week)	ONS ²²	130.550.210.81	(2.56 to 0.96), 0.335	Not significant	Rate of cannabis use per 100 000 hospital admissions	NHS Digital hospital-admitted patient care activity ²³	190.080.139.43	(4.29 to 14.56), 0.001
2	Rate of substance use excluding alcohol (ICD-10 F11–F19) per 100 000 hospital admissions	190.080.03 0.26	(0.26 to 0.90), 0.256	Not significant	Rate of alcohol use per 100 000 hospital admissions	192.410.110.02	(0.11 to 0.07), 0.632	Not significant	
3	Proportion of males in population	ONS ^{17,24}	280.020.1154.48	(28.44 to 80.52) <0.01	Yes	Proportion of working-age adults in population	280.130.100.66	(8.31 to 6.99), 0.861	Not significant
3	Urbanicity (UK)	World Bank ²⁵	290.170.109	(4.60 to 13.39), <0.01	Yes	Proportion of population from BAME groups	ONS ^{17,24}	280.300.104.86	(2.28 to 7.45), <0.01
3	Proportion of the population not born in the UK	280.270.11 5.13	(2.60 to 7.65), <0.01	Yes	Rate of all consultation episodes involving psychosis diagnoses per 100 000 population	NHS Digital hospital admitted patient care activity ²³	190.730.120.02	(0.12 to 0.17), 0.738	Not significant
4	% of people reporting symptoms of severe common mental disorder in the past week	APMS ²⁶	40.100.11n.a.	4	Number of people per 1000 population assessed as having a psychotic disorder	40.140.09n.a.	5	Social support (Congdon social fragmentation index median)	
5	National census data ²⁷	30.010.09n.a.	6	Number of people in contact with secondary mental health services per 1000 population	NHS Digital Mental Health Bulletin ²⁸	141.800.261.2	(0.11 to 2.51), 0.068	Not significant	
6	Mental health spend (inflation adjusted) per capita (£)	NHS reference costs ²⁹	132.210.190.07	(0.16 to 0.03), 0.162	Not significant	Mental health spend per person in contact with secondary mental health services (£)	1350.900.100.01	(0.02 to 0.00)	
6	Mental health nurses number per 100 000 population	NHS Digital Mental Health							

Bulletin²⁸91.570.30n.a.6Nurses in community psychiatry number per 100 000 population90.080.10n.a.6Nursing support staff total number per 100 000 population90.370.28n.a.6Nursing support staff in community psychiatry per 100 000 population90.090.25n.a.6Number of psychiatrists per 100 000 population90.160.35n.a.6Number of CMHT patient contacts per 1000 population62.550.22n.a.6Number of CMHT contacts per person in contact with mental health services60.090.20n.a.7,8Number of CRT contacts per 1000 population62.240.33n.a.7,8Number of CRT contacts per person in contact with secondary mental health services60.000.01n.a.9NHS psychiatric beds per 100 000 populationNHS Digital Mental Health Bulletin: bed availability and occupancy data³⁰283.240.120.55 (0.75 to 0.3), <0.01Yes9Detentions in non-NHS hospitals per 100 000 populationNHS Digital MHA statistics – annual figures¹¹280.440.133.6 (2.43 to 4.78), <0.01Yes12Percentage of all detentions in non-NHS hospitals280.370.123.7 (2.23 to 5.17), <0.01Yes12Antipsychotic depot prescriptions (in 1000s)NHS Digital prescription cost analysis³¹164.000.250.17 (0.06 to 0.40), 0.137Not significant12Clozapine prescriptions (in 1000s)160.080.061.41 (0.80 to 3.62), 0.188Not significant14Readmissions to hospital following revocations of CTO per 100 000 populationNHS Digital MHA statistics – annual figures¹¹80.320.35n.a.15All place of safety orders per 100 000 population281.430.121.01 (0.61 to 1.42), <0.01Yes15Number of conversions from s.135 or s.136 to s.2280.210.136.74 (4.22 to 9.26), <0.01Yes15Number of conversions from s.135 or s.136 to s.3280.020.098.2 (5.68 to 22.09), 0.235Not significant¹²

Social factors

We considered whether the rise in detentions was related to: increased social and economic hardship, reduced social support, demographic change, increasing psychiatric morbidity, and increasing drug and alcohol use in the population.

Internationally, wealthy countries tend to have higher rates of detention.¹ However, at individual level, poverty and economic hardship, and lack of social support, are associated with increased risk of detention.³² The two periods of economic recession in the UK during the study period (1991 and 2008–2009)³³ coincide with or immediately precede periods of steepest rise in detentions in England. However, many established markers of economic hardship, including unemployment rate, poverty/relative poverty and income inequality, do not show clear evidence of change nationally over the study period (*Table 1*). Evidence of reduced informal social support or increased social discord during the study period is also limited: median scores for social fragmentation – an established indicator of informal social support,³⁴ collected every 10 years through national census data – have changed little. More specific indicators of social discord and discrimination, such as recorded hate crimes and racist incidents, have available data only for recent years and provide an inconclusive picture. Public attitudes to mental illness also appear to be unchanged or to have become more positive, based on available data from 1994 to 2014 (*Table 1*).

Men, younger adults (age 18–35) and people from Black, Asian and minority ethnic (BAME) groups are at increased risk of detention in England.^{35,36} The proportion of the population in England from all BAME groups has more than doubled between 1988 and 2016, as has the proportion of non-UK-born people in the population. The proportion of the population who are male has risen marginally. These rises may contribute to a rise in detentions (*Table 1*). Conversely, the proportion of the English population who are adults aged 18–35, the highest-risk age group for detentions, has fallen as the number of older adults has increased.

Available data suggest that psychiatric morbidity in England has increased during the study period, consistent with our fourth hypothesis. Adult Psychiatric Morbidity Survey (APMS) data collected every 7 years indicate a consistent rise in prevalence of people with common mental disorders with severe symptoms from 1993 to 2014, and a possible recent rise in prevalence of people with psychosis.²⁶ A clear causal pathway between increased overall psychiatric morbidity and more detentions is lacking, however. The increasing number of people seen in secondary mental health services (*Table 1*) may reflect increased numbers of people with a severe mental health problem, who are also at risk of detention. Alternatively, however, it could reflect increases in help-seeking or service accessibility, which do not influence rates of detention.

Contrary to our hypothesis, rates of drug and alcohol use in the general population in England have fallen over the

¹ OECD, Organisation for Economic Co-operation and Development; ONS, Office for National Statistics; n.a., not applicable; BAME, Black, Asian and minority ethnic; APMS, Adult Psychiatric Morbidity Survey; NHS, National Health Service; CMHT, community mental health team; CRT, crisis resolution team; MHA, Mental Health Act 1983; CTO, community treatment order; s., section (of MHA).

² Linear regression was conducted for this variable, not Prais–Winsten regression, as there was no evidence of auto-correlations.

past 20 years). However, psychiatric hospital admissions for people with substance use disorders have risen since 2010 (supplementary Appendix 1), with a significant association with detention rate across the whole study period for cannabis use (*Table 1*). Three potential, not mutually exclusive, explanations for this discrepancy are: (a) drug use has increased among people accessing mental health services, in contrast to the general population; (b) the greater availability of potent drugs, including forms of cannabis such as skunk,³⁷ and novel psychoactive substances with mental health risks³⁸ has increased the risk of detention among drug users with mental health problems; and (c) changing attitudes among mental health practitioners to risk and safety and perceived treatability have led to more detentions of people with mental health problems who use drugs, independent of changes in patterns of drug use. We lack evidence to definitively support or reject any of these explanations, and the causal association of drug use and detention rates is uncertain (supplementary Appendix 2, section 2).

Service provision

Changes in the availability or quality of (a) in-patient care, (b) community crisis care, (c) longer-term community care, (d) reduced continuity of care during assessment for compulsory admission, (e) staff attitudes to risk and safety and (f) changes in prescribing practice were all considered as potential contributors to the rising rate of detentions.

In-patient care

The rise in detentions has coincided with a dramatic reduction in NHS psychiatric beds in England (*Table 1*). Plausible mechanisms have been proposed for why reduced bed availability may lead to more detentions.³⁹ Offer of in-patient admission may be delayed until illness becomes more acute. Relapse and re-detention may be more likely if patients are discharged prematurely because of bed pressures. Patients may not accept voluntary admission if the only available beds are far from home or because levels of disturbance in in-patient wards have increased, as only the most severely unwell, mainly non-consenting patients are admitted. Some psychiatrists report a perceived need to (unlawfully) detain patients who could have been voluntarily admitted, in order to secure prompt access to a bed.⁴⁰ P.K. and colleagues³⁹ found that the association between bed reductions and detention rates at local level in England was strongest with a 1-year time lag, i.e. increases in detentions follow bed cuts. This suggests a possible causal relationship.

However, the same study found that a moderate correlation remained between NHS bed reductions and rises in detentions, both contemporaneously and with a time lag in the other direction, i.e. bed reductions following rises in detentions,³⁹ which less clearly indicates that bed reductions cause detentions. Increasing use of private beds (*Table 1*) and increasing access to community crisis alternatives⁴¹ may mitigate some pressures caused by NHS bed reductions. A recent systematic review found no studies that had demonstrated a relationship between detention rates and bed occupancy rates, another indicator of pressures on available beds.³² An even more recent study has reported no significant association between in-patient bed numbers and detention rates in a multivariate model, for the period from 1999 to 2016.⁴² Internationally, greater in-patient bed availability is associated with higher, not lower, rates of compulsory admissions.¹

Community crisis care

Specialist community crisis care has proliferated in England following the national mandate in 2000 to introduce crisis resolution teams in the NHS Plan,⁴³ and the accessibility of community crisis care may have increased further since 2011.⁴¹ However, no community crisis service models have been shown to reduce compulsory admissions.⁴⁴ Improvements in service quality in crisis resolution teams had no impact on rates of compulsory admissions in a recent English trial.⁴⁵ Hypotheses that reduced availability or quality of community crisis services has contributed to rising detention rates are not supported by available evidence.

Longer-term community care

We have limited evidence about how the quality of care in community services has changed since 1983. Over the past 15 years, the number of patients seen by mental health services has increased substantially, while overall mental health funding has increased only slightly and community mental health service staffing has remained relatively stable. Similar resources, spread across a larger patient group, have therefore led to a reduction in mental health spend per patient in secondary care, and in the number of contacts provided per patient in recent years in some service settings, for example community mental health teams (*Table 1*).

The extent and quality of community mental health service provision may relate to rates of detentions, although the relationship is complex. Interventions delivered in longer-term community care are best supported by current evidence as promising means to reduce detentions.⁴⁴ Weich and colleagues³⁵ found that higher spending on community mental health teams in England was associated with lower local detention rates, but that health service areas with community teams assessed as lower quality than others also had lower rates of detention. As their reach increases, community mental health services, especially higher-quality teams, may be getting better at detecting the need for detention, but at the same time becoming less able to provide intensive support to individuals where necessary to prevent detentions, as their resources are spread more thinly across a larger patient group. Adult social care spending has fallen since 2010–2011:⁴⁶ this could further reduce available support to prevent mental health crises and subsequent detentions.

Changes in prescribing practice

Regarding prescribing practice, reductions in use of clozapine and depot injections were proposed as factors that might increase patients' risk of relapse and therefore of detention. However, there has been no clear reduction in the prescription of clozapine since 2007.⁴⁷ National prescription cost data suggest that the number of items of depot antipsychotic medication prescribed has reduced marginally since 2000. However, although the association between depot prescriptions and (reduced) detentions was in the anticipated direction, this association was not statistically significant (*Table 1*). Furthermore, given variable dosing schedules, fewer prescriptions do not necessarily reflect a reduction in the number of people for whom depot medications are prescribed. Finally, there is some evidence that depot injections may not increase adherence in any case.⁴⁸

Staff attitudes to risk and safety

Risk and safety are important considerations for mental health staff,⁴⁹ and clinicians' attitudes and responses to risk are highly variable and subjective.^{50,51} Perceived risk has consistently been identified as the strongest predictor of outcome of assessments for involuntary admission in English studies.^{52–54} The amendments to the MHA in 2007 extended the reach of coercion in response to perceived risk by broadening legal definitions of mental disorder and treatability, and introducing community coercion through community treatment orders, and has been characterised as reflecting a more general societal preoccupation with risk minimisation.⁵⁵ Szmukler & Rose⁴⁹ identify an increasing salience for risk assessment in mental healthcare internationally. It is plausible that increasing focus by mental health staff on risk and safety may have contributed to the rise in detentions since 1983. The increase in detentions for assessment under section 2 of the MHA, rather than treatment under section 3, may be consistent with an increasing willingness by mental health staff to detain people in the context of potential perceived risks, not just established known risks. However, we cannot quantify any such change in attitudes or its impact on detention rates.

Continuity of care

We found little evidence regarding how changes in the continuity of care at MHA assessments may affect the outcome of assessment and thus detention rates. One small study suggests that presence of a community professional, such as the patient's care coordinator, may reduce the risk of a formal assessment for compulsory admission resulting in detention.⁵⁴ However, we lack information about the extent of any changes over time in the involvement in MHA assessments of practitioners, including general practitioners, who know the patient being assessed.

Legal factors

Three legal factors potentially relevant to detention are: (a) changing legislative approaches to patients who lack decision-making capacity but do not actively object to hospital admission; (b) the introduction of compulsory community treatment; and (c) the police's use of legal powers to bring people with suspected mental health problems to a place of safety for assessment.

Capacity and consent to treatment

Since the Human Rights Act 1998 came into force in England in 2000, enshrining the European Convention on Human Rights, it has been unlawful to admit anyone to psychiatric hospital on a voluntary basis who lacks the capacity to consent to this treatment. This requirement has been reinforced by subsequent English case law, most notably the 'Bournewood judgment' in 2004 and the 'Cheshire West' case in 2014. Deprivation of liberty safeguards (DoLS) were introduced in 2008 as an addition to the Mental Capacity Act 2005 (MCA): DoLS provide a legal framework for approving in-patient admission and treatment for people who lack decision-making capacity, without using detention under the MHA. It is hypothesised that the rising rate of detentions in England may reflect increasing compliance with human rights law through the application of the MHA rather than DoLS to those who might previously have been admitted voluntarily.

Available research suggests that, prior to the introduction of DoLS, as many as 20% of in-patients were non-objecting and voluntarily admitted, but lacked capacity to consent to admission.⁵⁶ In 2017–2018, however, fewer than 4000 DoLS applications were completed for patients in psychiatric hospitals,⁵⁷ i.e. only about 4% of roughly 100 000 admissions per year in total.⁵⁸ The uncertainty in extrapolating from one small research study's findings is acknowledged, and we do not know whether, in practice, some non-objecting patients who lack decision-making capacity may still be (unlawfully) admitted to hospital voluntarily. However, if detention under the MHA is always now used to admit the remaining non-objecting patients who lack capacity but are not subject to DoLS, this could explain a substantial proportion of the rise in detentions in the past decade.

Compulsory community treatment

The introduction of community treatment orders (CTOs) in 2008 has been proposed as a potential contributor to the rising rate of detentions, either by lowering the bar for readmission of patients subject to a CTO (through the use of recall to hospital) or by increasing the risk of relapse by facilitating earlier, premature hospital discharge following the index admission leading to the CTO. The use of CTOs in England increased year on year from 2008 to 2016, with the numbers of people readmitted to hospital from a CTO rising correspondingly (*Table 1*). However, a recent systematic review⁵⁹ provides clear evidence that internationally and in England, compulsory community treatment has no effect on raising or reducing readmission rates. This hypothesis is therefore not supported by available evidence.

Police use of place of safety powers

Police use of legal powers (s.135 or s.136 MHA) to convey someone to a health-based place of safety has risen markedly during the study period. This has led to a corresponding increase in the number of people admitted to psychiatric hospital following use of a police place of safety order (*Table 1*). It is unknown what proportion of these people might otherwise have been detained via a different pathway, but it is plausible that police are becoming better at identifying people who meet criteria for detention in hospital and bringing them to the attention of health services. Some of those who are now detained via a place of safety order may previously have been arrested or left in public spaces or at home.

Data recording

The Care Quality Commission proposed that more complete reporting of detentions by provider organisations may have led to an artefactual rise in recorded detentions over the study period.⁷ An analysis of patient records from 2007 to 2016 in six London boroughs⁶⁰ found substantially lower increases in detention rates in these boroughs than those observed nationally. However, the extent of missing data in the routine nationally collected KP90 data on detentions, and whether this has changed over time, are unknown.

'Double-counting' in official statistics may contribute to a rise in the recorded rate of detentions. Detention episodes within one provider organisation are reported in the KP90 data used for this paper as a single detention, even if a person is transferred from one form of detention to another during this episode (e.g. transfers from a MHA section 2 detention for assessment to section 3 detention for treatment). However, recorded detentions in the KP90 data are inflated by double-counting of transfers in care, where a patient is moved during detention from one hospital to another run by a different provider organisation.³⁶ This may account for between 12 and 20% of all detentions recorded in the data, and accounts for the big drop in English national detention records in 2017, when a new reporting system was adopted.³⁴ The increase in the use of private hospitals during the study period is associated with the rise in detentions (*Table 1*) and suggests that transfers of care during detentions might have increased, leading to more double-counting and an artefactual rise in reported detentions. However, the extent of any such rise over time is unknown.

Development of an explanatory logic model

From the evidence summarised above, and presented more fully in supplementary Appendices 1 and 2, ratings were made regarding the strength of evidence for each proposed hypothesis to explain the rise in detentions (*Table 2*). Table 2 Strength of evidence ratings for hypothesised explanations for the rise in detentions Explanatory factor Evidence for temporal relationship with change in detention rates a Evidence for, or self-evident plausibility of, causal relationship to risk of detention a Rating b (1) Social and economic hardship Equivocal Equivocal 1 (2) Increased drug and alcohol use Equivocal Equivocal 1 (3) Demographic change (increased numbers of those at risk of detention) Supported Equivocal 2 (4) Increasing rates of mental illness Supported Equivocal 2 (5) Reduced informal social support Equivocal Supported 1 (6) Reduced availability and quality of community mental health services Equivocal Supported 2 (7) Reduced availability of alternatives to admission Contradicted Equivocal 0 (8) Reduced quality and/or responsiveness of crisis services Equivocal Contradicted 0 (9) Reduced in-patient bed capacity Supported Equivocal 1 (10) Less continuity of care at MHA assessments Equivocal Equivocal 1 (11) Greater aversion to risk among mental health professionals Equivocal Supported 1 (12) Changes in prescribing practice Contradicted Equivocal 0 (13) Changes in legal and clinical practice in respect of capacity Supported Supported 2 (14) Introduction of CTOs (and earlier discharge) Supported Contradicted 0 (15) Police more likely to bring people to a health-based place of safety Supported Equivocal 2 (16) Better data reporting in recent years Equivocal Supported 1 (17) Increase in transfers between hospitals during admission leads to double-counting Equivocal Supported 1³⁴⁵

³ MHA, Mental Health Act 1983; CTO, community treatment order.

⁴ Contradicted, contradicted by current evidence; equivocal, absent or ambiguous evidence; supported, supported by current evidence.

⁵

0, hypothesis is contradicted by available evidence; 1, lack of evidence or available evidence is ambiguous or mixed; 2, hypothesis is supported by the balance of available evidence.

An explanatory logic model was then developed (supplementary Appendix 3). Hypotheses contradicted by available evidence were excluded from the model. Bold and dashed text boxes were used to distinguish components of the model supported by available evidence, and those for which available evidence was ambiguous or lacking. Arrows highlighted possible relationships between components of the model.

Following reviewers' feedback on the full logic model described in supplementary Appendix 3 and the initial paper draft, we decided to develop a second visual explanatory model for the observed rise in rates of detentions from 2010 onwards. The rationale for this second model is that more data are available for potential explanatory factors in this period. This complementary but simpler and clearer explanatory model distinguishes two overarching pathways to the rise in detentions during this decade: an increase in perceived need for detention; and an increase in actual need. This second model is shown in *Fig. 2*. *Fig. 2* Two proposed pathways to the rising rate of detentions in England 2011-16: a provisional explanatory model.

Discussion

Main findings

Our explanatory model shows that societal, service-related and legal factors may all contribute to the rise in detentions in England since 1983. Changes in legal approaches to safeguarding the rights of patients who lack decision-making capacity are a probable major contributor to the rapid increase in detentions in this decade. Rising levels of mental illness and demographic change in the population may both contribute. Mental health services and the police may be getting better at identifying people who meet criteria for detention, while in some community mental healthcare settings, increasingly stretched resources may reduce the availability and intensity of the preventive support that can be provided to patients to avert relapse or subsequent detention.

Other factors may be important, but we lack confirmatory evidence. These include: increased exposure of vulnerable groups to economic and social hardship, reduction of available informal social support, changes in drug use among the patient population, changes in public and practitioners' attitudes to risk and safety, and reduced NHS in-patient bed availability. The reported rise in detentions may have been inflated by the unreliability of available data.

Available evidence suggests that reductions in the availability or quality of community crisis care and the introduction of community treatment orders have not contributed to the rise in detentions. We also found evidence that public fear and exclusion of people with mental illness has decreased in England during the study period, in contradiction to a hypothesis that reduced tolerance of people with mental health problems has driven the rise in detentions.

Strengths and limitations

Our paper collects and appraises the available evidence for and against 17 hypotheses for the rising detention rate, finding evidence to support 4 and reject 3 hypotheses. It thus provides the most comprehensive and informed exploration to date of the rising rate of detentions in England. We identify ten limitations of this paper. First, reported detention rates are based on routinely collected national data that are not wholly reliable. Second, our list of hypotheses to explain the rising rate of detentions may not be exhaustive. For example, the impact on detention rates of changing practices in discharge and transfer of patients with mental health conditions from accident and emergency and general hospitals was raised during the peer review process for this paper. The selection and framing of hypotheses, and ratings of the strength of evidence supporting each hypothesis, will inevitably reflect the perspectives and biases of those involved. Both the MHA Review topic group and the paper's authors comprised a range of mental health stakeholders, but the most

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represented group in both was academic psychiatrists. Third, because of the breadth of the topic, searches for available evidence were not systematic, and relevant data or research may have been overlooked. Fourth, our evaluation has highlighted hypotheses for which corroborating evidence from explanatory variables is available. However, hypotheses for which we lacked any relevant data to explore associations with detentions may be equally important – for example, changes in attitudes to risk and safety and risk assessment practice among mental health professionals. Fifth, for some hypotheses for which potential explanatory variables were identified, we lacked sufficient data points to allow statistical exploration of their relationship to detention rates. For variables with at least ten data points for which we did conduct analyses, these were not informed by power calculations: potentially important relationships may not have achieved statistical significance. Sixth, identified associations between explanatory variables and detention rates do not determine whether relationships are causal. With the exception of in-patient bed numbers, we were rarely able to establish temporality to inform consideration of the direction of causation in associations. For many hypotheses, additional available research was insufficient to confidently infer or reject causality or establish mechanisms. For example, it is unclear why men and people from BAME ethnic groups are detained more often, and many proposed explanations lack empirical support.⁶¹ Seventh, for many of the explanatory variables that we examined, data regarding changes over time were only available at whole-population level, not specifically for those people who are detained, or vulnerable to detention, thus creating risks of ecological fallacies. This may have particularly limited our exploration of the impact of social and economic factors on detention rates. For instance, falls in overall poverty levels in England have not been experienced equally among all demographic groups,⁶² while the measure of income inequality used in our analyses (the Gini coefficient) has been criticised as being insufficiently sensitive to change.⁶³ We have been unable to locate evidence specifically for people with mental health problems regarding change over time in levels of unemployment, work precarity, disposable income, benefits sanctions, living alone or similar variables, with which to interrogate our hypotheses in more depth. Eighth, we used a single source of data for each population-level indicator used as potential explanatory variables, to allow comparisons of change over time. However, for some indicators, there were changes during the study period in data-reporting methods or acknowledged concerns about data quality, which may limit the validity of comparisons over time. Where identified, these are reported for each variable in supplementary Appendix 1. Ninth, for mental health service provision, staffing and funding, we have relied on available national data for mental health services in general. Specific changes or pressures for children’s or older adults’ services may be obscured. Last, we have mainly looked at the relationship between proposed explanatory factors and detention rates individually. We were limited in how far we could explore interrelationships between explanatory factors and cumulative effects of exposure to several factors.

For these reasons, our proposed explanatory logic model has limited empirical support. It does not offer certainty, but does illustrate likely and possible contributory factors to the rising rate of detentions in England between 1983 and 2016. We have looked specifically for evidence to explain the rise in detentions in England during this time period: our explanatory model may have less validity for other countries and time periods.

Implications for research

This study was limited by the limited information available from routine data about detentions in England. The complete KP90 data held by NHS Digital, which allowed us to compare rates of detention over time, could not yield answers to basic questions regarding in which clinical or demographic groups the rise was occurring. Better routine data are required. The change by NHS Digital in 2016–2017 to collecting complete data about detentions at individual patient level²⁶ may address this need to some extent over time. The development of local NHS systems that allow researchers to access detailed, anonymised records for all patients using local secondary mental health services⁶⁴ also enables more sophisticated understanding of risk factors for detention and changes over time.

Our study highlights numerous areas where further research is needed regarding the relationship of potential explanatory factors to rates of detention, especially for social and economic factors, and attitudes to risk and safety.

Public health research indicates that increasing psychiatric morbidity in England may be a result of increasing social deprivation,⁶⁵ and that specific social and administrative measures may also influence mental health outcomes: for instance, increases in ‘fitness for work’ tests being associated with more suicides.⁶⁶ We need a clearer and more nuanced understanding of the extent of exposure to social and economic stressors among people with mental health problems, how this may change over time and how, if at all, it relates to changes in rates of detention.

Practitioners' attitudes to risk and safety are variable and highly important regarding decisions to detain,^{48–51} but changes over time in clinical culture and practice are not easily evaluated empirically. More qualitative research to understand the nature and extent of practitioners' biases and group-level stigma has been called for, to aid understanding of the rise in detentions and the disproportionately high rates of detention for people from BAME groups.⁶¹ A better understanding of what drives clinicians' decision-making regarding detention is desirable, as is development and evaluation of interventions to improve the quality of risk assessment and encourage appropriate positive risk-taking.

In this context, three elements of the legal processes for detention are priorities for further research. First, there is a need to understand the causes and consequences of the specific rise in the use of section 2 of the MHA for assessment, rather than section 3 for treatment. Although this may simply be an appropriate response to more new people requiring detention,⁶⁰ the MHA Review expressed concerns that section 2 is being 'overused',⁶ either through a growing perception that it is less restrictive than a detention for treatment, or because it can be easier to complete, as does not require a place of treatment to be identified. Exploration of patient-level data is desirable regarding circumstances and rates of conversion from assessment and treatment sections, and their relationship to subsequent readmission rates. Second, research is required to understand clinicians' decision-making processes in using MHA or MCA DoLS processes to detain patients who are not objecting to admission but lack decision-making capacity, and how this choice affects patients' experiences and outcomes. Third, research is needed to understand the circumstances in which patients are discharged from detention following appeal to a tribunal. This may help identify uses of detention that were unwarranted or avoidable, and how these may contribute to the rising detention rate.

Implications for policy and practice

There is considerable uncertainty about many of our proposed explanations for the rise in detentions in England. Furthermore, interventions might help to reduce detentions, even if they are unrelated to the reasons for the rise: for example, improving community crisis care. For these reasons, implications from our study for policy and practice should be proposed with caution. However, we suggest three areas of priority for reducing detentions.

First, an increase in detentions appears to have been an unintended consequence of legislation and English case law regarding safeguarding the rights of non-objecting patients who lack decision-making capacity and require hospital admission. Clear guidance and training are required for practitioners regarding assessment of capacity and when detention under the MHA is indicated rather than use of DoLS provisions under the MCA. Sufficient staff, appropriately trained in both processes, are required to ensure that the most appropriate course of action can be used in each case.

Second, the past decade has seen a large increase in the number of people treated by secondary mental health services (in addition to the expansion of psychological services in primary care), and a corresponding reduction in the amount of care offered to each individual patient in some service settings. This appears to have been a *de facto* change in mental healthcare over the past decade rather than one explicitly planned in policy. Within any level of total investment, achieving the optimal balance between breadth and depth of care involves weighing many different aims and priorities. Consideration should be given by policy planners and commissioners to the share of healthcare funding provided to mental health services, and to the potential effect on detention rates of spreading mental health resources increasingly widely, and thus away from the high-need, low-number group of patients most vulnerable to detention.

Third, our study shows that not all the rise in detentions in England necessarily relates directly to mental health service provision: wider societal factors may be equally important to address. Potential contributory factors such as increasing psychiatric morbidity and social deprivation and inequalities require a broader public health and governmental response. More attention to the potential mental health impact of wider social policy is desirable.

Lived experience: commentary by Stephen Jeffreys and Stella Branthonne-Foster

Collectively, we have personal experience of community and in-patient mental health services. We commented on drafts of this paper but did not contribute to the design and scope of the project.

The authors highlight gaps in detentions data: lack of individual-level data and failure to differentiate between frequent individual detentions and detention of more people, plus limited monitoring of Equality Act 2010 protected characteristics.

The paper suggests that detaining more patients lacking capacity, who were previously admitted informally, is a major factor. However, this hypothesis relates only to the second period of steepest rise in detentions. Furthermore, it would be interesting to specifically examine child and adolescent mental health services data for similar trends.

The children and young people's landscape is vastly different from that of their adult counterparts and needs specific consideration. We regret that data on children and young people are merged into the overall national data-set; it is important to note the differences in services (both in-patient and community), and the needs and presentations of under-18s. We anticipate that absence of these data obscures factors specific to that age group.

The biggest increases in detention rates have coincided with two periods of recession, but the authors were unable to demonstrate the impact of austerity or find data specific to those with mental health problems. We suggest widening this investigation to encompass other and more intangible factors associated with austerity and neoliberal ideology, such as individualism, cuts in local services and financial uncertainty. As there has also been a substantial increase in demand on community mental health teams, this work should not be limited to rates of detention.

The paper reveals that MHA section 2 detentions have increased, with section 3 figures remaining stable. Are hospitals discharging patients more quickly and perhaps too quickly owing to pressure on beds, are they finding swifter methods of support and treatment, or are more people being detained under the MHA unnecessarily?

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Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjo.2020.64>.

[click here to view supplementary material](#)

Data availability

The data supporting the findings of this study are available within the article (and/or its supplementary materials).

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B.L.-E., C.M., S.S. were members of the Working Group for the Independent Review of the Mental Health Act 1983. B.L.-E., C.M., S.S., D.C.-K., P.K. and S.P.S. were members of the expert topic group on understanding the rising rate of detentions, which supported the Independent Review of the Mental Health Act. The topic group was chaired by S.W., and topic group members helped generate and refine study hypotheses. B.L.-E., S.W., C.M., S.S., S.J. and L.S.-R. designed the study. J.K. advised on relevant data sources. L.S.-R., L.M., N.L. and B.L.-E. extracted data, scoped relevant research papers and drafted hypothesis summaries for supplementary Appendix 2. L.S.-R. conducted data analyses, with advice from R.J.. B.L.-E. and L.S.-R. drafted the manuscript. All authors (L.S.-R., S.W., C.M.,

S.S., P.K., D.C.-K., S.P.S., R.J., J.K., L.M., S.B.-F., S.J., B.L.-E.) helped interpret findings, revise the manuscript and approved the submitted version.

Declaration of interest

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ICMJE forms are in the supplementary material, available online at <https://doi.org/10.1192/bjo.2020.64>.

Proposed hypotheses for the rising rate of detentions in England since 1983

We hypothesised the following 17 potential contributory factors to the rising rate of detentions, listed here with possible mechanisms for the hypotheses (how might exposure to the hypothesised risk factors cause or modify the risk of detention?)

Social factors

Social and economic hardship: increased exposure to social stressors leads to more frequent relapses in the patient population and/or increase in rates of people developing a mental illness, leading to more detentions (social stressors could include: poverty, unemployment, social inequality, benefits sanctions, exposure to discrimination or hate crime). Increased drug and alcohol use: increased substance misuse leads to increased risk of relapse in the patient population and/or increased rates of mental illness. Demographic change (increased numbers of those at risk of detention): some demographic groups are at higher risk of detention than others (i.e. men, people from BAME groups and young adults age 18–35): if the proportion of the population from these groups increases, we would expect higher rates of detention. Increasing rates of mental illness: a proportion of those with mental illness become so unwell that detention is required: higher rates of mental illness lead to more detentions. Reduced informal social support: the absence of informal support (and perhaps the increase in people living alone) leads to higher rates of relapse; it also makes delivery of community-based crisis care difficult, and admission more likely; bed pressures result in the eventual need for detention.

Service factors

Reduced availability and quality of community mental health services: reductions in the reach (number of patients seen) by community mental health ongoing care services leads to reduced capacity to prevent detentions. Reductions in the quantity and quality of care provided to current patients (possibly due to reduced investment in community mental health services) lead to increased rates of relapse, leading to more detentions. Reduced availability of alternatives to admission: reduced availability of less restrictive community alternatives to admission leads to more compulsory admissions for patients not prepared to go into hospital. Reduced quality and/or responsiveness of crisis services: later intervention, or the lack of home treatment services, will result in more patients needing to be admitted. Reduced in-patient bed capacity: lack of availability of beds (evidenced by reduction in bed numbers or increased bed occupancy rates) means that patients have longer to wait for a bed and are therefore more unwell at the time of admission; or are detained when voluntary admission was possible, in order to secure a bed; or are discharged prematurely to free beds, leading to more frequent relapse and re-detention. Less continuity of care at Mental Health Act (MHA) assessments: assessment of risk may be more conservative (and overestimated) by professionals who do not know the patient. Increased focus on safety and risk among mental health professionals: section 12 doctors and approved mental health professionals (AMHPs) have become more likely to detain patients with a risk and clinical presentation that would not have led to detention in the past, owing to changes in professional culture and attitudes to patient safety and risk management. Changes in prescribing practice: reduced use of depot medication over time has led to reduced medication adherence, resulting in

more relapses and subsequent detentions. Reduced use of clozapine over time has led to more relapses and subsequent detentions.

Legal factors

Changes in legal and clinical practice in respect of patients who lack decision-making capacity: following the *Bournewood* judgment (*HL v. UK* [2004] ECHR 471) in 2004, non-objecting patients who lack decision-making capacity, who might previously have been admitted to hospital informally, must now be subject to a 'lawful process', i.e. detention under the Mental Health Act 1983 or the Mental Capacity Act 2005 deprivation of liberty safeguards (DoLS). Introduction of community treatment orders (CTOs) (and earlier discharge): (a) there is a lower threshold for CTO recall than for admission following an MHA assessment, so CTO patients are recalled to hospital who would not otherwise have been detained, leading to an increase in compulsory admissions since introduction of CTOs in 2008; (b) CTOs are used as a means of facilitating early (premature) discharge, leading to frequent relapse and recall/readmission. Police more likely to bring people to a place of safety under section 135 or 136: increasing mental health awareness and use of MHA sections 135 and 136 by the police lead to patients being brought to a place of safety and subsequently detained, who would previously have been arrested or left at home/in public places and not have ended up detained through other routes.

Data-recording factors

Better data reporting in recent years: over time, service providers are submitting more complete data returns regarding detained patients, so underreporting of detentions in official statistics reduces. Increase in transfers between hospitals during admission leads to double-counting: increasing bed pressures lead to an increase in transfers between hospitals for patients during a detention (out-of-area NHS placements and use of private hospitals), leading to increased double-counting of detentions in KP90 data.

1.3.18 Dismantling the social safety net: social security reforms, disability and mental health conditions

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date

2020-10

Abstract

This article examines the effects of UK welfare reform since 2008 on people with mental health conditions and disabilities. The results have been profound, particularly during a time of economic austerity, damaging the social safety net and pushing many vulnerable people into poverty and hardship. It has perpetuated inequalities and increased the social exclusion of disabled groups. The holes in the safety net require repair, alongside extensive social policy reform to both protect and empower people with disabilities and long-term conditions.

Contents

- *Dismantling the social safety net: social security reforms, disability and mental health conditions*
 - *Disabilities and mental health conditions*
 - *Welfare reforms in the 21st century*

- *Changes in sickness and disability benefits*
- *Disability and poverty*
- *Financial impact of welfare reforms on people with disabilities*
- *Problems with benefit assessments*
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- *Effects on health and social services*
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- *Declaration of interest*
- *Supplementary material*

In his report following a visit to the UK in 2018, the UN special rapporteur on extreme poverty and human rights, Philip Alston, said that ‘the social safety net has been damaged by drastic cuts’ and that the net ‘has been systematically and starkly eroded, particularly since 2010’.¹ His report highlighted the effects of social service cuts, welfare reforms and austerity on poverty in the UK. This followed comments by the UN’s Committee on the Rights of Persons with Disabilities that the welfare reforms had led to ‘grave and systematic’ violations of disabled peoples’ rights.²

I examine here the results that this damage to the safety net has had on people with disabilities and mental health conditions in the UK with reference to the changes in welfare benefits that have taken place over the past 12 years.

Disabilities and mental health conditions

I have chosen to examine the effect of UK welfare reforms across all disability groups for several reasons. The first of these is practical, as many official statistics do not separate people with disabilities into those with mental or with physical problems. The groups of people and their conditions that are contained in the category of ‘disability’ is fluid and has changed over time.³ Recent shifts have broadened the scope, adding people with mental health conditions, intellectual disabilities, developmental disorders and sensory impairments. This is reflected in our anti-discrimination laws: the Equality Act 2010 defines disability as ‘a physical or mental impairment which has a substantial and long-term adverse effect on the ability to carry out normal day-to-day activities’. The terminology is also reflected in the term ‘long-term conditions’, which applies to many of the people who are receiving sickness and disability benefits and are commonly users of health and social services. People with long-term mental health conditions are likely to be: living in households below the poverty threshold, to be in debt or have financial problems, to be in receipt of benefits, to be without a paid job and to live in social housing, and they are about three times more likely to have multiple social disadvantages than the general population.⁴ Many people who have mental or physical disabilities are on low incomes, they share common difficulties and are vulnerable to the effects of benefit changes.

Welfare reforms in the 21st century

The provision of services and income transfers by the state to meet the welfare needs of the UK population and the concomitant expenditure grew in the 20th century. These provisions include personal social services, services for healthcare, education and housing and income transfers such as pensions and out of work payments. One function of the welfare state is to protect people in times of hardship.

Most agree that the golden age of the British welfare state occurred after the Second World War, with rapid reforms to create a more comprehensive and universal welfare state with an increase in resources to extend benefits and coverage.⁵ This was associated with a commitment to economic growth and full employment. The development of the modern welfare state has been a driver for the improvements in provisions for people with disabilities, including those for people with mental health conditions and intellectual disabilities.⁶

The golden age declined in the 1970s, and the 1980s saw a period of retrenchment and recalibration, with an abandonment of full employment and cuts to welfare provision, despite continuing growth in public expenditure.⁵ This was set against a background of increasing income and wealth inequality. In the late 1990s and most of the 2000s, the New Labour government's vision for welfare was for a system that enabled rather than provided. The challenge was to reduce worklessness and introduce new benefits and tax credits as well as introducing work support schemes. The recession in 2008 and the election of the coalition government in 2010 brought in a period of austerity and the introduction of further welfare reforms in 2012. The squeeze on expenditure and the roll out of the new benefits continue to this day, and the welfare state may face further retrenchment following the COVID-19 pandemic.

Changes in sickness and disability benefits

The two main direct payment benefits that are specifically aimed at people with ill health and disability are those that provide out of work payments (Employment and Support Allowance – ESA) and those that cover the extra costs of disability (Personal Independence Payment – PIP).⁷

ESA was introduced in 2008 as a result of the Welfare Reform Act 2007 and replaced Incapacity Benefit. Claimants for ESA are assessed through the process of the Work Capability Assessment (WCA) that includes face-to-face contact with a clinical assessor, who determines their ability to manage a variety of daily activities (physical and mental). The WCA process assesses whether a person is entitled to ESA based on their 'limited capability for work' (LCW) and their 'limited capacity for work-related activity' (LCWA). Those found to have LCW and not LCWA are placed in the work-related activities group (WRAG) and are expected to engage with job centre staff in seeking work. Those found to have LCW and LCWA are placed in the Support Group and are not expected to engage with work-related activity. For those in the WRAG, failure to engage with Job Centre staff can result in sanctions that may reduce or suspend benefit payments.

PIP, designed to replace the Disability Living Allowance (DLA) for people 16 years of age and over, was introduced as part of a range of benefit changes in the Welfare Reform Act 2012. Assessments for PIP, unlike those for DLA, are done by face-to-face interviews with a clinical assessor. Payment is given depending on the degree of difficulties experienced in activities of daily living and mobility.

Although these benefits represent the main direct payment to people with a range of disabilities, the 2012 Act also introduced further changes that have a significant effect on people with low incomes. These include: Universal Credit, the under-occupancy charge ('bedroom tax'), a benefit cap and the up-rating of local housing allowance rates by the Consumer Price Index.

Universal Credit was introduced in an attempt to simplify the delivery of benefits and is a single monthly payment that applies to people who are looking for work or are on a low income. It brings together six working-age benefits: ESA, along with the income-based Jobseeker's Allowance, Income Support, Child Tax Credits, Working Tax Credits and Housing Benefit. It rapidly hit the headlines because of its delayed payments, and its full roll-out has been delayed.⁸

Disability and poverty

Changes to the welfare state have effects on almost the entire population, but it is those on low incomes that are often disproportionately affected.⁹ This includes many with mental health conditions and disabilities. The latest figures on poverty in the UK (2017–2018) show that, of the 14 million people who live in poverty, 4 million have a disability and a further 3 million live with someone who has a disability. An estimated 13 million adults and children in the UK have a disability, 31% of whom live in poverty (the poverty rate among the non-disabled population is 20%). Nearly half of those who are disabled have a disability due to a mental health condition – for this group the poverty rate is 39%, compared with 30% among those with a physical disability.¹⁰ These figures have changed little over the past 8 years.

These figures reinforce the UN rapporteur's findings and point to a significant number of people with disabilities falling through the poverty safety net. It seems that benefits may not necessarily protect people with disabilities from falling into poverty.

Financial impact of welfare reforms on people with disabilities

Since 2012, organisations have warned about the impact of the cuts in benefits on people with long-term conditions.^{11,12} Recent economic modelling examining the impact of the benefit changes since 2008 shows that disabled people have lost, on average, £1200 each year, compared with £300 for non-disabled people.¹³ The benefit changes have most impact on those with intellectual disabilities, social interaction difficulties and mental health conditions.

Problems with benefit assessments

From the start of its implementation, the WCA process was reported to present difficulties for those being assessed. The Citizens Advice Bureau (CAB) reported that the assessment was not effectively measuring fitness for work, often ignored independent clinical evidence and was producing inappropriate outcomes.^{14,15} Claimants reported rushed assessments, inaccurate recording of their accounts and poor recognition of mental health problems.¹⁴ Many people report the process to be anxiety-provoking and a cause of deterioration in their health. The WCA remains widely condemned and seen in need of review.^{16,17} Official Department for Work and Pensions (DWP) reviews of the WCA have questioned whether descriptors are fit for purpose and whether the assessment is sufficiently fair and effective.¹⁸

The Court of Appeal in 2013 judged the WCA to substantially disadvantage people with mental health problems and said that the DWP had failed to make reasonable adjustments to ensure that people with mental health problems were treated fairly by the system.¹⁹ Disadvantages for people with mental health conditions include: finding it difficult to report on the nature of their condition or the way that it affects their functioning; difficulty in attending for interviews or expressing themselves at interview; the fluctuating nature of their conditions, symptoms, impairments and functioning, which may be difficult to describe or to assess; the subjective nature of many mental health conditions; and the presence of coexisting physical health conditions.

The actual rate of incorrect decisions made at ESA and PIP assessments is not known. People can appeal their ESA and PIP decisions, but first they must ask for a mandatory reconsideration from the DWP. Few of these mandatory reconsiderations lead to a change in the award (around 15% for PIP). However, for those who go on to be seen by an independent appeals panel, the majority win their appeals. In 2019, 73% of ESA appeals and 68% of PIP appeals were won by the appellant.²⁰

The failure of the WCA and the assessments for PIP to reliably identify those who are eligible for benefits is costly, not only in financial terms but also in human terms.²¹ Removal of benefits is experienced by claimants as rejection, with applicants feeling mistrusted and invisible, coupled with the stress of being in a cycle of assessments, rejections and appeals.²² People describe experiences of their difficulties being trivialised or seen as fraudulent. Overall, people with mental health conditions are relatively disadvantaged when applying for PIP. For people transferring from DLA, the likelihood of being found not entitled to PIP was almost two and a half times greater among people with mental health conditions than among claimants with physical disorders.²³

Many anomalies with the specific details of the assessments for PIP and ESA have been dealt with through the court system. In 2017, the High Court quashed the new government PIP regulations for mobility activities as they discriminated against people with mental health difficulties.²⁴ In 2019, the Supreme Court ruled on the scope of the term 'social support' in relation to the PIP activity of 'engaging with others'.²⁵ In 2020, the Court of Appeal upheld two successful High Court challenges brought by individuals and found that the government had unlawfully discriminated against people with severe disabilities who had moved onto Universal Credit.²⁶

One high-profile result of the financial insecurity experienced by people on welfare benefits is the rise of food banks in the UK. Prior to the current COVID-19 pandemic, many of the people using food banks were those who had been affected by the recent welfare reforms, particularly those with disabilities, lone parents and large family households. A large-scale survey of people using food banks in 2016–2017 found that two-thirds had a health condition and almost one-third had a mental health condition.²⁷ Half of the households included someone with a disability – these households were three times more likely to use foodbanks than other low-income households.

Perhaps the most serious outcome of the WCA process is its relationship to suicide. It is known that the occurrence of completed suicide increases during recessions, but there is also good evidence that the government's programme of reassessing for ESA is independently associated with an increase in suicides.²⁸ There are also several case reports of

the deaths of people by suicide or neglect whose benefits had been removed,²⁹ including the death of Errol Graham, a man with long-term mental health problems.³⁰

A recent report from the National Audit Office³¹ has revealed 69 suicides linked to the DWP's handling of benefit claims in the past 6 years. This is likely to be an underestimate, as the information held by the DWP on suicides is not exhaustive. The DWP is looking to improve the data collection and review process.

Conditionality and sanctions

The principle of conditionality (the attachment of behavioural conditions to the receipt of benefits) has long been part of welfare policy. It was, however, usually applied to recipients of unemployment benefits, who were expected to seek work. This has now changed, and under ESA regulations, conditionality is applied to sick and disabled people, many of whom are expected to engage in 'work-related activity' and who may receive sanctions, including the reduction of benefits, if they do not. The aim of conditionality for these groups is to help move people off sickness benefits into work. This has been combined with schemes to support people into work, such as the Pathways to Work and Work Programme schemes. The use of conditionality is widely debated and, as a policy, it ignores the barriers that people with disabilities face in getting into employment.^{32,33} It is unpopular, often regarded as punitive, undermines social citizenship, is ineffective in moving people into work and can damage people's health, thus making employment less likely.³⁴⁻³⁷ Disabled unemployment claimants are more likely to be sanctioned than non-disabled claimants.³⁴

Benefit stigma

Not only do people with disabilities associated with physical and mental conditions experience prejudice and discrimination linked to their conditions, they may also experience the stigma associated with claiming benefits and the shame associated with poverty. Overall, the UK public have low levels of understanding of the benefits system and people see the bulk of what the welfare state does as providing handouts to those who do not work.^{9,39} The largest proportion of the UK welfare budget is spent on pensions (42%), with 1% spent on unemployment benefits and 10% on incapacity, disability and injury benefits.⁴⁰ Overall, the public's impression is one of a system involving 'Them and Us'.⁹ These dichotomies have pervaded the language of welfare. Traditionally, for the poor the division is between the 'deserving' and the 'undeserving' poor. In contemporary government policy, the rhetoric has been one of 'a culture of welfare dependency', 'making work pay', 'scroungers', 'benefit cheats' and the 'hard-working majority', which has been reinforced by newspaper headlines and television programmes such as *Benefits Street*. It appears that in the 21st century we have shifted our gaze from the 'deserving' and 'undeserving' to 'strivers' and 'shirkers'.⁴¹

Effects on health and social services

Several recent reports have shown that dealing with people's benefit problems is putting increased pressure on mental health services and benefit and financial advice agencies^{42,43}. Community mental health teams are spending increased time managing patients' practical problems, including benefits, debt, housing and employment. Practitioners are aware that it is difficult to treat people's mental illness without finding solutions to their practical problems, which are in turn having a significant impact on the patients' mental health. Many of these problems require assistance beyond what can be provided by mental health practitioners, but accessing alternative forms of help and advice can be difficult, especially in the complex world of financial and welfare benefit systems. Nevertheless, access to help to resolve these practical issues is important to the patient's recovery and continuing engagement with health and social services (*Box 1*).
Useful information sources
Further information about social security benefits and mental health conditions can be found on the Royal College of Psychiatrists' webpages on social inclusion (<https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/other-policy-areas/social-inclusion>). Advice to clinicians regarding assisting patients in their application for benefits can also be found on those pages.
Other useful organisations are: •Mind: <https://www.mind.org.uk/> •Rethink Mental Illness: <https://www.rethink.org/> •Money and Mental Health Policy Institute: <https://www.moneyandmentalhealth.org/>

Conclusions

This article has documented some of the problems faced by people with mental health conditions and disabilities resulting from the changes that have emerged from welfare reforms instituted over the past 12 years. These changes, rather than enhancing support for people with disabilities, have been unjust and ethically unsound, undermining citizenship and damaging to peoples' health and well-being. It reinforces the extent to which many people with long-term mental health (and physical health) conditions are stigmatised and socially excluded and highlights the ways in which they are vulnerable to falling into poverty. This is not inevitable and can be changed by improving the social policies that determine our present welfare state. In narrow terms this means overhauling the current system of the provision of welfare benefits, starting with the ways in which people are assessed for ESA and PIP, removing sanctions for people with sickness and disability, increasing the actual benefit payments and improving the employment support offered to people on ESA. More generally, the broader aspects of welfare state provision (health, education, housing, social services) must become more sensitive to the needs of the range of people with disabilities. At present, the system appears at worst to be punitive and at best to provide an inadequate sticking plaster. The system needs to ensure that people with disabilities are not just supported but encouraged to thrive.

The welfare reforms have had a negative effect on our already stretched mental health and social care services. If we are to provide 21st century mental health services we need to acknowledge the role they play in our welfare state and in the treatment and care of people who live in the hinterlands of low income and poverty. We must also recognise the role of broader social and economic factors in the causation and exacerbation of mental ill health. At the minimum we must find ways of providing people who use services with access to good financial and welfare advice, but more broadly create a benefits system alongside health and social services that addresses the very problems that exclude many people with long-term conditions from playing an active role in society. We anticipate a further economic recession, this time with high levels of unemployment, following the COVID-19 pandemic. This may mean a further tightening of the screw for people with disabilities and long-term conditions. On the other hand, there exists a glimpse of a better world that offers the possibility of improving the social and economic environment for those vulnerable to the vicissitudes of economic, political and social forces.

Jed Boardman is a senior lecturer in social psychiatry at the Institute of Psychiatry Psychology & Neuroscience, King's College London and the Lead for Social Inclusion at the Royal College of Psychiatrists London, UK.

Declaration of interest

None.

Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2020.79>.

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1.3.19 Attitudes of care staff towards video consultations

Rory Shadwell Colin Hemmings Max Pickard

date

2020-10

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- *Attitudes of care staff towards video consultations*
 - *Declaration of interest*

We read with interest the excellent article by Johns et al on video consultations in mental health services.¹ Such video consultations can also be used with key informants such as care staff. In our specialist mental health service for people with an intellectual disability (also known in UK health services as learning disability) in Kent we have just completed a quality improvement project on attitudes towards video consultations among the staff in care settings.

We found that the majority of the care staff interviewed felt that video consultations would not have a negative impact on access to (67%) or on the quality of care (69%) provided by our mental health service for people with intellectual disability. Additionally, we asked care staff if they would consider using video consultations in place of face-to-face consultations beyond the time frame of the coronavirus disease 2019 (COVID-19) pandemic. Again, we found that the majority (66.7%) said they would.

Around a third of care staff stated that video consultations could be a good alternative to face-to-face appointments as they would allow them to still go ahead even if the service users declined to leave their accommodation. Other care staff explained that video consultations would allow clinicians to see the service users in their own environment and that they may make it easier to involve multiple healthcare professionals in an appointment. The most frequently cited benefit of video consultations was the potential to alleviate the worry and anxiety that some service users experience when going to a clinic appointment.

The attitudes towards video consultations among care staff were overall positive but they were not uniformly so. For example, it was mentioned that having a video consultation may mean that the service user is more likely to become distracted. Another respondent mentioned that for their service users, much of the information needed is derived from non-verbal communication and observed behaviour, which may be more difficult to assess over video. One carer stated that it would be too difficult to get their service user to cooperate with using the communication device.

These findings may be of particular significance in the world we face post-COVID-19 lock-down where individuals may experience increased anxiety associated with healthcare settings. The month of April 2020 saw a 48% fall in attendances to accident and emergency departments when compared with the previous year, and the fall was 72% for minor injury units and urgent care centres.² There may be some long-lasting public fear surrounding healthcare settings that disproportionately affects the most vulnerable patients and telepsychiatry may prove critical in reaching those individuals as well as the staff who care for them.

Declaration of interest

None.

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1.3.20 Sabyasachi (Sab) Bhaumik, OBE, MD, DPM, FRCPsych (Hon)

Regi Alexander Sheila Hollins

date

2020-10

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- *Sabyasachi (Sab) Bhaumik, OBE, MD, DPM, FRCPsych (Hon)*

Formerly Medical Director, Leicestershire Partnership NHS Trust, and Honorary Chair in Psychiatry, Department of Health Sciences, University of Leicester, UK

Sabyasachi (Sab) Bhaumik, who died of a massive cardiac infarction at the age of 66 years on 8 November 2019, was a leading figure nationally and internationally in the psychiatry of people with developmental disabilities. He served as Chair of the Faculty of the Psychiatry of Intellectual Disability at the Royal College of Psychiatrists (RCPsych) between 2006 and 2010, and before that as Chair of the Trent Division. In 2007, he established an international links group that brought together all the activities related to intellectual disability undertaken internationally by RCPsych members. Members of this committee have undertaken numerous educational, research and service development projects in India, Pakistan, Sri Lanka, Sudan, Egypt and other parts of Africa and East European countries. More recently he had taken on the role of the World Psychiatric Association's Intellectual Disability Taskforce Lead. On the national scene he was appointed an expert advisor to both the National Institute for Health Research and the National Institute for Health and Care Excellence.

Having recognised a real gap in the body of knowledge on the use of prescribed medications with people with intellectual disabilities, he and David Branford developed the *Frith Prescribing Guidelines for People with Intellectual Disability* (now in its third edition)¹ and started the annual conference on Therapeutics in Intellectual Disabilities, now in its 11th year. He published over 100 articles and book chapters in his field on a wide range of subjects, including the development of a competency-based framework in intellectual disability psychiatry, the relationship between autism spectrum disorder and visual impairment in individuals with intellectual disabilities, and health promotion in people with intellectual disabilities. Most recently he had (with R.A.) edited the *Oxford Textbook of the Psychiatry of Intellectual Disability*² and, with others, was in the process of editing a textbook on the psychiatry of intellectual disability across cultures.

He had a leadership role among UK psychiatrists belonging to ethnic minorities and served as President of the British Indian Psychiatric Association and Chair of the RCPsych's Diaspora Groups Committee. He spent a considerable amount of time abroad on visits to India training doctors in the psychiatry of intellectual disability and, in recognition of his academic contribution, was appointed Visiting Professor of Psychiatry at SRM University, Chennai, and the Father Muller Medical College, Mangalore, India.

Sab was born in Calcutta in 1952 to Gopal Bhaumik, a well-known Bengali poet, and Uma Bhaumik. After primary and secondary education in Calcutta, he graduated in medicine from R.G. Kar Medical College, Calcutta, in 1978. He then went to work in Khatra, a remote rural area. Equipment, medication and infrastructure were lacking but Sab made up for these with his commitment, compassion and honesty. When he left after 3 years to join an MD programme in pharmacology at Benares Hindu University, there were at least 200 people there waiting to see him off. Moving to the UK in 1985, Sab worked first on a psychiatric rotation in north Wales. He joined the Leicester Frith Hospital as a consultant in intellectual disability in 1992. Subsequently, he was appointed to various senior roles at the hospital – lead clinician, clinical director and medical director. After his retirement in 2013, he worked as a consultant psychiatrist and senior medical advisor to the hospital's board.

Sab was a man of extraordinary energy, generosity and kindness. He was always a powerful advocate for his patients, whom he saw as a marginalised group of people with developmental disabilities who often had neither equity of access nor equity of treatment. His Saturday mornings were spent at the hospital surrounded by people wanting his help and advice – psychiatrists preparing for the RCPsych membership examinations, registrars getting ready for consultant interviews and consultants seeking guidance on a range of assorted issues.

In 2005, he was awarded the Hospital Doctor of the Year award at the London Hilton on Park Lane, where his colleagues spoke warmly of his multidisciplinary approach. In 2006, his enormous contribution was recognised with an OBE for services to medicine. In 2012, he was appointed to an Honorary Chair in Psychiatry in the Department of Health Sciences at Leicester University, a reflection of his contribution to research and teaching. In 2015, the RCPsych awarded him its highest honour – an honorary fellowship.

Soon after his unexpected demise, his wife Susmita Hoare wrote eloquently about how Sab had a ‘magnetic quality to attract people’ and how ‘his honesty, compassion and ability to rise above petty jealousies made him one of a kind’. She spoke for many when she said, ‘Like a comet he blazed into our lives, touching everyone with love, laughter and hope – the world darkening as he left’.

Sab Bhaumik is survived by Susmita and his son Sugato, a junior doctor.

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1.3.21 Homelessness, housing instability and mental health: making the connections

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Abstract

Research on the bi-directional relationship between mental health and homelessness is reviewed and extended to consider a broader global perspective, highlighting structural factors that contribute to housing instability and its mental ill health sequelae. Local, national and international initiatives to address housing and mental health include Housing First in Western countries and promising local programmes in India and Africa. Ways that psychiatrists and physicians can be agents of changes range from brief screening for housing stability to structural competence training. Narrow medico-scientific framing of these issues risks losing sight of the foundational importance of housing to mental health and well-being.

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Mental illness and homelessness

The bi-directional relationship between mental ill health and homelessness has been the subject of countless reports and a few misperceptions. Foremost among the latter is the popular notion that mental illness accounts for much of the homelessness visible in American cities. To be sure, the failure of deinstitutionalisation, where psychiatric hospitals were emptied, beginning in the 1960s, led to far too many psychiatric patients being consigned to group homes, shelters and the streets.¹ However, epidemiological studies have consistently found that only about 25–30% of homeless persons have a severe mental illness such as schizophrenia.²

At the same time, the deleterious effects of homelessness *on* mental health have been established by research going back decades. Early epidemiological studies, comparing homeless persons with their domiciled counterparts, found that depression and suicidal thoughts were far more prevalent, along with symptoms of trauma and substance misuse.^{2,3} A recent meta-analysis found that more than half of homeless and marginally housed individuals had traumatic brain injuries – a rate far exceeding that of the general population.⁴ Qualitative interviews with street homeless persons bring to life the daily struggles and emotional toll of exposure not only to the elements but to scorn and harassment from passers-by and the police.⁵

In the USA, healthcare professionals were among the first responders to the homelessness ‘epidemic’ of the 1980s. The Robert Wood Johnson Foundation Health Care for the Homeless initiative funded 19 health clinics around the nation, beginning in 1985. Individual physicians, including Jim Withers in Pittsburgh and Jim O’Connell in Boston, made it their mission to go out on the streets rather than participating in the ‘institutional circuit’⁶ that led so many homeless men and women to cycle in and out of emergency departments, hospitals and jails. Health problems such as skin ulcerations, respiratory problems, and injuries were the visible indicia of what foretold a shortened lifespan.⁷ Less visible but no less dire are the emotional sequelae of being unhoused – children are especially susceptible to the psychological effects of homelessness and housing instability.⁸ The gap between mental health needs and service availability for the homeless population is vast.

The bigger picture: global housing instability and structural factors

Literal homelessness – sleeping rough in places unfit for human habitation – can be seen as the tip of an iceberg of housing insecurity affecting millions of people around the world.⁹ As with attempts to count the number of homeless people and the definitional difficulties attending such counts,¹⁰ providing an estimate of the number of housing-unstable persons globally is definitionally and logistically challenging. In terms of slum dwellers (a prevalent form of housing instability), Habitat for Humanity cites estimates ranging from 900 000 to 1.6 billion.¹¹ The Dharavi slum in Mumbai has one million residents squeezed into two square kilometres, one of the densest human settlements in the world.¹¹ Substandard housing affects the well-being of inhabitants – crowding, poor sanitation and infestations bring their own risks to health and mental health.¹²

Severe housing shortages in low-income countries contrast with the greater availability of housing in higher-income countries. And yet the visibility and persistence of homelessness in wealthier nations attests to the effects of growing income inequities in the midst of plenty. In the USA, attempts to address homelessness must take several structural barriers into account. First, housing is fundamentally viewed as a commodity and is bound up with economic gains in the

forms of tax benefits for homeowners and builders, equity or wealth accumulation from owning property, and developers' profits from housing market speculation.¹³ The worst 'slumlords' (landlords who own and rent decrepit properties to poor families) reap greater levels of profit than their counterparts who build for affluent buyers or renters.¹⁴ Second, exclusionary zoning ordinances ensure protection of single-family properties, thus reducing housing availability for renters and preventing multi-family dwellings.¹⁵ Finally, access to housing is not a purely economic proposition. The effects of centuries of *de facto* and *de jure* racial exclusion continue to uniquely harm African Americans in denying them access to housing and associated wealth accumulation, thus contributing to their disproportionate representation among homeless persons in the USA.¹⁵

The ultimate causes of homelessness are upstream, i.e. a profound lack of affordable housing due in large part to neo-liberal government austerity policies that prevent or limit public funding for housing, gentrification that displaces working and poor families, and growing income disparities that make paying the rent beyond the means of millions of households. Currently, more than half of US households must devote over 50% of their income to paying for housing, an unprecedented level of rent burden.¹⁴ Farmer refers to this phenomenon as 'structural violence': the combined and cumulative effects of entrenched socioeconomic inequities that give rise to varied forms of social suffering.¹⁶ Social suffering does not easily align with existing psychiatric nomenclatures and diagnostic algorithms, but its influence on health through chronic stress and allostatic overload weakens immune systems and erodes emotional well-being.¹⁷

International and national initiatives

Interestingly, since its 1948 declaration of a right to housing,¹⁸ the United Nations (UN) has generally steered clear of re-enunciating such a right until the Sustainable Development Goals (SDGs) were announced in 2015. Subsumed within SDG #11, labelled 'sustainable cities and communities', is Target 11.1 of 'safe and affordable housing for all by 2030'.¹⁹ The UN Special Rapporteur on the right to adequate housing, Leilani Farha, recently submitted a set of guidelines for achieving this goal.²⁰

In the global south, access to mental healthcare for the most vulnerable is extremely limited despite legislative initiatives to expand such care^{21,22} and reduce human rights abuses against psychiatric patients.²³ The Global Mental Health Movement (GMHM), which began with a series of articles in the *Lancet* in 2007 asserting 'no health without mental health',²⁴ came together to address a crisis that results in a 'monumental loss in human capabilities and avoidable suffering'.²¹ The *Lancet* Commission on Global Mental Health and Sustainable Development, part of the GMHM, has strategically partnered with the UN's SDGs to ensure that mental health and substance misuse are integral to the SDGs moving forward.²¹ And there are signs of progress – most originating in the work of citizen advocates and patients working through non-profit rather than formal government channels. In Chennai, India, a visionary non-profit known as The Banyan has pioneered a culturally and socially innovative approach, 'Home Again', to help homeless persons with severe mental illness recover their lives and live independently or return to their family homes.²⁵ In West Africa, advocates for AIDS and leprosy patients have turned their talents and expertise to developing programmes for persons with mental illness that are inclusive, rehabilitative and rights based.²³ Zimbabwe's 'Friendship Bench' programme, which situates attention to mental health within ongoing community activities, has been replicated worldwide.²⁶ Although the African approaches are not targeted at homeless persons, they have been heralded as low-barrier and inclusive – and by their location are likely to assist persons with housing insecurity problems among others.²¹ The recent *Lancet* Commission report on global mental health²¹ included mention of homelessness as both a cause and consequence of poor mental health.

The advent of Housing First has been a rare success story at the programmatic and systems levels in the US, Canada and Western Europe.²⁷ Begun in New York City as a small but determined counterpoint to 'treatment first' approaches making access to housing contingent on adherence, Housing First has achieved an impressive evidence base and extensive adaptations to new populations such as homeless youth, families and opioid users.²⁷ By reversing the usual care continuum of first requiring medication adherence, abstinence and proof of 'housing worthiness', Housing First is the prime exemplar of an evidence-based, cost-saving enactment of the right to housing. Importantly, it is not 'housing only', i.e. support services including mental healthcare are essential to its success.²⁸ Early reliance on assertive community treatment in Housing First support services was eventually expanded to include less-intensive case management supports for clients whose mental health recovery had proceeded further.²⁷

Another evidence-based programme known as critical time intervention (CTI) has proven effective in preventing home-

lessness pending discharge from institutional care.²⁹ Using time-sensitive intensive supports before and after discharge, CTI connects the patient or client with housing and support services to ease return to the community and avert falling into homelessness.²⁹ Like Housing First, CTI has focused on persons with mental disorders but has since been adapted for other at-risk groups, such as clients leaving substance misuse treatment settings or prisons.

In the USA, there are a few signs that housing as a social determinant of health is receiving greater recognition. The Obama-era Affordable Care Act offered states the opportunity to expand Medicaid eligibility to millions of low-income households, including coverage for mental healthcare.³⁰ Although federal rules prohibit use of Medicaid funds to pay for housing (with the exception of nursing homes), some states have creatively used Medicaid funds for all housing-related services short of rent, including move-in costs and follow-up supports.³⁰ Unfortunately, capital funding for building and developing new housing units remains woefully inadequate, and it is too often left up to the private sector to act on a profit motive incentivised by government subsidies and tax incentives.¹⁵ Given the current national political situation in the US, positive change at the federal level is unlikely, but states and cities continue to independently seek ways to move from shelters to housing.³⁰

The healthcare landscape in the UK offers opportunities for service integration under coordinated national healthcare, and the link between housing and health is evident in recent cooperation between the National Housing Federation and the Mental Health Foundation in providing supported accommodation for persons with mental disorders.³¹ In Western Europe, the establishment of FEANTSA (European Federation of National Organizations Working with the Homeless; www.feantsa.org) in 1989 with support from the European Commission has brought together representatives from 30 nations for programmatic and research initiatives (many using Housing First). Consideration of mental problems as cause and consequence of homelessness is a key component of FEANTSA's work, with psychiatrists actively involved in research at several sites, e.g. France's multi-city randomised trial of Housing First.³²

Psychiatrists and physicians as agents of change

In what ways can healthcare providers help? For housing-related risk assessment, family or general care physicians may make use of brief screening items inquiring about recent moves, evictions and rent arrears³³ as a means of ascertaining a patient's housing instability. Regrettably, there are limited programmes available to which to refer patients with 'positive' screens, but raising awareness and knowing a patient's life challenges can only improve care. Calls for medical training to include 'structural competency'³⁴ point to the broader importance of practitioners becoming versed in patients' life circumstances linked to poverty to contextualise their health problems. According to Metzl and Hansen,³⁴ structural competency is the practitioners' trained ability to recognise that patients' problems defined clinically as symptoms, attitudes or disease also represent the downstream implications of upstream decisions about housing affordability, healthcare availability, food delivery systems and other infrastructure supports.

Some physicians have called for the right to prescribe housing as a means of solving this underlying problem, with the added advantage of reducing medical costs.³⁵ Prescribing housing as a form of 'preventive neuroscience' has received support from the O'Neill Institute as a cost-saving humane investment in children's brain development.³⁶ Such attention to social and environmental determinants of health is hardly misplaced, as they account for 90% of health status, with only 10% attributable to medical care.³⁰

Homeless men and women have few encounters with physicians, much less psychiatrists and other formal mental healthcare providers. Those with diagnoses of severe mental illnesses might have an assigned psychiatrist to prescribe anti-psychotic medications, but these are brief encounters at best. Even in wealthier nations, psychiatrists working in the public sector are relatively fewer in number, overworked, underpaid and rarely able to address the hidden crisis of mental ill health wrought by homelessness and housing instability. In low-income nations, the service gap is even wider.²²

A recent US report on the alarming lack of access to mental healthcare even for the well insured points to a broad-based crisis in mental health services.³⁷ Ignoring laws ensuring parity, insurers provide much lower coverage for mental health treatment than would be tolerated for cardiac or cancer care, and out-of-pocket costs can run as high as \$400 per private psychiatrist visit.³⁷ The prospects for a homeless man or woman who is feeling anxious, depressed or suicidal are indeed dismal. Although many homeless and other low-income individuals in the US are enrolled in Medicaid, an acute scarcity of psychiatrists who accept Medicaid patients renders such coverage virtually unattainable in many parts of the US.³⁷

A caveat about the medico-scientific approach moving forward

Attempts to incorporate social determinants thinking into public policy discourse on the mental health benefits of stable housing still have some way to go in jurisdictions where the medico-scientific approach holds sway. As a case in point, witness the recent report by the prestigious US National Academy of Science, Engineering and Medicine (NASEM) on the health benefits of permanent supportive housing (PSH), a major source of housing and supports for formerly homeless persons with severe mental illness.³⁸ Acknowledging that research on the topic was severely limited owing to the recency of PSH and its many poorly defined iterations, the NASEM report nevertheless concluded that the health benefits of such housing were minimal, with the possible exception of persons with HIV/AIDS having improved outcomes.³⁸ The report argued for the need to identify ‘housing-sensitive’ health conditions to point future researchers in the right direction.³⁸

Such delimiting of what is important to ‘housing-sensitive’ medical conditions exemplifies the narrowness of the medico-scientific model set against a social determinants model combined with human rights. In response to such reductionism, the British Psychological Society recently proposed the Power Threat Meaning Framework as an alternative to the medicalisation of mental illness,³⁹ proposing that greater attention be given to the implications of power and inequality.

Homelessness represents an existential crisis that threatens mind and body alike. The concept of ontological security, having its modern origins in the writings of sociologist Anthony Giddens, offers phenomenological insights into the benefits of stable housing that domiciled persons easily take for granted. As noted by this author,⁴⁰ going from the streets to a home enhances one’s ontological security, as such a transition affords a sense of safety, constancy in everyday life, privacy, and a secure platform for identity development.⁴⁰ As with Maslow’s hierarchy,⁴¹ fundamental human needs must be met in order to satisfy higher-order needs such as belonging and self-actualisation.

Conclusion

Despite a plethora of research linking mental and physical health to housing stability, the salience of structural barriers is too often submerged in ‘blaming the victim’ for her or his plight. Physicians and healthcare providers receive little training in social determinants and often view them as off-limits or distracting from attention to signs and symptoms. Yet psychiatrists and other mental health professionals can become agents of change by paying greater attention to the social determinants of mental health and seeking structural competence in their practice. It is difficult to overestimate the benefits of having a stable, safe home as fundamental to mental health and well-being.

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Declaration of interest

None.

Supplementary material

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1.3.22 Placing poverty-inequality at the centre of psychiatry

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Abstract

We examine epidemiological evidence for the central role of inequalities (principally economic) in driving the onset of mental disorders, physical ill health and premature mortality. We locate the search for solutions in current UK contexts, and include known and likely effects of the COVID-19 pandemic. Prevention of mental disorders and adverse outcomes such as premature mortality must begin with efforts to mitigate rising poverty-inequality.

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We can't go on like this. As clinicians in the UK and elsewhere, we are asked to treat rising numbers of people with mental health problems – definitely not the 'worried well' but patients with life-changing mental disorders. Rates of adult mental disorders and addictions are high, and that 'disease burden' bears no relation to the resources allocated to address it internationally.¹ Childhood mental disorders appear to be increasing, with rates of diagnosed illness of 15% in one large Danish cohort.² We see higher rates of psychological and physical morbidity in older people and, despite many examples of good professional practice, older adults' teams do not receive the resources needed to manage these.³ Even if we receive the long-promised extra funding to treat people with mental disorders across their lifespan, our recent gains with #ChoosePsychiatry will not deliver the numbers of psychiatrists we will need, let alone the nurses and other health and social care professionals. And so we look to prevention. Stopping these disorders from occurring, or reducing their severity, will reduce the distress of becoming unwell and alleviate the considerable costs to carers and wider society. Prevention is the first duty of the health system and those who work in it, on moral, ethical and sustainability grounds.

Where do we start with prevention?

Many would begin with adverse childhood experiences (ACEs). The original concept arose from a prospective study of childhood obesity,⁴ but their wider predictive value merits study. Hughes et al⁵ demonstrate increased relative risks in adults with four or more ACEs: doubled risks of heart disease (95% CI 1.66–2.59), alcohol misuse (1.74–2.78), and cancer (1.82–2.95); tripled rates of chest diseases (2.47–3.77) and anxiety (2.62–5.22); a four-fold increase in ‘low life satisfaction’ (3.72–5.10) and depression (3.54–5.46); and a 30-fold increased risk of a suicide attempt (14.73–61.67). For selective or targeted prevention, we look at the other end of the (shorter) life of someone with severe mental illness (SMI);⁶ we might start with smoking, obesity, alcohol and substance misuse. All four shorten life expectancy and healthy years expectancy (life before multimorbidity begins) and make our task of improving quality of life in SMI even harder. Then there is a sixth area, fair access to medical care: current national strategies to improve physical health outcomes in people with SMI and treatment of all mental disorders focus on this. Older citizens, who began life as ‘baby boomers’, have acquired the nastier metaphor of a ‘ticking time bomb’ in terms of likely health and social care costs. The prevention of many dementias (vascular dementia, alcohol-related brain damage, head injury) is achievable.⁷ Seven challenges then, maybe for seven Royal College of Psychiatrists-led intercollegiate Committees? No, there is a better way. Behind all seven of these, Michael Marmot’s ‘causes of the causes’, prevention has one major focus: *poverty-inequality*.

What are the consequences of poverty-inequality?

‘Inequality exists in the stresses and strains on family life, which shape the environment in which children grow up. It is the divergence in life expectancy between deprived and affluent areas, and the growing burden of poor mental health among disadvantaged groups’.⁸ In his accessible book, *The Health Gap*, Marmot⁹ concludes that ‘the (health) gradient involves everyone, rich, poor and in between’ (p. 26). Poverty is not inevitable, and ‘in the US, after transfers and taxes, child poverty is higher than Lithuania – 23% compared with 15% – despite having similar levels of poverty pre-tax’ (p. 137). Life expectancy, and specifically why this is falling in the UK (and was falling before COVID-19) among older and poorer citizens, is key to understanding why we need fundamental change. Marteau and colleagues¹⁰ studied the UK government’s ambitions to reverse this rising mortality: ‘the leading causes of years of life lost in England are tobacco use, unhealthy diet, alcohol consumption, and physical inactivity. All of these behaviours are socioeconomically patterned’. The scientific literature has reached a consensus on the health harms of poverty-inequality. In their study of multimorbidity in the ethnically diverse London borough of Lambeth (where a third of a million are registered with a general practitioner (GP)), Ashworth et al¹¹ concluded that: ‘acquisition of multimorbidity is patterned by socio-economic determinants’, with depression and asthma as early drivers of poor physical health. The US and the UK have similar high levels of inequality, and their inhabitants can expect to lose 7–9 *healthy* years (free from physical disability) by the age of 50 if they are poor, compared with their fellow citizens at the least deprived end of the gradient.¹² All the evidence points to poor mental health, from common mental disorders through to SMI, as the means whereby poverty wrecks *physical* health.

But rich people get mental disorders too

Yes, they do. But they get better from depressive episodes faster and relapse less, in contrast to people on lower incomes, who have higher prevalence rates and worse outcomes.¹³ We also concede that most people who grow up in poverty do not develop a life-changing episode of depression, let alone SMI. But the antecedents of SMI are complex, and our understanding of why people develop psychosis is changing, building on the seminal work of Jim Van Os on the toxic effects of urbanicity¹⁴ – with consistent evidence of the cumulative effects of social disadvantage. Work with case-control groups in south London showed consistent odds ratios (ORs) for subsequent psychosis in people below the poverty line of 4.50 (95% CI 2.89–7.00) and 2.95 (1.89–4.61), for 1-year and 5-year *pre-symptom onset*, respectively. These ORs were the single highest predictors of psychosis, other than the related but confounded OR of 12.05 (7.13–20.35) for being unemployed on presentation to psychiatric services.¹⁵ Outcomes in adults with first-episode psychosis are complex and improving slowly in our professional lifetimes (with adequately resourced early intervention services); even at 5-year follow-up, Mattsson et al¹⁶ showed financial strain and social networks to be strong, independent predictors of outcomes.

Lessons from history

We cannot ignore poverty as a predisposing, precipitating and maintaining factor in most of our patients' disorders. Early in the neuroleptic era, we knew that poorer people had worse outcomes in schizophrenia, stayed in hospital longer, and were socially isolated even if they achieved discharge,¹⁷ but our textbooks called this 'social drift' despite prior debunking of the drift hypothesis.¹⁸ Hindsight is easy, certainly, but perhaps we should look to psychiatry's institutional bias. We still speak of a problem of *stigma* (negative societal attitudes) rather than acknowledging the reality that people with SMI have lower status conferred on them and face institutional obstacles to achieving their life goals, and calling this out as subcitizenship.¹⁹ At the time we started writing this, we welcomed the stated intention of the UK government to reverse a decade of austerity, signalled first in October 2018²⁰ and often repeated during the first weeks of the spring 2020 lockdown. In advocating a broader role for busy psychiatrists in opposing regressive social policies, we are echoing the 'wake-up call' to colleagues from 2008: '[it is] fully consistent ... to think of psychiatry as being the only specialty in which its practitioners are fully trained doctors, incorporating psychology and social-based knowledge and skills as major components of training'.²¹ Not 'social workers with stethoscopes' but clinicians with public health knowledge who understand the environments in which our patients live. And die.

What we know about the effects of COVID-19 (so far)

COVID-19 has changed how every health professional practises. Each health specialty must play its part in mitigating and preventing further adverse outcomes. The virus leaves a trail of delirium, depression and anxiety, perhaps post-traumatic stress disorder in those who survive,²² and further misery for those bereaved. COVID-19 has revealed and exacerbated inequalities. Examination of death rates in the first 20 283 hospital deaths with proven COVID-19 in England and Wales shows major differences between the richest and poorest regions: 'people living in more deprived areas [for example, the London boroughs of Newham and Brent, in the context of an early first peak in London] have experienced COVID-19 mortality rates more than double those living in less deprived areas. General mortality rates are normally higher in more deprived areas, but so far COVID-19 appears to be taking them higher still'.²³ At the time of writing, recording of the proportions of deaths among Black, Asian and minority ethnic (BAME) groups was incomplete, but preliminary figures, not least those for deaths among our BAME colleagues working in health and social care, have shown an excess. Health gradient differences are among the lessons of the pandemic: the age-standardised mortality rate of deaths involving COVID-19 in the most deprived areas across England was 55.1 deaths per 100 000 population, compared with 25.3 deaths per 100 000 population in the least deprived areas.²³ We have yet to learn the full extent of excess deaths from COVID-19 among our patients across age groups, regions and specialties. It is too late for them, but we will not dodge the hard questions. As mental health professionals, we cannot remain as observers; we must now act on poverty-inequality.

Solutions in this issue

This issue opens with a contribution from two people with lived experience of SMI. Smoking remains a challenge in mental health services, and you will read about tobacco poverty and how to achieve more 'quits'. *Housing First* shows the evidence for changing how we approach this issue. We feature the Glasgow perspective on how we might progress, as well as an article on the cruelty of 'reforms' to the safety net benefits system. There is a biomedical perspective too.

What have we left out?

To name just five areas, we have not raised here the related premature mortality of people with personality disorders and intellectual disabilities, often worse even than that in people with SMI,⁶ nor the excellent work by patients, carers and professionals to reduce high-dose prescribing of psychoactive medications in intellectual disability.²⁴ Health inequalities drive the UK's obesogenic environment, which is relevant to premature mortality in general but specifically to COVID-19 deaths. Cuts to addictions services are considered elsewhere, alongside the opioid crisis that has crossed the Atlantic.²⁵

Solutions beyond this issue

As we mature as clinicians, our goals of intervention adjust to realities and hard-won experience. We do not see patients as a collection of neuroreceptors (including subtype and putative phenotype); we devise complex formulations to persuade patients towards self-management and empowerment, consolidating their (real not virtual) social networks and support systems. To achieve this, we will need to practise *psychosocial education*. Communicating complex information about the drivers of mental disorders might be easier if our patient has just one, but aetiology (causes of the causes) is shared. Beyond your wards and clinics, other health professionals also need to know what we know. Do our GP letters communicate the individual drivers of someone's misery (inadequate housing, precarious income, indeterminate status to remain, no locally available stop smoking services, the pressures of raising children when a parent has mental health or substance issues, etc.), or is it easier to write about medications and risk? It is a great start to identify what we can do better where we work^{9,26} – and we cannot dispense social prescribing unless we understand our local communities.

From public education to public engagement

Do you know who leads on inequalities in your local organisations? Are there aspects of your practice where inequalities are making outcomes worse, and are you in a position to influence mitigation for these? Regional structures and local alliances have the potential to achieve results beyond the ephemeral 'levelling up' of current public discourse. Of course there will be political voices (of all shades and volumes) to keep us quiet, but we are 'following the science'. The Royal College of Psychiatrists has joined with many partners in Equally Well (www.equallywell.co.uk) to use the available evidence to reverse rising SMI mortality. We hope this special issue of the *BJPsych Bulletin* will get people thinking and talking. What will *you* do to achieve a wider societal dialogue? Our College and others are building resources to tackle poverty-inequality, but we need all the help we can get.

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P.B. devised and wrote first drafts of this article to frame a special issue of the *BJPsych Bulletin* on poverty. A.J. commented on these drafts and enhanced the content on BAME inequalities and prevention.

Declaration of interest

P.B. remains the lead for public mental health at the Royal College of Psychiatrists, and represents the College in the Equally Well collaborative, hosted by the Centre for Mental Health; he is also a former Trustee of the Mental Health Foundation.

Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2020.85>.

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1.3.23 Ciaran Mulholland: the Psychiatrist's Manifesto

Claire Mckenna¹

date

2020-10

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London-based neuropsychologist Vaughan Bell recently mused on Twitter: 'I'm always slightly mystified why the situation in Northern Ireland gets ignored by the wider UK mental health community. Thirty plus years of armed conflict, highest prevalence of mental health problems in the UK, shockingly low level of investment in services' (@vaughanbell, 2 Feb 2020; Tweet reproduced here with permission). I confess, I myself have wondered.

Inequality is indeed writ large in the mental health of Northern Ireland's populace. The statistics are alarming: deaths by suicide have doubled since the ceasefire heralded by the Good Friday Agreement in 1998 and are now the highest in the UK; there is a 25% higher prevalence of mental health problems in Northern Ireland compared with England; and Northern Irish people are prescribed more psychotropic medication than any other European population.

¹

Claire Mckenna talks to Ciaran Mulholland, clinical director of Northern Ireland's Regional Trauma Network about the legacy of 'the Troubles' and why psychiatry is inherently political

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Professor Ciaran Mulholland took time out to talk to me during a 2019 conference on ‘Psychiatry and Conflict’ in Belfast, where he was speaking in his role as clinical director of Northern Ireland’s unique Regional Trauma Network. Set up in 2017 as a fitting legacy for the 3700 killed and 55 000 injured in the conflict, it aims to provide a world-leading mental health service, across a network of voluntary and statutory sectors, for victims of all forms of trauma in Northern Ireland.

A legacy of conflict and deprivation

Mulholland’s first posting as a consultant adult psychiatrist was in 1998, the year the worst of the violence stopped. His base was the socially deprived area of Newtownabbey on the Northern outskirts of Belfast: “‘There was a lot of paramilitary activity in the area. There were also parts of the catchment area where many ex-soldiers, ex-policemen and ex-security forces were living, who clearly had their own experience [...] A lot of what I dealt with was trauma related, where the individuals in some way have been impacted by the Troubles.’”

Newtownabbey is a microcosm of Northern Ireland’s more deprived communities. Many moved there to get away from the violence in Belfast in the 1970s, some involuntarily: “‘That means the local community is quite atomised and not as cohesive as you might get in some parts of Northern Ireland, which is one of the reasons Newtownabbey has quite high rates of psychiatric problems.’”

Northern Ireland has higher rates of mental illness than the rest of the UK across all types of mental health conditions. Why have so many people not seen the dividends of peace reflected in their mental health? Mulholland says the causes are complex: socioeconomic deprivation is strongly associated with mental illness; there is a long legacy of underfunding of mental health services (half the proportion of health funding compared to England); there is a tribal political structure, leading to impasses in policy decision-making; and the psychological ripples of the Northern Ireland civil war continue to reverberate 23 years after it ended.

And then there are those stark suicide statistics: 143 people died by suicide in Northern Ireland in 1996. When last recorded in 2015, the figure had more than doubled to 318. It’s tempting to attribute the lower rates in wartime to a protective ‘Blitz-spirit’, which bonds people together through shared adversity. Mulholland thinks this could be a factor in more deprived communities, but we have to be careful not to over-interpret.

He points out that during the years of the Troubles, paradoxically, policing by paramilitaries kept drug misuse in Northern Ireland lower than anywhere else on these islands – which is now not the case. There is also some evidence that, for people in their 50s or 60s, who lived through the worst years of violence, their untreated trauma was a factor in their suicide decades later. Most people who die by suicide in Northern Ireland don’t have contact with mental health services, so tackling it can’t be addressed by mental health services alone.

PPE: politics, psychiatry and economics

We’re talking in the Harland Bar, named after the local shipyard, in the shadow of the four hulking steel prows of Belfast’s Titanic building. It seems an apt place to meet, for a man whose political life has been bound up with the struggles of the blue-collar worker: “‘Well, I mean, I am a socialist, you know. I’m on the left and my version of socialism is avowedly anti-sectarian. So, I’ve not needed to be in either camp. I’ve a very clear, distinctive view about there being a third tradition in Northern Ireland, which is kind of around labour and socialist politics.’”

Northern Irish psychiatry is a small community, where reputations travel by word of mouth. Mulholland seems to plough his own furrow, more or less. Genial and unassuming in manner, the only signifiers of non-conformity are the Dr Martens boots he wears with his suit. There is no evidence of the reputed (possibly apocryphal) Trotskyite student streak.

Mulholland says that doctors in Northern Ireland have always had strong links with the socialist tradition. The nascent socialist and labour movement was stymied by the eruption of the civil war in 1968–1970. Sectarianism has dominated the political discourse ever since. He describes the influence of these socialist roots on his professional life: “‘It was just central to my work from the day I began working as a doctor, even before I trained in psychiatry. Perhaps that was of assistance to me that I wasn’t as focused on the biology as a causative factor and as a sole explanatory factor, as maybe some other doctors were.’”

In the Northern Ireland context, he thinks socialism has a unique ability to straddle the sectarian divide: “‘I think socialism properly speaking is neither Unionist nor Nationalist and seeks to unite people [...] And it’s around issues like health and education. That’s how you unite people in terms of what they have in common as opposed to dividing them.’”

Although for some people socialism is conflated with the ‘Red Peril’, Stalinism, et cetera, Mulholland is at pains to stress that fundamentally it’s about creating a more equal society: ‘That’s [Stalinism], not my version of socialism. It has to be democratic or it’s not socialism’.

Mulholland sees the current resurgence of socialism (among young people in particular) as a renunciation of individualism. He detects a growing public awareness that collective purpose is needed to reduce social inequality and to improve our mental health: “‘I think it’s the impact of the global crisis of 2007, 2008, 2009 [...] that led to people who hadn’t previously questioned the system, how it operated, asking profound questions. And I think that’s now magnified by other developments, for example the question of the future of the planet, the environment [...] if you study that particular threat carefully, and you think about what the alternatives are, it does suggest transformational change is required.’”

What is at psychiatry’s cutting edge?

No, it’s not the sexy neuroscience. ‘I suppose I’ve always been interested in prevention and early intervention’, Mulholland explains, ‘in the sense that if psychiatry has a cutting edge it’s about: How early can we intervene?’

If circumstances hadn’t changed suddenly in 2012 he might have stayed in his first consultant job in Newtownabbey. He collapsed at work, was rushed to theatre with a haemoglobin of 3 and was diagnosed with a rare form of stomach cancer. There was no Damascene moment, but after 9 months off, with time to take stock, he came back to find a small pot of money available to do some innovative work.

One of the earliest advocates in Northern Ireland for early intervention in psychosis services, he now works as a consultant psychiatrist with STEP (Service, Treatment, Education and Prevention), Northern Ireland’s only early intervention service for the ‘at-risk mental state’, which he helped set up in the Northern Trust area. He is also one of the clinicians who has done most to fertilise the ground for mental health research in Northern Ireland. He co-leads the mental health special interest group in the Northern Ireland Clinical Research Network.

His research interests primarily focus on first-episode psychosis, prevention of transition to psychosis and the impact of trauma on mental health. Northern Ireland has higher rates of psychosis than most places in the UK (excepting parts of London with a high African–Caribbean population).

There is a burgeoning evidence base that early intervention can improve outcomes for young people with psychotic illness and even prevent transition from at-risk mental states in some cases. Though as Mulholland says, it can be quite difficult to prove a negative.

The Belfast fixator

Northern Irish medicine has some grim claims to fame because of medics’ unique war-zone experience. The ‘Belfast fixator’, for example, was designed here by an orthopaedic surgeon to heal injuries from beatings and explosions.

Four out of ten adults in Northern Ireland have been directly or indirectly affected by Troubles-related trauma, Mulholland says. According to data collected between 2004 and 2008, 8.8% of the population met criteria for post-traumatic stress disorder (PTSD) at some point in their lifetimes (higher even than in other, more intense conflict zones such as Lebanon and Israel).¹ The methodology of that paper has been pored over since, but he backs up its findings: “‘It is clear and demonstrable that other places have higher rates of trauma with lower rates of PTSD. Some other factors must be at play [...] one of the areas which we are compared to, for example, is Israel [...] but there is evidence that Israeli society is particularly cohesive. That’s a protective factor and perhaps our society is not quite so cohesive and that’s how rates [of PTSD] have crept up.’”

How then does a trauma history affect the trajectory of severe mental illness such as bipolar disorder and psychosis? When Mulholland was training, the dominant paradigm was a biomedical one, but he says, “‘I was always interested

in the idea that actually psychological trauma was more central to the aetiology and the course of schizophrenia than was allowed for. And it was around that time in the 1990s [...] that evidence began to emerge from groups all over the world, that psychological trauma can actually cause psychosis.”

Although this is more widely accepted now, he allows that there is much work to do to develop causal models of psychotic illness.

The Northern Ireland Regional Trauma Network, of which he is clinical director, was set up with a research focus from day one. Randomised controlled trials looking at epigenetic factors in the intergenerational transmission of trauma and psychological treatments of trauma are in the offing.

Mulholland discusses the emerging evidence that psychological trauma causes brain damage, particularly to the hippocampus and amygdala. He says there is evidence that damage can be repaired with medication and psychological therapy: ‘So a psychological insult causes brain damage and psychological therapy causes brain repair. I think that’s very exciting and it opened up an entirely new way of looking at the brain’.

How does he respond to critics who, on the basis of the association between trauma and mental illness, question the validity of a biological contribution to psychiatric disorders? He suggests that we avoid ideological entrenchment: “‘I would have an issue with the individuals who practise biological determinism [...] but I think equally now we have strident voices where it’s psychological determinism, where it’s your psychology that determines everything, and that’s clearly not always the case.’”

Media and mental health

Mulholland has long had an interest in the portrayal of mental health in film and media. He helped organise a symposium on ‘Film and the politics of mental health’ in 2016, with a focus on two countercultural figures, Franco Basaglia and R.D. Laing. I wonder whether I’ve caught a glimpse of the radical psychiatrist within, but he remains elusive.

Mental health anti-stigma messages sometimes seem at saturation point in the media, but it’s not the ‘worried well’ Mulholland wants to target: “‘I think it’s one role of psychiatrists to ensure that there’s greater understanding that there is such a thing as a mental illness. I think that actually is important. You could say it’s a concept or a construct and it is in a sense, of course, but I think it’s important for us to make the case that sometimes there is demonstrable pathology, which means that a person’s way of being is different, which meets all the criteria for illness and that ought to be addressed.’”

In a socially conservative society like Northern Ireland he thinks this is especially crucial. The BBC’s Countryfile programme shone a spotlight on mental health problems among gay farmers last year. Mulholland was involved with the episode, which interviewed a Northern Irish farmer who had suicidal feelings as a result of repressing his sexual identity.

Since then he has been working with the BBC on a Horizon programme (screened in spring 2020), about prominent 1990s comedian Tony Slattery. In particular, he wants to highlight the genesis of mental illness through trauma: “‘He [Slattery] received a diagnosis of bipolar affective disorder after his parents died. He went into the media and began to talk about a traumatic experience at the age of 8 and once he began to talk about it, he wanted to explore it further. So we worked with the producers of Horizon and made a programme all around this, about his life trajectory, his life course, but going beyond that to examine bipolar disorder as a concept – what the biological underpinnings of bipolar disorder might be and the role of trauma in bipolar disorder.’”

Not another brick in the wall

Early-life adversity remains the fulcrum of Mulholland's interests. Northern Ireland has higher levels of multiple deprivation (defined as an inability to access three or more basic necessities) than the rest of the UK. The most deprived areas are also those most affected by the Troubles.² He references the zeitgeisty book *The Spirit Level*,³ which made a compelling case that socio-economic inequality, rather than poverty per se, drives poor mental health: "So in the United States and the United Kingdom, where neoliberal ideas were most to the fore, appear to have higher rates of mental problems compared to more cohesive societies like the Scandinavian countries where there are lower rates of social division."

We discuss economist Lord Layard's seminal 2006 report, which led to the Improving Access to Psychological Therapies (IAPT) programme in England. Among the criticisms of Layard was his framing of anxiety and depression as discrete illnesses that, when individually treated could return people to economic productivity, rather than formulating these problems as people's responses to the difficult socioeconomic circumstances in which they find themselves.

Mulholland demurs: "I think in the main it's [IAPT] been an excellent initiative that has brought psychological therapies to large numbers of individuals who've benefited and who wouldn't have received such treatment. I think Northern Ireland would benefit from a similar initiative."

In the manner of Sophie's choice, I ask him to pick one thing that would have the biggest impact on mental well-being in Northern Ireland. A glimpse of the radical psychiatrist emerges at last: "Our society is dysfunctional. It's a function of the level of division in society that we are literally divided by walls, physical walls [the incongruously named 'peace walls' that separate Catholic and Protestant communities], but we're also divided by metaphorical walls in various ways. There's clear evidence that those who live close to the physical walls, the 'peace lines' that separate our communities, have higher rates of mental health problems. 'So, in Northern Ireland [...] in my working lifetime, the number of consultant psychiatrists has doubled. Where's the demonstrable impact on the rates of mental health problems? Can we prove that we are effective? I think there's a real challenge there. Whereas we can demonstrate that if you make real changes to societal structures, that *will* have an impact on rates of mental health problems."

Long live the (democratic, peaceful) revolution.

1.3.24 Safeguarding the physical health of people with severe mental disorders during the COVID-19 pandemic

Shuo Zhang Jayati Das-Munshi Graham Thornicroft

date

2020-10

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- *Safeguarding the physical health of people with severe mental disorders during the COVID-19 pandemic*
– *Declaration of interest*

The coronavirus disease 2019 (COVID-19) pandemic is putting unprecedented stress on global healthcare systems. Psychiatrists have also seen great changes to their day-to-day practice with a move towards telephone and video consultations alongside general practice and secondary care colleagues. As we move towards operating in these new ways for the foreseeable future, it is likely that COVID-19 will further exacerbate multilevel risk factors for excess mortality in people with severe mental disorders (usually understood to include people with psychosis, bipolar disorder or major depressive disorder).

People with SMD already have a 2–3 times higher premature mortality rate, accounting for a 10–20-year reduction in life expectancy, mediated through increased exposure to risk factors for non-communicable diseases, such as smoking, harmful use of alcohol, sedentary behaviour, iatrogenic effects of medications and inequitable access to healthcare

services.¹ Those with SMD also often receive poor quality care, including health promotion and prevention, screening and treatment.

Individuals at higher risk for severe COVID-19 infection and mortality are people aged over 60; with underlying conditions such as obesity, hypertension, diabetes, cardiovascular disease, or chronic respiratory disease; and those who smoke.² For other infectious diseases, people with SMD are likely to be at increased risk of: (a) exposure to the disease; (b) accessing less effective healthcare; and (c) increased vulnerability for significant morbidity and mortality.¹

Although there are overlaps with pre-existing multilevel risk factors,³ there are some important differences. For individuals with SMD, disorder-specific factors of COVID-19 such as early symptoms being common and non-specific could delay diagnosis, and it is possible that people with SMD may be less able to self-monitor and raise concerns if their condition deteriorates. Furthermore, COVID-19 has the potential to mimic signs and symptoms seen in severe clozapine-associated complications, such as neutropenic sepsis and myocarditis, which can be difficult to clinically differentiate from severe COVID-19.² We anticipate that health-related behaviours, such as tobacco use and associated higher prevalence of underlying lung disease in the SMD population, will increase the risk of COVID-19 complications and deaths from pneumonia.

Individual vulnerabilities are exacerbated by health system factors such as absence of relevant shared guidelines for the management of COVID-19 from physical health and mental health bodies, diversion of resources from mental health settings, high rates of COVID-19 illness within the health workforce, and the challenges of infection control management in mental healthcare settings, exacerbated by global shortages of personal protective equipment (PPE).

People with SMD have continued higher exposure to sociocultural risk factors including experiences of stigma and discrimination, living in deprived neighbourhoods, and limited family and community resources.³ At present the impact of these factors within the context of the COVID-19 pandemic is unclear.

We suggest the following measures to address individual, facility and health system determinants of health.

Individuals should be supported with infection prevention, for example the direct provision of education about hand-washing, social distancing and the signs and symptoms of COVID-19 along with health promotion strategies such as smoking cessation or harm reduction, reducing drug and alcohol use, and optimising conditions such as diabetes mellitus, chronic respiratory conditions and cardiovascular health. People with SMD should maintain contact with mental healthcare teams and receive ongoing review of mental health needs. At present although there has been some specific guidance on supporting people with cognitive impairment and dementia,⁴ it remains unclear what the impact of the pandemic may be on people with SMD, a group who may be especially vulnerable because of pre-existing social isolation, which may be further exacerbated by social distancing measures.

Staff at mental health community and residential facilities should have equal access to PPE and training on infection control in order to reduce the risks of infection. Urgent reviews of visitor policies, and assurance of sick pay for self-isolating staff are also needed.

Further consideration is needed to optimise effective delivery of care when mental and physical health staff reduce routine face-to-face meetings, and to minimise disruptions in the supply of medication and routine monitoring of medications such as clozapine and lithium. People with SMD may need additional support in accessing services when community health centre staff adopt new ways of working, such as telephone or video consultations.

People with SMD should be offered the same level of treatment for physical healthcare in line with the principles of non-discrimination, the Right to Health, and the fundamental demand of the United Nations Sustainable Development Goals,⁵ namely to 'leave no-one behind'.

Declaration of interest

None.

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1.3.25 Poverty and mental health: policy, practice and research implications

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Abstract

This article examines the relationship between poverty and mental health problems. We draw on the experience of Glasgow, our home city, which contains some of Western Europe's areas of greatest concentrated poverty and poorest health outcomes. We highlight how mental health problems are related directly to poverty, which in turn underlies wider health inequalities. We then outline implications for psychiatry.

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 - *Poverty and mental health*
 - *Excess mortality and mental health in Glasgow*
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 - * *Reinvigorate social psychiatry and influence public policy*
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 - * *Embed poverty-aware practice and commissioning*
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Doctors have often played leading roles in social movements to improve the public's health. These range from the early days of John Snow isolating the role of contaminated water supplies in spreading cholera, through to advocating harm reduction, challenging HIV stigma and, more recently, highlighting the public health catastrophe of mass incarceration in the USA.¹ Almost all examples are rooted in poverty. There is now increasing recognition that mental health problems form the greatest public health challenge of our time, and that the poor bear the greatest burden of mental illness.²

Our article draws on data from Scotland, and especially Glasgow, which contains some of the areas of greatest need and widest health inequalities in Western Europe. However, the relationship between poverty, social stress and mental

health problems is not a new phenomenon and was reported by social psychiatrists half a century ago in Langner & Michael's 1963 New York study³ and consistently since then. Poverty is both a cause of mental health problems and a consequence. Poverty in childhood and among adults can cause poor mental health through social stresses, stigma and trauma. Equally, mental health problems can lead to impoverishment through loss of employment or underemployment, or fragmentation of social relationships. This vicious cycle is in reality even more complex, as many people with mental health problems move in and out of poverty, living precarious lives.

Poverty and mental health

The mental health of individuals is shaped by the social, environmental and economic conditions in which they are born, grow, work and age.⁴⁻⁷ Poverty and deprivation are key determinants of children's social and behavioural development^{8,9} and adult mental health.¹⁰ In Scotland, individuals living in the most deprived areas report higher levels of mental ill health and lower levels of well-being than those living in the most affluent areas. In 2018 for example, 23% of men and 26% of women living in the most deprived areas of Scotland reported levels of mental distress indicative of a possible psychiatric disorder, compared with 12 and 16% of men and women living in the least deprived areas.¹¹ There is also a clear relationship between area deprivation and suicide in Scotland, with suicides three times more likely in the least than in the most deprived areas.¹²

Inequalities in mental health emerge early in life and become more pronounced throughout childhood. In one cohort study, 7.3% of 4-year-olds in the most deprived areas of Glasgow were rated by their teacher as displaying 'abnormal' social, behavioural and emotional difficulties, compared with only 4.1% in the least deprived areas. By age 7, the gap between these groups had widened substantially: 14.7% of children in the most deprived areas were rated as having 'abnormal' difficulties, compared with 3.6% of children in the least deprived.¹³ National data from parental ratings of children's behaviour show a similar pattern: at around 4 years of age, 20% of children living in the most deprived areas of Scotland are rated as having 'borderline' or 'abnormal' levels of difficulties, compared with only 7% living in the least deprived areas.¹⁴

These findings reflect a broader pattern of socioeconomic inequalities in health that is observed internationally.¹⁵ The primary causes of these inequalities are structural differences in socioeconomic groups' access to economic, social and political resources, which in turn affect health through a range of more immediate environmental, psychological and behavioural processes.^{16,17} A wide range of risk factors are more prevalent among low income groups for example, including low levels of perceived control¹⁸ and unhealthy behaviours such as smoking and low levels of physical activity,¹¹ although these are best understood as mechanisms that link the structural causes of inequality to health outcomes.¹⁷

Excess mortality and mental health in Glasgow

Glasgow has some of the highest Scottish rates of income deprivation, working-age adults claiming out of work benefits, and children living in low-income families.¹⁹ Moreover, the city also reports poor mental health, relative to the Scottish average, on a host of indicators, including lower mental well-being and life satisfaction, and higher rates of common mental health problems, prescriptions for anxiety, depression or psychosis, and greater numbers of patients with hospital admissions for psychiatric conditions.¹⁹

These statistics are consistent with Glasgow's overall health profile and high rates of mortality. Life expectancy in Glasgow is the lowest in Scotland. For example, men and women born in Glasgow in 2016–2018 can expect to live 3.6 and 2.7 fewer years respectively than the Scottish average.²⁰ Within Glasgow, men and women living in the most deprived areas of the city can expect to live 13.5 and 10.7 fewer years respectively than those living in the least deprived areas.²¹

The high level of mortality in Glasgow can largely be attributed to the effects of deprivation and poverty in the city, although high levels of *excess* mortality have also been recorded in Glasgow, meaning a significant level of mortality in excess of that which can be explained by deprivation. For example, premature mortality (deaths under 65 years of age) is 30% higher in Glasgow compared with Liverpool and Manchester, despite the similar levels of deprivation between these cities.²² Crucially, this excess premature mortality is in large part driven by higher rates of 'deaths of despair'²³ in Glasgow, namely deaths from suicide and alcohol- and drug-related causes.²²

It has been proposed that excess mortality in Glasgow can be explained by a number of historical processes that have rendered the city especially vulnerable to the hazardous effects of deprivation and poverty. These include the lagged effects of historically high levels of deprivation and overcrowding; regional policies that saw industry and sections of the population moved out of Glasgow; the nature of urban change in Glasgow during the post-war period and its effects on living conditions and social connections; and local government responses to UK policies during the 1980s.²⁴ On the last point, Walsh and colleagues²⁴ describe how the UK government introduced a host of neoliberal policies during this period – including rapid deindustrialisation – that had particularly adverse effects in cities such as Glasgow, Manchester and Liverpool. While Manchester and Liverpool were able to mitigate the negative effects of these national policies to some extent by pursuing urban regeneration and mobilising the political participation of citizens, there were fewer such efforts made in Glasgow, which contributed to the diverging health profiles of the cities.

These researchers have also suggested that this excess mortality may partly reflect an inadequate measurement of deprivation.²⁴ However, that does not capture the reality of living in poverty. One aspect of this lived experience that may be important is the experience of poverty-based stigma and discrimination.²⁵ Stigma is a fundamental cause of health inequalities,²⁶ and international evidence has demonstrated that poverty stigma is associated with poor mental health among low-income groups.²⁷ Individuals living in socioeconomically deprived areas may also experience ‘spatial’ stigma, which similarly has a range of adverse health effects for residents²⁸ and, crucially, may be unintentionally exacerbated by media and public health professionals’ reports of regional health inequalities.²⁹ Given the continued focus on Glasgow’s relatively poor health it is possible that the city is more vulnerable to such stigmatising processes. However, we stress that additional research will be required to test whether stigma is an important aspect of the lived reality of poverty, particularly as several psychosocial explanations have already been offered for the excess mortality, with varying levels of supporting evidence.²⁴ The notion of intersectional stigma is also gaining traction and requires further research.

Understanding the life-course impact of poverty on mental health is also important. Childhood adversity is one mechanism through which poverty and deprivation have an impact on mental health. Adverse childhood experiences, such as exposure to abuse or household dysfunction, are relatively common in the population. Marryat & Frank examined the prevalence of seven adverse childhood experiences among children born in 2004–2005 in Scotland, and found that approximately two-thirds had experienced at least one adverse experience by age 8.³⁰ Moreover, the prevalence was greatest in low-income households: only 1% of children in the highest-income households had four or more adverse childhood experiences, compared with 10.8% in the lowest-income households. Adverse childhood experiences are also strong predictors of mental health in adulthood: individuals who have experienced at least four are at a considerably greater risk of mental ill health, problematic alcohol use and drug misuse.³¹ It has also been suggested that experiences of childhood adversity and complex trauma may contribute to Glasgow’s – and Scotland’s – excess mortality, particularly that which is attributable to violence, suicide and alcohol and drug-related deaths.³² The implications are significant for psychiatry. Not only does it offer a broader explanation of causation; it also highlights the importance of supporting early interventions for young people’s mental health and supporting the families – including children – of those experiencing mental health problems.

Implications

When faced with the scale of the challenge the response can be daunting. This is especially so at a time when we see increasing poverty and socioeconomic inequalities within our society and challenging political conditions. The complexity and enduring nature of the problems necessitate a multilevel response from psychiatry across practice, policy, advocacy and research, which we explore in this section. We argue that this response should address three broad areas.

Reinvigorate social psychiatry and influence public policy

The demise of social psychiatry in the UK and USA in recent decades has deflected focus away from the social causes and consequences of mental health problems at the very time that social inequalities have been increasing. Now is the time to renew social psychiatry at professional and academic levels. There is considerable scope to form alliances with other areas – especially public mental health agencies and charities. Psychiatry as a profession should support those advocating for progressive public policies to reduce poverty and its impact. If we do not, then, as Phelan and colleagues outline, we will focus only on the intermediate causes of health inequalities, rather than the fundamental causes, and this will ensure that these inequalities persist and are reproduced over time.³³ Activism with those who have consistently highlighted the links between poverty and mental health problems, such as The Equality Trust, may effect change among policy makers.

Tackle intersectional stigma and disadvantage

We must understand, research and tackle stigma in a much more sophisticated way by recognising that mental health stigma does not sit in isolation. We need to understand and address what Turan and colleagues define as intersectional stigma.³⁴ Intersectional stigma explains the convergence of multiple stigmatised identities that can include ethnicity, gender, sexuality, poverty and health status. This can then magnify the impact on the person's life. In this context, the reality is that you have a much greater chance of getting a mental health problem if you experience poverty. And if you do, then you will likely experience more stigma and discrimination. Its impact on your life will be greater, for example on precarious employment, housing, education and finances. It is harder to recover and the impact on family members may be magnified. Intersectional stigma remains poorly researched and understood,³⁵ although the health impact of poverty stigma is now emerging as an important issue in studies in Glasgow and elsewhere.²⁵

Embed poverty-aware practice and commissioning

We conclude with our third idea, to ensure that poverty-aware practice is embedded in services through commissioning, training and teaching. This means that recognising and responding to poverty is part of assessments and care. Income maximisation schemes should be available as an important dimension of healthcare: how to access benefits, manage debt, access local childcare and access support for employment at the earliest stages. This needs to be matched by a major investment in mental health services focused on low-income areas, to address the inverse care law.³⁶ These principles are already being put into action. For example across Scotland, including Glasgow, several general practices working in the most deprived areas (referred to as Deep End practices) have recently trialled the integration of money advice workers within primary care, which has generated considerable financial gains for patients.³⁷

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Both authors were fully and equally involved in the design of the article, drafting the article and making revisions to the final version and are accountable for the integrity of the work.

Declaration of interest

None.

Supplementary material

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1.3.26 The one, the few and the many

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Abstract

Inequality is a significant and reversible risk factor for mental disorders which demonstrates the essentially political nature of psychiatry. The *BJPsych Bulletin* is pleased to make space for those at the frontline of this inequality. Two experts by experience explain how financial concerns exacerbated their distress and the benefit of social interventions.

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 - Nikita Egan, *Expert by Experience, Equally Well UK*
 - Ben Russell, *Expert by Experience, Equally Well UK*
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Psychiatry's great appeal is also its Achilles' heel. It embraces a multitude of perspectives which can appear mutually incompatible, drawing accusations of vagueness and incoherence. This themed edition of the *BJPsych Bulletin* will, I hope, demonstrate that such criticisms are wrongheaded. It has been a pleasure to work with Peter Byrne to produce this edition on inequality, a recognised but still under-appreciated driver of mental illness about which he is passionate and persuasive. Although epidemiological studies can feel rather detached or aloof, they have identified some of the most significant and well-replicated risks for developing mental disorder, something that cannot be said for the majority of experiments in neuroscience, despite its glossy allure. Nevertheless, accommodating psychiatry's various perspectives involves somehow tethering known risk factors to plausible biological mechanisms, whether one considers the suffering a disorder or not. For clinicians, it is the individual patient who must be the focus, but too often our concern with odds ratios and objective data can come across as alienating. These different and incommensurate levels of analysis remind me of the various forms of government – by the one, the few or the many – and that psychiatry is inextricably political. Inequality is a reversible cause of mental disorder, and inequality is a political choice. If doctors find it hard to be heard in the political realm, how much harder must it be for those who suffer the consequences of inequality? I am especially pleased to include in this article contributions from two experts by experience, Nikita Egan and Ben Russell, both from

Equally Well UK (<https://equallywell.co.uk/>), a collaborative – led by Centre for Mental Health in partnership with Rethink Mental Illness – that champions parity of esteem. Their moving accounts of illness and alienation underscore why we do what we do and, I hope, establish the Bulletin's increased focus on co-production and, in our own small way, sharing the levers of power. Over to you, Nikita and Ben.

Nikita Egan, Expert by Experience, Equally Well UK

'We as a species are not very good at asking for help. In doing so, we are admitting, to ourselves at least, that we aren't as independent as we might have hoped – that we're fallible. If we consider this natural discomfort felt when asking for help, is it any wonder that applying for benefits such as UC [universal credit] and PIP [personal independence payment] can often seem like a humiliating ordeal?

'It was a previous CPN [community psychiatric nurse] who advised me to apply for PIP, stating that I shouldn't see it as a benefit, but more to put me on an equal playing field with my peers who didn't face a daily struggle with their mental health. When the form did arrive it seemed condescending, but also forced me to look inwards to my own daily difficulties. When the form was complete, I asked my CPN to read it. Did she think I'd exaggerated? Did she not really think I should apply? Thoughts like this were a daily monologue in my head, but having read horror stories from other applicants, I didn't hold out much hope anyway. Being awarded the higher rate for daily living and lower for mobility was such a contradictory feeling, especially as I didn't have a face-to-face assessment. Is this my life now, living on benefits? Accepting handouts?

'The time to apply for UC didn't arrive until 2018 when my marriage ended. I had nothing except my PIP and no choice but to apply online for UC. In my head all I could think of was 'going on the dole'. As I filled in my disability, details of the emotions of the PIP application process came flooding back.

'The face-to-face assessment was terrifying, especially finding out that my date and time were the same as the letter given to 12 other people. The paranoia was terrible, and so many obscure ideas ran through my mind. I began to panic as I scanned the room; everyone else seemed to have a physical impairment. As it turned out the assessment was with a compassionate nurse. My form and records had been checked; I just had to confirm some details and give a copy of my prescription.

'PIP and UC – based on the decision that I have limited capacity to undertake paid work – allow me to pay my rent and bills, and also to enjoy an albeit thrifty life with my children. Many others are not as lucky, and don't have the support to make and endure application processes.

'Personally, I don't think of myself as living on benefits. I think of myself as living, however I can.'

Ben Russell, Expert by Experience, Equally Well UK

'It's difficult to focus cause I'm being harangued from all sides. I run from room to room to escape, but they follow me. I turn around suddenly, hoping to catch them in the act, but there's no one else there. I am alone. I realise, all of a sudden, that I'm ill again. I hear a hissing sound and spin around and see a fox standing there with blood-red eyes and its hackles raised. I scream and *run* to the next room, but the fox is already in there. In fact, it's in every room I run to waiting for me. It's difficult because knowing I'm ill doesn't stop me being ill. I go into town hoping that the fresh air will do me good, but there are people following me. If they catch me, they'll do experiments on me, so I run back to my flat and lock the door behind me. I don't know how long I've been ill for, but there's a mound of envelopes in my letterbox. More than likely bills. But I can't function, let alone pay them. I also don't remember the last time I ate. Nothing makes sense.

'I've also not been paying my bills. The mortgage company send me threatening letters, as do the council. I'm also unable to work. My phone is vibrating on the coffee table. There're seven missed calls. I answer warily, ready to be berated some more. It's my nurse. She says that she's been trying to contact me for days. I tell her that I'm not right in the head. An indeterminable amount of time passes before my nurse comes to my flat. She says that I need to be in hospital, but I'm worried about my flat. I get personal independence payments, but they're not enough to cover my mortgage. I was working as a hod carrier, but then I became unwell with my mental health and no longer have a job. My nurse is insistent anyway. I go to hospital. On the ward, my family are contacted. They arrange to help pay my

bills, which is the luckiest thing, because I was about to lose my flat. The important thing, they said, was getting well. And so many people in my position don't have that chance. The crisis team also help me get in touch with my creditors and arrange payment plans.'

Many thanks to Nikita Egan and Ben Russell for agreeing to share their experiences. Their contributions are invaluable.

Norman A. Poole is Editor of the *BJPsych Bulletin* and a consultant neuropsychiatrist at St George's Hospital, South West London and St George's Mental Health NHS Trust, UK.

Declaration of interest

None.

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1.3.27 Freda E. Martin, MD, FRCPsych, FRCPsych (Canada)

Dora Black

date

2020-10

Contents

- *Freda E. Martin, MD, FRCPsych, FRCPsych (Canada)*

Formerly Chair, Department for Children and Parents, Tavistock Clinic, London, and Executive Director, CM Hincks Treatment Centre, Toronto, Canada

Freda Martin, who died in Toronto on 2 August 2019 at the age of 87, was one of the early pioneers of family therapy, first in the UK and then in Canada. In 1962, while working at the Tavistock Clinic, London, in collaboration with Janet Knight, she published an important paper describing the assessment of disturbed children involving the whole family.¹ At that time, the standard assessment of such children involved the mother being seen by a social worker, while the child saw the psychiatrist. Fathers were either not seen at all or seen usually on only one occasion with the mother. Freda Martin, with Rosemary Whiffen and John Byng-Hall, influenced both by John Bowlby and the family therapy movement in the USA, was able to demonstrate how not just assessing but treating the whole family as a unit often illuminated the family dynamics in a manner impossible to achieve when family members were seen individually.

Freda came to the Tavistock Clinic with an unusual background. Arriving there in 1960 as the first psychiatrist with a Jungian, rather than a Kleinian, analytic training, she was not aligned with the existing predominantly psychoanalytic factions. This enabled her to be eclectic in her clinical work and to espouse her belief in the importance of multidisciplinary teamwork, involving psychiatrists, psychologists, social workers and psychotherapists.

Initially, she met much hostility at the Tavistock Clinic from those who found it difficult to accept that an analyst could embrace such views. She persisted, first as one of a number of colleagues and later as Chair of the Department for Children and Parents.

In 1975, she returned to Canada, eventually becoming Executive Director of the CM Hincks Treatment Centre in Toronto. Here she was able to introduce clinical approaches derived from attachment theory. According to a colleague, she brought to Canada the importance of early intervention to promote physical and emotional well-being in all children, as well as her belief in the importance of postgraduate training for all disciplines, which she regarded as equally necessary for helping children and families. Today these ideas are accepted and practised, even in centres formerly devoted to only one treatment mode for disturbed children.

She initiated postgraduate multidisciplinary training and research into what previously had been a purely clinical setting. The renamed Hincks Dellcrest Centre Gail Appel Institute, now part of the Hospital for Sick Children, Toronto, came into being in 1986. It required new, expanded premises. Freda Martin persuaded the Board to construct a seven-floor building on the clinic car park. It was opened by John Bowlby.

She continued to develop new approaches to treatment applying them, for example, to the successful treatment of anorexia in adolescents. In a seminal paper published in 1990,² she described what she called ‘run-away’ effects at various systemic levels (physiological, individual, family, social), which triggered dieting behaviour in perfectionistic personalities.

Creating a link with the University of Toronto, where she was an assistant professor, enabled her to create fellowships to train social workers and psychologists, educators and psychotherapists in family therapy and infant mental health.

Freda Martin (née McQueen) was born in Niagara Falls, Canada, on 11 April 1932 to Andrew, an engineer, and Lily. She studied medicine at the University of Toronto Medical School, qualifying in 1956. In 1959, she came to the Maudsley Hospital, London, for postgraduate psychiatric training. She was appointed a senior registrar at the Tavistock Clinic in 1960, shortly afterwards becoming a consultant and then Chair of the Department for Children and Parents.

Freda met her husband Kenneth Martin, an adult psychiatrist who worked mainly in private practice, at the Maudsley. They had two children. Freda and her family loved to relax in the family ‘cottage’ by Devil Lake, where they sailed, canoed and entertained friends.

After leaving her full-time post in 2005, Martin became involved in advising the provincial and federal governments about the importance of teaching parents and educators about early physical and emotional development. She set up and evaluated 3-year ‘learning through play’ courses all over Canada. Later, she worked in Jamaica and Latvia with senior professionals using this material to train parents, carers and nursery staff. These activities were funded by the Canadian International Development Agency. After full retirement, she took singing lessons and enjoyed singing in a choir. Very recently she helped children to read as well as reading to fellow residents in her retirement home.

Freda is described by family members and her many devoted colleagues as outstandingly creative, decisive, forthright and brisk. She was not afraid to speak her mind, although she was always regarded as kind and supportive to staff and students.

The daughter of a close friend described her as a ‘bullshit detector’. When this same friend was terminally ill, Freda, in the words of her friend’s daughter, ‘enabled mum to articulate and process her own death’, with support and love, helping the family in their grief.

Kenneth died in 2012. Freda is survived by her two children, Andrew and Peter, as well as by two grandchildren.

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1.3.28 Are UK care homes ready for the telemedicine revolution?

Meta McGee Claire Potter Joseph Kane

date

2020-10

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 - *Declaration of interest*

The restrictions implemented by coronavirus disease 2019 (COVID-19) have reawakened discussion surrounding the use of telemedicine in routine clinical practice.¹ Nursing home residents have emerged as a particularly vulnerable group, not only with respect to the virus itself, but to the effects of social distancing² and disruption to the services in place to support them. In working to stop the spread of COVID-19 within their facilities, many homes have found it difficult to sustain the non-pharmacological mainstays of management of delirium and behavioural and psychological symptoms of dementia.² Telemedicine, a proposed solution to these difficulties, has been demonstrated to be both valid and acceptable to patients with dementia and care home staff³ but it does not appear to be part of routine practice in the UK.⁴

We therefore aimed to determine nursing homes' capacity and enthusiasm for telepsychiatry assessments. Over a 2-week period in June 2020, we contacted senior staff at the 70 nursing and 'elderly mentally infirm' homes falling within the Belfast Health & Social Care catchment area and administered a short survey via telephone. Two questions; 'how would you rate your facilities' current capacity to participate in mental health assessments via video link?' and 'how interested would you be in establishing the capacity to participate in mental health assessments via video link?', were answered using a five-point Likert scale.

Participating nursing homes (56/70; 80%) reported that reliable WiFi connections and appropriate equipment (such as a tablet device, or desktop or laptop computer with webcam) were available in 41/56 (73%) and 40/56 (71%) facilities, respectively. Staff at 21/56 (38%) reported that they already felt they had the capacity to facilitate such consultations (answering '5' on the Likert scale); 16/56 (29%) felt they had little (5/56; 9%) or no capacity (11/56: 20%) to currently do so. Nursing home staff answering '3' (10/56; 18%) or '4' (9/56; 16%) on the Likert scale indicated some capacity to participate in remote consultations, although they felt they would not be able to do so on a routine basis. Respondents were 'very interested' in establishing capacity to use remote consultations in 44/56 (79%) of surveys.

Most nursing homes possess the appropriate equipment to facilitate telemedicine, and the majority (84%) demonstrate an enthusiasm for doing so. The failure to adopt telepsychiatry may therefore be more closely related to factors within mental health services, such as our access to appropriate equipment, than those within nursing homes. A survey of American psychiatrists working in nursing homes reported widespread support for telemedicine, but only 13% felt they had access to appropriate equipment.⁵ It would appear, however, that obstacles to telemedicine go beyond hardware; in spite of most respondents' access to equipment, we observed considerable variation in their perceived capacity to engage with remote consultations, perhaps suggesting a lack of comfort or familiarity with the medium. We suggest that before telemedicine becomes part of, as has been suggested, 'the new normal', that more detailed exploration is conducted regarding the attitudes and skills of professionals on both sides of the webcam.

Declaration of interest

none.

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1.3.29 The affective neuroscience of socioeconomic status: implications for mental health

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Abstract

We review basic science research on neural mechanisms underlying emotional processing in individuals of differing socioeconomic status (SES). We summarise SES differences in response to positive and negative stimuli in limbic and cortical regions associated with emotion and emotion regulation. We discuss the possible relevance of neuroscience to understanding the link between mental health and SES. We hope to provide insights into future neuroscience research on the etiology and pathophysiology of mental disorders relating to SES.

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- *The affective neuroscience of socioeconomic status: implications for mental health*
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Low socioeconomic status (SES) is a potent risk factor for mental disorders, particularly mood and anxiety disorders.^{1–3} Life's challenges weigh more heavily on people with fewer financial resources and less education, and the impact of

SES on emotional well-being is substantial. For example, Guhn et al⁴ found an adjusted odds ratio for mental health conditions 25–39% higher for children of low-income families compared with others. A Canadian government survey⁵ found that disabling mental health problems are twice as common among those without a high school diploma compared with college graduates.

In this article we review what is known about the affective neuroscience of SES and sketch some of the implications this field of science might have for mental health. We begin with basic definitions and distinctions. ‘Affective neuroscience’ is the study of neural mechanisms underlying the experience, expression and regulation of emotion. Given that the brain is shaped by a combination of genes and environment, explanations in terms of the brain and the environment are not mutually exclusive. SES is a complex construct, or more accurately an interrelated set of constructs, that captures differences in material and social wherewithal. It has been measured in terms of financial attributes (e.g. income, wealth), neighbourhood characteristics (e.g. rates of unemployment and crime near one’s home), educational and occupational background and self-reported social standing, among other approaches. Although these measures are all distinct from one another,⁶ they are normally moderately correlated.⁷ Here we will seek broad generalisations within this relatively small literature, referring therefore to SES in general rather than making distinctions among more specific measures. Similarly, we will generalise across life stages at which participants’ SES was measured. All of these distinctions undoubtedly have scientific and clinical relevance, which should also be examined. Nevertheless, for a preliminary review, we choose to begin by aggregating findings as much as possible.

Many useful insights into the aetiology and pathophysiology of mental disorders have come by studying the brain. Here we explore the possible relevance of neuroscience to understanding the link between mental health and SES. Recent attempts to link SES and psychopathology through the brain have adopted different concepts from psychology and neuroscience as explanatory frameworks. These include the effects of stress on the brain,⁸ the role of self-regulation in mental health⁹ and the distinction between adversities consisting primarily of deprivation (prevalent in low SES) and those consisting primarily of threat (such as accompanies abuse¹⁰). These frameworks are not mutually exclusive, and the goal of our review is neither to adjudicate between them nor to develop a fourth alternative. Rather, we aim to gather the most comprehensive collection to date of research findings related to SES, brain and affect, and attempt a provisional integration that will enable empirical generalisations and highlight consistencies and inconsistencies.

The neuroscience studies reviewed here are basic science research, carried out with normal people of varying SES. Note that in some studies SES is not the focus of the study but included as a covariate. In some of these cases the range of SES is restricted and the power to detect SES effects is therefore attenuated. *Figure 1* depicts the systematic review process. *Fig. 1* Flowchart for the systematic review. Relevant studies were identified through searches of the database PubMed throughout 13 March 2020. The search required that studies used at least one of the following socioeconomic status (SES) keywords in the full paper: socioeconomic status, poverty, income, neighbourhood quality, neighbourhood disadvantage, educational attainment, social class, social standing. Identified studies also used at least one of the following social and affect-related keywords in the entire paper: emotion, threat, fear, angry, sad, happy, reward, social interaction, hostility, rejection. In addition, the keyword of neuroimaging method was included: fMRI. This search identified 166 results, which were screened for the inclusion criteria.

The resulting functional magnetic resonance imaging (fMRI) studies manipulated emotional states experimentally inside the scanner with emotionally evocative stimuli or tasks. The most common methods involve photographs of faces expressing different emotions or of affectively valenced objects and scenes, and signals that money has been won or lost in a game. Less frequently, studies have used other kinds of stimuli or experiences to evoke emotion and these will also be described.

Subcortical and cortical bases of negative affect

Textbook coverage of affective neuroscience invariably begins with subcortical systems, particularly the amygdala and ventral striatum. These appear to respond automatically, without the need for conscious awareness of the emotion (e.g.^{11,12}), and play crucial roles in the experience and expression of emotion. Many other regions, cortical and subcortical, also participate in emotion and there is no simple mapping of specific emotions to specific brain areas.¹³ Emotion is best thought of as a construction of the brain as a whole.¹⁴ Nevertheless, many studies take the amygdala as a starting point in the investigation of emotion and the brain, especially negative emotion.

Brain responses to negative facial emotions

Although the amygdala plays a role in a range of emotions, its most consistent role is in negative emotions. The amygdala is most readily activated by viewing facial expressions of fear and anger. Our review identified a substantial number of studies that have compared low- and high-SES individuals under these experimental conditions. In the majority of studies, lower SES by at least one measure was associated with stronger amygdala reactivity to negative facial emotions. Young adults whose parents were of lower SES showed greater amygdala activation when viewing angry faces compared with control conditions in two studies.^{15,16} In another study, negative facial expressions elicited greater amygdala reactivity for young adults from lower-SES families, taking into account parenting quality and maternal mental health.¹⁷ Emotional faces more generally evoked greater right amygdala activation in adults of lower SES.¹⁸ The same study showed that SES was associated with strength of coupling between right amygdala and right insula.¹⁸ In a study of first-time mothers viewing the faces of either happy or distressed infants, the right amygdala was more active to depictions of distress in mothers of lower SES.¹⁹

Three other studies yielded partial support for a relationship between amygdala reactivity to negative facial emotions and SES. The support from these findings was qualified by participant gender in one case (only for women²⁰), ethnicity of depicted face in another (only for Black emotional faces in a study with Mexican American participants²¹) and history of violence exposure in a third (only in non-exposed participants²²). In only one study testing the relationship between amygdala reactivity and SES was a significant relationship not found, and this study had relatively little variance in SES among the participants (all were recruited through an antipoverty programme²³). Finally, in a memory study with emotional faces as retrieval cues, testing the hippocampus as a region of interest (ROI), there was less activity in the posterior hippocampus in lower-SES individuals when they watched angry faces.²⁴

Brain responses to other negative stimuli

Apart from facial emotional cues, other stimuli that have been used to evoke negative emotions include unpleasant sounds, social rejection and loss of money. In one study unpleasantly loud auditory stimuli were used to evoke emotional states in participants of varying SES, violence exposure and ethnicity, generally with a warning tone but occasionally without.²⁵ When trials without a warning cue were considered, family income was negatively associated with hippocampal activity, consistent with greater effect of unexpected negative stimuli with lower SES. SES showed the opposite effect with cued noise, with higher neighbourhood deprivation (i.e. lower SES) showing lower activity in the hippocampi and amygdalae, perhaps related to reduced preparatory regulatory effects.

Two studies have used the sound of babies crying, contrasted with white noise, with participants of varying SES. The crying was rated as more annoying,²⁶ but effect of SES on neural response to the cry in non-parent adults was complex and difficult to interpret; there was generally more activation in the insula and several other regions in women from low-SES backgrounds, with the opposite pattern in men. Another study of mothers hearing baby cries found less activation associated with lower SES in frontal and temporal cortical regions, but differences in classic emotion-related areas were not found.²⁷ Although baby cries communicate urgency and distress, they may function less as generic signals of threat or harm and more as triggers for complex, evolved systems of parenting behaviour.²⁸

Social rejection is another kind of experience that evokes negative emotion. The so-called ‘social pain’ that results from rejection is not typically associated with amygdala activity, but has a more distinctive functional anatomy including the dorsal and ventral anterior cingulate, anterior insula and also the ventromedial prefrontal cortex (vmPFC) and orbital

cortex regions (see meta-analyses^{29–31}). Gonzalez et al³² assessed responses to exclusion in the classic ‘cyberball’ rejection task in young adults of varying neighbourhood SES, and tested whether SES was associated with dorsal anterior cingulate cortex (dACC) and insula responses. The insula was not reliably activated by exclusion in this study overall, nor as a function of SES, but lower SES was associated with a larger dACC response. Related to social rejection is negative social evaluation. Muscatell et al³³ had participants read negative versus neutral or positive personal assessments of their performance in an interview, and *a priori* regions of interest were the dorsomedial prefrontal cortex (dmPFC) and amygdala. Although amygdala activity did not differ with subjective social status (and it was not stated whether the task evoked amygdala activity in this condition for participants in general), dmPFC activity was evoked by negative evaluations and was higher in lower-SES participants.

Finally, the aversive experience of losing money, a secondary reinforcer, which differs in some ways from primary aversive stimuli such as pain,³⁴ has been assessed during fMRI in two studies with participants of varying SES, neither of which found effects of SES.^{35,36}

Summary

There is a trend, across various forms of negative emotional state, for lower-SES individuals to have more brain activity in at least some emotion-related areas. This includes evidence from tasks using emotional facial expressions, loud noises and social rejection. This generalisation, although reasonably broad, does not extend to all of the literature. In particular, two studies using infant cry sounds show SES effects, but these effects are complex and cannot be interpreted as simply more activity in emotion-related areas, and two studies of monetary loss failed to show effects of SES at all.

Subcortical and cortical bases of positive affect

The anatomy of positive affect overlaps with some of the areas mentioned above in connection with negative affect, consistent with the complex, emergent nature of emotion in the brain. Studies of positive affect use depictions of happy faces and scenes and the occurrence of desirable outcomes such as the winning of money or points in games. The region most often associated with positive affect is the ventral striatum, which consists primarily of the nucleus accumbens and part of the caudate nucleus, although other cortical regions are also engaged, including the medial and orbital frontal cortex, cingulate cortex and anterior insula.³⁷

The literature on the neural correlates of positive emotion and SES is relatively small. One study, already mentioned in connection with negative emotion, is also relevant to positive emotion. In this study, mothers viewed happy as well as unhappy baby faces, and some of the areas activated by the happy faces, including the left amygdala and the right insula, differed by SES and specifically were less active in the lower-SES mothers.¹⁹

Silverman et al³⁸ exposed participants to affectively valenced pictures of people, objects and scenes and contrasted neural responses to positive images (e.g. an amusement park) relative to neutral images (e.g. furniture). They found lower activity in response to the happy pictures in lower-SES participants in a variety of areas, including the striatum.

Other studies have induced positive emotional states with monetary gains during simple games. The focus of most studies on SES and reward has been on reward anticipation, rather than the receipt of the reward itself. Reward anticipation is a motivational state sometimes associated with ‘wanting’, in contrast to the response of ‘liking’.³⁹ Response to receipt of a reward has either not been shown to differ by SES^{35,40} or the study design has not allowed reward receipt to be examined separate from reward anticipation because of block rather than event-related design.³⁶ In contrast, reward anticipation generally evokes more activity for lower-SES participants. Romens et al⁴⁰ found heightened response to the anticipation of reward in medial prefrontal cortex (mPFC) in lower-SES girls, and no locations of reduced response. Gonzalez et al⁴¹ found a similar relationship in striatal and other regions. Quevedo et al³⁵ covaried SES in a study of the effect of attachment style on reward, and although the range of SES was relatively narrow, they found that maternal unemployment and lower family income during childhood were associated with higher striatal activity and amygdala activity respectively, during reward anticipation. When anticipating a larger but lower-probability reward, lower-SES adolescents show more mPFC activation.⁴²

Summary

Positive stimuli may evoke smaller responses in people of lower SES, although the evidence is limited, while reward anticipation may be accompanied by greater activation.

Networks for emotion and emotion regulation

Emotion regulation refers to self-induced changes in intensity and duration of emotional experience, typically for the purpose of reducing negative experience. These changes can be accomplished by either conscious, explicit strategies or automatic, implicit processes.⁴³ One of the most effective explicit emotion regulation strategies is cognitive reappraisal, by which we volitionally reinterpret the meaning of stimuli in order to alleviate negative feelings. A recent review suggests that explicit emotion regulation engages the dorsolateral, ventrolateral and dorsomedial frontal and parietal cortex.⁴⁴ Kim et al⁴⁵ showed disturbing pictures to participants of varying SES and instructed them to reduce negative emotion through cognitive reappraisal, for example viewing a picture of a bruised and beaten woman and reappraising it as a picture of an actress playing the role of a violence victim. They found that individuals of low SES recruited less prefrontal activation than their higher-SES counterparts and showed less reduction in amygdala activity during reappraisal, consistent with this emotion regulation strategy being used less effectively by these participants. However, gender seems to moderate the effect of SES on prefrontal activity related to emotion regulation:²⁰ in males but not females when considered separately, activation in dorsolateral and ventrolateral prefrontal cortical regions (dlPFC and vlPFC) during cognitive reappraisal was positively correlated with SES.

Another form of emotion regulation is implicit, involuntary emotion regulation, which does not require effortful use of a strategy or conscious monitoring of emotional state, but is simply evoked automatically.⁴⁶ Implicit emotion regulation is omnipresent in our encounters with emotional stimuli, with ventral ACC and vmPFC engaging automatically to modulate subcortical activity.⁴⁴ By its nature, implicit regulation is not carried out following instructions, so it can be difficult to determine in any given task whether these ventral anterior activations represent regulatory activity. In any case, less functional coupling between the amygdala and vmPFC has been found in low-SES individuals when processing negative emotion.⁴⁷ In the same intensively studied group of participants (see also^{20,45,47}), Liberzon and colleagues⁴⁸ found less prefrontal activity in lower-SES participants in a task designed to evoke implicit emotion regulation, although in this task the finding was localised to lateral rather than medial regions.

Studies of participants at rest provide additional evidence concerning limbic–cortical interactions. Functional connectivity between the amygdala and the vmPFC was found to be weaker in participants of lower SES, and this difference in brain activity accounted for SES disparities in vulnerability to stressful life events.⁴⁹ Connectivity of the amygdala and hippocampus to prefrontal regions was also reduced in lower-SES children, and these differences fully mediated the relationship between SES and later depression.⁵⁰ Finally, connectivity between the ventral striatum and ventral PFC is reduced in low SES, and this fully mediated the relationship between SES and anxiety.⁵¹

Conclusions

We offer this preliminary review of the literature as a starting point, to be refined as the literature grows and our understanding of SES and affective neuroscience advances. It is limited in part by the small size of the literature. Our search method uncovered only 27 studies, and many of these involved small samples ($n < 50$ for half of the studies) or a restricted range of SES. In addition, affect and SES are both complex constructs, and each has been operationalised in numerous different ways in the studies reviewed here. Is it sensible to group the sight of a frightened face, the sound of a crying baby and the loss of small sums of money into a common category of ‘negative emotion?’ We did so here provisionally, to help organise our review at a very general level, recognising that important differences may be glossed over. The studies reported here were also heterogeneous in terms of participants’ ages. Finally, the studies measured SES in different ways, for example in childhood or adulthood, and according to income, educational attainment or neighbourhood deprivation. In attempting this first broad review of SES and the neural bases of emotion, we do not distinguish between different measures of SES, and we report findings as positive if any measure of SES shows a statistically significant effect.

For the reasons just mentioned, any conclusions from this review must be considered very provisional. Nevertheless, some trends can be discerned, and these may be relevant to the SES gradient in mood and anxiety disorders. Socioeconomic disadvantage shapes the brain's response to emotional stimuli, such that negative stimuli appear to evoke a stronger response and positive stimuli may possibly evoke a weaker response. This amounts to an overall bias towards the negative and away from the positive for lower SES, which would be expected to indicate a greater susceptibility among low-SES individuals to depression and anxiety. In contrast, anticipation of reward appears to evoke more activity in people of lower SES, which in one study mediated the relationship between socioeconomic disadvantage and adolescent depression symptoms.⁴⁰ Greater reactivity to the promise of reward may contribute to disorders of impulse control.⁵² Finally, in at least a few studies functional networks that may serve to regulate emotion are weaker in people of lower SES, and these differences too have been found to mediate risk for psychopathology.

Given the disproportionate mental health burden borne by those of low SES, it makes sense to deploy the full range of approaches to understanding and addressing this inequity, from the sociological to the neuroscientific. High priorities for future research will be to expand the evidentiary base relating SES, brain function and psychological symptoms, and to establish how social and economic factors external to the individual may give rise to the neural and psychological vulnerabilities reviewed here. In aiming to understand the interrelations among psychology, biology and social context, it should be possible for mental health and well-being to be more widely enjoyed throughout society.

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Literature reviewed and interpreted by both authors; first draft written by Y.H.; revisions by both authors.

Declaration of interest

None.

Supplementary material

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1.3.30 Mental health, smoking and poverty: benefits of supporting smokers to quit

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Abstract

Smoking rates among people with common mental health conditions remain around 50% higher than those in the wider population; this is a significant cause of the 10–20-year reduced life expectancy of

people with mental health conditions. However, the effects of smoking go far beyond physical health. Research estimates that smokers with mental health conditions could be spending as much as £2200 a year on tobacco, pushing an estimated 130 000 people with a common mental disorder into poverty. The Government has set a target for England to be smokefree by 2030; however, without a dramatic increase in support, smokers with mental health conditions risk being left behind. Action on Smoking and Health provides the secretariat for the Mental Health & Smoking Partnership. The Partnership aims to reduce the inequality in smoking rates between people with mental health conditions and the wider population. It brings together Royal Colleges, third-sector organisations, trade unions and academia to review progress and highlight areas for further action.

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 - *Supplementary material*

The challenge

People with mental health conditions die on average 10–20 years earlier than individuals in the wider population.¹ High smoking rates are one of the key reasons for this health inequality.² Smoking rates remained largely static among people with mental health conditions during the 20 years from 1993 to 2013, at around 40%.³ Although new figures suggest that this prevalence is starting to decline, smoking rates among people with common mental health conditions remain around 50% higher than those in the wider population.^{4,5}

However, the effects of smoking go far beyond reduced life expectancy; it influences employment prospects,⁶ reduces earnings,⁶ increases care needs⁷ and causes poverty.⁸ Higher smoking rates are associated with every indicator of disadvantage, but most adult smokers want to quit.⁹ Smokers with mental health conditions are aware of the risks to people around them from second-hand smoke and see this as a motivator to quit; clinicians must offer support to enable them to do so.

The challenge of The Mental Health and Smoking Partnership is to help tackle these inequalities.¹⁰ The Partnership was established in 2016 following publication of *The Stolen Years: The Mental Health and Smoking Action Report* by Action on Smoking and Health (ASH), with the ambition of reducing smoking prevalence to 5% or less among people with mental health conditions.¹¹ The report sets out the sector-wide action needed to reduce smoking rates among people with mental health conditions, from reviewing the training of the mental health workforce to building the research base on peer support and expert-by-experience-led interventions.

Three years on, the Government has published the Tobacco Control Plan for England,¹² NHS Long Term Plan¹³ and Prevention Green Paper,¹⁴ committing to reducing smoking prevalence among people with mental health conditions.

However, change is not happening quickly enough. The recent Green Paper *Advancing our Health: Prevention in the 2020s* sets an ambition to end smoking in England by 2030, defined as a prevalence of 5% or less.¹⁴ To achieve this, using the latest publicly available data,¹⁵ it is estimated that the annual rate of decline from 2014–2030 among people with mental health conditions needs to be an ambitious 1.82 percentage points a year, more than double the previous rate of decline. Unless we dramatically increase the support available, this target will not be met, and people with mental health conditions will be left behind.

Tobacco, health and poverty

In his landmark 2010 report, *Fair Society, Healthy Lives*, Michael Marmot made clear the moral dimension of tackling health inequalities: ‘Inequalities are a matter of life and death, of health and sickness, of well-being and misery. The fact that in England today people from different socioeconomic groups experience avoidable differences in health, well-being and length of life is, quite simply, unfair and unacceptable’.¹⁶

Half of all lifetime smokers will die from their addiction, that is, more than 96 000 people every year in the UK. For every smoker who dies, an estimated 30 others will be living with smoking-related diseases.¹⁷ This should be reason enough to act.

However, there are also short-term, immediate benefits to quitting smoking. Smoking decreases disposable income (defined as household income after tax and National Insurance contributions), which can be returned to the household when smokers quit. Smokers in social housing spend, on average, 14.6% of their disposable income on tobacco, compared with 6.9% among owner occupiers and 5.8% of those living in privately rented accommodation.¹⁸ This has substantial economic consequences, with more than 1 million people – including 263 000 children – living in poverty as a direct result of income lost to expenditure on tobacco. The proportion of social housing tenants living in poverty increases from around a quarter (28.3%) to two in five (42.8%) once the costs of smoking are considered.⁸

Research commissioned by ASH and Public Health England has shown the extent to which people with mental health conditions are economically disadvantaged due to smoking.¹⁹ Higher rates of smoking are found among people with a mental health condition living in poverty (*Table 1*). Looking at the number of cigarettes smoked and taking into account purchases of illicit and cheap tobacco, researchers estimate that smokers in poverty spend an average of around £1200 a year on smoking, at 2015 prices.¹⁹ However, adjusting for underreporting of the amount of tobacco smoked, smokers with a mental health condition below the poverty line could be spending over £2200 a year on tobacco.¹⁹ *Table 1* Smoking prevalence according to mental health disorder and poverty¹⁹ Type of disorder reported Smoking prevalence in whole population Smoking prevalence among those in poverty Common mental disorder 34% 46% Currently taking psychoactive medication 34% 46% Longstanding mental disorder 40% 52%

Using the conservative estimate of £1200, researchers estimate that around 130 000 people with a mental health condition are pushed into poverty by expenditure on tobacco. *Table 2* shows a breakdown of smokers with common mental disorders, those taking psychoactive medications and those with longstanding mental disorders across the UK, who are pushed into poverty by expenditure on tobacco.¹⁹ *Table 2* Population estimates of the number of UK adults with a mental disorder who are in poverty and who smoke, and who are drawn into poverty by their expenditure on smoking¹⁹ Common mental disorder (CIS-R score >12) Currently taking psychoactive medications Longstanding mental disorder Smokers with disorder who are in poverty a Smokers with disorder who are in poverty b Numbers with disorder drawn into poverty by smoking a Smokers with disorder who are in poverty a Smokers with disorder who are in poverty b Numbers with disorder drawn into poverty by smoking a UK 1 217 733 904 647 135 304 553 801 405 28 255 38 071 110 425 420 100 062 England 1 021 983 759 225 113 554 464 778 340 133 46 478 601 835 357 034 83 977 Scotland 103 011 76 527 11 446 64 848 34 284 46 856 66 235 98 784 64 Wales 58 913 43 767 65 462 6 793 19 607 26 793 4 694 20 582 48 41 North-

ern Ireland³³ 82525 128375815 38311 257153819 91911 8172779¹²³

The effects of expenditure on tobacco are compounded by lower earnings among smokers in employment, with non-smokers earning on average 6.8% more than smokers. Smokers are also significantly less likely to be in employment than never-smokers. Long-term smokers are 7.5% less likely to be in employment than never-smokers.

People with mental health conditions are more likely to be unemployed, to receive benefits and to be living in relative poverty than those without mental health conditions.^{2,20} It is well documented that debt and financial stress can exacerbate mental ill health and that people with mental health conditions are more likely to experience debt problems.²¹ The interactions between smoking, poverty, debt and mental health suggested by these studies are important reasons to support smokers to quit.

Effects on mental health

Further motivation to support smokers with mental health conditions to quit comes from the positive influence this can have on mental health. Quitting smoking is associated with reduced depression, anxiety and stress, as well as improved positive mood and quality of life compared with continuing to smoke.²² For some people with mental health conditions, smoking can feel like ‘self-medicating’, and people say that it is an important way for them to deal with stress. However, this relief is temporary, linked to relieving withdrawal from nicotine and in the long term it can exacerbate symptoms.²³ The effect of smoking cessation on anxiety and depression appears to be at least as large as that of antidepressants.²²

Not only does smoking cessation improve physical health and reduce the chances of developing a smoking-related disease, supporting smokers to quit can also lift them out of poverty, return valuable disposable income to households and improve mental health.

It is also crucial that we remember that a majority of smokers want to quit.⁹ This is true among all smokers, including those with mental health conditions.²⁴ An even larger majority (71%) of smokers wish they had never started.²⁵

Providing support to quit

This raises the question: are services doing enough to support smokers with mental health conditions to quit? In 2016, the Five Year Forward View for Mental Health set a target for all in-patient mental health services to be smokefree by 2018.²⁶ This commitment was reiterated in the Tobacco Control Plan for England, which stated that it would include ‘providing integrated tobacco dependence treatment pathways’¹² in line with National Institute for Health and Care Excellence (NICE) guidance: *Smoking: Acute, Maternity and Mental Health Services* (PH48).²⁷ There are no specific targets for community mental health services, yet ASH’s survey of community mental health practitioners, discussed below, shows that there is a need to focus on the support provided by community mental health teams.

¹ CIS-R, revised Clinical Interview Schedule; HBAI, households below average income.

² Poverty based on 60% median gross income within survey.

³

Poverty based on HBAI poverty threshold.

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In-patient settings

This 2018 target has been missed. A 2019 survey of mental health trusts in England found that nearly one in five (18%) did not have a comprehensive smokefree policy in line with NICE guidance.²⁸ Over half (55%) of trusts reported not always asking patients about their smoking status on admission, and 57% of trusts said that staff accompany patients on escorted leave to smoke every day, a practice which is: ‘...outdated. It reduces the resources available to deliver clinical care²⁹ and causes direct harm to patients.’¹²

Further, although all trusts reported that they offer nicotine replacement therapy (NRT) to patients, only 49% offered varenicline (Champix).²⁸ This is likely to be due in part to historic misunderstandings about the effects of varenicline on mental health. However, evidence shows that varenicline is not associated with negative outcomes for people with mental health conditions.^{30–32} As reflected in the Royal College of Psychiatrists’ position statement on prescribing of varenicline: ‘varenicline is a generally safe and well-tolerated medication which has been proven to increase rates of smoking cessation in psychiatric and non-psychiatric populations’.³³

However, prescribing rates for varenicline are falling fast, particularly for people with mental health conditions. Primary care data for over 200 000 smokers shows that smokers with mental health conditions were 31% less likely to be prescribed varenicline than NRT, despite varenicline being more effective.³² Smokers with mental health conditions who were prescribed varenicline were 19% more likely to have successfully quit at 2-year follow-up, compared with those prescribed NRT.³²

These policies must be addressed to ensure that all smokers are being offered the best support available to quit, in line with NICE guidance. Smokers with mental health conditions are often more heavily addicted,² and ensuring they have access to the most effective pharmacotherapy is essential to supporting quit attempts.

ASH’s survey also showed significant variation in approaches to vaping, from allowing a range of devices to be used across trusts, to prohibiting the use of e-cigarettes. National guidance from PHE,³⁴ the Royal College of Physicians³⁵ and the Royal College of Psychiatrists³³ highlights that vaping is substantially less harmful than continuing to smoke. Under UK regulations, the Medicines and Health Care Products Regulatory Agency (MHRA) oversees notification of new nicotine-containing e-cigarettes and e-liquids, and operates a yellow card reporting system for any adverse reactions.³⁶ A report is not proof that a reaction was caused by vaping, just that the reporter suspected it might have been. From 20 May 2016 through to 9 January 2020, the MHRA had received 84 yellow card reports on 245 adverse reactions, including 27 serious respiratory events.³⁷ In 2019, over 3.6 million people in England were estimated to be using e-cigarettes.³⁸

E-cigarettes are the most popular aid to quitting smoking in England,³⁹ and research has shown that using an e-cigarette along with behavioural support can be twice as effective for quitting smoking compared with using NRT.⁴⁰ Further, vaping is much cheaper than smoking. Research suggests that smokers who switch to e-cigarettes spend around £417 a year on vaping, substantially less than the estimated expenditure on tobacco of £1200 a year.⁴¹ These benefits should not be underestimated, and trusts should review policies in line with the latest evidence^{37,42} and national guidance.⁴³

Smokers also want greater provision and variety of support. In a focus group with 12 participants with experience of in-patient services or with family in in-patient services, no participant felt that the support offered on admission to a smokefree in-patient service was sufficient.⁴⁴ They noted that smokefree often felt like a ‘checkbox exercise’ rather than part of their care, with references to clear failings in the support options available: ‘*Handing someone a card with a number should not, in my opinion, count as actively giving someone smoking cessation support – that’s what I’ve had. But they can say they’ve given you some support; the fact that you couldn’t use the phone at the time doesn’t seem relevant*’.

To reduce the inequality in smoking rates between people with mental health conditions and the wider population, it is essential to improve the support offered in in-patient services. There are examples of trusts leading the way on this agenda, offering excellent support and engaging with smokers to ensure that they are addressing the broader social aspects of smoking and not just physiological withdrawal. Public Health England’s videos on implementation of NICE PH48 illustrate some of these examples.⁴⁵ If we are to achieve a smokefree 2030 for people with mental health conditions, these examples must become the norm.

Community services

A similarly patchy picture of support is seen in community services, which support the majority of people with mental health conditions.⁴⁶ Although there is less evidence here, a small-scale, self-selecting survey conducted by ASH of 103 mental health nurses (representing 33 trusts) and 171 psychiatrists (representing 48 trusts) found that over 55% reported receiving no training on supporting smoking cessation.⁴⁷ Only around a quarter of respondents said that they 'always' or 'usually' delivered very brief advice on smoking.

Prescribing medications for smoking cessation was reported to be similarly uncommon in community settings. Three-quarters (76%) of qualified nurses said that they never prescribed smoking cessation medications (NRT or varenicline), as did three-fifths (59%) of psychiatrists.⁴⁷

What works?

This absence of support is concerning, especially as there is a strong evidence base around what works to support smokers to quit. Smokers are three times more likely to quit successfully with the support of a specialist stop-smoking service than when attempting to quit unaided.^{48,49}

The Smoking Cessation Intervention for People with Severe Mental Ill Health (SCIMITAR) pilot⁵⁰ and randomised controlled trial (SCIMITAR+)⁵¹ were built on this evidence base. The SCIMITAR trials tailored the support set out in NICE guidance for people with mental health conditions, showing that such an approach is both effective and cost-effective. SCIMITAR compared the effectiveness of combined behavioural and pharmacological support for smoking cessation with usual care.⁵¹ Trial-condition participants received face-to-face behavioural support delivered by a trained mental health professional and prescriptions of their choice of smoking cessation medications, the most commonly chosen being NRT. Adaptations for people with severe mental health conditions – including extended pre-quit sessions, 'cut down to quit', and home visits – were offered in the trial arm. Compared with usual care, this intervention more than doubled quit rates at 6-month follow-up and showed significant improvements after 12 months.⁵¹

Participants in the SCIMITAR trial reported that the intervention being delivered by mental health nurses was important to them. It was important that they felt this support was being delivered by someone who would understand their mental health diagnosis without judgement and with professional expertise.

An ASH/Rethink focus group participant highlighted clearly the unique part a mental health nurse could play in supporting smokers: *'Community mental health nurses visit people in their own homes, and they see how that person is managing. Smoking's expensive ... if it's the difference between paying your electricity bill and buying a packet of fags... If this person is struggling, the community mental health nurse is in a good position to advise and act as a sign-post ... and link with GP services and the local chemists that offer smoking cessation'*.⁴⁴

This illustrates the value of training mental health professionals to deliver smoking cessation advice and support. However, studies have shown that mental health staff may not see addressing smoking as part of their role. One study found that only 48% of respondents felt that addressing smoking was within their remit as a mental health professional,⁵² and one in five were not sure whether quitting smoking would have a positive effect on recovery or thought quitting smoking could have negative effects.⁵²

The persistence of these myths undermines the potential for mental health services to support smokers to quit, and highlights the need for smoking and smoking cessation to be included in the training of mental health professionals.

Making change happen

Population-level interventions that have driven down smoking rates nationally have largely failed to reach smokers with mental health conditions. Although the specific commitment to supporting people with mental health conditions to stop smoking in the NHS Long Term Plan is welcome, the pace of change is currently slow.¹³ Transformation funding through the NHS Long Term Plan will not be in place nationally until 2023–2024.¹³ Although this additional funding and national commitment is welcome, it will not, on its own, help enough smokers with mental health conditions to quit.

Smoking rates among people with mental health conditions will not reach the national ambition of 5% or less by 2030 without a trained workforce that sees smoking and smoking cessation as part of their role. The current lack of training in smoking cessation among the mental health workforce, as evidenced by trust and community surveys, is a problem that must be tackled if staff are to be able to deliver on these commitments.

Smokers expect doctors to ask them about smoking and deliver advice. If clinicians are not asking about smoking, it sends the signal that this is nothing to worry about. All psychiatrists should be able to deliver very brief advice, an evidence-based brief intervention on smoking that asks about smoking status, advises that support is available that will increase the chances of successfully stopping, and signposts smokers to further support. This is not designed to support someone through their quit attempt; it is about raising the issue and motivating smokers to try to quit.

Smokers with mental health conditions are likely to be more heavily addicted and therefore can find quitting harder.² Ensuring that smokers with mental health conditions have access to the right pharmacotherapy to support them to quit is essential. Mental health trusts must ensure that the most effective treatments, including combination NRT and varenicline, are on their formularies and that they are being prescribed to patients in line with NICE guidance.^{27,53}

Psychiatrists have a key role in reducing smoking among people with mental health conditions and in turn need appropriate training to deliver this. Although people can become immune to statistics about disease and death caused by smoking, reminding them about the effects that smoking has on well-being and quality of life is always worthwhile.

The number of people with mental health conditions pushed into poverty by smoking demands urgent action. Although quitting smoking will not solve poverty for everyone with a mental health condition, giving people the support they need to quit is a big step in the right direction.

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V.S. led on the writing of this article, with input and review from C.O., who has been overseeing the work of the Mental Health and Smoking Partnership.

Declaration of interest

None.

Supplementary material

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[click here to view supplementary material](#)

1.3.31 Child psychiatry: a model for specific goals for in-patient treatment linked to resources and limitations in out-patient treatment

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2020-12

Abstract

I present a rationale for two different types of in-patient child psychiatric unit: 24/7 intensive units and 24/5 child and family units. Intensive units address safety requirements. The developing personality of young people is at the centre of in-patient approaches on the child and family units. This requires attachment-informed practice. Families must always be involved and placement of units must facilitate their participation. The primary skill characterising these units is use of the milieu for therapy and combining this with family therapy. In other words, nurses and allied professionals need to be the dominant force in unit development, under the reflective guidance of consultants and clinical psychologists.

Contents

- *Child psychiatry: a model for specific goals for in-patient treatment linked to resources and limitations in out-patient treatment*
 - *Safety first – 7 days a week (24/7)*
 - *Working with personality – 5 days a week (24/5)*
 - *A plea*
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Sitting beside a nurse from a county in California at an international conference I realised for the first time that areas in the USA provide third-world levels of child psychiatric treatment. She was the only clinical worker for children and adolescents with psychiatric problems for a county with a total population close to 100 000. She arranged for patients to fill out forms, which were then sent to an adult psychiatrist, who prescribed medication over the phone. My concern is that general UK provision has for a long time been critically vulnerable because of the extremely low staffing levels and lack of obligation to provide a comprehensive service within each health trust. I do not believe that the UK model of service provision is conducive to making a leap forward with services tied to a tiers model. Yet there is no evidence of what ingredients might promote a healthier service. Even though we have evidence that in-patient treatment can give benefits,¹ we have no conceptualisation of how the complex interconnected processes on an in-patient ward might be working. Instead I will present here an analysis of how need can be formulated to suggest an alternative service model which can identify the elements that need addressing. Although I have been working within the well-endowed Norwegian health service, and there is no chance of the UK approaching the same level of provision in the near or distant future (we have over ten times the resources compared with the UK and other wealthy countries²), analysis of

what is required is no different. Having worked outside the taken-for-granted world of UK child psychiatry, a different perspective can be generated which maybe leads to new possibilities.

Safety first – 7 days a week (24/7)

The top priority has to be given to ensuring safety, when, by virtue of the young person's mental state, the patient or their VIPs (I will use 'very important person' to cover the adults responsible for ensuring the patient's care – biological parents, foster parents, etc.) have been in danger. This has to be available 24/7 and it requires a mix of out-patient provision and emergency out-of-hours service in liaison with a unit available to admit patients 24/7. The issue of whether it is desirable to provide more than 09.00–17.00 h out-patient provision to enable both VIPs and patients easier access to specialist services needs to be debated. Or could emergency services be staffed with child and adolescent psychiatric expertise? (In Oslo there is a psychiatric emergency department which is staffed until 23.00 h, covering the time after out-patient departments cease their obligation to evaluate emergencies at their closing time. Some privileged populations in the UK have access to services with such out-of-hours specialist cover.) Why is it not expected that all emergency departments should be catering for the second highest cause of mortality among our adolescents after accidents?

Rather than going into the pitfalls of evaluating potentially suicidal behaviour, as only one potential reason for acute referral, I will only remind us here that those with greater experience refer fewer patients for admission because of potential suicide. This underlines why highest-quality expertise is needed in the front line.

It is not the Axis I diagnosis that determines the need for admission, but the necessity of an alternative 'containment' of the patient to that available at home. Two factors operate here: the state of the child and the processes at home. The ICD-10 system's Axis V diagnoses of the psychosocial context were included as of prognostic importance and needed to be addressed in treatment plans. Context matters as much as the young person's 'state' – and it is entwined in the same complex causal system, such that states evolve to 'traits' depending on the maintaining influence of context processes. No admission should occur without the possibility of integrating approaches to the child's state, as well as addressing precipitating and maintaining factors in the context of the episode. The younger the patient, the more important the context factors in treatment. Here, planning for young people differs from that for adults. Out-of-region 'refuse recirculation' is detrimental to patient recovery and welfare and can be expected to be associated with need for more frequent readmissions. Every such unit needs to be able to work with family, school and local resources – and that means fathers as well as mothers.

The critical elements concern ensuring highest expertise during out-patient evaluations, with ideally similar levels of expertise available 'out of hours', and an in-patient resource that is equipped to address the patient's state as well as the context factors. The level of staffing needs to be high – and, importantly, consist of a stable group of nurse therapists (use of locums is countertherapeutic to the teamwork required). A higher level of staffing and greater stability of staff leads to reduced needs for restraint or emergency medication.¹ Staffing needs to include other therapists working in the patient 'milieu'² who are expert in childcare issues, such as residential social workers. They need to be used to working with complicated family dynamics, where abuse of power – both verbal and physical – may well be a problem. Safety is primarily ensured by these staff, to a greater degree than by doctors and clinical psychologists, who provide the back-up understanding of the treatment needs and reflection on the treatment dynamic as it evolves. The high

¹ The Norwegian adaptation of the Quality Network for Inpatient CAMHS (QNIC), known as KvIP (www.akuttnettverket.no/kvip-barn-og-unge), has found that an emergency sedation regime has not proved necessary, and it was recently removed from the list of standards. This is attributed to the higher levels of stable qualified staffing.

²

In Norway the staff are collectively known as milieu therapists, and include both nurses, childcare workers and other professionals, besides the non-milieu psychologists and child psychiatrists.

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staffing levels enable the intensive approach required, and this suggests that the proposed 24/7 acute admission units should be called intensive units, as in UK adult psychiatry. Because transfer of patients between units and therapists creates lacunae of security, such intensive units should be able to keep treating their patients who require longer than an acute admission. This most vulnerable group of patients needs help to set up their transfer back to the context from which they were admitted, so that a return to their out-patient department will succeed without the patient isolating themselves in connection with the transition. An adequate model for practice needs to include an ambulant service from the intensive unit to anchor the patients in meaningful activities at home – school, clubs, sports, etc. – so that any tendencies to isolation can be mitigated.

Working with personality – 5 days a week (24/5)

There is another group of patients who can also benefit from admission, albeit not the intensive kind with a focus on security. Often these have been referred for diagnostic evaluation and treatment. But in principle there is little to suggest that an admission should be used for diagnosis, given the skills that need to be available on an out-patient basis (in my practice the costs of 1 year's admission was the equivalent of 4–5 full-time out-patient clinicians). What cannot be done there? Out-patient clinicians cannot easily evaluate problems arising at bedtime and during the night! Usually such referrals for diagnosis are a 'cop out'. Any referral precipitated by lack of progress in out-patients requires that the covering letter identifies the barriers preventing progress – and how these might be more successfully addressed during an admission. In my experience this does not happen. Additionally, on admission, objective criteria should be decided as to how far treatment needs to have come before transfer back to out-patient provision can occur successfully.

Do we know what the barriers are likely to be? They are not the Axis I diagnoses, as all of these can potentially be treated outside institutional services. I have my experience to go on from Norway, and it may be very different in the UK. My guess is that the barriers are universal, but seldom acknowledged. The elephant in the room, the dimension not talked about in child psychiatry, is personality, both that developing in the patient and in the VIPs. Progress in treatment depends on working with both the patient and the VIP and establishing an alliance with them that facilitates their ability to take chances in doing things differently. But this is easier for some than others. The more insecure a VIP or patient the greater their need to do things to feel in control of the situation. These individuals can be impulsively dramatic. And they take fewer chances to do things differently – for the VIP to read the child's signals differently, to understand their vulnerabilities in new ways, or for the child to respond to their fears as much as to fight their way out of a corner, to take chances to tell others what they are going through. In such control-focused meetings things continue to happen impulsively with little reflection, according to well-worn strategies. As Peter Cook replied to Dudley Moore when asked what he had learnt from his mistakes: 'I could repeat them exactly'. This tendency to impulsiveness associated with lack of change can easily suggest to the therapist that they are missing something and that a diagnostic admission is required. Instead I suggest there is a need for an admission to a totally different sort of unit than the intensive unit. There will be no sole focus on the Axis I diagnosis, Axes II–V being at least as significant for the admission – and assuming that Axis VI scores (Children's Global Assessment Scale, CGAS) are at least under 40. Admitting patients with primarily personality problems to an intensive unit is expected to be counterproductive.

A child and family unit can have a lower staffing level. It is not apparent to me that it should be a 24/7 unit, as there are advantages of the patients being at home at weekends. Therefore a 24/5 unit would be better. It needs to be able to address the impulsive responses to which the patients and their VIPs are disposed, fuelled from their implicit memories. The milieu staff would interact with patients in the 'here and now', allowing response patterns characteristic of the dispositional representations³ of the patients' personalities to be revealed, and would set up situations to create optimal learning opportunities. The staff would be grounded in understanding of personality, a field with which child psychiatry is only slowly coming to grips. My suggestion is that adapting Clarkin's⁴ conceptualisation of personality and informing it with knowledge about child development will give us personality as reflecting factors present at birth or by the end of the first years of life (Clarkin used the short-hand 'temperament', as if it were an obviously genetic factor) in interaction with attachment strategies, and influenced by experiences of trauma and loss. This would have given us the personality dimensions suggested, but not adopted, for DSM-5.

The advantage of such a unit operating 24/5 is that the focus is continually on patterns that recur in the home environment. Has the treatment week led to different patterns at the weekend? During the week it is necessary to work with the patient, but also with parental responsiveness and the parent's ability to identify precipitating and maintaining factors in their child's disturbance. Each weekend is not a break from treatment, but a time for renewal and update of

the treatment contract, refreshing and refining the focus for all concerned. With clarity preceding admission in what needs to have changed before out-patient treatment can resume, the approaching discharge timing will be clear to all involved 'en route'. If issues of security arise during the weekends then a temporary move to an intensive unit may be required, but the priority is a thorough analysis of the sequences that precipitated the situation by the staff from the 24/5 unit.

These units will often find they are working in the no man's land between child-protection services and medicine. Child psychiatric services will always need to have close liaison with social services and make use of consultation from child-protection services – and provide corresponding consultation to child-protection services.

A plea

From my position across the water it is indefensible to be bussing young patients out of region. Every patient should be getting eventual need for admission met within easy travel distance of home so that family approaches can be integrated with the in-patient treatment. If a unit is designated as an intensive unit it should not be allowed to close its doors to local acute admissions. It should be under an obligation to provide the 24/7 service required even if it means temporary beds. Any other arrangement rewards keeping patients longer than required to enable the unit to avoid the crushing work of new admissions; and frees the out-patients from pressure to ensure a rejuvenated service for the returning patient. Tier 4 expertise should be available primarily on an out-patient basis. An admission is not to a hierarchically superior service, but to one of two possible treatment units providing distinctly different provision, where the role of the milieu staff has primacy in the treatment strategy.

Simon Wilkinson, MD, FRCPsych, has run the adolescent in-patient units at the National Centre for Child Psychiatry, Oslo, Norway. He has retired from clinical practice although is still employed by Oslo University Hospital and Akershus University Hospital to provide psychotherapy supervision for junior doctors in training.

Declaration of interest

None.

Supplementary material

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[click here to view supplementary material](#)

1.3.32 Emergency workers' experiences of the use of section 136 of the Mental Health Act 1983: interpretative phenomenological investigation

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Declaration of interest: None.

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Abstract

Aims and method

To explore the experiences of emergency workers dealing with incidents in which section 136 of the Mental Health Act 1983 is invoked by the police. Data from interviews with police officers and ambulance workers in a London locality were subject to interpretative phenomenological analysis.

Results

Participants felt they were the first port of call and that training should be improved to help them deal with those experiencing mental health crises in the community. Police participants noted time pressures trying to gain individuals' trust and described section 136 detention as sometimes feeling like a betrayal of the individual. Most participants had negative experiences of admissions to the 136 suite; several suggested ways of improving the admissions system. Several went beyond their expected duties to ensure that distressed individuals were supported before accessing mental healthcare services.

Clinical implications

Improving training of emergency workers in dealing with mental health crises would also help with aftercare decision-making. Learning identified from the participants' experiences lends support to collaboration between emergency and mental health services, an important step towards improving the section 136 process so that detainees can access help without unnecessary delay.

Contents

- *Emergency workers' experiences of the use of section 136 of the Mental Health Act 1983: interpretative phenomenological investigation*
 - *Method*
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Section 136 of the Mental Health Act 1983 for England and Wales (amended in 2007) permits police officers to legally detain someone who is in a public place and is believed to be at risk to themselves or others and to be requiring immediate care or control.¹ Detainees are taken by police and the ambulance service to a designated place of safety for assessment, with arrangements for treatment and aftercare.^{1,2} According to the Act, a ‘place of safety’ could be a police station, a unit in a psychiatric hospital or another suitable residential place willing to temporarily accommodate a detained person.^{2,3}

Implementing section 136 not only requires quick thinking but can pose a challenge for emergency workers with limited or no training in mental health.^{1,4,5}

Two papers^{6,7} exploring police officers’ experiences of section 136 highlighted participants’ concerns about vulnerable individuals being turned away from in-patient mental health services. There is a paucity of research on the experiences of ambulance and paramedic workers. This study aims to fill this gap by exploring emergency workers’ experiences of section 136 and how they make sense of them.

Method

Participants

Emergency workers were purposively sampled on the basis of the roles they undertake and their experiences of implementing section 136. Four individuals from a police force and three from an ambulance complex in a London locality participated. This sample size is consistent with the interpretative phenomenological analysis (IPA) literature, which suggests the appropriateness of relatively small samples, for whom the research questions are significant.^{8,9,10}

Characteristics of the participants (who were allocated anonymised identifiers such as PO1) are presented in *Table 1*.
 Table 1 Participant characteristics at time of interview
 Participant identifier Role Gender
 Police 1 (PO1) Police officer Male
 Police 2 (PO2) Police officer Female
 Police 3 (PO3) Police officer Male
 Police 4 (PO4) Police mental health liaison officer Male
 Ambulance worker 1 (AMB1) Ambulance worker Female
 Ambulance worker 2 (AMB2) Ambulance worker Male
 Ambulance worker 3 (AMB3) Paramedic Female

Ethics

This research received ethical approval from the London South East National Health Service Research Ethics Committee in 2011, reference number 11/LO/1002. Participants were given a detailed information sheet and completed a written consent form.

Data collection and analysis

Police officers ($n = 4$) and ambulance workers ($n = 3$), not known to each other, participated in separate interviews (data were collected between 2012 and 2014). In keeping with the IPA approach, open-ended questions were used inviting participants to tell their stories in their own words, with prompts where necessary.^{8,11}

The following are examples of questions asked.

Ambulance workers: ‘Please could you tell us about your recent experiences of taking someone under a section 136 from a public place to a place of safety?’. Prompt: ‘How do you feel about dealing with incidents of this nature?’.

Police officers: ‘Please could you tell us about a recent experience of sectioning someone?’. Prompts: ‘What factors are involved in making this decision? Did you feel that your action(s) were justified?’; ‘Have your encounters with individuals in these kinds of situations affected, if at all, the way you view people with mental illness?’.

Interviews took place at police stations or ambulance complexes and lasted around 50 min. The third author (L.S.) took summary notes of the interviews to supplement the audio transcripts. Responses were digitally audio-recorded and transcribed into text verbatim by the first author (M.G.).

A framework underpinned by the IPA literature was developed and used to inform the analysis process.^{5,8,10} Questions were asked of the data by M.G. to aid the process of identifying themes: (a) What experiences are being shared and how are respondents making these meaningful to one another?; and (b) What are the consensus, conflicts/contradictions and how these are being managed?^{12,13}

Themes were deemed to be prominent if they occurred in approximately one-third to half of participants' accounts.^{9,11} For example, most participants referred to their experiences of interacting with individuals in distress, how they felt about engaging and showing empathy. This was deemed to be a shared experience and characterised by the theme: 'Making yourself human as first responders'.^{14,15}

Quality checks were undertaken by M.G. and L.S., which involved comparing a random selection of themes alongside verbatim quotes. This was done to ensure that themes closely reflected the participants' experiences and it fits with the epistemological approach.^{9,16}

The findings are presented under the thematic headings below. Quotes from the participants are interwoven with interpretative commentary that encompasses emotions evoked as well as the language and text they relate to.

Results

Making yourself human as first responders

Participants described themselves as the '*first responders*' and spoke of how they approached and communicated with the individuals involved. Some were sensitive to the way a uniform or emergency vehicle can be perceived. Communication was seen by these participants as 'Essential for people who may be suffering from some sort of psychosis, sort of gaining trust, turn your radios down, taking off your hat. Essentially try and be the only person talking to them' (PO3).

Police participants reflected that detaining and removing someone against their will could generate feelings of betrayal towards the person they were trying to build trust with. The main challenge for them was in encouraging individuals to accept help voluntarily. Some of the police officers felt that they did their best to demonstrate that their role is not only about enforcing the law, but also supporting individuals in difficult and sensitive circumstances: "It takes a good few hours to build rapport with her, which can be difficult if someone is going through an episode. You don't want them to feel humiliated or mocked. Because you want them to know you are there to help' (PO1)."

Participants tried to make sense of the barriers and pressures that made it difficult for them to establish a rapport: "Making yourself more sort of human to them. But the problem is your lifeline is your radio and so by turning it down you are not hearing what's happening outside' (PO2). 'We are under pressure from our radio, from our supervisors. So, it sounds awful but it is time-consuming. In this day and age we do not have 2 hours spare, which sounds awful to say. But you end up having to build that rapport up, say "come on you know what, the best thing to help you is to voluntarily go with the ambulance". And probably 7 out of 10 it works' (PO2)."

The excerpt below is a good example of the police officer involving a family member to support a distressed individual. It brought about a sense of reassurance for the parties involved in ensuring that the person was supported in keeping themselves safe: "Like, the lady, she was holding a knife to her throat. We ended up calling her son to say "look, your mum, she's voluntarily said she can come to hospital. This is what's happened. We just want you to be aware because I think she could do with a loving face, like have someone from the family there"" (PO3)."

The 136 suite

The place of safety or ‘136 suite’ was salient for the participants as the transition point into in-patient mental health-care. All of the participants spoke less favourably of their experiences of trying to get individuals admitted into the suite. Strong feelings were voiced regarding the potential welfare of detainees in situations where there were delays. Ambulance workers felt for individuals who had little or no choice but to wait inside an emergency vehicle: ‘I find once you get to [hospital X], I’ve waited 2 hours before to get into the 136 suite and that can cause issues with the patient’ (AMB2).

When considering what the waiting might involve, the ambulance workers reflected that ‘We’re not allowed in the building. So, we just literally sit outside in the ambulance or in the police van’ (AMB2).

Unlike ambulance workers, police officers were able to enter the 136 suite and liaise with staff there. Ambulance worker participants often speculated on what goes on inside the facility, which may have generated some friction between the ambulance workers and mental health workers at the 136 suite. They wondered what happened to individuals who were admitted and how they got on: ‘Once we take someone to [hospital X], we don’t see what happens’ (AMB2).

The exchange below illustrates the police liaising with mental health workers at a 136 suite. There is a sense of the parties colluding with each other, together with somewhat blurred boundaries around responsibility. The liaison between police and hospital staff amplifies a sense of being in an awkward position and of feeling overwhelmed, in a situation in which there are no clear answers regarding care decisions: “‘It went back and forth, our inspectors got involved. Hospital staff basically turned around to us and said that if we left the hospital they would let him walk out of the hospital and into the street, where he would then become our responsibility again [...] And that if he was to attack someone it would be on the basis that the police left him and that they washed their hands of him [...] We explained that we had no powers, essentially the only thing we had was a breach of the peace, inside the facility whilst he was there [...] This went on for about 2 hours, this debate’ (PO1).”

Most of the participants’ experiences at the point of entry to the 136 suite were negative. However, there was a unique example in which an individual under a section 136 was able to access the care they needed, in a timely and seamless manner: “‘I think I had a positive one. We had a gentleman who was out on the street. The police were already there when we arrived on the scene. And it was called in by friends of his because he was behaving erratically [...] When we got there he was in the back of a police van, but his behaviour was quite self-harming, even though he was quite chatty [...] And then what we’ve got in place was that a paramedic travelled with the police in the van to ensure the safety and the care for the patient. And actually we did take him straight to the 136 suite on this incident and he was booked straight in. So that worked really well. But that was during the day. It was early. It was a weekday. So everything was in place on that incident’ (AMB1).”

Training and quest for collaboration

When participants reflected on their skills in dealing with individuals experiencing mental health problems, there was a unanimous view that training and opportunities were somewhat limited. The participants reflected on specific areas that they felt could influence their practice, given their involvement in section 136 detentions. For example, ambulance workers felt that they would benefit from a better understanding of substance misuse and mental illness: “‘I’d like to have more training [...] Historically, our training has been a bit ad hoc [...] I think it’s got to be around drugs and alcohol, what that impact is on how we are assessing a patient. Because as you can imagine, probably 75 per cent will have drugs and alcohol on board’ (AMB2). ‘There is no training on what you might want to look for, how it might present itself and different types of mental health, erm, issues. I don’t think there were any role-plays or anything like that, which I think could possibly be helpful’ (PO3).”

Ambulance workers put forth some practical suggestions that they felt would benefit professionals and detainees, with an emerging consensus towards a more collaborative approach. One respondent referred to the potential of a bed management system that he had found successful in general accident and emergency (A&E) settings: “‘A bed manager in A&E is always well versed on what beds are available. So ITU beds, neonate beds [...] Why isn’t that available in psychiatric healthcare?’ (AMB2).”

The same respondent speculated as to whether such a system could be applied in the 136 suite to ease the transition into hospital care: “So, we’re on a job with someone who is going to get 136’d [...] So rather than waste half an hour with the police trying to ring the 136 suite, because they are obviously busy preparing for two to come in, why don’t we get someone to just say “There’s no beds. Your nearest bed is there”. Bang! Why can’t we do that?” (AMB2).”

Further suggestions were put forth to minimise waiting times and ensure that detainees were promptly received and attended to at the 136 suite: “It needs some immediate action. It’s not something that can be delayed [...] Can we go early with the information that we’re going to be taking a patient there?” (AMB3).”

In some cases, there was a sense of commitment and willingness to go beyond the remit of their roles, for example: “If we’re going to be spending this long with patients [...] waiting to convey them to the 136 suite, if we can find out more information on the scene then let’s do it” (AMB2).”

Discussion

This research is the first of its kind to collectively explore and combine findings from police and ambulance workers’ experiences of detaining individuals under section 136 of the Mental Health Act (England and Wales).¹ This piece of work highlights that lived experience plays a key role in service development in a range of settings. Two key aspects of experience emerged from the findings: (a) therapeutic engagement in a crisis and (b) drawing on the expertise and experiences of the parties involved in a section 136 admission.

Personal engagement

Professionals felt that how they approached and engaged with individuals had made some difference in those people’s willingness to accept help. Police participants felt pressured by their agency to prioritise other emergencies over mental health incidents.^{17,18} It is not entirely clear how much time emergency workers can devote to situations in which mental health problems are suspected. This was a source of conflict for study participants. Therapeutically engaging and gaining trust were seen by participants as an important first step and in the detainee’s best interests as a way of enabling them to access immediate support.

Accessing the 136 suite

A pressing concern for participants was the inordinate amount of delay regarding decisions on granting access to the 136 suite (the place of safety). In some cases, detainees were having to wait for longer than necessary inside an emergency vehicle or were refused entry, which generated further distress. The findings also point to friction between the emergency and mental health services regarding responsibilities of care. The collusion between the parties can have implications for the waiting time for detainees in need of immediate care and support. These findings were similarly noted in Burgess *et al*⁵ and Riley *et al*⁶ and is at odds with key recommendations from the Royal College of Psychiatrists’ section 136 national guidance. According to these guidelines: 136 suites should agree to accept an individual before the emergency services begin their journey and have the necessary staff on hand to receive individuals without delay or recourse to emergency professionals.^{2,17} In contrast, another finding conveyed an emergency worker’s experience where the section 136 journey for the detainee in question was smoother and well supported. This finding highlights what one can learn from personal experiences and consider how these can inform future practice. A prominent aspect to this study was that emergency workers wanted to be more involved in the section 136 process and to work jointly with staff at the 136 suite. This was evidenced by their efforts to seek out practical solutions for the dilemmas they experienced. The participants felt that this way of working would enhance the quality of the experience for detainees accessing mental healthcare.^{10,19}

Training

This study has shown that ambulance and paramedic workers play a pivotal role in dealing with individuals experiencing mental health problems in a community setting. Yet, training for this group of professionals is somewhat limited. There was a general consensus regarding the improvement of training to enable emergency workers to feel more confident in recognising how mental health problems can present, dealing with crises and engaging with individuals affected.^{6,14,19}

Given this, future work needs to prioritise interdisciplinary training to enable the various agencies to appreciate the roles and limitations of their services. These different agencies can learn a lot from each other.²⁰ In keeping with suggestions in previous work, involvement of patients and carers could enhance the quality of the training for emergency workers, by bringing in their lived experiences.^{7,20} This is another important area, which would benefit from being further explored in future research.

Strengths and limitations

Interpretative phenomenological analysis (IPA) captured emergency workers' experiences of the section 136 process and how they were affected by it. Situating the study in a catchment area of a National Health Service mental health trust in London could be seen as both a strength and a weakness, since the views expressed only reflect those who took part in the study. It is possible that the views of emergency workers with different characteristics in other areas of England and Wales will vary. Further research in other geographical areas could help to ascertain whether this perspective of section 136 detainment could be understood more widely.

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Data availability

Data are available from the authors.

M.C. and S.G. conceived and designed the study, contributed to interpretation of the data, and critically revised the manuscript for important intellectual content. M.G. contributed to study design, acquired the data, led data analysis and interpretation and drafted the manuscript. L.S. contributed to data acquisition and interpretation.

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1.3.33 Systemic racism and mental health services: the time is now

Roxanne Keynejad Alice DeBelle Julia Ogunmuyiwa Arleen Elson Marilia Calcia

date

2020-12

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- *Declaration of interest*

The killing of George Floyd refocused global attention on racial injustice. UK Covid-19 death rates are highest among Black, Asian and minority ethnic (BAME) groups,¹ with systemic racial inequality a central cause.² Although BAME people face many inequalities, Black people's unique experiences require particular attention.³

In mental healthcare, we must consider links between psychiatric symptoms and experiencing racism, systemic racism within services and medico-legal interfaces. The *Delivering Race Equality in Mental Health Care* (DRE) agenda⁴ was prompted by the 1998 death of David Bennett, an African–Caribbean patient, following in-patient restraint. DRE prioritised reducing fear of services, developing culturally appropriate therapies, and engaging BAME groups and patients in training, policy development, service planning and provision.

A DRE progress review⁵ advocated dedicated community development workers, engagement projects, training, clinical trailblazers and measuring progress. Patients, professionals, campaigners and academics attributed continued race inequality in mental healthcare post-DRE to institutional racism, inadequate training, poor system design and lack of an empowering culture.⁶

In our experience, DRE is not prioritised. Core training competencies of 'cultural diversity', evaluating institutional prejudices, respect for diversity and evaluating biases are neglected. Despite a strong position statement,⁷ racism is absent from MRCPsych examinations. Static e-learning modules replace interactive, in-person training that could stimulate engagement, discussion and reflection. Black leadership and collaboration with Black community stakeholders are lacking in mental health trusts serving largely Black populations.

Mental health service leaders must role-model, reflecting on personal and workplace unconscious biases.⁸ We should each ask of our own organisation, how equitable is provision? Do Black patients have equal access to psychological therapies and specialist services? Are their perspectives represented? Do we foster dialogue with local communities? Do Black staff experience disproportionate bullying and harassment? Can they speak up if safeguards are lacking? Identifying and ameliorating clinical inequalities should drive research, so that treatments meet Black patients' needs.⁹

'We do not need another review, or report, or commission to tell us what to do' about race inequality in the UK,¹⁰ nor in mental healthcare. To address mistrust, services must acknowledge and address inequalities experienced by Black patients. We welcome RCPsych's appointment of presidential race equality leads and hope they will forge multidisciplinary alliances to mainstream anti-racism across mental health professionals.

It should not have taken a death to trigger the biggest race equality focus in mental health services' history, nor should it have been so rapidly forgotten. Black stakeholders must be empowered to occupy positions of influence, but it is not Black staff or patients' responsibility to effect change; organisations must be accountable. In a mostly White-led profession, tackling systemic racism will inevitably cause discomfort. Mental healthcare, with its recognition of transference and countertransference, and prioritisation of supervision, reflection and psychotherapeutic skills, is well-placed to lead the difficult discussions the health service needs. Silence is not neutral. The time is now.

Declaration of interest

None.

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1.3.34 Critical psychiatry: an embarrassing hangover from the 1970s?

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Abstract

Critical psychiatry is associated with anti-psychiatry and may therefore seem to be an embarrassing hangover from the 1970s. However, its essential position that functional mental illness should not be reduced to brain disease overlaps with historical debates in psychiatry more than is commonly appreciated. Three examples of non-reductive approaches, like critical psychiatry, in the history of psychiatry are considered.

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- *Critical psychiatry: an embarrassing hangover from the 1970s?*
 - *Psychiatry's response to anti-psychiatry*
 - *Historical foundations of critical psychiatry*
 - *The forgotten psychiatrist Ernst von Feuchtersleben*
 - *Adolf Meyer's psychobiology*
 - *George Engel's biopsychosocial model*
 - *Conclusion*

The Critical Psychiatry Network has promoted critical psychiatry for the past 20 years.¹ It is a small group of psychiatrists and although psychiatrists in general may be aware of its critique, it remains a minority perspective. In this sense, critical psychiatry still seems marginal to mainstream practice. This may be because of its association with so-called anti-psychiatry. Although the first modern use of 'anti-psychiatry' was probably by David Cooper in his book *Psychiatry and Anti-Psychiatry*,² the term has generally been applied by mainstream psychiatry to denote criticism that it does not accept. For example, Martin Roth, when he was the first president of the Royal College of Psychiatrists, identified an international movement against psychiatry that he regarded as 'anti-medical, anti-therapeutic, anti-institutional and anti-scientific'.³

¹

Declaration of interest: D.B.D. is a founding member of the Critical Psychiatry Network.

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Psychiatry's response to anti-psychiatry

Anti-psychiatry, perhaps most associated with the names of Thomas Szasz and Ronald Laing, now tends to be seen as a passing phase in the history of psychiatry.⁴ In this sense it was an aberration, a discontinuity with the proper course of psychiatry. However, it is difficult to accept that there was no value in the approach and what may be more beneficial is to look for the continuities, rather than discontinuities, with orthodox psychiatry. In fact, anti-psychiatry is not a single perspective; for example, Szasz equally rejected both mainstream psychiatry and Laing's views.⁵

Part of how psychiatry was able to move on from anti-psychiatry was by trying to make psychiatric diagnoses more reliable; for example, through the American Psychiatric Association's publication of the DSM-III. Another way was by avoiding ideological disputes engendered by anti-psychiatry, by encouraging eclecticism in practice that includes psychosocial as well as biological factors.⁶ The challenge to a narrowly biomedical model, which was of such concern for anti-psychiatry, was thereby averted.

Mainstream psychiatry now tends to regard anti-psychiatry as a 'straw man' argument. It was sustained by the counter-culture of the 1960s and without this support it has waned away. Social cultural critiques, with which anti-psychiatry was aligned, are no longer academically respectable. Critical psychiatry, by apparently resurrecting anti-psychiatry ideas, may therefore seem like an embarrassing hangover from the 1970s.

Historical foundations of critical psychiatry

The history of psychiatry can be understood as a conflict between two factions of somatic and psychic approaches rather than a simple chronological development. Critical psychiatry is part of this debate. The essential position of critical psychiatry is that functional mental illness should not be reduced to brain disease. Its challenge to reductionism and positivism, including mechanistic psychological approaches, creates a framework that focuses on the person and has ethical, therapeutic and political implications for clinical practice. This editorial focuses on conceptual issues, as the more practical aspects of critical psychiatry could be said to follow from its theoretical position. This is not meant to detract from these central practical concerns of critical psychiatry, such as the political and socioeconomic origins of mental illness.

The argument of critical psychiatry is that psychiatry can be practiced without taking the step of faith of believing that functional mental illness is owing to brain pathology. This anti-reductionism is primarily explanatory rather than ontological and does not undermine the importance of organic factors. Functional psychiatry could be said to be doomed to a kind of descriptivism rather than being able to become a mechanical natural science. Historically critical psychiatry may actually be more integrated with mainstream psychiatry than is commonly appreciated.

Modern psychiatry has its origins in the Enlightenment of the 18th century.⁷ The problem of knowledge began to shift away from philosophy toward science. Critical engagement of reason with itself created a descriptive approach to madness. Psychiatrists were originally called alienists, identifying mental alienation.

Descartes had separated the soul from the body, and, reacting against this Cartesianism, anthropology established itself as an independent discipline, concerned with the study of man as a psychophysical unity. In this context, medical psychology had its origin with two major variants of anthropological thinking.⁸ A medically orientated anthropology represented by Ernst Platner, among others, was one version, and can be seen as the root of biomedical psychiatry. Physiological knowledge of humans seemed to create the possibility of a natural scientific psychology. The other version was Immanuel Kant's pragmatic anthropology, which may be seen as the origin of critical psychiatry. Kant believed that a natural science psychology was impossible to realise in practice. Applying a physico-chemical mechanistic approach to life cannot accommodate the purposiveness of living beings. Organisms, unlike machines, are self-organising and self-reproducing systems. Kant was clear that it is futile to expect to be able to understand and explain life in terms of merely mechanical principles of nature.

Building on this proto-psychiatry, the first half of the 19th century saw the development of anatomoclinical understanding. Relating symptoms and signs to their underlying physical pathology was a major advance for medicine and still underlies our modern understanding of disease. Pathology emerged as a distinct discipline with autopsy findings of lesions in organs and tissues being related to clinical examination at the bedside. Histological studies established cellular abnormalities for disease.

Applying this anatomoclinical method to psychiatry was not as successful because it was not always easy to relate mental conditions to underlying brain pathology. The enthusiastic search for anatomical localisation in psychiatry led to fanciful notions later in the 19th century. For example, Theodor Meynert (1833–1892) delineated various ‘fibre-systems’ in the brain and deduced functions for these ‘pathways’. Meynert’s research may have appeared so successful because it seemed to give a material explanation of the basis of mental illness. Despite his skills in brain dissection, his theories were not based on empirical findings. They were eventually attacked and labelled as ‘brain mythology’, particularly after his death.

It was eventually established that dementia paralytica was a late consequence of syphilis. Senile dementia was also seen as having a physical cause such as Alzheimer’s disease. Focal abnormalities in the brain were identified and physical causes of learning disability were recognised. However, most psychopathology is functional, in the sense that there are no structural abnormalities in the brain.

Wilhelm Griesinger (1817–1868) was dedicated to the idea of the pathology and therapy of mental diseases as a mechanical natural science, although he remained aware of the gap between this ideal and reality. Nonetheless he set the trend for this positivist biomedical understanding that has dominated psychiatry since the middle of the 19th century. His aphorism that ‘mental diseases are brain diseases’ could be seen as the origin of modern biomedical psychiatry with its wish to find a physicalist basis for mental illness. Such a positivist reduction of mental illness to brain disease is what causes such concern for critical psychiatry.

This historical narrative is necessarily selective and schematic. It is more of a genealogy, attempting to make the origins of critical psychiatry intelligible. Psychiatry and its critical version had their origins at the same time in medical psychology. Incorporating the anatomoclinical way of understanding disease into psychiatry, particularly following Griesinger, has eclipsed a more critical understanding of mental illness. There have, nonetheless, been non-reductive approaches in modern psychiatry that amount to a critical position. For reasons of space, this editorial will consider just three examples: Ernst von Feuchtersleben, Adolf Meyer and George Engel.

The forgotten psychiatrist Ernst von Feuchtersleben

In the same year, 1845, that saw the publication in German of the book that gave Wilhelm Griesinger his reputation in psychiatry, Ernst von Feuchtersleben produced his psychiatric textbook⁹ based on his lectures. Following Kant, he recognised that the mind–brain problem is an enigma, which can never be solved. He was aware of the somatic bias in medicine and one of the aims of his lectures was to encourage young physicians to study its psychical element. As far as he was concerned, all physicians should have a clear understanding of the relationship between mind and body.

Feuchtersleben took a holistic approach to medical psychology. Materialism, in the sense of reducing mind to body, as far as he was concerned, explains nothing because such reductionism leads to the loss of meaning of human action. Mental illness is deduced rather from the relationship of mind and body without necessarily being able to explain this relationship. There is a limit to the natural scientific understanding of mental life.

Philipp Carl Hartmann, his teacher and Chair of General Pathology, Therapy and Materia Medica at the Vienna Medical School, influenced Feuchtersleben.¹⁰ Hartmann’s understanding of disease as a dynamic process was a corrective to the physicalist perspective. Although both Hartmann and Feuchtersleben of course recognised that mental activity has a physical basis, they were clear that physiology is not able to derive the activities of the mind completely from the laws of the physical world. Despite the success of Feuchtersleben’s book, biomedical approaches became more dominant and his psychosomatic viewpoint had no impact in the second half of the 19th century.

Adolf Meyer's psychobiology

Adolf Meyer was regarded as the Dean of American psychiatry in the first half of the 20th century. His approach, called psychobiology,¹¹ has an integrated understanding of mind and brain. Meyer began his career as a pathologist and moved into the clinical field, standardising procedures for history-taking and mental state examination. Psychopathology needs to be studied functionally in experiences and social interactions rather than organically at the level of neurobiology. Psychobiology was not an aetiological psychiatry, in the sense of providing psychoanalytical mechanisms or Kraepelinian disease entities.

Meyer viewed mental activity and brain activity as a single biological response. Mental dysfunction, as much as brain disease, is a medical condition resulting from pathological processes. As far as Meyer was concerned, functional mental illnesses are failed adaptations, rather than distinct brain diseases. He was fond of calling a 'neurologizing tautology' any attempt to reduce mental illness to brain disease.

Meyer's ideas never really take hold as a systematic theory of psychiatry. This was partly because of his pragmatic compromising attitude. He was prepared to accommodate all perspectives in psychiatry even if he disagreed with them. He recognised this himself in a heartfelt note he wrote a few years before he died, saying, 'I should have made myself clear and in outspoken *opposition*, instead of a mild semblance of harmony'.¹²

George Engel's biopsychosocial model

George Engel's biopsychosocial model¹³ to integrate biological, psychological and social factors in medicine and psychiatry was a deliberate challenge to biomedical reductionism. Engel acknowledged the historical significance for his integrated and holistic model of the work of Adolf Meyer. He recognised the difficulties in overcoming the power of the prevailing biomedical structure, whose dogmatism he thought needed to be neutralised. As far as he was concerned, doctors had become insensitive to the personal problems of patients and were preoccupied with procedures. This was a crisis for the whole of medicine, not just psychiatry. An integrated understanding of the whole person, including emotional needs and life issues, forms the basis for patient-centred medicine.

The biopsychosocial model accepts the inherent uncertainty in psychiatric and medical practice. By contrast, the biomedical perspective seems to have an advantage because of its perceived potential for certainty in the understanding of mental disorder. The biopsychosocial model can be seen as too vague by comparison.

Further, the biopsychosocial model is often used in an eclectic way in current psychiatric practice. It is commonly said that biological, psychological and social must all be taken into account in psychiatric assessment, as though all three are more or less equally relevant in all cases and at all times. This ill-defined basis for practice may create theoretical inconsistency, such as viewing more minor psychological disorder as psychosocial, whereas more severe mental illness is identified as biological in origin. It may also lead to the combination of psychotherapy and biological treatments without any systematic theory to support such a strategy. This eclecticism has been critiqued¹⁴ and does seem to have outlived its usefulness.

In fact, Engel's original version of the biopsychosocial model was not eclectic and eclecticism has more to do with the mainstream response to anti-psychiatry.¹⁵ The conflict created by the split between biomedical and biopsychosocial models has encouraged the compromise of eclecticism to avoid ideological argument.

Conclusion

To be clear, critical psychiatry is encouraging the integration of mind and body, not their separation. The brain is the origin of the mind and minds are enabled but not reducible to brains. In other words, mental disorders show *through* the brain but not necessarily *in* the brain. Critical psychiatry argues that believing that functional mental illness is a brain disease is more like a faith that doctors are obliged to believe rather than a scientific position.

As demonstrated with three examples, this essential position of critical psychiatry has been expressed in the history of modern psychiatry. At the same time as Griesinger was steering psychiatry toward a positivist understanding of mental illness, Feuchtersleben based psychiatry on Kant's critical philosophy. Meyer's psychobiology provides a legitimate

theoretical framework for critical psychiatry, although any neo-Meyerian position must take into account Meyer's tendency to compromise and cannot simply be a restatement of his legacy. Engel's biopsychosocial model also provides a valid anti-reductionist position for critical psychiatry, although it should not be associated with the eclecticism it has come to acquire in current psychiatry.

In summary, critical psychiatry should not be seen as an embarrassing hangover from the 1970s. It can be understood as a non-eclectic, biopsychosocial, neo-Meyerian approach to psychiatry based on Kant's critical philosophy. This position should not be overly polarised in an argument against the biomedical model and recognises that other models, such as the psychodynamic and psychoanalytic, also emphasise psychic aspects. An integrated mind-brain understanding needs to be enriched by a biology that accepts the limitations of a mechanistic interpretation of mental illness and life in general. Critical psychiatry has relevance for modern psychiatry.

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1.3.35 The HCR-20 and violence risk assessment – will a peak of inflated expectations turn to a trough of disillusionment?

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Abstract

The HCR-20 has taken on a life of its own. In forensic services it has been elevated from helpful aide-mémoire into a prophetic tool worthy of Nostradamus himself. Almost every outcome is interpreted through it. Despite the evidence of its limited utility, the difficulties of predicting rare events, the narrative fallacies and other heuristic biases it creates, and the massive opportunity costs it entails, commissioners and services alike mandate its use. Yet in routine practice the problems are not acknowledged, multiple conflicts of interest lie unobserved and other opportunities are neglected.

Contents

- *The HCR-20 and violence risk assessment – will a peak of inflated expectations turn to a trough of disillusionment?*
 - *Limitations to SPJ tools*
 - *The consequences of ignoring these limitations*
 - *What can we do?*

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Declaration of interest: E.S. is involved in the use of SPJ tools as part of the routine clinical care of detained patients.

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Violence risk assessment is a core part of forensic psychiatry. It has evolved from an unstructured clinical and anecdotal exercise, through the use of actuarial tools and is now dominated by a variety of structured professional judgement (SPJ) instruments. Of these the Historical Clinical Risk Management-20 (HCR-20) is pre-eminent. It has itself evolved: first published in 1995, it is now in its third iteration. Initially it was used as an aide-mémoire to assist clinicians and others to systematically assess what were believed to be risk factors for violence across time: historical (ten items), clinical and risk management (five each). In 2001 further materials were added, including scenario planning.

The HCR-20 is the most widely used violence risk assessment tool in the world,¹ and in the UK it has become the ubiquitous gold standard for the risk assessment of violence in forensic services. NHS England commissioners of secure services for forensic patients mandate an HCR-20 assessment, updated every 6 months, even when there is no history of violence. As can be the case with many expert judgements,² any outcome can be seen through its lens. In cases of disaster, ‘the HCR-20 was completed incorrectly’, ‘the recommendations were not followed’, ‘it was not updated on time’ and, most seriously, ‘there was no HCR-20’. When there is success then the merits of the risk assessment and assessor are praised. Fearing blame in the event of failure, my psychologist colleagues spend dozens of hours reading through volumes of notes and the outputs are so long as to be unreadable. Explanations of previous violence are formulated, estimates of risk made and future risk scenarios hypothesised. The tool is over-relied on to guide patient management through complex systems of care, a task it cannot achieve. Curiously, updates are frequently done after clinical decisions about management have been made. But the limitations are not acknowledged and they are legion. Some are relevant to violence risk in general and others specifically to SPJ tools and the HCR-20 in particular.

Limitations to SPJ tools

- There is no grade 1 randomised controlled trial (RCT) evidence for the effectiveness of SPJ tools in reducing violence; the only RCT tested the Short Term Assessment of Risk and Treatability (START) and gave a negative result.³
- Most items in structured risk assessment instruments, especially the Psychopathy Checklist –Revised (PCL-R), and many in the HCR-20 do not predict violence.⁴
- Random combinations of risk factors are as useful as those assembled in standardised instruments.⁵
- The HCR-20 ignores pertinent facts regarding the importance of adherence to specific drug treatments and risk.⁶
- The area under the curve (AUC) measure of utility bears very little relevance to use in clinical practice and ignores the difficulty of prediction when base rates are low.⁷ It is a concept rarely used in other areas of medical practice, where positive predictive value (PPV) is the usual measure.
- As with any attempt to predict rare events⁸ (p. 170) the PPV of the HCR-20, as with other risk tools, is poor and it produces many more false- than true-positive findings.⁹
- High-quality negative evidence regarding the utility of multiple risk tools is not noticed, is refuted and as yet has had no impact on commissioners or services.^{9,10}
- Intellectual and financial conflicts of interest in the publications on various SPJ tools are not mentioned.¹¹ Those who submit research papers on the HCR-20 and other risk instruments rarely, if ever, declare an interest in receiving fees from training in its use. Yet it is a ‘product’, like a pharmaceutical agent, and one for which they stand to gain financially if it is promoted. Similar conflicts may exist for those who conduct serious adverse incident reviews recommending improved use of risk assessment if this is also a service they provide on a commercial basis.
- The narrative explanations of risk formulations and future risk scenarios are accepted. They are not seen as rhetorical devices requiring empirical validation, unlikely to be correct in systems too complex for analysis. To make sense of the world humans require stories that examine concrete events, ignoring chance and the things that did not happen. Any recent salient event is a candidate to become the kernel of a narrative explanation.¹²
- Narratives combined with recent or high-profile events feed heuristic biases, including representativeness, availability and, most important, affect.^{13,14} In forensic services our patients have often violated basic human norms: rape, incest, murder, mutilation and losses of control.¹⁵ At times we will be disgusted. This is rarely acknowledged and instead there is a serious risk that an emotionally driven sense of disgust¹⁴ will result in the immediate generation of opinions for which the supporting evidence is subsequently found, with risk assessment becoming confused with the assessment of outrage¹⁶ and becoming a moral exercise.¹⁷
- Whatever our organisations may tell us, it feels as if there is only punishment for failure and so an increasing tendency to risk aversion is inevitable.¹⁸
- The definition of violence used in the HCR-20 is so broad (including verbal threats) as to be meaningless in the services we work in.

The consequences of ignoring these limitations

Ignoring these difficulties is not just a failure of a tool. It has enormous consequences for patients, professionals, the public and those who pay for our services. The patients we care for face prolonged detention and the opportunity cost of professional time that could be spent delivering interventions. The patients we do not care for face delays in accessing care, often untreated and in inadequate facilities in prison. As professionals we become preoccupied with avoiding failure instead of achieving improvement and it often feels like the risk that is being managed is the risk to ourselves and to, or even from, our organisations. An explicit analysis of risk will be an important part of a patient's treatment, but in the context of deficiencies in treatment and access to care, an HCR-20 will not protect us, or our organisations, from litigation or public criticism. Instead of trying to determine what the prospective risk is given the facts and the base rates, we anticipate how failure will be perceived in hindsight. Those that fund our services complain that too many are detained,¹⁹ while removing funding from objective research.²⁰ Inquires²¹ continue to recommend interventions that do not work – case management,²² risk assessment and community treatment orders²³ – and themselves can fuel narrative fallacies.²⁴ Through our overvalued ideas regarding risk assessment, forensic services are left caring for a tiny percentage of mentally disordered offenders, who we dare not part company with, and at vast expense.²⁵

What can we do?

The argument is not that risk assessments should be abandoned, only that we should be much more circumspect about their power, utility and explanatory value, and recognise how narratives may mislead as well as explain. This is now the position in the related field of suicide risk assessment. In stark contrast to the requirements for secure services and the use of the HCR-20, the National Institute for Health and Care Excellence (NICE) advice is: 'Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm'²⁶ (p. 8), for the simple reason that we cannot stratify risk using the tools available. The information they provide regarding the likelihood of the outcomes we are really concerned about is of no practical use.²⁷ But it is very hard for systems to change and for professionals to give up their sincerely held beliefs. This is the case throughout medicine. It takes an average of 17 years to translate research findings into practice.²⁸ Although short structured assessments would be helpful, our attempts to stratify risk of violence are not useful and should be abandoned, as should narrative explanations of the past and hypothesising future scenarios. It is not particularly useful to say that a man who has been violent in the past might be violent in future if intoxicated, threatened, feeling disrespected or aggrieved, lost to follow-up, non-adherent to antipsychotic or mood stabilising medication and in contact with a vulnerable potential victim.

Some hope that technology will provide a solution. But it took the resources of Deep Mind's artificial intelligence (AI) capabilities, combined with a vast sample of over 700 000 patients, to develop a system to predict the highly specific outcome of acute kidney injury within the tight window of 48 h in highly monitored in-patient environments.²⁹ So why do we think that we can predict violent behaviour over timescales of weeks, let alone months or years, on the basis of human analysis, or that in future AI will be able to make longer-term predictions about far more complex human behaviours? Even if such analytic systems are developed, it is questionable whether clinicians, patients or the legal system would accept them. It is likely that highly discriminatory variables would be key factors in AI algorithms – gender, age, ethnicity, residence in a high crime area, peer group criminality – and there would be fears that the scenarios of *The Minority Report* would emerge.³⁰ Instead the approach adopted by NICE regarding suicide and self-harm should be taken, with the emphasis on the delivery of effective treatments, ensuring services are adequately resourced and developing better habits regarding quality.³¹

A hint of change?

A quick search using Google Trends shows that online interest in the HCR-20 has fallen dramatically, from a peak in September 2007 to date. The Gartner Hype Cycle,³² with its phases of a technology trigger, a peak of inflated expectations, a trough of disillusionment, a slope of enlightenment and then a final plateau of productivity, is held as an example of the boom, bust and then stabilisation of new technologies. But perhaps this is what is happening already?

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1.3.36 A model for specific goals for in-patient treatment linked to resources and limitations in out-patient treatment

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Abstract

The author reflects on the Norwegian inpatient service descriptions contained in Wilkinson's article, considering the challenges laid out in his piece from the perspective of a child and adolescent psychiatrist working in a hospital crisis setting, as well as within the context of child and adolescent mental healthcare staffing across the UK.

Contents

- *A model for specific goals for in-patient treatment linked to resources and limitations in out-patient treatment*

As a paediatric liaison psychiatrist, I was dubious about how an article that concerns itself with goals for in-patient care would speak to my own experiences and practice. I need not have worried; Wilkinson's paper¹ is rich in reflections about the core issues at play in child and adolescent psychiatric practice and has relevance for all child and adolescent psychiatrists.

Wilkinson writes from the vantage points of retirement and from being 'over the water'. Having spent his working life practising in the well-funded healthcare system of Norway, he brings a huge amount of digested clinical encounter to his analysis of how in-patient services are most usefully oriented, around safety and the developing personality. He argues for two different types of in-patient unit, which might be considered as future service development objectives within the UK. Both rely on considerable expertise and stable staffing. His 'safety first' model requires most child and adolescent psychiatric expertise at the emergency and out-patient levels, with less direct psychiatric input during

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Commentary on... Child psychiatry. See this issue.

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in-patient admission. He acknowledges that we are a long way from a point where we might manage this, but how far off are we?

In the UK, the number of consultant child and adolescent psychiatrists per head of child population is significantly, perhaps scandalously, lower than for other specialties. As of September 2019, provision ranged from 2.8 consultant child and adolescent psychiatrists per 100 000 children in Kent, Surrey and Sussex to a high of 10.7 per 100 000 children in North Central and East London. This compares with 29.3 consultant paediatricians per 100 000 children across England. Most UK general hospitals do not have not a single consultant child and adolescent psychiatrist in their employ. Accordingly, the majority of emergency departments catering for under-18s have no departmental consultant child and adolescent psychiatrist either.

Wilkinson's powerful charge really resonated with me for this reason: 'Why is it not expected that A&E departments should be catering for the second highest cause of mortality?' It is clear what he means by 'catering for'; he has earlier described using in-house 'child and adolescent psychiatry expertise'.

He notes the value of front door expertise: 'those with greater experience refer fewer patients for admission because of potential suicide'. Experienced staff also take less time to come to a decision and tend to provide greater psychological containment, be this in the care of a child with a perturbing mental health presentation or one with a serious physical ailment. Junior psychiatrists, emergency department staff of all grades, and patients and their families all know this. So why are we not stacking more experience to the fore as per Wilkinson's 'safety first' model?

In discussing why local in-patient work is so vital for the 'safety first' cohort, Wilkinson describes the task thus: 'It is not the axis 1 diagnosis which determines the need for admission, but the necessity of an alternative "containment" of the patient to that available at home. Two factors operate here: the state of the child and the processes at home.' Working in an emergency setting, a very large proportion of those we refer for admission fall into the second bracket. This is the reason I have watched the stripping back of family therapy provision within in-patient settings with a deal of dismay.

Wilkinson highlights the need for high and stable levels of staffing in the 'intensive' (24/7) units needed for the 'safety first' cohort. This brings us back to the central importance in recovery at any state or stage of relationships and attachment. How many of our child and adolescent in-patient units have 'a stable group of nurse therapists'? How many even have enough staff each shift? He comments on the reduced need for restraint and sedation in Norwegian units, an enviable outcome of such stable staffing.

Going on to consider the needs of a second cohort of patients, he describes how counterproductive it is to admit those with developing personality issues to the same type of unit as that used for the 'safety first' cohort. He proposes instead a weekday unit, with greater direct involvement by psychiatry, who are less directly involved in day-to-day patient care in the 24/7 'intensive' units. The benefit of a 5-day unit is the testing out and information gathering that can be garnered by weekends at home.

In the UK, psychiatric admission for those with personality issues is generally to the same unit as the 'safety first' cohort. The idea of the 24/5 unit, with its strong emphasis on attachment, trauma and loss, sounded like an extension of what our current dialectical behaviour therapy teams offer, but with the added containment for the rest of the system of not having responsibility for the child or young person during their most risky stages. Our 'ordinary' in-patient units already focus on axes 2–5. And I don't think most in-patient settings in their current form are failing to consider trauma and loss. But staffing issues are the real 'elephant in the room'. We have so much nursing 'churn' and such a paucity of senior staff capacity that both the intensive 24/7 unit model, with its reliance on stable nursing staff and high-level emergency and out-patient expertise, and the 24/5 'developing personality' unit model, with its reliance on intensive consultation and liaison with other agencies, especially social care, feel like impossible dreams for us here in the UK.

It would be easy to close by asking 'Please can I move to Norway?', but I suppose the challenge laid down to us in this paper is this: what can we do individually as citizens, or as a professional collective, to try to address this most gross injustice of utterly inadequate mental health services, emergency, out-patient and in-patient, for some of the most vulnerable members of our society?

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None.

1.3.37 Feasibility and utility of enhanced sleep management on in-patient psychiatry wards

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Abstract

Aims and method

Sleep disturbance is common in psychiatry wards despite poor sleep worsening mental health. Contributory factors include the ward environment, frequent nightly checks on patients and sleep disorders including sleep apnoea. We evaluated the safety and feasibility of a package of measures to improve sleep across a mental health trust, including removing hourly checks when safe, sleep disorder screening and improving the ward environment.

Results

During the pilot there were no serious adverse events; 50% of in-patients were able to have protected overnight sleep. Hypnotic issuing decreased, and feedback from patients and staff was positive. It was possible to offer cognitive-behavioural therapy for insomnia to selected patients.

Clinical implications

Many psychiatry wards perform standardised, overnight checks, which are one cause of sleep disruption. A protected sleep period was safe and well-tolerated alongside education about sleep disturbance and mental health. Future research should evaluate personalised care rather than blanket observation policies.

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- *Feasibility and utility of enhanced sleep management on in-patient psychiatry wards*
 - *Method*
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 - * *Protected sleep time*
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 - * *Hypnotic issuing before and during the SleepWell pilot*

- * *Sleep environment*
- * *Staff and patient feedback*
- *Discussion*
- *Supplementary material*
- *Data availability*
- *Declaration of interest*

Normal duration and timing of sleep is vital for mental and physical health and yet the majority of patients on a psychiatric ward experience sleep disturbance.¹ Sleep disturbance is an independent risk factor for suicide.^{2,3} Poor sleep is often attributed to the psychiatric disorder requiring in-patient treatment, but is also attributable to the ward environment. Noise, light and regular, typically hourly, overnight observations disturb patients independent of the psychiatric diagnosis.⁴ Primary sleep disorders, including obstructive sleep apnoea and restless legs syndrome, are increased in psychiatry patients and also disturb sleep.⁵ For a subgroup of patients, insomnia-specific cognitive-behavioural therapy can be effective within an acute psychiatry ward.⁶

Nursing observations are designed to enhance care and reduce risk, but may paradoxically increase sleep disturbance. To date, little research has focused on the effect of and need for regular overnight observations within psychiatry. Understandable concern about patient safety is one reason for frequent physical checks, despite no direct evidence that fixed timing checks reduces risk.^{7,8}

After review of current observation policy across a large mental health trust, a pilot scheme to enhance sleep was introduced (the SleepWell programme). This was a package including reduction of overnight noise and light, formal staff education about sleep and sleep disorders, a protected sleep period for those deemed safe and screening for sleep apnoea and restless legs syndrome for all in-patients. There was a service evaluation of adverse events, including harmful behaviours before and during the change in night-time observations, alongside detailed patient, staff and carer feedback over the assessment period. Cognitive-behavioural therapy for insomnia (CBTi) was made available to two of the seven wards that undertook the pilot. Issuing data of hypnotic medication was assessed before and during the pilot period.

Method

This was a service evaluation of a pilot scheme to enhance sleep and adjust overnight nursing policy. As such, formal ethical approval was not required, but the design, safety and existing trust operating procedures were reviewed before commencement, by the medical staff committee, the trust board and an existing trust safety programme ‘positive and safe’, which was aimed at reducing restrictive interventions while managing challenging or violent behaviour. Seven adult wards across one large mental health trust (Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust) were used for the pilot. To ensure a range of patients they included a 16-bed male and two 16-bed female adult acute in-patient units based on two separate sites, a 26-bed long-stay rehabilitation unit with shared house, a 16-bed mixed neurorehabilitation ward, a 12-bed in-patient dementia service and an 18-bed psychiatric rehabilitation and recovery unit.

Staff training

Two designated staff representatives from each unit were identified as sleep leads to facilitate development and delivery of the necessary practice changes. Before implementation there was education about sleep and sleep disorders from K.N.A., and creation of an educational package labelled as SleepWell. The service evaluation was designed as a 6-month intervention, with 3 months to identify and educate sleep leads and then 3 months of the SleepWell programme in place with protected sleep during this time. Project supervision and clinical governance came within 'positive and safe', with monthly reports from all sleep leads.

Ward environment and protected sleep time

The ward environment was assessed for all pilot wards and all staff reported weekly during the 3-month pilot on night noise reduction measures. Eye masks and ear plugs were offered to all suitable patients. The trust estates department were involved for wards that required any adjustment to soft-closing bins and doors. Non-caffeinated drinks were offered to the patients in the evening. Set wake-up and bed times and reduction in large meals before bed was encouraged. An agreed addition to the assessment tool was developed to highlight those safe for protected sleep time after at least 72 h on the ward. This was set at 00.00–06.00 h. There was in addition screening for obstructive sleep apnoea, using the validated STOPbang screening questionnaire.⁹ A score of >3 indicates an >50% chance of having obstructive sleep apnoea. Screening for restless legs syndrome was undertaken with a single validated screening question with additional prompt to differentiate from drug-induced akathisia.¹⁰ The SleepWell pathway is shown in *Fig. 1*. This included asking all patients 'Is sleep a problem for you?'. On every pilot ward, information about the SleepWell project was displayed and all patients and carers were informed about the change in policy on admission (shown in Supplementary Appendix 1 available at <https://doi.org/10.1192/bjb.2020.30>). For those with persistent insomnia on two of the acute wards (with adequate and trained psychology provision), CBTi was offered on a weekly basis as a small group therapy and, following existing published protocols developed from the Oxford Ward Sleep Solution study, this is modified to allow for the in-patient setting and encompasses education about sleep, sleep hygiene, sleep scheduling and relaxation, but does not use sleep restriction.⁶ Fig. 1 SleepWell algorithm used on all wards. CBTi, cognitive-behavioural therapy; MDT, multidisciplinary team; SSRI, selective serotonin reuptake inhibitors.

Feedback and review of incidents and hypnotic prescribing

The quantity of hypnotics (zopiclone, temazepam, melatonin and promethazine) issued to each ward was examined across two time periods: January to March 2019 (the SleepWell pilot time period) and January to March 2018 (before the SleepWell intervention). The specific number of patients deemed safe for protected sleep time and the number who completed sleep disorder assessments were also recorded. Interviews with staff and patients across all wards provided feedback for qualitative analysis of the intervention. Incident rates are routinely recorded within the trust by incident report forms (IR1) via an electronic incident reporting system. The number and type were looked at during the time of the pilot and for a further 5 months after this period, and compared with a similar 8-month period before the SleepWell pilot. A comparison between incidents recorded over 24-hour periods and specifically during the protected sleep time was made. Ongoing review of the incident data continued after the service evaluation for an 8-month period in total, as all pilot wards elected to continue protected sleep time. No patient-identifiable data were used at any stage.

Results

Protected sleep time

After assessing those who needed more frequent observations for reasons of physical health or safety, an average of 50% of patients were able to have protected sleep time during their in-patient stay (range 44.3–60%); the data for the different wards is summarised in *Table 1*. The psychiatric rehabilitation and recovery ward was excluded from the data below because patients were not on hourly observations as standard, but instead had established protected sleep time of 00.00–07.00 h living within long-stay flats and houses. *Table 1* In-patients on the six wards during the 3 month SleepWell pilot where there was a change to night-time observations

Ward	Total number of patients on the ward	Number of patients on protected sleep	Percentage of patients on protected sleep
All wards combined	2501	1164	46.4%
Acute adult male	793	544	68.6%
Acute adult female	1201	260	21.6%
Acute adult female	2125	564	26.5%
Dementia service	105	50	47.6%
Neurorehabilitation	168	50	29.8%

Adverse events during protected sleep time

Incident data was compared between 1 January 2018 to 31 August 2018 and 1 January 2019 to 31 August 2019, which included the SleepWell protected sleep period. Far fewer incidents occurred at night in any of the different incident categories both in 2018 and 2019. No serious adverse event, suicide attempt or suicide occurred as a result of the overnight protected sleep period. The deaths that occurred were in-patients on the psychiatric rehabilitation and recovery and dementia wards and were attributed to an expected decline in physical health conditions. A single death occurred in an elderly patient overnight, but this was off-site in an acute medical ward and was attributable to perforated bowel. Across all seven pilot wards, the total number of patients absent without leave or absconding decreased during the SleepWell pilot. Serious incidents requiring security decreased and self-harm decreased during the night, although not during the day, as did inappropriate patient behaviour at night. Aggression and violence increased between 2018 and 2019, with most of the incidents reported on the male high-dependency unit (264 of 781 incidents). It should be noted that there was a trust-wide implementation of a no-smoking policy at the beginning of 2019, and an increase in aggression and agitation was noted (mostly related to wanting to smoke on the trust premises). The results are summarised in *Table 2*.

Adverse event	Number of incidents during 00.00–06.00 h	Jan–Aug 2018	Jan–Aug 2019
Aggression and violence	483	781	468
Absent without leave and absconded	173	174	43
Self-harm	156	193	26
Inappropriate patient behaviour	76	115	4
Substance use/misuse/prohibited items (excluding smoking)	54	103	6
Death	35	11	8
Security	87	76	65

Hypnotic issuing before and during the SleepWell pilot

Review of hypnotics use (*Table 3*) showed a 25% decrease in the quantity of hypnotics ordered to the wards during the SleepWell pilot period. There were specific decreases in zopiclone 7.5 mg and 3.75 mg tablets, promethazine hydrochloride 10 mg and 25 mg tablets and melatonin 2 mg modified release tablets. There was an increase in temazepam 10 mg and 20 mg tablets, but the total number of all prescriptions issued decreased. Specific ward issuing data highlighted that six of the seven wards ordered less hypnotics from pharmacy. *Table 3* Hypnotic issuing during the SleepWell pilot compared with a similar time period before the pilot

Drug description	Quantity of hypnotics issued	Jan 2018–Mar 2018	Jan 2019–Mar 2019
Zopiclone 7.50 mg tablets	796	421	21
Zopiclone 3.75 mg tablets	828	590	90
Promethazine hydrochloride 25 mg tablets	81	46	30
Promethazine hydrochloride 10 mg tablets	112	0	20
Temazepam 10 mg tablets	336	366	20
Temazepam 20 mg tablets	14	160	2
Melatonin 2 mg modified release tablets	278	240	7
Total	3178	2407	147

Sleep environment

The input from estates varied upon the different wards, but included blackout blinds and dimmer lights to ensure light levels throughout the night were kept to a minimum. Soft-closing doors were fitted on two wards. Loud-closing bins were identified and replaced. Eye masks and ear plugs were available on request for all wards. The Rehabilitation and Recovery Unit was structured in bungalows, with fewer noises and disturbances, and so little adaptation was therefore necessary. The volume of night nurse calls was reduced to a minimum and staff were encouraged to report any issues relating to noise/light promptly during weekly meetings.

Posters were put on walls to remind staff and patients about the need try to keep the noise levels to a minimum at night-time. Carers and staff were invited to feedback on changes and given information about sleep and sleep hygiene (included in the Supplementary Appendices).

Staff and patient feedback

Before

One key theme running throughout the feedback collected before the pilot was about the negative effect the ward environment had on patient sleep. The main environmental factors noted were noise, temperature, lighting, bedding and other patients.

After

Post-pilot feedback from ward staff was universally positive and many commented that the ward environment was more peaceful and settled. A focus on bed-time routines was perceived by staff as helping better sleep and, overall, this was well-supported by staff, although there was initial anxiety before implementation about not checking on patients and assessing risk caused some disagreement about which patients were safe to go onto protected sleep. More standardised sleep assessments were not possible within the framework of a service evaluation primarily assessing safety and feasibility. Making this a documented, multidisciplinary team decision helped to reassure staff alongside involving the night coordinators.

Patients who did comment preferred being on protected sleep time: some did not notice a difference and had not been woken, but others expressed feeling safer without people looking into the room, and those who had been readmitted described it as better than previous admissions. All carers were positive about the intervention, with none asking for more frequent observations to be restarted. No patients or carers had concerns about the protected sleep time. All in-patients were asked about the SleepWell programme and typical comments from patients from all of the wards are summarised in Supplementary Appendix 2 but included 'better than last admission', 'I feel safer now' and 'I don't worry about people looking into my room on a night'.

Screening for sleep disorders

The numbers documented as screened were small on the acute wards despite encouragement throughout the period of SleepWell. A total of 39 out of 125 and 37 out of 79 patients were assessed for obstructive sleep apnoea and restless legs syndrome on the acute adult wards, respectively, with nine positive screens for obstructive sleep apnoea (STOPbang score >3). Using the screening tools, no sleep disorders were identified on the rehabilitation wards or the dementia unit.

CBTi

CBTi was implemented on two adult acute wards (one male and one female), with 25 patients assessed as suitable based on length of stay, problematic insomnia and ability to attend therapy. Thirteen (52%) then accepted therapy and attended at least four sessions.

A total of 85 admissions came to the two wards during the 3-month assessment period; only 27 were suitable and approached, 18 accepted and 13 completed. The majority not suitable were either transferred or due for imminent discharge, but 15 had decline in mental state and were unable to engage in therapy. All treated had either paranoid schizophrenia, psychosis or depressive disorder, reflecting the typical case mix of the two wards. Mean insomnia severity index before treatment was 18 (range 6–28), and completion insomnia severity index was 14 (range 6–16).

Discussion

In this pilot study, a protected sleep time and improved education around sleep were safely incorporated into a personalised care plan for adult psychiatric in-patients. There were no serious adverse events or deaths related to the change in policy, ward demands for hypnotics were reduced and both staff and patient feedback was positive.

For psychiatry patients, sleep disturbance is an independent risk factor for suicide,^{2,3} and has been shown to independently predict lower quality of life, higher symptom severity and less benefit from treatment, with Kallestad et al suggesting that sleep should be seen as a 'stand-alone therapeutic entity, rather than an epi-phenomenon of existing diagnoses'.¹¹ However, there have been few systematic studies of the factors that adversely affect sleep on in-patient units. A large, questionnaire-based survey showed 66% of in-patients had poor sleep quality independent of gender or diagnosis.¹ Previous work from our acute in-patient, psychiatry wards demonstrated high levels of objective sleep disturbance and suggested that a number of environmental factors within the ward, including noise levels at night and hourly observations, were disruptive and therefore paradoxically may be worsening mental health and delaying recovery.⁴ Measures to stabilise sleep by using a high-intensity, modified version of CBTi has been shown to be possible and highly effective in acute psychiatry in-patients,⁶ although it was carried out maintaining overnight hourly observations.

The need to protect sleep as part of treatment has to be set against the importance of a safe level of observations for those at high risk of harm from mental or physical health problems. The National Institute for Health and Care Excellence guidelines define various levels of observation determined by a risk assessment, especially for severe self-harm, suicide, violence and absconding.¹² Within physical health units, this initial assessment is rapidly followed by a personalised care plan, allowing for a step down to a protected sleep period where possible. This is shown to balance prevention of acute physical health deterioration with a minimum of intrusive night-time observations. The National Institute for Health and Care Excellence defined the purpose of observation as to 'provide a period of safety... with observation levels set at the least restrictive level, for the least amount of time'.¹²

With specific regard to suicide risk, sleep deprivation owing to frequent checks may still be justified if it can be shown to reduce the frequency of suicide or severe self-harm. However, 91% of those who commit suicide do so while under intermittent observation,¹³ and the most recent review from the National Confidential Enquiry into Suicide⁸ emphasised the avoidance of routine, non-personalised checklists. A recent review of the timing of suicide data highlighted a far lower risk of suicide occurring overnight during the night periods of 23.00–07.00 h⁷ and challenged the perceived benefit of frequent observations. Despite these recommendations, frequent and typically hourly checks throughout the night remain widespread across acute mental health trusts throughout the UK.

Psychiatric nursing observations remain fundamental to the emotional and physical support of the patient, and current guidelines advise 'minimising the extent to which patients feel they are under surveillance, while encouraging communication, listening, and conveying to the patient that they are valued and cared for'.^{13,14} This guidance is somewhat in contrast to typical night-time observations, which require the staff member to clearly see the patient is breathing. This can involve opening the window hatch in the door or entering the bedroom and shining a torch on the patient's face, switching on a light or physically waking the patient.¹⁵ Patient and staff feedback highlighted complaints about the intrusive nature of checks and dislike of the observation policy. During the pilot, support for nursing staff was vital so that staff felt protected and supported to change a policy that might expose them to criticism. In practice, only

50% of patients were deemed safe to be placed on protected sleep, with others requiring more regular observation and input for physical or mental health needs. This still allowed a greater level of necessary engagement for night staff for patients requiring more support or observation for their safety. However, the detailed work required to reassure staff before implementing the policy took an average of 3 months alongside the monthly meetings during the project. It is of note that all wards elected to continue the protected sleep period after the initial service evaluation.

A wide range of incident data is collected across the trust, and the main aim of the pilot was to use this data to show that serious adverse physical or mental health events were not increased in those on protected sleep time, and that there were no serious adverse events in those patients on protected sleep as an important safety measure. It would remain important to have ongoing monitoring of safety for those on protected sleep time and a flexible protocol that allows for any patient to have increased frequency of observation if there was clinical concern. Longer-term assessments would be required to assess for a consistent change in behaviour or any sustained improvements in night-time agitation.

High rates of obstructive sleep apnoea are found in those with severe mental illness, with a prevalence of 25% reported across all psychiatric disorders and the highest frequencies seen in major depressive disorder.^{5,16} Risk factors for obstructive sleep apnoea include male gender, age >55 years, reports of sleepiness and obesity and the STOPbang questionnaire has recently been validated as an effective screening tool in the psychiatric population.¹⁷ An in-patient admission is an opportunity to assess physical health, with increasing recognition of the poor cardiometabolic health of many patients with psychiatric disease.¹⁸ Obstructive sleep apnoea screening should ideally be part of this screening or at least considered as a modifiable cause of poor sleep. Use of the STOPbang questionnaire in our pilot remained challenging, with small numbers of STOPbang scores recorded in records. This may reflect acutely unwell patients or the number of other assessments also required for this group; however, those who were screened were often at risk, which allowed further investigation and lifestyle advice.

Hypnotics carry a risk of diversion and respiratory depression in overdose. Those issued hypnotics while on a psychiatry ward in the UK will typically remain on them at discharge, with a substantial percentage still using them at 12 months.¹⁹ A recent review of the side-effects and benefits of a range of hypnotics highlights the limited evidence base of antihistamines in particular, and the potential for dependency. There is also a falls risk in the elderly.²⁰ The total number of hypnotics issued to the wards decreased by 25% during the 3-month pilot period. This may reflect some hypnotic prescribing being partly attributable to a noisy environment and the observations themselves. However, the analysis did not include patient-level data, so future work would be needed to look at individual prescriptions over longer periods of time. The change in prescribing may also reflect increased knowledge of non-pharmacological strategies to manage poor sleep and the improved ward environment.

There are several limitations to this small study. Standardised sleep assessments were not undertaken, partly because of the variable ward populations and need to assess initial feasibility of protected sleep time. It was not possible to assess any effect on duration of in-patient stay or whether different mental health diagnoses were more or less able to have protected sleep time. Although a small number were able to have CBTi, many were excluded because of short-stay rehabilitation, highlighting the need to communicate to community teams for follow-up therapy. No cases of restless legs syndrome were detected, which likely reflects the lack of recognition of this syndrome and the need for more training. This pilot was designed to evaluate patient safety first and foremost, but a future, much larger trust-wide research study is underway to address patient-level data regarding diagnoses, patient-level prescribing data and patient stay for those on protected sleep time compared with those not on protected sleep time. Although some categories of incident increased, including aggression, this was felt to relate to factors outside of SleepWell, including the particular patient group on the high-dependency male rehabilitation ward and the implementation of the trust-wide smoking ban. It should be noted that even within this increase, far few incidents of any type occurred during the 00.00–06.00 h time window.

In summary, this is the first pilot trial within a UK adult psychiatry unit to formally evaluate the feasibility and safety of a protected sleep period. A trust wide review of the observation policy is now underway, but any personalised care plan for a patient should include an evaluation of the patient's sleep. Improving and stabilising sleep disturbance should be part of routine in-patient psychiatric care, with a personalised assessment of the risk versus the benefit of waking the patient at night.²¹

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Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2020.30>.

[click here to view supplementary material](#)

Data availability

Data are available from the author.

C.N. led on project design and development of all SleepWell material and CBTi. E.P. analysed incident data and contributed to manuscript writing. A.P. contributed to analysis of all prescribing data, manuscript preparation and review. A.R. contributed to project design, dissemination of SleepWell and data analysis. R.L. contributed to qualitative feedback and data analysis. P.K. contributed to project design, implementation and assistance with manuscript preparation. S.W. contributed to project design and implementation, supervision of students and manuscript preparation. K.N.A. contributed to project conception, design, development of SleepWell material, supervision, data analysis and manuscript preparation.

Declaration of interest

None.

ICMJE forms are in the supplementary material, available online at <https://doi.org/10.1192/bjb.2020.30>.

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Award-winning investigative journalist Robert Kolker follows the success of *Lost Girls* with the incredible story of the Galvin family and the impact of schizophrenia on their lives.

Kolker follows the story of Don and Mimi Galvin who, along with their 12 children, represented the ‘perfect all-American family’ – that is until 6 of their sons developed schizophrenia. After a whistle-stop tour of the history of psychology and psychiatry, Kolker deftly navigates us from the first Galvin brother’s diagnosis in the 1960s through many pharmacological, genetic and psychological advances right up to our present-day understanding of schizophrenia. The book examines the conflicts within psychiatry over the years, poignantly portraying a family lost in the gulf of a speciality at war with itself.

Kolker deals sensitively and compassionately with the more challenging themes of sexual abuse, suicide and even murder, presenting the differing experiences of many of the family members in a thoughtful and considered way. A real strength of this book is that it also considers the experiences of ‘well’ family members, whose lives are so affected by their brothers’ illness. The hero of this story is undoubtedly Mimi Galvin: dismissed early on as the typical ‘schizophrenogenic mother’, she provides a lesson in love, loss and resilience and reminds us of the lengths to which a mother will go to protect her family.

Despite being marketed to the general public, the skilful mix of scientific detail coupled with engaging storytelling makes this book essential reading, particularly for psychiatry trainees. In addition to its clear educational value, for me this book served as a reminder of the importance of compassion in our services – not only to the patients themselves but to all those involved in their care.

You need look no further than the acknowledgements section to see the time, effort and genuine care that went into putting this story together with the help of the remaining Galvin family members. I believe this is something that, as psychiatrists, we can also bring to assembling and understanding our own patients’ stories.

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1.3.38 Police involvement, characteristics and outcomes of place of safety referrals in the Scottish Highlands

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Abstract**Aims and method**

To characterise police involvement with those detained under place of safety legislation and determine factors associated with admission to hospital. Place of safety referrals over a 1-year period were identified retrospectively and evaluated.

¹ **Declaration of interest:** None.

Results

Place of safety legislation is generally used with regard to concerns about suicide. Individuals are often removed from high-risk areas and referrals to police are frequently initiated by individuals themselves. A diagnosis of mental illness or personality disorder predicted hospital admission. Presence of senior nursing staff at assessment, but not the seniority of the doctor, was associated with discharge.

Clinical implications

Closer multiagency working is required as police are currently being recruited to fill a void between mental health services and the population they serve. Junior doctors require more senior support in making complex, and often risky, emergency management decisions with this population.

Contents

- *Police involvement, characteristics and outcomes of place of safety referrals in the Scottish Highlands*
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Place of safety legislation permits police officers to remove individuals thought to be mentally disordered and in need of immediate mental health assessment to a facility where this assessment can be carried out. Such legislation exists in many countries, including the UK,^{1,2} Germany,³ South Africa,⁴ Australia⁵ and the USA.⁶ Powers and legislation vary between and within countries but in general police must suspect a mental disorder *and* perceive significant, acute or serious risk of danger or harm to the individual concerned or to others in order to permit removal to a place of safety. In Scotland this power is detailed under section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003¹ (this detention lasts for up to 24 h or until the individual has been assessed); similar powers in England and Wales are under section 136 of the Mental Health Act 1983.²

There have been efforts to reduce use of police stations as a place of safety, reduce overall use of the legislation and improve knowledge of the legislation.^{7–9} Practice, however, remains variable across Scotland¹⁰ and the rest of the UK.^{11,12} In Scotland the use of this legislation is rising, with 795 detentions in 2015–2016, up from 130 in 2006–2007.¹⁰

There is reasonable reporting of place of safety use and the characteristics of those subject to the legislation^{1,5,13–15} but little is known about the nature of police involvement and which factors, if any, are associated with hospital admission. This study in the Scottish Highlands aimed to characterise the nature of police involvement with those detained under place of safety legislation, the demographics of this population and aspects of the assessment process to determine factors that might be associated with admission.

Method

We conducted a retrospective study by review of medical case records, including Place of Safety forms (POS1, v7.0) completed by police constables, of all individuals brought under place of safety legislation to New Craigs Hospital, Inverness in the NHS Highland region (the designated place of safety for the NHS Highland health board) between April 2016 and March 2017. All place of safety referrals were included in the project, including repeat detentions for any one individual. Individuals who were already in-patients when the place of safety legislation was applied were excluded from the analyses regarding admission to hospital.

Referrals were identified by collecting POS1 forms from the medical records department and cross-referencing with a place of safety referral record sheet in the intensive psychiatric care unit (IPCU), which is where most place of safety referrals are assessed. The junior doctor's assessment book and mental health assessment team's diary were also consulted to ensure that as many place of safety referrals as possible were identified. In an attempt to determine completeness of these records the Mental Welfare Commission for Scotland was contacted. Information about the assessment team's wider activity was gained from their team diary, which is updated reliably after each assessment. The POS1 form completed by police is not statutory and therefore any referral identified in case notes as being under place of safety legislation was included.

The POS1 form has an open text box to give details of the 'circumstances giving rise to the removal of the aforementioned person to a place of safety.' In all cases where a POS1 form was available this information was qualitatively analysed to characterise the nature of police involvement, the reasons for concerns and the reasons for the decisions made. Diagnosis was determined from clinical records and kept to broad ICD-10 diagnostic categories; more than one diagnosis was permitted, for example comorbid substance misuse and personality disorder. Diagnoses were often already established from clinical records rather than being based on the single urgent assessment.

Population data for calculating rates of referral are from census data from National Records of Scotland, a non-ministerial government department charged with collecting information about Scotland's people and history.¹⁶

The project was part of service development and audit and therefore did not require ethical approval.

Statistical analysis

Statistical analyses were performed using Minitab 17.1.0 and SPSS 22.0 statistical software, both for Windows. The association between categorical and outcome variables was assessed using Pearson ²-tests; where the cell count was low the likelihood-ratio chi-squared test was used. For continuous variables, Student's *t*-tests were performed. Given repeated referrals of some individuals, multivariable binary logistic mixed-effects regression was performed to predict admission using individuals as the random effect in order to account for individual-specific effect and control for the fixed effects of age, gender, diagnosis and distance from place of safety on detention. Robust estimation procedure was used to obtain the estimate of covariance matrix in order to ensure that model assumptions were met. Estimates of effects are presented as odds ratios (OR) and 95% confidence intervals (CI). The level of significance was set at $P < 0.05$.

Results

We identified 237 place of safety referrals over the 1-year study period. Of these, 97% ($n = 231$) were recorded on the place of safety record form in the hospital IPCU and 99% ($n = 234$) had a completed POS1 form. The yearly referral rate under place of safety legislation for the health board was 74 per 100 000 population (NHS Highland serves about 320 000 people and is sparsely populated, covering an area of 32 500 km²: around a quarter of this population live in Inverness and surrounding areas). The referrals were for 185 different individuals, with 30 (16%) being brought on more than one occasion over the study period (the highest number was five referrals, which occurred for three individuals).

Time variation in place of safety referrals

The rate of referral was similar throughout the year and did not vary by month ($\chi^2 = 12.06$, $P = 0.359$) or day of the week ($\chi^2 = 4.63$, $P = 0.592$). Detention under place of safety legislation was most likely to occur between 12.00 h and 17.00 h and least likely between 06.00 h and 12.00 h ($\chi^2 = 48.81$, $P < 0.001$), however no particular time of detention was associated with admission to hospital ($\chi^2 = 6.99$, $P = 0.221$).

Characteristics and outcome of individuals referred

The characteristics and outcomes of place of safety referrals are detailed in *Table 1* (analysis of 230 referrals). The admission rate overall was 33% ($n = 75$), with only 15% ($n = 11$) of those admitted being involuntarily under the Mental Health (Care and Treatment) (Scotland) Act 2003. The admission rate for those brought on place of safety legislation is not significantly different from the admission rate for those seen by the assessment team referred from other sources, i.e. referred by health professionals not police ($\chi^2 = 0.41$, $P = 0.521$); 79% ($n = 182$) of those referred had at least one previous contact with local mental health services. *Table 1* Characteristics and outcomes of place of safety referral

Measure	All	Admitted	Not admitted	P
Referrals, n (%)	230 (100)	75 (32)	155 (68)	
Age, years: mean (s.d.)	35.5 (12.1)	36.5 (12.9)	34.9 (11.7)	0.408
Males, n (%)	151 (66)	43 (57)	108 (69)	0.065
Previously known to local services, n (%)	177 (77)	55 (73)	122 (79)	0.364
Assessed with senior nurse present, n (%)	198 (86)	58 (77)	140 (90)	0.026
Grade of assessing doctor, n (%)				
Foundation year	249 (21)	19 (25)	30 (19)	0.809
General practice trainee	75 (33)	23 (31)	52 (34)	
Core psychiatry trainee (year 1 or 2)	62 (27)	21 (28)	41 (26)	
Core psychiatry trainee (year 3) or above	44 (19)	12 (16)	32 (21)	
Diagnosis, broad ICD-10 category: ^b n (%)				
Substance use disorders	115 (50)	27 (36)	88 (57)	0.003
Non-affective psychotic disorders	17 (7)	13 (17)	4 (3)	<0.001
Affective disorders	9 (4)	6 (8)	3 (2)	0.033
Anxiety and stress disorders	16 (7)	7 (9)	9 (6)	0.324
Eating disorders	1 (0)	0 (0)	1 (1)	–60
Personality disorders	79 (34)	30 (40)	49 (32)	0.209
Intellectual disability ^c	13 (6)	7 (9)	6 (4)	0.093
Developmental disorders	0 (0)	0 (0)	0 (0)	–
'No mental illness'/social stress ^d	45 (20)	3 (4)	42 (27)	<0.001
Approximate distance of detention from hospital, n (%)				
0–5 miles	154 (67)	42 (56)	112 (72)	0.018
5–10 miles	9 (4)	4 (5)	5 (3)	–
10–15 miles	13 (6)	5 (6)	8 (5)	–
15–20 miles	14 (6)	7 (9)	7 (5)	–
>20 miles	13 (6)	9 (12)	4 (3)	–

Where individuals were not admitted most were discharged to their own home or in care of friends/family ($n = 136/155$, 88%); in a small number of cases individuals were taken into police custody ($n = 6$, 4%) or transferred for medical care in the local general hospital ($n = 7$, 5%).

It is local policy for place of safety referral assessments, where possible, to be performed by two assessors. All place of safety referrals were seen by a doctor (of various grades but generally junior doctors in training up to CT3 grade; in only one case was assessment by a consultant) and most with a senior assessment nurse present ($n = 198$, 86%) – where senior assessment nurses were not available, doctors completed assessments with ward nursing or auxiliary staff or alone. There was a high degree of variability in admission rates, with a median of 29% (IQR = 39, range 0–100), but this was not influenced by the training grade of the doctor ($\chi^2 = 1.60$, $P = 0.809$). The presence of a senior assessment nurse was associated with patients not being admitted following assessment ($\chi^2 = 4.98$, $P = 0.026$).

Admission was less likely for individuals where it was thought difficulties were related to substance misuse ($\chi^2 = 9.88$, $P = 0.003$), social stress ($\chi^2 = 14.18$, $P < 0.001$) or if there was felt to be no evidence of mental illness ($\chi^2 = 6.43$, $P = 0.011$). A personality disorder diagnosis was proportionately more common in those admitted following assessment but not significantly so ($\chi^2 = 1.57$, $P = 0.209$). Diagnoses of non-affective psychotic disorders ($\chi^2 = 16.07$, $P < 0.001$) and affective disorders ($\chi^2 = 4.55$, $P = 0.033$) were more prevalent in individuals admitted following assessment.

Most of the place of safety referrals were from the local area, with 67% ($n = 154$) from within 5 miles of the hospital – this gives a yearly referral rate of 248 per 100 000 population for Inverness. The number of referrals reduces with increasing distance from the hospital but as distance from hospital increases admission is more likely ($\chi^2 = 11.87$,

² Excludes individuals who left the hospital during an in-patient stay and were returned by police under place of safety legislation.

³ Diagnosis obtained from assessment/discharge letters and kept in broad diagnostic categories, more than one diagnosis was permitted owing to frequent comorbidity, e.g. personality disorder and substance misuse.

⁴ Also known as learning disability in UK health services.

⁵ It was not possible to determine the location of detention in 12% ($n = 27$) of referrals from the Place of Safety (POS1) forms.

$P = 0.018$). The prevalence of substance misuse diagnoses reduces with increasing distance from the hospital ($\chi^2 = 12.18$, $P = 0.016$).

If individuals were admitted to hospital the median length of stay was 6 nights (IQR = 22, range 0–136). Significantly shorter admissions were seen for individuals who had a substance misuse diagnosis ($\chi^2 = 11.32$, $P = 0.023$). No other diagnoses were associated with the length of admission.

Nature of police involvement from POS1 forms

Police were alerted to individuals subsequently detained on place of safety legislation in a variety of ways (Fig. 1). Usually the alert came from concerned friends or family members (26%, $n = 62/234$), but it was also common for individuals to make themselves known to police (23%, $n = 53$), usually by telephone (15%, $n = 34$) but in some instances by walking into police stations (7%, $n = 16$). Fig. 1 How police were alerted to individuals subsequently detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (total $n = 234$). Self-contact included presentation to a police station, telephoning police or approaching police in the street. Professional report was concern raised by health professionals or mental health support agencies such as Breathing Space. In some cases it was not clear from the Place of Safety (POS1) form details how the police had been alerted.

The most common reason cited for police being involved was expression of suicidal ideation (73%, $n = 167/230$) (Table 2); 28% ($n = 65$) of individuals had made a gesture towards suicide (e.g. holding knife at their throat or being at a risky area on a bridge), and only 7% ($n = 17$) had made an attempt on their life (e.g. cut at their throat or removed from river after jumping in). Voicing suicidal ideation ($\chi^2 = 23.58$, $P < 0.001$), making a suicidal gesture ($\chi^2 = 5.45$, $P = 0.020$) and making an attempt on their life ($\chi^2 = 4.43$, $P = 0.035$) were all associated with not being admitted to hospital. Table 2 Qualitative analysis of Place of Safety (POS1) forms for place of safety referrals a Details recorded on POS1 forms All b ($n = 230$) Admitted ($n = 75$) Not admitted ($n = 155$) P Descriptors of harm to self, n (%) Voiced suicidal ideation 167 (73) 40 (53) 127 (82) <0.001 Had made suicidal gesture 65 (28) 14 (19) 51 (33) 0.020 Had made suicide attempt 17 (7) 2 (3) 15 (10) 0.035 Voiced intent to self-harm 24 (10) 4 (5) 20 (13) 0.057 Had performed self-harm 17 (7) 2 (3) 15 (10) 0.035 Police noted previous suicide attempt 20 (9) 5 (7) 15 (10) 0.413 Other descriptors, n (%) Precipitating events, e.g. break-up/debts 28 (12) 4 (5) 24 (15) 0.027 Anxiety 4 (2) 2 (3) 2 (1) 0.454 Depression/low mood 16 (7) 3 (4) 13 (8) 0.220 Odd beliefs, perceptual disturbance, paranoia 34 (15) 18 (24) 16 (10) 0.006 Agitation/emotional/strange behaviours 38 (17) 17 (23) 21 (13) 0.081 Expressed intent to harm others 3 (1) 1 (1) 2 (1) – Location of detention under place of safety legislation, n (%) Public minor road 56 (24) 18 (24) 38 (25) 0.932 High-risk area, e.g. bridge/major road 39 (17) 12 (16) 27 (17) 0.788 Inside public building 31 (13) 12 (16) 19 (12) 0.436 Directly outside own home 21 (9) 9 (12) 12 (8) 0.293 Inside own home 15 (7) 2 (3) 13 (8) 0.100 Within hospital grounds 5 (2) 2 (3) 3 (2) 0.721 Rural area, e.g. woodland 6 (3) 1 (1) 5 (3) 0.371 Unclear 57 (25) 19 (25) 38 (25) 0.893⁶⁷

In only a small proportion of referrals did police give information beyond that focusing on suicidality. Of note, there was infrequent recording of the events that led to the individual now experiencing difficulties. Where this was detailed it was usually brief and a social stressor (e.g. split from partner or financial concerns) – in cases where a stressor was identified (by police) individuals were usually not admitted ($\chi^2 = 4.87$, $P = 0.027$). Police did report details about odd beliefs, paranoia or perceptual disturbances (e.g. hearing voices or responding to unseen stimuli) in 34 referrals (15%) – this was associated with admission to hospital ($\chi^2 = 7.51$, $P = 0.006$) and with non-affective psychotic disorder diagnoses ($\chi^2 = 4.85$, $P = 0.028$). In the small number of referrals in which police described behaviours (outwith the suicidal acts/gestures), these descriptions were often very general and would not necessarily be related to mental ill

⁶ POS1 forms were available for 227 of the 230 referrals.

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Excludes individuals who left the hospital during an in-patient stay and were returned by police under place of safety legislation.

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health, for example ‘highly emotional’, ‘acting in a strange manner’, ‘agitated’, ‘shouting nonsense’, ‘unpredictable’ or ‘hysterical.’

Police were called to a range of areas in response to concerns for individuals subsequently detained under place of safety legislation (*Table 2*). The location from which individuals were removed was not associated with subsequent admission to hospital even when removal was from high-risk areas such as bridges or major roads ($\chi^2 = 0.07$, $P = 0.788$). In 7% of cases ($n = 15/230$) it appeared that individuals had been removed from their own home, which is not permitted under place of safety legislation in Scotland.¹

Multivariable binary logistic mixed-effects model

When controlled for age, gender and distance from the place of safety (i.e. the hospital) in a multivariable binary logistic mixed-effects regression with individuals as the random effect, the odds of admission were significantly higher for diagnosis of non-affective psychotic disorder (OR = 32.93, 95% CI 4.33–250.17, $P = 0.001$), affective disorder (OR = 15.13, 95% CI 2.15–106.61, $P = 0.007$), anxiety and stress disorder (OR = 7.01, 95% CI 1.21–40.93, $P = 0.037$), intellectual disability (OR = 17.58, 95% CI 2.32–130.02, $P = 0.007$) and personality disorder (OR = 5.49, 95% CI 1.21–24.86, $P = 0.027$) relative to those without a diagnosis of mental illness. Substance misuse was not significantly associated with admission (OR = 2.78, 95% CI 0.64–12.08, $P = 0.170$). Although not statistically significant, the individual’s age was positively associated with admission and the odds of admission were higher for women than men. Also, odds of admission increased with distance from the place of safety – the farther the distance the higher the odds of admission. The use of individuals as the random effect ensures that extra-individual variations resulting from repeat referrals are adjusted for and this is evidenced in the size of the confidence intervals of the estimates.

Discussion

Place of safety referrals constitute a significant proportion of urgent mental health assessments within the NHS Highland region – up to one-third of assessments within the study hospital. The recording of these referrals in the hospital appears to be reliable and numbers are in keeping with data from the Mental Welfare Commission for Scotland.¹⁰ NHS Highland accounts for perhaps up to 20% of all place of safety referrals in Scotland;⁸ this is proportionately lower than a local study 10 years ago, when up to 50% were in the NHS Highland health board.^{7,8} However, it is of note that in the current study almost 70% of place of safety referrals occurred within a few miles of the designated place of safety. This is unlikely to be simply due to population factors despite the place of safety being located in Inverness. The place of safety referral rate per year for Inverness is 248 per 100 000 – over 10 times the rate for Scotland as a whole and 3 times that for the health board with the highest referral rate in Scotland.¹⁰ Under-reporting in some Scottish health boards is likely to contribute to this variation but does not fully explain the vast differences. Looking more broadly, this referral rate is also significantly higher than in studies in England, where rates are reported between 59.8 per 100 000 in the North-East¹² and 169 per 100 000 in Ipswich, Suffolk.¹¹ There appears to be excessive use of this restrictive legislation in Inverness – factors driving this are likely to be poorer joint working, workload pressures and a lack of availability of alternative options of disposal/help for those in crisis. There are a striking number of referrals where individuals have sought help from police rather than from local mental health services. This supports the proposal in a recent Mental Welfare Commission for Scotland place of safety report that there is a gap between service provision and the needs of this distressed population.¹⁰

Police are responding to distressed individuals in a range of locations, from their own home to high-risk situations on major roads or high bridges. Where place of safety legislation is used, this is overwhelmingly in response to concerns about suicide risk. This study does show that police do well in identifying those in need of mental health support – the admission rate of police referrals is identical to that from other sources and they detail evidence of psychosis on their referrals. The language used by police in describing behaviours includes terms such as ‘highly emotional’ and ‘hysterical’ – these are commonly used terms but could be stigmatising for those with mental health difficulties. Targeted training and support for officers may well improve their interaction with distressed individuals and make involvement with police a less daunting experience for those with mental health problems.

The characteristics of those referred under place of safety legislation in the Scottish Highlands are similar to those reported elsewhere in terms of age, gender and outcome.^{11,13,14} However, in this study substance misuse problems

are possibly more prevalent and were felt to be contributing to presentation in almost 50% of referrals whereas the proportion of severe mental illness is probably slightly lower.^{6,14} The compulsory admission rate is significantly lower (15%, compared with up to 50%) than in other reports, likely reflective of the lower proportion of individuals with severe mental illness.^{11,13}

This study identified that presence of senior nurses influenced outcomes of assessments and recognised that there is significant variability in admission rates by doctors at all training grades. It is therefore important to ensure that experienced staff are conducting assessments and consideration should be given to a model that ensures multidisciplinary input such as that used in England and Wales,² where approved mental health professionals (AMHPs) support the assessment process, including follow-up care arrangements for those not admitted. Further, with evidence in Scotland that trainees are doing fewer emergency assessments,^{17,18} ensuring that trainees are well supported by senior medical staff in completing these assessments is crucial.

Predicting outcomes and length of hospital stay

Predicting outcome of assessments is challenging given the nature of any mental health crisis, as difficulties are very individualised. However, diagnosis appears to be a primary factor in the decision-making process. In general, where referrals are identified as being related to primarily social stressors or substance misuse problems admission to hospital is avoided or, where felt necessary, kept as short as possible. A diagnosis of severe mental illness was associated with admission but not any particular length of admission, and perhaps in some cases a short admission plays a containing role rather than being for treatment itself when individuals are presenting via police. Personality disorder diagnosis was associated with admission to hospital despite extensive local training, resource and a new integrated care pathway which states that admission for those with personality disorder is ‘at best neutral and at worst harmful’.¹⁹ It is likely that a combination of factors influence the decision to admit – those with personality disorder diagnoses may be in a high degree of crisis that cannot always be de-escalated over a single assessment and may be thought of as being at high acute risk of suicide, given their language, circumstances, social supports or expression of plans for suicide following assessment if they leave the place of safety. In addition, they may be displaying ‘pseudopsychotic’ phenomena that are felt to require admission for further assessment. In this context the seniority and experience of the assessing team is also likely to be important.

If individuals were detained further from the place of safety, admission was more likely – this is probably related to service provision in more rural areas, i.e. lack of crisis response teams as well as practicalities in supporting discharge to more rural areas in the evenings and overnight.

Expression of suicidality or self-harm in itself is not helpful in determining outcome, although it is an important factor in decision-making and risk assessment/management. Given that suicidal expression is actually associated with not being admitted, it may be that in such circumstances services could offer alternative interventions or supports (to police and individuals) to avoid use of legislation and the ‘frightening’ experience of being detained under place of safety legislation.²⁰ Future studies exploring outcomes and service use in those with suicidality not admitted would be helpful in guiding service development and delivery.

Strengths and limitations

This study has a lengthy period of data collection and a relatively large sample. This makes it similar to other studies in this field, which helps to allow any variation/patterns to be identified. Characteristics of the population are also similar to those reported elsewhere. This is the first study to analyse the nature of police involvement and link this with outcome of the mental health assessment. Efforts were made to ensure that all recognised place of safety referrals, especially those with completed POS1 forms, were identified over the study period – unfortunately, despite being contacted the Mental Welfare Commission for Scotland did not provide information to cross-reference those included in the project, which would strengthen the data-set. However, given the multiple sources and communications systems within the hospital and across the health board we are confident that the majority of place of safety referrals were identified. The study was carried out retrospectively, which limits the information available. Given the retrospective nature and use of a clinical cohort, diagnostic categories were kept broad and thus open to a degree of interpretation. However, the decisions and diagnoses made reflect day-to-day practice and thus findings are clinically informative.

Improving practice

When individuals are brought by police to a place of safety it is important to complete an individualised assessment. Diagnosis is an important factor in the decision-making process and practitioners should remember that individuals not expressing suicidal ideation also have a significant mental health burden and may require admission. Experienced practitioners should be involved in multidisciplinary assessment where possible and it is crucial that junior medical staff are well supported by senior colleagues in making decisions.

Police are frequently responding to mental health crises and seem to do well in identifying those in need of urgent service contact. Training would likely improve knowledge and interaction between service users and police²¹ but is unlikely to have a major impact on the use of legislation or characteristics of those referred.^{6,14,20} Street triage services where police work more closely with mental health services (via telephone or in mobile units) are becoming established across the UK and are positively received by police officers.²² Recent systematic reviews highlight that there is a suggestion of positive outcomes such as reduced referrals and use of police jurisdiction²³ but there remains limited robust evidence of efficacy and a lack of clarity on the best model for services.²²⁻²⁴

Ultimately this study identifies a breakdown between mental health services and those who require support, with police being recruited to fill the void. Joint working to improve awareness of and access to mental health services before crisis will be important in reducing use of restrictive legislation and improving outcomes.

We thank the nursing and medical staff of Affric Ward, New Craigs Hospital, Inverness, for their assessment of patients and record-keeping of police place of safety referrals, and the medical administration staff for their assistance in sourcing medical records and POS1 forms. We also thank Dr Amy MacAskill (consultant psychiatrist) and Barbara Brodie (clinical effectiveness coordinator) for their advice and guidance in putting together this study.

S.S. is the lead author; he designed the projected, carried out data collection, completed initial statistical analysis and wrote the majority of the paper. J.E. provided support to the basic statistical analysis and data presentation within the paper, carried out analysis for the multivariable binary logistic mixed-effects model, and wrote the sections describing statistical testing and the output of the multivariable binary logistic mixed-effects model. Both authors were involved in production of the final version after peer review and meet ICMJE criteria for authorship.

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1.3.39 Psychoeducation and motivational interviewing to reduce relapses and increase patients' involvement in antipsychotic treatment: interventional study

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Abstract

Aims and method

To assess whether the combination of motivational interviewing and psychoeducation affects relapse rate and stimulates involvement of people with psychosis in their treatment. We conducted an interventional study including patients with schizophrenia or schizoaffective disorder treated with oral antipsychotics, without previous experience of long-acting injectable antipsychotics (LAIs). They were randomised to either psychoeducation with motivational interviewing or a control group. Hospital admissions 18 months before and after the intervention, and switches to LAIs 18 months after the intervention, were recorded.

Results

The two groups each comprised 101 participants. Fourteen from the intervention group and seven from the control group switched to LAIs. Five in the intervention group instigated the switch themselves, compared with zero controls ($P = 0.06$). Fourteen in the intervention group were readmitted to hospital during follow-up, compared with 23 in the control group ($P = 0.14$).

Clinical implications

Psychoeducation with motivational interviewing may increase patients' involvement in their treatment and reduce the relapse frequency.

Contents

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Adherence to pharmacological treatment by people with psychotic disorders is one of the major challenges in psychiatry, and its lack is an important predictor of relapse, even with small gaps in treatment, regardless of formulation.^{1,2} However, in observational studies long-acting injectable antipsychotics (LAIs) reduce the risk of discontinuation when

compared with oral treatment.³ Patients are seldom encouraged to participate in the choice of antipsychotic medication and formulation,⁴ which is unfortunate, as it is known that their attitude to treatment becomes more positive with increased knowledge and experience of the treatment.⁵ Psychoeducation alone is not enough to improve adherence,⁶ but a combination of psychoeducation and motivational interviewing seems to be more promising.^{7,8}

We studied switches from oral antipsychotics to LAIs as a proxy for patients' involvement and adherence and hospital admissions as a proxy for relapse rate.

Method

We included 202 people with schizophrenia and schizoaffective disorder on oral antipsychotic treatment and no earlier experience of LAIs who were part of an earlier study conducted by our group.⁹ In the earlier study, apart from the individuals on oral treatment included in this study, we also included people currently on LAIs and questioned all participants on their perceptions and knowledge of antipsychotics in general, using semi-structured interviews.

The participants in the current study were block-randomised by diagnosis (schizophrenia/schizoaffective disorder), gender and age into two separate groups: either the intervention with psychoeducation and motivational interviewing group or a comparison group with no intervention. Participants in the intervention group were enrolled on giving written informed consent to participate in an intervention and to grant access to their own medical chart. If an individual refused to participate or was excluded for another reason, their matched comparator was excluded as well. The study was approved by the Regional Ethical Review Board in Stockholm (ref. 2015/47-31).

Psychoeducation

As part of our earlier study, participants in the intervention group underwent a single semi-structured interview by a study nurse specialised in mental health (L.C.), in which perceptions and knowledge of antipsychotic formulations were examined.⁹ In summary, the earlier study revealed that participants lacked knowledge regarding differences in plasma concentration, side-effects and risk of readmission to hospital between LAIs and oral treatment. At the end of the interview, the study nurse provided psychoeducation, discussing and correcting misconceptions of the differences between oral and LAI antipsychotics. The risk associated with gaps in medication was also discussed.

Motivational interviewing

The semi-structured interview, which included questions on beliefs and attitudes to treatment, was followed by an adapted form of motivational interviewing based on the original principles of the technique.¹⁰ L.C. had received training from a professional trainer on motivational interviewing in a 3-day course prior to the study. Participants were encouraged to discuss their personal ideas and ambivalences regarding their illness and treatment. Focus was on relapse-preventing factors, quality of life, exploring their own personal goals and treatment strategies, with no preference for either oral or LAI antipsychotics.

Follow-up

Data on admissions were extracted from the participants' medical records during the 18-months before and after the intervention. Participants were not called for extra visits during the follow-up, and clinical events were noted as they appeared in the medical charts. Hospital admission was considered a proxy for relapse. We observed the frequency of participants in each group with a hospital admission before and after intervention respectively. During the follow-up period, we also measured the number of participants who switched from oral to LAI antipsychotics. We noted whether the switch had been instigated by the participant, by clear indication of this in the medical chart, as opposed to it being described as a decision made by the treating psychiatrist or not described at all. The former was considered a proxy for increased patient involvement.

Statistical analysis

Anonymised data were analysed using Prism 5.03 for Windows. Sample comparisons were made using Fisher's exact test for categorical variables.

Results

In total, there were 101 participants in the intervention group and an equal number of comparators. Characteristics for both groups were proportionately matched regarding gender (46% females) and diagnosis (70% schizophrenia). The median age was 50 years for both groups, but the ranges differed slightly (21–84 years and 24–79 years for the intervention group and the comparator group respectively).

Switching

After 18 months, 14 participants (14%) from the intervention group had switched to LAIs, compared with 7 (7%) in the comparison group ($P = 0.17$, *Fig. 1*). Five out of 101 participants (5%) in the intervention group suggested a switch themselves, compared with zero in the comparison group ($P = 0.06$). Regarding switching by decision of the psychiatrist, there was no significant difference between the groups (9 v. 7, $P = 0.80$). *Fig. 1* Hospital admissions before and after intervention and switches to a long-acting injectable antipsychotic (LAI).

Hospital admission

In the intervention group, 20 participants (20%) were admitted to hospital at least once during the 18-month period before intervention, compared with 19 (19%) of the comparators ($P = 1.0$, *Fig. 1*). The numbers of participants admitted during the 18-month follow-up period after intervention were 14 (14%) and 23 (23%) respectively ($P = 0.14$).

Discussion

In this interventional study, we found that a single session of psychoeducation and motivational interviewing in combination may promote patients' involvement in treatment choices of oral and LAI antipsychotics and reduce relapse frequency.

The higher number of participants switching to an LAI in the intervention group could reflect less resistance to changing their medication after psychoeducation and motivational interviewing. However, as at least five participants in the intervention group actively initiated the discussion of switching, the higher switching rate could also be explained by increased involvement in their treatment. This supports results from an earlier study by Barkhof et al, in which a targeted use of motivational interviewing seemed to improve medication adherence at least for certain groups of people with psychosis.¹¹ Their adapted form of motivational interviewing had an active provision of psychoeducation, which makes it to some extent comparable to our interview, although their intervention included several sessions and included people with a recent relapse.

The number of participants admitted to hospital at least once in the 18-month period before intervention was comparable between groups, with only one more participant in the intervention group being admitted. In the follow-up period after intervention the corresponding analysis showed, however, nine fewer admissions in the intervention group. This could indicate an effect of psychoeducation and motivational interviewing on admission frequency, which in turn could be a result of increased adherence and involvement in antipsychotic treatment. This is in line with previous studies, which have reported positive effects of the combination of psychoeducation and motivational interviewing on adherence.^{7,8,11}

Exploring patients' fears is a less frequently used technique, as reported in our earlier study, and participants in the same study lacked knowledge.⁹ Moreover, other research groups have reported reluctance among medical professionals to initiate the discussion of treatment.^{4,12} The possible positive effect of psychoeducation and motivational interviewing may encourage a more exploring approach in treatment discussion with the patient.

Limitations

Our study has several limitations. Individuals with cognitive disorders and acute relapse at the time of inclusion were excluded from the study, and generalisations to these patient groups cannot be made. Not all targeted individuals were included in the intervention group, either because they could not be reached or they opted out, and their respective comparators were then not included.⁹ The participants were enrolled during regular visits, which are scheduled at least yearly, so the 18 months before intervention should be enough for most eligible participants. One could argue that patients who agreed to participate and had a least one visit in connection with the intervention represent a group with more commitment to their treatment and less prone to relapse at baseline than patients in general, creating selection bias. However, the number of admissions was comparable between the intervention group and the comparison group in the 18 months before intervention, suggesting similar illness characteristics. We lacked information on confounders such as socioeconomic status, illness duration and substance misuse. However, their potential impact on the results was limited by the randomisation process. All intervention visits were conducted by the same person, assuring consistency across visits. We used hospital admissions and switch to an LAI as proxies for relapse and for patient involvement respectively, which may be questioned. However, these outcomes were readily available hard outcomes in the medical charts,

Clinical and research implications

A combination of psychoeducation and motivational interviewing may be a valuable tool in the care of people with schizophrenia and schizoaffective disorder, stimulating their involvement in treatment and reducing the frequency of readmissions, but further study is needed to corroborate the findings of this study.

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Data availability

Data associated with the manuscript is available with the corresponding author.

G.B., L.C., A.B. and L.Ö. contributed to the overall study design. L.C., A.B. and L.Ö. planned the logistics and L.C. did all the interviewing and stored raw data. G.B. and L.Ö. compiled data and carried out statistical analyses. G.B., L.C., A.B. and L.Ö. interpreted the results and wrote the manuscript.

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Declaration of interest

L.Ö. has received speaker honoraria from Otsuka Pharma Scandinavia AB and H. Lundbeck AB, and has accepted travel and hospitality payment from Otsuka Pharma Scandinavia AB.

Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2020.28>.

[click here to view supplementary material](#)

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1.3.40 The critique of psychiatry as we enter the third decade of the 21st century

: Commentary on... Critical psychiatry

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Abstract

Critical psychiatry takes the position that ‘mental illness’ should not be reduced to ‘brain disease’. Here I consider whether this particular stance is outdated in light of more recent exchanges on reductionism, which consider questions raised by new mental health sciences that seek truly integrative and specific biopsychosocial models of illness.

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¹ Declaration of interest: None.

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See this issue.

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The anti-reductionist position of critical psychiatry

According to Duncan Double, the essential position of critical psychiatry is that ‘functional mental illness should not be reduced to brain disease’.¹ As it stands, this claim is ambiguous with regard to the basis of the normative (ethical) prescription contained within it: why does critical psychiatry maintain that we should not reduce ‘mental illness’ to ‘brain disease’? We are provided with a clue as to Double’s view when he writes that ‘most psychopathology is functional, in the sense that there are no structural abnormalities in the brain’.¹ Accordingly, we should not engage in such a reduction because we do not possess the evidence that it can be done. To insist on this reduction, and on the treatments and practices it entails, can therefore be construed as ethically problematic. Now this sort of justification for critical psychiatry’s essential position lands us in indeterminate territory: it relies on establishing the presence of ‘structural abnormalities’, which depends on how we define this term, on the state of the science and on the nature of evidence and its interpretation. There will always be claims and counterclaims as to the evidence for the biological basis of ‘mental illness’.

There is another more substantial argument that can be provided in support of critical psychiatry’s position: we should not engage in the offending reduction because even if there were ‘structural abnormalities in the brain’, the subject matter – ‘mental illness’ – requires an altogether different approach for its classification, understanding and management. Double seems to intend something like this when he argues, along with von Feuchtersleben, Meyer and Engels, for a holistic, non-reductionist and integrative conception of ‘psychopathology’. This is a valuable analysis, and it is hard to disagree with the general direction of Double’s argument in this regard: mental health conditions cannot be understood, treated or managed through radically reductionist concepts and approaches. And radical reductionism is the villain that critical psychiatry, on Double’s account, is engaged in a fight with. It is a reductionism that is so obtuse, it has no place for meaning, human relationships or social context. And it was certainly evident in the early days of psychiatry, through the wild goose chase prompted, in part, by the discovery of the celebrated causal connection between general paresis of the insane and the syphilis spirochaete. How far does this view exist today?

We can quarrel endlessly about critical psychiatry’s representation of the views of its opponents, and it is unlikely that we can ever resolve this to everyone’s satisfaction. Instead, I shall introduce a more recent exchange on reductionism, and from there we can discern where things are at and what critical psychiatry has to say to us today.

Towards a truly integrated understanding of health

In a paper published in the *BMJ* in 2012, White and colleagues argue for an end to the distinction between mental disorders and brain disorders in favour of a single overarching category: disorders of the nervous system.² One of the arguments they make in support of this proposal is that psychosocial factors ‘interact strongly’ with neurological disorders, whereas ‘disorders of the mind are rooted in dysfunction of the brain’.^{2,3} Psychological, social and biological causal and risk factors run across all medical conditions, whether mental or physical.² If so, there might not be much sense insisting on the distinction between mental disorders and brain disorders, especially, they argue, considering recent advances in the neurological and genetic bases of mental disorders. Standing in contrast to White and colleagues’ proposal is a position paper by Bracken and colleagues that rejects the suggested equivalence between psychiatry and neurology: ‘Psychiatry is not neurology; it is not a medicine of the brain. Although mental health problems undoubtedly have a biological dimension, in their very nature they reach beyond the brain to involve social, cultural and psychological dimensions’.⁴

These two papers, although they argue for opposite conclusions, are both non-reductionist in the sense that they do not propose a radical disavowal of non-biological causal and risk factors. Accordingly, neither falls foul of critical psychiatry’s essential position as articulated by Double. A key point on which they differ is a question of emphasis: White and colleagues emphasise genetic and neurological factors, whereas Bracken and colleagues emphasise psychosocial factors. Where should we stand on this point?

There is no doubt that mental health conditions and neurological conditions demonstrate ‘multifactorial pathways’, as White and Colleagues note. Nevertheless, psychosocial factors are more prominent in mental disorders across a wide range of dimensions.⁵ To the extent that this is the case, psychiatry differs from neurology in that it ‘has particular expertise in the management of psychosocial factors as well as internal biological factors’.⁵ We could take this observation to support the view that, in order to preserve the emphasis on psychosocial factors, we should not collapse the

distinction between mental disorders and brain disorders. Or we could decide that the terms of the debate and the forced choice between them are out of keeping with developments in the new mental health sciences. Here, gene–environment interactions, social determinants of health over the life-course, individual psychology and neuroscience are all relevant for an integrated understanding of health. As Derek Bolton puts it: ‘[These] new sciences do not work with ideological battles between the biological, the psychological, and the social, the old parallel universes with poor communication between them; rather they work with all of these factors and the diversity of interplay between them’.⁵

There is much work to be done, both empirical and conceptual, to understand how social, psychological and biological factors interact in specific conditions. However, that work applies across the board to all conditions of health-related interest.^{6,7} The aim is to move beyond a biopsychosocial model that is integrative only in name and towards one that can provide concrete risk and causal pathways across the range of factors of relevance to a particular health condition.

Critical psychiatry may have run its course, but the critique of psychiatry continues

Where does this leave critical psychiatry? Double’s editorial seeks to advance two aims. On one hand, it wants to affirm critical psychiatry’s continuing relevance as the defender of the position that ‘functional mental illness should not be reduced to brain disease’. On the other hand, it acknowledges that it might be beneficial ‘to look for the continuities, rather than discontinuities, with orthodox psychiatry’.¹ On the first aim, we have seen that it is possible to debate whether we should end the distinction between mental disorders and brain disorders without falling into the radical reductionism that critical psychiatry positions itself against. Moreover, as suggested above, the new mental health sciences have moved beyond the terms of this debate and seek genuinely integrative and specific biopsychosocial models of health conditions. Accordingly, in so far as critical psychiatry requires the continuing relevance of its essential position, then it might have run its course. This leaves us with the second aim of the editorial, from which, on Double’s own analysis, one gets the sense that there is very little that separates critical psychiatry from ‘orthodox psychiatry’. And that is not a bad thing, for it can be taken by critical psychiatry as a triumph, as evidence that its message has got through.

But critical psychiatry does not exhaust the constructive critique of psychiatry and society, which, as we enter the third decade of the 21st century, is going strong. For example, there are continuing debates on the boundaries of illness and on the definition of mental disorder (e.g.^{8,9}); there are attempts to resolve the classificatory complexity of mental health conditions and to critique the validity of existing classifications (e.g.^{10–12}); questions continue to be raised about the nature of mental disorders (e.g.^{13,14}); controversies remain surrounding the efficacy and risks of antidepressant and antipsychotic medications (e.g.¹⁵); debates continue on the ethical complexities raised by capacity assessments and coercive interventions (e.g.^{16,17}); and challenges to medical concepts and approaches – to medicalisation more generally – are experiencing a resurgence through mental health activism (e.g.^{18–22}).

In the midst of these exciting and still largely unresolved problems, the version of critical psychiatry presented by Double in his editorial is of historical value; it reminds us of a radically reductionist position that now – in light of developments in the science and philosophy of mental health – appears false and outdated.

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1.3.41 Clinical course of 12 patients on a Covid-19 dementia isolation ward

Richard Kerslake Scott Cherry Jessica Buckle Richard Harris Richard Caplan

date

2020-12

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- *Clinical course of 12 patients on a Covid-19 dementia isolation ward*

– Declaration of interest

Older adults have been particularly vulnerable to outbreaks of severe acute respiratory syndrome coronavirus 2 (Covid-19), and mortality rates increase with age.^{1,2} Physiological comorbidities and nutritional status are contributory factors, but there is limited understanding of the influence of mental illness, particularly for patients with dementia.³⁻⁵ Furthermore, cognitive impairment may also increase the risks of contracting Covid-19.⁶

We have summarised our experiences from a psychiatric in-patient unit to describe the clinical outcomes of 12 patients admitted to a dementia specialist ward, which later became closed to admissions after nine of the patients were isolated with confirmed or suspected Covid-19. The following patients, all over the age of 74, were selected to illustrate the typical clinical course that was observed in the most unwell patients. To ensure anonymity, patient initials, ages, and gender identifiers have been removed.

In Case 1, the patient had diagnoses of mixed Alzheimer's and vascular dementia, type 2 diabetes mellitus, hypertension and previous traumatic subdural haemorrhage. Isolation was commenced after a new cough, low oxygen saturations and vomiting were observed. The patient was then transferred to the acute hospital and treated with empirical antibiotics. Despite this, the patient refused all oral food and fluids, and a decrease of 24% of pre-Covid total body mass was recorded. The patient later developed hypernatraemia and an ischaemic left leg and was subsequently discharged to a palliative care hospice on an end-of-life care pathway.

In Case 2, the patient with a diagnosis of mixed Alzheimer's and vascular dementia and no relevant past medical history developed a cough and oxygen saturations of 88% on air. The patient was transferred to the acute hospital, diagnosed with lobar pneumonia, started on antibiotics and returned to the ward 5 days later. Throughout the period of isolation, food and fluid intake was observed as being minimal. Twelve days after isolation, a serum sodium level of 147 mmol/L was recorded, with a decrease of 12.7% of pre-Covid body mass. Features of pneumonia and dehydration persisted, with the serum sodium level climbing to 152 mmol/L. Following three further episodes of care at the acute hospital, the patient was treated on an end-of-life care pathway and died 30 days after isolation. Of note, 4 days before isolation was commenced, this patient was medically reviewed for a cough which was thought not to be due to Covid-19. Causes of death were certified as (1a) pneumonia, (1b) Covid-19 infection and (2) end-stage dementia.

In Case 3, the patient had a previous acquired brain injury and mixed Alzheimer's and vascular dementia, with past medical history including epilepsy and chronic obstructive pulmonary disease. Isolation nursing commenced after a new cough was noted, 5 days after a possible cough was interpreted as 'throat clearing'. Eleven days after isolation, the patient was initiated on antibiotics at the acute hospital after a significant drop in oxygen saturations was recorded. Serum sodium levels were sampled at 151 mmol/L, corresponding with a limited fluid intake. A decrease of 23% of pre-Covid body mass was recorded. Thirteen days after isolation, the patient developed hyperactive delirium with clinical signs of dehydration, serum sodium of 156 mmol/L and urea of 15.1 mmol/L. The patient was subsequently transferred to the acute hospital and placed on an end-of-life care pathway.

In Case 4, the patient had diagnoses of Alzheimer's dementia and treatment-resistant depression, having been admitted from the acute hospital. Isolation was commenced, followed by transfer back to the acute hospital, after oxygen saturations dropped to 90%. After correction of hypokalaemia and commencing antibiotics for pneumonia, the patient returned to the ward. Six days after the initial Covid-19 symptoms, the patient was readmitted to the acute hospital for management of reduced oxygen saturation and refeeding syndrome. A further 21 days later, the patient was placed on an end-of-life care pathway. The cause of death was recorded as (1a) end-stage dementia in Alzheimer's disease and Covid-19 infection and (2) urinary tract infection (treated).

All isolated patients with reduced mobility were prescribed venous thromboembolism prophylaxis. All isolated patients with a cough or fever were prescribed prophylactic antibiotics in case of a secondary bacterial pneumonia. All confirmed or suspected Covid patients were prescribed additional nutritional supplements. These plans were implemented with advice from acute hospital and dietician colleagues.

Of the remaining eight patients on the ward, one was asymptomatic throughout the 14 days of isolation despite testing positive for the virus, and four further patients tested positive, requiring various levels of medical input before being safely discharged. A further three patients did not record a fever, nor develop a cough, and did not test positive on throat or nasal swabs and were nursed separately.

In summary, of the nine patients who were confirmed or suspected of having contracted Covid-19, four subsequently received end-of-life care, eight required admission to an acute hospital for medical input, and all nine patients survived the period of isolation, which lasted at least 14 days.

All confirmed or suspected Covid patients were prescribed additional nutritional supplements under the guidance of a dietician. Adherence to these was variable but generally poor. Despite this, four patients experienced a weight loss of between 13% to 24% during their period of isolation. This weight loss was observed in the patients with the poorest outcomes.

Six patients also experienced clinical levels of dehydration, identified initially by raised serum sodium levels, despite best attempts to encourage oral fluids while being nursed in isolation. These patients also required the highest levels of medical input.

In our opinion, patients with dementia who contract Covid-19 are likely to require high levels of medical oversight to monitor their physical health, experienced nursing care to encourage adequate fluid and food intake, and input from a dietician to ensure nutrition is optimised.

The clinical outcomes of patients with dementia who contract Covid-19 are variable and difficult to predict. It can be expected that patients will require episodes of care in an acute hospital for physical consequences of Covid-19 that cannot be addressed on a psychiatric ward. Physical deterioration and death do not tend to occur during the 14 days of isolation and are usually due to secondary consequences of Covid-19, of which weight loss, dehydration and rising serum sodium are worrying clinical signs.

Self-reporting of Covid-19 symptoms by patients with dementia can be unreliable and can delay isolation nursing, putting other patients at risk.

Management of symptomatic patients who have refused confirmatory swabs must be carefully considered, balancing the risks and benefits of treatment in the Covid-19 cohort area or treatment among well patients.

Early discussions related to ceilings of care, Do Not Attempt Cardio Pulmonary Resuscitation orders and the application of end-of-life care pathways were recognised as essential to ensuring that the patient's prior wishes and best interests were considered.

We sincerely hope that the details we have included here will be of interest and use to readers. We will happily respond to any questions that may arise.

Declaration of interest

None.

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1.3.42 Disclosing mental illness: a doctor's dilemma

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date

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Abstract

There is increasing evidence that doctors have high levels of mental illness, and there are concerns that, for some, this may be exacerbated by their working environment. It can be difficult for doctors to disclose mental illness, either to senior or junior colleagues, and perhaps even harder to know what, if anything, to say to patients. Many doctors may be unsure of their position as regards disclosing to governing bodies; others may disclose widely on social media. I am a psychiatrist who also has a significant mental illness, and refer both to my personal experience and the literature to explore some of these issues.

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I became a consultant psychiatrist 14 years ago. When I started life as a psychiatric trainee, some 9 years prior, I had already been advised that this was not a good idea, as it would probably be too stressful for me. You might wonder why, given that I had previously completed general practitioner (GP) training; but I had also had the misfortune to have been a psychiatric patient. Briefly, I became ill in my GP trainee year, with what was almost certainly a perinatal mood disorder. I was in and out of hospital over the following 2 years, and had several courses of electroconvulsive therapy (ECT), before finally recovering sufficiently to return to work.

This was one of the hardest times of my life. I had minimal help with this return, and just had to apply for locums, at which I failed, and then 6-month junior hospital posts. There was no phased return, and I did full resident on-call from the start. I was determined and driven – I had to be. Just your average doctor, really, and with the usual tunnel vision. I regret this time, when I was a new mother, and recovering – it should have been gentler – but I felt that unless people saw me as tough, there was little hope of ever returning to work.

I was diagnosed with psychotic depression, and subsequently with bipolar disorder. After that first episode, I believed that I would never be ill again, until it became apparent, even to me, that this was a long-term condition, something that would probably never go away entirely. I have indeed had relapses, and my most recent encounter with ECT was this past year.

The high risk of anxiety, depression and suicide in doctors, particularly anaesthetists, general practitioners and psychiatrists, has been highlighted by Clare Gerada, and a link made between fear of exposure and suicide.¹ A recent survey by the British Medical Association (BMA) has emphasised the concerning levels of mental health problems in doctors and students, and how their working environment may have contributed to these.² Some of the reasons for these difficulties have been examined in Caroline Elton's book, *Also Human: The Inner Lives of Doctors*,³ which explores the stresses unique to medicine, the way doctors can be treated and what happens when they can no longer carry on.

Over the years I have chosen at times to disclose my illness, and at times to keep silent – probably more often somewhere in between, leaving out the nasty bits. My first really public disclosure was a *BMJ* article in 2012,⁴ but I had always been fairly open with colleagues. Interestingly, doctors do not always behave as they think they will, with younger doctors and doctors in training less likely to disclose mental illness.⁵

How one decides when to disclose, and how much should be said, often depends on the context. Initially I felt that I was the only doctor to whom this had happened, and only when a kind supervisor gave me an article by the late Belinda Brewer⁶ did it occur to me that this was unlikely. That brief article affected me profoundly, and I have found reading personal accounts hugely helpful, as both a patient and doctor. *Doctors as Patients*, edited by the late Petre Jones,⁷ contains many different accounts, as well as guidance and advice, and is a book I have come back to when unwell. It is sobering to reflect on the loss of both of these doctors, and I want to acknowledge their courage.

Rees et al have acquired a considerable amount of qualitative data from interviewing doctors, and have commented on the importance of the reaction to the first disclosure of mental illness, whoever this is made to.⁸ This has obvious implications for the training and support of those who actually support junior doctors and medical students.

Disclosing to patients

Disclosure of one's own illness to patients is a thorny area, and I do not think I have ever done it, although I have at times been tempted. But I have always thought this will make it more about me than them. It will close down the channels of communication, as my feelings become theirs. I work in a chronic pain clinic, and do not share my sciatica woes either. However sore I am, I cannot actually feel their pain.

De Vos et al discuss the use of disclosure by therapists in recovery, and make the important point that this must be done thoughtfully, without specific details of symptoms, and with support.⁹ There are growing numbers of blogs about the experience of mental illness, including those by doctors and psychiatrists. It is clear upon reading them that there is no one answer, implying that a great deal of consideration must be taken to ensure good patient care while treading sensitively. Howe specifically explores self-disclosure in psychiatrists, and concludes that a psychiatrist should only disclose what they are comfortable with, and what will benefit the patient.¹⁰

As a patient, I do not think that I would want my psychiatrist to disclose anything too personal to me. If they told me that they had been depressed, I think I would, in a peculiar way, feel out-manoeuvred, that there was no point in describing things further, as they already knew. Yet there can also be the odd sense that one's psychiatrist does not actually exist as a person themselves, leading to curiosity and sometimes alienation, which may be stronger when the patient is also a doctor.

As a doctor, my hope is that my experience will come through, that I will show rather than tell, and that this may influence my interactions with patients. I know that there is a school of thought that demonstrating one's own vulnerability may provide hope to a patient. Even then, I think the time to do so would be when the patient is better and less vulnerable themselves, as there is always a power imbalance in the patient–doctor relationship.

There is, of course, the reality that a patient may ask about your personal experience, particularly if you write or talk about it. I have always done this to some extent, but have expanded my efforts recently, both on Twitter and by blogging, and was interviewed on television earlier in 2019.¹¹ It is perhaps easier for me as an established consultant, with supportive colleagues and managers, but my main reason for speaking out is that my children are older now, and understand more about my illness and why I would speak about it. As regards to patients, I would always tell them if they asked a direct question. I might say that the focus should be on them, and I might say that I would rather not discuss it in any detail, but I would not deny it.

Disclosing to colleagues

Applying for training is both harder and easier now. I applied to several local training schemes, resulting in one outright rejection and two interviews. At both, I told them of my illness; one offered me a shorter contract in case I was not up to it, but the other just offered me the job. I was, and am, very glad that they knew of my illness from the beginning, and I experienced no stigma during my 2 years there, only support. But one would not now mention this at interview, which would, in any case, be done nationally. This lessens prejudice, but it also lessens your chance of discovering the right place to work, which I was fortunate to do. In other words, not being politically correct can, at times, be a bonus.

Throughout my training, I mostly worked with great consultants who knew my history, but I also tried to seek such people out whenever I could. There will always be those who, for whatever reason, are less able to support a trainee with difficulties, and my advice would be to avoid them whenever possible. The Royal College of Psychiatrists has resources for doctors and trainees returning to work,¹² as does the Psychiatric Trainees Committee,¹³ which can be helpful both for those returning and those supporting them.

Perhaps I share too much, but I would advise trainees to definitely tell their educational supervisors, and usually their clinical supervisors, of any significant mental illness (definitely if not entirely well). My own problems had been rather public, being an in-patient in the local hospital, so I felt I had little option. You do not have to tell everyone with whom you work, any more than you have to tell them about other conditions, but sharing with your supervisors can make life smoother. Sometimes it is hard to do this face to face; I would then consider emailing what you want them to know, explaining that it can be difficult, and this can give both some time to reflect before speaking.

Disclosing to governing bodies

The main body that governs doctors is the General Medical Council (GMC), and this can become very frightening when unwell. Unless a doctor is attempting to work against medical advice, the GMC should not become involved and the doctor should receive local support and treatment. This can include taking time off, but a reduction in hours or a phased return may also be recommended, and occupational health are well placed to help with this. There is no automatic need to inform the GMC unless there are legal issues, such as a drink driving charge, or other probity issues, when self-disclosure for health assessment should first be encouraged.¹⁴

Those doctors who are seen for health assessments face a number of possible outcomes, including not working for a period or working under supervision. I work as a health examiner and supervisor, and have seen how difficult this can be; there is undoubtedly much fear and stigma, but doctors often do very well, and many return to work. The GMC continues to work hard to dispel these fears as much as possible, and to provide more support, particularly following the concerns around increased suicide rates;¹⁵ but it is vital that doctors also receive support and validation from other sources, given that this can threaten the very meaning and identity of being a doctor.

When medical students apply to join the medical register, they too need to disclose any health conditions that may affect their fitness to practise.¹⁶ Medical schools have processes to manage students' fitness to practise, and should be able to provide help and advice for those with pre-existing conditions.¹⁷

There are services available, such as the Psychiatrists' Support Service,¹⁸ which provides anonymous telephone support to all grades of psychiatrist, and NHS Practitioner Health,¹⁹ which launched an immediate crisis text line this year, available to all doctors in England and Wales. Others include the BMA Doctor Support Service²⁰ and the Doctors' Support Network.²¹ DocHealth is a brief psychotherapy service available across the UK, staffed by medical consultant psychotherapists, and subsidised by the BMA and Royal Medical Benevolent Fund.²²

Disclosing being a doctor

It is extraordinary that saying one is a doctor can sometimes be harder than saying one has a mental illness. I was once part of a patient and carer group at the Royal College of Psychiatrists; it was a good experience, but I left because I did not really fit in, being a doctor as well as a patient. It is probably even harder being a doctor when an in-patient on a psychiatric ward, but this was not something that I ever broadcasted. I remember a patient shouting at me when, as a junior doctor, I visited a ward where I had previously been a patient: ‘You used to be one of us [patients], and now you’re one of them [doctors] and how did that happen?’ At times I felt like a combination of a fake patient and an incompetent doctor.

Disclosure to the wider community

More recently I have posted on Twitter, making it obvious I am both doctor and patient. The same things that garner support for a patient can enrage the online community when a doctor is involved. For me, one obvious example has been ECT, which I had this past year and have had previously. However, I recognise that although I am trained as a psychiatrist, my personal experiences are anecdotal and I try to present them as such, rather than generalising. I think this does take the heat out of things, although not always. I would, however, advise others not to post on Twitter when less well; there are many other gentler online forums that can provide helpful support. I have used the Doctors’ Support Network forum, which is completely anonymous, and a specific group for doctors with bipolar disorder.

I have started to speak and write more publicly about my illness,¹¹ although I find that it is actually quite easy to hide behind a pen or a lens. I have also spoken directly to both trainees and retired psychiatrists, which is more daunting, but also more rewarding; and I hope to continue to tell my story to others, both to help them know that they are not alone and to highlight what support is out there.

Receiving disclosures

Inevitably as a psychiatrist and trainer I have received disclosures from others regarding mental illness and other sensitive issues. I find this hard, and I think it is right to find it hard, not least because it has usually been very difficult for the trainee to raise. Acknowledge it, make no assumptions and ask how much the trainee wants to say. Ask them if they want to talk about it again, and think about what they have told you. Most importantly, remember that they are not you. Treat them normally, and do not make them feel that they have become ‘special’ or ‘different’. Help them, and guide them to find treatment if necessary, but do not be their doctor. Getting the balance can be very difficult, and it can sometimes be useful to discuss this confidentially, and with consent, with other senior colleagues involved in training.

When trainees are aware of my own illness, I sometimes worry that it makes it harder for them to talk of theirs. They may feel mine is ‘better’ or conversely ‘worse’, and that their illness is less important. So I try to open up generally about mental illness, in the hope that it will make it easier for them, particularly in the way that I talk about patients and other trainees.

‘Why?’ is a common question to ask, when doctors, nurses and others choose to work in psychiatry after an episode of mental illness, and there is no one answer. It is very hard to predict who will cope, who will shine, even, and who will find it hard. I can see, with hindsight, why I was advised against another long period of training and grinding exams, given the length and severity of my illness, and I now feel minimal resentment about this. I did feel angry with those who asked if I was trying to cure myself, but on the whole, they were not psychiatrists. And now, when I talk to others, I know it is important not to blind oneself with preconceptions, to know that there is not one route for all. Because I did, it does not mean all others should.

My illness has had a profound effect on my life and my work. I worked much harder and was far more organised during my psychiatric training than I had been previously. I had to be – there was always this thing at the back of my mind, this thing over which I had little control. I was determined to pass exams, even doing a Master’s degree during my maternity leave. I felt that if I did not do well, my abilities would be questioned and put down to mental illness. I still think this is a difficult area; we all have times when we may perform less well, and there is little doubt that supervisors may wonder about mental health in a trainee with a history of illness, when they otherwise would not.

This is reasonable, and hopefully not punitive in any way. But as a trainee you fear assumptions, even if they are based on some truth. So supervisors must be alert, yet resist jumping to conclusions, and the way to manage this is to get to know your trainees well. It can be difficult, I know this now as a trainer; sadly, there is often nowhere where trainers and trainees all meet for coffee or lunch, the kind of things that make this happen.

Living and surviving

It is unsurprising that I have always been interested in doctors' accounts of mental illness. They make me feel less alone, they inspire me, and above all they are all different. The accounts by Linda Gask²³ and Cathy Wield²⁴ are moving and human, and lifted me out of my self-obsessions. They, too, are real people, things happened to them, and they are doctors. The recognition that you can recover, succeed and then get ill again was also important – these are not always stories with a happy ever after. Kay Redfield Jamison's account of having bipolar disorder is a wonderful book, describing the experience of changing moods, as well as combining this with a remarkable career researching and treating the very illness that nearly destroyed her.²⁵ Mike Shooter, past president of the Royal College of Psychiatrists, describes becoming better able to recognise the warning signs of illness, and knowing when to stop.²⁶

For better or for worse

But the big question, for me, is whether my experiences make me a better doctor and psychiatrist, or even a better person. There is much written about the importance of lived experience, and it can all get a bit competitive. I trained in general adult psychiatry, but work in addiction psychiatry. I think I knew that working in general adult would potentially be harder, with reminders and triggers of what had happened to me, and that it would be very easy for me to become over-involved in a way that would be good for neither me nor patients. I am still drawn to occasional patients, where I think, 'that could be me', and I have to remind myself that no-one is exactly like another, no-one can experience the thoughts and suffering of someone else.

When I first started working in psychiatry, I think that I did feel that my lived experience made me better than others, and that I could more easily understand what patients were going through. I am much less sure now. There was a lightbulb moment for this, when I lost a baby late in pregnancy, early in my training. I was devastated. But it suddenly came to me that everyone's experiences are personal, that I had no idea what another mother would feel. It was a short step to realising that my experiences of altered mood, of side-effects and drugs, was only mine. I think what happened made me more alert to suffering, hopefully more empathetic and more prepared to listen. But I would never now say to someone, 'I know exactly how you feel'.

Whether I am a better psychiatrist because of my experiences is difficult to say, as I can never know what the alternative would have been. One thing I am fairly sure of is that I am a far worse patient. I question and doubt, and my knowledge, particularly of psychiatric medication, is very unhelpful. Obviously I want to think I am a better psychiatrist, but I do not think you need to have experienced psychiatric illness to be excellent. Most of us will experience difficulty and sorrow in our lives, and these will change us and make us what we are. There is no one prescription for empathy.

I would like to thank Dr Cate Bailey for inviting me to write this article, and for her very helpful comments regarding content and structure.

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Declaration of interest

None.

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1.3.43 Kenneth Kendler: fully human

Claire McKenna¹

date

2020-12

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- *Kenneth Kendler: fully human*

“We shall not cease from explorationAnd the end of all our exploringWill be to arrive where we startedAnd know the place for the first time.” T. S. Eliot, ‘Little Gidding’ (from *Four Quartets*), 1942”

Born the son of two experimental psychologists (his father a ‘classic New York Jewish character’, his mother a ‘very intellectual, incisive’ woman who ‘overcame a lot of prejudice about being a woman in academia’), Professor Kenneth Kendler’s parents were initially sceptical about his choice of a career in psychiatry: ‘In my parents’ days (they would have trained in the late 1930s and early 1940s), the smart people went on to get a PhD and the physicians were sort of second class. They basically were either psychoanalysts or they went to state hospitals and gave lots of people ECT . . . My father, for example, worked in the mental health system during the Second World War. So he had a lot of contact with psychiatrists and was not, on average, very impressed’. He thinks he made them proud in the end though: ‘I think eventually I convinced them one could do rigorous research in this area’.

At the time of writing, Kendler is the second most highly cited psychiatric researcher in the world. Already a renowned expert in psychiatric genetics, he diverged later in his career to become an eminent scholar in the philosophy, and latterly the history, of psychiatry. He has gone to the lengths of employing a German speaking translator for the past few years, so he can read Emil Kraepelin’s writings in the original. These later interests were in part an attempt, it seems, to resolve his own *sturm und drang* about classification in psychiatry: ‘You cannot understand where we are in psychiatric nosology without understanding the historical context within which it exists’, he told me. In thinking about the arc of his career, I was reminded of the T. S. Eliot quotation in the epigraph to this piece.

¹

Claire McKenna talks to Kenneth Kendler, psychiatric polymath, about the consolations of philosophy, poetry and theology

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His new book *Toward a Philosophical Approach to Psychiatry*¹ is a compendium of his most important philosophical papers, as well as some of his historical and genetics papers (necessary to understand his thesis about the nature of psychiatric illness). He is an exceptionally clear and engaging writer, which makes the book an accessible read for psychiatrists who are not academic philosophers.

When I talked to Kendler via Skype in March 2020 he seemed pretty serene in his quarantine. Holed up in his home in Virginia because of COVID-19, he remained hard at work. It seems a labour of love for him. ‘That’s what my kids say,’ he laughs, ‘This isn’t work for you, Dad!’ His eyes wrinkle quickly and frequently into mirth throughout the interview. His formidable intelligence combines with a warm and easy manner, which transmitted through the ether. In his scholarly search for what ails us, he seems more aware than many of the humanity that gives meaning to this suffering.

Kendler’s philosophical stance is poetically summarised (in a riff on Gerard Manley Hopkins) in the title of his 2015 paper, ‘The dappled nature of the causes of psychiatric illness: replacing the organic–functional/hardware–software dichotomy with empirically based pluralism’.² His philosophical approach to psychiatry is very much of the pragmatic kind. He examined my more speculative questions briefly during this interview (about mysterianism for example) and, in a manner I imagined might be born of his decades long habit of daily meditation, let them float away like flotsam of the mind, finding them unhelpful to advance his project.

‘It’s been a wonderful and fulfilling career,’ he says, but it is one that’s far from over yet. Now aged 69, he still directs a research institute at Virginia Commonwealth University, he teaches, edits the journal *Psychological Medicine*, serves on the DSM steering committee and is very active in several psychiatric genomic consortia groups. The fifth in the series of his books (edited with Joseph Parnas and Peter Zachar), based on presentations at the philosophy of psychiatry conferences in Copenhagen that they organise, is just coming out.³ He has also raced out a series of papers this year based on a close reading of Kraepelin’s original textbooks. ‘I can’t write it fast enough,’ he says, as he chips away at the great edifice of our ignorance, one flake at a time.

This conversation has been condensed and edited.

What are you most proud of in your prolific career?

That’s a really hard question. I think I’ve managed to show how careful methodological approaches can clarify how the familial influences on psychiatric illness act. I think they’re quite strong, if you had to rank all the other components, but they’re subtle and we tend to have very simplistic solutions, i.e. it’s all genetic or it’s all our environment. So, I think in the research I’ve done, I’ve laid some foundations for a kind of sound, rigorous empirical approach to these questions. And I think in the philosophy work, which has been later in my career, it’s been closely related to the empirical work, of trying to provide a contextual framework for thinking clearly about these conditions and human behaviour.

Because, of course, it’s our academic discipline, but we’re also studying ourselves and our own behaviour. It’s especially hard to think clearly and avoid previous biases. Its complexity is simply overwhelming. And although overly simplistic, one human reaction to great complexity is to develop tunnel vision. That’s one way to get closure. But that’s a bad way to do psychiatry. It’s a bad way to do it clinically and a bad way to do it research-wise. So, I’m trying to provide a framework to think clearly and rigorously. I guess that would be the most important. I think I contributed a bit.

I read two lovely papers^{2,4} of yours about a philosophical framework for psychiatry, which I thought were really good primers. I wanted to ask you a bit about the importance of philosophy for psychiatrists. It can sometimes seem to psychiatrists quite arcane and not necessarily applicable to their day-to-day practice.

Well, I have to say that this is not novel. We all make philosophical assumptions about the things we do and think. And you can either examine them or you can’t. But it’s not that they’re not there. And in psychiatry, they’re legion. Like, how does the mind relate to the brain? You cannot begin to practise psychiatry without thinking about those questions. How do you interpret evidence from different layers of science? So, we might study personality theory, we might study parent–child relationships, we might study molecular genetic variants, we might study signals in the amygdala or the nucleus accumbens. How do we put those all together? How do they relate to one another?

What you’ve just highlighted is that it’s very difficult to do psychiatry well, because of the different styles of thinking we need. And humans tend to think in heuristics, so we tend to default to that more categorical thinking. And it’s oftentimes really hard, actually, to hold in mind all of that pluralism whenever you’re with patients. For example, when I’m talking about a patient to colleagues and I’m thinking about a psychosis spectrum, at the

end of it the question is, well, ‘Is it psychosis or is it not?’ So, we default to a binary. I wonder whether it’s the nature of our brains that we think like this?

I think you’re probably right, that goes back to my concerns that, in the face of overwhelming complexity, it’s very understandable to simplify. I do believe rather deeply in pluralism, both in our research and in our clinical perspective. The best of psychiatrists, we have to wear a range of glasses: when we see someone acutely in an emergency room setting, versus in long-term therapy, those are not the same approach.

You know, ‘Beware the man with only a hammer, as he will see only a world full of nails’. And some people are like that. I grew up at a time when they were full of the hubris of biological psychiatry. And people would say things – they were not bad human beings – but they’d say things like, well, you wouldn’t talk with an individual with schizophrenia, any more than you want to work with a broken computer. Just give them their medicines. And I think that’s stunningly arrogant. People with schizophrenia have all the fears and wishes that we have. And providing good care is a very human process. That doesn’t mean I don’t try to think rigorously about dopamine pharmacology, but I think that’s a stunning misdeed to only think about that. And it’s not terrifically different from the psychoanalyst who used to say that thinking about the person as a working brain as well as a mind was somehow a defensive reaction. So, we’re full of these in this field of mental health of ours.

That analogy that you just used about seeing nails everywhere – similarly, I sometimes feel that as psychiatrists we’re using a sledgehammer to crack a nut. Psychotropic medication is so non-specific in it’s mode of action. Do you ever get that kind of cognitive dissonance?

The short answer would be yes. In my practice, I try to develop a nuanced and collaborative approach. I mean, I didn’t ever have to do very high-productivity kind of out-patient work. So, I think I was probably a bit spoiled. I hardly ever made any money at it, so I was not very good!

Yes, I agree. It’s truly a challenge. And especially, you know, there are certainly quite ill individuals, with schizophrenia for example, where medical models are needed. The traditional psychological therapies really have very limited effectiveness, but what helps is to provide support, often on quite practical matters, to your patients. But again, in those situations, the level of trust is a very important thing. In caring for people with psychosis, when their psychosis starts coming, do they feel that they can call you? So, I think those human things matter a whole lot in addition to getting the psychopharmacology right.

Did you coin the term ‘patchy reductionism’? I learned it from your writings.

No, that’s from Ken Schaffner.

I think it’s a helpful concept that we proceed in psychiatry by incrementalism.

Correct.

And in terms of your career progression, I’ve asked you about some of the high points, but do you have any wrong turns or regrets about how you’ve proceeded in your career at all?

I wish I had studied way more statistics. I did a fair amount. So, for a psychiatrist, I know a good bit. As a research physician, you make a bargain. So I spent my 20s, while most of my PhD colleagues were getting trained in research, going to medical school and getting psychiatric training. It means that there are limits. I will never be as good as they are in some particular areas. I try to compensate for that with a broader vision and understanding.

I did have this naive idea when I was travelling around the back roads of Roscommon County in particular, Tyrone, Fermanagh and other places [for the Roscommon family study of schizophrenia], that we were going to crack and definitively solve the genetics of schizophrenia. And that was certainly naive. I was naive along with many other people. But we’re making real progress now, real progress. But it’s not at all simple.

I was fascinated to read that you’d considered graduate school in religious studies at one point. Your positivist approach to psychiatry and then theology are quite different approaches.

I continued with my Biblical studies throughout my adult life. I meet with a nearby Rabbi on most weekends for an hour and a half of study.

I got very interested in religious studies but I think I made the right decision. But those broader issues about human existence have been an important interest to me. And I think it's not unrelated to the philosophical issues.

How do you square the metaphysics and theology with the empiricism?

Intellectually, I am a hard-nosed agnostic. But emotionally, there's no question that there are theistic elements within me, and that's been true my whole life, which my parents were very puzzled about. I don't really feel I need to apologise for that.

We've been working on the Book of Genesis now for about three and a half years and I find those very meaningful comments on human experience. I mean, I love Homer and I think one can learn tremendous amounts about humans in Tolstoy and others. There is a descriptive approach to the nature of human experience in high-quality poetry that I have always found to be useful. It's a different way of knowing, absolutely. But they are mutually enriching. So, I am quite intolerant of the Richard Dawkinses of the world. It's so full of hubris to feel that so much wisdom and human struggle, which has been articulated in a religious context – to sort of wipe that away with one sweep as if that's just, you know, silliness. I have very little patience for that.

That kind of tallies with what Noam Chomsky has written – that there are limits to what we can understand with science. I have a quote from him here: 'It is quite possible – overwhelmingly probable, one might guess – that we will always learn more about human life and human personality from novels than from scientific psychology'.

Well that's a question of epistemology. That is the ways of knowing. That's not very different from Karl Jaspers' 'of explanation and understanding' actually. It's actually very similar to that. And does clinical psychiatry rely on both of those? Absolutely. Good psychiatry is always going to involve first-person, empathic understanding and that is our *craft*.

I worry that for people like Richard Dawkins, scientism has become a bit of a religion. Do you think that?

Well, with the following exception. If you were to ask me what is the best way to get to know about the mechanistic features of any part of the universe, I would say science is. Now, when you're talking about the human mind and its emotions, that's a different business. So in the sense that one can have hubris that science can explain things that it's not very good at, like the meaning of life or the origin of the universe, then yes, I would agree, that's scientific hubris, perhaps.

And it's funny the way that we sometimes slip as psychiatrists. I'm certainly not comfortable with the role that society calls for us. You know, as religion has gone down for people, now it's the psychiatrist who goes on talk shows. And boy, that bothers me a lot. And then, of course, they want us to comment on political figures and all that stuff. That is a big mistake.

It's kind of like psychiatrists have become the priests of scientism.

That's really a misunderstanding and it's amazingly widespread.

There's this attribution to us of some special form of human wisdom. It's amazing how intelligent people tend to have these feelings. It's just so strange the things that we get projected upon us as psychiatrists.

Were your parents religious?

Not at all. They were very Jewish, but not at all religious. I mean, if you've seen Woody Allen movies, yes? That's my father. But they grew up at a time when being religious they thought was superstition.

And if we were going to be psychoanalysts about this, do you think that you might have had some unconscious urge to rebel?

Well, I don't actually think that my interest in religion was primarily rebellion. It was something much more deep. You know I read a lot of Walt Whitman and William James's *Varieties of Religious Experience* when I was a teenager. I was reading Alan Watts, reading a lot of Gary Snyder poetry and other 'Pacific Poets'. I was trying to make sense out of life in the way that I emotionally came toward it.

Is it mainly poetry that you read in terms of the arts?

I certainly would read poetry more than I would read fiction nowadays. I certainly started out with it. I mean, Gary Snyder is probably my paradigmatic poet of interest, and Kenneth Rexroth.

I always have several books of poetry on my table that I read.

What do you get out of those?

The best kind of poems are just like little prayers, little senses of pulling on the special, the contingent, even – if you want to use the word – ‘sacred’ out of our everyday life experience, which as we know kind of rushes by us. Poetry is kind of grabbing this potent observation and thinking through the emotional implications of often very small things in our lives.

1.3.44 Evaluation of the effectiveness and acceptability of intramuscular clozapine injection: illustrative case series

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Abstract

Aims and method

A series of eleven patients prescribed intramuscular clozapine at five UK sites is presented. Using routinely collected clinical data, we describe the use, efficacy and safety of this treatment modality.

Results

We administered 188 doses of intramuscular clozapine to eight patients. The remaining three patients accepted oral medication. With the exception of minor injection site pain and nodules, side-effects were as expected with oral clozapine, and there were no serious untoward events. Nine patients were successfully established on oral clozapine with significant improvement in their clinical presentations.

Clinical implications

Although a novel formulation in the UK, we have shown that intramuscular clozapine can be used safely and effectively when the oral route is initially refused.

Contents

- *Evaluation of the effectiveness and acceptability of intramuscular clozapine injection: illustrative case series*
– *Method*

¹ Declaration of interest: None.

** How to use intramuscular clozapine**– Results*** Patient characteristics*** Use of intramuscular clozapine*** Prescribing and administering experiences**– Discussion*

Clozapine remains the gold-standard intervention for treatment-resistant schizophrenia (TRS), offering a wide range of benefits.¹⁻⁵ Case reports and series describing the use of intramuscular clozapine for patients unable or unwilling to take oral treatment have been published from authors based in Israel, the Netherlands and Australia.⁶⁻⁹ Although it is possible to successfully administer clozapine via a nasogastric tube as an alternative to the oral route, the more conventional option of an injection is usually preferable if a suitable preparation is available.¹⁰ Reports of the use of both intramuscular and nasogastric clozapine show that this ‘assertive’ approach can often result in improvements in mental state and a reduction in incidents and segregation, as well as facilitating progression to a less-restrictive environment. Also in practice, a stated intention to use ‘enforced’ nasogastric or intramuscular clozapine is often sufficient to persuade patients to accept the less intrusive oral route.^{11,12} Clozapine remains an underused treatment and ‘enforced’ clozapine in particular has been seen as controversial in the UK.¹³⁻¹⁵ The use of, and attitudes to, intramuscular clozapine in the UK have, to date, been described in poster presentations only.¹⁶⁻¹⁸ We now present the use of intramuscular clozapine in five UK settings with eleven in-patients.

Method

Data was collected between January 2017 and July 2018 at five UK sites: two medium-secure units, two high-secure hospitals and a locked rehabilitation unit. Clinical records were used to identify patients prescribed intramuscular clozapine, and their demographics, previous, response to clozapine use, use of oral and intramuscular therapy, subsequent response as assessed by clinical team impressions, adverse effects from intramuscular treatment and subsequent stabilisation on oral therapy were recorded. Pharmacy staff were consulted to report on the nurses’ practical experience of using the intramuscular formulation.

How to use intramuscular clozapine

Clozapine preparation and availability

Clozapine for injection is an unlicensed ‘special’ product made in the Netherlands by Brocacef and imported to the UK by Durbin PLC via Mawdsleys. The minimum order quantity is two packs of ten 125 mg/5 mL ampoules costing approximately £2000 in total. Hospital pharmacy departments have experienced delays with importation, supply shortages and stock being sent with a shelf life of only 2 months. When new, the ampoules have a 2-year shelf life in the dark at 25°C.

Legal authority

In England and Wales, incapacitous or non-consenting patients detained under the Mental Health Act (1983) may be administered drug treatments for mental disorders for longer than 3 months only if a second opinion appointed doctor approves the treatment, including the route of administration. A rationale needs to be given for the use of unlicensed preparations and so, even if the current authority includes oral and/or intramuscular antipsychotics, a separate request for this preparation will be required. The legal authority to allow enforced blood taking as part of clozapine treatment is provided by section 63 of the Mental Health Act (1983) as long as there is valid authority for the clozapine treatment itself.¹⁹

Administration and dosing

Administration is by deep intramuscular injection. Depending on the volume of injection, the gluteal, lateral thigh or deltoid injections sites were used in this series. The Brocacef preparation has no UK licence. The Netherlands licence specifies that volumes of 2–4 mL should be administered into the gluteal muscle and not the arm or thigh, and that volumes >4 mL should be given as separate injections. There is no evidence base to favour one site over another. Teams may choose to split doses exceeding 4 mL.²⁰ As the bioavailability is approximately twice that of oral preparations, oral doses are halved and injections are usually given once daily. Given the practical limits of administering large volumes of intramuscular medication initial plans for titrations up to volumes of 3.5 mL (87.5 mg intramuscular clozapine is equal to 175 mg oral clozapine) may require flexibility, depending on the response. This would enable the use of intramuscular clozapine beyond the initial 14-day titration.

Liaison with clozapine monitoring services

Although the intramuscular preparation is an unlicensed product, the aim is to establish the patient on oral clozapine as quickly as possible, with as little intramuscular use as possible (preferably none). The treating psychiatrist, pharmacy and patient will need to be registered with a clozapine monitoring service so as to allow oral clozapine to be dispensed. In practice, patients have been registered with a monitoring service. Oral clozapine has been prescribed and, if refused, then intramuscular injections of clozapine administered. Blood monitoring at the required intervals continues, so ensuring that the patient remains registered and that oral clozapine can be dispensed. The clozapine patient-monitoring service manufacturing the relevant oral brand of clozapine has no responsibility for the use of intramuscular clozapine. Our series involved patients registered with all current UK clozapine providers.

Available protocols and guidelines

Several trusts have produced guidelines and suggested dosing schedules for the use of intramuscular clozapine, which are available online.²¹

Results

Patient characteristics

All eleven patients identified were male: ten had a primary diagnosis of schizophrenia (ICD-10 code F20)²² and one had a primary diagnosis of bipolar disorder (ICD-10 code F31).²² The indication for clozapine was treatment resistance following previous failed treatments, including high dose and antipsychotic polypharmacy. Most had demonstrated a response to clozapine treatment previously, but had discontinued owing to various patient or clinician variables: complaints about blood monitoring, sedation, and a coincidental fall in platelet count owing to immune thrombocytopenia. At least two patients had experienced severe rebound psychosis when oral clozapine was stopped. All the units included have a smoke-free policy, which had been instigated before the data collection period, and so all patients were non-smokers. See *Table 1* for a summary of the patient demographics.

Table 1 Patient demographics

Patient	Age at first episode of psychosis (years)	Age at this admission (years)	Duration of psychosis at intramuscular clozapine prescription (years)	Previous clozapine response	Previous clozapine dose (mg/d)	Setting
1	17	24	Poor	1	100	MSU
2	28	34	Partial	3	50	MSU
3	22	39	17	Partial	3	HSS
4	23	37	14	N/A	N/A	HSS
5	21	47	26	N/A	N/A	AMSU
6	17	37	1	2	71	HSS

Use of intramuscular clozapine

In three patients the offer to choose between the oral and intramuscular route was sufficient to establish oral clozapine maintenance treatment at between 400 and 425 mg/day, with significant benefit. In the remaining eight patients intramuscular clozapine was required, and between 1 and 99 doses were administered per patient, predominantly into the gluteal muscle, with one being given into the lateral thigh after a patient developed nodules in the gluteal muscle, and one into the deltoid muscle when the patient refused to have the clozapine by any other route (it was the first dose at only 0.25 mL, and no additional effects were noted). Seven patients resisted intramuscular administration to the extent that restraint was used on between one and nine occasions during the initial 14-day dose titration. Restraint was required to take a blood sample in two individuals, one on five occasions and the other on four occasions, and there were no adverse effects during restraint. The remaining patients did not resist. By the end of 5 months, nine patients had been established on oral clozapine, the majority of these showing improvement at doses between 150 mg and 400 mg/day (mean 228 mg/day). No serious adverse effects occurred owing to either the injection itself or associated episodes of restraint. Minor injection site pain occurred in three patients; one experienced sedation, and the patient who had 99 doses of intramuscular clozapine experienced some injection site nodules. There were no injection site abscesses or infections. The maximum reported dose of intramuscular clozapine administered was 250 mg in 10 mL, which was given across three injection sites. *Tables 2 and 3* describe the use of intramuscular clozapine in this series.

Table 2 Use of intramuscular clozapine: titration over initial 14-day protocol (see section *How to use intramuscular clozapine*)

Patient	Route of first clozapine dose	Oral clozapine doses in titration	Intramuscular clozapine doses in titration	Restraint
1	Oral	9	5	2
2	Oral	0	14	4
3	Intramuscular	1	4	2
4	Oral	1	3	1
5	Oral	1	3	1
6	Oral	1	4	0
7	Oral	1	4	0
8	Oral	1	4	0
9	Intramuscular	0	1	1

Table 3 Use of intramuscular clozapine after 14-day initial titration

Patient	Intramuscular clozapine doses	Total
1	2	13
2	1	15
3	4	13
4	1	15
5	1	15
6	0	13
7	0	13
8	0	13
9	1	13

Serum levels were obtained from two patients who had intramuscular clozapine continuously for five or more days; see *Table 4*. The levels were consistent with the equivalent oral doses.²³ With regards to target plasma levels, all units aimed for the usual recommended plasma range, 0.35–0.6 mg/L, but then would be guided by individual patient symptoms and side-effects; higher than usual levels were used in certain cases. *Table 4* Clozapine serum levels

Intramuscular dose, mg	Equivalent oral dose, mg	Clozapine, mg/L	Norclozapine, mg/L
150	300	0.26	0.11
125	250	0.30	0.13

²

MSU, medium-secure unit; HSS, high-secure services; N/A, not applicable; Rehab, low-secure unit.

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Prescribing and administering experiences

Nurses were familiar with the practice of intramuscular antipsychotics and in general terms the procedure was perceived as acceptable: the injection solution was reportedly easy to draw up and, despite the bright yellow colour of the solution, the syringe markings were clearly readable and administration was easy, with very little resistance against the plunger when administering.

Nurses needed reassurance and reminding about maximum volume for single intramuscular administration, so when, for example, 10 mL was administered, three injections (4 mL + 3 mL + 3 mL) were used. Overall, nurses reported that they were confident in their ability to administer intramuscular clozapine.

Doctors required advice on bioequivalence of oral and intramuscular clozapine and how to word the prescription so that it was clear the intramuscular was only to be used if oral was declined. They also occasionally needed to be reminded to document the rationale for intramuscular treatment in clinical notes and in the associated care plan. Assistance was sometimes needed, especially initially, to complete the required application and gain approval by trust approval bodies.

In the unit where nasogastric clozapine had also previously been used, the procedure for administering intramuscular was seen as much simpler, faster and less stressful for patients. However, the limitations on dosing with the intramuscular formulation owing to volume considerations were a perceived disadvantage in patients who had experienced benefit and were poorly compliant on higher doses after the initial titration.

Discussion

When presented with a patient with TRS who refuses clozapine and consequently faces distress, disability, risk and a potentially extended length of stay, clinicians can feel that they are dealing with an impossible problem.⁵ Alternatives to clozapine are unlikely to work and may well cause harm, although a cycle of depot changes, high dose or polypharmacy regimes may still be attempted.^{24,25} ‘Enforced’ clozapine (i.e. via nasogastric or intramuscular) is a rarity and, but for the handful of case series above, barely described in the literature; there is believed to be no previous published experience of its use in the UK. Although some NHS trusts have published guidelines for the use of intramuscular clozapine, these do not provide for all eventualities and will likely need adapting to local and individual patient circumstances, often while treatment is taking place; indeed, a flexible and pragmatic approach is more likely to succeed. Difficult decisions will include not only deciding whether to use the intramuscular route at the outset, but also when to stop treatment. Neither oral clozapine nor intramuscular clozapine will provide a solution to every patient with TRS; for example, the intramuscular route may result in patient benefit, but not within the time frame or ceiling dose allowed within a protocol agreed by the governance structure of the institution. In these cases the clinical team may need to consider higher doses and/or multiple intramuscular clozapine injections over the course of the day. A higher-strength solution for injection would be very useful and could enable intramuscular clozapine to be given as the doses increase during the titration, and to continue at higher maintenance doses if the oral dose is refused later in the treatment. Presently one unit in the study prescribes intramuscular clozapine doses lower than the equivalent oral dose if 48 h of non-adherence is approaching, essentially to prevent the need for retitration. An alternative would include the nasogastric route; however, nasogastric administration of clozapine is culturally less acceptable and less routine than intramuscular in mental health settings. With nasogastric administration, more time is needed in the restraint position, therefore reducing patient safety, and there is a risk the patient could vomit up the medication. The clinical team needs to consider whether the benefits of improvement, possibly in the long term, justify the short-term risks of daily restraint or the complications of using an unlicensed, relatively unused intramuscular drug treatment. Although in our series there were no adverse outcomes from the episodes of restraint, it does not necessarily follow that the procedure is devoid of risk. Our series is unusual compared to the experience elsewhere in that greater number of patients had a much higher number of injections. In the Israeli and Dutch series most patients were established on oral clozapine after one intramuscular dose only, almost all within 2 weeks of starting treatment with clozapine, and only one had treatment for 3 months. It is possible that our sites, which were all secure units, selected for a patient cohort that was more clinically complex and hence more difficult to treat.

In conclusion, given the lack of new treatments for TRS in recent years, it is essential that clinicians deliver the treatments that are likely to work, and clozapine in particular. The intramuscular route can be used to remove one of the impediments to its use, namely refusal of oral treatment. Although our experience was in secure settings, the use of

intramuscular antipsychotic medication is used throughout different mental health settings and there is no reason to suggest that 'enforced' clozapine, whether using the intramuscular or any other route, should be confined to secure services. As was found in the series from the Netherlands and with nasogastric clozapine in the UK, many patients accept oral clozapine when faced with the coercive alternative, which is ultimately the desired outcome. There has been concern that the procedure itself might be aversive and painful; however, reports of injection site pain and inflammation were very low. We have demonstrated that the use of intramuscular clozapine, although not without some drawbacks, is overall easy, safe and effective.

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All authors made contributions to the conception and design of the work, revisions for important intellectual content, approved the final version for publication and are accountable for all aspects of the work.

1.3.45 Efficacy of a dementia intensive support (DIS) service at preventing admissions to medical and psychiatric wards: qualitative and quantitative evaluation

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Abstract

Aims and method

To establish whether a dementia intensive support (DIS) service that is part of a crisis resolution and home treatment team for older people is preventing admissions to acute hospital and psychiatric wards. The number of referrals in 2017 to the DIS service was established and those admitted to hospital ascertained. Senior doctors examined 30 sets of notes in detail and reached a conclusion on whether DIS had contributed to admission prevention. This information was then re-examined in two meetings with at least eight senior psychiatrists present. A consensus opinion was then reached as to whether DIS had contributed to admission prevention in each case.

Results

Over 12 months, 30/171 patients (18%) referred were admitted to hospital. For the subset of 30 referrals examined in detail, DIS contributed to admission avoidance in 21 cases (70%).

Clinical implications

Our evaluation demonstrates that the DIS service is an effective way of preventing admission.

Contents

- *Efficacy of a dementia intensive support (DIS) service at preventing admissions to medical and psychiatric wards: qualitative and quantitative evaluation*
 - *Method*
 - *Results*
 - *Discussion*
 - * *Strengths and limitations*
 - * *The wider evidence base*
 - * *Service implications*
 - *Data availability*
 - *Supplementary material*

Dementia has become a major health concern in older people, with prevalence rates in those over 65 years of age estimated at 7.1%. The overall economic impact of dementia in the UK was costed at £26.3 billion, with an average annual cost of £32 250 per person, in 2013.¹

A quarter of hospital beds are occupied by people with dementia.² Admissions to hospital for patients with dementia are not always preventable but should be avoided where possible, as they are associated with increased length of stay, morbidity and mortality.³

The efficacy of crisis resolution and home treatment teams (CRHTTs) in general adult services is reasonably well established, with a Cochrane review confirming that crisis care was acceptable and less expensive. In addition, repeat admissions were avoided and users of crisis services showed greater improvements in their mental state and reported greater satisfaction than those who received standard care.⁴ However, the evidence base is much slimmer for older people and for people with dementia specifically.^{5,6}

Cambridge and Peterborough NHS Foundation Trust (CPFT) covers the county of Cambridgeshire (including Peterborough) and some small areas of adjacent counties in England. The total population served by CPFT is approximately 1 million people, of whom 165 000 were over the age of 65 at the last census in 2016. There were an estimated 8600 people with dementia in 2016, a number expected to increase to 16 110 by 2031.⁷ We have two regional CRHTT services for older people across the county (CRHTT-OP North and CRHTT-OP South), each covering approximately half of the county. To reduce or prevent hospital admissions, our dementia intensive support (DIS) service in CPFT was set up in its current format in 2016. The DIS service forms part of CRHTT-OP South. The role of the CRHTT-OP service is to support both people with dementia and people with functional health problems in crisis at home or in their community settings. The overall aim of CRHTT-OP South/DIS is to reduce or prevent hospital admissions of older people and to facilitate their discharge from hospital.

In this service evaluation, endorsed by management (authors B.R.U. and R.K.), we sought to examine the effectiveness of the DIS service in the South of CPFT, since additional funds were given to the service in 2016. In 2017, the period covered in this study, the team received referrals mainly from general practitioners who referred to a triage hub,

from the first response service (FRS) – a 24-hour trust-wide telephone triage service which accepts self-referral from individuals of all ages – and from liaison psychiatry services. The minimum guaranteed response time by CRHTT-OP South is 24 h and the maximum is 5 days. CRHTT-OP South usually provides contact with patients for between 2 and 6 weeks. Patients may then be referred onto community mental health teams for ongoing support or back to their general practitioner. Two old age consultants share the work of this team (0.9 whole-time equivalents to CRHTT-OP South) and also share the in-patient work of the functional ward. All clinicians in the team have several years' clinical experience. The team works from 08.00 to 20.00 h, 7 days a week, and operates with two shifts a day; each shift comprises 3–4 community psychiatric nurses, 1–2 community support workers, a team leader (working 09.00–17.00 h on weekdays) and full-time administrative support for the team from 08.30 to 17.00 h on weekdays. Non-medical clinicians usually undertake the initial assessment of all patients referred to the service, with medical support provided as needed. All patients seen receive a comprehensive psychiatric assessment and risk assessment recorded on our electronic notes. In addition, the interventions by the DIS team are noted in the patients' electronic progress records and letters to the general practitioner (GP). Pharmacological (antidementia drugs, antipsychotics, benzodiazepines and antidepressants) and non-pharmacological interventions for behavioural and psychological symptoms of dementia (BPSD) (typically, exploration of the reasons for the behaviour and suggestions of ways to address it, as well sensory and music stimulation and assistive technology, as described in NICE guidelines from 2018⁸ and Alzheimer's Society guidance from 2011⁹) are employed.

We evaluated, using qualitative and quantitative methodology, whether the involvement of the DIS team did lead to prevention of admission to hospital for older people with dementia.

Method

This service evaluation was approved by the CPFT governance committee and did not require ethics approval.

We first examined the total referrals to the DIS service over the year (2107) and recorded the number of admissions to medical and psychiatric wards. Exclusion criteria were referrals that the DIS team felt to be inappropriate (e.g. the patient needed a referral to social care or was not deemed to be in a crisis and was referred to the community psychiatric team) or where the patient was not seen because they were admitted to acute hospital before CRHTT-OP South engagement. All patients had a diagnosis of dementia.

We then invited eight senior psychiatrists (consultants and specialist trainees) to support this retrospective study and to examine the notes to see whether the DIS service had prevented admission to hospital. At the time the patients were seen by CRHTT-OP South, some of these doctors were working in CRHTT-OP South but others were working in the community teams or liaison service or had not joined CPFT yet. All patients referred to and contacted by the DIS team in June 2017 ($n = 12$) and November 2017 ($n = 18$) were included and the outcome of that contact with the CRHTT during that episode of care was noted, together with the number of days in contact with the DIS. The months were chosen at random. Basic demographic data were collected on the patients and the average length of time spent with the DIS team was calculated. In addition, notes were examined by J.S.R. and L.C. to identify the main reasons for referral and the main interventions offered by the team for each of the 30 patients. The frequencies of these reasons for referral and main interventions recorded were noted. The eight senior psychiatrists were asked to evaluate each patient's notes following referral to CRHTT-OP South in these 2 months to assess whether the DIS team had helped to avoid hospital admission (medical or psychiatric). The notes themselves were not anonymised, but J.S.R. ensured that the clinicians were not given patients from areas that they usually covered clinically, to try to avoid bias in their interpretation, and when these patients were discussed by the group this was done in an anonymous fashion to avoid bias as far as possible. Clinicians had to summarise on a pro forma the issues pertinent to the DIS contact and then reach a conclusion as to whether the DIS service had contributed to 'admission prevention'. In cases where patients had been admitted to hospital, it was straightforward to conclude that admission had not been prevented. In cases where the patient had not been admitted, a qualitative judgement had to be made as to whether, from the type of interventions provided by the DIS team (psychosocial or medical), hospital admission had been avoided. The pro formas regarding the DIS team's involvement were then re-examined collectively in two group governance meetings to provide an 'expert consensus opinion' on whether CRHTT-OP South had contributed to admission prevention, with eight senior psychiatrists present at each meeting.

Results

Figure 1 shows the total number of patients referred to the DIS service from January to December 2017 and the number of admissions to medical and psychiatric wards from those referrals. There were 171 referrals during that period, 30 of whom (18%) were admitted, i.e. approximately 1 in every 5 patients referred to the DIS was admitted. Fig. 1 Total referrals accepted by the dementia intensive support (DIS) team over 2017 and numbers admitted to psychiatric and acute (medical) hospitals.

The demographics of the patients whose records were examined in detail by the expert panel are shown in Table 1. The average length of stay with the DIS team was 19 days (range 4–43 days). The ICD-10 diagnoses were: Alzheimer's disease (14 patients), vascular dementia (5), Alzheimer's of mixed type/atypical (4), dementia not otherwise specified (3), dementia with Lewy bodies (2), alcoholic dementia (1) and frontotemporal dementia (1). Four of the patients with Alzheimer's disease were noted to also have delirium and one patient with Alzheimer's of mixed type was noted to have delirium and alcohol dependence. Table 1 Demographics of patients with dementia seen by the dementia intensive support team over 2 months in 2017

Month	Sample size, n	Male	Mean age, years	Age range, years
June	126	83	70	–96
November	189	166	–98	–98
Combined	301	582	66–98	–98

The main reasons for referral to the DIS team and their frequency are noted in Table 2. Aggression (verbal and physical) was the most common reason for referral but often several reasons were noted. The key interventions that were recorded in the electronic notes and the frequencies of these are also summarised in Table 2. Combinations of interventions were often offered. Table 2 Reasons for referral to the dementia intensive support (DIS) team and key interventions offered

Frequencies reported	Main reasons for referral to DIS (usually a combination of reasons)	Key interventions offered by DIS team (usually a combination of interventions)
18	Aggression (physical and verbal)	Advice and support for carers
11	Agitation	20 Pharmacological interventions for BPSD
10	Shouting out/disruptive behaviour/entering other residents' rooms	17 Non-pharmacological interventions for BPSD
10	Worsening hallucinations or delusions	16 Referral for increased social support/different care home/respite
4	Sexual disinhibition	9 Supportive counselling/advice to the patient
3	Depression	4 Recommendation of a change to physical health medication
2	Supporting discharge from ward (acute or psychiatric)	4 Admission to psychiatric ward
2	Safeguarding issues	4 Admission to acute hospital
2	Delirium management	4 Recommendation of a move to a higher level of care in the same care home
1	Suicidal in the context of a new diagnosis of dementia	1 Fall prevention
1	Carer burnout/stress	1 Delirium assessment management
1	Key interventions offered by DIS team (usually a combination of interventions)	1 Educational programme for care home
1		1 Benefits advice to carers

Table 3 shows the number of patients for whom admission was considered to have been avoided by DIS engagement, as well as the average across both months. There were some discrepancies (three in total) between the initial assessor's views and those of the group in deciding whether an admission had in fact been prevented by DIS engagement with the patient. The group view prevailed and is quoted in Table 3. In our qualitative judgement, the DIS service contributed to admission avoidance for 21/30 patients referred (70%), averaged over the 2 months. Table 3 Admission avoidance over 2 months in 2017

Month	Admission avoided (group decision)	Admission avoided (initial assessor's view)
June	11/12 (92%)	10/18 (56%)
November	10/18 (56%)	21/30 (70%)
Combined (June and November)	21/30 (70%)	21/30 (70%)

1

BPSD, behavioural and psychological symptoms of dementia.

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Discussion

Our service evaluation shows that over a 1-year period only few referrals received by the DIS service were admitted to medical or psychiatric wards (18%). We conducted a qualitative review of patients referred in 2 months of the year using a panel of senior doctors. These doctors examined 30 referrals to DIS in detail to judge whether DIS had contributed to admission prevention. The panel felt that the DIS service contributed to admission avoidance for 70% of patients referred to the service in these 2 months.

Strengths and limitations

Previous criticism of crisis and home treatment studies centres on the definition of a 'crisis' and whether all referrals would in fact meet 'thresholds' for admission. This study sought to circumvent this issue to some extent by examining whether patients in crisis who were seen by CRHTT-OP South had received an intervention from the team which contributed to admission prevention. However, we acknowledge that the discussions that took place among the panel of senior clinicians were of a qualitative nature and subjective. However, the strength of this methodology was that the decisions were not left to a single clinician but were examined by a group of senior clinicians and decision makers in the service.

Although we tried to minimise bias by giving the assessing clinicians patients not from their own teams and by anonymising data when discussed as a group, sometimes clinicians may have recognised the patient under discussion from the particulars of the clinical history, which could have introduced some bias. A further limitation is that this is a naturalistic study and it is possible that not all of the interventions offered were recorded. Only the major interventions identified by the authors examining the notes (J.S.R. and L.C.) have been noted.

The wider evidence base

We acknowledge that case-control studies are needed to be sure of the efficacy of DIS services. Such studies are very difficult to set up as most services now have some form of crisis or intermediate care service to prevent admission of people with dementia to hospital, and services frequently change structure or function over time.

The most recent systematic review of the literature on crisis team management of dementia in older people, from 2017, describes the results of six cohort studies and one case-control study.⁵ However, several studies include both patients with functional and psychiatric disorders, making direct comparisons with our study more difficult. A positive effect on factors such as reducing the number of hospital admissions, readmissions, length of stay and mortality rates was reported in these studies. However, caution needs to be exercised in interpreting the review's findings as the studies were small, of variable design and sometimes lacking in statistical rigour.⁵ There was only one case-control study (from the USA) in which a non-randomised concurrent control treatment outcome trial was conducted.¹⁰ This study reported a lower mortality rate, a significant decrease in hospital readmissions (with people remaining in their homes for longer), significant improvements in caregiver outcomes ($P < 0.001$) and fewer neuropsychiatric symptoms for those in the intervention group. It is difficult to be sure how reproducible this service would be in the UK. In addition, the control group did not seem to be similar to the intervention group as they were more likely to die in the first year, suggesting that they may have been a more physically ill group from the outset. Further case-control studies in the UK are needed to establish whether DIS teams are effective in reducing admissions. Our own previous cohort study is one of the few to examine this question before and after the introduction of an ageless CRHTT in the UK,¹¹ but it did not examine crisis services for patients with dementia specifically (all crises for older people were included) and other service changes may have affected the result.

Service implications

Commissioners of our service have enthusiastically endorsed the approach of crisis and home treatment: indeed, ‘at home is best’ is the top priority for the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP).¹² This has been reflected in additional investment in DIS teams as one of the key areas for the STP investment fund. This study shows that very few patients referred to our service over the year required hospital admission. Admission cannot always be prevented and of course the reasons for in-patient admission to psychiatric or acute hospital are notoriously complex to analyse (and beyond the scope of this study), involving specifics of particular patients, carers and clinicians. Supportive measures (such as care packages, medication and explanation about the management of delirium) may help to support carers and prevent acute hospital admissions. However, these patients were all referred in crisis and, although some were excluded by our expert panel as not reaching the threshold for the DIS team having contributed to admission prevention, many were helped by interventions from the team. The DIS team has therefore proved to be a worthwhile asset to our service.

We thank Dr Ian Rowbotham, CRHTT consultant in the North of CPFT, for advice and discussion in the early phase of the project, and Christie Walker for administrative support. We thank the librarians at Fulbourn Hospital Library for help with the literature search and sourcing paper.

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Data availability

The data associated with the manuscript are available from the corresponding author.

All authors made substantial contributions to the conception or design of the work or to the acquisition, analysis or interpretation of data for the work. All authors helped to draft the work or revise it critically for intellectual content. All authors gave final approval of the version to be published and agreed to be accountable for all aspects of the work in accordance with ICMJE criteria.

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Supplementary material

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[click here to view supplementary material](#)

1.3.46 Supporting people in mental health crisis in 21st-century Britain

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Abstract

Recent years have seen a surge in interest in mental healthcare and some reduction in stigma. Partly as a result of this, alongside a growing population and higher levels of societal distress, many more people are presenting with mental health needs, often in crisis. Systems that date back to the beginning of the National Health Service still form the basis for much care, and the current system is complex, hard to navigate and often fails people. Law enforcement services are increasingly being drawn into providing mental healthcare in the community, which most believe is inappropriate. We propose that it is now time for a fundamental root and branch review of mental health emergency care, taking into account the views of patients and the international evidence base, to ‘reset’ the balance and commission services that are humane and responsive – services that are fit for the 21st century.

Contents

- *Supporting people in mental health crisis in 21st-century Britain*

Recent years have seen a surge of interest in mental healthcare. Media columns, royal endorsements, prominence in policy and legislative agenda all point to the gradual erosion of stigma surrounding mental illness. However, the most recent Care Quality Commission report on mental health services showed that services still struggle to provide people with the help they need, with 40% of National Health Service (NHS) providers being rated as poor or requiring improvement in the most fundamental domain of all, safety.¹ Although this is widely acknowledged, it has not as yet been remedied and is particularly problematic in the management of so-called mental health crises.

Emergency medical services still operate on the historically established principles developed during the birth of the NHS, with a single means of emergency transport to large accident and emergency (A&E) departments staffed and equipped to largely deal with physical problems. This was entirely understandable in an era when few treatments were available for mental health crises and few people presented to services, but it has become increasingly outdated over time. A significant and rising proportion of A&E attenders come with a mental health crisis of some sort.^{2,3} Many community mental health services (for all age groups) are increasingly stretched owing to a period of significantly rising demand, and the relatively flat workforce is leading to more people presenting in crisis as we are less able to intervene early and avoid such presentations. It is important to bear this wider picture in mind while thinking about emergency mental healthcare.

There have been welcome developments in emergency mental healthcare, including crisis teams,^{4,5} but these are generally restricted to those already under secondary mental healthcare, with only one service in England to our knowledge

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Declaration of interest: None.

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being genuinely ‘open access’, with people able to just turn up and be seen. Otherwise, people must go through a general practitioner, the police, or A&E. Indeed, many crisis services have shrunk in recent years, with providers being ‘freed’ from adhering to the evidence-based care of the national service framework and operating under reduced funding.⁶ Many struggle to offer a fast and flexible service to those in need in the face of increasing demand, and many people are discharged early from hospital or not admitted owing to chronic NHS mental health bed shortages.

Other developments have included police street triage services,⁷ which despite their name often support people in mental health crises in their own homes as well as in public places. Their introduction has come alongside a welcome drop in the use of police custody for up to 24 h under section 136 of the Mental Health Act, although overall section 136 use has not seen such reductions.⁸ However, these welcome reductions in police custody use are not universal and cannot solely be attributed to triage services, as both legislation and policy have also substantially changed.⁹ Street triage services vary markedly; while being part of a crucial safety net, they operate alongside police officers, which consumes significant police time and means that for many the response to their health crisis comes in a police car – a marked contrast to physical care, and distressing and stigmatising for many.

Other welcome initiatives include places where people in crisis can drop in and receive support, generally from staff employed in the charity/third sector. Terminology varies (crisis café, safe haven, etc.), as do mode and hours of operation. Again, provision is variable and few such places, if any, are open 24/7. We could find no empirical evidence for their effectiveness or specific service models or components of models.

The result of all the above is a patchwork of provision developed during isolated attempts to patch up the problem of mental health crisis response rather than developing system-wide solutions. They make crisis care hard to negotiate for anyone, let alone people in distress and their families. It is widely agreed that the current evidence base is poor.^{2,10–12} We need to ask ourselves some fundamental and difficult questions. Are busy A&E departments the right place for those in crisis, such as those at risk of suicide or self-harm, or those with symptoms of psychosis? Are uniformed police officers the correct response to people in distress who have not acted unlawfully? Why are there so many cracks in provision that people can, and do, fall through during crisis?

We believe a root and branch review of crisis services based upon evidence from this country and overseas is needed. This should be guided by those who receive services and their families, alongside those who provide them. Such a process could move our mental health crisis services (belatedly) into the 21st century. We need to be bold. Initial evaluations of dedicated mental health ambulances in Sweden that work on a similar basis to their physical counterparts are encouraging, with much demand and favourable reports of patient experience.¹³ In Australia, projects of peer-to-peer support with care packages to avoid hospital admission have shown encouraging results.¹⁴ We need to evaluate the current movement of crisis cafes and safe havens rigorously, both in terms of effectiveness and of models that work (or don’t).

The NHS long-term plan (www.longtermplan.nhs.uk) has an ambitious vision for emergency mental health services in particular, with improved access and greater patient focus. It also promises a bolstering of services for people with severe and enduring mental illnesses, and that out of area placements (OAPs) will end. Unfortunately, a very recent NHS report¹⁵ has shown that OAPs are actually rising again. However, detailed analysis of spending commitments and the current worsening workforce problems in all disciplines makes it clear that these worthy ambitions cannot be realised without a step change in our thinking about and our valuing of mental healthcare. This, alongside the review of mental health legislation and the universal acknowledgment that services are inadequate, means that now is the time to invest in the future by taking a considered and evidence-based approach to decide what should be available to provide the best experiences of care and the best outcomes. To continue with our ongoing *ad hoc*, piecemeal approach does our patients a disservice.

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1.3.47 The emotional and mental health needs of young carers: what psychiatry can do

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Abstract

Aims and method

To review the literature on the emotional and mental health needs of young carers of parents with mental illness and the extent to which such needs are recognised and supported by professionals. Three databases were systematically searched from 2008 to 2018, and five studies met the inclusion criteria.

Results

The key findings were that young caregivers had a significantly higher dose-response mortality risk than their peers; were at increased risk of mental health difficulties, especially where the ill family member was a parent and had mental illness or misused substances; were overlooked by professionals owing to a lack of awareness; but could derive benefits from their caring role when appropriately supported.

Clinical implications

Young carers are at increased risk regarding emotional and mental health needs; this risk could be mitigated by professionals recognising the young carer's role and including them in their parent's treatment plan.

Contents

- *The emotional and mental health needs of young carers: what psychiatry can do*
 - *Background*
 - *Aim*

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- *Method*
- *Results*
- *Discussion*
- *Limitations*
- *Conclusion*

Background

Societal awareness of young carers and the potential effects of caring on their health and development has increased in the past 20 years.¹ A ‘young carer’ is ‘a child or young person under 18 who provides regular or ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances’.^{2,3} The 2011 Census in England and Wales showed that 166 363 children in England cared for their parents, siblings or family members, an increase of 20% on the number recorded in the 2001 Census.^{4,5} However, this was thought to be an underestimate.² The prevalence of informal caring in the underage population was estimated as a minimum of 2–4% in Western countries.⁶

Dearden and Becker reported that most young carers cared for parents, particularly mothers, although some provided support for grandparents, siblings or other relatives. Tasks undertaken by young carers included housework, general healthcare – for example, assisting with mobility or giving medication – intimate personal care such as bathing or toileting, and emotional support.⁷ Emotional support by young carers was more likely to be offered to parents with a mental health problem.^{7–10} Caring responsibilities ranged from a few hours a week to over 100 in extreme cases.¹¹

Half of all conditions supported by young carers involved physical health, but almost a third (29%) were for mental health problems, while 17% related to learning difficulties and 3% were for sensory impairments.^{7,12} Extrapolating from these figures suggested that 55 000–60 000 children in the UK cared for a parent with mental illness.¹³ According to 2018 estimates for England, 3.7 million children aged 0–17 (31.7%) were in a household where a randomly selected adult had at least moderate mental health symptoms, including 1.6 million (13.5%) where the adult had severe mental health symptoms.¹⁴

For psychiatrists, the young carers most likely encountered in work are those of their adult patients with mental illness. Estimates in Australia and the USA of the proportion of people accessing mental health services who were parents ranged from 20 to 60%.^{15–18} In the UK, the majority had common mental disorders such as depression or anxiety, but some (0.5%) had a psychotic condition.¹⁹ According to recent UK estimates, parents comprise at least 25% of adult mental health patients with significant interpersonal/personality difficulties, including 63% of women with psychosis and 25% of adults in acute psychiatric hospital settings.²⁰

The 2011 Census in England and Wales showed that one in eight young carers was under the age of ten, and some were as young as five.⁵ According to Canadian research among youth aged 15–24 years, females accounted for the majority of carers, and there was an increasing feminisation of care as youth aged, the differences being most acute at the highest care levels.²¹ It was suggested that this pattern was similar to that in the UK and Australia.^{7,10,21} A further UK survey suggested that young carers were 1.5 times more likely than their peers to be from Black, Asian or minority ethnic communities, and twice as likely to not speak English as their first language. They were 1.5 times more likely than their peers to have a special educational need or a disability.¹¹

How the young carer and parent were viewed often depended on the disability or diagnosis, such that having parents with mental health problems was presumed to pose more adverse challenges.¹ Young carers were often considered as a homogenous group; however, it has been argued that those caring for a mentally ill parent could experience particular risks and needs. Studies from several countries have found that children of parents with a mental illness were at a greater risk of poorer outcomes than their peers,^{22,23} with higher rates of mental illness²⁴ and poorer development in behavioural,^{25,26} social,²⁷ and academic²⁸ domains.²² According to Pakenham and Cox, the presence of any family member with an illness was associated with a greater risk of mental health difficulties for young people, relative to their peers from ‘healthy’ families. This risk was further elevated if the ill family member was a parent and had mental

illness or abused substances.²⁹ In the UK, parental mental ill health was a significant factor for children entering the care system.³⁰

Aggregated data suggested that a child had a 30–50% chance of developing a serious mental illness if they had two parents with mental illness.³¹ A child of a parent with an affective illness had a 40% chance of developing an affective disorder by age 20, compared with a 20–25% risk in the general population.^{32–35} However, the increased risk noted in these studies may have a multifactorial aetiology.

It has also been argued that younger carers can sometimes overcome the effects of extreme adversity³⁶ with information, recognition of their role, and inclusion in their parent's treatment plan. Studies suggest that some young carers may even derive some benefit from their caring role.

Aim

The main aim of this literature review was to explore the emotional and mental health needs of young carers and their circumstances, particular those related to their parents' mental health. The review also explored the extent to which the needs of young carers were recognised and supported by the psychiatrists and other professionals working with their parents.

Method

The PRISMA guideline³⁷ was followed to search three databases (EMBASE, Medline and PsychInfo), which are accessible from the Royal College of Psychiatrists library. The search covered 2008–2018 using the terms 'emotional health or emotional stability or psychological health or social psychology or mental health' and 'young carers' or 'young and carers' or 'young caregivers' or 'young and caregivers'. Boolean operations and truncations were employed to allow for alternative endings in the keyword searches. The search was limited to the past 10 years in order to focus on more recent developments in the field, which are more likely to be relevant to current practice. Additional literature was accessed through contact with the authors of some of the papers, a charity that supports young carers, and references from retrieved papers.

Studies were included if they were published in English and involved a primary study published in the past 10 years that identified the emotional and mental health needs of young carers and had a minimum of 14 participants. The latter criterion was based on the fact that very small sample sizes would limit the generalisability of results to the wider young carer population.³⁸ Four hundred and eighty-eight abstracts were identified; initial screening identified 43 relevant studies, whose full texts were assessed. Finally, five studies were selected (*Fig. 1*). *Fig. 1* Study selection

Results

The literature review focused on five recent papers published between 2013 and 2018 which investigated the emotional and mental health needs of young carers, the circumstances which gave rise to them, current psychiatric practice and possible improvements. One study³⁹ was census-based, retrospective and longitudinal. The others, reflective of the majority of studies in the search, were qualitative and recorded the experiences of young carers. The papers showed the increased and particular needs and risks of young carers of a parent with mental illness, with one study identifying what it referred to as a 'young carer penalty'.³⁸ The census-based study further found a higher mortality risk among young carers.³⁹ The shortcomings of mental health services in their consideration of young carers were also raised. The studies are summarised in *Table 1*. *Table 1* Summary of studies reviewed

design, country and sample
Results
Conclusion
Leu *et al*⁵⁴

(*n* = 30) Semi-structured interviews

Switzerland

16 young carers aged 10–17 years

14 young carers aged 18–25 years
Tasks depended on nature of illness/impairment and availability of other family carers. Intensity varied from part- to full-time responsibility
Highlighted importance of communication with family, professionals and peers
Millenaar *et al*⁵³

(*n* = 14)Semi-structured interviews

The Netherlands

14 children aged 15–27 years living with a parent with young-onset dementia (YOD)Divided into three themes that demonstrated effects of dementia on daily life, different ways of coping, and children’s need for care and supportIn addition to practical information, more accessible and specific information about diagnosis and course of YOD needed to provide better understanding for children. Underlined need for personal, family-centred approach.Packenham and Cox²⁹

(*n* = 2474)Questionnaire Survey

Australia

2474 youth aged 9–20 years (‘healthy family’ *n* = 1768, parental illness *n* = 336, other family member illness *n* = 254, both parental and other family member illness *n* = 116)Presence of any family member with illness associated with greater risk of mental health difficulties for youth. Risk elevated if ill family member is parent and has mental illness or substance misuseSerious health problems within household adversely affect youth adjustmentStamatopoulos³⁸

(*n* = 15)Two focus groups and one in-depth interview Canada

15 young carers aged 15–19 yearsEvidence for unique ‘young carer penalty’Ongoing youth caregiving constitutes a form of hidden labour that carries with it a range of benefits and penaltiesTseliou *et al*³⁹

(*n* = 19 621)

Census-based mortality linkage study

Northern Ireland Caregivers aged 5–24 yearsYoung caregivers more likely than non-caregiving peers to report chronic poor mental health. They also differed from older caregivers and were at significantly higher mortality risk than peers. Dose-response relationship between hours devoted to caregiving and mortality risk evidentYoung caregivers at significantly increased risk of poor health outcomes

A study by Pakenham and Cox examined differences in adjustment between children of a parent with an illness and peers from ‘healthy’ families, controlling for whether a parent or non-parent family member was ill, the illness type, demographics and caregiving.²⁹ The study was questionnaire-based and had a total sample of 2474 youths, comprising those from ‘healthy’ families = 1768 and those from families with parental illness = 336, other family member illness = 254, and both parental and other family illness = 116. The youths, aged 9–20 years, were recruited in Queensland, Australia, mostly from schools. However, recruitment also took place through church groups (*n* = 35), scouts (*n* = 23), university vacation care (*n* = 13), and a young carer association (*n* = 42) in order to achieve more diversity in the sample.

The youths completed questionnaires to obtain information on their age, gender, home postcode, employment, dual-versus single-parent family, number of siblings and ethnic background. An eight-item family responsibilities subscale of the Young Carer of Parents Inventory⁴⁰ was used to assess youth caregiving. A range of positive and negative youth adjustment outcomes were assessed by behavioural-emotional-social difficulties, somatisation and health. Positive adjustment outcomes were assessed by family satisfaction, life satisfaction, positive affect and pro-social behaviour.

The results showed that the presence of any family member with an illness was associated with greater risk of mental health difficulties for youths compared with their peers from ‘healthy’ families. Using Cohen’s effect size conventions, the effect sizes for the significant outcomes for parental illness group ranged from small (0.22) to very large (1.0), but they were uniformly small for the ‘other family members’ illness group (range 0.08–0.18). This risk of poorer adjustment was elevated if the ill family member was a parent and had mental illness or misused substances. The latter risk held even when caregiving and demographic factors were considered. Incidentally, caregiving itself was associated with poorer adjustment in six of the seven outcomes considered, even after controlling for illness type and a range of sociodemographic factors.

Parental illness and illness in other family members were both significantly associated with more negative outcomes compared with ‘healthy’ families for all but two outcomes. The effect of ‘parental illness’ was significantly larger than for ‘other family member’ illness for all but one outcome, although the effect sizes were small. However, as these data were cross-sectional, the associations may not be causal, as it is also possible that the additional risk attributed to caregiving may be confounded by other unmeasured factors such as genetic influences.

A recent study³⁹ investigated the association between caregiving and health/mortality risk in young caregivers when

compared with non-caregiving peers and older caregivers. They used a census-based record to link all residents enumerated in the 2011 Northern Ireland Census with subsequently registered deaths data, until the end of 2015. Among those aged 5 to 24 years in the 2011 Census, approximately 4.5% were reported to be caregivers. The presence of a chronic physical and/or mental health condition was measured through the Census, and all-cause mortality was assessed by official mortality records.

This study found that young caregivers had a significantly higher mortality risk than their peers (adjusted hazard ratio = 1.54, 95% CI: 1.10, 2.14). A dose-response relationship between the hours devoted to caregiving duties and mortality risk was evident. Young caregivers were also more likely to report chronic mental health problems than their non-caregiving peers (adjusted odds ratio (OR) = 1.44, 95% CI: 1.31, 1.58).

Further, young carers differed from older caregivers, with the odds of reporting poor mental health inversely related to age. Tseliou *et al* maintained that although the majority of studies found that caregiving may be associated with poor mental and emotional health,^{41–44} this had been moderated by growing recognition that older caregivers had a reduced mortality risk compared with non-caregiving peers.^{45–52} At older ages, less intense caregiving was associated with a reduced risk of chronic poor mental health. However, by 25–44 years old, this was reversed such that a positive dose-response association was observed between caregiving status and mental ill-health. This adverse effect was most evident among 5–17-year-olds. In this younger cohort, those providing more intensive caregiving were more than twice as likely as non-caregiving peers to have poor mental health (adjusted OR = 2.46, 95% CI: 1.70, 3.56).

Light caregiving may be associated with a positive effect on physical health, such as fewer chronic mobility problems compared with non-caregivers.³⁹ However, this apparent benefit of caregiving was not observed among younger carers providing higher levels of care. The authors hypothesised that the protective effect of light caregiving, especially for older carers, could be due either to the physical requirements of the caregiving role or an instance of ‘selection into the role’ by healthier individuals.³⁹ To further illustrate the differential effect of care givers’ age, the authors stratified the data by age group (young adults versus children and adolescents) and found that although less-intensive caregiving in the older cohort was associated with 35–40% reduced odds of reporting chronic mobility problems, those aged 5–17 were more likely to report mobility problems (OR = 1.61, 95% CI: 1.16, 2.23).³⁹

Although the census-based study by Tseliou *et al* had unsurpassed population coverage and encompassed many hard-to-reach groups, it was nonetheless limited by the fact that it may have missed a disproportionate number of young adults and caregivers in deprived inner-city areas. Also, the proxy nature of census returns makes it likely that the parent or guardian completed the ‘self-assessed’ health question, which might have led to confounding, although not for mortality risk.

The literature search identified a study which explored the experiences and needs of children living with a parent with young-onset dementia.⁵³ The study recruited 215 patients and their families through memory clinics, regional hospitals, mental health services and specialised day care in The Netherlands. For ethical reasons, inclusion was restricted to children older than 14 years. There were a total of 35 eligible participants living in 29 families, of which 15 agreed to participate. The method involved semi-structured interviews with 14 of the young people, six males and eight females, aged between 15 and 27, with an average age of 21 years. In three families, the mother had dementia. The mean age of the parent was 53.6 years. Five of the parents had Alzheimer’s disease, four had frontotemporal dementia, one had vascular dementia and one had dementia not otherwise specified. Most of the parents had mild to moderate dementia. The type of care the young people provided included housekeeping tasks (cooking, cleaning, and grocery shopping), supervision and social contact.

Semi-structured interviews were analysed using a qualitative inductive content analysis, which revealed three major themes. The first theme indicated the effects of dementia on daily life, including changing relationships within the family, children’s difficulties managing responsibilities while maintaining a life of their own, and children’s concerns about their future. The second theme reflected the different ways the children coped, including acceptance, avoidance, searching for relief and actively dealing with changes. The third theme revealed the need for care and support. Many children wanted to know more about dementia but received little information after the diagnosis from either their parents or healthcare professionals. In addition, they wanted practical guidance in dealing with their parent.

However, the study by Millenaar *et al* was limited by the less-than-optimal representativeness of the sample due to the restricted availability of children in the target population and high refusal rates. The authors acknowledged that these sampling difficulties may have led to an underestimation of needs, because those who were not included may have

found it too demanding to participate in the study or too difficult to talk about their needs.

A qualitative study with young carers and young adult carers in Switzerland further explored the role of communication with professionals about the caring situation.⁵⁴ Interviews were conducted with 16 carers aged 10–17 years and 14 aged 18–25 years. The interviews were recorded, transcribed and analysed following a grounded theory approach.

The study reported that the participants found talking to professionals was often seen as difficult. The young people described situations in which they were simply overlooked by experts from healthcare or social services. It was recognised this generally did not happen because of malicious intent by professionals, but rather owing to a lack of awareness about young carers and their roles and responsibilities.⁵⁵ In particular, getting into contact with healthcare professionals in hospitals seemed to be challenging when young people were the main carer. Information was often withheld by healthcare personnel owing to a perceived need for confidentiality. Some young adult carers had to resort to alternative ways, for example, the internet, to access necessary information when neither professionals nor the care-receiving family member provided it.

In the final study selected for this literature review, a qualitative focus group design was chosen to explore the ‘lived realities’ of young people providing unpaid familial caregiving in Canada.³⁸ Two focus groups and one in-depth interview were held with 15 young people aged 15–19 years, who were current or past members of a formal young carers programme. Participants also completed a short survey after the discussion, representing a form of ‘concurrent triangulation’. Purposive sampling was used to recruit young carers.

Over half the youth provided care primarily to a sibling, with the next largest group caring for a parent, and several caring for multiple family members. The main conditions ranged from substance (alcohol) abuse to terminal cancer to autism, and a high likelihood of comorbidity existed. A diverse range of ethno-racial profiles were captured, with just under half the participants self-identifying as Caucasian and the remaining as Arab, Black, South Asian and Chinese. However, gender imbalance was evident, with only three male young carers in the sample. The author maintained that this partly reflected the conflict boys experienced when discussing or recognising their care contributions. ‘This gendered reticence by young men due to the presumed violation of expected gender roles makes it more difficult for them to get recognition and receive dedicated support as carers’.³⁸

The young carers derived a range of positive benefits, including added maturity, empathy and the strengthening of familial bonds. However, they also incurred a range of difficulties that caused short- and long-term harm to their personal and professional development. Together, these difficulties presented what the author referred to as a ‘powerful young carer penalty’, a term used to highlight the personal (emotional, familial and social) and professional (education and employment-based) disadvantages incurred by the young person’s substantial and ongoing caregiving.³⁸

Discussion

The main aim of this literature review was to investigate the emotional and mental health needs of young carers and their circumstances, particular those relating to their parents’ mental health. It also explored the extent to which the needs of young carers are recognised and supported by psychiatrists and other professionals working with their parents, with shortcomings raised. The review concentrated on five papers that showed the increased and particular needs and risks of young carers of a parent with mental illness. One even found a higher mortality risk among young carers. The findings are further explored here.

According to Pakenham and Cox the type of illness present in the home was associated with differential adjustment outcomes, with mental illness and substance problems associated with more negative adjustments across a range of outcomes.²⁹ They suggested a potential explanation for these findings: that in general, compared with physical illness, mental illness and substance misuse were less understood in the community and more likely to be associated with greater social disadvantage, unpredictability of symptoms, family and social disruption, stigma, discrimination and parent-child attachment difficulties.

These results are similar to findings from previous studies. Cooklin and Hindley suggested that parental mental illness could be responsible for serious interruptions in a child’s cognitive and emotional development.⁵⁶ They cited a list of adversities faced by children affected by parental mental illness, which could affect their emotional life, attachment and development. These included the ill parent’s disordered thinking and behaviour, the loss of emotional closeness and the witnessing of distressing side-effects of treatments.⁵⁶ According to Mechling, many children witnessed or had to

assist their parent in a mental health crisis, such as a suicide attempt, psychotic episode or aggressive state,⁵⁷ leading other authors to highlight that this was a responsibility beyond young people's years.^{8,58,59}

Millenaar and colleagues discussed the influence on the daily lives of children of parents with young-onset dementia. Children felt that the child-parent bond was inverted as their parent became increasingly dependent.⁵³ There was more tension at home due to the stress of the caring process and changes in the parent with dementia. They witnessed strain on a healthy parent, had difficulties adjusting to the behavioural, cognitive and personality changes in the parent with dementia, and had to contribute more to the household. Millenaar *et al* also suggested that parents of young carers were not always aware of their child's needs.

Similarly, according to Stamatopoulos, substantial caregiving by young people affected their joint familial, social and emotional well-being. Numerous young carers revealed strained familial bonds, often linked to a real or perceived inequality in the provision of care, in addition to limited opportunities for socialisation outside the household. A heightened sense of missing out created strain on existing friendships and was tied to an inability to partake in social outings outside school.³⁸ Unbalanced friendships, resulting from parental-role spillover, further strained young carers' existing peer network.

Pakenham and Cox hypothesised that the elevated mental health problems in children of a parent with illness relative to those from healthy families were due to their extra caregiving demands.²⁹ However, they found that the effects on youth adjustment of a family member with serious illness were not attributable in the main to factors such as differential access to community services, being in a sole parent family, the age or gender of the youth, or increased caregiving responsibilities, although all these factors were implicated in adjustment outcomes. They acknowledged that the absence of significant interactions in their results was not consistent with a previous study,⁶⁰ where a complex set of potential moderators including age of children, socioeconomic status and single parenthood were identified. Stamatopoulos also found that the severity of the 'young carer penalty' was associated with two key factors: family size and type of condition requiring care. Specifically, participants from single-parent and single-child families generally incurred a greater 'penalty', as did those providing care in the context of more stigmatised illnesses such as mental illness and substance abuse, and/or more debilitating physical illness or disability.³⁸

In their study on the variation of caregiver health and mortality risk by age, Tseliou *et al* proposed a number of reasons that caregiving may be deleterious to the health and well-being of young carers.³⁹ Providing care could have interfered with schooling and the formation of healthy social networks, thereby creating issues with other aspects of social and emotional development and leading to a problematic transition to adulthood. The authors suggested that many of the positives associated with caregiving at older ages may not hold true for younger ages. At older ages, where activities such as paid employment no longer applied, caregiving may provide a purposeful role that tightens interpersonal bonds appropriate to expectations of both age and existing relationships, and may be seen as a natural progression, with positive caregiving attributes being associated with lower mortality risk. At younger ages, the expectations of role relationships and function are different, and significant caregiving responsibilities are likely to be at variance with perceived social norms. In contrast to older ages, young caregivers may feel constrained in undertaking a role they had little choice in accepting and that they considered inappropriate for their age. The authors highlighted that the feeling of duty to provide care has been linked to high caregiver burden and worse outcomes among child caregivers.

Leu *et al* raised the failure among professionals to identify young carers and some potential causes of their health and emotional difficulties.⁵⁴ Although many parents may have had an earlier diagnosis of, for example, depression, bipolar disorder, schizophrenia or personality disorder, they may later have gone unnoticed by services.⁵⁷ A secure attachment between child and parent could have been undermined if the parent was inadequately treated or supported.⁶¹ When treatment did occur, clinicians may not have asked whether the adult client had children, and, if parental status was discussed, the focus of treatment was on the adult and the child's needs may have been overlooked.⁵⁷ Millenaar *et al* found that professionals in contact with families often failed to identify children as providers of informal care because they did not ask about their caring role.⁵³ A Royal College of Psychiatry report recognised that professionals may have agreed that offering support to the children of their patients was important but often felt this was not their role, and their natural sympathy and alliance with their patient may have led to 'blindness' about the needs of the child.³³ Staff in mental health teams or in-patient services may have seen themselves as solely the 'patient's person'.⁶² Some may have seen it as above or outside their expertise or responsibility, and therefore the province of someone else's responsibility.⁶² Wolpert *et al* maintained that the needs of young carers had been traditionally overlooked, falling between adult and child mental health services. However, Child and Adolescent Mental Health Services only see a small proportion of

children affected by parental mental illness.⁶²

Cooklin suggested that for some young carers, the involvement of services can sometimes worsen aspects of their experiences. Even though a young carer had often been managing the situation for months, no one asked their advice, what they knew about their parent's illness, or what made it better or worse.¹³ Ali *et al* found that young carers received several kinds of information about mental illness and advice about what to do as long as the person with the mental illness was within the healthcare system, but as soon as they were discharged, support for the young carer ended too.⁶³ Despite the statutory requirement in the UK that mental health services elicited the views of children and young people about the care plans for their parents' treatment, relatively few were talked with directly about the nature of the illness.⁶² McAndrew *et al* cited young carers' experience of their relative being discharged from hospital but no one explaining about changes in their medication, the administration of which had previously been the young carer's responsibility.³⁰ Similar to other young carers, some children of parents with young-onset dementia were not included in conversations with healthcare professionals after diagnosis.⁵³

Not all children of parents with a mental illness reported poor outcomes.^{22,38} Dearden and Aldridge maintained that there were positive aspects of caring for children and parents, as long as support services were in place which adequately addressed the needs of all family members. These positive aspects included enhanced maturity, responsibility and independence, life skills, increased understanding about disability issues and stronger family ties.⁶⁴ According to Fraser and Pakenham, this led to the development of a resilience model whereby the potential harmful effects of risk factors were mitigated by the influence of protective factors. Interventions should therefore focus on targeted modification of risk factors such as isolation, while promoting protective factors including independence and psychosocial skills.²²

Bilsborough reported ten demands of mental health professionals by young carers, of which the top three were (a) introduce yourself, (b) tell us who you are and what your job is, and (c) give us as much information as you can.⁶⁵ Cooklin identified what children said they needed: a two-way explanation of the parent's illness' access to a neutral adult with whom the child could discuss the illness and contact in times of crisis, and who could act as the child's advocate; an opportunity for the child to address their fears that they would 'catch' or that they 'caused' the illness or that the parent may die from it and/or they might not see them again; interventions to diminish the child's social isolation, to learn they are not the only one with the problem, and to allow them to meet other young people with similar experiences; and rebalancing the child's inverted role as carer, including opportunities to do childish or youthful activities with other young people and sharing the load of responsibility with one or more adults.⁶² However, Cooklin warned of the dangers of offering counselling unless the child explicitly accepted the idea of therapeutic help, as this might increase their unwelcome sense of identification with the ill parent and define them as on a similar pathway.⁶²

It was noted that family work or therapy has become more available within adult mental health services.⁶² Thus, a 'whole family approach' model, developed in the UK has begun to be the dominant paradigm internationally. In an NHS England presentation, Cooklin recommended that all psychiatric adult care plan assessments should establish: knowledge of all children face to face; who if anyone has assessed the needs of the child or the effects of the parent's illness on them, and what if any referral needs to be made; and who has explained the patient's illness to the child.⁵⁶

In the UK, the Care Act 2014 and Children and Families Act 2014 provided statutory recognition for young carers' entitlement to regular assessments of their ability and suitability to provide care, and, importantly, of the effects of the role on them.⁶⁶ Of note, the UK alone was classified as 'advanced' in an international comparison of awareness and policy responses to young carers.⁶⁷ The UK was advanced in terms of awareness, research, law, social policy, government guidance and service delivery. No country was identified as having developed extensive awareness or sustained or sustainable policies. The analysis noted that the reality in most countries is that young carers still fall through gaps in policy and legal safety nets.

Limitations

The main limitation of studies in this review was the absence of intervention studies relating to young carers. Most of the studies were qualitative and recorded the experiences of young carers and professionals in contact with them. Although the qualitative studies were limited by small sample sizes, resulting in poorer generalisability of their findings, they had the strength of seeking out more detailed and in-depth accounts.²¹ The review was limited by searching only three main databases. Also, the search was limited to recent papers published in the past 10 years. Finally, only the first author applied the selection criteria.

Conclusion

This literature review found that children and adolescents who cared for a parent with illness may be at higher risk of a range of emotional and mental health needs. Those who specifically care for a parent with mental illness could be at an increased risk, possibly owing to the potential for a more disordered relationship with the parent as a result of their mental illness. However, it is argued that such adversities could be mitigated with the help of information, recognition of the young carer's role, and their inclusion in the parent's treatment plan. Internationally, the UK appears to afford the most recognition to young carers. However, many young carers in the country are still falling through the net because mental health professionals who treat their parents fail to recognise the significance of young carers. Changes in practice to address this are crucial.

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1.3.48 Who wants to be a psychiatrist? Northern Ireland foundation doctors (2006–2018) are positive toward psychiatry as career choice

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Abstract

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Aims and method

Northern Ireland presents itself as an anomaly – a region in which only 31.8% of doctors enter into any training programme after completion of the Foundation Programme, but where Core Psychiatry has been consistently oversubscribed. Here, we aim to find what other regions can learn from this success. All doctors of any grade, working in psychiatry, who had been through the Foundation Programme were questioned on their motivations for becoming a psychiatry trainee.

Results

Sixty-two doctors currently working in psychiatry responded, including over 60% of current trainees, and 45% stated they had not considered a career in psychiatry before their foundation attachment. Over 80% preferred foundation placements in FY2 only, rather than in either foundation year 1 or FY2.

Clinical implications

This survey identifies that for the majority of people who ultimately chose to train in psychiatry, in a region that has consistently attracted candidates to core and higher level training, completion of a foundation psychiatry post was an influencing factor in this decision. A strong majority of doctors prefer the foundation psychiatry placement to be offered in FY2.

Contents

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Recruitment into core psychiatry training in the UK has been a longstanding area of concern.¹ Despite the success of the Royal College of Psychiatrist's 'Choose Psychiatry' scheme and the subsequent increase in the fill rate in 2018,² there still remains 18% of posts that are not filled nationally. There are, however, variations based on geographical area, with Northern Ireland consistently achieving a 90–100% fill rate at core recruitment.

Following the Collins Review³ in 2010 highlighting the need for more community foundation placements and the Royal College of Psychiatrists recruitment strategy⁴ of 2011, one option put forward was to increase exposure to psychiatry during the Foundation Programme. A target was set to have 22.5% of all foundation year 1 (FY1) and 22.5% of all foundation year 2 (FY2) doctors offered placements in psychiatry. Northern Ireland is the only region of the UK that does not offer any placements in FY1, but it does offer a 4-month psychiatry placement to approximately 33% of FY2 doctors.

In this survey we aimed to explore why psychiatry doctors working in Northern Ireland chose their specialty and whether having a psychiatry foundation post in FY2 influenced their career choice. We also examined the opinions of

the doctors who chose psychiatry following an FY2 placement on when psychiatry should be offered in the Foundation Programme.

Method

Participants

The participants for this survey were doctors working in psychiatry in Northern Ireland who had completed Foundation Programme training since its establishment in 2006. This consisted of a group of psychiatry core trainees, speciality trainees (in all areas of psychiatry) and consultants.

Survey design

The survey was designed using the SurveyMonkey online questionnaire system, following collaboration between the Northern Ireland Foundation School and the Northern Ireland School of Psychiatry.

The survey questionnaire (*Fig. 1*) consisted of 12 questions establishing baseline demographic data with regards to gender, medical school, year of graduation, current grade, year entering into core psychiatry training and, if applicable, year entering specialist training in psychiatry. There were questions that established the trajectory of foundation training and if this was planned, coordinated by the UK Foundation Programme and the duration of their foundation programme. Respondents were asked if they had considered a career in psychiatry before selecting their foundation programme and what may have influenced their decision in this (i.e. undergraduate experience, training reputation). The respondents were then asked if they had a psychiatry placement in foundation training and if they agreed with the statement, 'After completion of a psychiatry post within foundation training I was influenced to pursue a career in psychiatry'. The final question was examining the preferences of respondents in the option of having psychiatry available as a preference in FY1 (which is not currently offered in Northern Ireland but is offered in other parts of the UK). The nature of the survey resulted in retrospective data being collected. Fig. 1 Survey questionnaire. FY1, foundation year 1; FY2, foundation year 2.

Distribution

It was an open and voluntary survey. The survey was populated via an email from the current Head of School of Psychiatry to all doctors who had been enlisted in psychiatry training from 2006 (i.e. after the first full 2-year cycle of the Foundation Programme). The survey was open for 3 weeks. This email list was obtained from records within the School of Psychiatry at the local deanery (Northern Ireland Medical and Dental Training Agency; NIMDTA). Reminders were sent via email and social media to encourage completion. The survey was sent to 92 psychiatry trainees and 25 specialty doctors/consultants; as updated lists of consultant emails are not held by the deanery, emails may not have reached all the doctors who were no longer in training, so the figure of 25 is approximate.

Analysis

Following the closure of the online survey, the results were collated in their entirety for evaluation by the authors. Quantitative data was exported to Microsoft Excel 2016 (v.16.0) for analysis. As a portion of the data was from 'white space' or free-text questions and thus qualitative in nature, these were assessed for common themes.

Results

A total of 67 participants responded to the survey, and demographic data is represented in *Table 1*. Of the 12 questions, 7 were answered by all respondents (questions 2, 3, 4, 6, 7, 8 and 10). Of the remaining questions, there were 66 responses, with the exception of one in which there were 65 responses (question 11). The majority of the respondents were female ($n = 42$, 63.6%). *Table 1* Demographic data Total ($n = 67$) Gender Female 42 (63.6%) Male 24 (34.3%) Current grade Specialty trainee 32 (47.8%) Core trainee 26 (38.8%) Non-trainee doctors (i.e. consultant, specialty doctor) 9 (13.4%) Foundation scheme 2-year planned programme 60 (89.5%) Recruited to a 1-year standalone FY2 programme 5 (7.5%) Other 2 (3%) Psychiatry placement in Foundation Programme In FY13 (4.5%) In FY2 (first placement) 33 (49.3%) In FY2 (second placement) 13 (19.4%) In FY2 (third placement) 11 (16.4%) No psychiatry placement 10 (10.4%) Considering psychiatry before Foundation Programme Yes 37 (55.2%) No 30 (44.8%)²

A high proportion of respondents had completed their undergraduate training at Queen's University Belfast ($n = 62$, 92.5%) and year of graduation ranged from 2006 to 2016. The vast majority of respondents had completed their foundation training within the deanery in Northern Ireland, NIMDTA ($n = 63$, 94.0%).

The majority of respondents were in training; almost half of respondents were currently in specialty training ($n = 32$, 47.8%), with a slightly smaller percentage in core training ($n = 26$, 38.8%). Consultants made up a small proportion ($n = 7$, 10.4%), with a smaller number of specialty doctors and associate specialists ($n = 2$, 3%). *Figure 2* shows the distribution across training levels. *Fig. 2* Grade breakdown of participants, $n = 62$. LAS, Locum Approved Service; LAT, Locum Approved Training; SAS, Specialty and Associate Specialist; ST, Senior Trainee; CT, Core Trainee.

The year of entering core psychiatry training ranged from 2007 to 2017, and year of entering into specialty training ranged from 2011 to 2018 for those that this was applicable to.

The vast majority of respondents were recruited through the Foundation Programme UK system on a planned 2-year Foundation Training Scheme ($n = 60$, 89.6%). A small number ($n = 5$, 7.5%) were recruited through the Foundation Programme UK system on a single 1-year FY2 programme.

The majority of participants had a foundation placement in psychiatry ($n = 60$, 89.5%). The breakdown of when participants had their placements is shown in *Table 1*. Those who had a psychiatry placement in FY1 had completed their foundation training outside of Northern Ireland.

When asked if they had considered a career in psychiatry before selecting their foundation programme, 55.2% of respondents ($n = 37$) reported they had and 44.8% ($n = 30$) reported they had not. When asked what influenced their decision to choose (or not choose) to pursue a career in psychiatry before commencing foundation training, the most commonly cited theme was undergraduate experience of psychiatry ($n = 47$, 70.1%). Generally, the majority of respondents who cited this as a factor reported a positive contributor ($n = 34$, 72.3%) toward their choice to pursue psychiatry as a career. The second most commonly cited factor was the positive reputation of psychiatry training in Northern Ireland ($n = 20$, 29.9%). This factor encompassed the positive reputation of training and also of having positive interactions with trainees and consultants in their undergraduate training. The third most commonly cited factor positive influencing people's decision to enter psychiatry was of having an interest in the subject ($n = 11$, 16.4%).

Other less commonly cited positive factors were of having a qualification in a related field (such as psychology), enjoyment of a psychiatry locum post, the expectation of a positive work–life balance over the course of their career, media and mental health group influences and future job prospects.

The most commonly cited reasons that led people originally to not consider psychiatry as a career was a negative or

²

FY2, foundation year 2; FY1, foundation year 1.

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ambivalent undergraduate experience ($n = 13$, 19.4%) Those that were negative or ambivalent reported not enjoying their experience, feeling daunted by how different psychiatry was from other medical specialties and also by their experiences in in-patient settings in undergraduate training.

Exposure to negative opinions of psychiatry in placements in other specialties was also cited as a reason people did not consider psychiatry. In response to the statement 'After the completion of a psychiatry post within foundation training I was influenced to pursue a career in psychiatry', the majority of respondents agreed with it ($n = 60$, 92.%).

The final questions gathered the views of respondents as to whether psychiatry should be offered to FY1 doctors. The majority of respondents ($n = 54$, 81.8%) felt that psychiatry should only be offered as an FY2 rotation in the Foundation Programme. By far the most commonly cited reason for this was to allow for the development of general skills and improve general medical and surgical knowledge in FY1 ($n = 42$, 77.8%). Many felt this to be important as often psychiatry units were isolated from acute hospitals and out-of-hours work in psychiatry is often non-resident with senior assistance also being non-resident. One respondent felt that a job in psychiatry for an FY1 may not be representative of a psychiatry experience as the doctor would likely complete more administrative and medical tasks. Another respondent felt that FY2 was when doctors are more likely to be considering their career options.

For those who reported wishing to have a psychiatry placement in FY1 ($n = 12$, 18.2%) the most common reason for this was that it would give doctors earlier exposure, which may encourage them to apply for psychiatry ($n = 8$, 80.0%). Some reported they had missed an application process owing to having psychiatry as their last rotation in their FY2 year. Two respondents reported that psychiatry would be useful in FY1 to give doctors early exposure to a more holistic care approach.

Discussion

This survey adds to previous findings⁵⁻⁷ that exposure to psychiatry in foundation training is a powerful tool in recruiting doctors to work in the field. Remarkably, of doctors working in psychiatry in Northern Ireland, 45% had not considered a career in psychiatry before their foundation placement, and 92.31% went on to agree with the statement 'After the completion of a psychiatry post within foundation training I was influenced to pursue a career in psychiatry'.

Doctors working in psychiatry spoke positively of the undergraduate experience and the close local ties between the medical school and the deanery in establishing a programme that encouraged them to apply. Northern Ireland has one medical school, Queen's University Belfast, of which around 70–80% of foundation doctors working in Northern Ireland graduate from.

In considering recruitment strategies, the proportion of those who are attracted after undergraduate level should not be underestimated: in a survey including 51 core trainees, Denman *et al*⁸ found that most chose psychiatry during their foundation placement as opposed to as an undergraduate, a finding that resonates with our conclusion of the importance and influence of foundation training experience to the specialty's recruitment. There has been extensive research into the factors that affect recruitment into psychiatry and our findings are similar to those identified in previous studies.⁹

The importance of a positive experience of psychiatry in medical school has been highlighted in numerous studies. Mukherjee *et al*¹⁰ identified the significance of a genuine interest in the subject as being important to recruitment and proposed that the way some undergraduate placements are structured (mainly in acute in-patient settings) expose students to complex patients who are potentially the most unwell, perhaps resulting in a skewed perception of those with mental illness. They highlight the need for more doctors to complete foundation placements in psychiatry and that the process of choosing a specialty within a year of qualifying disadvantaged psychiatry in terms of recruitment, it being a career choice for 'late bloomers'. This was specifically highlighted in our study with one participant missing the application window owing to not having a psychiatry placement until the end of their foundation programme, forcing them to wait a further year before applying. They also identified a perception that psychiatry was less scientific and of lower status than other areas of medicine as an important factor with regards to negatively affecting recruitment.

Given the unique cohort of doctors in Northern Ireland, we looked to establish what attitudes were toward the current approach of having 100% of psychiatry placements in FY2. An overwhelming 81.82% felt that this was what they would personally choose. They speculated that a FY1 doctor may be seen as the 'medical doctor' and may not get the same breadth of experience of acute psychiatric care as an FY2 doctor.

This survey identifies that a strong majority of doctors prefer the foundation psychiatry placement to be offered in FY2, from a region that has consistently attracted candidates to core and higher level training. As a region without an FY1 placement, the generalisability of the results must be considered as a weakness of the survey. It could be argued that those who stated that they would prefer psychiatry in FY2 have limited frame of reference for such an argument.

We believe there are a number of reasons that could help explain why recruitment in Northern Ireland is higher than in other regions in the UK. As we have already alluded to, there is a sense of collegiality in Northern Ireland with regards to the speciality. Northern Ireland has one medical school, one medical training body and one Royal College of Psychiatrists headquarters, allowing for the promotion of psychiatry to be streamlined and coordinated between these entities.

There has been a concerted effort to promote psychiatry in undergraduate training and to ensure that this is of good quality. Medical students have a 6-week placement in psychiatry in their 4th year and also opportunities earlier in their studies to partake in psychiatry-themed, student-selected modules. Enthusiastic psychiatry trainees are also visible within the undergraduate teaching, delivering teaching sessions to a variety of undergraduate years, promoting the speciality from the start of the curriculum. Queen's University produces proportionally more psychiatry doctors than any other university in the UK, which is indicative of the successes of these efforts.

Following a positive undergraduate experience, more doctors then experience a FY2 placement in psychiatry than in other regions in the UK, which this survey has shown to be an important influencing factor for those not previously considering the specialty. The structuring and delivery of psychiatry training is potentially another important reason why Northern Ireland has higher recruitment figures: psychiatry training has a good reputation in Northern Ireland because of its weekly protected teaching time, with subsequent examination pass rates that are above the national average.

Nationally there is evidence of green shoots in psychiatry recruitment⁹ and there is a momentum being built by the Choose Psychiatry movement. However, there is still cause for concern with recruitment of doctors into psychiatry and continued efforts are needed to build upon the progress already made. Here we show that a strong foundation programme in Northern Ireland, focused on FY2, showcases the specialty as a beacon for recruitment in the UK. This is reinforced by strong links at local university and college level, supported by trainers who buy into personal and professional development and trainees who provide role modelling at an early stage for trainee doctors.

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We confirm that all authors listed above satisfy the four ICMJE criteria. M.D. was involved in designing questionnaire, collecting and collating data as well as analysis and write-up. A.G. was involved in analysis of data and write-up. D.H. was involved in design of questionnaire and review of write-up. E.O. was involved in design of questionnaire and review of write-up. L.P. was involved in design of questionnaire and review of write-up. A.C. was involved in design of questionnaire and review of write-up.

1.3.49 Representation of Black, Asian and minority ethnic patients in secondary care mental health services: analysis of 7-year access to memory services in Leicester and Leicestershire

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Abstract

Aims and method

We aimed to explore access by Black, Asian and minority ethnic (BAME) elders to the memory services in Leicester and Leicestershire, examining any trends over time. We then compared the odds of referral by ethnicity, using observed versus expected referrals for the city of Leicester. We gathered data on a comprehensive county-wide memory clinic used by people with suspected dementia and memory problems from the Trust electronic record system during the period 2011–2017. For Leicester city, we compared referral rates for 2011–2017 and compared observed and expected referral rates with demographics from the UK Census 2011.

Results

In Leicester, there was a significant underrepresentation of referrals from the BAME population as compared with the White population in 2011, 2012 and 2013, when compared with population estimates of those aged 60 years from the 2011 UK Census Leicester city data. Data for the Black population were too small for comparisons. The odds of being referred to a memory clinic for the White group was double that of the Asian group in 2011 (odds ratio 2.15, 95% CI 1.52–3.02) and nearly 1.5 times in 2012 (odds ratio 1.40, 95% CI 1.01–1.93). This difference did not persist after 2014. However, this differential odds of referral changes when the age difference between the groups is accounted for. After adjusting for age, there were no differences between the two groups in their odds of referral to the memory clinic from 2011 to 2013, but from 2014 to 2017, members of the Asian group had higher odds of being referred.

Clinical implications

The relationship between BAME and access to memory services is complex. The relative lower prevalence of Asian people among referrals to memory services in Leicester from 2011 to 2013 may partly be explained by the lower ages of the Asian population at referral. The higher prevalence of Asian people in 2014–2017 may be owing to use of denominators from the 2011 UK Census, which are likely to be disproportionately low for this group. Further studies are needed to explore any potential barriers to the access of services by BAME communities.

Contents

¹ Declaration of interest: None.

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There are an estimated 25 000 people currently living with dementia from Black, Asian and minority ethnic (BAME) backgrounds in the UK.¹ It is estimated that this figure will rise to 50 000 by 2026 and 172 000 by 2051, given the growing and ageing UK BAME population.² This increase parallels the projected increase in the numbers of older BAME people. In 2001, approximately 532 000 people from BAME groups were aged 65 years, and this is expected to rise eightfold to approximately 3.8 million by 2051.³

BAME people are generally underrepresented in dementia services and often present later in the course of the illness⁴; development of appropriate health and social care services to meet their needs has been a longstanding priority. A national study⁵ found that the incidence rates of dementia diagnosis are higher among Black ethnic groups compared with White and Asian groups in the UK. This study reported that the incidence of dementia diagnosis was 25% higher among Black women than White women, and 28% higher among Black men than White men. Asian women and men were 18% and 12% less likely than White women and men, respectively, to have a dementia diagnosis. Vascular dementia is thought to be more common among Asian and Black Caribbean people because they are more prone to important risk factors for vascular dementia, such as cardiovascular disease, hypertension and diabetes,⁶ and some evidence suggests that people from BAME groups present later in their illness.⁷

In the UK there are primary care-based studies estimating the prevalence of dementia diagnosis rates⁸ in BAME groups, but there are not many county-wide studies on mental health services use within secondary care services by people with dementia. UK-based secondary care studies tend to have small population sizes; a recent study⁹ examined data on referrals to an inner London memory service to explore any differences in referral rates, cognitive assessments and stages of dementia at presentation. Although Black and Black British patients comprised a quarter of all referrals, Asian patients comprised only about 2.6% of the referrals. Another secondary care study¹⁰ paradoxically found BAME overrepresentation, but this is the only UK study to find this. Such studies that are small and with seemingly opposite findings suggests that referral patterns may not necessarily reflect the BAME distributions in the local population and could well be representative of other factors. Further, it emphasises the need for studies with larger BAME population samples.

Several qualitative studies have explored why BAME groups may be reluctant to seek professional help for symptoms owing to dementia.^{4,11–13} There are several barriers to seeking help identified for South Asian people. They include patient, carer and community factors, health professional factors and the type of services concerned.¹⁴ Health professional factors include culture and communication, lack of knowledge of dementia, lack of knowledge of available services (including any for BAME groups) and high workload/lack of time. There are several other reported barriers, such as

lack of support, time and financial constraints, stigma, diagnostic uncertainty and disclosure of the diagnosis.¹⁵ Furthermore, interventions raising awareness¹⁶ have not shown much improvement in diagnosis or management,¹⁷ which might suggest an associated reluctance to seek help.

Demographic characteristics of Leicester and Leicestershire

Leicester is unique in the UK in probably now being the only city to have a sufficiently large BAME population (with only 51% reporting themselves as White British) in the UK Census 2011 data; population changes have been affected over time by immigration patterns. Further, Leicester is also unique in having a South Asian population as the majority within the BAME population. Additionally, Leicester has the highest proportion of BAME adults of any city in the UK, with the BAME population being the majority population in some areas. The Leicester data from the 2011 UK Census gave the three main ethnicity estimates in the city to be 51% White, 37% Asian and 6% Black.¹⁸ The Leicester Action Plan 2016/7 estimates that 3000 people aged >65 years in Leicester live with dementia, and this is forecast to increase to about 4500 people by 2030.¹⁹ Estimates suggest that each year about 850 people diagnosed with dementia are from Black and minority ethnic backgrounds.²⁰ Leicester has a high-performing diagnosis rate for dementia of 88.4% of the predicted population value.²⁰

The demographics of Leicester show that the increase in the proportion of those aged >65 years is much greater in the South Asian population than other groups, and that overall, the proportion of this age group from BAME communities will have risen from 31% in 2016 to 40% in 2026.¹⁹ This raises the question of whether local referral patterns reflect the real prevalence of the Asian population among BAME referrals. It provides us with a good opportunity to explore secondary care service use by BAME groups in a setting where the BAME population is high, in a city with only about 51% reporting themselves as White British in the UK Census 2011 data.¹⁸

Aims

First, we wished to examine the access by BAME elders to memory services in Leicester and Leicestershire and examine any trends over time. Second, we aimed to compare the odds of referral by ethnicity, using observed versus expected referrals for the city of Leicester.

Method

Data collection

We gathered data on comprehensive county-wide memory clinic use within mental health services by people with suspected dementia and memory problems. For this we used the Leicestershire Partnership National Health Service Trust (LPT) electronic record system, RiO.

The LPT moved to an electronic system of patient records in 2010 and this included electronic records of all referrals to the memory clinics, out-patient referrals and referrals to the community mental health teams. As a part of a National Institute of Health Research (NIHR) study, the findings of which will be reported elsewhere, we identified all referrals to the LPT memory clinics where patients suspected of cognitive disorders and dementias would be referred and diagnosed. Memory clinics provide assessment for cognitive problems across the city and county to adults referred with suspected memory problems. Patients are offered comprehensive assessments, including standardised tests, brain imaging and neuropsychological tests as needed. Diagnoses are considered by a multidisciplinary team and appropriate treatments and follow-up are arranged as required.

For this study, we report only the findings of ethnicity data and findings related to patients referred to mental health services for the elderly who were referred by general practitioners for memory assessment. Ethnicity was coded as per the National Health Service (NHS) criteria for recording ethnicity data at the time of referrals. We were able to stratify the data according to the ethnicities as recorded on NHS patient-recording systems. The data collected included data for older people referred for a memory assessment, but not those suspected of having a young-onset dementia or cognitive syndromes in younger adults, this information being reported separately. We collected date of referral,

ethnicity recorded at the point of receiving the referral, gender, general practitioner details and whether the case was active or discharged. Age was not routinely recorded at the time of receiving the referrals.

We collected data for 8 years, from 1 January 2010 to 31 December 2017. Analysis used anonymised data from a yearly referral database with LPT maintained for the purpose of service monitoring and includes all the referrals received by the Trust. NHS ethnic data categories include White British, White Irish, Asian or Asian British, Black or Black British, any other White, mixed, Chinese, other ethnic, not known and not stated. We studied patterns yearly to look for any emerging trends.

Ethics approval for this study was granted by University of Leicester as a part of the NIHR study application (reference PB-PG-0416-20019). The study also had approval from the LPT Research and Development Department (ELMH0818; Integrated Research Application System reference 232861).

Age imputation

The age distribution of the entire Leicester city population at risk was already known for 2011 in 5-year age bands. As age was not routinely recorded at the time of receiving referrals, we collected these data only for a sample of randomised individuals. Because we lacked age information for the non-randomised referrals, we decided that it was reasonable to assume that the age distribution for the randomised referrals (in 5-year bands) would be the same as for the non-randomised referrals, and imputed the age data on that basis. So, if a third of randomised White referrals in 2011 had ages in the 80–84 years age band, the same proportion was imputed for non-randomised White referrals in 2011. This resulted in the creation of seven data-sets, one for each year (2011–2017). Age distributions were calculated and created separately for the non-randomised referrals in the two ethnic groups in each year. In each year, the total number at risk was the same, so no account was taken of population growth in those aged 60 years, for which we had no information. The total number at risk in each year consisted of 49 115, with the number at risk being constrained to be constant from 2011 to 2017. The number of referrals in each year was subtracted from the number at risk to give the number of non-referrals. The numbers of non-referrals in the years subsequent to 2011 were not removed from the at-risk group to take into account the fact that the referrals in previous years may no longer have been at risk of being a referral. Having estimated the numbers of referrals and non-referrals in each age band in each year for each ethnic group, we generated these data in Stata version 14 for Windows, using the ‘gen’ command.

Statistical analysis

A separate analysis was performed for each year, and *P*-values were correspondingly adjusted for multiple comparisons with the Bonferroni method (significance level $0.05/n$, two-tailed). Logistic regression was used to compare proportions of referrals between ethnic groups, using 5-year age bands to calculate age-adjusted odds ratios and 95% confidence intervals. Population-at-risk estimates were derived from the published UK Census (2011) data for Leicester. Age was only available in the form of six (mainly 5-year) age bands, ranging from 60–64 to 85 years and was treated in the logistic models as a continuous predictor, ranging from 1 (60–64 years) to 6 (85 years). We used 60 years as the cut-off for population-at-risk estimates, as it is reflective of the age generally used as a cut-off age for population-at-risk estimates in defining older adult services and has face validity in clinical practice. However, beyond 2013 it is highly likely that the denominators for the two ethnic groups will have both increased and also diverged non-trivially, leading to potential biases in the estimated proportions and differences in proportions, so estimates of individual proportions and differences in proportions beyond this time should be treated with caution.

Randomisation

Simple randomisation by a computerised program (SAS version 9.4 for Windows) had previously been carried out from the memory clinic referrals in the White and Asian groups separately, to obtain a representative sample of 260 cases from each group; the ages of referral were then individually collected from those case notes for comparison. The number of Black referrals was too small for meaningful comparisons, and hence this study did not include data for the Black population. All analyses were exploratory.

Results

Over the analysed period, LPT memory services received a total of 15 634 referrals, of which 191 (1.2%) had been entered in error. These included referrals that were deemed inappropriate or had other medical problems present and hence were not suitable for memory clinic assessments. A total of 1493 (9.6%) people had blank values in the ethnicity data rows, whereas 'not known' ethnicity was recorded in 994 (6.4%) people. These missing data were missing at random with no consistent pattern, and were all excluded from the analyses. Formal statistical analyses were conducted on just the two main groups of interest here, namely White British and Asian groups; other ethnic groups and mixed groups were excluded because of the low numbers in each group. Comparisons of the main groups are shown in *Table 1*. *Table 1* Referral data for Leicestershire memory clinics, 2011–2017 Referrals by ethnicity N Gender % Female Percentage of the sample, N = 15 443 Male Female White British 11 1664631653558.572.3 White Irish 152658757.21.0 Asian or Asian British 112847665257.87.3 Black or Black British 141677452.40.9 Any other White 2889319567.71.9 Mixed 35171851.40.2 Chinese 93666.60.06 Other ethnic 37162156.70.2 Not known 99445354054.36.4 Not stated 149365184256.39.7

Despite the overall higher proportion of BAME in Leicestershire compared with many other counties, during the period 2011–2017, of all the referrals across the county, only 1128 were Asian (7.3%) and 142 were Black (0.9%).

The proportion of Asian ethnicity referrals was higher in the city of Leicester (*Table 2*), but it was still only 22.6% compared with the expected Asian proportion of 37% based on the 2011 UK Census data population size estimates. *Table 2* All memory services referrals for Leicester city and county, 2011–2017 Total referrals Referrals White White, % Asian Asian, % Black Black, % City 4182252960.5% 94622.6% 1202.9% County 11 452863775.4% 1821.6% 220.1% Total 15 63411 16671.4% 11287.2% 1420.9%

Yearly comparison of referrals in Leicester city and Leicestershire county

We have presented the referral rates among the three largest ethnic groups over the period 2011–2017 (see *Table 3*). Referral numbers increased consistently in all the groups for part of this period. There were 529 referrals combined in all the three groups in 2011, peaking at 3313 in 2016, but then decreasing to 2033 in 2017. This drop may be explained by the increase recorded in the 'not known' and 'not stated' ethnic categories. White British referrals increased from 461 in 2011, peaking at 2350 in 2015 and dropping to 1337 in 2017. Asian ethnicity referrals also rose from 43 in 2011, peaking at 295 in 2015. Black ethnicity referrals were relatively low throughout, ranging from 5 in 2011 to 25 in 2017. *Table 3* Annual referrals for Leicester and Leicestershire (n, % referrals) White British Asian Black Other White Not known Not stated Total n, % n, % n, % n, % n, % n, % 2011 461, 87.143, 8.15, 0.09, 1.72, 0.32, 0.35292012870, 87.543, 4.34, 0.020,

2.017,
1.77,
0.799420131422,
76.0113,
6.018,
0.944,
2.3195,
10.445,
2.4187020142142,
76.5228,
8.128,
1.053,
1.8254,
9.051,
1.8280020152350,
78.5294,
9.825,
0.864,
2.1134,
4.4201,
6.7299120162068,
62.4242,
7.325,
0.755,
1.6166,
5.0725,
21.8331320171338,
65.8148,
7.226,
1.228,
1.3226,
11.1458,
22.52033

The proportion of White British referrals fell over this period from 86.9% in 2011, to 65.6% in 2016 and 65.7% in 2017 (*Table 3*). In contrast, referrals from the Asian population remained relatively similar over this period, from 8.1% in 2011, peaking at 9.8% in 2015 and then slightly falling again to 7.2% in 2017. The Black population proportion remained low, rising from 0.09% in 2011 to 1.2% in 2017.

Comparison with Leicester city population estimates

As the raw referral rate data suggested a lower referral rate among BAME groups compared with the White British population, for Leicester city we compared annual referral rates between 2011 and 2017, based on an estimate of the population at risk, derived from the 2011 UK Census. We obtained this population-at-risk estimate by an age-defined cut-off of 60 years, obtained by stratification of the known population estimates taken from the 2011 UK Census data. A cut-off age of 60 years holds greater relevance and reflects the age cut-offs normally associated with the way services reflect clinical practice. We restricted this analysis to Leicester city as the city has a sufficiently large BAME population to make statistical comparisons meaningful. It is interesting to note that the referral patterns from the city rose from 2011, peaking in 2016, but fell again in 2017 (*Table 4*). *Table 4* Comparison between Asian and White groups in Leicester city (unadjusted) 2011 UK Census White Asian Comparison 166 636 122 470 Population at risk ($n > 60$) 34 750 14 365 n Rate per 1000 n Rate per 1000 White (reference) versus Asian, odds ratio (95% CI) 2011 2075.96 402.78 2.15 (1.52–3.02) 2012 1624.66 483.34 1.40 (1.01–1.93) 2013 35710.27 1006.96 1.48 (1.18–1.85) 2014 48513.96 19113.30 1.05 (0.88–1.25) 2015 52615.14 25317.61 0.86 (0.73–0.99) 2016 45213.01 18813.09 0.99 (0.83–1.18) 2017 2657.63 1238.56 0.89 (0.71–1.11) Total 24547.06 9436.56 1.08 (1.00–1.17)

To control for the effects of age at presentation, we compared the White ethnicity and Asian ethnicity groups, using age-adjusted logistic regression over the period 2011–2017 (*Table 5*), with data from each year being analysed separately. There is a clear trend between 2011 and 2015 showing the odds ratio changing increasingly in favour of Asian patients being referred. *Table 5* Comparison of Asian and White groups in Leicester city in 2011–2015, adjusted for age (results 2011–2017) Year Odds ratio (95% CI) for ethnicity

1/odds ratio P -value for ethnicity Odds ratio (95% CI) for age P -value for

age Pseudo

r^2 2011 1.13 (0.80–1.60)

0.930.482.92 (2.57–3.32) <0.001 0.17020120.87 (0.62–1.22)

1.150.432.03 (1.83–2.24) <0.001 0.09620130.80 (0.63–1.03)

1.250.062.68 (2.46–2.92) <0.001 0.17120140.72 (0.60–0.86)

1.37 <0.001 1.74 (1.65–1.83) <0.001 0.07720150.51 (0.43–0.60)

1.92 <0.001 2.19 (2.07–2.31) <0.001 0.13820160.67 (0.56–0.80)

1.49 <0.001 1.80 (1.71–1.90) <0.001 0.08520170.61 (0.48–0.76)

1.640.001 1.77 (1.65–1.89) <0.001 0.074²

At any given time only a proportion of patients referred for a memory clinic were actively being managed within the service. Some would be waiting for an assessment and some would have been assessed, treated and discharged. To get a fair representation, we compared the numbers of referrals that were considered actively open to see if they matched estimates of patients with suspected dementia in Leicester. As of 2017, there were 932 open cases in the city, with White British cases being 54% of the total. We compared the active cases from the three groups with their at-risk estimates in Leicester city (based on the Leicester 2011 UK Census). Statistical comparison of active memory clinic use data shows significantly lower use by BAME groups. The odds of being actively open to the memory clinic were 1.67 (95% CI 1.42–1.96; $P < 0.0001$) times lower in the Asian population (24% of active cases compared with the 40%

²

Reference category for ethnicity is Asian (coded as 0). Age is modelled as a linear and continuous variable, so for 2011, for every rise in age category (5-year bands), the odds of being referred increase by a factor of nearly 3. After Bonferroni correction for multiple comparisons (0.05/14), the adjusted significance level becomes 0.003, so all results for 2014–2017 are significant.

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of total at-risk Asian population estimates), whereas the odds of being actively open to the memory clinic were 2.72 (95% CI 1.79–4.15; $P < 0.0001$) times lower for the Black population (among the 2.4% of active cases compared with the 7% of total at-risk Black population estimates).

Discussion

Referrals of patients to memory services in Leicester and Leicestershire have increased fourfold over the period 2011–2017, although the drop of 39% between 2016 and 2017 is not easy to explain. We found that Asian people represented 22.6% of all the memory service referrals in Leicester city and 1.5% within the county of Leicestershire. The Black population appears to be severely underrepresented among referrals to the service.

Referrals from White British groups rose sharply from 2011 to 2014, but then stabilised. Interestingly, the referrals from the BAME groups have correspondingly not increased, suggesting the role of other factors (i.e. access difficulties, immigration changes) that need to be accounted for. However, this could be partly explained by the higher proportion of ‘not known’ or ‘not stated’ ethnicity groups. The role and the nature of the assessments in memory clinics have also perhaps changed over these times, with increasing awareness of the newer concept of minimal cognitive impairment and changes to the assessments of cognitive issues associated with functional illness and/or physical illnesses. There could also be influences arising out of the National Dementia Strategies²¹ and the changes within primary care (such as Quality Outcomes Framework targets)²² or the changes in costs associated with anti-dementia drug prescribing. This may mean that the population presenting to memory clinics for assessment may have altered in its composition over the years, with a greater emphasis on early assessment for cognitive problems. Administrative reasons may affect data collection, explaining the higher ‘not stated’ scores, and perhaps political influences affect the ethnicity documentation or the ‘not known’ scores. We suspect these uncoded data may also affect the ongoing activity and open case contacts, and may need to be taken into account when interpreting the results.

In this study we demonstrate underrepresentation of Asian ethnicity groups in Leicester city memory clinic referrals in 2011, 2012 and 2013 when we compare them with unadjusted population-at-risk estimates derived from the Leicester BAME demographic data from the 2011 UK Census. However, this difference can be explained by the finding that the Asian population is younger than the White population at the time of the referral. After adjusting for age, there were no ethnic differences between the two groups in their odds of being referred to memory clinic before 2014, from which time the denominators become increasingly unreliable. Age is thus the more important predictor of being referred to memory services. For every rise in age category (5-year bands), the odds of being referred increased by a factor of around 1.5 to 3. There is a clear trend between 2011 and 2015 showing the odds ratio changing in favour of Asian people being referred. There may be two main reasons for this. First, this is likely to be because of the denominator for the Asian population increasing more than the denominator for the White population, leading to increasingly high numbers at risk for Asian people relative to White people. However, we could not take this into account in the analyses as the data which could confirm this are not available. Second, it is also possible that the clinical presentations in this group may be such that general practitioners feel more inclined to refer to memory clinic for a specialist assessment. We cannot identify any other factors that might change the likelihood of Asian people being referred compared with White people, regardless of the number at risk, and there are no changes that we can identify in referral methods or local clinical practices.

As far as we know, this is the first comprehensive study of BAME referral rates at a county-wide level within secondary care services. Although there have been other studies looking at secondary care memory clinic use, they have been confined to district or borough levels, often covering a few memory clinics and community mental health teams. This study’s strength is that it covers the whole of Leicester/Leicestershire, which has multiple memory clinics and covers all the community mental health teams in the county. By that nature, our study is comprehensive and cover practices across an entire healthcare system.

Reinforcing the findings from other UK studies, our findings also suggest underuse of services by BAME groups within secondary care memory services; however, the lower odds in the BAME group of being referred to services may be explained by their lower ages at the time of referral. The odds of getting referred to memory services are changing, with the odds ratio favouring Asian people being referred in the latter years of the sequence. However, this finding is likely to be owing to underestimation of the population at risk for this group. This is an important finding as Leicester has a very high BAME (chiefly Asian) population in inner city areas and so arguably has sufficient BAME populations

to study trends in service use by BAME (chiefly Asian) groups. A study such as ours helps in adding substantively to findings in this area, where there have previously been contradictory reports.

Our findings reinforce the need for more in-depth research to identify reasons for varying presentation of BAME patients in memory clinics and mental health services across different regions and also across different generations.

Limitations

Despite the comprehensiveness of the study, the numbers in the BAME population in Leicester are relatively small. It is possible that with greater numbers and larger studies across regions, the outcome may be different. Moreover, Leicester's geographical and historical immigration patterns are unique and a similar study elsewhere may have different findings. Consideration should also be given to the role of the primary care physicians and the diversity of the ethnic backgrounds they may come from, which could affect referral practices. A major limitation is using the age data from the 2011 UK Census to adjust rates beyond the year of the census. The population profile would have changed since the 2011 UK Census data estimates, and comparing the referral rates in the latter years with this data would limit its applicability, but the 2011 UK Census data remains the last officially published national estimates of UK population data. Also, an at-risk population with an alternate cut-off age other than 60 years may result in different findings.

There may be other reasons apart from age and ethnicity that could also explain the underrepresentation of BAME patients in our sample. Additional missing variables relate to physical morbidity and health service use elsewhere (e.g. acute physical health services), traditional cultural practices and reluctance in seeking help from Western services, the role of the extended family system, and the perception of the inevitability of dementia and it being seen as a part of normal aging decay. The barriers these pose should be explored in further studies.

This study is limited by the way ethnicity is coded by NHS staff at the point a referral is received. Further, the categories have been broadly classified; not analysing further subtypes of ethnicity and its clinical implications may be a limitation, but it was beyond the scope of this study. Similarly, there are changing migration patterns and intergenerational differences, which again are beyond the scope of this study.

In light of these limitations, caution is needed in interpreting the findings. BAME groups by their nature are heterogeneous and subject to constant change, owing to cultural, immigration or political influences. BAME groups may vary in different geographical regions and may be affected by other factors, such as economic indicators and deprivation. It is possible that the BAME groups in Leicester may be economically not as deprived as in other areas such as the north of England, and the pattern of referrals to memory services in such areas may be different. Furthermore, there are intergenerational effects and as such a repetition of this study in the coming decades may reveal different findings.

Future work

Future work is needed to carry out additional investigations into any perceived barriers to help-seeking in BAME populations. We are currently in the process of undertaking an NIHR-funded study to look at diagnostic challenges and the severity of presentation of dementia in BAME populations, and this will be reported in due course.

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All authors contributed to the design of the study and production of the manuscript. H.S. led the project and is guarantor of the paper. The statistical analysis and calculations was led by J.B. E.B.M.-L. and A.W. contributed to study design, interpreting the LPT data and the statistical analyses and their interpretations.

1.3.50 Psych Socs: student-led psychiatry societies, an untapped resource for recruitment and reducing stigma

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2020-06

Abstract

Medical recruitment and retention are national problems. Psychiatry has been more affected than many specialties, as a result of stigma from the public and other healthcare professionals. The Royal College of Psychiatrists has undertaken several initiatives to redress this, notably the ‘Choose Psychiatry’ campaign. In this editorial we argue that student-led university psychiatry societies are a wonderful but frequently untapped resource to help attract the brightest and best medical students to our profession. We describe the activities of three ‘Psych Socs’ across the UK and propose next steps to continue this work.

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2019 saw the best psychiatry core trainee recruitment for some years, with 92% of places filled.¹ However, the figures for higher training remain a concern, with a cumulative fill rate of 52% and considerable regional variation in both core and higher training.¹ Staff recruitment and retention remain key challenges across the National Health Service,² with overall vacancies predicted to double by 2030.³ Psychiatry has historically faced unique difficulties, not least stigmatising attitudes from the public, other doctors and medical students,⁴ and we need to remain active and focused on attracting the brightest and best to our profession. The time at medical school is a key period when attitudes and beliefs about psychiatry are most susceptible to change,⁵ and students' personal experience of psychiatry has been described as the 'critical variable' in recruitment rates.⁶

A survey by Curtis-Barton and Eagles⁷ reported 'push' factors that discouraged students from choosing psychiatry as a career, including a perceived lack of scientific evidence underpinning diagnoses, the perception that patients generally have a poor prognosis, the amount of 'paperwork' in the specialty and general stigma about mental illness. A qualitative study conducted at the University of Bristol echoed these findings, adding that the emotional burden of seeing patients at the lowest point of their lives and the focus on 'non-medical' social issues were also reasons reported by students choosing not to pursue psychiatry.⁸

Psychiatry and general practice have been shown to attract most negative comments or 'bashing' from academic staff, doctors and students.⁹ Halder *et al*¹⁰ found that across 18 medical schools, 16% of medical students considered psychiatry as a future career upon entering medical school; by the final year 17% reported still seriously considering it, but only 3% had decided to actually pursue the specialty. A total of 27% of students reported that they had changed their future specialty choice as a result of 'direct bashing'.⁹ By the latter years of undergraduate study, the point at which many students begin direct psychiatry teaching, many more medical students held negative beliefs about the specialty less adaptable to change.^{11,12}

Conversely, a positive experience of a psychiatry rotation and extracurricular enrichment 'pull factor' opportunities, such as engaging electives and special study modules, can ignite an interest and have been found to be one of the strongest predictors of career choice.^{5,10}

Royal College strategies

The Royal College of Psychiatrists (RCPsych) has attempted to tackle both push and pull factors. In 2016, it ran the 'Anti-BASH' campaign,¹² utilising the Twitter hashtag '#banthebash' to identify and address badmouthing, attitudes and stigmatising in healthcare, in particular from clinicians in other specialties.

More recently, the College has emphasised positive pull factors, offering free Student Associate membership¹³ to the College and providing free access to network events and College journals.¹⁴ The 'Choose Psychiatry' campaign¹⁵ has adopted a strategy of demonstrating the many positive aspects of a career in psychiatry, with the use of short video-clips encompassing real-life patient stories and the impact that psychiatry has made on their lives, as well as pieces by psychiatrists explaining why they chose and enjoy their careers. This encourages viewers to join the conversation on social media, using the hashtag #choosepsychiatry.

The 1-year 'Psych Star' scheme supports medical students through mentoring and financial support.¹⁶ A 2-year 'Foundation Fellowship' offers a parallel route for foundation year doctors, with both schemes supporting candidates to act as local ambassadors for promotion of the specialty. Although it is not possible to causally link these efforts and the recent improved recruitment, we should still acknowledge the College's work to achieve this result.

Psychiatry societies

A less-explored area is the momentum generated by university psychiatry societies (Psych Socs), which are led by students with support from clinicians and the RCPsych. These bottom-up initiatives host diverse local events with the aims of raising the profile of mental health issues, challenging stigmatising attitudes by increasing understanding of the central role that psychiatry has in medicine and inspiring students to choose psychiatric careers. They also come together annually for a national Psych Soc conference, hosted by one of the organisations. Here we describe the types of activities undertaken across three UK societies, in London, Birmingham and Belfast.

Augmenting the syllabus: guest lectures and exam practice

The societies host diverse free guest lectures across the range of psychiatric subspecialties complementing and extending the undergraduate curriculum. Mukherjee *et al*⁵ argued that placing a particular focus on liaison psychiatry during undergraduate teaching allows students to appreciate that psychiatry has a central role in the aetiology and outcome of many medical disorders. In our Psych Socs, we have had particularly positive experiences when collaborating with other university societies to promote this understanding (see *Box 1* for more detail): for example, gastroenterology societies to discuss eating disorders; paediatrics and obstetrics and gynaecology societies to discuss perinatal psychiatry, autism and neurodevelopmental disorders; emergency medicine societies to learn about patients presenting in crisis; and oncology societies to discuss psycho-oncology. Some Psych Socs also organise additional examination practice, for example via mock OSCEs and history-taking workshops, as well as providing more links and discussion around psychiatry electives and research opportunities. *Box 1* Examples of well-received Psych Soc events ‘Evolution and the brain’, discussing how brain functioning and psychopathology can be understood using evolutionary perspectives. ‘Real people sharing real stories’, five students shared their personal experiences of living with mental illness. ‘Time to put the psychedelics back into psychiatry?’, a discussion on psychedelics in modern psychiatry. ‘Trauma and violence’ with trauma surgeons, a psychiatrist and young victims of knife crime discussing post-traumatic stress disorder. ‘Through the lens’ mental health photography workshop with the Health and Humanities society, discussing the portrayal of borderline personality disorder in the arts. Psychiatric themes in Don Quixote and Othello syndrome in ‘A Winter’s Tale’ ‘Homelessness and healthcare’ with individuals who had been street homeless, describing how this impacted their ability to access care, and their experiences of living in the streets. ‘Disfigurement and quality of life’, with maxillo-facial surgeons and psychiatrists discussing the impact of facial surgery on perceived quality of life. ‘Mental health in developing countries’ hosted by psychiatry trainees and ‘Students for Global Health’, discussing different practices in other countries, and career opportunities in international assistance. ‘Not guilty by reason of insanity’, exploring the roles of forensic psychiatrists. ‘Mental disorder and autonomy: classical and romantic perspectives’, a seminar co-hosted with a Philosophy Society discussing varying philosophical views of mental illness across time. ‘Sex and psychiatry’ seminar with the university ‘Sexpression’ group, discussing psychiatric bases for dyspareunia, tocophobia and so forth.

Talks on novel fields not typically covered in lectures are usually very popular, such as evolutionary psychiatry, psychosexual medicine and cutting-edge research (for example, therapeutic use of psychedelics). These have the additional value of attracting a wider range of medical students who might not attend more ‘standard’ psychiatry talks, and indeed are often enriched by pulling in students from different disciplines, such as philosophy and the arts, and members of the local community. This reinforces a message of mental health at the centre of medicine and society, and challenges stigmatising attitudes.

Crucially, as membership is open to all students, these events are great opportunities to attract pre-clinical medical students several years before their psychiatry teaching and placements, and potentially before more significant exposure to any ‘psychiatry bashing’.

Tackling stigma and discussing student mental health

Brown and Ryland¹⁷ emphasised the importance of involving people with mental health disorders in student education, particularly those who have recovered, as placements are often too short for students to experience this. Psych Soc speakers are encouraged to explore relevant case studies, and we endeavour to invite speakers with lived experience. One Psych Soc has published a single-arm pre–post comparison study, which demonstrated statistically significant reductions in student stigma in the domains of knowledge, attitude and behaviour following exposure to a perinatal event when a mother spoke of her personal journey.¹⁸

Students can feel less able to disclose their own mental health problems because of perceptions of peers' negative views,¹² and successful Psych Soc events have also discussed and promoted resources for student well-being especially during examination periods. Psychiatrists have helped with this, with events on 'Mental Health in Healthcare' and 'Bipolar Disorder: Don't Believe Everything You Hear' hosted by health care professionals who themselves have recovered from psychological problems.¹⁹ This also addressed psychological challenges and pressures students might face once qualified.

Work in the arts

Broader Psych Soc initiatives involving the arts have proved very popular. These have included a student film and book club (one in conjunction with the local psychiatry trainees' book group) and exploring the perception of mental illness in popular literature and media. Popular talks have discussed the portrayal of psychopathology in historic literature, such as Othello syndrome in 'A Winter's Tale' and wider psychiatric themes in 'Don Quixote'. The 'MedFest' film festival is a popular international event for Psych Socs and mental health more broadly, displaying and discussing short films that touch on pertinent issues in mental health.

Dissemination through new tools: social media

Psych Socs successfully use a range of social media, from Facebook to Twitter and Instagram, and more 'old-fashioned' email to reach students. These regularly share information regarding wider opportunities, such as summer schools (unlike many parallel schemes in other specialties, most of these are free), RCPsych events, prizes and bursaries, student-selected components in psychiatry, research and elective opportunities and so forth. They also provide guidance and encouragement to students on becoming College Associate Members of the College, and advertise College resources, articles and podcasts. Anecdotally, many students have informed us that Psych Soc posts on social media have alerted them to opportunities of which they had previously been unaware.

In October 2019, Queen's University Belfast 'Mind Matters' Psych Soc hosted a highly successful 1-hour 'Twitter Takeover'. Numerous psychiatrists and other Psych Socs across the country participated, answering questions on how medical students can get involved with psychiatry early, personal reasons for choosing psychiatry, upcoming events and interesting books and articles relevant to students. Twitter in particular affords an opportunity to engage and connect with the many psychiatrists and medical students online, unhindered by distance.

Starting a Psych Soc

Medical students and psychiatrists interested in starting a Psych Soc at their own local university should firstly endeavour to recruit a core committee of students for the academic year. The committee should attempt to make contact with the Undergraduate Lead for Psychiatry at their university, the RCPsych regional division and other local psychiatrists. Such contacts may be called upon to act as speakers at evening lecture events, mock OSCE examiners and mentors.

Psych Socs should also contact the RCPsych to receive funding for events, as each university society receives a grant of £500 per annum. The College also offer free promotional material such as pens, key rings and leaflets, which can be handed out as 'freebies' during events. The RCPsych website includes detailed advice for setting up a local Psych Soc, event ideas and contact details for useful stakeholders.²⁰

Psychiatrists' perspectives and next steps

As senior clinicians, we recall the difference that enthusiastic and passionate trainers, teams and rotations made to our career choices at all stages, from medical school through to our own training.²¹ Sadly, we have also all experienced the negative effect of 'bashing' of psychiatry and our patients by other medical students and doctors. All psychiatrists need to remain proud advocates for our profession and remember that every contact counts. The recent College initiatives for recruitment appear to be paying dividends with the positive message of 'Choose Psychiatry' particularly pleasing.

The Psych Socs, however, speak to students in a way we cannot, and it is heartening to see the positive energy they generate. Enthusiastic medical students deliver the compelling message that psychiatry is a mainstream part of medicine and offers a diverse and rewarding career and a flexible work–life balance. Their bottom-up initiatives relevant to their local teaching and training, identification of gaps and novel areas they wish to explore, and the fun, interesting and culturally broader events in turn have refreshed us. The Psych Socs typically offer compensation to speakers through covering their expenses, but in our experience the real payment is the pleasure of sharing and contributing to their enthusiasm.

Several next steps can be recommended both locally and nationally. Students require enthusiastic engagement from local psychiatrists: as guest speakers, mock OSCE examiners and mentoring via 'buddy schemes'. The relationship should be reciprocal: assisting students with areas they request as needing redressing, but also using our contacts and experience to suggest and link-up additional input. Students often need discrete guidance in organising events and making sure that these are well balanced in the views that are expressed.

Nationally, the RCPsych has created a supportive linking webpage to share ideas and learning; this and the annual National Student Psychiatry Conference need to be nurtured and grown. In a time of austerity, there are inevitable challenges about 'who funds' travel and attendance, but medical schools and the College need to continue to encourage and maximise subsidised student engagement, including through poster presentations, oral presentations, student sections and prizes. This is not just a 'central' issue, it falls to all divisions and faculties to review their engagement. We propose that Psych Socs are an excellent opportunity for outreach to catch the best future colleagues. As a College we need to be better at recognising, celebrating and sharing what is working with our medical students. A recently published RCPsych report²² makes explicit recommendations for a range of initiatives on enhancing interest in psychiatry, including developing medical student psychotherapy schemes and Balint groups, and better working with Psych Socs. The College's Choose Psychiatry Committee has an initiative to make sure that each Psych Soc for the next academic year has a link senior member of the Committee to help support local initiatives.

We believe that university Psych Socs are a secret, but as yet not fully exploited, tool to improve recruitment into psychiatry, as well as promoting respect for the profession and mental health amongst those who do not become psychiatrists. They offer a valuable opportunity for students and psychiatrists to work together, and for us to continue to encourage the brightest and best to join what we know to be the most rewarding of medical specialties.

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All authors met all four ICMJE criteria for authorship, jointly conceiving and writing the manuscript.

1.3.51 What neuroscience has already done for us

: Commentary on... Why hasn't neuroscience delivered for psychiatry?

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Abstract

Each of the components of the biopsychosocial model of mental illness is important for understanding mental illness. Biological and genetic abnormalities have been demonstrated in major mental illnesses. These are leading to changes in our understanding of these conditions, as well as our understanding of the link between life events and mental illness.

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 - : *Commentary on... Why hasn't neuroscience delivered for psychiatry?*
 - * *Brain imaging and schizophrenia*
 - * *Genetics in intellectual disability and depression*
 - * *Epigenetics and treatment targeting*
 - * *Conclusions*

As readers will be well aware, the biopsychosocial model has underpinned psychiatry for several decades.¹ Each component of this model is important for our understanding of mental illness. Professor Kingdon is therefore correct to say in his interesting editorial that neuroscience is unlikely to hold all of the answers to why people develop mental disorders and when they occur in their lifetime.² I challenge, however, his assertion that 'biological changes have yet to be shown to be relevant to the major mental disorders'.

¹ **Declaration of interest:** None.

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See this issue.

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Brain imaging and schizophrenia

Taking schizophrenia as an example, there are clearly demonstrable differences in the brains of individuals with schizophrenia compared with those of controls. It was first shown in the 1970s that people with schizophrenia had enlarged cerebral ventricles.³ Since then abnormalities in both grey and white matter have been convincingly demonstrated in the disorder.⁴ More sophisticated brain-imaging techniques have allowed the discovery in recent years that differences in brain volume are present even in medication-naïve individuals with first-episode psychosis.⁵ It seems increasingly likely that there are differences in volume even before the at-risk mental state, although this remains difficult to prove definitively.⁶⁻⁸

Recently developed scientific techniques such as the use of induced pluripotent stem cells to create a ‘cortex in a dish’ (*aka* brain organoids) have allowed tantalising insights into why these imaging abnormalities may emerge. Using cells from individuals with schizophrenia (some with a range of predisposing genetic abnormalities) multiple studies have shown abnormalities such as impaired cellular differentiation and synapse formation.⁹⁻¹¹

These studies add to the emerging hypothesis that the brain of someone at risk of schizophrenia differs from controls at an early stage and that these differences increase as psychosis emerges. These neuroscientific findings are a good fit with the long-standing findings from more psychosocially focused research that differences can be seen in childhood behaviour in those who later develop schizophrenia.¹²⁻¹⁵ They also suggest that, to develop better treatments for schizophrenia, we need to look beyond compounds targeting dopamine receptors.

Genetics in intellectual disability and depression

I would also challenge Professor Kingdon’s assertion that no genetic findings of use to the practising psychiatrist have been found for the major mental illnesses. Genetic testing for copy number variants is starting to form part of practice in intellectual disability services.^{16,17} Using his example of depression he is correct to say that the much vaunted candidate genes studied in the 1990s and 2000s have not been replicated in later, large studies.¹⁸ However, more recent, vastly better powered studies have produced findings of greater potential use. The most recent genome-wide association study on depression found 87 independent loci that were associated with depression, with a startling lack of genes involved in the 5-HT system.¹⁹ This may suggest that, although drugs acting on the 5-HT system are effective in treating depression for many people, disturbances in 5-HT are not the cause of depression. Findings such as these are likely to be of great benefit in developing new treatments.

Epigenetics and treatment targeting

Neuroscience can also help us to explain the link between life events, which are frequently assessed in psychosocial research, and mental health outcomes. For example, epigenetic studies have shown that maternal behaviour influences the expression of genes, including those involved in the glucocorticoid stress response.^{20,21} Because this work was done in rats it was possible to demonstrate that this effect was not genetic as it was abolished by cross-fostering with more affectionate mothers.²¹ Childhood maltreatment such as physical abuse has long been recognised as a risk factor for mental illness. Recent genetic and epigenetic studies are helping us to understand why some people are more resilient to the effects of this abuse than others.^{22,23} It has been suggested by some authors that this information could be used to better target childhood interventions, such as providing more intensive interventions to those likely to be least resilient to the effects of childhood maltreatment.

Conclusions

Our understanding of mental health problems has started to change radically in the past few decades. It is only 50 years since it was widely believed that parents could be responsible for their offspring developing schizophrenia.²⁴ Within the past 50 years patients with intractable epilepsy were cared for in psychiatric hospitals, something that would now be unthinkable, and the parent–child relationship was seriously considered as a cause of epilepsy.^{25,26}

This improvement in understanding has the potential to reduce stigma, to ultimately lead to new treatments and to provide patients with a better understanding of what is happening to them and why. It is critical that mental health researchers work together, rather than in methods-based silos, to further improve our understanding of why and how patients develop mental health problems.

L.I.S. has received research funding from BRACE, Dementias Platform UK, the British Neuropathological Society and the David Telling Charitable Trust.

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1.3.52 Highlighting some of the challenges COVID-19 has posed to the European Convention on Human Rights

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date

2020-08

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- *Highlighting some of the challenges COVID-19 has posed to the European Convention on Human Rights*

The European Convention on Human Rights (ECHR) came into force in 1953 to guarantee specific rights and freedoms for people in countries that belong to the Council of Europe and to protect their human rights and prohibit unfair and harmful practices.¹

COVID-19 took the world by storm and invaded all aspects of humanity. The ‘normal approach’ we had to life and issues relating to everyday living changed. New norms/ways of thinking as well as laws² emerged to tackle the sweeping public health crisis with consequent implications for accepted rights and freedoms under the ECHR.

Governments’ world over (including Europe) variously imposed lockdown measures to limit the spread of the disease and subsequently introduced schemes to alleviate the financial difficulties imposed on their populace and pioneered schemes such as volunteer services to help the less able with shopping, collecting medication from pharmacies etc, to lessen the hardship(s) imposed by lockdown measures.

The powers available to public authorities under Article 5(1)(e) of the ECHR to lawfully detain people for the prevention of the spreading of infectious diseases were imposed by governments across Europe with the consequence that health and law enforcement agencies acquired powers to confine otherwise healthy individuals to their homes and to isolate and screen individuals suspected to have contracted COVID-19 using powers under Article 5(1)(b) of the ECHR.³

The promotion of powers under Article 5(1)(e) of the ECHR did not seem to have been extended to the promotion of provisions of Article 5(4) of the same convention, which allows for everyone deprived of their liberty by arrest or detention to be entitled to take proceedings by which the lawfulness of their detention shall be decided speedily by a court and their release ordered if the detention is not lawful.

The exigencies of COVID-19 especially in the early stages meant that health resources were diverted to combat/contain the pandemic with the consequent effect that the care of some individuals were delayed and, in some instances, can-

celled, for example clinics and operations, possibly leading to death as an indirect consequence of COVID-19 and interference with Article 2 rights of these individuals.

There were concerns about issues relating to the blanket approach taken to writing ‘DNAR’ (do not resuscitate) on the notes of older adults and people with intellectual disabilities without proper consultation⁴ in disregard of their Article 8 rights.⁵

There were also problems with the supply and availability of personal protective equipment⁶ to health and care professionals, with consequence on the human rights of workers⁷ to be protected from toxic exposures at work.⁸

There were concerns that the exigencies of the pandemic had the potential to cause doctors to consider factors such as the availability and capacity of current resources⁹ when making decisions about whether to continue life-saving treatment on an individual with a potential scenario where an individual could be deprived of continued treatment, consequently interfering with their Article 2 rights.¹⁰

A Court of Protection judgment¹¹ considered the interface between the right to private and family life (Article 8), right to liberty and security (Article 5) and right to life (Article 2) among others, and drew out the primacy of absolute rights under ECHR such as Article 2 rights over qualified and limited rights (Article 8 and Article 5 rights, respectively).

Patient consultation via telephone and video calls has grown in popularity and acceptance¹² with possible implications for Article 8 rights of patients. The effect of the lockdown on the physical and mental health of the populace as well as mortality rates, including suicides will become apparent as time goes on.

Time will tell with regard to whether the exigencies of COVID-19 had an impact on the speed of hospital discharge as well as the care of people in care homes and the care and survival of the less able and whether this interfered with their Article 2, Article 3 and Article 8 rights.¹³

Although there is the possibility under Article 15 of the ECHR for governments, in time of war or other public emergency threatening the life of the nation, to temporarily derogate from their obligation to secure certain rights and freedoms under the Convention,¹⁴ some of the measures put in place to tackle the exigencies of COVID-19 will endure long after the pandemic has abated in the UK – otherwise we would have learnt nothing from the pandemic and forgotten nothing. There is therefore the need, going forward, to carefully calibrate the fine balance between public health needs and safety with human rights.

The understanding is that the European Charter of Fundamental Rights that brings together the fundamental rights of everyone living in the European Union, including the rights protected by the ECHR (as brought into UK law by the Human Rights Act) will stop having effect in the UK after the UK leaves the European Union. The government has however guaranteed UK’s continued commitment to ‘respect the framework’ of the ECHR.¹⁵

None.

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1.3.53 The value of assessing suicidal ideation

Gethin Morgan

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2020-02

Contents

- *The value of assessing suicidal ideation*

The paper by Gibbons *et al*¹ concerning the distress experienced by psychiatrists who lose a patient through suicide is very welcome. We all know that such an event is difficult to bear, and this paper will encourage us to get support from others if things get really difficult, rather than soldiering on alone.

In describing how hard it is in clinical practice to detect suicide risk, let alone prevent it, the authors assert that recent research based on meta-analyses provides no evidence that suicide risk assessment in clinical practice can usefully guide clinical decision-making.

I believe that such a bald overall dismissal is regrettable because it discourages acquisition and critical evaluation of relevant clinical skills. Furthermore, I submit that it is not justified in the case of psychiatric in-patient care when addressing the problem of suicide prevention in the immediate or short-term future.

Surely all would agree that in managing severe short-term risk we ignore evaluation of suicidal ideation at our peril. When less immediate short-term risk is considered, there is also much to affirm the important role of assessing suicidal ideation in guiding clinical decision-making.

We described two series of psychiatric in-patients (1982–1984, N = 27; 1991–1993, N = 18) who died by suicide either during hospital admission or within 2 months of discharge from hospital.² In each of these, a high proportion of patients, 20/27 (74%) and 15/18 (83%), had discussed their suicidal ideas with members of staff in the ward during their in-patient stay. Suicidal ideation, as recorded contemporaneously in the case notes and not retrospectively, was a key clinical feature in delineating these patients, because they could not be distinguished from others in the ward across a range of behaviours. 12/27 (44%) and 9/18 (50%) showed significant clinical improvement during their in-patient stay, even though stress in the community had remained unresolved. In the 10 years that had elapsed between our two series, the proportion of patients that killed themselves after discharge from hospital increased from 7/27 (26%) to 11/18 (61%).

These findings, based as they are on two small series of suicides, must be regarded as provisional. Yet they do suggest that knowledge of suicidal ideation can be useful in guiding clinical management decisions. Clinicians should be vigilant that clinical improvement in these particular patients may be temporary and misleading, possibly related to removal from stress in the community. They should be particularly careful to ensure that such stress has been resolved, or at least contained, by planned provision of adequate ongoing support in the community if discharge from hospital is envisaged. With the increased emphasis on community care, the proportion of these patients who kill themselves after discharge from hospital is likely to have increased further since our studies took place. Our findings suggest that clinicians should be mindful of the increased hazard which is likely to be associated with premature discharge of these patients from hospital.

Our in-patient psychiatric wards should be fertile ground for the necessary further research that is needed to clarify the many other possible aetiological factors in these suicidal deaths, and so help in the development of good clinical practice. The identification and evaluation of suicidal ideation must surely have a central role in this.

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1.3.54 The recruitment legacy of COVID-19

Rajaei K. Sharma Bhupinder Sharma Harriet L. Ogle

date

2020-08

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- *The recruitment legacy of COVID-19*

With increasing thought being put into COVID-19 and the implications for psychiatric care in the months and years to come, it would be remiss to not consider the potential impact this could have on recruitment to the specialty.

Recruitment in psychiatry is a national, if not global problem, and has been for some time. Although frequently highlighted, there has been limited work clarifying the reasons behind the problem, which in turn has led to muted and potentially ineffective responses. This could all now be amplified by the COVID-19 crisis.

We know that foundation doctors already have very low exposure to psychiatry placements and teaching; the proportion of psychiatry teaching time has been found to be as low as 2.3% relative to surgical and medical specialties seeing 44.1%. We also know that there is a significant correlation between trainees having a foundation placement in psychiatry and going on to apply for specialty training.¹ This has been replicated in targeted studies with a surprisingly high 45% of psychiatric specialists found to not have even considered the specialty before their foundation years.²

So, it is not an understatement that the current foundation year trainees are to be drastically affected. Not only have rotations been paused, but huge numbers have been redeployed. Already, the invaluable experiences of an entire cohort have been curtailed, with more likely to follow. Additionally, national exams have been cancelled; the impact of this and the choices made thereafter may even lead to very immediate-term shortages and unknown ramifications.

This is before we even consider those that will shortly follow them through, the medical students. The proportionally enormous amount of time lost directly affects many of the clearly identified factors attracting students to the field such as placement and elective exposure.³ There have recently been some targeted strategies implemented by the Royal College of Psychiatry to try and improve recruitment – especially the ‘Choose Psychiatry’ campaign – these outreach programmes might serve to be a much-needed lifeline more than ever before. Psychiatric societies within universities might be the great untapped resource that prevail the shutdown and educational restrictions.⁴ Could they, in turn, be a vital commodity?

There is a growing recognition that although it may appear to be minutiae relative to the scale of a global pandemic, COVID-19 could have a profound effect on the career progressions of a generation of doctors.⁵ Only by addressing this early and actively can we mitigate potential disaster for years to come.

None.

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1.3.55 Challenges during the transition from child and adolescent mental health services to adult mental health services

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Abstract

The transition from child and adolescent to adult mental health services for young people with mental health problems is of international concern. Despite the high prevalence of mental disorders during adolescence and their tendency to continue during adulthood, the majority of young people do not experience continuity of care. The aim of this review paper is to unravel the complexity of transitional mental healthcare to clinicians, policy makers and mental health service managers, and to address challenges to a smooth transition process at all levels.

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- *Challenges during the transition from child and adolescent mental health services to adult mental health services*
 - *Challenges regarding transitional mental healthcare*
 - * *Policy and organisational level*
 - * *Service level*
 - * *Level of the individual*
 - *Improving transition through specific interventions*
 - *Improving clinical practice*
 - *Conclusion*

Young people's transition from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS) has gained increasing international interest in recent years. At around the age of 16–18 years, young people with chronic mental health problems are confronted with two simultaneous transitions: a situational transition (from CAMHS to AMHS) and a developmental transition (to adulthood).¹

Transition is defined as an efficient, planned, patient-oriented process that meets the medical, psychosocial and educational/occupational needs of young people with chronic conditions.² Additionally, the developmental perspective

¹

Declaration of interest: None.

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is important in conceptualising transition as young people, those aged 16–24 years, are confronted with changes in various life domains.^{3,4}

The transition age refers to the age at which the care of the young person in CAMHS is continued in AMHS, and in most cases, concerns young people in the 16–18 year age range. The following findings linked with psychopathology are relevant for transitional care at this time point: first, psychopathology has a high persistence from an early age into adulthood⁵; second, the onset of many psychopathologies has been shown to coincide with the transition age.^{6,7} Critical changes in the brain occur during late adolescence, which make this age group more vulnerable for developing psychopathology.⁷

Moreover, 75% of all psychiatric disorders in adults start before 24 years of age, and 50% before 14 years of age.⁸ However, there is a discord in the pattern of increased risk of psychopathology in young people and mental health service use.^{1,9} Older adolescents access care far less (28.9%) than 13- to 16-year-olds (50.9%) or adults over 26 years (41.1%).^{10,11} Furthermore, the gap between CAMHS and AMHS, the so-called ‘transition gap’, results in a clear discontinuity of care. A sizeable number of youth and young adults who ‘fall’ in this transition gap access adult services at a later point in time, when more serious and chronic problems have developed.^{12,13}

The care gap affects not only the young people, but also their families, communities and society as a whole. Mental health problems are associated with poorer physical health and poorer functioning in the social, educational and economic life domains.¹⁴ At the societal level, the presence of a mental disorder during childhood leads to a 10-fold higher health cost during adulthood compared with children without mental health problems.¹⁵ To date, it is unclear what the real societal impact of the care gap in late adolescence is and to what extent adequate transitional care reduces this impact.

The aim of this paper is to summarise the new insights and developments investigated since the review of Singh in 2009.¹² Furthermore, this paper includes research on youth mental health services and shared management components, which is one of the limitations of the review of Paul *et al.*¹⁶

Continuation of care is a complex process, with important players at the policy and organisational level, service level and at the level of individuals: patients, their families and healthcare providers. However, care discontinuity cannot be explained by only one level.^{4,17} This paper attempts to unravel the complexity of transitional mental healthcare to clinicians, policy makers and mental health service managers, and to address challenges to a smooth transition process at all levels. The advantage of splitting the findings according to the three levels makes the extensive research regarding transition more manageable. Furthermore, it emphasises the complexity of the topic, but also makes clear that solutions are possible at every level.

Challenges regarding transitional mental healthcare

Policy and organisational level

Improving transitional care has been on the policy agenda in different European countries for some time now; however, it has been one of a number of competing priorities. Furthermore, there has been a gap between policy and implementation in practice, insufficient research regarding transition, and a lack of transition protocols guiding transitional care of service providers.¹⁶

Historically, the way in which mental health services have been structured, with separate facilities for children/adolescents and adults is a significant bottleneck to transitional care.¹³ Eligibility thresholds for referral to CAMHS and AMHS often differ; thereby causing young people to fall through the care gap.^{4,18} Furthermore, the CAMHS-AMHS interface is characterised by different cultural approaches, a lack of communication and doubts about AMHS staff being proficient in managing young peoples’ care.¹⁹

Waiting lists form another major barrier in the provision of mental healthcare to youth and young adults.^{20,21} As a result, young people presenting with a mental health problem at 17 years of age are often referred directly to AMHS because the waiting time for CAMHS coincides or exceeds their 18th birthday, i.e. the transition boundary. Adult services, in turn, hesitate to treat these young people before 18 years of age, because the expertise or the adjusted setting for this patient group is lacking, or because internal or external regulations prevent care providers from forming a treatment

plan. Young people who have attended CAMHS but find themselves on a long waiting list for AMHS – usually with no interim support in place – describe this as highly anxiety-provoking.²²

Another challenge is the lack of training requirements for care providers and variations in the content of training programmes.^{23,24} The knowledge clinicians in either child/adolescent or adult speciality acquire about young people largely depends on whether they are provided with adequate training on psychopathology of adolescents. A lack of confidence amongst mental health practitioners to work with young people in transition is an area of concern frequently identified by young people.²²

Healthcare financing is another policy challenge affecting the care trajectories of young people. Gaining financial responsibility at the age of majority can have a real effect on the provision of care in some countries. Differences in financial benefits for minors versus adults may relate to the cost of a consultation, the possibility to organise family therapy or the reimbursement of medication. Some health insurance policies provide partial reimbursement for therapy sessions for young people up to 18 years of age, but not for (young) adults. Hence, although they have reached the age of majority and the ability to organise their mental healthcare independently, young people often still remain financially dependent on their parents to pay for their care. If there is a serious disruption in the parent–child relationship, the continuation of care at a new mental health service may be in jeopardy.

Service level

Different treatment approaches at CAMHS and AMHS pose a significant challenge. In CAMHS, treatment is reported to be more family-oriented and holistic, inherent to the legal position of the parents, whereas in adult psychiatry, individual patients and their symptoms are the main focus. These differences are described by young people and their families as an important reason for discontinuing care in AMHS.²⁵ This perception may also lead to hesitance among CAMHS clinicians to refer young people.¹⁶ In addition, the lack of common registration and information systems hampers the exchange of information between services.¹⁷

Level of the individual

Youth and young adults

Characteristics specific to young people can influence the transition process. Having a severe and enduring mental illness, e.g. schizophrenia, enhances the chance of being referred to AMHS, whereas having a neurodevelopmental disorder decreases the chance of being referred. Moreover, receiving medication, having a history of hospital admissions and living with both parents or independently are all variables that can determine whether a young person is more likely to be referred.^{4,26–28}

Even if a transition to adult services has been carefully planned, a young person's urge for autonomy and self-determination may influence their care trajectory. For example, the young person can decide to abandon psychological care or to not make the transition to AMHS, even when a referral has been made.^{4,26,28,29} The reasons for this are diverse: young people want to solve their problems themselves, or they may not want to repeat their story to a new clinician. The lack of information about mental healthcare, the stigma associated with mental health problems,^{30,31} anxiety about how confidentiality is handled and the physical accessibility of mental health services can all act as barriers to seeking help or accessing care.³² Young people have also suggested that further investments should be made to improve the accessibility of mental healthcare and have pointed out to the importance of e-health.¹⁷

Furthermore, service (dis)engagement is influenced by an identity change that accompanies the transition from CAMHS to AMHS. Besides adopting an adult identity, transitioning to AMHS implies adopting a new illness identity.³¹ Although CAMHS is associated with temporary psychopathology, AMHS is associated with having a severe and enduring mental illness, as this is often the prerequisite for being referred to or accepted by AMHS.⁴ Disengagement can be attributed to failure in adopting a new illness identity, an illness identity that is incompatible with AMHS service remit or fractious professional relationships between CAMHS and AMHS during the transition, which causes anxiety and uncertainty to the young person.³¹

Although young people want to make autonomous decisions and are concerned about the confidentiality of information, the loss of parental or other psychosocial support is an important negative factor for care continuation or adequate help-seeking behaviour.³²

The relationship of trust with the CAMHS clinician must not be forgotten, as at the transition to adult services this relationship comes to an end. Entering into a new social and trust relationship at an AMHS can be daunting for young people. On the other hand, a positive relationship with the new clinician can enable the development of other positive relationships.³³

The parents and important others

The parents' position changes the moment a young person becomes an adult, as their legal right to be involved in the care for their child is no longer there. Furthermore, because of the distinct service cultures, CAMHS and AMHS clinicians' training regarding family involvement differs considerably; in adult psychiatry, the focus is more on the individual, not the family.^{25,34}

The need to give a young person autonomy to make their own decisions regarding treatment can be a difficult process for the parents, who may also require additional support.³⁵ Many parents and carers would like to remain involved in the treatment, although they respect their child's wishes and their right to privacy.^{36,37} They also want psychoeducation about how to deal with their child and to attend parent support groups where they can benefit from increased knowledge, shared recognition and exchange of experiences.³⁸

The clinician

Mental healthcare transition should be a planned and efficient process. This implies starting on time to prepare individuals and their families for the transition. Some authors state that this process should start at 14 years of age,³⁹ whereas others stress that it should start at least 1 year before the transition boundary.⁴⁰ For the process to be efficient, by the time the young person reaches the transition boundary it should be clear whether they need further care or not, and whether this care will be continued in CAMHS or whether a referral to AMHS, or another type of service (e.g. private practice), is appropriate. In any case, the clinician should consider all these options to make the best possible decision.

To date, there is no consensus about this decision-making process, and the follow-up trajectory of the young person thus depends on the practitioner's clinical judgement. Because of the lack of transition protocols, this clinical judgement is not usually based on a structured assessment of transition-relevant factors, such as severity of symptoms, the patient's motivation regarding further mental healthcare and the risk and protective factors in several psychosocial domains.¹³ CAMHS and AMHS should, therefore, be supported in the initiation, advancement and supervision of the transition process. The National Institute for Health and Care Excellence and Cleverley *et al* have produced guidelines on transition.^{41,42} The Managing the Link and Strengthening Transition from Child to Adult Mental Healthcare (MILESTONE) project developed an instrument for assessing transition, the Transition Readiness and Appropriateness Measure, a process called managed transition, which uses the Transition Readiness and Appropriateness Measure to guide clinicians' actions, and training regarding transition.^{43,44}

The transition process is also influenced by professional relationships between CAMHS and AMHS. Clinicians' decisions regarding referrals may depend on the (not always comprehensive) knowledge they have of the other care provider and their prior experience with the service and clinician.⁴⁵ Furthermore, incompatible beliefs about who is responsible for the different steps during the transition process, lack of confidence in AMHS staff in managing young people and different cultural approaches in service delivery may also impede the transition process.^{18,46}

Improving transition through specific interventions

Some of the above-mentioned challenges provide directions as to what should be done in clinical practice and at policy level to improve the transition process. On the other hand, effect studies are lacking and there is a need for longitudinal research about different transition trajectories and health outcomes.^{16,47} Although care trajectories, transition experiences and quality of transition have been investigated within the UK,¹ Ireland,^{28,46} the USA and Australia,¹⁶ no research has been performed about the care and transition trajectories (both the experiences and the quality) in relation to their effects on mental health in the long term. The MILESTONE project contains a prospective study on the longitudinal outcomes and experiences of young people reaching the transition boundary within eight different European countries, taking into account differences in the organisation of mental health systems, the age at which transition takes place and the available services.^{43,44} The MILESTONE study will result in evidence- and practice-based guidelines that clinicians can follow to support their decision-making and direct their actions.

To prevent young people from falling through the care gap and to tailor services to their specific needs, new service models have been developed. Examples include mental health services in Australia, Canada and some European countries that target the age group of 0–25 years. Besides solely focusing on mental health, these services take into account all aspects of psychosocial functioning.^{48–50} Despite the aim of trying to solve the problem of a shortage of tailored services for this target group, some of these services are faced with an additional transition boundary: the first around 12 years of age and the second around 25 years of age, both of which need to be optimally managed. At the current time, it is too early to conclude if these models provide an answer to the longstanding problems of transition barriers.

An alternative approach to bridge the transition gap is by improving the liaison between CAMHS and AMHS, but keeping services as they currently exist. To achieve this, diverse models to enhance joint-working between services, including transition clinics and transition coordinators have been suggested.^{51–54}

Improving clinical practice

Policy makers should consider implementing the topic of transition in the training program of clinicians as 94% of European psychiatric trainees indicated further training regarding transition is necessary.²³ Furthermore the distinct split between CAMHS and AMHS should be revised as well as the separate funding, which may hamper collaborative efforts.^{13,42}

To ensure that the transition process is better managed, the transition should be mentioned to the young person well in advance,^{17,41,42} whereby the young person should be involved in the decision-making during all phases of the process.^{22,42,55} Guidelines and criteria regarding optimal transition can guide clinicians during their clinical practice.^{4,41,42} Furthermore, standardised assessment of the young persons' needs when approaching the transition boundary should become routine, although it is rarely done nowadays.¹³

Conclusion

The transition from CAMHS to AMHS is an important process for young people with mental health problems. Literature shows that continuation of care is a complex process, with important players at policy and organisational levels, service level and at the level of individuals: patients, their families and healthcare providers. At the moment, specific programmes for young people are being developed. However, research such as the MILESTONE project is needed to support these interventions in an evidence-based manner.

We would like to thank Marc Hermans, past president of the European Union of Medical Specialists (UEMS) board of psychiatry, for inviting us to join the UEMS working group regarding transition. We are also very grateful for the whole UEMS working group on transition for their interest and plans to make transition part of the training of psychiatrists throughout Europe. Furthermore, we would like to thank all members of the MILESTONE consortium.

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1.3.56 Management measures for non-medical staff on psychiatric hospital wards during the COVID-19 pandemic

Lei Yang Dongmei Wu

date

2020-08

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- *Management measures for non-medical staff on psychiatric hospital wards during the COVID-19 pandemic*

A notice issued by the National Health Commission in China on 18 March 2020 highlighted the need for psychological counselling for those affected by COVID-19, vulnerable groups, health workers and those fighting the virus on the frontline.¹ Data shows that 323 patients with severe mental disorders had been diagnosed with COVID-19 across the country as of 19 February 2020.² The development of an epidemic poses great challenges for psychiatric hospitals.

There are visitors and non-medical staff who work in hospitals, such as cleaners, who have no medical experience or knowledge about prevention of infectious diseases. In order to ensure the safety of in-patients and staff, it is necessary to formulate management measures for non-medical staff.

First, there needs to be strict implementation of a system for non-medical staff to sign in and out of the ward. The following details should be entered into a table: name, date of going out, time of going out, reason for going out, estimated return time, actual return time, temperature at return, exact location of outing, etc. They can leave the ward only after a nurse has signed it.

Second, it is essential to follow procedures formulated by the wards and service providers. Wards should undertake temperature monitoring of non-medical staff at least twice a day. Wards should be responsible for monitoring the non-medical staff's work, including the wearing of protective clothing and ensuring that proper hand washing is carried out. Cleaners are required to clean and disinfect tableware and dining tables after meals. Staff need to strictly implement management regulations when transporting patients' specimens. Unless essential, wards and service providers should not replace permanent staff with temporary or agency staff. There must be epidemiological screening of new recruits to ensure that these personnel do not have a history of epidemiological exposure, fever or any respiratory symptoms.

Third, wards need to provide training and guidance. The ward's head nurse needs to consider the different educational levels of non-medical staff when developing and undertaking training regarding epidemic prevention knowledge and skills to ensure all training is appropriate. The training needs to focus on disinfection, isolation, hand hygiene and wearing protective clothing. The responsible nurse is in charge of daily guidance for non-medical staff. When problems are identified with epidemic prevention they should correct issues without delay.

Fourth, wards and service providers need to work together on management supervision. The ward's head nurse needs to evaluate the impact of training on non-medical staff daily. Service provider managers need to check the results of training and keep corresponding records. The head nurse of the department needs to supervise the work of non-medical staff in wards under their jurisdiction. Then, they need to check the preventive knowledge and skills of the non-medical staff members and report the results to the director of nursing. The chief manager needs to undertake special inspections to assess the mastery of epidemic preventive knowledge, skills and the quality of work in the hospital on a weekly basis.

Finally, it is important to keep an eye on the psychological status of non-medical staff on wards. On account of the long-term exposure to a dangerous environment, coupled with patients' uncooperative attitudes, loud yelling or violent behaviour, their visitors and caregivers are prone to psychological difficulties.³ As cleaners frequently enter or leave wards, the exposure risk increases. If there are any signs of anxiety or panic, non-medical staff should receive psychological interventions to help them properly handle negative feelings.

Recently, the number of cases of COVID-19 outside of China has become very serious. This letter aims to formulate epidemic prevention and control measures for non-medical workers in psychiatric hospitals. It is hoped that these measures will be of value for both domestic and foreign epidemic prevention efforts.

None.

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1.3.57 Section 12 approval: fit for purpose?

Darryl Ballantyne-Watts

date

2020-06

Contents

- *Section 12 approval: fit for purpose?*

I read this article¹ with some interest, and with some alarm. Yes, striving for ‘evidence-based improvements’ in the Section 12 approval/reapproval process is an understandably good thing. However, basing recommendations on a 21.7% (5/23) return rate for a questionnaire is never going to change much behaviour. Not even when this information is ‘triangulated ... with other sources’ are many heads going to be turned.

I believe that those of us who carry out Section 12 assessments in the real world are all too aware of the lack of hospital resources and are thus inclined to seek out every community solution for disposal, given the availability of ‘alternative to hospital’ teams these days. Particularly when we are considering complex mental illness and mental disorder matters in a social context coupled with a healthy assessment of risk, the decision to detain to hospital for assessment cannot be taken easily or lightly.

Knowing the precise wording of mental health law is important, and we all want to ‘do things right’. But in a complex, sometimes heated, community situation we are required to complete the harder additional task of ‘doing the right thing’, which takes time, thought, experience and some element of wisdom. I am not at all sure that the solutions proposed in this paper will take many in that direction.

None.

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1.3.58 Reviewing the burden of comorbidity in patients receiving specialist in-patient treatment for drug and alcohol problems

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date

2020-08

Abstract

1

Declaration of interest: None.

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Aims and method

To compare and contrast the burden of comorbidity in a population receiving in-patient treatment for substance misuse with that of a cohort admitted to the same unit 4 years previously. The Charlson Comorbidity Index (CCI) was used to quantify patients' comorbidity and predict 10-year survival.

Results

There was a marked reduction in predicted 10-year survival: in 2014, 22% of patients had a predicted 98% chance of 10-year survival, whereas only 2% in the 2018 cohort had a predicted 98% chance. Additionally, in 2014 only 9% of patients had a <20% 10-year predicted survival chance, whereas 28% in 2018 had a predicted 10-year survival chance of <20%. In this time, funding for services was cut by 23% and the 12-bed unit was reduced to 8 beds. This resulted in an increase in the average waiting time from 30 to 65 days. In 2018, more patients were admitted for alcohol detoxification, rising from 79% to 93% of admissions. Chronic respiratory disease remains the most prominent comorbidity; however, there is also an increase in the percentage of patients with liver disease.

Clinical implications

In-patient substance misuse units are known to serve individuals with complex illnesses. With service funding cuts, subsequent bed reductions and increased waiting times, this complexity is increasing, with a considerably higher burden of comorbidity. The consequential increased mortality risk highlights the ongoing need for adequate community and in-patient services with integrated care of mental and physical health alongside social work.

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 - * *The Ritson Clinic and government policy on drug and alcohol services*
 - * *Reductions in 10-year predicted survival*
 - * *Increasing burden of comorbidity*
 - * *Limitations*
 - * *Implications*

It is widely accepted that there are social, psychological and physical harms associated with chronic substance misuse.¹ It has also been identified that drug and alcohol misuse are independent risk factors for physical illness in people with pre-existing mental illness.² Furthermore, the World Health Organization (WHO) found alcohol consumption to be the third highest risk factor, in high-income countries, for disease burden, superseded only by smoking and hypertension.³ Specialist in-patient units offer drug and alcohol detoxification and stabilisation to individuals with complex problems, whose substance misuse needs cannot be met in the community. Despite this, there have been significant funding cuts for alcohol and drug prevention, treatment and support services in Scotland in recent years.⁴ This study seeks to

describe and evaluate the burden of comorbidity carried by a current population of in-patients in a substance misuse unit in Edinburgh. It was anecdotally noted among the staff of this unit that in-patients were requiring more medical intervention. We therefore sought to compare the disease burden of a patient cohort in 2018 with that of a 2014 cohort in order to identify any developments in the prevalence or character of comorbidity carried by this population. These data provide invaluable insight into a high-risk population and aim to recognise any areas of developing trends within this group, to identify possible areas for intervention in the future.

Method

We conducted a retrospective study of in-patients over a 6-month period in 2018. We sought to explore the population's characteristics and compare these with the data collected by Mogford & Lawrence for their primary study conducted in the same unit in 2014.⁵ To quantify comorbidity, cumulative disease burden scales are used. These are calculated by attributing scores to specific diseases, health behaviours and medications, which are weighted according to their impact on morbidity and mortality. These scores are combined to assign an overall index of comorbidity, which can be used to compare, contrast and track change in individual patients or patient groups. The Charlson Comorbidity Index (CCI) has previously been used across a wide range of clinical settings and a variety of patient populations, including the 2014 cohort. To allow a direct comparison of patient cohorts, the same CCI was implemented to quantify comorbidity in the repeat patient cohort in 2018. There is a strong base for using the CCI, which has been deemed valid and reliable for estimating the burden of comorbidity in clinical research.⁶ The index records 16 diagnoses, including chronic respiratory disease and congestive heart failure. These details are all obtained as part of the routine documentation completed on admission to the unit. These 16 diagnoses have validated predictive value when calculating projected 10-year survival. The impact of age on predicted survival is accounted for by the addition of an age-based score to the raw CCI. The version of the CCI used is an extended one that includes four additional items that predict healthcare cost, but are excluded from the calculation of predicted 10-year survival.⁷ This version held the additional benefit of including a greater breadth of conditions/factors, specifically hypertension, skin ulcers or recurrent cellulitis, treatment with warfarin and the presence of depression. The individual patient scores could then be used to calculate their predicted 10-year survival.

We assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. Ethics approval was not required.

Participants

There were a total of 138 participants, who were admitted over a 6-month period to the Ritson Clinic at the Royal Edinburgh Hospital in Scotland. All the patients who were admitted to the unit were included in the data-set. The Ritson Clinic is a specialist unit that provides in-patient detoxification, stabilisation and replacement therapy for people with alcohol, opiate and other drug dependencies such as benzodiazepines, stimulants and novel psychoactive substances. All of the patients have complex psychiatric and social needs that are best met in an in-patient setting. Referrals are received from a range of community teams, including general practice and substance misuse services as well as some acute services such as the regional infectious diseases unit. These are all within the local National Health Service (NHS) health board of Edinburgh and the Lothians, with a population of over 800 000. The participants included in the study were 'recruited' retrospectively from the 6-month period immediately prior to the start of data collection. The period covered was from 19 April to 22 October 2018. The original study recruited patients from 26 May to 27 November 2014 in a prospective manner.⁵

Data collection

All collected data had been gathered during the in-patient admission clerking that was part of routine practice at the unit. As with the data collection in 2014, a brief paper recording tool was used for standardised collection of data. The authors, A.B. and A.M., completed the brief paper recording tool, retrospectively, that was created for completion during admission in the 2014 study. This information included a full psychiatric history, substance misuse history, medical history, physical examination and appropriate investigations, including a routine set of blood tests. To provide collateral information, a full range of data sources were used to complete the summary. These sources included a verbal report from the patient, electronic patient records, out-patient letters, previous discharge letters and general practitioner clinical summaries. The CCI provides detailed and specific descriptions of the inclusion criteria for each diagnosis, allowing for objectivity and repeatability in assessment so that each diagnosis was given the appropriate score. This data collection was conducted in the same manner as the data collected from 2014 cohort had been, as provided by Mogford & Lawrence, to allow for direct comparison.⁵

Results

In total, 138 patients were admitted during the repeat 6-month period of data collection. This compares with 175 patients admitted during the original period of data collection in 2014. The profile, number of patients admitted for alcohol detoxification, substance misuse diagnosis, the presence of a diagnosis and prevalence of cigarette smoking are shown in *Table 1*. The average age of patients for treatment has increased from 44 years to 49 years. There has been an increase, from 80% to 93%, in the number of patients who were admitted for alcohol detoxification. There has been a slight fall, from 80% to 76%, in the number of patients who were smokers at the time of admission. At the time of data collection for the 2018 study, 14% of the 2014 cohort was deceased and 2% of the current cohort was already deceased. *Table 1* Study group characteristics

	2018 cohort	2014 cohort
Age, years: mean (range)	49 (23–70)	44 (19–73)
Male, <i>n</i> (%)	60 (43)	111 (63)
Female, <i>n</i> (%)	78 (56)	64 (37)
Patients admitted for alcohol detoxification, <i>n</i> (%)	128 (93)	139 (80)
Comorbid depression diagnosis, <i>n</i> (%)	100 (72)	82 (47)
Cigarette smoker, <i>n</i> (%)	105 (76)	138 (80)
Patients deceased at 2018 data collection point, <i>n</i> (%)	3 (2)	25 (14)

The proportions of patients with each of the CCI items are summarised in *Fig. 1*. Within both cohorts, the condition with the highest prevalence was depression. Of note, however, this has shown a marked increase, from 47% in 2014 to 72% in 2018. Depression is the only psychiatric condition included in the CCI. There was a small reduction in the percentage of patients with chronic obstructive pulmonary disease (from 26% in 2014 to 22% in 2018), which we would expect with the reduction seen in the percentage of smokers over this period. In the 2018 cohort there is an increase in prevalence of both mild liver disease (from 19% to 21%) and moderate to severe liver disease (from 6% to 14%). This is in the context of an increased number of admissions for the purpose of alcohol detoxification. There is also a marked increase in the percentage of patients who met the criteria for diagnosis of dementia (from 6% in 2014 to 16% in 2018). *Fig. 1* Comparison of comorbid diagnoses/factors recorded for the 2014 and 2018 study cohorts. COPD, chronic obstructive pulmonary disease; TIA, transient ischaemic attack.

Table 2 presents the comparison of the distribution of CCI scores and associated 10-year mortality. The percentage of patients with a predicted 10-year survival chance <20% has increased from 9% to 28%. In 2014, 63% of patients had a predicted 10-year survival chance >90%, whereas in 2018 this was only 16%. *Table 2* Comparison of Charlson Comorbidity Index (CCI) scores and predicted 10-year survival for 2018 and 2014 cohorts

CCI score	Predicted 10-year survival chance	2018, <i>n</i> (%)	2014, <i>n</i> (%)
>5	<20%	38 (28)	16 (9)
2–4	20–49%	17 (12)	13 (7)
0–1	50–74%	24 (17)	12 (7)
3–7	75–90%	37 (27)	24 (14)
>8	>90%	22 (16)	110 (63)

As shown in *Fig. 2*, in 2014 only 7% of patients were predicted to have no chance of survival at 10 years, compared with 15% in 2018. There were just 2% of patients with a 10-year predicted survival chance >98% in 2018, whereas this was 22% in 2014. The interaction between age and predicted survival is demonstrated in *Fig. 3*. The number of younger patients carrying a high burden of comorbidity has increased. *Fig. 2* Comparison of predicted 10-year survival for the 2014 and 2018 study cohorts. *Fig. 3* Comparison of age and predicted 10-year survival for the 2014 and 2018 study cohorts.

Discussion

The Ritson Clinic and government policy on drug and alcohol services

The Royal Edinburgh Hospital site is currently being redeveloped, with the Ritson Clinic being one of the last areas of the hospital to undergo service redevelopment. This has led to considerable discussion about whether the unit would be best placed at a medical hospital or on a psychiatric site and about level of intervention the in-patients require. In addition, on a wider scale, there is ongoing debate regarding the allocation of resources to fund specialist in-patient treatment of drug and alcohol problems within NHS Lothian. The original study⁵ helped make the case for the ongoing availability of a medically supported in-patient unit for the treatment of alcohol and drug use disorders within NHS Lothian. In the intervening period, service pressures have increased and available bed numbers have decreased. Between 2016 and 2017 direct Scottish Government funding for alcohol and drug partnerships (ADPs, local partnerships between health boards, local authorities, police and voluntary agencies to tackle alcohol- and drug-related problems) fell by 22%.⁴ In Lothian, the ADP funding allocations for alcohol and drug prevention, treatment and support services was cut from £11 469 680 in 2015–2016 to £8 887 133 in 2016–2017.⁸ As a consequence of this reduction in national funding, by January 2018 the number of beds in the Ritson Clinic was reduced from 12 to 8. These changes have occurred in the context of changes in public health policy, which increasingly focuses on the preventability of drug- and alcohol-related deaths. The average waiting time for an admission to the Ritson Clinic has increased from 30 days for the 2014 cohort to 65 days in 2018. The average length of admission was 8.9 days for the 2018 cohort. The unit receives referrals from community addiction services, general practices (including practices for those without fixed accommodation), in-patient and out-patient hepatology teams, alcohol liaison nurses and the regional infectious diseases unit. These are screened using admission criteria originally based on Scottish Intercollegiate Guidelines Network (SIGN) guidelines.⁹ This ensures that admission for in-patient treatment is limited to those who could not have their needs met in the community; by its very nature, this predisposes them to carry a higher burden of comorbidity.⁸ It is worth noting that there are other factors that may contribute to increased morbidity in this patient group that were not accounted for in the study, such as poor nutrition and blood-borne viruses such as hepatitis B or hepatitis C. This study did, however, look at the prevalence of smoking in the patient group. Evidence suggests that the prevalence of smoking in the Scottish population is falling. In 2017, it was estimated that 18% of the Scottish adult population smoked.¹⁰ Despite showing a small improvement between 2014 and 2018, the in-patients included in our study still have a considerably increased prevalence of smoking; 76% of the 2018 cohort were current smokers, which will contribute to their overall increased morbidity and mortality.

Reductions in 10-year predicted survival

Data from the Office for National Statistics for 2011–2013 estimated the predicted 10-year survival chance for a 45-year-old Scottish male to be 96.6%.¹¹ Comparatively, in the original cohort, among patients aged between 45 and 55, the mean predicted 10-year survival chance was 68.6%. In the 2018 cohort, this had reduced to 55%. There are multiple likely contributing factors to the increase in predicted mortality over the 4 years. The increased waiting times and reduced bed numbers have certainly played a role. When screening referrals to the unit, the patients with the greatest need are given preference, with those with highest immediate risk to physical well-being taking precedence. This is also likely to explain why there is an increase in the number of patients admitted for treatment of alcohol dependence over the 4 years, as the risk to physical health from alcohol withdrawal is usually greater than that of drug stabilisation or detoxification, therefore these patients are admitted preferentially. As per the SIGN guidelines any patient who is confused, has a history of seizures or hallucinations, has an acute physical or psychiatric illness, including multiple substance misuse, has previously failed home-assisted detoxification or has a home environment unsupportive of abstinence is deemed to require in-patient detoxification.⁹ These broad inclusion criteria cover much of the patient population that would require alcohol detoxification and also go some way to explain why the large majority of admissions, in both 2014 and 2018, were for treatment of alcohol dependency, despite the Ritson being a unit that treats both drug and alcohol problems. With increased waiting times and pressure on beds, the triage of referrals requires ever more challenging clinical decision-making.

Increasing burden of comorbidity

The Ritson Unit currently forms part of the Royal Edinburgh Hospital site, which provides only psychiatric care and is not a medical hospital. Anecdotally, among the multidisciplinary team, it was felt that the patients being admitted to the unit had increasingly complex medical problems, requiring more medical intervention beyond the capabilities of the unit. Patients admitted to the unit who become acutely medically unwell often require transfer across the city to the medical hospital, as their physical health needs cannot be safely managed within the psychiatric hospital setting. Our data have supported this impression that patients are indeed carrying a higher burden of comorbidity. In quantifying this burden, the study demonstrates the ongoing and growing demand for in-patient facilities to treat this unique population of patients, whose needs intersect mental and physical healthcare services. To improve outcomes for these patients, a more collaborative and proactive approach in the development of these services is required. This is in accordance with the recommendation of increased funding and an emphasis on better integrated care made by NHS England in its NHS Long Term Plan.¹²

Limitations

The study was conducted using the CCI, which is a useful tool for comparison of predicted mortality. We have compared two groups, admitted over the same length of time. However, because the capacity of the unit was reduced between the two studies, we compared a smaller, of an already small, sample (138 patients in 2018, compared with 175 in 2014). This meant that we used percentages for data analysis rather than gross numbers of patients. The CCI does not give an indication of the impact of morbidity on quality of life, nor does it demonstrate causation. A further limitation of the study is that the data were collected retrospectively. The initial study was carried out prospectively and by different clinicians, so there may have been a resultant difference when scoring the patients. However, the CCI is based on objective measures, so variability should be limited. The score is predicted over 10 years, and we have repeated the study after 4 years. We are therefore unable to compare the predicted mortality with the actual mortality. Furthermore, one cannot extrapolate the current number of deceased patients to draw any conclusions about the accuracy of the scoring in this patient group. In addition, although the score demonstrates a declining trend in health outcomes in this patient population, it does not provide any indication of quality of life or functionality of patients.

Implications

The original data collected in 2014 showed a high burden of physical illness carried by those admitted for in-patient treatment for substance misuse. The data collected in 2018 confirm what was suspected from observations made by the healthcare professionals working within the service: that patients being admitted have an increasing burden of comorbidity, requiring more intervention from specialties, and ultimately are likely to have worse long-term health outcomes. At 4 years, 14% of patients originally audited were deceased. It is recommended that the study is repeated after 10 years, to assess the accuracy of the score at predicting mortality in this population with complex, specialist care needs. The intersection between physical healthcare requirements and psychiatric and substance misuse needs continues to present a unique challenge in caring for this group of patients. Although the current trend is to move towards a more community-based healthcare model, the increased comorbidity and growing waiting lists identify the ongoing need, within this population, for in-patient services. There is clearly a requirement for healthcare providers and facilities that can provide safe and effective treatment of the combined conditions and substance misuse needs of these patients. Quantifying the degree of comorbidity within this population remains valuable for the allocation of resources and development of services with an emphasis on integrated care.

Daniel V. Mogford and Rebecca J. Lawrence, both consultant psychiatrists with NHS Lothian, Edinburgh, UK, conducted the 2014 data collection and provided non-financial advice and support for the current study.

A.M. has met all four ICMJE criteria with regard to her contribution. She helped follow up the previous cohort of patients and contribute to the collecting of new retrospective data. She placed the data in the spreadsheets for analysis. In collaboration with A.B. she contributed to the drafting, editing and review of the final paper. A.B. has met all four ICMJE criteria with regard to her contribution. In her role as ward doctor she gathered retrospective data and contributed to the analysis and interpretation of the data. This involved using spreadsheets to input the data and attributing

the score. She formulated the formulae to analyse and compare the results. She contributed to the drafting, editing and review of the final paper. Both authors agree to be accountable for the work and to answer any questions regarding the work.

Alice Bradley, BMBS (Peninsula College of Medicine and Dentistry) is a Junior Clinical Fellow in general surgery at NHS Fife, and she was a foundation year 2 (FY2) doctor in NHS Lothian at time of writing. **Amy Martin**, MBChB (University of Aberdeen) is a general adult higher psychiatry trainee in NHS Lothian (ST4) and was a core psychiatry trainee (CT3) at time of writing.

1.3.59 Clozapine and COVID-19

Edward Silva Siobhan Gee Shubulade Smith Fiona Gaughran

date

2020-08

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- *Clozapine and COVID-19*

The COVID-19 pandemic presents psychiatrists prescribing clozapine with complexities over and above the general difficulties already described among Chinese psychiatric in-patients.¹ Some common initiation effects of clozapine: isolated fever, tachycardia or a mildly raised C-reactive protein² may be difficult to differentiate from intercurrent infection, including COVID-19.³ Other laboratory anomalies may add to confusion. Given COVID-19 infection deaths that are not the result of acute respiratory distress syndrome are often from fulminant myocarditis, for which a raised troponin is a poor prognostic feature, troponin levels taken routinely during clozapine initiation will need to be interpreted carefully. However, while leucopenia is a reported blood dyscrasia with COVID-19, to date neither neutropenia nor agranulocytosis is.

In the absence of an antibody test for COVID-19⁴ we rely on reverse-transcriptase polymerase chain reaction COVID-19 testing, which does not have 100% sensitivity in the initial phase of infection, so a single negative test does not exclude infection. Once an antibody test becomes available it will be a useful addition to pre-clozapine investigations.

Comorbidities such as diabetes, hypertension, respiratory illness and cardiovascular disease are very common in patients taking clozapine but are associated with adverse outcomes in the event of COVID-19 infection, including increased mortality rates. It is not known whether the antibody deficiency described in patients taking clozapine will further compromise this vulnerable group.⁵ These are not, however, indications to stop clozapine, which itself has serious adverse consequences. Rather patients need clear advice and, if possible, assistance regarding self-isolation and other precautions advised. Obesity and sleep apnoea may also contribute to poor outcomes and continuous positive airway pressure treatment, which can be an aerosol-generating procedure,⁶ may be a risk to staff.

Individuals already established on clozapine and managed in the community may require changes to their management. In view of recommendations for social distancing, the use of clozapine clinics for routine blood testing should be reconsidered. Instead, blood tests may be better performed in patient's homes, with staff using personal protective equipment and at, or near, the maximum intervals permitted. While the standard blood monitoring frequencies are at weekly (weeks 1–18), fortnightly (weeks 19–52) and four-weekly (over 52 weeks) intervals, clozapine can still be dispensed and administered with satisfactory monitoring at 14-, 21- and 42-day intervals, respectively.

Inevitably many patients taking clozapine will present with flu-like symptoms. An urgent full blood count will be required to exclude neutropenia with appropriate action. Many, however, will have another cause and so the evolving National Health Service recommendations regarding isolation and hopefully testing for COVID-19 infection should be followed. The combination of flu-like symptoms, chest pain and shortness of breath will, as community prevalence of COVID-19 increases, be much more likely to be because of COVID-19 than clozapine-induced myocarditis, except perhaps within the first 60 days of treatment.⁷ However, such a presentation will still need investigation and cessation of clozapine may on occasion be required as well as urgent general medical assistance. Careful documentation of symptom

profiles and investigations will aid subsequent decisions regarding clozapine re-challenge. In the event of COVID-19 infection the acute-phase reaction may result in reduced activity of cytochrome P450 1A2, raising clozapine levels and so an urgent trough clozapine level will be needed with a reduction in clozapine dose if required. This effect may be amplified if hospital admission is indicated necessitating abrupt change in smoking habits.

In summary; COVID-19 presents us with extreme difficulties regards clozapine initiation, the risks of COVID-19 are insufficient to justify stopping clozapine, an action which presents its own serious problems, precautions must be taken now to help protect our high-risk patients as COVID-19 infection may jeopardise both their physical and mental health.

F.G. has received honoraria for advisory work and lectures or continuing medical education activity support from Roche, BMS, Lundbeck, Otsuka, Janssen and Sunovion, is a collaborator on an NHS Innovations project co-funded by Janssen and has a family member with professional links to Lilly and GSK, including shares. E.S. has received speaker fees from Janssen and Novartis.

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1.3.60 Social media, self-harm and suicide

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Abstract

Use of social media by people with mental health problems, and especially those who are prone to self-harm, has potential advantages and disadvantages. This poses a dilemma about how and by how much the form and content of social media sites should be regulated. Unfortunately, participation in the public debate about this dilemma has been restricted and high-profile discussion of necessary action has been focused almost entirely on how much suppression of content is justified. Professional bodies, including the Royal College of Psychiatrists, should be doing much more than they are to shape how the debate is conducted.

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- *Social media, self-harm and suicide*
 - *The dilemma*
 - *The public debate*
 - *The missing element: clinical and academic leadership*

The dilemma

There are, broadly speaking, positive and negative accounts of how people with mental health problems, and especially those with a history of self-harm, experience social media.^{1,2} Negative accounts have been emphasised in mainstream media,³ with social media presented as places where you are drawn into an immersive atmosphere of depressive messages and images that act as enticement to self-harm and suicide. More positive accounts from young people suggest that social media can also offer a space where you can come out of hiding, share otherwise secret fears with peers, and gain an element of support and advice.⁴

In the former view, risk of suicide is increased by the mood-lowering effect of the content and by a sort of creeping familiarity with the idea of self-harm or suicide – called sometimes desensitisation or normalisation – and greater awareness of the methods involved. In the latter view, the social or networking function creates opportunity for reducing the sense of disconnection or lack of belonging, and the sharing of detail allows some alleviation of the burdensomeness of feeling uniquely troubled (these and other ideas about risk of suicide are discussed by Joiner⁵). This Janus-faced nature of social media is well outlined in a report by Barnardo's about young people, social media and mental health – *Left to Their Own Devices*.⁶

The natural conclusion is that different people are likely to be affected differently by their online experiences, and the same person may be affected differently on different occasions. Which raises the question – how to minimise risk without at the same time suppressing useful content? This is a dilemma that requires a careful public debate involving as many interested parties as possible in coming to a solution that considers all the competing demands of the situation.

There are three issues that contribute to the complexity of the problem.

First, examination of online material about self-harm reveals substantial diversity in form and content.⁷ Those who post and those who respond to posts are engaged in conversations not just about the manifest topic of self-harm and suicide, even when the relevant posts are explicitly tagged as self-harm: content is also about emotional problems more generally, about relationships, fitting in or belonging, and about attractiveness, sexuality and body image. The mixture of textual and visual messaging leads to communication the ambiguity and irony of which can be missed by reading one without the other.

Second, much of this may be regarded as helpful by those who access it,⁴ even when the content includes direct communication about self-harm with images of self-injury. Such images can help an isolated person (anything up to a half of people who self-harm do not seek help for their problems⁸) feel less alone. The images may come with messages about self-care or harm minimisation. It is reasonable to conclude that content which some people find unhelpful is found helpful by others, and that whether particular content is found to be helpful or unhelpful by a particular individual depends on the immediate circumstances in which it is accessed.

Third, it is not clear what the putative pathway to harm is, following exposure to self-harm material online. Words such as graphic, explicit or glamorising are in themselves not tightly defined, but they imply that the underlying mechanism is an invitation to copy the behaviour. Linking this argument to suicidal behaviour is problematic – for example most online images of self-harm are of self-injury (cutting or burning) and yet these are extremely rare methods of suicide, especially in young people. If the putative pathway to suicide is not by copying then presumably it is by exposure leading to low mood and hopelessness – in which case it is not clear that images of self-injury are more problematic than other mood-influencing content.

These sources of ambiguity raise the serious possibility that clumsy, excessive or inconsistent intervention – in the name of reducing harmful exposure and (by implication) habituation or normalisation – may have the unintended

damaging consequence of increasing the sense of disconnectedness and burdensomeness experienced by people with mental health problems who self-harm.

The public debate

In the UK, this public debate has centred recently on the suicide of teenager Molly Russell, not least because her father has pressed forcibly the case for the damaging effect of social media and the need to suppress content that might (in his view, definitely does) encourage suicide. The BBC opened their coverage with an aggressive interview⁹ of Steve Hatch, the managing director of Facebook in Northern Europe, by Amol Rajan, who is the BBC's Media Editor rather than somebody with expertise in self-harm or suicide. Not long afterwards the government produced a White Paper – *Online Harms*¹⁰ – that bundled encouraging self-harm or suicide with incitement to terrorist activities, dissemination of child pornography, and drug dealing on the dark web. The main direction has not therefore been about self-harm and suicide prevention, but about steps to regulate the tech giants.

The response from the principal player in this case – Facebook/Instagram – has been dispiriting. After an attempt to use Nick Clegg as a front man, they announced earlier this year a ban on images of self-harm described as graphic or explicit¹¹ – with no definition of either offered by way of clarification. Now Instagram has announced a ban on drawings or cartoons depicting self-harm.¹² There is again lack of clarity about exactly what this means: in the cited article the specific example is of text linked to an innocuous drawing. What is happening, in the absence of serious discussion of the pros and cons, is a piecemeal suppression of visual content of social media postings.

The missing element: clinical and academic leadership

Where is the commission-like meeting of organisations, clinicians, academics and people with personal experience, that should be leading the debate and informing the decisions? Neither the social media companies nor the government has shown an interest in organising such an activity. The mainstream media, as one might expect, just want a story to tell, sentimental or sensational if possible. Samaritans has an interest¹³ but progress is painfully slow.

What is striking in all this is the absence from the debate of the professional bodies – the Royal College of Psychiatrists, the British Psychological Society, the Royal College of Nursing, the Health and Care Professions Council. Although members of the Royal College of Psychiatrists may have an online presence, and although the College has issued (rather one-sided) advice to its members¹⁴ and further guidance about professional standards of online behaviour is forthcoming, the College has conspicuously not been organising the high profile, mature debate that is needed to replace what is going on now. The absence of professional bodies from that role represents a failure of leadership in an area of public health where they should be at the forefront of educating the general public about self-harm and suicide, and modelling how intelligent decisions should be made on complex and important topics. It is time our College took the lead, initiating the establishment of a joint working group with the key professional bodies, third-sector organisations and people with personal experience. The role of such a body is not to establish the practicalities of regulation or control of content, but to offer the best available advice about what such content should be. The group should have a strong policy related to communication and dissemination of its discussions and not just await the production of a report – the aim is as much to model how discussion should happen as it is to achieve any other outcome.

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1.3.61 Adjustment to short-term imprisonment under low prison staffing

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Abstract

Aims and method

To understand experience of early imprisonment in one prison under low staffing levels. A researcher, independent of the prison, interviewed each prisoner soon after reception and 3–4 weeks later. The first question of the second interview was: 'I'd like to start by asking you about your experience of the last 3–4 weeks in prison'. Data are verbatim answers to this. Narratives were brief, so responses from all 130 participants were analysed, using grounded theory methods.

Results

The core experience was of 'routine' – characterised by repetitive acts of daily living and basic work, and little reference to life outside prison – generally resolved passively, towards boredom and 'entrapment'.

Clinical implications

This 'routine' seems akin to the 'institutionalism' described in the end days of the 1960s' mental hospitals. In an earlier study of similar men at a similar stage of imprisonment, under higher staff:prisoner ratios, experience was initially more distressing, but resolved actively and positively, suggesting that staff loss may have affected rehabilitative climate.

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 - *Method*
 - * *Overview*
 - * *Ethics*

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 - * *The core experience of this imprisonment*
 - * *The model of adjustment to this imprisonment*
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More men are imprisoned in England and Wales than in any other Western European country.¹ Many prisoners have at least one mental disorder,² but few are transferred to a healthcare setting for treatment, so most treatment and most programmes for offending behaviour are delivered in prison. Any impact of these is likely to be affected by the prison milieu. Studies have shown that people seem to be particularly vulnerable during early imprisonment, especially to self-harm,^{3,4} although there is widespread evidence of adjustment, including improvement of mental state over 4–6 weeks.^{5,6} Since these studies, however, there have been substantial cuts to prison staffing in England and Wales – about 40% in publicly run prisons since 2013.⁷ Over the same period, prisoner suicide, self-harm and violence rates have risen.⁸ Austerity in public service delivery is far from unique to the UK, so it is important to understand day-to-day prisoner experience and adjustment under reduced staffing. In one prison in public management, for example, prison officer numbers had been cut from 200 in 2013 to 148 in 2016, while the number and type of prisoners had remained more or less constant; there were 763 prisoners, of whom 52% were unsentenced or serving sentences of less than 6 months, in 2013, compared with 770, of whom 57% were similarly short-term, in 2016.^{9,10} Our research question was: How did new receptions in this prison affected by staff cuts experience day-to-day living during the first 4–5 weeks of a new imprisonment?

Method

Overview

Applying a grounded theory approach, a researcher employed independently of the prison recorded prisoners' responses to an open question about experience of the current imprisonment. This study was designed to stand alone, although it was embedded in a larger study, a randomised controlled trial of a 9-group intervention for alcohol misusing prisoners.

Ethics

The overarching study, including the qualitative components, had ethical approval from the National Health Service Health Research Authority National Research Ethics Service (NRES) Committee East of England – Essex (IRAS ref. 140458; REC ref. 14/EE/0046). Information leaflets about the research were made available to all prisoners on reception. Each potentially eligible prisoner was approached by the researcher, who explained the research to each man in private, assured him that neither his treatment in the prison nor in the criminal justice system more widely would be affected by a decision to participate or not and answered any questions about the research. Confidentiality was assured, except with reference to any specific information about intent or plan to harm self or others or to escape from the prison. Consenting men were asked to sign a consent form. Each man had at least 24 h to reflect before full participation and could withdraw at any time if he changed his mind about the research. The rate of refusal to participate was below rates reported in similar studies (P. J. Taylor, personal communication, 2019), but still about one in five men approached for screening refused and 27 (11%) of the eligible men initially agreeing to participate subsequently withdrew.

Sample

Participants were recruited between June 2014 and August 2016, from men newly received into one UK prison. In a two-stage screening process, the first stage was to identify, from records, all men likely to be in prison on this occasion for under 12 months (short-term prisoners) but to remain in this prison for at least 1 month, thus likely to acquire sufficient experience of the environment to be able to describe living in the prison and adjusting to it rather than talk about receiving a prison sentence *per se*. About 1 week after reception, a researcher invited these men to meet her to explore willingness to participate, to take formal consent from those willing and to complete a second, face-to-face screen for alcohol¹¹ or drug¹² misuse. All 238 consenting men screening positive for substance misuse were included; 197 remained for interview on a subsequent day up to a week later about pre-prison life experiences and their mental state. Between 3 and 4 weeks later, those still in prison and consenting were interviewed about their experience of this imprisonment and their mental state was re-evaluated. Data from the opening of this second interview are analysed in the study we report here.

For the trial, the men were randomised to receive either standard prison regime alone or prison regime and a 3-week group programme between these two interviews. The group programme included motivational work and self-management skills development, delivered by clinical psychologists from a local health board. Both intervention and treatment-as-usual men were included in this qualitative work.

Procedures

All interviews were conducted in private, by the same researcher on both occasions for each man. The data for this study were responses to the opening question of the second interview: 'I'd like to start by asking you about your experience of the last 3–4 weeks in prison'. After this, only simple, neutral prompts were used to encourage the men to talk freely about this, for example 'go on', 'tell me more'. Each prisoner's responses were documented contemporaneously and any abbreviated words or phrases written up in full immediately after the interview was complete. The interviews were not audio-recorded; audio-recording is commonly discouraged in grounded theory work and external researchers are not generally permitted to take recording equipment into prisons. Once each man had said everything that came to his mind, unprompted by us, about this imprisonment, he was asked some specific, supplementary questions about aspects of the imprisonment, including how much time he spent out of his cell, whether he had work, education and/or outside visitors, and whether he got on with prison staff and other prisoners. In turn, we were able to access independent reports on this prison from Her Majesty's Inspectorate of Prisons.^{9,10} These two separate sources of data allowed some *post hoc* consideration of the extent to which reported experiences fitted with actual activities on the one hand and general prison conditions on the other.

Data analysis

Anonymised, free narrative data were analysed in two batches – control- and intervention-arm men – by researchers blind to trial-arm membership and without reference to answers to specific questions about this imprisonment. This was to allow for the possibility that participating in groups as part of the trial affected the standard prison experience. The narratives tended to be short, a third of them not more than three sentences, so we decided to analyse all of them rather than defining the sample size by data saturation as would be more usual in a study of this kind. We used a grounded theory approach to analysis.^{13,14} The first narrative was examined, and categories of information contained in it extracted into a table, as far as possible labelling each category with a word or phrase used by the participant, with the supporting evidence of the full quotation. The second narrative was analysed in a similar way, using already identified categories where possible and adding new ones as appropriate. Two of us analysed the first 10 narratives masked to each other, then compared the ratings. Differences between us lay only in the extent to which we had listed each item as a separate category of routine – for example ‘having food’ as a common term for taking meals rather than listing each meal as a separate category. It was agreed that even the smallest of categories would be listed initially, after which both extractions were in full agreement.

We then completed first-level category identification from each batch separately (see Supplementary Tables 1 and 2 available at <https://doi.org/10.1192/bjb.2020.2>). It was apparent that very similar categories of experience were emerging, regardless of trial arm, so data from all the men were combined for further analysis. Using constant comparative analysis, higher-order categories were allowed to emerge, and then a core category, which best encompassed all the other categories.

Results

Sample characteristics

In total, 130 men provided valid interviews. Given the sample size, we have not tabled each man’s personal characteristics for context but provide the following summary. Their mean age was 30 years (s.d. = 7.9). Most (101/130) had been in prison before, with a mean total time spent in prison, after adding their various remands and sentences together, of just over 5 years (5.17, s.d. = 5.65). Two-thirds had mental health concerns (87/130), over a quarter physical health concerns (36/130) and screening confirmed that all were struggling with problem substance use.

The core experience of this imprisonment

The core category or concern was of ‘routine’ within the prison. The most repeated elements were activities of daily living (‘got up’, ‘made a cuppa’, ‘food’, ‘fag’, ‘nap’, ‘TV’, ‘association’ (when prisoners are allowed to mingle freely out of their cells), ‘cleaning’), with most men making some reference to at least one of these. Most of these activities were just listed to us – without further comment – but in a few cases comments were explicitly negative – ‘do a bit of work, well I say work, fuck around on the computer. I’m wasting time [...] really’ (141); ‘I’m fed up of TV’ (230) (the number shown in parentheses indicates the particular man making the statement). A few men mentioned going to the gym or taking other forms of exercise, and a few were explicit about not doing so. Other activities sought by the men as part of a healthy routine but which required more initiative met mostly with limits and frustration. These activities were work, education and courses. Few men reported attending education or courses, but most were preoccupied with seeking work – ‘my brain needs to focus on something’ (217). More than half reported actually working, although often repetitive cleaning or prison maintenance, with some explicitly objecting to this: ‘I don’t want to just work for the prison’ (154). Others were explicit about the frustrations of trying to get ‘real work’: ‘I’m frustrated because I didn’t get a job’ (217). Many seemed accepting, coming back to the concept of routine: ‘You get into a routine and tell yourself it’s not forever’ (215).

This dreary routine also seemed to encompass the men’s experience of the outside world. Few men volunteered reference to family or friends, and most of these only in terms of ‘routine visits or phone calls’. The few men who referred to outside events with emotion were all negative: ‘they wouldn’t let me go to my Dad’s funeral; I was a bit upset’ (120);

'Nan passed away [...] someone came from the chapel [...] he asked if I was alright and if I was going to do anything stupid while I was in here' (211).

The model of adjustment to this imprisonment

The men all felt some sense of movement over the 3 weeks in relation to this 'routine'. Two directions of resolution were apparent. The stronger was passive movement towards feeling ever more trapped or 'banged up'. The weaker, experienced at all by very few, was of 'being busy' and even of 'time flying'.

Passive resolution was characterised by comments such as: 'The same stuff, day in day out, it just does your head in' (100); 'spend all my time sweltering in my cell' (219); 'banged up most of the time' (109). For a few, though, even this restrictive routine provided a kind of stability: 'I'm settled now. Been in 10 times and got my routine now' (128); 'I like the routine of prison' (253).

The very few men who described more active movement towards 'being busy' and 'time flying' were not only looking for 'new opportunities', but considered that they had found them: 'it's busy, and I like to keep busy' (106); 'time goes quicker now I'm doing stuff' (117). Just two men stood out as different because they specified that they themselves were trying to help others, which gave them a sense of purpose: 'I'm also the smokers' champion – I give people advice on coping strategies, just like being a listener really' (134); 'I've been cleared to be a prisoner listener. History of self-harm, so surprised, didn't ever think I would. Look forward to starting that' (153). Further, when these more positive things happened, prison staff were invariably also seen in a positive light and as helping them to move in a positive direction.

Barriers to and facilitators of adjustment

In this model of adjusting to imprisonment, the men volunteered particular barriers and facilitators as affecting direction of movement towards being trapped and bored or towards being busy. These broadly fell into two types – personal or prison issues.

Personal issues

The few personal issues raised relating to life outside prison were almost invariably described as problems, leaving the men feeling more restricted and trapped: 'I'm stressing a lot, thinking I'm a parent, shouldn't be here, I should be out there looking after my missus and kids' (102).

Reports of the impact of relationships in prison were more mixed. Some liked their relationships with other prisoners and thought they helped pass the time positively: 'chill out with the boys and have a chat, the boys are all good in here' (103). Most were more negative, with 'routine irritations' beyond their control promoting a negative path towards an increasing sense of entrapment: 'me and my cell mate just end up bugging the shit out of each other' (100); 'It's hell in here – kicking doors, bunch of kids' (207). There was an occasional report of loss of an in-prison attachment as a stressful 'outside-prison' issue: 'I was in with my other mate, but he went to [another] prison. I'm gutted. I won't be seeing him for three years – that's how long he's got left. I'll have to do another sentence to see him' (141).

Another major personal issue frequently referred to was ill health. Most comments indicated that this was a real barrier to progress and left individuals feeling restricted. Occasionally, these were in the form of a simple statement of fact: 'my liver is fucked' (112); 'I got a diagnosis. PTSD' (230). Sometimes state of health was a more explicit barrier: 'Won't let me go to the gym because of my blood pressure' (101); 'Sleeping mostly. My head is shot' (223). Six men, though, thought prison was helping or could help their health specifically: 'No, it's brilliant. I feel better and put a bit of weight on' (138); 'I've seen mental health today – let them know my frustrations. She is going to help me' (134).

Prison system issues

The prison system issues that most felt frustrated by were the 'routine blocks', or barriers, to their efforts which left them trapped in their poor health, boredom and numbing routine. Very occasionally, this was attributed to staff personally – 'Staff don't care' (238) – but mostly to the system. This was of particular concern in relation to health: 'I'm waiting to see the dentist. Remember I had toothache last time you came [3 weeks before]? Well I've got an abscess now. I asked to see the dentist, but I've not heard back' (147); 'I still haven't seen mental health' (222); 'I was pissing blood and passed kidney stones on Monday. There is no help in here' (148). Prison issues posing barriers to occupation were commonly described, with most wanting to be productive but being frustrated in their efforts: 'I've applied for everything, I'll do anything' (262); 'You read the prison policies and they say you must work and I'm here begging for it. I've spoken to the officers [...] I've put three apps [applications] in so far. I said I would kick off in a week if I didn't get something but my partner said it's not worth it' (217); 'You don't seem to get anywhere when you put the applications in – we made a complaint but I haven't heard anything about that either' (247); 'I think the system is designed to break you' (156). Prison-system problems were thus generally seen as frustrating recovery and a direct barrier to progress.

Discussion

'Routine' is, by definition, made up of a series of repeated, expected actions. In some form, it is ubiquitous among human beings. It may be imposed in order to influence behaviours. Institutions, almost by definition, impose routines, whether deliberately or otherwise, so it may seem unsurprising that men put routine at the core of their experience of being in prison. The routine that most men reported, however, was impoverished and seemed comparable to reports from the end days of the big 'asylums' for people with mental disorder, in which the patients tended to become as impoverished as their environment.^{15–17} Wing¹⁸ subsequently emphasised that this could happen in the community too if resources were limited. A difference between the patients described by Wing and colleagues and these prisoners is that none of these prisoners had enduring psychotic illness, so it is possible that they were less vulnerable. A few prisoners welcomed the basic, limited repetitiveness of the experience and a very few found positive ways through the system. Most were explicit about finding the limitations frustrating and being unable to affect their situation. To what extent, however, could we rely on these accounts from, perhaps, disgruntled men and to what extent is this a consistent experience?

Other evidence on the experience of being in this prison

There is an independent inspectorate of prisons for England and Wales (HM Inspectorate of Prisons), which conducts reviews of individual prisons as well as occasional thematic reviews of needs and services in them (<https://www.justiceinspectorates.gov.uk/hmiprisons/>). Fortunately, an unannounced inspection of this prison took place in 2016, more or less at the same time as this research. The resultant report, despite referring to 'a decent, hard-working staff group who had maintained good relationships with the men in their care, and had done well to keep the prison stable through some challenging times' (p. 5), highlighted how low staffing levels had affected the responsiveness of staff to the needs of the men in the prison.¹⁰ In 2016, for example, only 16% of prisoners' call bells were responded to within 5 min, compared with 39% in 2013; timetabled activities were run less often, application response rates fell from a 59% within 7 days in 2013 to 31% in 2016, and only 5% of men reported spending more than 10 h out of their cells in 2016 but 10% in 2013, all significant differences. This all fits with the limitations that the men in our sample were citing. It indicates that the prison milieu may be subject to substantial changes over time. This has implications for all prisoners and their chances of 'reform'. From a trialist's perspective, it is clear that 'treatment as usual', the traditional standard against which psychosocial interventions are evaluated, must be measured in some detail in order to understand its meaning and potential impact. For clinical and criminal justice system practice, staff should be aware of the potential impact of the milieu on what they can deliver.

How prisoner experience after staff cuts compares with experience at a better staffed time

We were able to consider the model of prisoner experience and adjustment for the years 2014–2016 in the context of data we collected in a similar way from similar men in this prison (and another in South Wales) in 2007–2008, before the prison staff cuts.¹⁹ In that study, narratives were much longer and richer, to the extent that we had clear data saturation (no new categories of information emerging) after just 20 cases. This in itself fits with the possibility that the later sample of men were, indeed, already so restricted by their ‘routine’ that they were less engaged in thinking and talking about themselves and their experiences. The core concern of these similar men in prison during the better staffed period was of the losses inflicted by the imprisonment and how awful the experience was. Although, even then, there was some passive resolution of this concern by ‘getting used to it’, most invoked a sense of active movement towards becoming ‘alright’, which meant feeling and getting better, making positive changes and developing good relationships. The men in the earlier sample spoke much more about how much they were missing people, freedom, information and other resources, whereas those in the current sample were much more focused on prison *per se*. The study samples were of different men, but as their age, sentences, prior experience of imprisonment and rates of reported mental health difficulties were so similar (the earlier sample is described in Taylor *et al*, 2010⁵), it is reasonable to consider that the difference in prison milieu and experience has had an impact.

Souza & Dhami,²⁰ in a quantitative study of men in two English prisons at about the same time as our earlier study, also cited losses of family, friends and freedom as the hardest experiences reported by first-time and recurrent male prisoners, but also some resolution of problems through improving health and having opportunities for rehabilitation. They then argued that positive engagement or not was better explained by aspects of life before imprisonment and overall exposure to imprisonment than by prison security or regime. They could not envisage the extent of imminent cuts, and we must now question whether, for most prisoners, impoverished regimes force their focus onto prison conditions *per se* and limit capacity for concern about others and/or reflection and development.

The advantages of richer routines

Behan²¹ examined the specific prisoner experience of educational programmes. Although some prisoners wanted to ‘better themselves’, gain new skills and prepare themselves for work on release, some used these programmes as a way of coping with their imprisonment, saying that it took their mind off their experience in prison and ‘killed time’. This use of education to better oneself or as a coping strategy resonates with the narratives given by our sample of men, some of whom were clearly wanting to develop their skills and abilities, whereas others just wanted to get out of the cell or the wing or simply fill the time. Behan suggests that attendance for experiences such as education may also give a greater sense of agency in being able to control their prison routine. Our men commonly found themselves frustrated and without agency because they wanted to be at education or, more likely, work and could not get there.

Nurse *et al*²² found, in a qualitative study of prison environment and mental health of prisoners and prison staff, that understaffing and a lack of activities led to increased stress and frustration among prisoners. The men in their sample, like those in ours, viewed any activity as important to ‘stimulate your mind’. Nurse and colleagues, however, found more tension between prisoners and staff than in either of our studies. Their data were, however, collected through focus groups rather than individually. It may be that prisoners feel more need to complain about staff when other prisoners are listening than when they can talk in private.

Reiter *et al*²³ were wide ranging in their inquiries about prison experience, covering a broader range of prisoners and prison conditions than we did. All our prisoners were living in ‘ordinary locations’ within the prison during the study. Nevertheless, it is striking that in the relatively well-staffed Danish prisons of the Reiter study, men’s experiences had more in common with those in the earlier of our studies. The Danish prisoners too seemed very aware of what they were missing by being in prison and, although making references to in-prison conditions, did not appear so mentally bound by their routine as the men in our ‘austerity prisoner sample’.

Limitations

This was a qualitative component of a wider study and not set up as a primary open inquiry in its own right. Nevertheless, the question about experience of imprisonment was planned, open ended, consistent and posed before any other questions at the second interview after the men had had about a month of experience of imprisonment. The interviews were not audio-recorded, so the notes and final written record of the responses could not be checked except against each other, but as responses were generally not long or complex, we think it extremely unlikely that any key word or phrase was missed. The researchers collecting the data experienced some of the same frustrations in accessing the prisoners as the prisoners did in their daily living, which could have coloured data recording, but consistency on some key issues with the report published by HM Inspectorate of Prisons¹⁰ mitigates against this.

We have suggested that the dull, restricted, almost institutionalised experience of the men, so different from that of an earlier cohort, related to staff cuts. It is impossible to rule out other explanations completely, but the reduction in prisoner officer numbers from about 200 to fewer than 150 was the main observable change. Numbers and types of prisoner overall remained the same and there were only modest differences between research cohorts in likely key measures. Although all of the men in our later cohort screened positive for substance misuse so did 84% in the earlier cohort; 74% of the men in the earlier cohort had had prior experience of imprisonment, but so did 80% in the later cohort.

Summary and implications

Focus on prison ‘routine’, which tended to leave prisoners feeling trapped, dominated short-term prisoners’ accounts of their time in this one UK prison at any time between July 2014 and August 2016. They did not raise concerns about the awfulness of the losses of family, friends and freedom incurred by imprisonment, as men in an earlier cohort had done, and hardly referred to the outside world. They rarely reported any positive resolution, which had been prominent among the men in the earlier study. The large change in staffing levels made a difference to the environment, and it seems that the core experience and adjustment of prisoners cannot be assumed to be a constant in such a context. Indicators that the later men were experiencing ‘institutionalism’, not apparent in an earlier, better staffed time, should concern those who fund and commission prisons.

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Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2020.2>.

[click here to view supplementary material](#)

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1.3.62 Evaluation of the physical health of adolescent in-patients in generic and secure services: retrospective case-note review

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Abstract**Aims and method**

To assess physical health needs of adolescent in-patients by routine monitoring. A retrospective analysis of case notes was conducted on a 6-month intake to generic and secure adolescent mental health units in Greater Manchester, UK.

Results

Fifty individuals were admitted (52% female, average age 15.84 years). Diagnoses varied and 66% were prescribed medications before admission. All had a physical health assessment, which identified various physical health risk factors. Average body mass index was 25.99 (range 15.8–44), and increased during in-patient treatment for 84% of individuals who had their body mass recorded more than once. A total of 28% of individuals smoked. Lipids and prolactin levels were elevated across the sample.

¹ **Declaration of interest:** None.

Clinical implications

This evaluation strengthens the argument to optimise physical healthcare for adolescent in-patients and develop physical health interventions, particularly given that we observed elevated lipids and prolactin. Physical health and well-being may not be prioritised when assessing and managing young peoples' mental health, despite their increased vulnerability for comorbid conditions.

Contents

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People with serious mental illness (SMI) experience poor physical health, resulting in an estimated loss of life of 30 years.¹⁻³ This is because of unhealthy lifestyles, medication side-effects and inadequate physical healthcare.^{1,2,4} It occurs early, often preceding the onset of illness, thus offering the opportunity to intervene to prevent comorbid conditions.^{5,6} Young people with mental health disorders are a vulnerable group requiring additional physical healthcare.^{1,7} Adolescent in-patients are particularly at risk, given the 'obesogenic' environment.^{8,9} This refers to additional restrictions and barriers to living a healthy lifestyle, such as reduced opportunities to exercise, lack of control over dietary intake and increased access to highly calorific snack foods. It may also be their first contact with mental health services, and affords the opportunity to intervene on an individual level through treatment access, and on a wider scale. For example, ensuring the environment encourages a healthy lifestyle and reduces the chance of iatrogenic harm. However, the precise physical health needs of adolescent in-patients is still unclear. A previous Australian study found that physical health problems are common in adolescent mental health settings, yet often go undetected and untreated.¹⁰ Previous evaluations suggest physical healthcare is inconsistent across services, including in-patient units, neurodevelopmental clinics and community services.¹¹⁻¹³ Therefore, indicators of poor physical health are missed. However, this issue has not been evaluated in UK generic/secure adolescent in-patient services, where individuals present with a range of disorders on a variety of medications. Therefore, we aimed to evaluate the physical health needs of adolescent in-patients by routine monitoring in services in Greater Manchester, UK.

Method

A retrospective analysis was conducted on electronic files of individuals admitted to generic and secure adolescent in-patient units over 6 months in Greater Manchester, UK (August 2018 to February 2019).

Setting

The service is made up of units Junction 17 (generic) and Gardener (male secure). Junction 17 is a 20-bed, mixed-gender, generic adolescent in-patient service that provides various evidence-based treatments for young people with complex mental health needs. The young people admitted to the unit present with mental health symptoms that are of a severity such that they are unable to keep themselves safe, or require intensive treatment above and beyond the scope of community mental health teams. Individuals have a range of diagnoses and mental health needs, yet all are experiencing a high level of psychological distress. It also has a day service to provide alternatives to in-patient care (patients attending this were excluded from this evaluation). Referrals are received via regional child and adolescent mental health services and adult mental health services for adolescents aged 13–18 years with needs that cannot be met safely within the community. They receive intensive therapies and treatment in line with National Institute for Health and Care Excellence (NICE) guidelines and have access to a range of psychological therapies (individual and group), occupational therapy based activities and family interventions. The Gardener unit is a specialized, ten-bed, national medium secure in-patient service for adolescent males with complex health needs that cannot be met safely within the community or by standard mental health services. It is one of seven nationally commissioned services by National Health Service (NHS) England for adolescents. Referrals are received from mental health teams via a national referral process. There is also an onsite educational facility for young people provided by the Bury Educational authority. Multidisciplinary teams consist of consultant psychiatrists, psychiatric trainees and colleagues from nursing, psychology, occupational therapy, family therapy, dietetics, social work and advanced practitioners with non-medical prescribing and physical health monitoring skills.

Although ethical approval and informed consent were not sought, the evaluation was considered necessary by the clinical leads within the trust who are responsible for approving audit and service evaluations. The audit and evaluation team at Greater Manchester Mental Health NHS Foundation Trust was informed of the rationale for this evaluation and reviewed the data that was to be extracted, along with the clinicians' approval. They approved this process and provided the research team with a list of patient identification numbers to be used to extract the data. No identifiable information was extracted from the patient files and the process was conducted in line with the local guidance for service evaluations.

Outcome measures

A structured audit tool was developed with Microsoft Excel. The following demographics were collected: gender, ethnicity, employment and living status, legal status and age on admission. Clinical variables included primary diagnoses, length of stay, discharge status and medication. Medication was recorded at two time points; the first was upon admission (this included any pre-existing prescriptions before their admission) and the second included medications prescribed at the time of discharge, or any current medications if the individual remained an in-patient at the time of the search. To maintain patient confidentiality no identifiable information was recorded.

The Physical Health Improvement Tool (PHIT) is a standardised measure developed within the service to collect physical health data for individuals upon admission. It is an electronic document that enables clinicians to record physical health assessments (blood tests, electrocardiogram (ECG), body mass index (BMI)), body composition, physical health observations, and lifestyle factors such as smoking habits, alcohol use (Alcohol Use Disorders Identification Test; AUDIT¹⁴), substance use, physical activity and diet, sexual health and referral to other services, e.g. sexual health services. BMI was recorded on the PHIT tool shortly after admission; some individuals also had their BMI recorded at subsequent time points, which enabled change in BMIs to be calculated.

The standard procedure for physical health monitoring is set according to the local physical health and well-being policy (Greater Manchester West Mental Health NHS Foundation Trust Physical Health and Wellbeing Policy, 2011).¹⁵ The policy recommends a PHIT¹⁶ assessment within 24 h of admission, and all individuals are to be offered appropriate

lifestyle interventions in line with NICE guidelines.⁷ The PHIT tool enables clinicians to select whether individuals were offered lifestyle interventions such as smoking cessation, diet and exercise advice, and referral to drug, alcohol and sexual health services.

Data extraction and analysis

A manual search of patient files was conducted from 12 to 19 February 2019 for the previous 6-month intake across generic and secure services (August 2018 to January 2019). Descriptive analysis was conducted with SPSS version 22 for Windows (IBM Corp., 2013) and Microsoft Excel 2016 for Windows.¹⁷

Results

Sample

Fifty individuals were admitted between August 2018 and January 2019 to the generic and secure services (52%, $n = 26$ females, 76% White British; *Table 1*). The average age at admission was 15.84 (range 13–21, s.d. 1.46) years. Average length of stay was 49 (range 2–169, s.d. 44.1) days. Nine (18%) were detained under the Mental Health Act 2007.¹⁷ *Table 1* Demographic information

Inpatient admissions	n	%
Junction	174	59%
Gardener	51	10%
Gender		
Male	24	48%
Female	26	52%
Ethnicity		
White British	38	76%
Any other White background	3	6%
Other ethnic group, Chinese	1	2%
Mixed, any other mixed background	1	2%
Other ethnic group, any other	1	2%
Black/Black British, any other	1	2%
Black/black British, African	2	4%
Employment status		
Education/training	35	70%
Unemployed	4	8%
Not recorded/stated/unknown	1	2%
Living status		
Lives with parents	5	10%
Not recorded	4	8%
Legal status	19	38%
1983 MHA section 47/49	1	2%
1983 MHA section 36	1	2%
1983 MHA section 22	4	8%
Informal	7	14%
None	3	6%
Discharge outcome		
Remains current inpatient	1	2%
Discharged	3	6%
Diagnoses		
Depressive/mood disorders	9	18%
Adjustment disorders	8	16%
Mixed anxiety and depressive disorders	7	14%
Null/not recorded	6	12%
Autism/Asperger syndrome	4	8%
Attention disturbances	3	6%
Psychotic disorders	3	6%
Conduct disorders	3	6%
Eating disorders	2	4%
Anxiety disorders	2	4%
Obsessive–compulsive disorder	1	2%
Learning difficulties	1	2%
Intentional feigning of symptoms	1	2%

Diagnoses and medication

Individuals had a range of diagnoses, primarily mood disorders (e.g. moderate depressive episode) ($n = 9$, 18%), adjustment disorders ($n = 8$, 16%) and mixed anxiety/depressive disorders ($n = 7$, 14%) (see *Table 1* for full list of diagnoses). Thirty-three (66%) were prescribed medication on admission and 32 (64%) received medication upon discharge or at the time of the search. A total of 38% ($n = 19$) were prescribed antidepressants, 18% ($n = 9$) were prescribed antipsychotics and 2% ($n = 1$) were prescribed anxiolytics at discharge or time of the search. A range of non-psychotropic medications were also prescribed to individuals for physical comorbidities such as digestive complaints and dermatological issues (see Supplementary Tables 1 and 2 available at <https://doi.org/10.1192/bjb.2019.68>).

Physical health assessments

All new admissions received a physical health assessment, recorded on the electronic records with the PHIT tool. However, the extent to which the assessments were completed in full varied for each variable, and some information was missing at the time of the search either because of a delay in paperwork processing or patient or staff non-adherence.

² MHA, Mental Health Act 2007.

Smoking and alcohol use

Smoking rates were higher than the general population as 28% currently smoked, compared with the average of 12% for young people in the UK.²⁰ The amount of cigarettes smoked daily varied ($m = 11$, range 2–40, $n = 7$) and two individuals reported the age they started smoking (9 and 11 years). Nine smokers used cigarettes (64%) and three used roll-ups (21%). Six (42% smokers) individuals received nicotine replacement therapy as part of their routine care (Table 3). Table 3 Lifestyle assessments Physical lifestyle assessment Yes, n (%) No, n (%) Not reported, n (%) Reports a diet high in fat and salt 30 (60%) 20 (40%) Lives a sedentary lifestyle 8 (16%) 42 (84%)—Aware of the risks of a sedentary lifestyle 44 (88%) 6 (12%)—Referral made to physical activity advice 1 (2%) 18 (36%) 31 (62%) Smoking status Non-smoker (history unknown) 23 (46%) Current smoker 14 (28%) Never smoked 10 (20%) Ex-smoker 3 (6%) Alcohol use Completed, n (%) Mean (s.d.) Range Units of alcohol consumed per week 49 (98%) 1.02 (4.44) 0–30 AUDIT total 49 (98%) 0.81 (2.40) 0–14 Frequency of alcohol consumption Yes, n (%) Weekly (4 or more) 1 (2%) Weekly (2–3 times) 1 (2%) Monthly (2–4 times) 4 (8%) Monthly or less 3 (6%) Never 40 (80%) Not recorded 1 (2%) Quantity of drinks on typical day None 40 (80%) 1 or 2 4 (8%) 3 or 4 3 (6%) 10 or more 1 (2%) Not recorded 2 (4%) Times consumed 6 (female) or 8 (male) drinks on a single occasion Daily or almost daily 1 (2%) Weekly 1 (2%) Monthly 0 Less than monthly 4 (8%) Never 42 (84%) Not recorded 2 (4%) Substance use Yes 6 (12%) Yes previous 3 (6%) No 39 (78%) Not recorded 2 (4%)⁵

As part of the initial PHIT assessment individuals were screened for alcohol use with the AUDIT tool.¹⁴ Alcohol consumption was low, and most individuals abstained ($n = 40$, 80%). Individuals were also screened for substance use ($n = 48$, 96%). Six (12%) used substances on admission and three (6%) used substances previously, including cannabis, cocaine, ketamine, LSD and aerosols.

Sexual health

Sexual health was discussed with ten individuals. This included whether they practiced safe sex ($n = 10$, 20%) or used contraception ($n = 9$, 18%). For females, relatively few files contained information on human papillomavirus vaccination status ($n = 9$, 35%), whether they experienced amenorrhoea ($n = 6$, 23%) or if they were pregnant ($n = 5$, 19%; no pregnancies). For males, the presence of symptoms such as erectile dysfunction were discussed with some individuals ($n = 5$, 21%). One referral was made to sexual health services.

Discussion

The entire sample received routine physical health monitoring, and multiple various health recordings were conducted as part of these assessments. Individuals had a range of diagnoses, and displayed evidence of physical health issues requiring some form of assessment, monitoring and intervention. This is consistent with adult in-patient populations. Individual risk factors for poor physical health included high levels of obesity upon admission, subsequent weight gain, high levels of self-reported sedentary behaviour, increased smoking rates and some evidence of increased levels of lipids and prolactin. For some young people prescription of medication with metabolic side-effects included increased sense of hunger. Therefore, some of the antipsychotic medications may also be a risk factor, although only 18% of young people were prescribed antipsychotic medications in this cohort. Further information is needed to establish the dietary intake of young people and there is a need to introduce standardised measures for physical activity and diet. This evaluation highlights the vulnerability of young people admitted to in-patient wards and emphasises the opportunity this presents for physical health to be monitored, assessed and treated routinely. Although many risk factors for physical

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AUDIT, Alcohol Use Disorders Identification Test.

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health may predate the admission, contact with health professionals during an in-patient stay affords the opportunity for healthcare provision.

Clinical implications of findings

Our findings have important clinical implications for adolescent in-patient settings.

The ‘obesogenic’ environment

The ‘obesogenic’ environment of in-patient wards has frequently been discussed in the literature.^{8,9} This has been attributed to higher energy intake through increased access to high-calorie foods, reduced energy expenditure through inactivity and fewer opportunities to engage in exercise.^{8,9} Our evaluation adds further evidence to this as individuals had high BMI values, which rapidly increased with duration of stay. Weight gain in mental health services is often attributed to side-effects of antipsychotic medication; however, only a small proportion of young people were prescribed antipsychotics and those who were not also gained weight.

Unhealthy lifestyles were often reported by the clinicians. Although many received advice on living a healthy lifestyle, research has consistently shown that advice alone is insufficient to result in meaningful behaviour change.^{21–23} Clinicians should be aware of using proactive approaches to implementing lifestyle interventions and encouraging uptake of routinely offered physical health activities, such as occupational therapy groups (e.g. walking). People with SMI experience significant barriers to living healthily, such as low mood and anxiety, poor motivation, lack of social support, reduced opportunity, lack of knowledge and skills, financial barriers and employment difficulties.^{24,25} This group also has additional restrictions of being on secure and adolescent in-patient wards, living in a contained environment with relatively reduced access to facilities and outdoor opportunities. Therefore, interventions taking these additional barriers into account need to be explored, and these difficulties should be considered when attempting to promote health and well-being in this setting.

Because of the limited data available on food intake on the in-patient wards, we were unable to assess the adolescents’ diet. At the time of this evaluation, routine dietary assessments were not yet conducted upon intake. This is an important and valuable opportunity to collect information on young people’s eating habits and identify appropriate interventions to promote healthier diets. Systematic ways of recording food choices and dietary intake will need to be developed to facilitate this process. This could include simple charting of meal options on patient files, and conducting routine diet assessments with individuals, such as 24-hour recall to include any other foods consumed outside of regular mealtimes. Monitoring of diet will allow appropriate interventions to be targeted to those who are most in need to prevent the likelihood of weight gain.

Other physical health issues

Many patients were prescribed medications to alleviate physical health problems upon admission. There was also evidence of dysregulated blood metabolites and elevated levels of prolactin in over half of this sample, which is common in people with SMI.²⁶ Hyperprolactinaemia can have serious consequences, such as hormonal disturbances causing sexual dysfunction, facial hair and acne, disruption to usual pubertal development in young people and increased risk of developing cancers such as breast cancer.^{26–28} This is addressed appropriately within the service and monitoring of bloods is conducted routinely. It is important for clinicians and healthcare teams to maintain routine monitoring of blood metabolites and endocrine markers as there are often no obvious symptoms to indicate individuals are at risk. Ensuring blood tests are conducted routinely, regardless of medication or diagnosis, is important. Additionally, information about sexual health screening was variable, and at the time of the search only 10% had discussions about their sexual health. This is a common issue across adolescent services. For example, a previous review found that only 37% of young people had sexual health screening upon admission to an in-patient unit.²⁹ This represents a missed opportunity for management of sexual health in a high-risk group.

Importance of monitoring

We add to the growing evidence that physical health monitoring in mental healthcare is necessary, particularly for adolescents.^{11–13,30–32} Previous research also shows that metabolic abnormalities are common in adolescents receiving mental healthcare, but often go unnoticed and untreated.^{6,10,13,21} Individuals admitted to generic and secure mental health wards have a wide range of difficulties and non-specific mental health needs, and may or may not be prescribed psychotropic medication. It is therefore important to develop clear guidelines and policies that focus on adolescents in mental healthcare, regardless of their diagnosis or physical health status. Senior clinicians should acknowledge this when developing the standard operating procedures for their units and ensure that physical health is a fundamental part of individuals care when staying on adolescent in-patient units.

Recommendations and future work

There is a pervasive need to explore health interventions for this group and identify the best way to deliver these within in-patient settings. Future work should focus on developing physical interventions to reduce the cardiometabolic risk associated with the in-patient environment. Hayes *et al* reviewed non-pharmacological interventions delivered on in-patient wards and found psychosocial programmes, such as therapy-based activities, family interventions and mindfulness-based activities, were common.³² Yet, few studies have been conducted offering physical health interventions within this setting, or even those across the general population, despite the benefits of exercise for adolescents.³³ Further, a recent review showed that despite being recommended by NICE, lifestyle interventions are not consistently offered across mental health trusts in the UK.³⁴ Standardised guidance also needs to be developed to guide clinicians and ensure adolescents are receiving high-quality physical healthcare regardless of diagnosis and in-patient status. This includes introducing formal assessments of diet and physical activity to better quantify adolescents' needs. Ensuring access to interventions alongside continued monitoring of physical health is imperative to improving outcomes for adolescents.

Strengths and limitations

To date, this is the first evaluation of adolescent in-patient generic and secure services that assesses routine monitoring of physical health. The findings carry significant implications for service development. This work has only been made possible because of the high levels of work happening within the unit to record all of this data, and the importance placed on ensuring the physical health assessments are conducted for all young people on admission to the units. However, this clinical audit taken from a cross-section of this population is only representative of one specific area, and the trans-diagnostic nature of the service means that physical health issues identified may change over time given the rapid turnover of young people, particularly within generic in-patient services. However, it is likely that the issues and difficulties identified here will be prevalent across mental health trusts. There is potential that some assessments identified as missing had indeed been conducted, and the data may have been uploaded after the files were searched. There is also potential for the data to exist in paper format within the service, or exist elsewhere in the electronic files rather than the physical health tool, thus resulting in some missing data. As with all routinely collected measures, they are subject to human error and reliant on accuracy of the clinicians completing the forms.

In conclusion, this evaluation strengthens the argument for optimising physical healthcare for adolescent in-patients. Adolescents admitted to generic and secure in-patient services show increased cardio-metabolic risk in the form of weight gain, obesity and dysregulated blood metabolites. We suspect that our findings are not unique to this unit and there is a need to consider physical health in adolescent in-patient services across the UK. There is a need to implement standardized routine monitoring guidelines for physical healthcare for adolescent in-patients, given their increased vulnerability, and also develop appropriate interventions in collaboration with young people to tackle the physical health disparities experienced by this group.

We acknowledge the work of all the clinicians and staff at the adolescent generic and secure in-patient services at Greater Manchester Mental Health NHS Foundation Trust to which this service evaluation would not have been made possible.

Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2019.68>.

[click here to view supplementary material](#)

This research has received no specific grants from any funding agency, commercial or not-for-profit agencies.

The data included in this manuscript was extracted from routinely collected data from within the service. The data is available on secure NHS servers and, for the purpose of this study, no identifiable information was collected.

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1.3.63 Lean management in a liaison psychiatry department: implementation, benefits and pitfalls

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Abstract

Aims and method

To apply process mapping, a component of lean management, to a liaison psychiatry service of an emergency department. Lean management is a strategy that has been adapted to healthcare from business and production industries and aims to improve efficiency of a process. The process consisted of four stages: individual interviews with stakeholders, generation of process maps, allocation of goals and assessment of outcomes.

Results

There was a significant reduction in length of stay of psychiatric patients in the emergency department (median difference: 1 h; $P = 0.015$). Five of the six goals were met successfully.

¹ Declaration of interest None.

Clinical implications

This article demonstrates a management intervention that successfully reduced length of stay in an emergency department. Further to the improvements in tangible (quantitative) outcomes, process mapping improved interpersonal relations between different disciplines. This paper may be used to guide similar quality improvement exercises in other areas of healthcare.

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Lean management is a process that has been adapted for use in healthcare from business and production industries. Its usefulness has been demonstrated in medical settings, where it generates enhanced staff understanding and improved, coordinated delivery of care.¹⁻³ Research indicates similar benefits in behavioural crisis units⁴ but its use in an emergency department liaison psychiatry setting has not been demonstrated. Although psychiatric patients comprise a minority of emergency department presentations, they require a disproportionate amount of time and resources, which can frustrate emergency department staff and cause negative attitudes towards such patients.^{5,6} Myriad factors underlie this, such as lengthy waiting times, interpersonal difficulties and procedural ambiguity. These factors are often long-standing and resistant to change, but lean management processes, when executed appropriately, are an accessible and effective way of effecting meaningful change.

Prolonged length of stay was a recurrent source of contention and discontent in this emergency department before the process was undertaken. Boarding or lodging of psychiatric patients awaiting admission to psychiatric units is common and, for various reasons, these patients spend longer in the department than their medical and surgical counterparts.⁷ The requirement for 'medical screening' is contributory, but avoidable non-clinical factors, such as health insurance or lack of transport, are known to play a significant role.⁸ In addition to straining resources, patients who spend longer in

an emergency department are more likely to suffer adverse outcomes or incidents, such as medication errors.⁹

Workplace incivility is a further stressor that is reportedly commonplace in emergency departments,¹⁰ and is compounded by the phenomenon of ‘silo working’, whereby different departments operate in isolation from each other.¹¹ In addition to contributing to an unpleasant work environment, interpersonal conflicts interfere with provision of collaborative and efficient care. Efficient and coordinated delivery of care is essential to optimising the quality of treatment provided.¹²

Aims

To execute and describe a quality improvement process consisting of: mapping the psychiatric patient’s journey through the emergency department, using data from all involved healthcare professionals (stakeholders) identifying weaknesses in the system, such as duplication of work, role confusion, communication errors and unnecessary delays(iii) generating immediate and short-, medium- and long-term goals to improve service provision.To evaluate and quantify outcomes of the quality improvement process, including: (i) length of stay of patients in the emergency department before and after the quality improvement intervention(ii) attainment of goals after intervention.

Method

Setting

This quality improvement exercise was executed in the emergency department of an urban university tertiary-referral hospital, processing in excess of 55 000 patients per year. This is a 24-hour emergency department that receives on average 29 psychiatric referrals per week. Mental health assessments are carried out by the consultation liaison psychiatry service during working hours and on-call psychiatry out-of-hours.

The process was executed in four stages: stage I – stakeholder interviewsstage II – generation of process mapsstage III – interdisciplinary meetingstage IV – assessment of outcomes.

Over a period of 3 months, we conducted interviews with 11 staff working in the emergency department.

Selection of participants

The proposal for this project was submitted at an in-house Emergency-Psychiatry Management Meeting. We applied to interview 11 stakeholders – staff members from different disciplines who are routinely involved in providing care for mentally ill patients in the emergency department. They were: one emergency department triage nurse, one emergency department nurse, two emergency department doctors, one liaison psychiatry registrar, two liaison psychiatry nurse specialists, one psychiatry registrar on-call, one social worker, one healthcare assistant and one security staff. The data were to be collected by a senior member of the psychiatry team not routinely involved in first-line care in the emergency department.

Ethical approval

Exemption from ethical approval was granted by the Ethics Committee in St Vincent’s University Hospital, Dublin, on the basis that there was no direct patient involvement in this study.

Stage I: stakeholder interviews

The purpose of stage I interviews was to elicit details of individual staff members' management of psychiatric patients in general, in order to map a generic template of the interaction, from beginning to end, between psychiatric patients and specific disciplines, such as social work.

Duration of interviews was 40–60 min, concluding when no new data were being generated.

In an individual face-to-face meeting, the stakeholder was invited to describe their involvement with psychiatric patients in the emergency department, beginning from the point at which they first become aware of the patient and concluding with their last contact with the case. The participants were asked to describe interactions with psychiatric patients in general, rather than specific issues that had arisen with individual patients.

The purpose of the interview (stage I) was explained to each participant. They were informed that they would be invited to participate in stages II and III at a later date. They were advised that the interviewer would redirect them if they began to engage in stage II or III discussion.

Participants were first asked open questions, such as 'Tell me about your first contact with a psychiatric patient in the emergency department', followed by more closed questions, such as 'How long does this component take?' Further questions were raised to identify specific weaknesses, such as duplication of work, role confusion, communication errors and unnecessary delays.

To reduce bias from the interviewer, the participant was allowed to speak without interruption except when redirection or clarification was required. Participants were redirected back to the routine care pathway if they began to discuss problem-solving.

Stage II: generation of process maps

A working flow diagram of each participant's involvement was drawn up during the interview and the participant was asked to make any comments or changes before the meeting ended.

The information was transformed into an overview process map showing the patient journey and maps representing the role of each individual stakeholder (*Figs 1 and 2*). Fig. 1 The overview process map, detailing the pathway of psychiatric patients through the emergency department. (a) Baseline map; (b) map with problem areas superimposed (marked by 'no access' symbol). ED, emergency department; SW, social work; GP, general practitioner. Fig. 2 An individual process map representing the role of the liaison psychiatry nurse specialist: 3–4 h pathway of patient assessment and management in the emergency department (ED). HCA, healthcare assistant; OPD, out-patient department; ED, emergency department; GP, general practitioner.

Stage III: post-interview stakeholder focus group and goal-setting

All stakeholders and heads of departments (medical, nursing, liaison psychiatry, social work, security) were invited to participate in a focus group. The focus group consisted of ten individuals.

The overview (integrated) map and individual maps (*Figs 1 and 2*) were scrutinised for weaknesses or pinch points. No solutions were suggested or elicited at this stage. Weaknesses were itemised into four groups: role confusion, duplication of work, unnecessary delays and communication deficits. A problem list was collated and distributed. Stakeholders were asked to categorise items according to priority (1, low priority; 2, medium priority; 3, high priority) and to mark a timeline for implementation (immediate, less than 1 month, more than 1 month). After consensus was reached on target areas (items that scored >20), stakeholders were invited to generate potential solutions. Responsibility for each target area was allocated (*Table 1*). *Table 1* Results of six targeted areas for change, including action prescribed, individual assigned and projected timeline

Proposed improvement	Weakness targeted	Action	Person responsible	Timeline
At 6-month follow-up ^a	Efficient handover after psychiatric assessments	i, ii, xiii, xiv	Designated emergency department staff members (team leaders A and B)	to be the contact for psychiatry staff about all psychiatric patients in the emergency department
	Psychiatry consultant to inform psychiatry staff;		emergency department clinical nurse manager	to

inform emergency department nurses Immediate Target met on projected timeline Emergency department staff access to liaison psychiatry team at morning shift-change i, ii, iii, xiii, xiv, xvii Priority discussion for emergency department nurse manager or social worker or emergency department doctor at liaison psychiatry handover meeting at 09.00 h Psychiatry consultant to restructure handover meeting Immediate Target met on projected timeline Refine referral pathway (emergency department to psychiatry) v, vii, viii, ix, x, xi Default referral to psychiatry is by emergency department medical staff, not triage or emergency department nurse. MITT to reflect this Emergency department consultant to change MITT protocol. Emergency department nurse manager to inform triage nursing staff. Immediate Target met on projected timeline In limited circumstances, as defined, direct referrals are possible Emergency department and psychiatry consultants to agree criteria for direct referral pathway between emergency department and psychiatry Immediate to 1 month Target met on projected timeline Define medical screening vii, x, xi Emergency department and psychiatry consultants to collaborate on medical screening requirements Emergency department and psychiatry consultants 1 month Target revised and excluded at clinical meetings (see section IV: attainment of outcomes) Prevent or manage acute agitation in psychiatric patients v, vi Implementation of psychiatric medication chart for patients awaiting transfer to approved psychiatric unit. Psychiatry will prescribe 'as required' medication and give advice proactively and preemptively Psychiatry consultants to inform psychiatric registrars Immediate Target met on projected timeline Formalise the role of security staff vi, xv Clarity about legal obligations and safeguards in relation to restraint and detention Psychiatry consultants to provide formal written guidance and training for security staff 1 month Target met on delayed timeline (3 months)²³

Stage IV: assessment of outcomes

Outcomes were evaluated 6 months after completion of stage III. Outcomes were patient length of stay in the emergency department and attainment of goals (*Table 1*).

Statistical analysis

Lengths of stay of samples of patients referred for psychiatric assessment were measured over a 3-month period before commencing the process (January–March 2017) and over a 3-month period 6 months after the intervention (January–March 2018). In total, 190 pre-mapping patients and 190 post-mapping patients were compared. Distribution of data was calculated using the Shapiro–Wilk test. Statistical significance was calculated using the Mann–Whitney test and effect size was calculated by the difference between median lengths of stay in the pre-mapping and post-mapping groups. This was a convenience sample that represents over half the total number of psychiatry consults in emergency department over the 3-month post-mapping period. This was a convenience sample that represents over half the total number of psychiatry consults over a 3-month period, chosen from cases that were labelled as psychiatry consults on the emergency department's patient-processing software.

² MITT, Mental Illness Triage Tool.

³

a. Five of the six targets were met, one on a delayed timeline. One target was discarded at subsequent clinical meetings.

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Results

Stage I: stakeholder interviews

Each of the 11 interviewees described their involvement with psychiatric cases, which were mapped onto individual maps (*Fig. 2*). The difficulties encountered were also elicited and categorised into four problem areas and 17 targets (i–xvii). Delays: on-call psychiatry doctors reported delayed handover of updates from emergency department staff(ii)emergency department nursing reported delayed handover from psychiatry team following assessments(iii)social work reported that the patient stay was prolonged by delays in referral from emergency department and psychiatry staff(iv)social work reported that medical and psychiatric assessments were delayed by failure to assess patients in tandem with social work assessment.Role confusion: the discipline responsible for the management of acute agitation (emergency department doctors or psychiatry doctors) was unclearthe role of security staff in the care of psychiatric patients, in particular the statutory limits of their interventions, was unclearthe medical discipline responsible for ‘medical screening’ (emergency department, psychiatry or general medical), and the definition of ‘medical screening’, were unclearit was unclear which medical discipline (emergency department or psychiatry) was considered to be the treating team of patients following completion of psychiatric assessmentconsequent to role confusion (viii), it was unclear which discipline was responsible for further referralsconsequent to role confusions (vii) and (viii), it was unclear which discipline was responsible for further investigations, such as blood tests/ECG/urine toxicology.Duplication of work: the emergency department nurse and triage nurse both reported routinely making phone contact with psychiatry doctors to inform them of the arrival of psychiatric patients, in addition to the referral that was made by the emergency department doctor after their assessment; the expectation from these phone contacts was unclearsome disciplines reported carrying out overlapping assessments, e.g. social work and psychiatry.Communication difficulties: emergency department nurses reported a failure by psychiatry to keep emergency department staff updated on psychiatric management planspsychiatry staff reported a difficulty identifying emergency department staff to receive updatessecurity staff reported failure of medical staff (psychiatry and emergency department) to update the security team, leading to a longer security intervention than needed in some casesthe healthcare assistant reported delayed updates after change of treatment plans, leading to a longer healthcare-assistant intervention (1:1 special) than needed in some casesthe social worker reported delayed referrals of child welfare issues to social work.

Stage II: generation of process maps

Individual process maps (*Fig. 2*) and an overview process map (*Fig. 1*) were developed for discussion at stage III.

Stage III: post-interview stakeholder focus group and goal-setting

Following presentation of maps and completion of worksheets, the highest-ranked problems were targeted for intervention and a projected timeline was assigned. The consensual goals were: to ensure efficient and comprehensive handover between liaison psychiatry and emergency department staff following psychiatry assessments (targets i, ii, xiii, xiv)to facilitate emergency department staff accessing the liaison psychiatry team for updates at morning shift-change (09.00 h) (targets i, ii, iii, xiii, xiv, xvii)to refine the referral pathway (emergency department to psychiatry) in order to clarify the role of each individual and the appropriate timing of referrals and to prevent staff making repeated and redundant contacts about the same patient (targets v, vii, viii, ix, x, xi)to establish a definition of ‘medical screening’, the process of medical assessment before psychiatry referral (targets vii, x, xi)to prevent or effectively manage acute agitation in psychiatric patients (targets v, vi)to formalise the role of security staff in the management of psychiatric patients, including education about statutory obligations and limitations (targets vi, xv).

Stage IV: assessment of outcomes

Length of stay

A statistically significant Shapiro–Wilk test indicated a non-normal distribution of data (2017 $P < 0.001$; 2018 $P < 0.001$), indicating suitability for non-parametric analysis. There was a statistically significant improvement in the median length of stay between the pre-mapping group and the post-mapping group (median difference: 1 h; $P = 0.015$). The median length of stay pre-mapping was 8 h (interquartile range, IQR = 8) and post-mapping was 7 h (IQR = 7). There was a particular improvement in the number of psychiatric patients spending over 24 h in the department: length of stay exceeded 24 h for 5% of psychiatric patients in the pre-mapping group and 2% in the post-mapping group.

Attainment of goals

Five of the six targets were attained to the satisfaction of stakeholders, four on the projected timeline and one on a delayed timeline (*Table 1*).

One of the targets – ‘define medical screening’ – was revised and excluded at a subsequent clinical meeting, after concerns were raised that the implementation of such a definition could lead to a rigid clinical approach to screening psychiatric patients.

Discussion

Process mapping, a component of lean management (‘lean’), is one of a number of management tools that aim to improve efficiency and eliminate ‘waste’.¹³ Lean was originally applied to the motor industry in Japan but the underlying philosophy lends itself to many types of organisation, including healthcare. Lean scrutinises and evaluates each component of a process so that ineffective, inefficient or potentially harmful elements (‘waste’) can be fixed or discarded.

Lean processes have been applied to other healthcare services, including ambulatory care settings¹ and interventional radiology.² Process mapping has been successful in these settings in identifying problems, reducing errors and generally improving efficiency; however, the outcomes in most of the previous studies have taken a qualitative approach rather than quantitative. Some studies have measured patient satisfaction before and after implementation of this method, but found no statistically significant difference.¹⁴ To our knowledge, the benefits of this method have not been studied in liaison psychiatry. The differences that exist between liaison psychiatry and other services, in particular the inherent unpredictability of an emergency department liaison psychiatry service, make it a unique setting that warrants particular attention. Lean methods have been applied to acute emergency settings³ and behavioural health crisis settings,⁴ both more similar to our service, but those studies did not assess the function of an emergency psychiatry service within a general emergency department, as is commonly the setting for the provision of emergency psychiatric care in Ireland and the UK. One such study of a stand-alone crisis centre found a significant improvement in door-to-door dwell time, but, as a disparate service to ours, without comparable interdisciplinary challenges, the findings are difficult to relate to a hospital setting.⁴

The use of process mapping in the present study afforded us the opportunity to visualise the journey of the psychiatric patient as they interacted with each individual stakeholder (*Fig. 1*) and as they were processed through the interdisciplinary department (*Fig. 2*). Doing so, we were able to set realistic, practical, timely and finite goals, thereby measurably improving efficiency. Further to this, we hoped that this process might help to improve the quality of working relationships between individuals and departments.

Lengthy waiting times of mentally ill patients in an emergency department exert stress on resources and increase the risk of adverse incidents.⁹ Before undertaking this quality improvement project, their median length of stay in this department (8 h) significantly exceeded the national target of 6 h. The National Emergency Medicine Programme in the jurisdiction of Ireland aims to ensure that 95% of patients are processed within 6 h.¹⁵ Process mapping and the series of interventions that followed led to a significant reduction in length of stay (median 7 h), with a particular reduction in the number of lengthy waiting times (5% exceeding 24 h pre-mapping, 2% exceeding 24 h post-mapping). This

outcome, we postulate, was achieved by improving staff relations and agreeing on a series of low-burden and low-cost practical changes.

One such practical change was the management and prevention of acute agitation in mentally ill patients in the emergency department. The application of process maps enabled the stakeholder group to deconstruct the chain of events leading up to acute agitation: delayed handover following psychiatric assessment caused ambiguity about management (*Table 1*, proposal (a)) psychiatric registrars reported being unable to identify the appropriate person in the emergency department to receive handovers (*Table 1*, proposals (a) and (b)) the head of emergency department nursing observed that delays in administration of oral medication in the early stages of behavioural disturbance precipitated escalation of the behavioural disturbance, requiring emergency administration of intramuscular medication (*Table 1*; proposal (e)) healthcare assistants observed that long periods spent in the contained environment of the emergency department led to patients becoming more irritable, but the assistants did not feel equipped to supervise time out of the department security staff were willing to supervise breaks with the healthcare assistant, but were unclear about their legal obligations and safeguards in relation to restraining and detaining patients (*Table 1*; proposal (f)).

Consensus on such solutions could not have been reached in the absence of this process, as non-clinical security staff and healthcare assistants – who provided important information and insights that were key to implementing solutions – are not routinely consulted by senior clinical and management staff. These types of solution, especially in cases such as this, reduce risks to patients and staff and reduce the burden on resources, thereby allowing the department to run more efficiently.

Further to these measurable benefits, process mapping facilitated progression from silo working to a cohesive team approach. The phenomenon of silo working leaves individual staff members feeling isolated and unsure about what to do or where to find help,¹¹ especially in highly stressful situations such as a patient's acute agitation. Clarification of departmental policies and pathways, paired with improved individual flexibility and collegiality, empowered individuals to navigate difficult situations as a team so that interdisciplinary solutions were generated with minimal conflict. Process mapping provided a structure for this conversation to take place, thereby enhancing collegiality and collaborative care.

Limitations

For process mapping to be successful in creating a consensus of opinion, the interviewer must remain objective. This process-mapping exercise was led by a senior registrar on the psychiatry team. Ideally, the lead role would be undertaken by an external participant, to avoid introducing interviewer bias (or the perception of interviewer bias by the stakeholders). This was not possible within the limits of our resources. This did not emerge as an obstacle in this study, probably because of the considerable trust between the specialties, but an independent interviewer would be essential if relationships were more fractious.

Compounding this, participants in this project were vulnerable to recall and reporting bias due to the retrospective nature of the interviews and the fact that they were asked to consider the pathway common to the majority of psychiatric cases, rather than specific cases.

Having evaluated the success of this process, it appears that neither of these limitations was prohibitive.

Recommendations for utilising process maps in healthcare

Adhering to structure

We found that both the interviewer and stakeholders were tempted to offer personal conclusions and suggestions in stage I, which could have led to individual maps being contaminated by an individual's personal agenda. It was important throughout this process to remind the stakeholders that any useful solutions must be raised through the focus-group meeting in stages II and III.

Completing the full process

Change management requires energy and motivation and we found that sustaining momentum was a struggle at times. Process mapping does not serve its function if it ends after stage I, so persistence through stages II and III is needed to enable meaningful change to be made. It can be a challenge to convince busy professionals to sacrifice valuable time, but the value of participation en masse cannot be matched by only one or two people. Active involvement of consultants and heads of department from the outset is vital.

A word of caution

Not all situations are amenable to process mapping, so this method should be carefully considered before applying it to a problem situation.

Process mapping is a tool developed to examine a process, not a population. It is not designed to mediate interpersonal conflicts. Although we observed an improved sense of trust and collegiality, process mapping cannot enhance trust in a relationship where none exists.

The problems described herein are particular to our liaison psychiatry service, and may not mirror the challenges faced by other specialties or services; however, the general challenges encountered in the day-to-day provision of healthcare (e.g. inefficient use of resources and a tendency to resort to silo working) are ubiquitous across all settings. We have identified a method of overcoming these pitfalls. This experience can provide a blueprint for undertaking this kind of work in other fields of healthcare. We have found it a useful tool for enhancing working relationships and implementing immediate, lasting and meaningful change.

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1.3.64 Section 12(2) MHA approval process is fit for purpose

Masum Khwaja

date

2020-06

Contents

- *Section 12(2) MHA approval process is fit for purpose*
 - *Declaration of interest*

Rigby and McAlpine¹ have confusingly conflated criticism of Section 12 Mental Health Act (s12 MHA) approval courses, attendance at which is only one of several statutory criteria for s12 approval, with criticism of the overall process of s12 approval. This letter addresses some of the limitations of the article, which in hindsight I'm sure Rigby and McAlpine would prefer to have entitled: 'Are s12 approval courses fit for purpose?'

Before reading further, readers should understand the following. •A s12-approved doctor is legally defined as 'a medically qualified doctor who has been recognised under section 12(2) of the MHA as having specific expertise in the diagnosis and treatment of mental disorder' and has had training in the application of the MHA.²•The criteria for s12 approval are contained within the statutory instructions³ and represent the Government's requirements regarding the

work experience, training and qualifications doctors need to possess before they can legally be considered to have the 'specific expertise in the diagnosis and treatment of mental disorder' required to be an s12-approved doctor. •Regional s12 approval panels have robust governance structures and procedures in place, including audit, that ensure that only those doctors that meet the statutory criteria are approved. •Doctors require only a basic working knowledge of the MHA to be involved in MHA assessments (MHAAs). •Doctors do not need to be s12 approved to be involved in MHAAs. If they are not s12 approved then it is preferable that they have personally treated the patient in the past or have some previous knowledge of the patient's case. •S12 approval courses are not courses on which doctors learn about the MHA, or how to conduct MHAAs, for the first time. The courses serve to reinforce and enhance attendees' knowledge of the MHA and of the MHA Code of Practice. They offer valuable time for discussion among clinicians, with a solicitor present, with debate often focused on the intricacies of the MHA as opposed to the basics. •Not all s12-approved doctors are actively involved in detaining patients under the MHA. Examples include medical members of the first-tier tribunals (mental health), Second Opinion Appointed Doctors (SOADs) and doctors who produce independent expert reports for court.

Aspects of Rigby and McAlpine's article that need highlighting include the following. •Rigby and McAlpine imply that s12 doctors may not be 'equipped with the knowledge and skills', particularly knowledge of the MHA, to consider detention of patients under the MHA and that this may have contributed to a rise in detentions over the past decade. There is no evidence to support their view, which in any case has not considered that the decision to apply to detain a person under the MHA does not lie with s12 doctors but with, usually, an approved mental health professional (who makes the application). •Rigby and McAlpine declare that a 'lack of formative assessment [in relation to s12 course objectives] is particularly concerning considering that there is evidence to indicate that there are inadequacies in many psychiatrists' understanding of the relevant [MHA] legislation'. Once again, this is an eye-catching assertion for which they offer no convincing evidence. The two papers they cite are more than 20 years old, from 1999 and 1997 respectively, and pre-date the introduction of routine s12 approval courses, which commenced around 2002. •Rigby and McAlpine state that international applicants with MRCPsych may not be aware of the UK MHA as 'the MRCPsych does not assess UK mental health law'. However, they neglect to mention that s12 legal instructions require that 'if the applicant has completed all or a substantial part of their training outside England or Wales, that the applicant must provide evidence of 'steps the applicant has taken to familiarise themselves with psychiatric practice and the organisation of psychiatric services in England or Wales, including the practical application of the 1983 Act'.³ Furthermore, the MRCPsych curriculum is different to the requirements for core training (e.g. Workplace Based Assessments (WBPA)), and the knowledge and skills pertinent to s12 approval are mostly gained outside preparation for the MRCPsych examination. •In criticising references for s12 approval, Rigby and McAlpine fail to appreciate that references for s12 approval are not restricted to commenting on an applicant's ability to undertake an MHAA but also require referees to be able to comment on, for example, the applicant's report writing and attendance at legal hearings, or that referees are, as always, bound by General Medical Council guidance in that references must be honest, objective and include all information relevant to a colleagues' competence, performance and conduct.⁴ •The response rate of their survey was only 21.7% (5/23), which is far too low for the results to be usefully interpreted regardless of triangulation.

In summary, Rigby and McAlpine offer no convincing evidence that attendees of s12 courses do not have a working knowledge of the MHA sufficient to undertake MHAAs, or that the introduction of an additional requirement for s12 approval, to pass a multiple choice question (MCQ) and clinical examination, essentially on the MHA and on conducting MHAAs, is required.

We would also argue that, other than theoretically, Rigby and McAlpine provide no evidence that s12 courses, as they are currently delivered, fail to fulfil their core objectives or require major revision, or that the s12 approval process is anything but fit for purpose.

It is always important to consider how training may be improved; in relation to s12 courses, as Rigby is aware, the London Approval Panel have suggested that benchmarking MCQ course material and content across s12 courses nationally might support the development of improved course material and potentially of a 's12 course MCQ self-assessment revision aid' focused on the essential aspects of mental health law and the Code of Practice akin to mandatory training on the MHA recommended by the MHA Code of Practice and monitored by the Care Quality Commission.⁵

The development of continuing professional development material relevant to building or maintaining the skills and knowledge required to act as an s12-approved doctor, and support from employers to evidence experience pertinent to s12 approval and reappraisal in annual appraisals, are areas that those interested in supporting doctors to improve

practice in relation to their s12 work might also wish to focus on.

Declaration of interest

M.K. is Chair of the London Section 12 and Approved Clinician (s12/AC) approval panel. This letter was submitted on behalf of the Chairs of all four regional s12/AC approval panels in England.

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1.3.65 The Parliamentary Scholar Scheme: a way to engage doctors in healthcare policy and politics

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2020-06

Abstract

The Royal College of Psychiatrists' Parliamentary Scholar Scheme gives higher trainees in psychiatry the opportunity to spend 1 day a week in the House of Lords working alongside a peer with an interest in health. This article describes the work of the House of Lords and Parliament using examples from the experiences of 2017–2018 scholars and outlines ways doctors can get more involved in policy and politics.

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- *The Parliamentary Scholar Scheme: a way to engage doctors in healthcare policy and politics*
 - *What the House of Lords and Parliament do*
 - *Members of the House of Lords*

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Declaration of interest: J.P. continues to work as a parliamentary researcher in the Houses of Parliament 1 day a week. S.H. received funding from the Royal College of Psychiatrists to pay for travel expenses to enable participation in the scheme.

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- *Work of the House of Lords*
 - * *Making and changing laws (legislation)*
 - * *Debating public policy*
 - * *Checking and challenging the work of the government (scrutiny)*
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- *The role of the College*
- *What we learnt and skills we developed*
- *How doctors can get involved*
- *Conclusions*

The Royal College of Psychiatrists set up its Parliamentary Scholar Scheme in 2017 with Professor the Baroness Hollins, who is a cross-bench peer in the House of Lords. Professor the Baroness Hollins, a former Consultant Psychiatrist and College President, spends much of her time in the Lords campaigning to improve services for people with learning disabilities, which is one of her specialist areas of interest. The Parliamentary Scholar Scheme, now supported also by the BMA Foundation, gives higher trainees working in psychiatry the opportunity to spend 1 day a week, as a special interest session, in the House of Lords working alongside a peer with an interest in mental health. Peers on the scheme come from across the political spectrum; in the 2017–2018 cohort there were peers from the Conservative, Labour and Liberal Democrat parties as well as from the cross-benches.

The scheme gives trainee psychiatrists hands-on experience of working in the field of health policy as well as wider politics. The psychiatric higher trainee curriculum requires the development of ‘effective leadership skills’ and ‘an understanding of organisational policy and practice at a national and local level in the wider health and social care economy’.¹ The scheme clearly allows participants to develop such skills but it aims to go further – to enable the trainees to develop skills in influencing the mental health agenda.

There are other schemes available to support trainees to develop leadership skills, for example the National Medical Directors Fellowship Scheme² and the Darzi fellowship scheme.³ However, as far as we are aware, the Parliamentary Scholar Scheme is the first programme to give trainees experience of working in the House of Lords. Given the current recruitment and retention problems within the mental health workforce,⁴ this scheme is certainly something that makes psychiatry training stand out from other specialties and may help encourage more doctors into the profession.

This article aims to guide readers through the work of Parliament, mainly focusing on the House of Lords, using examples from our experiences as 2017–2018 scholars.

What the House of Lords and Parliament do

The UK Parliament is made up of the House of Commons, House of Lords and the monarch. Members of the House of Lords, known as peers, are appointed by the Queen (the monarch) on the advice of the Prime Minister and are unelected. The House of Lords has three main roles: making laws, debating public policy and holding government to account. Members of Parliament (MPs) have the power to overrule the Lords, but the Lords can still be very influential in terms of making/changing legislation and policy.

Members of the House of Lords

Peers are often experts with experience from outside of Parliament, for example, the peers we worked with had experience of working in psychiatry, nursing, surgery, trade unions and the civil service. Most are ‘life peers’, although 92 (at the time of writing) sit by virtue of a hereditary title. Life peers are appointed by the monarch on the advice of the Prime Minister to serve for life; the title is not transferable when they die.⁵ Peers are nominated either by their political parties or by the House of Lords Appointments Commission, which recommends people for appointment as non party-political life peers.⁶

Work of the House of Lords

Making and changing laws (legislation)

Bills (draft laws) are introduced to Parliament and then repeatedly reviewed, debated and amended by both the Lords and the Commons. There is a process known as ‘ping-pong’ where the Bill goes back and forth between each House as amendments are made and agreed or rejected. When the Bill is agreed by both Houses it is given Royal Assent and becomes an Act of Parliament.⁸ An example of a Bill that was going through Parliament while the 2017–2018 scholars were in post was the Mental Health Units (Use of Force) Bill, otherwise known as ‘Seni’s Law’. The Bill was proposed by Steve Reed, MP for Croydon North, following the death of one of his constituents, Seni Lewis, in 2010. Seni died aged 23, after being restrained on a mental health ward by 11 police officers. The Bill started in the Commons, went to the Lords, amendments were considered in both Houses and then it became an Act in 2018. The new legislation means that mental health units will have to take steps, including better training for staff, to reduce the use of force against patients. Robust data on the use of force will be collected and police will have to wear body cameras when called to mental health settings; recordings from these cameras can be used in evidence.^{9,10}

Another example is the Mental Capacity (Amendment) Bill, which is now enacted¹¹ and lays out a new legal framework to replace Deprivation of Liberty Safeguards. Some of the 2017–2018 scholars were able to research the framework, liaise with experts and organisations with interests in the area, and contribute to topics such as the role of care home managers in overseeing the safeguards and the central importance of a person’s wishes and feelings when decisions are made about them. Many peers spoke on this Bill as it passed through the House of Lords and some of the 2017–2018 scholars were able to support their peers in drafting speeches using their own experience of working in mental health services and research briefings.

One peer put down an amendment to the EU Withdrawal Bill when it passed through the House of Lords in 2018. The amendment focused on the mutual recognition of professional qualifications, which is about ensuring that professional qualifications (e.g. medical degrees) continue to be recognised in the EU and UK after Brexit. The 2017–2018 scholar attached to this peer undertook some research in this area using a briefing from the Parliamentary library and liaising with relevant organisations, such as the British Medical Association (BMA) and legal firms to seek their perspectives. The scholar then used this information to draft a speech for their peer for the debate on the Bill.¹²

Debating public policy

Alongside debates on specific legislation there are also debates on topical issues and public policy. It is during these that members are able to give speeches, giving their opinions and arguments and the relevant government minister has to respond. Members may speak because they have a particular interest in the area of debate or particular expertise. The 2017–2018 scholars had the opportunity to contribute to a variety of speeches for their peers on topics related to mental health, for example for debates on access to mental health services for people from Black and minority ethnic groups¹³ and to debates on wider healthcare system issues such as long-term NHS sustainability and global nursing.^{14,15}

Checking and challenging the work of the government (scrutiny)

Select committees

MPs and peers hold the government to account. One way of doing this is through the select committees run in the Commons and the Lords. The most important one for health is the House of Commons Health and Social Care Select Committee, which conducts inquiries on a range of topics. Anyone can submit a proposal to a select committee and, as a group of scholars, we submitted a proposal for an inquiry into the state of drug and alcohol services in England. An inquiry we followed during our time in Parliament focused on the impact of Brexit on medicines, medical devices and substances of human origin. Experts (including doctors), interested organisations and members of the public can submit written evidence to inquiries, for example in this one, the BMA and the Academy of Medical Royal Colleges both submitted evidence. The committee also took oral evidence from a range of expert witnesses, including the Rt Hon Jeremy Hunt (the then Secretary of State for Health and Social Care) and Dr Ian Hudson (Chief Executive, Medicines and Healthcare products Regulatory Agency), which some of the 2017–2018 scholars were able to watch. The committee used this evidence to write a report with a series of recommendations. For example, one of the recommendations was that the government should ‘produce a comprehensive list of all the issues relating to the supply of medicines, medical devices and substances of human origin which require contingency planning for the UK leaving the EU [...] with evidence that plans are in place to address identified risks to patients’.¹⁷ The government has to respond to each published select committee report and to consider its recommendations, which may or may not influence government policy. The government published its response to this Brexit report in July 2018 and in answer to the recommendation above it said, ‘At this stage we do not have plans to publish a comprehensive list of the issues relating to medicines, medical devices and substances of human origin. We will continue to be as transparent as possible, but whilst we are engaged in on-going negotiations it is vitally important that we manage information carefully in order to not disadvantage the UK’s position’.¹⁸

Written and oral questions

Members also hold the government to account by asking oral or written questions that the government is required to formally answer on the record. Questions on health and social care are answered by the Ministers for Health and Social Care. At the time of writing, Matt Hancock MP is Secretary of State for Health and Social Care. However, there are other government health ministers to be aware of, for example Jackie Doyle Price MP is currently the Parliamentary Under Secretary of State for Mental Health, Inequalities and Suicide Prevention and, in the Lords, the Parliamentary Under Secretary of State (Lords) for Health is Baroness Blackwood. As part of their role, the 2017–2018 scholars drafted oral and written questions that could be used by their peers to put to House of Lords ministers. Ideas for questions came from recently published reports, government announcements and stories in the media.

Oral questions are posed each day in both Houses. In the House of Lords, there is a 30 min slot for four oral questions, which peers have to submit in advance. The peer stands up for their slot and puts their question to the minister for the appropriate department, who has to respond; there is then time for other peers to ask the minister supplementary questions on that topic. The 2017–2018 scholars also identified upcoming oral questions in the chamber that could be of interest to their peers and drafted supplementary questions to be used in the brief debate to further clarify or challenge the government’s position. An example of an oral social care question asked by one of the peers we were working for during our time on the scheme was ‘To ask her Majesty’s Government what steps they are taking to support (a) the care sector, and (b) those receiving care, in the light of the retrospective change in guidance on the application of the national minimum wage to sleep-in shifts for care workers’.¹⁹ This question was asked following a widely publicised media story about sleep-in carers being able to claim minimum wage for overnight shifts and was answered by Lord O’Shaughnessy, the then Parliamentary Under Secretary of State (Lords) for Health.

Peers and MPs can submit written questions to government departments that ministers have to respond to within certain time frames. Peers can table up to six questions each day and can expect an answer within 14 days. For example, when the report by the Parliamentary and Health Services Ombudsman on NHS eating disorder services²⁰ was published, one of the shadowed peers asked a series of questions about improvements that could be made to medical training and funding, one of which was, ‘To ask Her Majesty’s Government, following the conclusions of the Parliamentary

and Health Services Ombudsman, *Ignoring the alarms: how NHS eating disorder services are failing patients* (HC 634), published on 6 December, what assessment they have made of the recommendations set out in that report; and what discussions they have held with the General Medical Council on reviewing the eating disorders training for junior doctors'. This was answered by Lord O'Shaughnessy.²¹

Other work of peers

All-party parliamentary groups (APPGs) are informal cross-party groups that have no official status within Parliament. They are run by and for members of the Commons and Lords. Many choose to involve individuals and organisations from outside Parliament in their administration and activities. Examples are the Acquired Brain Injury APPG, the Mental Health APPG and the Psychology APPG.²² The 2017–2018 scholars were able to attend meetings and contribute to the work of some of the APPGs. In 2017–2018 the APPG for Mental Health was chaired by Helen Whately MP and its secretariat was provided by the Royal College of Psychiatrists and Rethink. Some of the 2017–2018 scholars had the opportunity to work on the APPG for Mental Health's inquiry into the Five Year Forward View for Mental Health.²³ One of the scholars went on a visit to see some of the new services set by Central and North West London NHS Foundation Trust as a result of the Five Year Forward View and to understand the challenges and opportunities involved. We helped with reviewing evidence and recommendations for the report using our clinical expertise.

Day to day, most peers have meetings with a wide range of people, such as politicians, representatives from charities, think-tanks and NHS organisations, journalists and lobbyists. The 2017–2018 scholars had the opportunity to shadow peers and also contribute to some of these meetings. There are always events taking place in Westminster, for example we were able to accompany our peers to events such as the launch of the report by the Lancet Commission on Liver Disease, the launch of the Schizophrenia Commission report and the Parliamentary Conference on Mindfulness.

Peers also receive correspondence from a wide variety of sources, including members of the public, interested organisations and other politicians. The 2017–2018 scholars were able to help their peers with responding to enquiries and drafting letters.

The role of the College

Our links with the Royal College of Psychiatrists were invaluable, and the advice from its Public Affairs team enabled us to navigate what can be a complex parliamentary process. They were also able to support us with our parliamentary research on specific topics related to mental health. More broadly, the Public Affairs team works with parliamentarians, arm's-length bodies and other political stakeholders to campaign and influence mental healthcare. It sends out written briefings to parliamentarians on mental health topics which are coming up in debates, oral questions or Bills to give an overview of the topic but also to give the College's perspective (for example with the Mental Capacity Bill). Team members regularly meet with politicians face to face about different mental health issues. The Public Affairs team, alongside Rethink, coordinates the APPG on Mental Health and helps to plan their activities and inquiries for the year. The team also sends out a weekly email to College members entitled 'Political Week', which gives an overview of any mental health topics that have come up in Parliament.

What we learnt and skills we developed

Our 1-year scholarship was an exciting and unique opportunity to learn more about the interface between politics and healthcare and how Parliament works. As trainees it gave us a better understanding of the wider mental health system and its interactions with government. We developed skills in leadership, policy analysis, speech writing and influencing the mental health agenda, all of which will be helpful for us as consultant psychiatrists. Within the Healthcare Leadership Model,²⁴ these skills correspond to the 'connecting our service' domain, as we were able to develop an understanding of how different services connect to the broader health landscape, how complex relationships form and how decisions are made. It also corresponds to the 'influencing for results' domain, as we were able to develop our communication skills and our ability to influence people.

During our time, we were able to meet with a number of MPs and peers who are influential in healthcare to learn more about how they got into politics, their day-to-day work and what their priorities are. In return, we were able to share with them our experiences of working in front-line mental health services. Some of us took our peers to visit our clinical teams so that they could get an in-depth understanding of what it is like to work in psychiatry.

All of us have been able to share our learning with colleagues through teaching sessions, blogs and conference presentations. At present there are no objective data to examine the impact of the scheme, but this could be gathered after further cohorts of scholars have completed the placement.

How doctors can get involved

There are lots of different ways doctors can get involved in healthcare policy and politics. One way is to join a political party, which will allow you to develop an understanding of the political system and to become politically active. You can write to your local MP, or a peer in the House of Lords with an interest in your issue. Politicians' interests are listed on their Parliament webpage. The select committees regularly run inquiries and, as a doctor, you can submit evidence, propose a topic or go to watch the evidence sessions. You can follow what goes on in the Houses of Commons and Lords by reading Hansard (<https://hansard.parliament.uk>), watching Parliament TV (<https://www.parliamentlive.tv/Commons>) or listening to the BBC Radio 4 programme 'Today in Parliament' (<https://www.bbc.co.uk/programmes/b006qtqd>), which provides a 30 min summary of the day's events.

If you have an interest in a particular topic you can campaign for it on social media, write blogs or articles for newspapers or go on TV or radio. The difficulties with the revised NHS junior doctor contract a few years back led to many more doctors becoming politically active. There are also roles for doctors in organisations that lobby government, for example the BMA. Many medical Royal Colleges have a policy and/or parliamentary committee which will influence policy and you may be able to get involved with this. The Royal College of Psychiatrists produces a weekly political update that you can sign up for. This will keep you up to date with forthcoming parliamentary business.

Of course, if you are a psychiatry higher trainee you can apply to the Parliamentary Scholar Scheme, which (at the time of writing) is in its third year. It is advertised on the Royal College of Psychiatrists website usually in the spring.

Conclusions

Our participation in the 2017–2018 Parliamentary Scholar Scheme was a unique opportunity for us as trainee psychiatrists to learn more about healthcare policy and Parliament. It has enabled us to develop skills in leadership and influencing that will stand us in good stead for our future careers as consultant psychiatrists.

The idea of the medical profession turning to soft power to influence policy has been proposed recently.²⁵ Our experience of working in Parliament has demonstrated the many areas where policy is made, challenged and communicated. The scope for those with first-hand knowledge of the healthcare system to have input into the areas where policy is influenced is there, but it requires knowledge of the system and a willingness to suggest solutions, not just to criticise the end product.

We thank Olivia Clark, Jonathan Blay, Rebecca Couper (Royal College of Psychiatrists) and Professor the Baroness Hollins and the other peers associated with the scheme.

We confirm that we meet all four ICMJE criteria for authorship. J.P., P.L., F.T. and K.M. designed, drafted and revised the article. S.H. designed and revised the article.

Jen Perry is a consultant psychiatrist with Camden and Islington Mental Health Trust, London, UK; **Paul Lomax** is a specialty trainee with South West London and St George's Mental Health NHS Trust, UK; **Fiona Taylor** is a consultant psychiatrist with Camden and Islington Mental Health Trust, UK; **Susan Howson** is a consultant psychiatrist with Devon Partnership Trust, Exeter, UK; **Kathleen McCurdy** is a consultant forensic psychiatrist with Oxleas NHS Foundation Trust, Dartford, UK. All five authors were higher trainees on the 2017–2018 Parliamentary Scholar Scheme.

1.3.66 Standing with our medical colleagues

Sarah Castle

date

2020-08

Contents

- *Standing with our medical colleagues*

Like many of us I am increasingly concerned about the possible effects of coronavirus on myself, my family and our community and patients. With family in Italy, I am mindful of the need there for other medical professionals to be brought in to work alongside their acute medical colleagues. This has included those more distant from acute medical work now, such as pathologists and even in some cases psychiatrists.

Little has been spoken about our role in regards to COVID-19 should we see similar scenes here in the UK and what our possible involvement might be. It would be easy to adopt a ‘protectionist’ attitude and leave the messy stuff to ‘real doctors’.

As a psychiatrist, I am a doctor of the mind and body. Of course, I would never advocate working beyond our professional competencies; however, I feel we have a strong duty to stand beside our medical colleagues be it pushing trolleys, taking blood or sweeping floors if the need arises. We spend so much time and energy trying to reduce the splitting that occurs between ‘medicine’ and ‘psychiatry’; surely we cannot hide behind this very split now when our colleagues and indeed our communities may need us if an outbreak worsens to the degree that many fear. Surely then we must stand together as one profession.

None.

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1.3.67 Quality improvement in mental health services

Billy Boland¹

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Declaration of interest B.B. is the faculty lead for quality improvement for the Faculty of General Adult Psychiatry at the Royal College of Psychiatrists; is on the advisory board of the Money and Mental Health Policy Institute; and periodically writes a blog on matters relating to leadership and quality improvement for The BMJ. As part of leadership development he visited GlaxoSmithKline to learn about its approach to quality improvement. GlaxoSmithKline has developed its own approach and did not specifically adopt lean or the Model for Improvement discussed in this article.

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Abstract

Quality improvement (QI) approaches are becoming increasingly important in the delivery of mental healthcare internationally. They were originally developed in the manufacturing industry, but the principle of having a systematic approach to improvement has spread to many other industries, not least to healthcare. Quality improvement approaches in healthcare were pioneered in the USA at organisations such as Virginia Mason and the Institute for Healthcare Improvement. In recent years, they have become firmly established in mental health services in the UK's National Health Service (NHS). There are a number of different approaches to quality improvement, but two leading models have taken root: 'lean thinking' (also known as 'lean methodology' or simply 'lean'), which arose out of Virginia Mason, and the 'Model for Improvement', which came out of the Institute of Healthcare Improvement. This article describes these two quality improvement approaches, critiques their philosophy and explores how they can apply in the provision of mental healthcare, particularly with reference to the use of data, evidence and metrics.

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 - *Lean thinking*
 - *Challenges engaging with the lean principles*
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 - *Model for Improvement – evidence of impact*
 - *Conclusion – the essence of theories of improvement science*

Lean thinking

Getting to the essence of ‘lean’ is made challenging by the ambiguous language and definitions in the field. Hallam captures this well in observing that the term ‘lean’ has been used interchangeably to describe four different dimensions, specifically ‘the operating philosophy, the tools, the activities, and the state of the manufacturer’ (cited by Stone¹). In his review on the science of lean, Kyle Stone defines the lean thinking paradigm as the ‘operational philosophy’ of the organisation’ which ‘differentiates between waste and value’.¹

Muda (Japanese for waste) is defined by Womack & Jones as ‘any human activity which absorbs resources but creates no value’² (p. 15). The ‘powerful antidote’ to tackling waste, they argue, is lean thinking. Five ‘lean principles’ are proposed. Data, evidence and metrics, and their application are not specifically addressed within the principles, but their use in realising the principles is clearly important. Definitions of the principles exist, but there are challenges in engaging with them and applying them to healthcare. The next section considers these challenges in relation to the key concept of each principle.

Challenges engaging with the lean principles

Specifying value

Womack & Jones argue that value can only be specified by the ‘ultimate customer’² (p. 16), but fall short of clarifying who that is. They make a compelling argument that those who design and deliver the business can never truly know the value that customers seek and must work hard to understand the customer’s wants and needs in building their product. How one defines or identifies the ‘ultimate customer’ is not made clear. Instead, readers are encouraged to maintain a dialogue with a broad customer base and continually evolve their product. They offer a number of lenses through which one can see value, such as ‘challenging traditional definitions of value’ (p. 31), defining value in terms of the ‘whole product’ (p. 32) and tackling the ‘target cost’ (p. 35), yet crucially they do not define what value actually is.

Specifying value is key to making best use of data, evidence and metrics, as all efforts should be directed towards improvement aimed at achieving the target ideal value. Having a robust definition of value is necessary in order to demonstrate, using data and evidence, whether or not value has been achieved. Progress towards achieving ideal value can be measured using metrics.

The value stream

Liker & Ross define the value stream as ‘core customer-focussed business processes’³ (p. 241). Womack & Jones offer a more granular explanation: “‘The Value Stream is the set of all the specific actions required to bring a specific product (whether a good, a service, or, increasingly, a combination of the two) through the three critical management tasks of any business: the problem-solving task running from concept through detailed design and engineering to production launch, the information management task running from order-taking through detailed scheduling to delivery, and the physical transformation task proceeding from raw materials to a finished product in the hands of the customer.’² (p. 19)”

Both definitions are inadequate as they fail to get to the heart of the matter and they leave important questions unanswered. The Liker & Ross definition is narrow and wholly business oriented. Why should the value stream only regard ‘core’ business processes, and how are these defined? The mass production examples given in both texts do not fully translate to a complex multiservice industry such as healthcare. Which business processes in healthcare are ‘core’? Does that mean ‘non-core’ services do not deliver value?

In contrast, the Womack & Jones definition is too verbose and meaning is obscured as a result. It is also internally incoherent, as although it begins by explaining that a product can be goods or services, later parts of the definition are articulated only in terms of goods, for example ‘the physical transformation task proceeding from raw materials to a finished product’² (p. 19).

In establishing the value stream, obtaining information (data and evidence) from those involved in delivering the work is crucial to truly understanding what is happening. Evidence from customers (such as patients and carers) is important in understanding what value is actually delivered at relevant points through the stream. Metrics can be used to indicate whether value has been delivered, provided that the value has been clearly specified. For example, in mental health services patient-reported outcome measures (PROMS) and patient-reported experience measures (PREMS) can give some insight into patients' experience of services and service impact.⁴

Flow

Frustratingly, a 'lean' definition of flow is hard to come by, and most authors appear to have resorted to explaining what it is not. Womack & Jones explain that it is not batch processing or doing tasks in batches that inherently cause waiting and queuing² (p. 50). In their analysis of lean in an emergency department in an NHS hospital in Nottingham, Timmons and colleagues talk of the lean principle in the healthcare setting in terms of 'ensuring that there is a continuous flow throughout the process. Standardising processes around best practice allows smooth running, which frees up time for creativity and innovation'.⁵

Flow can be quantified with respect to value and so can be amenable to the generation of metrics. Indirect measures of waste (*muda*) are useful data and evidence proxy indicators for flow. For example, measures of defects, overproduction or waiting can all give useful insights into the performance of flow⁶ (pp. 82–84).

Pull

Pull also seems to be defined by what it is not. For example, Womack & Jones offer: 'you can let the customer pull the product from you as needed rather than pushing products, often unwanted, onto the customer'² (p. 24) and 'pull in simplest terms means that no one upstream should produce a good or service until the customer downstream asks for it'² (p. 67). Although, on the face of it, pull seems a wholly transactional concept, Liker & Ross emphasise 'even a well-designed pull system does not automatically solve all our problems and is dependent on human judgement and discipline'³ (p. 177). Once more in these definitions we see a focus on goods rather than services, and so aspects of the human nature of pull are obscured. For example, in their new study of lean in a Finnish healthcare service, Hihnala and colleagues state that, although work and workflow can be ordered to create pull, 'It emerged [...] that a common set of values that respects human dignity came [sic] more important'.⁷

Pull too can be amenable to metrics to help maximise value. Measures of demand can be a useful source of data, which can be used to evidence how to manage the flow. Qualitative sources of evidence can include customers' (patients' and carers') accounts of their experience and motivations to make use of the service⁶ (p. 96).

Perfection

This is yet another concept with a shadow side. Womack & Jones once again avoid defining it, but talk of it as being the continuous application of the previous four principle concepts to strive to continue achieving better products² (p. 25). Perfection is never achieved, but there is always room for improvement. Actually, what they are truly referring to is the continual pursuit of identifying and eliminating waste (*muda*).

Metrics are important here as perfection needs to be defined. Perceptions of perfection can change over time, so descriptions need to be clear and revised regularly. Perfection may be best approached incrementally (monitored through metrics) and is never reached. Evidence demonstrating approaching perfection can be quantitative (e.g. in consistency of data) or qualitative (e.g. in having a culture free of fear that promotes quality improvement).

Lean in practice: a case example

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) were supported by Virginia Mason in the USA in adopting lean.⁸ Virginia Mason's own lean processes were adapted from the Toyota Production System, with a strong focus on eliminating waste (*muda*) and the use of metrics to measure improvement.⁹ TEWV have made a number of high-impact changes to the way their processes operate that have had benefits (brought value) to patients. One of these, the purposeful in-patient admission (PIPA) model, which was trialled on two adult wards, saw their original bed occupancy of 106% reduce by 22%, a 57% reduction in length of stay, a 72% reduction in reports of violence and aggression, and a 100% reduction in complaints (p. 62).¹⁰

Lean techniques they used to achieve these changes included: a move from a weekly ward round to daily multidisciplinary team meetings – to remove 'batching' of decision-making (to improve *flow* of the *value stream* of clinical decisions and interventions) visual control boards on the wards – to map the patient journey (*flow*) removal of waste (*muda*) from the office and patient literature – ensuring that only necessary literature were on the ward creating standard processes for each step of the patient journey and changing the layout of the ward environment (to improve *flow*).

The Health Foundation is now exploring how other organisations might benefit from lean and is conducting research into the effect a partnership with Virginia Mason would have on five other NHS organisations.¹¹

Lean thinking – evidence of impact

Although there are countless books and journal articles on the subject, Stone¹ identifies three 'voids' that lean research is yet to adequately tackle: the relationship between planned organisational change and human resource development intervention the relationship between planned organisational change theories and lean theories the 'human' factor – by this he means how best to engage staff in lean.

In contrast, in *The Toyota Way*, Liker defines the tenth of the 14 management principles of Toyota as 'develop exceptional people and teams who follow your company's philosophy'¹² (p. 184) and explains that at the company the Toyota Production System was originally called the 'Respect for Humanity System'¹² (p. 186). Nevertheless, other than his own observations, and a critique of theories of behaviour, Liker offers no empirical evidence for human resources and the human factor.

The Model for Improvement

Don Berwick, the improvement champion who has led the Institute of Healthcare Improvement (IHI) in the USA and who was called on by the then Prime Minister David Cameron to help make the NHS safe for the future¹³, writes an impassioned introduction for *The Improvement Guide*, a key text that describes the Model for Improvement.¹⁴ Notably though, the authors of the guide, who Berwick says he is still learning from, are largely statisticians by training. This is important, as the focus in lean is on waste and flow, whereas data, and the use of data, are at the heart of the Model for Improvement.

Berwick calls the model the 'most useful single framework' he has encountered¹⁴ (p. xiii). Founded on the work of Deming, also a statistician, the 'System of Profound Knowledge' is fundamental to the Model of Improvement. The system asserts that, through developing appreciation for a system, understanding variation (data, evidence and metrics are clearly important here), building knowledge and getting to grips with the human side of change, one is better equipped to make improvements¹⁴ (p. 76). Applying the Model for Improvement to an improvement challenge helps the leader organise an approach by guiding them through the following key questions. 'What are we trying to accomplish?' is about being specific and defining the problem. This makes it measurable and potentially subject to metrics. The question is also used as a call to arms, by clearly describing what is expected, and to create ownership, through encouraging others to contribute to creating this definition or 'charter'¹⁴ (p. 89). There are some darker sides to how this statement is used to motivate change, of the stick rather than carrot variety. For example, Langley and colleagues¹⁴ suggest choosing goals that are clearly unachievable using current practices, being explicit that previous tools will be removed whether change happens or not, or simply stating that the current service will no longer be provided if change does not happen. Thus, although values of addressing the 'human side' of change are espoused, the

authors are not shy of using traditional ‘machine metaphor’ classic top-down management theory¹⁵ (p. 18) if they think it will help towards achieving the goal. This seems to be in contrast to the approach Berwick advocates in his work on patient safety for the NHS, where he says, ‘Fear is toxic to both safety and improvement’.¹³ ‘How will we know that a change is an improvement?’ is sometimes abbreviated to ‘measures’. This is all about how to demonstrate the impact of change using data, evidence and metrics. Three different types of measures are encouraged: outcome measures that observe the outcome in question, process measures that monitor whether activity to achieve the outcomes is performed, and balancing measures that look at whether there are any unintended consequences of change¹⁴ (p. 96). One could argue that the model encourages only superficial engagement with the ‘is the change an improvement?’ part of the question by focusing on measures. For example, in a healthcare system where increasing discharge is the aim, is there enough challenging of the assumption that discharge is the right thing? ‘What change can we make that will result in improvement?’ is often abbreviated to ‘changes’ and is about identifying initiatives that could bring about change¹⁴ (p. 93). Methods for developing change are promoted, including ‘logical thinking about the current system, benchmarking or learning from others, using technology, creative thinking and using change concepts’¹⁴ (p. 120). ‘Changes’ can be opportunities to put evidence into practice, and could be an application of evidence-based medicine, such as the implementation of National Institute for Health and Care Excellence (NICE) guidance.¹⁶ Dozens of change methods are proposed that can be used in the Model for Improvement and many of these, such as ‘use pull systems’, ‘eliminate things that are not used’ and ‘match the amount to the need’, have clear roots in lean thinking¹⁴ (p. 358). Langley and colleagues acknowledge the overlap with other improvement approaches: ‘Several of the concepts are included in other approaches to improvement, such as Total Quality Management, Reliability, Safety, Six-Sigma, and Lean’¹⁴ (p. 358).

With the three Model for Improvement questions answered, improvers are ready to make use of the ‘plan–do–study–act’ (PDSA) cycle. PDSA can be used to ‘turn ideas into action and action into learning’¹⁴ (p. 97). There are four distinct phases to PDSA: the intervention or test should be planned, the plan should be executed and data recorded, data are analysed, and reasonable action is taken on the findings (essentially action is based on evidence).

The cycles of PDSA can be used to ‘build knowledge’ both of the improvement challenge faced and potential solutions.¹⁷ PDSA cycles are recommended by NICE to bring about improvements through implementing NICE recommendations.¹⁶ A model akin to ‘plan–do–study–act’, called ‘plan–do–check–act’, has been used in lean in, for example, work on patient safety.¹⁸

The Model for Improvement in practice: case examples

East London NHS Foundation Trust (ELFT) adopted the Model for Improvement, supported by the IHI. The trust’s work to reduce violence on in-patient wards saw a 40% reduction in violence across six wards and reduced costs related to violence by £181 296 (data are for 2015–2016).¹⁹ The Care Quality Commission (CQC), the UK’s healthcare regulator, has rated the organisation as ‘outstanding’ and commented: “‘ELFT has invested over the previous two years in a wide scale quality improvement programme. This has been embraced by staff. The methodology has successfully encouraged innovation and improvement which CQC inspectors were able to see throughout the inspection. There was a genuine passion to ensure that the services provided are the best possible.’²⁰”

The teams used the Model for Improvement questions to define and drive their work. They agreed what they wanted to *accomplish* (to reduce physical violence by 30%) and the *measures* to determine whether a change was an improvement (the main outcome measure used was ‘rate of incidents of physical violence per 1000 occupied bed-days’). In generating ideas for change, the team worked with staff and patients, and then used PDSA cycles with wards from across the trust to test the favoured change strategies. Staff came together at 6-weekly intervals to learn from each other and review data to consider whether improvement was happening.²¹

Hertfordshire Partnership University NHS Foundation Trust has also employed the Model for Improvement, launching it in 2015. Subsequently, the 2016 national NHS staff survey reported that the percentage of staff in the trust who said they were able to contribute to improvements had increased to 76%, from 70% the previous year. The Picker Institute, which analyses the data for the NHS, reported this as a statistically ‘significant improvement’ and above the national average for mental healthcare.²² The trust was also rated ‘outstanding’ by the CQC in May 2019. It said: “‘The delivery of innovative and evidence based high quality care was central to all aspects of the running of the service. There was a true sense of desire to drive service improvement for the benefit of patients, carers, and the wider

system, evident throughout the inspection. Staff included patients in service improvement and used their feedback to change practice.’²³”

Model for Improvement – evidence of impact

Evidence for PDSA in a UK healthcare context is varied. A systematic review of quality improvement methodologies carried out by NHS Scotland found that the evidence for PDSA in the NHS was ‘mixed’. It found that, in large projects taken forward by the NHS Modernisation Agency, work often did not proceed beyond ‘plan–do’. Other initiatives, such as work on the 4-hour emergency department (A&E) waiting target, could lead to problems elsewhere in the system (such as the patient waiting in a medical assessment unit instead). Success can be context dependent, with ‘striking differences’ between organisations using PDSA in quality improvement collaborations.²⁴ Furthermore a multisite cluster-randomised study comparing the effectiveness of different change initiatives within healthcare services in the UK found no difference between standard dissemination of guidance versus standard dissemination plus PDSA in the implementation of the guidance.²⁵

Conclusion – the essence of theories of improvement science

Considering these two approaches to quality improvement, a number of factors emerge as the essence of these theories: They aim to be pragmatic, seeking to clearly describe the problem and bring about real-world change. Although they draw on scientific theory, they are about implementing and applying scientific method to bring about improvement. The sensible use of data, evidence and metrics is essential in order to demonstrate change. They are about both processes and people. Automation can enhance productivity, but it is people that bring about change. They are sensitive to context. The evidence base demonstrates that improvement methods can succeed and fail, but identifying win factors can be a challenge. Leadership, engagement and culture are all extremely important. They are not discrete. The various improvement methods have considerable degrees of overlap and borrow from each other, for example lean can employ a ‘plan–do–check–act’ cycle, the Model for Improvement can use lean concepts.

The Health Foundation has summarised a similar list of ‘underlying principles’, which include understanding the problem, understanding the processes and systems, analysing demand, capacity and flow, choosing tools for change and evaluating change²⁶ (p. 11). In September 2018, the CQC published a report into what it had learned about embedding a quality improvement culture within healthcare organisations. It states, ‘We would expect that a hospital trust committed to delivering high-quality care should be embedding a systematic and effective approach to QI’.²⁷ Regardless of the provenance of the approaches and their evidence base, in the UK at least, it looks like they are here to stay for the foreseeable future. Clinicians will benefit from understanding quality improvement and could do much to shape how it is received and applied in their context.

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1.3.68 Do foundation doctors meet the mental health competencies in the foundation programme curriculum?

Jack Haywood

date

2020-02

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- *Do foundation doctors meet the mental health competencies in the foundation programme curriculum?*

In recent years, the UK Foundation Programme has been adapted in order to meet the changing demands of patients, as well as those of foundation year doctors. A broadening of the Foundation Programme in 2014 stipulated that 100% of foundation year doctors should undertake a placement including community care from August 2017.¹ Further to this, in 2015, Health Education England set a target that 45% of foundation year trainees should complete a psychiatry placement to gain exposure to mental healthcare.² However, it is important to recognise that mental health problems do not present just in the psychiatry setting. General practice (GP) and accident and emergency (A&E) are arguably 'gateways' to accessing mental healthcare in the National Health Service.

The Foundation Programme Curriculum 2016 outlines the expectations for what foundation doctors should learn. With the changes to community placements outlined above, I conducted a study to assess whether doing a foundation year placement in psychiatry, A&E and/or GP affects trainees' ability to meet the Foundation Programme mental health competencies. I used a cross-sectional questionnaire to ask foundation year 2 (FY2) and CT1/ST1 trainees whether they felt they had met 17 mental health-related competencies from the curriculum.³ This was sent electronically via Foundation Schools.

A total of 360 trainees took the survey. Of all the trainees, only 29.7% (n = 107) were aware that there are specific mental health competencies in the Foundation Programme curriculum that they should have met. Fourteen of the 17 competencies were self-assessed to have been met by trainees who completed a placement in psychiatry, compared with 15 out of 17 in A&E and 13 out of 17 in GP. By comparison, only nine competencies out of 17 were met by those who did not have a placement in any of the three specialties. Interestingly, in all groups, the competencies that should have been met by the end of FY1 were more successfully met than those for FY2.

These results were for trainees who may have taken one, two or all three specialties in their foundation year training. When considering each specialty uniquely, ten out of 17 competencies were met in psychiatry, whereas only six were met in A&E and nine in GP.

These results suggest that a combination of these three specialties may be more beneficial than one specialty alone, or none at all, in order for trainees to feel they have met the mental health competencies. There is also a case to be argued that trainees should be educated about the curriculum, as many were not aware they had the competencies to meet.

Further research should involve asking assessors to make the same competency assessments about the foundation year trainees, moving away from self-assessment to a work-based assessment.

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1.3.69 Section 12 approval: fit for purpose?

Nidhi Gupta William Calthorpe

date

2020-06

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- *Section 12 approval: fit for purpose?*

We compliment Rigby and McAlpine on a well-written editorial on Section 12 approval.¹ The authors raise several pertinent issues about Mental Health Act (MHA) detentions and note that there has been a 47% increase in the rate of detentions countrywide. They are of the opinion that the increase in detentions is mainly attributable to clinicians not being equipped with the necessary knowledge and training. Rigby and McAlpine suggest more rigorous evidence-based training reinforced by appropriate assessment, including summative assessment using criteria-referenced methods with pass marks determined by the Angoff method. The authors also feel that the approval and revalidation processes need to be more robust.

We, however, are of the opinion that the authors have taken an Occam's razor view by largely attributing the problem to clinicians' training. In our opinion, increases in detention rates are due to multiple factors, and the 'fix' is not as binary as upgrading training of clinicians or making the approval and revalidation processes more robust. The process of MHA assessment requires two doctors, of which one has to be an independent Section 12 doctor, and an approved mental health professional (AMHP), who is usually (but not invariably) a social worker. All three have to agree to detain a patient with a mental disorder. It is pertinent that the final responsibility for detaining someone under an MHA belongs to the AMHP, who then submits an application to a local hospital for an in-patient bed.

We quote verbatim from the 2018 Care Quality Commission report² on the use of the MHA to detain people: "1. The apparent rise in rate of detention since 2010 is in part due to the national data return being more complete.2. More people are being detained on more than one occasion during a calendar year than was previously the case.3. Bed numbers have fallen and more people with severe mental health problems are living outside of a hospital setting, and so are at greater risk of being detained.4. Some people are being detained under the MHA who would previously not have been detained. This is because clinicians are applying the criteria for detention differently to people with certain types of disorder (such as dementia or personality disorder). It could also be because more people with mental health problems are coming to the attention of mental health care workers (for example, through schemes that divert people from the criminal justice system).5. People who need admission and who would previously have agreed to informal admission are now refusing and are being admitted as detained patients.6. Admissions (some of which would be formal) that could in the past have been prevented are now not being prevented because less restrictive alternatives in the community are not available.7. There has been an increase in the total size of the population of England and an increase in the size of those sections of the population that are more at risk of detention.8. There has been an increase in the prevalence of risk factors for detention, such as social exclusion and problematic, untreated drug and alcohol misuse."

Glover-Thomas, in a recent review, notes that the availability of mental health beds has decreased, thereby delaying the 'preferred option' of voluntary admission of patients. Therefore, in circumstances when clinicians deem a patient to be in need of care in hospital, resorting to detention 'may be the quickest means of opening up services'.³ This factor – in our view – is consequential in 'bumping up' detention rates.

The number of appeals to mental health review tribunals (MHRTs) in England and Wales has risen steadily, from 904 in 19804 to 31 469 in 2014.⁵ This reflects the parallel increase in the number detained. However, the percentage of patients who are successful in obtaining discharge at MHRT hearings is relatively low (only 9% of all hearings in 2013–2014 resulted in discharge⁶), suggesting that patients have been detained appropriately. This, in turn, suggests that training for Section 12 approval is not a factor. However, we agree with Rigby and McAlpine that improvements in training would be beneficial to clinicians in terms of increasing their confidence and knowledge.

None.

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1.3.70 Improving patient flow in acute psychiatric wards: enhanced bed management and trusted assessment

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2020-08

Abstract**Aims and method**

In three localities in a mental health trust in England, an enhanced bed management team was established to improve patient flow and reduce out-of-area placements. Trusted assessments were provided to support risk management and conflict resolution. Two measures of flow were compared before and after the team was established.

Results

The trusted assessment recommendation was for discharge in 70% of cases. The number of out-of-area placements was significantly reduced ($P < 0.05$), saving £616 876 over a 12-month period. Patient flow was significantly improved in one of the three localities as measured by patients/bed/6-month period ($P < 0.05$). In one of the other localities increased use of trusted assessment input and reduced numbers of patients being transferred in are recommended to improve flow.

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Declaration of interest: None.

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Clinical implications

Mental health trusts should consider the establishment of an enhanced bed management team, including trusted assessment, as a safe and cost-effective approach to improving patient flow and reducing the need for out-of-area placement.

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NHS England's Five Year Forward View for Mental Health¹ mandated that access should be increased to high-quality community care, avoidable admissions should be prevented and treatment delivered as close to home as possible (recommendation 22). Out-of-area placements were to be completely eliminated by the financial year 2020–2021. 'Financial incentives and levers' were to be deployed to deliver on the key outcomes anticipated in recommendation 22. Consequently, mental health trusts working under contracts where these levers were being deployed had been losing substantial amounts of non-returnable funding through the use of out-of-area placements at a cost of £608/day. It is known that patient outcomes when admitted out of area are significantly worse than for those admitted locally.² The Five Year Forward plan, however, set targets without acknowledging that many mental health trusts were already 'under-bedded' in relation to their population size and level of social adversity and under-resourced in terms of community provision. Also, critical indicators for admission/discharge and estimated discharge dates were being underutilised by crisis teams and ward staff, leading to unnecessarily prolonged in-patient stays.³ Meanwhile, since the plan was written and distributed, a number of factors have come together to increase the pressure on scarce in-patient bed resources.⁴ In particular, the percentage of patients admitted under the Mental Health Act 1983 has increased, as has length of stay. Intellectual disability ('learning disability') beds were being reduced for both the forensic and working-age adult populations. One possible explanation was put forward that clients are declining informal admissions as the acute wards are perceived as stressful and end up eventually being admitted for a longer period under the Mental Health Act.⁵ This is paralleled by nursing staff opinion that acute in-patient wards are now best viewed as 'mini-PICUs'. Reduction in the use of the Mental Health Act 1983 is an objective of the Independent Review of the Act (which was completed in December 2018 and for which a white paper is proposed in the next session of parliament), and this could potentially improve flow through acute admission beds. Over the past 5 years there has been a 50% increase in accident and emergency (A&E) department attendances for mental health problems.⁶ This has led to increased pressure on crisis and liaison specialist services and, at times, perhaps unnecessary admission under the Mental Health Act. Presentations with intoxication from alcohol and other substances have been rising. We have also seen a surge in the use of 'gate sections' from Her Majesty's Prisons. This occurs when a prisoner has been mentally ill, was not transferred to prison under section 38 but is detained under the Act 'at the gate' at the time of their release. People whose primary diagnosis is a personality disorder are frequently kept too long under assessment in in-patient units, where risk may

increase rather than decrease. Their difficulties have often arisen from prolonged or repeated traumatising experiences in childhood or adolescence, and they may be better supported with effective community psychological management programmes,⁷ avoiding off-licence use of psychopharmacology and potentially further traumatising coercive in-patient treatment under the Mental Health Act.⁸ Any such admissions should be brief and require a team or pathway-based attitude supporting positive risk management. Risk averse practice has been rising owing to the negative consequences ensuing if the discharge and community plan are not effective in preventing a serious adverse outcome. All of these factors have combined to make the current in-patient experience of care potentially a stressful one for patients and staff alike.

There is no doubt that the spiralling development of specialist teams (while a good thing for their target populations) has significantly weakened the generic community mental health teams. Waiting lists for key worker allocation are lengthening and, at times, individuals are discharged too soon, removing ongoing support with well-being activities (including medication concordance support). Another factor that has driven admissions up is that nobody 'owns the flow'. Sector and integrated psychiatric services would facilitate a discharge if an admission was needed. However, 'split' in-patient and out-patient consultant psychiatrist posts have contributed to impairing pathway ownership of the flow of patients into and out of acute units as well as causing patient dissatisfaction with perceived lack of continuity of care.⁹ As a result of this accumulation of factors, many trusts across the UK have found themselves in great need of a solution to the problem of lack of available admission beds that arises as they do not have 'the right patient at the right place at the right time' on their care pathway. Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (NTW), which covers a population of approximately 1.5 million, decided that effective and prompt discharge to the correct treatment pathway needed to be facilitated and the trust board mandated a director to take responsibility for this crucial area. The enhanced bed management (EBM) service was created as one of a number of interlinking strands to deal with rising demand for in-patient admission. The other strands included the establishment of a personality disorder hub, improving crisis assessment and home treatment teams and improving rehabilitation flow. This paper reports early findings from evaluation of our EBM service.

Method

In response to the above pressures, NTW decided to implement the EBM approach across all acute psychiatric wards in three localities. The EBM team included three discharge facilitators and five bed managers. There were also one nurse manager, one part-time administrator, one part-time social worker, one research assistant and two part-time consultant psychiatrists (both 0.4 full-time equivalent). A system of linked detailed electronic bed boards was introduced in all acute wards trust-wide to regularly update critical indicators, estimated discharge date, mental health cluster and Mental Health Act status. Discharge facilitators attended all multidisciplinary team (MDT) meetings and clinical bed managers were available for consultation on a locality basis. 'Trusted assessments' were made available on request by the MDT with the agreement of the responsible clinician. The purpose of the trusted assessment was to complete a full review of the history, interview the patient and all pertinent staff and give an independent and comprehensive opinion to all parties on diagnosis, treatment and management. Trusted assessments began in January 2018, continued throughout that year and are ongoing. The impact of EBM on out-of-area placements (adult acute) was calculated by comparing a proxy of flow (number of out-of-area placements/month) between the calendar years of 2017 and 2018. The impact on flow as measured by patients/bed was compared between the first 6 months and second 6 months of 2018 (the second reflecting the period when the full team was operational). Unpaired *t*-tests were used to compare the periods in question.¹⁰ All other statistical analyses were performed using IBM SPSS Statistics (for Windows), release 24.0.0.2. Further exploration to understand the impact of internal transfers examined length of stay data for all patients discharged from adult acute wards in the trust during the financial year 2018–2019. Outcomes and recommendations from the first 50 trusted assessments were determined by case note review in March 2019.

Ethical approval was not sought as this project was a service evaluation and there was no randomisation and no treatment being tested.

Results

Out-of-area placements

The number of out-of-area placements was reduced by over 60%: in 2017 the monthly mean was 5.25 (65 placed in the year); in 2018 the mean was 2.4 (29 placed in the year) ($P < 0.05$). This equated to a saving of £616 876 in otherwise lost revenue (the figure given for savings does not include the cost of the EBM team).

Patient flow

Flow (patients/bed/6-month period) showed a significant improvement in one locality ($P < 0.05$) in the period of full operation of EBM, compared with the preceding 6 months: 4.83–5.5 (167 admissions rising to 246, with 56 transfers reducing to 52 over that period). In the other two localities one already had acceptable levels of flow and these did not change significantly (5.2–5.36; 253 admissions rising to 260 and 56 transfers reducing to 35). In the other locality flow remained lower, at 4.6–4.65 (284 admissions reducing to 253 and 46 transfers increasing to 71). The three localities had 57, 70 and 54 acute beds respectively. Patient flow is locality specific and deemed acceptable in two NTW localities, because if all three localities were hitting the same flow targets of 5.2–5.5 patients/bed/6-month period then there would have been no out-of-area placements and only infrequent admissions into leave beds.

Trusted assessment uptake

To examine the potential impact of trusted assessment uptake on locality patient flow, a *post hoc* correlation between number of trusted assessments provided and proportionate increase in flow was calculated. In locality 1, where 9 trusted assessments were requested, the proportionate change in flow was 0.13. The flow figures for locality 2 were 0.02 (with 14 trusted assessments) and for locality 3 they were 0.13 (with 19 trusted assessments). A correlation between proportionate change in patient flow and number of trusted assessment requests was significant, with a two-tailed Spearman's rho of 1.0; $P < 0.001$.

Length of stay

A more detailed exploration of the factors affecting flow data was undertaken. Initial flow data indicated that flow was noticeably low on one ward in particular. The consultant body suggested that looking after relatively more intra-trust, cross-locality 'transfers in', who would, by implication, be more ill, might explain the lower flow. Examination of data for 1 year of patients who had been discharged showed that intra-trust, inter-locality transfers indeed stayed significantly longer than those who were admitted and discharged from the same ward (mean stay 70 days compared with 32 days; $P < 0.001$). If short-stay patients (in for less than 20 days) are removed from this analysis, a statistically significant difference remained (83 v. 59 days; $P < 0.001$). Overall then, intra-trust transfers stay significantly longer than those remaining on the ward on which they land and this ward had a much greater proportion of transfers in. However, both male wards in this locality had, proportionately, a considerably greater number of transfers in, contributing to lower flow data for the whole locality. Clarity, then, about the greater numbers of transfers in and their associated length of stay initially suggested an explanation for this low flow (many more transfers in, who stay longer). However, further analysis of the pathway indicated that these patients had remained on initial wards before the transfer for a mean of 18 days. If the same group of short-stay patients are again removed, the mean rises to 21 days, corresponding almost exactly to the difference in mean of total length of stay between the groups of those transferred and those remaining (24 days) once the short-stay group was removed from the data. Thus, the length of stay on the wards on which the patients land after the initial stay was examined. This showed that male transferred-in patients in this locality as a whole stayed significantly longer after their arrival on the destination ward than male transfers in in the other localities (means: 38, 46 and 71 days; one-way ANOVA, d.f. = 2; $F = 4.6$; $P = 0.01$) indicating a difficulty with the male pathway as a whole in this locality rather than just one ward.

Trusted assessment recommendations

Examination of 'the first 50' outcomes showed that the trusted assessments recommended discharge for 35 (70%) of patients they were asked to assess and, of these, 19 were discharged within 2 weeks; 25 of the 35 were discharged within 4 weeks. There were no untoward incidents in the follow-up period after discharge (which was obviously different for each patient, depending on the timing of trusted assessment provision): the mean was 149 days (range: 89–355). This amounted to 3730 people-days among 25 people. Thirteen of this 25 experienced a readmission (eight had one readmission, four had two and one had three readmissions) for a median of 9 days in total. Considering the impact of the trusted assessment on overall care, this 25 had experienced a mean of 7321 days as in-patients since their very first admission and 21 863 days living in the community (ratio 0.33). In the intervening 3730 people-days, these 25 patients experienced a mean of 35.4 days as in-patients and 251.5 in the community, a ratio of 0.14.

Discussion

These results show that, by investing in an enhanced bed management (EBM) service, improvement in quality of care and substantial financial savings can be achieved by preventing unnecessarily long hospital stays.¹¹

Trusted assessments

Although the clinical bed managers, discharge facilitators, EBM social worker and research assistant were broadly welcomed by in-patient teams, the role of the trusted assessment was viewed initially with some suspicion, as the exact nature of the role was not understood for some time. The initiation of the concept of trusted assessment required the agreement of the responsible clinician. There was not a uniform uptake across the three localities. This might indicate ambivalence on the part of the MDT or the responsible clinician. We are not aware of any vetoing of a trusted assessment by the responsible clinician when it was requested by the MDT. In a parallel project to build consensus there was 89% agreement with the following statement among a multiprofessional consultant staff group: 'Given consensus that the needs of current in-patients should be balanced with the needs of those waiting admission, a trusted assessment is helpful in contributing a view that explicitly takes account of the wider needs of the system and when such needs are incorporated into the trusted assessment thinking these should be explicitly articulated in the report'. A trusted assessment is only undertaken at the request of the MDT and with the full consent of the responsible clinician. Trusted assessments were able to support the MDT in relation to difficult discharge situations.

The trusted assessments recommended prompt discharge in 70% of cases and were able to support MDTs in terms of mediation between different views and positive risk management to achieve prompt discharge.

Specific locality-based analysis of patient flow highlighted difficulties that required detailed analysis of data on length of stay to fully understand local problems, ensuring that possible solutions could be developed. Rather than showing that transfers in alone explained the problem on one ward, this analysis revealed that there were whole-locality pathway problems. A number of patients were waiting for a rehabilitation bed and there were fewer discharge options in terms of supported accommodation in that locality. Further, the locality in question did not make use of trusted assessments, whereas the locality that optimised flow was a heavy user of trusted assessments.

Trusted assessment has been operating in acute hospitals for some time but with a slightly different role, where a number of different providers agree that the trusted assessment will decide on the most appropriate discharge package once that discharge has been decided on.¹² Our model of trusted assessment, within mental healthcare, is that the various teams within the trust agree to clinical mediation, positive risk management or other care strategy with the contribution of an experienced clinician working within EBM. This team can be consulted in relation to EBM establishment and working practice, and the multimodal linked bed boards viewed. If the important targets of the Five Year Forward plan are to be achieved within a system of suboptimal bed provision, our findings show initial support for the contention that EBM, incorporating trusted assessments, is a safe and viable option.

Study limitations

This is the first publication of the impact of such a service. Different comparison periods were used for out-of-area placements and flow because trusted assessments began in January 2018 but the full EBM team was not functioning until mid-2018. It is likely that the impact on out-of-area placements when next measured will be further enhanced. A further limitation of this report is that the case note review of the impact of the first 50 trusted assessments was done by a non-masked team member.

Implications for other mental health trusts

This service development took place in a mental health trust that already had an ‘outstanding rating’ from the Care Quality Commission. In-patient beds, rehabilitation beds, community and other resources were all close to the median in the NHS benchmarking document.¹³ The Five Year Forward plan, however, set targets without acknowledging that many mental health trusts were already ‘under-bedded’ in relation to their population size and level of social adversity and under-resourced in terms of community provision. It is certainly the case that there are mental health trusts where much higher numbers of out-of-area acute beds are chronically in use. If the important targets of the Five Year Forward plan are to be achieved within a system of suboptimal bed provision, our findings show initial support for the contention that EBM, incorporating trusted assessments, is a safe and viable option. The generalisation of these findings to other trusts and settings will depend on an adequate number of acute psychiatric beds being funded and a number of other locality-specific factors. These include the level of social deprivation and adequate funding of crisis/home treatment teams and other community mental health provision. Mental health trusts might consider appointing a senior clinician or director with responsibility for pathway synchronisation and ownership of patient flow. This model may also prove beneficial for older adult and rehabilitation services.

All authors contributed in a substantial manner to the design of this project or the acquisition/analysis or interpretation of the data and drafted or critically revised the manuscript and approved the final version. All authors also agreed to be accountable for all aspects of the work in insuring that all questions relating to accuracy or integrity are appropriately investigated and resolved.

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1.3.71 Authors’ reply

David Rigby Lynsey McAlpine

date

2020-06

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- *Authors’ reply*

We are delighted that the publication of our article has generated a debate around the Section 12 approval process and welcome the opportunity to respond to the three letters. Before responding to some of the criticisms of our article, we think that readers would benefit on some narrative on why we chose to publish this article. At a similar time to attending a Section 12 approval course, the first author had also attended an advanced life support (ALS) course. These

courses have some similarities in that they are 2-day events with teaching on performing specialised tasks which are required in order to work in certain specialties or positions of seniority after accreditation from a respected body.

However, the author's experience of the two courses also had notable differences. To name a few: the ALS course came with an extensive manual, knowledge of which was tested in a multiple choice question; the large majority of the course was spent undertaking simulations of the tasks in which the course was accrediting competence; and IDs were checked and significantly late arrivals would have resulted in course failure, and therefore the course was promptly attended.

By contrast, the Section 12 course had several late arrivals and some early leavers. There were no ID checks. Teaching, although of a high standard, was mostly lecture based and didactic and, most worryingly, a significant minority of attendees spent large amounts of time using their phones during the course. There was no simulation training on performing Mental Health Act assessments (MHAAs) in the course.

Although anecdotal, these differences should cause concern to those with responsibility for Section 12 approval. As we demonstrated in our article, our belief that the difference in engagement in these two courses is due to lack of assessment in the Section 12 approval process is based on pedagogical research that shows that students will not engage in effective learning when they are not assessed.

We accept Dr Khwaja's criticism that we do not have contemporaneous evidence of a lack of knowledge or skills in Section 12-approved doctors but argue that – in contrast to the current situation – the onus should be on Section 12 approval courses to establish through assessment that participants have in fact acquired appropriate knowledge and skills.

We note Dr Khwaja's suggestion to change the title of our article, but we stand by our original title as we believe that there are concerns in multiple domains of the Section 12 approval process. For instance, many National Health Service trusts only allow Section 12-approved doctors to perform MHAAs. The MRCPsych exams do not assess knowledge of mental health law. Therefore, it is entirely possible for a doctor to receive Section 12 approval who has never performed an MHA, simulated or real, or who did not attend the approval course, instead asking a colleague to sign in, or attended the course but chose to engage with their phone rather than the course content. Essentially, UK doctors receiving Section 12 approval will not have had any formal assessment in their knowledge and skills in relation to performing an MHAA.

Dr Khwaja notes that international candidates are required to have evidence of having undertaken supervised MHA assessments. Surely this disparity should be corrected and extended to all Section 12 approvals in the UK? He also notes that only a basic working knowledge of the MHA is required to conduct an assessment, but this should not negate responsibility for assessing Section 12 doctors for any knowledge of the MHA.

The authors are aware that Section 12 approval is not required to take part in an MHA but argue that this is even more reason to ensure that Section 12 doctors have the appropriate knowledge and skills to undertake assessments if they are to be relied upon as one of two doctors with specialist skills. At the time of writing this letter, proposals to amend the MHA to allow only one doctor to detain a patient were under consideration owing to the Covid-19 pandemic, focusing our concerns into even sharper relief. Dr Gupta's letter states that we attribute the recent 47% rise in detentions primarily to the issues we have raised. Our article does not make this claim and we detail some other likely contributory factors. However, this very significant rise in detentions gives an additional reason to raise the standards of the accreditation process.

We agree with Dr Khwaja's statement that the approval courses can allow for debate around the intricacies of mental health law but assert that this should occur as well as, rather than instead of, ensuring basic competencies.

We of course accept Dr Ballantyne-Watts comment regarding the very low response rate to the questionnaire but want to highlight that the survey was conducted to try to ascertain what degree of standardisation there was between approval courses; we do not base our conclusions upon the questionnaire. We found the lack of engagement from course organisers frustrating and concerning, and this was a driver for writing the article. We plan to survey attendees of the approval courses to shed further light on this issue and perhaps the issue of smartphone usage and expect a much higher response rate.

We know of no other accreditation process in medicine that takes place with the lack of rigour described in this letter and in our article. We accept that the question of requisite knowledge and skills in Section 12-approved doctors is an

open one and would again welcome the opportunity to collaborate on performing a study to address the need for more up-to-date research in this field.

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1.3.72 A day in the life of a psychiatrist in 2050: where will the algorithm take us?

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date

2020-06

Abstract

Digital phenotyping (such as using live data from personal digital devices on sleep, activity and social media interactions) to monitor and interpret people's current mental state is a newly emerging development in psychiatry. This article offers an imaginary insight into its future potential for both psychiatrist and patient.

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- *A day in the life of a psychiatrist in 2050: where will the algorithm take us?*
– *A vision of the future*

The most exciting development in modern psychiatry is arguably the field of digital phenotyping. Encompassing data related to sleep, speech, activity, social media and keypad interactions, digital phenotyping promises to measure and interpret human behaviour at unprecedented scale. In psychosis, researchers strive to use such data to predict relapse, while others aim to predict suicide risk using machine-learning techniques.^{1,2} However, with the field in its infancy, the potential social effects of such technological advances are unclear. How successful will digital phenotyping be in clarifying psychiatry's uncertainties? Most importantly, where will the algorithm take us?

¹ Declaration of interest None.

²

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A vision of the future

Arriving at work, Dr Singh rests her coffee on the desk and logs into her electronic record system. Ahead of her first appointment she browses the neuroimaging, bloodwork and behavioural data for her patients that day. Reminiscing on how quickly this new world had been sold to the profession, she remembers a lecture, 30 years ago, marking her first encounter with digital phenotyping. ‘Where will the algorithm take us?’, the conference programme asked, leaving Dr Singh shocked at the science fiction surrounding her. The algorithms, already claiming more accurate suicide risk assessment than clinicians, had begun to quantify mood, anxiety, sleep, physical activity, interpersonal interactions and geolocation as markers of social functioning.³ A former Director of the Institute of Mental Health had left to join Silicon Valley as early as 2015 and social media companies boasted about their own suicide risk screening tools only 3 years later.^{4,5} While psychiatrists of the past stole glimpses of psychopathology from snapshot mental state examinations and unreliable histories, the ‘big data’ revolution promised to chart patients’ entire behavioural phenotype for doctors to assess. Even the machines were learning, they claimed.

Steve’s alarm woke him. The day introduced him with a motivating message, psychoeducation they called it, as he hunched over a bowl of cereal, inputting its nutritional information to his diet-tracking app. The phone prompted him of his exercise schedule for later that day, a pending mood assessment and reflective diary entry, shortly followed by a reminder for his annual appointment with his psychiatrist.

Meanwhile, Dr Singh, like the rest of us, played catch-up. Medical students continued to read textbooks and revise mental state examinations. Mental health legislation remained reliant on risk, while algorithms predicted numbers but failed to rationalise their judgements in a way that humans could understand. Dr Singh watched the world reduce itself to binary, while her former colleagues – the radiologists and general surgeons she’d known since medical school – began fearing losing their jobs to automation and robotics. Governments, eager to improve ‘population well-being’ and keen to avoid culpability for suicide and violence, implemented their own machine-learning projects. Insurance companies demanded that their clients wear smartwatches, such that their every behaviour could be monitored.⁶ The rush towards big data, ‘the new oil’ as one economist put it, spared no profession, field or domain of daily life.⁷ As the future came to stay, the algorithms marked their next victim. Psychiatry?

Yes, Steve replied, as the receptionist beckoned him towards the sign marking the out-patient department. He took a seat in the waiting room, reflecting on what to do. How he might break the news. Remembering, tentatively, how he had stood on the bridge, looking across the city, contemplating ending it all. It was News Year’s Eve 2049, the new year coaxing him intolerably, daring him on. The fireworks exploding in the distance. A note waiting at his flat. A future without a place for him. He hadn’t seen his psychiatrist since then. Would she know what had happened?

Yet in this brave new world, technology wasn’t just an adjunct to clinical decision-making. It strove to compete, claiming a therapeutic relationship of its own with patients. As early as the 2010s, self-help phone applications advertised themselves with taglines such as ‘rule your mind or it will rule you’, while others offered individualised therapy through artificial intelligence techniques.⁸ The market flooded well beyond the traditional boundaries of academia, researchers were inundated with innovation but starved of time to regulate it. A 2018 analysis found that only 14 of approximately 100 studies using mental health apps had clinically validated evidence of their effectiveness.⁹ However, fears about the field’s lack of regulation could only chase the technology into the future.

His phone knew. The app which monitored his mood knew, as did the one which monitored his geolocation. Maybe the software which monitored his sleep had worked it out too. He was sure that some of his social media followers had guessed. His internet searches knew. His family didn’t. His phone had recognised something his friends had missed. Perhaps it was his phone which had stopped him. Or had it merely helped him stop himself?

In anticipation of Steve’s appointment, Dr Singh downloaded his data. She analysed the GPS data first, before turning to the sleep data, exercise records and daily mood assessments. She was sceptical of algorithms that claimed to close the loop between users and their care, seeking to displace the clinician. Even the most well-intentioned apps, the most effective, lacked something, she felt. But she didn’t resist the technology entirely. With data of its own, psychiatry demanded parity with physical health. Digital biomarkers offered patients objective evidence for years of lived experience and routine dismissal. The algorithms informed clinical decisions, streamlined cloudy diagnoses and personalised treatment choices. Yet alone they lacked something profoundly human, profoundly therapeutic.

Steve walks into the clinic and sees his doctor of 17 years. A tear drops from his cheek. The psychiatrist offers a tissue.

More come. They forget the numbers for a moment. A moment's pause in a world bustling of answers. A moment of silence in a world full of data. Steve looks up. 'It's good to see you' he says, wondering how to tell someone what they already know.

They talk, and they reflect. Dr Singh browses Steve's numbers in the way that doctors have glanced over blood tests and clinical observations for years. Steve adds meaning to the data, reflects on the read-outs, adds humanity to the algorithms. Together, they identify where the models shadow their subject like ill-fitting clothes. Algorithms worked in broad assumptions, clinical acumen dealt with individuals, Dr Singh explained, as she tailored the numbers to the man in front of her.

She was reasonable, Steve felt. He liked her. An ally with whom to navigate this increasingly impersonal world. As the appointment drew to a close, Dr Singh offered Steve an outreach service. We can have the data alert us if anything takes a turn for the worse, she explained, a run of poor sleep or abnormal text messaging could prompt your community team to check up on you, or even drop you a visit. It was something which had appeal, a safety net he wondered if he'd benefit from.

Dr Singh was hesitant to offer the remote-monitoring outreach service to all her patients. The qualitative studies had identified that some found it too intrusive, whereas others worried they would become fixated on their own mental health, causing an anxiety of its own.¹⁰ Historical concerns around the medicalisation of everyday experience persisted in new forms. Part of her was relieved when Steve declined.

New Year's Eve 2050. Another year had passed. As 2051 beckoned, Steve continued to struggle with his symptoms. He'd developed coping strategies, the data had helped him identify his triggers of relapse. Sometimes he wondered if the algorithms knew him better than he knew himself. And he wondered if that was OK. With their help, he'd learnt to predict and prepare for his relapses. At his most optimistic he wondered if he'd managed to prevent them.

After seeing her last patient for the day, Dr Singh turned back to her computer. Flicking through the screens, she glanced through a collection of records the remote-monitoring outreach programme had flagged for her attention. A man with schizophrenia exhibiting an unusual geolocation trail and a woman with bipolar disorder whose sleep had become increasingly erratic. She would call them in the morning, reassured that even technology could not evade the uncertainties of clinical practice. After shutting down her computer and returning her coffee mug to the kitchen, Dr Singh exited the clinic into the cold December evening.

Approaching midnight, Steve's phone notified him of another upcoming daily mood assessment. He glanced down, hesitated and turned it off. Placing his phone on the table next to him, he looked to the sky, stood up and walked towards the fireworks.

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1.4 2019

1.4.1 The requirement for a general psychiatric assessment risks psychopathologising the experience of transgender people

Michael Shaw

date

2019-2

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- *The requirement for a general psychiatric assessment risks psychopathologising the experience of transgender people*

This paper and the service from which the statistics are drawn appear concerning on a number of levels. It appears unlikely that the fundamental assertion which underpins the statistics in this paper is accurate, namely that ‘our case note review was able to capture all patients referred within a certain time period in this geographical area’.

The authors state that: ‘All individuals who request treatment for gender dysphoria in Oxfordshire are referred to a single clinician (C.B.) for psychiatric assessment and subsequent referral to a specialist centre’, and later, ‘there is a single point of access in Oxfordshire for onward referral to specialist gender clinics’.

This referral pathway is not consistent with mainstream practice in other areas of England and is not supported by current protocols and guidelines representing best practice. The 2013 College Report *Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria* emphasises referral by or via a general practitioner, with no other gatekeeping requirement.

The requirement for a general psychiatric assessment is at best unnecessary and at worst risks psychopathologising the experience of transgender people who are presenting with gender dysphoria, an experience of discomfort or distress which is not psychiatric in nature.

There is local awareness of the unusual nature of the arrangement in Oxfordshire. The Oxford University LGBTQ+ society advises on its website: ‘N.B. A lot of GPs will seek to refer trans customers to psychiatrists (in Oxford, this is usually Dr Chris Bass), but this is a completely unnecessary procedure. If you’re seeking referral to a Gender Identity Clinic to receive hormone treatment or surgery, this will only lengthen the process. Psychiatric assessments are not required by Gender Identity Clinics, and your GP is qualified to make the referral’.

Given the high proportion of students who will have families of origin outside Oxfordshire and the high level of awareness within Oxford University that a psychiatric assessment is unnecessary, it appears likely that a significant number are bypassing the service.

Another factor not considered by the authors is the almost exponential rise in people presenting to gender identity services who are under the age of 17. Provision is via a centralised national service for young people. At 17, their care is transferred to an appropriate gender identity clinic. Transfers of care now comprise an increasing proportion of referrals to the Northern Region Gender Dysphoria Service. As this is the case nationally, such patients will also bypass Dr Bass and will not feature in the statistics presented.

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1.4.2 Night-time confinement and the practice of realistic medicine

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2019-2

Abstract

Summary

Night-time confinement is the practice of routinely locking patients in their rooms at night unless there is a contrary clinical indication. It is used in high-secure psychiatric hospitals. This article argues in favour of this practice on the basis of realistic medicine, an individual human rights based approach, the principles of mental health legislation in Scotland and England and cost effectiveness. This is not an academic debate. There is a real danger that those advocating against night-time confinement, if successful, will at best make little difference to the lives of our patients as they sleep, and at worst may hugely impoverish their lives because of reduced daytime activities.

Declaration of interest

L.T. is Medical Director at The State Hospital. Night-time confinement is used within this setting.

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- *Night-time confinement and the practice of realistic medicine*

I am not in favour of night-time confinement (NTC), but I am in favour of maximising the benefit to patients, and of efficiency and equity, as set out in the principles of mental health legislation throughout the UK; and I am for optimising our patients' opportunities for care, treatment and rehabilitation, and for 'realistic medicine'.¹ Realistic medicine places the patient at the centre of decision-making, and aims to reduce harm and waste, tackle unwarranted variation in care, manage clinical risk and innovate to improve so as to ensure a well-functioning and sustainable National Health Service (NHS). I am therefore not against NTC, the practice of routinely locking patients in their rooms at night unless there is a contrary clinical indication. This approach to NTC is used within the high-secure hospital (The State Hospital, Carstairs, Scotland) where I work.

The State Hospital is the high-secure psychiatric hospital for Scotland and Northern Ireland. In one capacity or another, I have worked there intermittently since 1992. Throughout this period we have always utilised NTC, but it is important to note that whether then or now, all patients who have need of an open door at night will have this; for example, because of poor mental or physical health, distress over a recent or pending event or risk of self-harm.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) visited the State Hospital in 2003. It highlighted the poor accommodation for patients but the issue of NTC was never raised, although it was raised at Rampton Hospital in 1994. In September 2011, we moved to a purpose-built new hospital within the same site. Our previous estate could accommodate up to 250 patients within ten wards. In our old hospital some patients had an open door. This literally meant an open door. There was no door-locking mechanism

for patients that could be overridden by staff. An unofficial quota operated within each ward. The wards contained between 24 and 26 patients and at any one time, approximately ten patients could have an open door. The admissions ward was excluded from this. Some patients did not want an open door because of their paranoia or legitimate concerns that other patients would enter their room. Others enjoyed the use of an open door, particularly as the majority of wards in the hospital at that time did not have en-suite facilities. This meant that patients could go to the toilet without having to ring a bell to attract the attention of staff.

The new hospital consists of four hubs, each with three wards for up to 12 patients. All rooms have en-suite facilities and televisions. The standard of these facilities is excellent, in fact, so good that a recent delegation from China asked to book in. The clinical model developed for the new hospital included the use of NTC for all patients. I emphasise again that any patient with a clinical need for an open door will have this. This allows us to use staff therapeutically during the day when patients are awake, rather than requiring an increased number of staff at night. Patients, named persons and carers were fully involved in developing the clinical model, during which time the views of these groups were considered, in addition to those of staff. Stakeholders reflected on the benefits of having staff available on shift during the day to support access to the grounds for escorted walks and to engage in structured activity.

NTC was also proposed because of the development of the en-suite facilities, the entertainment systems available in rooms and because the new hospital would be smoke free. No longer were the major motivating factors for an open door (the ability to go independently to the toilet and to get up to have a cigarette) relevant. NTC in its current form has been in place for almost 7 years. Never has this been the subject of complaint by a patient, named person or carer, nor raised by the Patient Partnership Group, the Carers' Group, the Independent Advocacy Service or the Mental Welfare Commission (MWC). The MWC is tasked under the Mental Health (Care and Treatment) (Scotland) Act 20032 with visiting people, monitoring the legislation, influencing and challenging all those involved in mental health and protecting the human rights of those under the care of mental health services.

The State Hospital is not alone in its use of NTC. It is used in all four high-secure hospitals in the UK. Rampton Hospital³ evaluated its use of NTC and found that there was minimal change to the experience of patients and staff following the introduction of NTC, and that NTC did not affect the patients' quality of life or produce adverse effects; indeed incidents of self-harm and aggression, and hours in seclusion reduced during the evaluation. In addition, patients appeared to go to bed earlier and sleep better, and were therefore better able to utilise the therapeutic programme during the day. Research with similar findings was also carried out at Ashworth Hospital.⁴

In practical terms, removal of NTC within The State Hospital would potentially have major resource implications in terms of nurse staffing and costs. Currently at night (21.00–07.40 h) within The State Hospital, there are 20 nurses for ten wards, with three additional staff members floating to give extra cover as required, plus the senior nurse in charge. This is a total of 24 staff members. There are two 'sides' to the shift, so a minimum of 48 staff are required to ensure daily cover.

The model of nursing that would allow the safe opening of all bedroom doors would require a minimum of 39 nursing staff plus the senior nurse in charge. This is based on three staff per ward plus eight incident responders and a duty resuscitation nurse. This a total of 40 nurses, or 16 per night in excess of the NTC model.

To realise the projected staffing model that could support the delivery of a non-NTC model, significant additional staffing would be required to be allocated for night duty. As 16 additional staff would be required for each side of the shift, this equates to 32 staff per week. Forty additional staff would actually be required when the percentage allowance is added on for training, leave and other absences.

There would be two options to realise this potential requirement to increase staffing. One would be to reallocate staffing resources from day duty to night duty, thus reducing staff availability during daytime hours by 16 staff per day (or 1.6 staff per ward). This would have an additional staffing cost for the night shift of £373 000. The other option would be to employ 40 new nursing staff to bridge the gap that this model would create.

It would be exceptionally challenging to recruit this number of staff in one cohort, and there would be a potentially destabilising effect of having a large influx of new clinical staff into a high-secure environment. In financial terms, employing 40 new nursing staff would cost £1.6 million, based on a projected average cost of £40 000 per post. Given that in 2017–2018 the State Hospitals Board for Scotland balanced its books with little to spare, and that it is most unlikely that further funding would be forthcoming for this from Scottish Government, this could only be paid for by reducing daytime staffing. This would likely have a direct and immediate detrimental effect on the care and treatment

of patients and is at odds with maximising the use of our staffing resource to best achieve safe, effective and person-centred care. As Scotland is moving to enshrine safe and effective staffing as part of our legislative framework, the current model of NTC could be argued to support achieving this legislative requirement in ensuring that our nursing staff are best deployed to meet the needs of our patients.

Undoubtedly some of the arguments above are utilitarian, but this in itself is an ethical theory. What then of other ethical and legal perspectives? The CPT report (2017)⁵ criticised the practice of NTC in English high-secure hospitals. It also criticised long-term segregation, but this is not a practice in use in Scotland. Specific powers to authorise NTC are set out in NHS England Security Directions (2013)⁶ and the 2015 revised Mental Health Act Code of Conduct.⁷ These state that NTC ‘should only be put in place where it is considered that this will maximise the therapeutic benefit for patients as a whole in the hospital’. CPT highlighted the importance of an individual perspective in the provision of psychiatric care and I would argue that each of our patients within The State Hospital is assessed for any negative effect that NTC may cause, and care is modified if this is identified. Indeed, The State Hospital adopted a human rights based approach over 10 years ago and this was independently evaluated by the Scottish Human Rights Commission⁸ and declared a good example for other public bodies. The UK Government⁹ in its response highlighted the public consultation on NTC, including patients in a high-secure setting, and the monitoring arrangements in place through the National Oversight Group for High Secure Services and announced its intention to review the use of NTC in light of the CPT’s comments.

It is the view of the Royal College of Psychiatrists’ Special Committee on Human Rights (SCHR) that NTC cannot be justified on ethical or human rights grounds (G. Szmukler, personal communication, 2017). The SCHR argue that NTC is incompatible with Article 5 (liberty and security) of the European Convention of Human Rights and probably Article 8 (private and family life), in that it is out of keeping with least restrictive measures found in the Mental Health Act Code of Practice 2015. SCHR considers the blanket imposition of NTC as an arbitrary restriction on liberty. They argue that NTC crosses a ‘red line’. Within The State Hospital, NTC was never introduced as a means to save money. It was brought in as part of a new clinical model that employed the same number of nursing staff for a reduced population, from 250 to 140 patients, but in smaller, more homely ward settings. Given that NTC within The State Hospital can be individually tailored regarding clinical needs and has never been the subject of any complaints or comments from patients, named persons, carers, advocacy, the Patient Partnership Group, staff or the MWC, it seems extreme to suggest it crosses a red line or that it constitutes inhuman or degrading treatment.

The SCHR suggests that NTC would be unlikely to meet criteria for a lawful restriction of persons’ residual liberty according to *Munjaz v UK* 2913/06 [2012] ECHR 1704. Residual liberty refers to a further deprivation of an individual’s liberty under Article 5 of the European Convention of Human Rights even if you are already detained. Further, they argue that Article 8 of the European Convention of Human Rights strengthens the importance of considering further restrictions in someone already detained, whose personal autonomy is limited.

SCHR argues that NTC is not compatible with the principles of the 2015 revised Mental Health Act Code of Conduct in England, chiefly the least restrictive option and maximising independence; respect and dignity; and purpose and effectiveness. The 2015 revised Mental Health Act Code of Conduct sets out five principles: least restrictive option and maximising independence; empowerment and involvement; respect and dignity; purpose and effectiveness; and efficiency and effectiveness. All principles are of equal importance, but their weighting may change depending on the context and nature of the decision being made. Surely here it is the principles of efficiency and equity, and purpose and effectiveness in promoting a system that supports recovery, that are of more importance than the least restrictive alternative. The Mental Health (Care and Treatment) (Scotland) Act 2003 has the underlying principle of least restrictive alternative enshrined within Section 1. It states that any function of mental health legislation should be discharged in a manner that appears to involve the minimum restriction on the freedom of the patient that is necessary in the circumstances. The person who is discharging the function shall have regards to the importance of the provision of appropriate services to the person who is subject to the certificate or the order concerned. It can be argued that minimum restriction should involve an open door at night-time, but this may be at the expense of providing appropriate services. Another principle contained within the Act is that of ‘the importance of providing the maximum benefit to the patient’. It is surely more important to have therapeutic opportunities open to the patients during their waking hours and to fulfil the principle of maximum benefit rather than argue that this is superseded by the principle of least restriction.

The debate about NTC is an example of the choices that the NHS, public, health professions and UK Government face. A legal case may result in a decision that removes NTC as an option, but this does not remove our responsibility for

such a decision if we promoted this to the CPT and we promote legal arguments in favour of removing NTC. Civil court decisions are seldom based on right or wrong. They reflect and may lead societal thinking. So have those who advocate for the abolition of NTC got this right and are thinking in advance of those of us mired in, or knowledgeable about, the practicalities of running high-secure services? Or are they advocating a view that, if successful, will at best make little difference to the lives of our patients as they sleep, given that we already open the doors of those in distress, and at worst may impoverish their lives because of reduced daytime activities if no new funding is forthcoming for the greatly increased costs? And even if new funding is made available, we have a responsibility to consider where it has come from in terms of NHS funding and what the opportunity costs will be. In considering the concept of value, increased daytime staffing is of high and personalised value to the patients, and increased night-time staffing is of low allocative (population) value. The CPT report highlights poor levels of activities for patients in high-secure care. At The State Hospital, this is our clinical priority. Patient activity levels will deteriorate if NTC is no longer permitted. I firmly believe that the principles of maximum benefit and efficiency and equity outweigh least restrictive alternative in the case of NTC. Indeed, removal of NTC may increase restrictions on patients during the daytime. NTC should remain in place. Improved opportunities for patient activity should be the campaign that unites us all.

Lindsay Thomson is professor of forensic psychiatry at University of Edinburgh; medical director at The State Hospital, Carstairs; and director of Forensic Mental Health Services Managed Care Network, UK.

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1.4.3 College Members whose deaths were reported at Council meetings between October 2016 and October 2018

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Amara, Ibrahim Benjamin, *Member*, Kingston, Ontario, Canada

Ainslie, John Archibald, *Member*, Canterbury, UK

Aungle, Peter George, *Fellow*, Dundee, UK

Bartrop, Roger Whitworth, *Member*, Roseville, New South Wales, Australia

Bearcroft, John Stephen, *Fellow*, Lymington, Hampshire, UK

Bech, Per, *Honorary Fellow*, Rungsted, Denmark

Behrendt, Ralf-Peter, *Member*, Le Vauquiedor, St. Martin, Guernsey

Berry, Colin, *Fellow*, Finham, Coventry, UK

Berstock, Reva Leah, *Member*, Hampstead, London, UK

Bindal, Kanwal Krishan, *Member*, Omagh, UK

Brodie, Harlow Keith Hammond, *Fellow*, Durham, North Carolina, USA
Black, Angus William, *Fellow*, Leven, Fife, UK
Bomford, John Powell, *Member*, Bendigo, Victoria, Australia
Brash, David Laurence, *Member*, Speers Point, New South Wales, Australia
Brown, Alexander Campbell, *Fellow*, Clifton, Bristol, UK
Bruggen, Peter, *Fellow*, UK
Buchan, Terry, *Fellow*, Lesmurdie, Western Australia, Australia
Burke, Terence, *Member*, Fintry, Turriff, UK
Calwell, William Perry Kirkwood, *Fellow*, London, UK
Campbell, Maria Theresa Goretti T., *Fellow*, Penrith, Cumbria, UK
Carlsh, Sidney, *Member*, Moseley, Birmingham, UK
Carson, James Alexander, *Fellow*, Melbourne, Victoria, Australia
Colville, John Robertson, *Member*, Dorchester, Dorset, UK
Davies, Roy James, *Fellow*, Burry Port, Wales, UK
De Alwis, Kithsiri Hemapala, *Member*, Kidlington, UK
Denford, John Douglas, *Fellow*, London, UK
Dolan, Robert, *Member*, UK
Duncan, Laura, *Member*, Inverurie, Aberdeenshire, UK
El-Bakly, Mohammad Madian, *Member*, London, UK
Farmer, Christopher John, *Fellow*, Vale, Guernsey
Enwere, Sampson Chukwuemeka, *Affiliate*, Milton Keynes, UK
Evans, Myrddin, *Fellow*, Llanddew, Brecon, UK
Famuyiwa, Oluwole Olumakinde, *Fellow*, Yaba, Lagos State Nigeria
Fine, Eric William, *Member*, Elkins Park, Pennsylvania, USA
Fink, Klaus Philip, *Fellow*, Hamburg, Germany
Flanagan, William Laurence, *Fellow*, Tullibardine, Auchterarder, UK
Flynn, Thomas Gerard, *Member*, Omagh, UK
Fottrell, Eamonn, *Fellow*, London, UK
Gallagher, Melanie Ellen, *Member*, Rathgar, Dublin, Ireland
Galvin, Fionnuala Delia Maria, *Member*, Moycullen, Co Galway, Ireland
Ghoshal, Jogeschandra, *Member*, Kirkintilloch, Glasgow, UK
Gledhill, Maureen Thelma, *Member*, London, UK
Green, Elizabeth Aimee, *Member*, UK
Hardman, Anthony Eric, *Fellow*, Southport, Merseyside, UK
Heaton, John Moorhouse, *Affiliate*, London, UK
Hertzog, Jeanne Lovell, *Foundation Member*, Emsworth, UK

Higginson, John Christopher, *Member*, Banstead, UK
Hoare, Peter, *Fellow*, Henley-On-Thames, Oxfordshire, UK
Hodgson, Oliver Ernest Fenner, *Fellow*, Histon, Cambridge, UK
Irvine, George Murray, *Member*, Sudbury, Ontario, Canada
James, Basil, *Fellow*, Townsville, Queensland, Australia
Jayawant, Girija Sandeep, *Affiliate*, Marston, Oxford, UK
Jimenez Leiva, David, *Member*, Pozuelo De Alacon, Madrid, Spain
Jones, Dilys Mair, *Fellow*, Old Windsor, Windsor, UK
Jones, Kingsley, *Fellow*, Loddon, Norwich, UK
Kane, Eileen Patricia, *Member*, Londonderry, UK
Kaplan, Theodore Harry, *Member*, Mount Carmel, Haifa, Israel
Kesharwani, Shailesh Kumar, *Affiliate*, Bolton, Lancashire, UK
Klasen, Henrika, *Member*, Haarlem, The Netherlands
Kornan, Paul Jacob, *Member*, Melbourne, Victoria, Australia
Lawler, Matthew Patrick Gerald, *Member*, Letterkenny, Co Donegal, Ireland
Lee, Catherine Ishbel Mackenzie, *Member*, Wexford, Ireland
Lekh, Sudesh Kumar, *Member*, Banstead, Surrey, UK
Leuvenink, Johannes Cornelius, *Fellow*, Dumfries, UK
Lewis, Dawn Christine, *Chair – Carer’s Forum*, Hereford, Herefordshire, UK
Liebling, Leonard Irving, *Fellow*, Sutton Coldfield, UK
Lucas, Christopher James, *Fellow*, Letchworth Garden City, Hertfordshire, UK
Lutchmun, Nemnarainsingh, *Member*, London, UK
MacBride, Timothy P, *Affiliate*, Letterkenny, Co Donegal, Ireland
MacCallum, William Andrew Gordon, *Fellow*, Belfast, UK
McBride, Thomas Mary, *Member*, Carrigawley, Letterkenny, Ireland
McConnell, William Brian, *Fellow*, Newtown Abbey, UK
Mahmoud, Ahmed Mohamed Ahmed, *Specialist Associate*, Nantwich, Cheshire, UK
Mahendran, Chelladurai, *Affiliate*, Harrow, UK
Malitz, Sidney, *Fellow*, Scarsdale, New York, USA
Manukulasuriya, Susil, *Member*, Aylesbury, UK
Maule, Rachel Emily, *Member*, Auckland, New Zealand
Mitchell, Alexander Ross Kerr, *Fellow*, Cambridge, UK
Nanayakkara, Vitharana Aratchi Gamini, *Member*, Oxford, UK
Ng, Hon-Shing, *Member*, Tuen Mun, Hong Kong
Oakeshott, Simon, *Member*, Great Shelford, Cambridge, UK
Ogunde, Cheyvonne Charlene, *Member*, Wibsey, Bradford, UK

Olamosu, Abayomi, *Affiliate*, Yeovil, Somerset, UK
Padamsee, Kabir, *Fellow*, Mill Hill, Brentwood, UK
Parker, Robert Renshaw, *Member*, Knowsley Village, UK
Pierce, Chester Middlebrook, *Honorary Fellow*, Jamaica Plain, Massachusetts, USA
Pilkington, Pamela, *Member*, London, UK
Pokorny, Michael Robert, *Fellow*, Mapperley Park, Nottingham, UK
Prentice, Rachel, *Pre-Membership Psychiatric Trainee*, Fulwood, Preston, UK
Priest, Robert George, *Fellow*, Iver, UK
Pugh, Caroline, *Member*, Holywood, Co Down, UK
Quinn, John Francis, *Member*, Monkstown, Co Dublin, Ireland
Raju, Sutharsan, *Member*, Bedford, UK
Reddie, Ethel Mary, *Member*, Bromsgrove, UK
Reveley, Adrienne Moore, *Fellow*, London, UK
Ritson, Roger, *Affiliate*, Douglas, Isle of Man
Roper, Peter Digby Lewington, *Member*, Montreal, Quebec, Canada
Scholefield, Charles, *Member*, Uldale, Wigton, UK
Shepperd, Margaret Joyce, *Affiliate*, Port Navas, Falmouth, UK
Stamp, Edwin Frederick Charles, *Member*, Mount Evelyn, Victoria, Australia
Stanley, Ann Katharine, *Fellow*, Thorpe, Norwich, UK
Strickland, Paul Laurence, *Fellow*, Manchester, UK
Timol, Sulaiman Ahmed, *Affiliate*, Thorpe Bay, Southend on Sea, UK
Toms, David Anthony, *Fellow*, Tipton St. John, Sidmouth, UK
Walczak, Paul Martin, *Affiliate*, Rochdale, Lancashire, UK
Walker, Derek Lindsay, *Fellow*, Painswick, Stroud, UK
Watt, Kerry Fiona, *Member*, Richmond, North Yorkshire, UK
Watts, Terence Christopher, *Member*, Glanamman, Ammanford, UK
Westerholm, Ronald, *Fellow*, Bishopston, Swansea, UK
Whewell, Peter John, *Fellow*, Gosforth, Newcastle upon Tyne, UK
Williams, Akintunde Olufolahan, *Member*, Liverpool, UK
Wilson, Lesley, *Member*, St. Lawrence, Jersey
Winn, Pauline Imogen Margaret, *Member*, Brentford, UK
Wool, Rosemary Jane, *Fellow*, Aston Clinton, Aylesbury, UK
Woolridge, James Bancroft, *Member*, Malanda, Queensland, Australia
Worters, Alastair Robin, *Fellow*, Eyemouth, UK

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1.4.4 Author reply

Josephine Fielding Christopher Bass

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Our paper aimed to highlight the marked increase in referrals seen locally within recent years. We accept that, as Dr Shaw notes, some people, particularly those from the student population who also have families of origin outside Oxfordshire, may have been referred directly to gender identity clinics and so were not captured by the data. This would mean that our findings likely represent an underestimate of the total increase in numbers of people seeking assistance from specialist clinics, which makes the increase we did find even more striking.

We also appreciate Dr Shaw's points regarding the referral pathway in Oxfordshire and the need to minimise the barriers transgender people experience to accessing services. The clinical pathway has indeed been reviewed and altered since the period described in the study, with service users now being referred directly by general practitioners, generally to the specialist clinic in Northamptonshire.

The clinic did not assess people under the age of 17, so we did not include data on this age group in our study, but it is certainly notable, as both Dr Shaw and Dr Clyde's letters highlight, that referrals to gender identity disorder services (GIDS) for children and adolescents have risen dramatically over the past five years. Dr Clyde in her letter draws attention to the high rates of referral to GIDS for children and adolescents since 2010, and in particular the increase in rates of referral of those assigned female at birth. This has also been our experience, although the increase was less marked in our adult population than in the child and adolescent population Dr Clyde describes, and it is interesting to consider possible reasons for this. In our data, we found a marked trend towards more natal females being referred over the six-year period from 2011 to 2016, with a ratio of approximately 1:2 compared with natal males requesting transition. In our previous audit published in 2011 and covering the period 2006–2011, this ratio was 1:3 (Saunders and Bass, 2011). However this apparent trend did not reach statistical significance in our data. We also identified 8.5% of people presenting with non-binary gender identities, which were not noted in our previous audit. The finding of increased rates of autism spectrum disorder is also of considerable interest, and our finding of 7.8% is almost certainly an underestimate. We agree that clinics are being overwhelmed, and that there is an urgent need for both more research and discussion in this rapidly changing field, in order to best meet the needs of transgender young people and adults.

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1.4.5 Trials and tribulations of S49 orders

Ilyas Mirza Mukesh Kripalani

date

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The Mental Capacity Act 2005 (MCA 2005) is an Act of Parliament, applying to England and Wales, that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.¹ Under section 49 (pilot order) of the MCA 2005, launched in 2016, the Court of Protection can order reports from National Health Service (NHS) health bodies and local authorities when it is considering any question relating to someone who may lack capacity, and the report must deal with 'such matters as the court may direct'.² This change has caused significant ethical challenges for psychiatrists.

With regard to professional implications, Section 49 reports require an opinion; according to British Medical Association (BMA) and General Medical Council (GMC) guidance, this falls under expert witness work. The recent Pool judgment is a reminder that the GMC is likely to consider that fitness to practice is impaired if a doctor acts outside what is considered their scope of work.³ The order is usually accompanied by an instruction letter containing legal precedents and a bundle sometimes containing conflicting assessments. Responding to such instructions require medico-legal training and experience in giving opinions to complex questions such as capacity to consent to sex, or consent to drink. We would argue that there is a blurring of boundaries between expert and professional witness. There is a need to clarify what legal safeguards are in place for the author of Section 49 reports, if their opinion is challenged, as it was in the Pool case.

In relation to patient care, the introduction of an automatic right to a medico-legal report, which was previously funded from elsewhere, has shifted the cost on to the NHS. Given that mental health services are still block funded; more work without additional funding leads to dilution of quality of care elsewhere in the system, affecting patient care. Lack of parity of esteem between physical and mental health funding makes this work an onerous burden. Increased workload without remuneration has an adverse effect on staff morale, influencing recruitment and retention within an already struggling NHS.

There is an urgent need to quantify the effects of these orders on services. The Royal College of Psychiatrists, working together with NHS England and the BMA, needs to define how medico-legal work can be safely done within existing resources. Moreover, the BMA, GMC, the College and NHS employers need to resolve the discrepancy that results from what is considered expert witness work by regulatory bodies being framed as normal NHS work by the Court of Protection.⁴ Legal safeguards need to be in place if NHS professionals become subject to legal challenge, e.g. from an aggrieved solicitor. Consideration needs to be given to a fresh legal challenge if it is evident that this pilot order is affecting patient care.

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1.4.6 Tick, tock, lock: night-time confinement in high security – history, practice, ethics and practicalities

Ed Silva Andrew Shepherd

Correspondence

Dr Andrew Shepherd

(andrew.shepherd-2@manchester.ac.uk)

date

2019-2

Abstract

Summary

Night-time confinement, locking patients in their bedrooms overnight, is practiced within high-secure hospitals in the UK. This article provides context, sets out the history and reviews the ethical and pragmatic issues at stake. Thought is given to the future, where we appear to be moving toward a different approach.

Declaration of interest

E.S. is a consultant forensic psychiatrist at Ashworth Hospital. All his patients are confined at night. He represents the Royal College of Psychiatrists Forensic Faculty at the National Oversight Group, which is the strategic advisory body providing assurance to NHS England regarding the commissioning and provision of high-secure services.

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- *Tick, tock, lock: night-time confinement in high security – history, practice, ethics and practicalities*
 - *History*
 - *Research evidence*
 - *NTC and values-based practice*
 - *Moving forward*

History

Patients in UK hospitals are routinely locked up alone in their bedrooms from 21.15 h until 07.15 h for no clinical reason. This has recently been criticised by the Committee for the Prevention of Torture (CPT) in a report to the UK Government;¹ hence this series of articles relating to practices in high-secure hospitals (Ashworth, Broadmoor, Carstairs and Rampton). Until the 1980s Blom-Cooper Inquiry,² it was unremarkable that patients in the then special hospitals were locked in their rooms at night. The pendulum swung, and the 24 h opening introduced by one inquiry was questioned by the security review that followed another,^{3,4} which proposed night-time confinement (NTC) for ‘high-risk’ individuals – although this was rarely, if ever, used. As with almost all developments in forensic psychiatry, the reaction to a high-profile offence, followed by yet another inquiry introduced the Dangerous and Severe Personality Disorders services, which practiced NTC from their inception in 2003.

The current practice of NTC in the high-secure services has been permitted by the High Security Psychiatric Services (National Health Service Commissioning Board) Directions (current edition available through <https://www.gov>).

[uk/government/publications/high-security-psychiatric-services-directions](https://www.gov.uk/government/publications/high-security-psychiatric-services-directions)). In 2011, the then Minister for Health, Andrew Lansley, first allowed the provider organisations to lock a patient's room at night only on the conditions that the room had a toilet and nurse call bell, or if the patient was continuously observed. No individual clinical reason to lock the door was required. Instead guidance required the decision to be made on the utilitarian argument that therapeutic benefit should be maximised for patients as a whole; for example, by releasing staff during the day. At the time, the chairs of the Royal College of Psychiatrists' Forensic Faculty and Special Committee on Human Rights wrote to Mr Lansley to express the obvious concerns (*de facto* restriction of liberty through seclusion). The directions were considered by each of the provider trusts boards and NTC has been established in all the English high-secure hospitals as well as in Scotland (through different legal mechanisms), and has remained a subject for review within the existing governance arrangements. The recent Care Quality Commission (CQC) (<https://www.cqc.org.uk/>) reports remarked on the absence of available structured activity during the day for some patients in high-secure services, contrary to the original rationale. Significant further scrutiny has also followed the 2016 UK visit by the CPT who, among other things, said that '... the systematic locking-in of patients at night, which amounts to ten hours of *de facto* seclusion, is not acceptable in a care establishment provided there are sufficient staff.'¹ (p. 75 para. 139).

In practice this means that, apart from the unrenovated wards in Rampton and Broadmoor, patients, with very few clinical exceptions, are locked in their rooms for 10 h per night, regardless of route to high security, offending history, current risk to others or dependency needs. It is quite possible for a patient to be subject to NTC in high security while awaiting transfer to low security or even, quite exceptionally, to a community placement. Although the guidance accompanying the directions requires clinicians to note the absence of contraindications to NTC, few if any psychiatrists in this invidious position do so (as evidenced by frequent discussions in peer supervision and other meetings); those that do not, find themselves in the curious position of being criticised by the CQC. Many, if not almost all, patients in high security have significant histories of self-harm or attempted suicide, and some present with ongoing extreme self-mutilation. At the time of writing, every patient in Ashworth is confined at night. Nursing staff now dispense night-time medication at 20.00 h and then muster patients to go to their rooms as the night shift arrives. Night-time staffing in the hospitals has significantly reduced, on occasion to levels that have been themselves seen as worryingly low. Curiously, most patients do not complain, either informally or otherwise, and some report feeling safer.⁵ At Forensic Faculty Committee meetings, it has been suggested that the obvious remedy is judicial review by a patient. This has not occurred.

Research evidence

As for many coercive approaches in forensic practice,⁶ there is a significant absence of evidence in the literature. A search identified two mixed-methods studies.^{7,8} The first, based on the experience at Rampton, demonstrated no statistically significant change pre- or post-implementation in its chosen measures addressing ward atmosphere, working environment and patient quality of life. Semi-structured interviews suggested staff observed a less negative effect than had been anticipated, whereas patients expressed a certain ambivalence. The findings from the study are potentially influenced by the close affiliation between researchers and the site of study, as well as by the choice of wards (acute admission) for the pilot. In the second study, based on the experience at Ashworth, measures were collected relating to sleep hygiene, behaviour and findings from a bespoke questionnaire, seeking to understand patients' concerns regarding NTC. No statistically significant changes were observed. However, a parallel investigation considering the attitudes of nursing staff revealed a universally negative attitude to it. The potential to generalise findings from the study were limited by difficulties in recruitment and implementation, which may have resulted in skewed findings in relation to the experience within the hospital as a whole. More generally, as noted above, there is a general absence of evidence in relation to the implementation of practices such as seclusion. A qualitative study, addressing the process of seclusion in forensic practice,⁹ identified clear communication of the 'purpose' of seclusion as being a key ingredient in managing distress associated with the experience. Widespread application of NTC could be seen as partially mitigating this factor if it is assumed to be a normal practice by patients, staff and others.

NTC and values-based practice

Building on the concept of principled ethical clinical practice, the Francis report¹⁰ has reiterated the call for care providers to develop a culture that focuses first on the patient and providing, within resource limitations, compassionate care that does not inadvertently restrict basic rights or cause avoidable harm.

The CPT report notes that NTC had the potential to cause individual anxiety and that there was a lack of evidence of individual risk assessment to mitigate this potential distress. Although the limited research evidence base surveyed suggests an absence of harm, the CPT also noted the absence of evidence of benefit and the CQC reports are mixed, again highlighting concern at the restriction of liberty and remarking on a lack of increased daytime structured activity by way of mitigation.

Individual autonomy is clearly restricted through the act of confinement at any time. However, arguments in relation to autonomy are complicated with mentally disordered offenders¹¹ because acts of violence against individuals or society more generally lead to a socially sanctioned act of imprisonment. Although the situation of forensic in-patients will vary, the majority are not subject to court-ordered punishment. This may add weight to the position outlined in the Tilt report,⁴ which proposes that specific 'high-risk' individuals may perhaps be 'proportionately' subject to NTC. The blanket application of this restriction regardless of risk, or progress along the care pathway, is confusing to many.

The argument raised in support of NTC is that of a justice-based position, whereby resources consumed in the staffing of night shifts, to allow free movement of patients, can be more appropriately allocated in the day, to increase the availability of therapeutically oriented activity. However, as has been noted by both the CPT and the CQC, there has been an absence of increased structured activity during the day even with NTC, suggesting that no benefit has emerged in this area. However, interpretation of this situation is complex because, with the notable increase in constraint on resources in recent years, it is hard to determine how services would currently appear had funding remained on the projected trajectory from the time of NTC's inception.

Moving forward

The current position with regard to the practice of NTC is therefore difficult, particularly in its current blanket implementation. There is also a pragmatic reality: even if the decisions were reversed, neither the money nor the staff are available to fill the gaps.

To return to the analogy of the pendulum, swings between restrictive and more liberal practice can be seen as an institutional group response to anxiety and external scrutiny.¹²⁻¹³ Generally, these changes are seen as being a collective response from within the group; however, in this situation the swing of the pendulum has been affected by the massive gravitational change of austerity. Clinical decision-making is forced, in that it is being subjected to either political pressure or fiscal reality, depending on one's viewpoint. As in other political arenas, it seems apparent that it is some of the most vulnerable in society who are subjected to restriction. There is also an 'invisibility' to the phenomenon, occurring as it does behind the opacities of our walls, and it is perhaps also curious that it took an investigation from the CPT, rather than our own governance structures, to switch the night light on, and so we should thank our European friends. Movement to a more dynamic and rational response is necessary. The pendulum must swing again, but how can this best be achieved?

Ed Silva is a consultant forensic psychiatrist with Mersey Care NHS Foundation Trust, UK; **Andrew Shepherd** is a clinical lecturer in forensic psychiatry at the University of Manchester, UK and is a SpR in Forensic Psychiatry at Ashworth Hospital, Mersey Care NHS Trust, UK.

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1.4.7 Lionel Hersov, MD, FRCPsych

Philip Graham

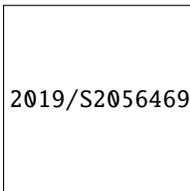
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- *Lionel Hersov, MD, FRCPsych*

Formerly Consultant Psychiatrist, Maudsley Hospital, UK; Professor, University of Massachusetts Medical School, USA



Shortly after South Africa joined the war against Germany, Lionel Hersov, who died recently at the age of 95, was 18 years old and just beginning his medical studies in Johannesburg. He volunteered for the South African Medical Corps Reserve and, from 1944 to 1945, he was attached as a medical orderly to the Royal Durban Light Infantry, 6th South African Armoured Division, and served first in the Middle East. He was then with the 5th Army Group as it fought its way up mainland Italy. His non-combatant status did not protect him against the threat of violence. On at least one occasion he was ordered to enter territory covered by enemy guns to check whether a fallen soldier had been killed or was lying wounded.

Nor was he protected from antisemitism. At another time, a German-speaking doctor pointed out to a severely wounded, captured German officer that the man treating his wounds was a Jew. The officer muttered 'Jude, schwein' as he spat at Lionel. He did not talk about his war experiences but, much later, visiting the battle sites in Italy with two of his children, he was deeply moved at the memory of friends who had not made it home.

At the end of the war, Lionel resumed his medical studies at the University of Witwatersrand, Johannesburg, qualifying as a doctor in 1948. Shortly after qualification, he decided to become a psychiatrist and worked in various junior posts in Johannesburg and Pretoria. However, training opportunities in psychiatry in South Africa were limited at that time. In 1952 he was accepted on the psychiatry training programme at the Maudsley Hospital, London. By 1955 he had decided to specialise in child psychiatry, and it was in this field that he made his mark. He only returned to South Africa subsequently for brief visits.

In the mid-1950s, child psychiatric practice in Britain and elsewhere was largely uninformed by scientific data. It was felt that the behaviour and emotional problems of childhood and adolescence were too complex to be studied in any systematic manner. Around that time, a small number of academically minded child psychiatrists, of whom Lionel Hersov was one of the first, decided that the time had come to apply scientific methods to the subject.

His chosen topic, which formed the basis of his MD thesis, was non-attendance at school. It was already known that children who failed to attend school fell into one of two groups. There were school refusers who were anxious about attending, either because of a fear of what might happen to them at school, such as being bullied by another student or a teacher, or because they were over-anxiously attached to their mothers.

Then there were truants who were usually rebelling against unsatisfactory home backgrounds and found little at school to interest them. Hersov was able to show that these two groups differed markedly in their relationships with their

parents, their personalities, their level of academic achievement and the presence of other behaviour disorders. His findings had major implications for clinical management.¹

After he left the Maudsley, he was appointed a consultant child psychiatrist, first at the Child Guidance Training Centre, London, and then at the Children's Hospital, Great Ormond Street, London. He returned to the Maudsley Hospital as a consultant in 1968, but also held a part-time appointment attached to the paediatric department at the Hammersmith Hospital.

While at the Maudsley, where he worked as a consultant child psychiatrist until 1994, he was an inspiring teacher and role model. Many of those who later made their mark in the field were led into it by his example. He was an astute clinician who formed excellent therapeutic relationships with the troubled children and families referred to him. While he had had experience of personal psychoanalysis, his approach was influenced not only by psychodynamic theory, but by a range of different perspectives. His colleagues found him to be a delightful man, tolerant and calm, with a talent for friendship. His warmth, humanity and wisdom were all deeply appreciated.

Shortly after the publication of papers arising from his research, he was invited to become Joint Editor of the recently founded *Journal of Child Psychology and Psychiatry and Allied Disciplines*. He acted as Senior Editor of this journal for 21 years, from 1963 to 1984. During his editorship, the journal gained so greatly in status and prestige, that, whereas in the beginning there were barely enough papers submitted to allow quarterly publication, at the time he stopped, it had an international reputation and began to appear six times a year, only accepting papers of very high quality. He retained his connection with the journal for a further 26 years, serving first as Corresponding Editor while in the United States, and then as Book Review Editor.

In 1977, he was invited by Michael Rutter to be Joint Editor of *Child Psychiatry: Modern Approaches*, the leading textbook in the field worldwide. He remained joint editor for the next two editions of this outstanding book. By now, Lionel's reputation as a leading academic had become international, and in 1978 he was elected President of the International Association of Child and Adolescent Psychiatry. The Congress held in Dublin in 1982, at the end of his presidency, was an event made memorable by the step-change in the quality of presentations.

In 1984, he moved to a position at the University of Massachusetts Medical School in Worcester, Massachusetts in the USA and remained there for over 6 years. There, he had a major influence on the teaching of child psychiatry and on clinical work. On hearing of his death, many of his former colleagues in Worcester referred to the contribution he had made there with extraordinary admiration. One wrote, 'Lionel was a wonderful man whose support to the emerging child division was phenomenal and long-lasting'. Another noted that 'While his expertise was child psychiatry, his knowledge went far beyond this...' Their recollections had a lighter side. Many recalled his predilection for frozen yogurt dessert.

After his return to London in 2000, Lionel was appointed Honorary Distinguished Visiting Scientist at the Tavistock and Portman NHS Trust and took a particular interest in mentoring psychiatrists in training. Earlier, he had held a number of other significant positions. From 1976 to 1984 he was Civilian Consultant in Child and Adolescent Psychiatry to the British Army, advising on matters arising with army families. In 2011 he was awarded an Honorary Doctorate jointly by the Tavistock Clinic and the University of Essex.

Although he did not practice his religion once he reached adulthood, Lionel's parents were both Jewish. They had migrated with their families from Russia in the later years of the 19th century. His father, Charles, was a shopkeeper, and his mother, May, née Goodman, looked after the family and helped in the shop. He was the oldest of three with a younger brother and sister. He was brought up in a small Transvaal town near Pretoria, winning a place at the University of Witwatersrand, Johannesburg, to study medicine in 1940. In 1952, shortly after he came to London for postgraduate training, he married Zoe Menell, a South African graduate of Vassar College, New York. She had just completed postgraduate studies at the Sorbonne, Paris. They had four children: John, an advocate for learning disabled adults; Gregory, a theatre director; Isabelle Mary, an art gallery curator; and Martin, a media company executive.

In his younger days, Lionel was a stylish tennis player and later took up squash, which he played highly competitively. In his early 70s, however, he developed quite severe back pain which limited his mobility. He remained an enthusiastic lover of jazz. Sometime before he died, he developed Alzheimer's disease, which clouded his last years. He is survived by Zoe and his four children, as well as five grandchildren.

Lionel Hersov, child psychiatrist, was born on November 19, 1922. He died on March 11, 2018, aged 95 after a long

illness.

Note: This obituary is based on one published in *The Times* on 18 May 2018.

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1.4.8 Contrast with referrals to Tavistock and Portman Gender Identity Disorder Service

Katherine Rae Clyde

date

2019-2

Contents

- *Contrast with referrals to Tavistock and Portman Gender Identity Disorder Service*

This article shows a modest increase in referrals year on year, approximately 18%, with a majority of referrals received being for those assigned male at birth (AMAB). This is an interesting contrast with data from the Tavistock and Portman Gender Identity Disorder Service (GIDS) for children and adolescents.

Referrals to GIDS have increased from 97 in 2009/10 to 2016 in 2016/17. From 2014/15 to 2015/16, referrals increased by over 100% and from 2015/16 to 2016/17 they increased by 41%. Ages at referral seen by the service ranged from a very few at 3 to 17 years old.

Also in contrast to this much larger increase in referral rates is a marked change in the proportion of those assigned female at birth (AFAB). Up until 2011 there were more referrals of those AMAB. Since then the number of those AFAB referred has grown steadily, and in 2016/17 more than twice as many referrals were made for those AFAB as those AMAB (data available on GIDS website).

We need to be looking as a profession at these striking differences, and more research is required to determine the reasons for them. It may be that reducing stigma has led to higher referral rates, particularly among teenage girls but it could also be that the characteristics of those being referred are changing. This links with the finding that there seems to be a higher prevalence of autism spectrum conditions (ASC) in clinically referred, gender dysphoric adolescents than in the general adolescent population. Holt, Skagerberg and Dunsford (2014) found that 13.3% of referrals to the GIDS service in 2012 mentioned comorbid ASC (although this is likely to be an underestimate).

In this context, it is alarming that referral rates are increasing at a rate that services and research cannot keep up with. Both the American Academy of Pediatrics and the Australian Standards of Care and Treatment for Transgender and Gender Diverse Children and Adolescents appear to support both medical and surgical transition in adolescents. And yet long-term outcomes in this group are not known. We know that adults who have gender dysphoria and who transition report the dysphoria beginning in early childhood. We do not know yet know that those experiencing dysphoria in childhood will go onto experience dysphoria in adulthood. Indeed, we know that 80% of individuals referred to GIDS do not proceed to transition.

In the UK, we are fortunate to have a national service for children that follows the best available evidence, but there is an urgent need for both research and discussion. This is not always easy in a highly emotionally charged atmosphere.

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This passionate book gives insights into ways to understand and support people living with dementia. It holds out a challenge to all of us to remember the impact – for better or worse – that our words and actions have on those with dementia. It highlights the imperative of acting in ways that value people with dementia and enable them to continue to make the most of their strengths; it does so by giving the reader constructive, tangible, feasible ideas.

In making his arguments, Sabat uses the biopsychosocial framework, speaking of the importance of taking a person-centred, holistic perspective to appreciate each different person and his or her communications and reactions. He argues that prejudice, stigma and misunderstanding undermine morale and damage the lives of people with dementia, leading to inappropriate regimes in care settings and disrupted confidence and relationships.

It could be argued that none of this is new. Arguments for holistic understanding of the impact of illness have been put forward for several decades, including in relation to dementia, and the need for person-centred care is already enshrined in UK and in global policies. However, the continuing shortcomings in care and the prevailing myths about dementia indicate that there is a continuing need to improve the respect and care we offer people with this disorder. One part of this is to educate successive generations of health and social care professionals about the nature of dementia and of person-centred care, which is where this book can assist.

The book provides a path into the territory of truly understanding the nature of the sometimes-slippery concept of person-centred care. Its success lies in its readability and it is easy to pick up. The text is written in accessible language and is broken into bite-sized chunks by the use of headings written in the form of italicised questions. The arguments are based on research evidence and case studies, illustrated by personal examples from the lives of people with dementia. The superficial softness of the text provides a clever medium for some challenging messages, which Sabat gently but insistently brings home. They are challenges that are hard to refuse.

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1.4.9 Subjective memory complaints after electroconvulsive therapy: systematic review

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Abstract

Aims and method

Few studies have looked at subjective memory impairment from electroconvulsive therapy (ECT) after treatment completion. We aimed to systematically review all available evidence for subjective post-treatment effects.

Results

We included 16 studies in this review. There was considerable between-study heterogeneity in clinical population, ECT modality and assessment scales used. The most common assessment scale (eight studies) was the Squire Subjective Memory Questionnaire. The majority of studies reported an improvement in subjective memory after ECT, which correlated with improved depression scores. Subjective complaints were fewer in studies that used ultra-brief pulse ECT. Longer pulse widths were associated with more subjective complaints, as was female gender and younger age of treatment in the largest study.

Clinical implications

There is considerable heterogeneity between studies, limiting meaningful conclusions. Ultra-brief pulse ECT appears to result in fewer subjective complaints.

Declaration of interest

None.

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Electroconvulsive therapy (ECT) is an effective treatment for major depression; however, there is debate around the specific long-term effects of the treatment on memory and the acceptability of this to patients.¹ There is wide variation in the post-treatment satisfaction rates after ECT, with previous studies showing that the percentage of patients who would consider having a second course of ECT varies between 36% and 98%.² Multiple studies have shown that dissatisfaction with ECT is related to feeling under-informed of potential side-effects.³⁻⁷

Pre-procedural fear and post-procedural assumptions that deleterious cognitive changes were a direct result of the treatment have been identified as the two areas most likely to lead to a negative view of ECT.⁸ Evidence suggests that clinicians tend to overestimate the effects of medical treatments and underestimate harm, so being able to accurately quantify the additional risk that ECT poses to subjective memory independent of the effects of depression would help both clinicians and patients alike and may improve outcomes.⁹⁻¹⁰ This review aims to summarise all studies that have assessed the post-treatment effects of ECT on meaningful memory loss.

Methods

This systematic review was completed in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses reporting guidelines (*Fig. 1*). *Fig. 1* Preferred reporting items for systematic reviews and meta-analyses flow diagram mapping search history. CINAHL, Cumulative Index of Nursing and Allied Health Literature database.

Inclusion criteria

Studies measuring subjective memory at baseline followed by at least one measurement after the completion of treatment, using a clearly described scale (such as the Squire Subjective Memory Questionnaire, SSMQ11), or questions that specifically assessed subjective memory were included.

A follow-up period of at least 24 h after the completion of therapy was considered sufficient to allow enough time for the acute effects of the final seizure to have passed and no limit was placed on the maximum length of follow-up. Both prospective and retrospective studies were included. Only published studies were included and studies in all languages were considered.

Studies measuring memory only during treatment were excluded. Squire's original studies from 1979 were excluded.

Information sources

The online databases PubMed, Google Scholar, Embase, PsychINFO and Cumulative Index of Nursing and Allied Health Literature (CINAHL) were searched for eligible studies. The following search terms and Boolean operators were used in PubMed as examples: 'subjective AND (ECT OR electroconvulsive)', 'memory AND (ECT OR electroconvulsive)'.

Study selection

Abstracts were screened for inclusion by two independent reviewers. Where any disagreement arose between reviewers, the full paper was requested. All full papers were read and scrutinised by both reviewers independently before deciding to whether to include them in the final review. Screened papers references were searched to identify any further papers.

Data collection process

Both reviewers used the same data extraction form and completed the data collection independently. Both reviewers screened all papers deemed eligible for inclusion and at the end of this process, data extraction forms were compared for agreement. Where data were missing from both forms and felt to be of significant value to the study question, the authors of the study were contacted directly.

Data items

The variables of interest from each study included the number and diagnoses of the patients involved in the study, the modality of ECT (e.g. unilateral versus bilateral or brief pulse versus ultra-brief pulse), the memory assessment method used, the results of this and the authors main conclusions.

Risk of bias within and across studies

Several sources of bias were considered including attrition bias, given the patient population in question, and also the risk of acquiescence and reporting or detection bias if memory assessments were carried out by the same team that performed the treatment. There was also a two-way risk of recall bias in this patient group with patients vulnerable to both underestimating and overestimating the extent of their memory impairment before ECT, because of the extent of their depression and the effect this is known to have on memory.

All studies described methods for dealing with missing data if applicable, with most studies reporting complete-case analysis or intention to treat.

Results

A total of 877 abstracts were identified for potential inclusion, of which 52 were felt to warrant full-paper requests. From these 52 and their reference lists, 16 papers were selected for inclusion in the final review (*Fig. 1*). The main reasons for rejecting papers were no baseline measure of subjective memory, paper measured objective memory only, no measurement of subjective memory beyond the final treatment and insufficient time between the final treatment and measurement of memory.

Synthesis of results

Because of significant clinical and methodological heterogeneity, it was not possible to perform a meta-analysis on the included studies. No two studies measured a comparable patient population, on the same scale, using the same ECT modality, at the same time points (*Table 1*). *Table 1* Summary of included papers

Study (first author, year)	Participants	Questionnaire used	Modality	Assessment	Results summary
Mohn 2016	23	<i>n</i> = 31	unipolar depression		
Everyday Memory Questionnaire					
Bifrontal	<i>n</i> = 1		unilateral	<i>n</i> = 22	
			mixed unilateral and bilateral	<i>n</i> = 8	
Baseline	6 weeks and 6 months				
Pre-ECT		104.0 (SD 37.9)			
6 weeks post-treatment		107.9 (SD 43.6)			
6 months post-treatment		98.6 (SD 42.6)			
					higher score indicates worse memory
Brus 2017	21	<i>n</i> = 1212	80% unipolar depression; 20% bipolar depression		
Seven-point variant of the 'failing memory' component of the Comprehensive Psychopathological Rating Score					86.9% had more than six treatments; 91.6% had unilateral electrode placement
Baseline and <1 week post-treatment					Subjective memory worsened in 28% of the sample (31% women <i>v.</i> 18% men; 32% young adults <i>v.</i> 22%

adults aged over 65 years); longer pulse widths correlated with more subjective complaints; no difference between bilateral and unilateral placement Bag 2016¹² $n = 140$, 24.3% unipolar depression; 59.3% bipolar mania; 16.4% bipolar depression SSMQBilateral, brief pulse; mean number of sessions was seven across all groups Baseline and immediately post-treatment Mean SSMQ score dropped 49.5 points between baseline and end of therapy; patients with bipolar disorder reported less complaints than patients with unipolar depression Kumar 2016¹⁴ $n = 75$, 77% unipolar depression; 10.7% bipolar type 1 disorder; 2.7% bipolar type 2 disorder; schizophrenia 2.7%; schizoaffective disorders 5.3% Subjective Assessment of Memory Impairment 96% received right unilateral; the majority received brief pulse Baseline and 1 day post-treatment No change in subjective memory score during therapy despite objective evidence of impairment-Mayur 2013¹⁵ $n = 40$, unipolar depression SSMQ Right unilateral; 50% ultra-brief pulse; 50% brief pulse Baseline, after 8 sessions and 3 months post-treatment Brief pulse: 21.6 at baseline ($n = 19$), 16.2 at 3 months ($n = 10$), within-patient change of +12.7; ultra-brief pulse: 23.2 at baseline ($n = 16$), 0.8 at 3 months ($n = 14$); within-patient change of 14.86 Fernie 2014¹⁶ $n = 126$, unipolar depression SSMQ and PRMQ Not described Baseline, 1 month, 3 months and 6 months post-treatment SSMQ improved from 14.1 at baseline to 4.58 at 6 months, with the greatest improvement seen 1 month after therapy: 1.59 (SD 2.73); PRMQ score improved by approximately 10% from baseline Fazzino 2013¹⁷ $n = 26$, unipolar depression Selected SSMQ questions 17/26 received right unilateral; 17/26 received ultra-brief pulse width 3–7 questions daily for 60 days (including treatment) No change in subjective memory scores despite objective memory improvement Ng 2000²² $n = 34$, unipolar depression Self-Rating Scale of Memory Function Right unilateral Baseline, after six treatments and 1 month post-treatment Improved subjective memory score at end of treatment; negative correlated with HRSD score Schulze-Rauschenbach 2005¹⁸ $n = 14$, unipolar depression SSMQ Right unilateral and brief pulse width Baseline and within 1 week of completing 5.5-point improvement in SSMQ score, although not statistically or clinically significant Frith 1983²⁴ $n = 70$, unipolar depression Single binary question: ‘do you experience memory problems?’ Bifrontal ECT, median course of eight sessions Baseline, after treatment and at 6 months Sham ECT responders, ECT responders and sham ECT non-responders all reported improvement in memory; ECT non-responders memory remained stably poor Smith 2010¹⁹ $n = 85$, unipolar depression SSMQBilateral ECT; half had ten sessions of continuation ECT Half had continuation pharmacotherapy Baseline (post- ECT), 12 weeks and 24 weeks Both groups’ SSMQ scores significantly improved from baseline; study looked at continuation treatment only Sienaert 2010² $n = 48$, unipolar and bipolar depression; 23% had psychotic symptoms SSMQ Ultra-brief bifrontal $n = 24$ and unilateral $n = 24$ Baseline and 6 weeks 73% patients were glad they had ECT; SSMQ performance strongly correlated with satisfaction on multiple regression analysis but also correlated with depression score, so may not be independent Berman 2008²⁶ $n = 333$, unipolar depression CFQ memory subscale 40% bilateral, 34.7% unilateral, 24.3% combination; 14% sine-wave, 86% brief pulse Baseline, 1 week and 24 weeks Baseline 14.97 (SD 6.75), 1 week 13.01 (SD 6.39), 24 weeks 14.05 (SD 6.85) (higher scores indicate greater impairment) Arts 2006²⁵ $n = 12$, bipolar and unipolar depression CFQBilateral Baseline, 5 days and 30 days CFQ score improved from coefficient of 0.2 at baseline to 0.17 at 30 days Coleman 1996²⁰ $n = 70$, unipolar depression SSMQMixture of bifrontal, RUL and bilateral Baseline and 2 months 31.5 at baseline, 5.4 at 2 months Ikeji 1999¹³ $n = 70$ ECT, $n = 70$ control; 30% unipolar depression; 37.1% schizophrenia; 28.6% mania; 4.3% schizoaffective disorders Two binary questions: ‘Is your memory poor?’ ‘Do you worry about your memory?’ Bilateral Baseline and seven intervals up to 6 months post-treatment Subjective memory complaints at 6 months: 37.1% of ECT group, 22.6% of control group¹

1

CFQ, Cognitive Failures Questionnaire; ECT, Electroconvulsive Therapy; HRSD, Hamilton Rating Scale for Depression; PRMQ, Prospective and Retrospective Memory Questionnaire; RUL, Right Unilateral; SD, Standard Deviation; SSMQ, Squire Subjective Memory Questionnaire.

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Participants

We found that 15 out of 16 studies reported that major depressive disorder in unipolar or bipolar depression was the indication for treatment in the majority of patients. One study reported 59.3% of their sample being treated for mania.¹² Two studies reported use in patients with schizophrenia and schizoaffective disorders, although it was unclear whether these patients were treated for their depressive or primary psychotic symptoms.^{13,14}

Assessment tool used and time points

The most commonly used tool for measuring subjective memory change was the SSMQ, with eight studies using all or part of this scale.^{6,12,15–20} This is an 18-item questionnaire assesses various aspects of subjective memory on a Likert scale from 4 (much worse) to +4 (much improved), providing a total score comparing current memory with a previous time point. For the purposes of these studies, it was assumed that memory was being compared to premorbid memory, although this was not explicitly stated in any study. Five of the six studies that provided group-averaged SSMQ scores showed sustained improvements from baseline after ECT treatment (*Fig. 2*). *Fig. 2* Subjective memory change over time. A comparison of studies using the Squire Subjective Memory Questionnaire (SSMQ). Studies used brief pulse unless stated otherwise.^{12,15,16,18,20} ECT, Electroconvulsive Therapy.

Modality

Pulse width

Four studies included patients who had received ultra-brief pulse width.^{2,15,17,21} Two of these compared brief with ultra-brief and both found longer pulse widths were associated with more subjective complaints.^{15,21} One of these studies demonstrated that this difference was not accounted for by use of bilateral versus unilateral.²¹

Laterality

Eight studies favoured or exclusively used right unilateral electrode placements, three studies favoured bilateral, one used bifrontal, three used a combination of bilateral, bifrontal and unilateral, and one study compared bifrontal with unilateral.

Discussion

Studies showed wide variation in the length of follow-up period used to assess post-treatment memory. Although this does not allow a truly longitudinal picture, it does allow the possibility of assessing whether patterns may exist at different times points post-treatment.

Short-term follow-up

A retrospective analysis of 1212 medical records from the Swedish ECT treatment registry found, compared with a pre-treatment baseline, 26% reported worse subjective memory post-treatment, defined by a two-point deficit on the subjective memory component of the Comprehensive Psychopathological Rating Scale questionnaire.²¹ In an attempt to stratify risk, the study found that more women suffered with subjective memory loss than men (31 v. 18%) and more younger adults than adults aged over 65 years (32 v. 22%). The large sample size adds validity to this finding. Patients were assessed within 1 week of treatment ending compared with the start of therapy, limiting the extrapolation of this data to long-term outcomes, and the majority of patients (91.6%) received unilateral treatment. Short pulse wave and remission of depressive symptoms were associated with reduced subjective memory complaints and no dose effect was found.

A more recent study of 140 in-patients, 75% with bipolar depression, undergoing ECT found a significant negative correlation between number of treatments and deterioration in subjective memory score across diagnostic groups tested within days of treatment by the SSMQ.¹²

Contrary to these findings, the only study to use the Subjective Assessment of Memory Impairment found no change in scores amongst participants between pre-treatment and immediately after completing the course of ECT.¹⁴ Two smaller studies, using different measures, found similar findings.¹⁸⁻²²

In a pragmatic study, an automated telephone system was used to intensively monitor day-to-day fluctuations in mood and memory in a small sample ($n = 26$) of patients undergoing out-patient ECT.¹⁷ Patients were asked daily questions related to subjective memory. Objective memory scores improved with time and were correlated with mood, whereas subjective memory scores remained stable. The authors suggested that objective scores could be used to counter subjective beliefs that may cause premature termination of ECT because of concerns over side-effects.

Medium-term follow-up: up to 3 months

Using the SSMQ, a 2013 study found that patients ($n = 35$) experienced a clinically meaningful and statistically significant improvement in subjective memory across most domains with no significant deterioration in any one domain, correlating with an improvement in depressive symptoms.¹⁵ This improvement was sustained after 3 months. A study of 48 patients in Belgium reported similar findings with improvements in SSMQ scores in both groups at 6 weeks post-treatment.²

In a case-control design involving 70 patients and 18 controls without depression, those in the ECT group reported worse subjective memory at baseline and a significant improvement immediately post-treatment. Interestingly, at 2 months, their SSMQ scores were no different from the control group who had not received ECT.²⁰ Improvements were closely correlated with mood scores and there was a possible relationship between greater autobiographical memory deficits and subjective memory problem complaints.

Medium-term follow-up: up to 6 months

A study of 31 patients in Norway measured cognitive function and subjective memory with the Everyday Memory Questionnaire before starting ECT, and at 6 weeks and 6 months post-treatment.²³⁻²⁷ There was no statistically significant change in subjective memory found between all three time points, suggesting subjective memory complaints were not simply correlated with mood.

A 2014 retrospective case-notes study of 126 patients in the UK found that subjective memory improved at 1 month, 3 month and 6 months after ECT.¹⁶ This improvement was closely correlated with an improvement in Montgomery-Åsberg Depression Rating Scale score, suggesting a causal link between depression and memory impairment that was reversible by ECT; however, complete information was only available for 56 patients. Further evidence of longer-term positive outcomes were found in a 2010 study of 85 patients that found significant improvements in subjective memory at both 12 and 24 weeks after the end of the acute treatment course.¹⁹

Comparing sham and real treatment, a study of 70 patients assessed subjective memory with a single yes/no question. The percentage of patients complaining of subjective memory problems had significantly improved at 6 months in three of the four groups (sham versus real; responders versus non-responders) and was no worse in the fourth (real ECT, non-responders).²⁴

Using a simple binary question, a Nigerian study ($n = 70$) found that 37.1% of the ECT group reported subjective memory problems at 6 months compared with 22.6% of disease-matched controls.¹³ All participants in this study recovered within six treatments, an unusually high response rate that may, when combined with the average age of 29.4 years, limit the generalisability of the findings.

Pulse width

All four studies that used ultra-brief pulse width reported a low incidence of subjective memory complaints and where a direct comparison was made, ultra-brief pulse width showed fewer side-effects than brief pulse, with no difference in treatment effect.^{2,15,17,21}

Six weeks after the end of treatment, 73% of the 48 patients who received ultra-brief therapy in a 2010 study were glad that they had received ECT and satisfaction was correlated with both subjective memory and depression scores.² A 2013 study comparing brief and ultra-brief therapy in 40 patients found improvements in memory at the end of treatment from both brief and ultra-brief pulse widths; however, ultra-brief therapy was superior, resulting in a resolution of memory problems that was sustained at 3-month follow-up, with no difference in treatment efficacy.¹⁵ A study of 26 patients undergoing ultra-brief ECT who were followed up on daily for 60 days found ultra-brief therapy to have no effect on subjective memory, as assessed by a selection of SSMQ questions.¹⁷ The majority of patients in this small sample were out-patients, reducing generalisability, and almost 40% were receiving maintenance ECT.

Limitations

Heterogeneity of studies

There were considerable differences in patient characteristics across all studies, including average age, diagnosis, gender and modality of ECT, and all combinations of electrode placement positions were used across studies. Within studies, only five delivered ECT with the same electrode placement and pulse width to all patients. This heterogeneity makes it very difficult to determine if any relationship exists between mode of delivery or demographic factors and risk of side-effects. Data on which patients are most vulnerable to ECT side-effects is still lacking.²⁸

Ratings scales

Seven different measures of subjective memory were used across the 16 included studies, making comparison between studies challenging. The SSMQ was the most widely used assessment tool, but doubt remains about how well subjective tools capture actual experience. A study reporting treatment satisfaction rates did not find the SSMQ to be an independent predictor variable in their multiple regression model.²

A further criticism of rating scales is that they produce a single summary or average score that may mask domain-specific complaints within the questionnaire. Studies using qualitative assessments of memory impairment have found subjective deficits at 24 weeks that were not picked up by scales designed to capture subjective experience.²⁶

A key limitation of all studies on ECT is the acceptability of the treatment versus the alternatives, which could include additional or alternative drug therapy or a longer period of illness. Also, with ECT usually being reserved for the most unwell patients, there are issues of impaired insight and recall bias that may undermine the construct validity of any subjective memory questionnaire in this patient population.

Conclusions

The few studies that assessed subjective memory several months beyond the end of ECT suggest that, on average, subjective memory scores tend to recover over time, with ultra-brief pulse showing fewer side-effects than brief pulse therapy. However, there is considerable heterogeneity both between and within studies, limiting meaningful conclusions. Past and future studies are vulnerable to high drop-out rates, observer bias and concerns over the face validity of standardised instruments designed to measure subjective memory. However, these tools and studies should not be dismissed as being unreflective of patient experience. Contemporaneous quantitative data provides a longitudinal picture, reduces hindsight bias and may be most useful in identifying common risk factors for significant memory loss rather than as a tool for identifying specific deficits. Future subjective memory studies should use the same outcome measure,

such as the SSMQ, and measuring subjective memory should become a routine part of ECT treatment and follow-up, ideally allowing an international registry to be created to help us identify those at low and high risk of memory impairment. Comparable outcome measures should ideally be collected for patients receiving alternative treatments.

More qualitative studies are needed to identify common experiences, effects and meaning of any subjective memory loss after treatment, and ultimately, whether this is an acceptable risk from this treatment for major depression. Both of quantitative and qualitative approaches may then be used to develop more sensitive memory assessment tools, providing more informative to both patient and clinician during joint discussions around whether to proceed with a treatment that remains one of the most effective and controversial in medicine.

Dr Simon Vann Jones is an ST5 in old age psychiatry at Cornwall Partnership Foundation Trust, Bodmin, UK. **Dr Rick McCollum** is a consultant in old age psychiatry at Devon Partnership Trust, Exeter, UK.

Emily's Voices is an autobiographical narrative of the experience of living with voices, and forms part of a growing movement to normalise and de-stigmatise voice-hearing. It can also be read as an astute critique of the effects of psychiatric knowledge on selfhood and identity. Knoll's story raises questions about what is at stake when we label psychological phenomena as symptoms of specific illnesses. Voice-hearing is often linked to schizophrenia, a diagnosis that can be a source of fear and stigma.

The relationship between voice-hearing and schizophrenia in modern medicine, and the perception of the schizo-disorders as 'madness proper', are largely a product of the diagnostic separation of affective and cognitive disorders, with hallucinations and 'bizarre' delusions chiefly assigned to the latter. This division does not, however, reflect the lived experience of many people who hear voices, as Knoll's story illustrates. Her voices emerge in response to escalating anxiety; that is, they appear to have a mood-congruent basis. Recent studies have suggested that it is not unusual for auditory verbal hallucinations to be induced by anxiety or depression, and this has also been the case historically. Throughout much of the 19th century, it was widely recognised that 'hallucinations of hearing' (as it was then referred to) manifested in a range of different mental states, and were often triggered by anxious or depressed mood. Following on from this, *Emily's Voices* contributes a crucial embodied perspective to existing challenges to dominant psychiatric nosology.

Emily's Voices can also be read as a manifesto for change. Knoll's narrative shows that a more flexible, person-centred approach to voice-hearing is urgently needed. Moreover, there is little evidence from Knoll's experience that receiving a psychiatric diagnosis (or several) is central, or even helpful, to her recovery; on the contrary, it reinforces her existing fears that she is 'crazy'. The various tools that enable Knoll to rebuild a life that is meaningful to her are not contingent upon a specific diagnosis. Making peace with her voices (however fraught that peace might be at times) becomes possible through interpersonal support, talking therapy and, perhaps most importantly, turning a difficult and traumatic experience into a resource, a form of expertise, through her work as a researcher into voice-hearing. This chimes with Callard and Bracken's suggestion that 'psychiatric diagnosis is not fundamental to the enablement of people with mental illness', but rather that the strategies that have held the most benefit for patients 'have not been diagnosis specific'.

In sum, *Emily's Voices* is a timely and important contribution to recent approaches to voice-hearing that seek to normalise this phenomenon and understand it at the level of lived experience, as well as to current debates about diagnosis in psychiatry and its relationships with therapeutic interventions, selfhood, stigma and shame. It is a moving story, and above all a courageous one, and I would recommend it to anyone with an interest in voice-hearing, whether that interest is professional or personal, or both.

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1.4.10 Psychological aspects of wound management following self-harm on psychiatric wards

Alla Rubitel

date

2019-4

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- *Psychological aspects of wound management following self-harm on psychiatric wards*

I note with interest the initiative by Buick *et al* to evaluate a peer-led workshop on suturing skills for doctors working in psychiatric hospitals.¹

The authors describe improved confidence of doctors with regards to suturing, associated with a reduction in transfers to accident and emergency (A&E) departments and a significant potential cost saving (calculated at £183.76 for each transfer that is avoided). It would be interesting to learn whether the intervention was associated with any change in the frequency of self-harm on the psychiatric wards.

Albert *et al* make important comments on the benefits for doctors in continuing to apply their basic medical skills in this context, and point to a cognitive–analytic model to describe role reciprocity in the case of self-harming patients having interventions for their wounds. It would be interesting to investigate further how in-house physical treatment may differ from A&E treatment concerning rescuer-to-rescued roles and reinforcement.

I would like to suggest that the decision to provide physical treatments (including suturing) – or the decision not to do so – will have an effect on the overall treating relationship and treatment frame.

What does it mean for a patient who expresses distress or hostility through cutting, when the doctor tasked with treating their psychological difficulties also becomes involved in the physically intimate act of suturing their body? How are the doctor's own emotional responses towards the patient's self-harm and the subsequent restorative procedure registered and managed when the doctor either performs the procedure directly, or sends the patient to A&E?

Perhaps these complex emotional factors could also be worked out in peer groups – in particular through Balint or other psychological case-based discussion groups.

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1.4.11 Cairns Aitken, CBE, MD, FRCPE, FRCPsych

Bruce Ritson

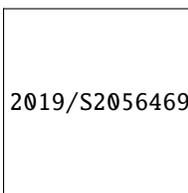
date

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- *Cairns Aitken, CBE, MD, FRCPE, FRCPsych*

Emeritus Professor of Rehabilitation Studies, Edinburgh University Medical School, UK



Cairns Aitken, who died of pulmonary fibrosis on 12 March 2018 at age 84, had a distinguished career as a Scottish psychiatrist and had many prominent roles in management within Scottish universities and the health service. Perhaps his major achievement was when, as Chair of the Royal Infirmity Trust, he masterminded the move of the Royal Infirmity of Edinburgh from its historic site in the city centre to its new building, on the periphery of the city, in Little France. This involved negotiating the rebuilding contract via the private finance initiative. He recognised the importance of clinicians' involvement in management at a time when many were wary of its inevitable conflicts and disputes. When Cairns encountered a challenge, he would always face it head-on and not shrink from difficult or unpopular decisions; he would identify a goal and then form a project team of skilled experts around him who would all work together to overcome obstacles and succeed.

Cairns held a number of other major positions. From 1984 to 1987 he was Chairman of the British Broadcasting Corporation Scottish Medical Advisory Board, and from 1991 to 1996 he was a member of the General Medical Council. He was appointed to the Human Genetics Advisory Commission in 1996. This public body was created to report on new developments in human genetics, and the consequences thereof, in relation to public health, insurance, patents and employment, and to advise on ways to build public confidence in – and understanding of – these developments.

In addition to all of Cairns' clinical and academic work, he became Chairman of the Council of Napier College and helped steer it from being a local college to becoming a national polytechnic and finally the renowned university it is today. This transition was an enormous achievement involving hours of painstaking negotiations. In 1990 he was made a Fellow of Napier University.

Many would have felt such an achievement was sufficient but Cairns then threw himself into a series of challenging projects, first as Vice Dean and then as Dean of the Faculty of Medicine from 1988 to 1991. Finally, he was appointed Vice Principal of Edinburgh University and was responsible for planning and budgeting at what was an exceptionally challenging time. He thus played a major part in forming the foundations of the University as it is today. He was a director of the Lothian Health Board from 1991 to 1993, which led to his role in the re-siting of the Royal Infirmity.

Cairns was born on 20 December 1933, an only child. His father was a qualified accountant, but his parents ran a hotel in Dunoon. Cairns attended Dunoon Grammar School before going to board, first at Cargilfield in Edinburgh and then at Sedbergh School in Yorkshire. He went on to study medicine at Glasgow University. While he was a medical student his mother died of severe asthma. He vividly recalled the stress and worry caused when she had severe breathless attacks. This had a profound effect on him and he felt the experience influenced his career choice and clinical outlook throughout his life.

Early exposure to psychiatry came from a chance meeting with a fellow medical student who told Cairns about free lodgings if you helped as a student at the Gartnavel Royal Mental Hospital. He described how, for 2 years, he enjoyed free accommodation, meals and an introduction to the fascinating challenges of a traditional psychiatric hospital.

Qualifying as a doctor in 1957, he went as an exchange Fellow to McGill University in Montreal. He obtained a short-service commission in the Royal Air Force (1959–1962) and joined the Institute of Aviation Medicine in Farnborough. This enabled him to travel widely and develop his clinical and research interest in treating phobias of flying. During this time, he had the fascinating experience of visiting NASA in its very early days. He was part of a delegation to Washington to hear the first American astronaut, John Glenn, give his report on his return from space to President Kennedy and the nation.

Cairns completed his specialist training in psychiatry at the Maudsley Hospital in London. In 1966 he was headhunted by Professor Carstairs to return to Scotland, first as a lecturer and then senior lecturer in the department of psychiatry, and then as a consultant psychiatrist at the Royal Edinburgh Hospital. Here he continued his research into asthma and psychosomatic medicine. In 1974 he was appointed professor of rehabilitation studies in Edinburgh. This new position was designed for someone who combined an interest in disability with an understanding of the interplay of biological, psychological and social factors in motivating or frustrating recovery. To meet these objectives, Cairns recognised the importance of a team including not only nurses and medical staff but also psychologists, physiotherapists, occupational therapists, the patients themselves and their families. This biopsychosocial approach to healthcare, for which he had advocated for so long, became a practical reality.

He edited the *Journal of Psychosomatic Research* from 1979 to 1986, was President of the Society for Research in Rehabilitation from 1981 to 1983 and was President of the International College of Psychosomatic Medicine from 1989 to 1994. He was a member of the Council for Professions Supplementary to Medicine from 1983 to 1990.

After so many years of public service, Cairns was awarded a CBE in 1998. Among his other honours, he received the Order of Merit of the Polish Republic in recognition of the important and continuing links between the Edinburgh and Polish medical schools.

In retirement he pursued many interests, for example, visiting and documenting all the inhabited islands of Scotland, tracing the journeys of Bonnie Prince Charlie and visiting all the Scottish hydroelectric schemes. Each of these projects was approached with energy and scientific rigour. They involved the preparation of meticulous reports and photographs. He was a skilled photographer and many of his photographs are in the Scran collection, available to the public. In his approach to these projects one detected the passionate and meticulous way in which he set himself objectives and approached challenges throughout his career.

Cairns was very fortunate in having a family who provided love, support and infinite tolerance. He was devoted to his wife Audrey and their three children, Robin, Gail and Shona. Tragically, Shona died of a bone tumour while a student at St Andrew's University. Cairns was also very proud of his two grandsons whom he was thrilled to see gain places at Cambridge and at his own, much-loved University of Edinburgh.

This article is based substantially on the article published online by *The Scotsman* on 24 April 2018. <https://www.scotsman.com/news/obituaries/obituary-prof-cairns-aitken-psychiatrist-who-played-a-major-role-in-the-creation-of-edinburgh-royal-i>

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1.4.12 College Members whose deaths were reported at Council meetings between October 2016 and October 2018 – ERRATUM

date

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- *College Members whose deaths were reported at Council meetings between October 2016 and October 2018 – ERRATUM*

We included in error Dr Thomas Mary McBride of Carrigawley, Letterkenny, Ireland in the *In Memoriam* list published in the February 2019 issue. The information supplied to us was inaccurate but records have now been updated. We apologise to Dr McBride for this unfortunate error.

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1.4.13 David James, FRCPsych, FRCPS (Glasgow, Hon), DCH, DipEd, DPM

Michael Morton

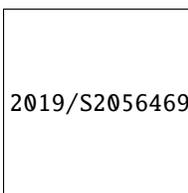
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- *David James, FRCPsych, FRCPS (Glasgow, Hon), DCH, DipEd, DPM*

Formerly Consultant Child Psychiatrist, Royal Hospital for Sick Children and Knightswood Clinic, Glasgow, Scotland, UK



David James, who died on 5 May 2018 at the age of 79, was one of three pioneer consultant child psychiatrists appointed in 1971 to develop a Department of Child and Family Psychiatry in the newly rebuilt Royal Hospital for Sick Children, Yorkhill, Glasgow. During higher training in psychiatry in the West Midlands, he studied the interplay of physical and mental disorder at Birmingham Children's Hospital. This expertise, together with his perspective on deprived families, was in demand in Glasgow at a time of rapid advances in paediatrics. He worked closely with the Yorkhill Renal Team to address psychosocial challenges arising in the new paediatric dialysis and transplantation service.

His work at Yorkhill laid the foundation for an award-winning paediatric liaison service, and, in 1989, his contribution to paediatrics was recognised with an honorary Fellowship of the Royal College of Physicians and Surgeons of Glasgow.

Facing pressures to base child and adolescent mental health services (CAMHS) entirely in the community, David fought hard for the continuation of a hospital psychiatric service. He became a consultant in Knightswood community CAMHS but also remained one of a small number of paediatric hospital-based psychiatrists in the UK, sustaining the Yorkhill service until a policy shift allowed the appointment of colleagues to develop a modern paediatric liaison service.

David enjoyed multidisciplinary working but was conscious of the particular responsibilities of doctors. He cherished the close relationships between paediatric specialists that grew up in the Children's Hospital. At a time when many child psychiatric teams were reluctant to use medical diagnoses, and some would not prescribe, David advocated for medical expertise, while awareness of the family and the social context of medical transactions informed his practice and prescribing. He was an early practitioner of family therapy. When faced with lack of progress, David always retained hope and when other professionals had decided that no more could be done he would continue his work with patients and their families, with some remarkable results. An enthusiastic teacher, he shared his wide experience through carefully co-authored textbook chapters.

Born in Harrogate and proud of his Yorkshire heritage, David studied medicine at Sheffield University, with house jobs at Sheffield Children's Hospital. In a year out of medicine, with teaching practice in an Approved School, he obtained a Diploma in Education and started to consider training as a child psychiatrist. After a spell in paediatrics at the Sheffield Children's Hospital, he moved back to psychiatry at Mapperley Hospital. Early in his career, as one of a Sheffield University team studying 'problem families', he co-authored a Royal College of Psychiatrists book, 'Families without Hope' (1975), which has been labelled a 'medical classic'.¹

David met Hilary, his future wife, in Nottingham. Respect for her career as an educational psychologist broadened David's expertise; he was highly knowledgeable about the effects of developmental and psychiatric disorders in the classroom. He leaves his wife, their two surviving children and four grandchildren, of whom he was very proud. His older daughter, also a doctor, pre-deceased him by three years.

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'I do not consider precision in diagnosis, or even assessment, to be the main goal. I want us to remember that helping a child forward is the main goal.' Andrew West's learned lament for what has been forgotten about the primary task of child and adolescent psychiatry is required reading for anyone engaged in child mental health. Often ironic, his text puts us in the position of a child visiting a Child and Adolescent Mental Health Services (CAMHS) clinic: 'the child will be looking for some genuineness ... children are as acutely aware of bullshit as they are of condescension and they are not fooled'. Here is a doctor who sees it as his duty to identify with his patient: 'I know what it feels like to be misunderstood,' says Andrew, taking the further step to see 'that it may not be in [the child's] greater interests to be free of this particular symptom'. That symptoms have functions is a sophisticated perspective, encouraging the clinician not to hurry too quickly to remove them.

Andrew cites the great paediatrician-turned-psychoanalyst Donald Winnicott's view that it is necessary to 'contain the conflicts ... rather than anxiously looking around for a cure' (p. 2).¹ In that spirit – though it may only be for a short time – the psychiatrist offers himself as a 'powerful therapeutic companion' who is 'able to slow time down and actually enable treatment to take place'. This creative encounter is not likely when the clinical service has a very limited number of answers. 'A parent says, "I want my child to behave better," and the clinician says, "this is ADHD; I suggest that you attend a parenting group and I can prescribe medication for your child"'. It is reminiscent of a conversation between two deaf people along the lines of, "are you thirsty? No, it's Friday".

Since diagnostic psychiatry became the dominant mode around three decades ago, too little attention has been paid

to consultative skills in the profession. Andrew West proposes an ethical practice for modern child and adolescent psychiatrists, placing particular emphasis on the initial assessment and on the ‘saying goodbye’, both of which can be powerfully therapeutic in themselves, whatever other clinical intervention may be provided. Dr West obliges us to see the experience from the patient’s and family’s point of view, where ‘treatment’ is not just what is ordered after an assessment but something that ‘begins at the point that the service accepts the referral’. A beautifully written, highly intelligent and inspiring book.

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1.4.14 Naomi Richman, BM, FRCPsych

Philip Graham

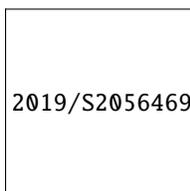
date

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- *Naomi Richman, BM, FRCPsych*

Formerly Reader, Institute of Child Health, and Honorary Consultant Child Psychiatrist, Hospital for Sick Children, Great Ormond Street, UK.



Naomi Richman, who died recently at the age of 84, carried out pioneering studies on the prevalence of emotional and behaviour disorders in pre-school children in the 1970s and 1980s. She was the first author of a monograph published in 1982 *Preschool to School: A Behavioural Study*¹. A review of this book began by quoting John Ruskin: ‘All books are divisible into two classes: books of the hour and books of all time’. There was no doubt into which category this monograph belonged, nor would her two co-authors – Jim Stevenson and I – have been in any doubt that she was the inspiration behind the study.

The study was carried out while Naomi was based at the Hospital for Sick Children, Great Ormond Street, and then at the Institute of Child Health, London. It involved more than 700 3-year-old children living in Waltham Forest. First, it demonstrated that it was feasible to produce criteria for a ‘case’ in pre-school children. This was achieved by the development of the Behaviour Screening Questionnaire, the first specifically designed for pre-school children. It allowed the calculation of the high prevalence of behaviour disorders in this age group: around 7% for moderate and severe problems. Further, by following children up to 8 years old, she and Jim Stevenson were able to show that, contrary to the then-current popular belief, behaviour problems in pre-school children and the language delay often associated with them were not transient and part of normal development, but often persisted at least well into the primary school years.

This study was the first (although many were later carried out by other researchers) that examined the stresses leading to behaviour problems in very young children. A particular set of problems related to bringing up young children in tower blocks, and much of the concern for family life in such buildings first arose from studies in which Naomi played a leading part. With Jo Douglas, she went on to develop behavioural methods of dealing with sleep problems in early childhood. These were evaluated using controlled designs and found to stand up to rigorous testing. Naomi and Jo published a best-selling Penguin book *My Child Won't Sleep*, which described their techniques, and then ran training workshops for health visitors, enabling them to apply this management approach.

In 1989, Naomi went to work for the Mozambique Ministry of Education, first on sabbatical leave and then full time, on a Swedish Save the Children Fund programme aimed at helping children traumatised by the civil war that was then raging in that country. She developed training programmes for teachers working in areas where large numbers of children had been in direct contact with war and violence. From her experiences in Mozambique, she developed her ideas regarding principles to help children involved in organised violence.

Naomi also worked in Angola (with Pam Zinkin and Nazeen Kanji), Central America, the occupied territories and South East Asia, organising training programmes for children similarly exposed to violence. She was strongly critical of medical approaches to so-called post-traumatic stress disorder. She saw this as an often inappropriately applied diagnosis that implied a psychiatric condition needing specialist therapy, without regard to the frequently ongoing nature of traumas and the ways culture influenced community attitudes towards them. Instead, in her influential articles and manuals, she emphasised the need for traumatised children to be reintegrated into their families and given appropriate education.

In 1996 after returning to the UK, Naomi carried out a comprehensive study of the psychosocial needs of Kurdish, Somali and Vietnamese refugee children and families in Hackney, London. Out of this work, she wrote a guide for professional workers entitled *In the Midst of the Whirlwind: Manual for Helping Refugee Children*.

Naomi was born and brought up in Leeds. Her father, Louis (a shopkeeper), and her mother, Gertrude (Gerti), were second-generation Jewish immigrants from Eastern Europe. She won a place at the local grammar school, Roundhay High School, and from there she went on to read medicine at St. Hilda's College, Oxford. After clinical training at the Middlesex Hospital Medical School, she did house jobs, one of them with the paediatrician Dermod McCarthy who insisted that parents of children in hospital should, contrary to the then-current practice, be allowed to visit at all times of the day.

Her psychiatric training was undertaken at the Maudsley Hospital between 1961 and 1964. After leaving the Maudsley, she spent some years in the USA, some of the time as a research fellow on a course in the epidemiology of mental handicap, which was run by Zena Stein at Columbia University Medical School, New York.

Naomi was active politically throughout her life, both as a left-winger and as a feminist. In 1980 she was one of a small group of women doctors who founded the organisation 'Women in Medicine' to combat patriarchal attitudes in the profession and to assist medical women in their careers. She remained highly active in this group until it disbanded in 2002.

She was a woman of wide interests with strong political views, feisty in her support for the underprivileged. A talented artist, she was also a keen and knowledgeable birdwatcher, gardener, theatregoer, swimmer in the Highgate Women's Pond and loyal friend to many. She did not have a family of her own, but developed very close, supportive relationships with her niece, Rachel, and nephew, David. In her later years she suffered from Alzheimer's disease. Not always an easy person, in her last years she became an altogether sunnier, more relaxed personality. Naomi died on 16 June 2018 and is survived by her niece, two nephews and three great-nephews.

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1.4.15 Sutures benefit not only wounds

Ann Maria Albert Karel Wildschut Marinos Chatzopoulos Johanna Selway

date

2019-4

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- *Sutures benefit not only wounds*
 - *Reputation*
 - *Self-esteem*
 - *Costs to other patients*
 - *Stigma*
 - *Perpetuation of self-harm behaviour*
 - *Mental health trusts' view*
 - *The way forward*

We compliment Buick and colleagues¹ for their innovative venture. We want to stress that the benefits of in-house management of minor wounds are far more than financial.

Reputation

Many foundation year, general practitioner and psychiatry core trainees go to psychiatry after doing their surgery and Accident & Emergency (A&E) posts, where they would have managed many wounds with glue, staples and sutures. However, while in psychiatry, they are 'duty-bound' to refer patients with self-inflicted superficial wounds to the A&E. This arrangement would make the A&E staff and others wonder why junior doctors relinquish this role when moving to psychiatry, especially if a few months earlier this had been part of their day-to-day role.

Self-esteem

When junior doctors who are skilled in the management of superficial wounds are forced by mental health trusts to refer patients with superficial wounds to the A&E department, many junior doctors will wonder why they are no longer being seen as suitable and competent enough to carry out this procedure.

Costs to other patients

Most psychiatric in-patient wards are understaffed. Buick and colleagues estimated the nursing costs under the presumption that only one nurse would go to A&E with the patient. Often, two or more nurses would have to accompany the patient to manage risks, including that of absconding. Nurses taking patients to the A&E for management of superficial wounds would result in less staff on the ward and less nursing care for those patients who do not self-harm.

Stigma

Taking every patient with superficial wounds to A&E would perpetuate the stigma about mental illness, mental health patients, services and staff.

Perpetuation of self-harm behaviour

At least for some patients who self-harm, being the centre of attention, and being taken to the A&E by ambulance and accompanied by one or more nurses is likely to perpetuate their self-harm behaviour.

The psychological dimensions of self-harm behaviour can be complicated. The cognitive analytic model offers an understanding of how relationship roles might play out in self-harm, whether self-to-self or self-to-other.

For some patients, self-harm can elicit unhelpful, reinforcing reciprocal roles and procedures, which may seem obvious if judged at face value only. Continuing to enact these roles may delay the adoption of more sustainable and healthy ways of dealing with distress. Being accompanied to A&E by caring professionals and receiving restorative care and attention there – while appropriate and wholesomely good – might feel rewarding. It has the potential to evoke a rescuer-to-rescued reciprocal role, or perhaps a caring-to-cared for role, but at substantial personal cost.²⁻⁴

For many patients, the same situation can indeed feel disempowering and punishing when they are not given a choice in how we care for them in the aftermath of self-harm. The National Institute for Health and Care Excellence emphasises the need for people to be fully involved with decision-making about their treatment and care.⁵

In the same context, it is possible for the patient to experience a more direct reward. If the social reinforcement of self-harm is rewarding enough, the individual may inflict more severe pain in order to continue receiving that positive reinforcement from their environment.⁶

Mental health trusts' view

Often, mental health trusts object to junior doctors managing superficial wounds based on unsubstantiated arguments, e.g.: •how do we prove that the junior doctor is competent?•what will happen if patients complain about scars?•how do we ensure that the equipment is of the required standard?•If they do so, both the trainee and the consultant need to be very clear that they are doing this outside any Trust governance structures and under their own assessment of the risks and consequences. There are no supporting Trust policies or guidance for this. It is a minefield for litigation.

The way forward

It would be helpful for the College to take a stand and advise the mental health trusts about the minimum services that need to be provided, to ensure that junior doctors have the necessary skills and enable them to provide the services that they are competent to deliver.

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1.4.16 Effects of suicide on psychiatry trainees

Marilia Calcia Alice Debelle

date

2019-8

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- *Effects of suicide on psychiatry trainees*

We read with interest the survey by Gibbons *et al*¹ and welcomed the idea of examining what kind of support may help clinicians deal with this difficult aspect of mental health practice.

It is interesting to note how some responses to the survey indicated that having experienced a patient suicide as a trainee had a significant influence on the responder's choice of subspecialty. This finding highlights how junior doctors, whether in a formal training programme or not, are particularly vulnerable to the adverse effects of a patient suicide, with potential effects on recruitment and retention in psychiatry.

In our mental health trust in South East London, trainee-led initiatives in collaboration with the postgraduate training department have been making changes to the learning and support offered to junior doctors who are involved in a serious incident investigation in the past 5 years.² The projects involve annual events to promote knowledge and discussion about quality and safety; discussions about the process of serious incident investigations and the support available at each junior doctor induction; and the development of a written resource on formal and informal sources of support for junior doctors involved in a serious incident investigation. These projects are under constant review in order to respond to trainee feedback.

We thank the authors for the valuable work exploring how suicide can affect doctors of any grade. We hope that mental health trusts and postgraduate training departments continue working to develop formal and informal support structures for doctors experiencing this difficult event.

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Lynne Jones has spent much of the last two decades setting up and running mental health programmes in places devastated by natural disasters and wars. Jones is a child psychiatrist, who began her career in the Allinton Psychiatric Hospital, the former Allinton Asylum. From the off, she cared more about pragmatic pacifism and 'doing the right thing', which included a commitment to living by her values of public service and altruism. She has a CV 'full of gaps': when she was at Greenham Common, Bosnia, on the Somali border in Ethiopia, in Kosovo, Ethiopia, Haiti, Tacloban, and many other places where bombs have fallen or tsunami have washed away communities. Jones says her mother thinks she is on 'an extended gap year'.

Her memoir has been compared to the writing of Oliver Sacks, which I think does them both a disservice. Jones' style and approach are different to Sack's pen portraits of neurological conundrum, although she does interlace clinical stories through her accounts. Her reminiscences of being with asylum patients on the dance floor evoke the recent work of Dr Charlie Howard, whose Music and Change project engages with teenage gangs at street level, co-producing models of care delivery.

Professionally, there is much to admire here, not least Jones' commitment to academic rigor despite being far from university departments. For instance, she describes staying on in Bosnia for an additional year after her contract had

ended to study the effects of war on children. Her contributions to the intellectual, cultural and academic life in the countries she is sent to are similarly admirably. These exchanges are two-way: by spending time with communities and by listening to young people, Jones provides solutions that work for them and their families. She wears diverse theoretical cloaks lightly, using combinations of systemic family therapy, medication, group therapy and supportive counselling. Her stance is pragmatic, for example commencing a young man on medication earlier than she would like so that she can monitor the effects before her likely evacuation from the country.

Jones writes without bitterness or naïvety, recognising that, as a humanitarian worker, she is sometimes a pawn in political game, for example when she is part of a wider evacuation of international aid workers and has to say hurried farewells to unwell patients and local colleagues. There must surely have been times when Jones was fatigued, professionally isolated, personally lonely. We don't hear about it. But though she is stoic, she is also angry, especially about the pseudoscience that underpins the trauma industry and the resultant thoughtless 'quick-fixes' from many who ought to know better.

The atrocities she describes are apocalyptic in both scale and terror. In them, she endures personal hardships: living without running water, without electricity, yet aware of her privileged status, her passport, her choice to be there, her safe home in the UK. Jones is repeatedly drawn back to disaster scenes, not because of their horrors, but because, 'I hope,' she says, 'that some [of their courage] will rub off on me'. In retelling these stories from her long humanitarian career, she passes some of that courage to her readers. Her beautifully weft stories of a lone psychiatrist bearing children's unbearable burdens are beacons of hope to their bomb-shattered childhoods and to our broken world.

In 2014, Jones and I were coincidentally participants on a memoir writing course run by the Guardian Newspaper. We have not remained in contact and she does not know I have read her book.

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1.4.17 The Islamic faith and best interests

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Abstract

This article reviews a 2017 Court of Protection case which assessed and decided issues relating to the Islamic faith and the Mental Capacity Act 2005. The case involved a 39-year-old Muslim man with learning difficulties. It centred on his ability to make decisions about two specific aspects of his faith – capacity for fasting and for the removal of pubic and axillary hair. The judgment describes how s.4 of the Act was applied in deciding these decisions under the doctrine of best interests. In doing so, it elucidates key principles which can be applied to similar cases of this and other faiths.

Declaration of interest

None.

Contents

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This article reviews the Court of Protection judgment *IH (Observance of Muslim Practice)* [2017].¹ The case involved a 39-year-old man, IH. It was an influential case as it considered the observance of Muslim custom and practice in patients who lack capacity under the Mental Capacity Act 2005² (MCA) and Islamic law. In reviewing the case, this article aims to bring out salient principles that may be of assistance to clinicians and services that have a responsibility for Muslim adults who lack capacity.

Background to the case

IH suffered from a profound learning disability, with the intellectual developmental level of a 1–3-year-old, and had a diagnosis of atypical autism. For the first 35 years of his life he resided in his family home, where he was principally cared for by his father, TH. IH was born in Pakistan but had lived in West Yorkshire all his life. His family, devout Sunni Muslims, engaged in all daily activities associated with the Five Pillars of Islam – faith, prayer, charity, fasting, and pilgrimage – as well as fasting during Ramadan and celebrating Eid (the Five Pillars being the foundation of Muslim life and regarded as obligatory for Muslims). While at home, IH would participate in some of these religious practices as he was able. This included daily prayers and, earlier in his life, attending Mosque, although he eventually stopped attending as his behaviour was occasionally disruptive to others. TH, being a devout Muslim, was motivated to ensure his son was supported, as was practical, to adhere as closely as possible to the Five Pillars of Islam.

Despite increased levels of support for the family, IH eventually moved into supported housing provided by the Local Authority. He required 2:1 support 24 hours a day, and was dependent on carers for all aspects of his care. His family visited regularly and he returned to the family home three times per week. IH experienced regular periods of agitation, which could occur ‘dramatically and without warning’. During these periods of agitation, which could be prolonged, IH had a tendency to kick, bite, punch, and/or spit at his carers, who had sustained injuries as a result.

The court was asked to consider two questions: 1) whether it was in IH's best interests to fast during the daylight hours of Ramadan; and 2) whether it was in his best interests for his axillary and pubic hair to be trimmed.

The position of the parties involved in the application

TH contended that the removal of IH's pubic and axillary hair was a compulsory activity stipulated under Islamic law, and hence there was a 'religious duty' to observe this (albeit he modified this stance following expert evidence as below). His father used to shave his son when he was at home and in the first year when he moved into accommodation. TH held the view that having his son's pubic hair shaved was IH's 'right' and something he would have chosen to do himself had he the requisite capacity to do so. IH was provided with Halal food to eat and celebrated Eid with his family, but he had never been expected to fast during Ramadan as it was recognised that he would not understand the purpose of food and drink being withheld during daylight hours and that this might have caused him distress.

The local authority's position was that it recognised the importance of facilitating the religious observances of an individual, even those who lacked capacity. It was agreed that staff members would carry out the hair removal process every two weeks, although in actuality this did not happen, and IH had not had his pubic or axillary hair shaved for three years and never by his carers.

IH's social worker, herself a Muslim, expressed the view that Islam was a significant part of IH's identity and 'something of which he should be proud', and that 'the observance of religious practices should be supported where possible to allow a person to continue to associate with their identity, background, culture and beliefs'. IH's main carer did not believe trimming of IH's pubic and axillary hair to be in his best interests, but the Team Manager of the Community Team for Learning Disabilities considered that, 'on a fine balance', it was.

While the court accepted that it was important to support the religious practices of IH, it concluded that the social worker 'had significantly misunderstood IH's capacity to understand and reflect the concepts associated with the religion' and that IH 'has *no* understanding of the concept of Islam ... he has *no* capacity to feel 'proud' of his religious heritage; nor is he able to actively 'associate with' an identity or culture ...'.

Capacity for fasting

There was no dispute among the parties that, according to the MCA, IH lacked capacity to make decisions regarding fasting during Ramadan. In relation to fasting, the judgment laid out six specific criteria that a person would be expected to understand in order to have capacity in this regard (*Box 1*). It was agreed that IH was not able to understand any of the six points listed, and that in view of the nature of his disability he would never acquire capacity to make these decisions and hence lacked capacity to make this decision. *Box 1* Specifies a person should be able to understand when making decisions regarding fasting. 1. What fasting is; the lack of food and liquid, eating and drinking. 2. The length of the fast. 3. If for religion, for custom (family or otherwise), for health-associated reasons or for other reasons. 4. If for religion reasons, which religion and why. 5. The effect of fasting on the body. 6. What the consequences would be of making a choice to fast and the risks of choosing to not fast or of postponing the decision.

Capacity for removal of pubic and axillary hair

The specific aspects that a person would be expected to understand in order to have capacity to make decisions in regards to the trimming or removal of hair for religious or cultural reasons were elucidated by the court (*Box 2*). It was again agreed by all parties that IH did not have, and would never acquire, capacity in this regard. *Box 2* Specifies a person should be able to understand when making decisions regarding removal of hair for religious or cultural reasons. 1. Which parts of the hair are being removed – pubic, axillary, perianal, trunk, beard, leg, torso or head. 2. Whether the reason for the hair trimming/removal is religious, for the maintenance of good hygiene, custom or some other. 3. If for a religious reason, which religion and why. 4. What the consequences would be of making a choice to have hair trimmed/removed, and of not trimming/removing the hair.

Requirements of the Islamic faith for those lacking capacity

When considering the degree to which those lacking capacity are expected to adhere to the Five Pillars of Islam, the court consulted Dr Ali, lecturer in Arabic and Islamic Studies at Cardiff University. Dr Ali advised that while certain actions under Islamic law are obligatory, allowances are made for those that are deemed to lack ‘legal competence’. This term was defined as ‘a capacity or a potential for mental functioning, required in a decision-specific manner, to understand and carry out decision-making.’ As with capacity under the MCA, capacity under Islamic law is always initially presumed to be present. A person can only be declared to be ‘legally incompetent’ by a court, following evidence from medical practitioners or experts in legal competence, whose opinions under Islamic law would be deemed ‘legitimate and authoritative’. A legally incompetent person (as well as terminally ill people, disabled people and minors) is deemed to be in a heightened state of spirituality and as such is exempt from adhering to many of the major rituals of Islam. All parties agreed that IH could be declared legally incompetent under Islamic law.

While fasting during the daylight hours of Ramadan is an obligatory custom for all legally competent Muslims, certain groups are exempt from fasting. These include minors, pregnant women, those who are travelling, the ill, and the incapacitous. Given that IH had been declared ‘legally incompetent’ under Islamic law, it was agreed that he met these exemption criteria and as such would not be expected to fast.

The holy book of Islam, the Qur’an, advises Muslims to uphold high standards of personal hygiene and to be ritually clean. As well as Quranic verses, there are teachings from Hadiths (traditions or sayings of the Prophet Muhammad revered as a major source of religious law and moral guidance second only to the authority of the Qur’an) advising Muslims as to the rulings of personal grooming. Under Islamic law, the cleaning of pubic or axillary hair is a religiously sanctioned practice deemed to be a normal human right (‘fitrah’) related to a pursuit for ritual purity and cleanliness. The removal of pubic and axillary hair is a recommended practice (‘mustahab’) but is not obligatory. While it would not be acceptable for a Muslim to expose his genitals, it is permissible for a Muslim who requires assistance with his care to have carers clean or shave his genitals. However, the removal of pubic and axillary hair is not a recommended practice for those that lack ‘legal competence’ and there is no suggestion that Islamic law requires IH’s carers to carry out hair removal on his behalf or that his religious rights are being violated by their not doing so.

Best interests decision-making

In determining what was in IH’s best interests in relation to fasting during Ramadan and removal of his axillary and pubic hair, the court analysed Section 4 MCA – Best interests. This stipulates that, as far as is ‘reasonably ascertainable’, IH’s past and present wishes and feelings (s.4(6)(a)), the beliefs that are likely to have influenced his decision had he had capacity (s.4(6)(b)), and the wishes of his family (s.4(7)(b)) should be taken into account. Explicit reference was made to the seminal Supreme Court judgment in *Aintree University Hospitals NHS Trust v James* [2013]3, which opined that any best interests test ‘should also contain a strong element of “substituted judgement”’, meaning that the person making the decision should place great emphasis on what the person is likely to have done had they had capacity to make the decision for themselves. However, while an important component, substituted judgement is not the entirety of a best interests decision. The Supreme Court further stated ‘The purpose of the best interests test is to consider matters from the patient’s point of view. That is not to say his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient’s wishes are’.

Was it in IH's best interests to fast during Ramadan?

All parties agreed that IH would not be able to understand the purpose of withholding food or fluids from him during the daylight hours of Ramadan, and that to do so may cause him significant distress. There were also concerns that fasting might lead to mild dehydration, which could amplify side-effects of medication. The court concluded that it was not in IH's best interests to fast during Ramadan and granted a declaration that he should be relieved of this obligation.

Was it in IH's best interests for his pubic and axillary hair to be trimmed?

The court noted that the local authority caring for IH had an obligation to 'create a care environment and routine which is supportive of the religion' of any person under their care and 'to facilitate the person's access to, or observance of religious custom and ritual'. The court cited the provision of IH with a Halal diet, despite him having no understanding of the fact that the food he was provided with was Halal and no understanding of the significance of a Halal diet, as an example of the local authority recognising the need to respect IH's religion. However, in regards to the custom of shaving of IH's pubic and axillary hair, the court concluded that there was no obligation on the local authority to ensure that this religious custom was observed. The court's best interests reasoning on this is described in *Box 3*. *Box 3*Text from the judgment in reaching the conclusion that it was not in IH's best interests for his pubic and axillary hair to be trimmed 'In short . . . there is simply no religious duty, or obligation on a person who lacks capacity ('legal competence' in Islam) to trim or shave his or her pubic and axillary hair, or on his carer to do so for them. IH does not need to acquire this state of ritual cleanliness in order to derive spiritual benefit as he already occupies an elevated status by virtue of his incapacity. Moreover, I am satisfied that IH himself derives no religious 'benefit' by having the procedure undertaken, as he would not understand its religious significance. It is of no consequence to me, in the consideration of these facts, that the carers may be blessed in the eyes of Islam in undertaking a 'praiseworthy' activity by trimming the hair; their interests are not my concern.' 'I agree with TH . . . that if IH had capacity he probably would have observed this custom. . . . It would have been entirely consistent with the religious and cultural norm within his home and community. . . . However, this factor carries little weight in my overall reckoning given that in progressive Islamic religious teaching, as an incapacitous person IH is exempt from observing the Islam rituals because he is already on a heightened state of spirituality.'

This assessment also considered in depth the practical intricacies of staff attempting such a procedure under the best interests doctrine. The court was concerned that even if IH was cooperative, the procedure was likely to be anxiety-inducing and distressing for him, which could heighten his propensity to agitation and aggression. The court acknowledged that, while IH did not 'have any sense of personal modesty', the nature of such a procedure incurred 'compromises to the preservation of dignity'.

Conclusions of the court

The court concluded that it was not in IH's best interests to (1) fast during Ramadan, or (2) to have his pubic and axillary hair shaved in accordance with Islamic custom. The balancing act contained within the best interests assessment was eloquently described by the presiding judge as: "I have faithfully endeavoured to consider these issues from IH's point of view, while ultimately applying a best interests evaluation. IH has a life-long developmental condition and has never had the capacity to understand the tenets of Islam; the benefits of adherence to such rituals do not obtain for him, but for others. The fact is that by reason of his disability IH is absolved of the expectation of performing this recommended procedure, and there is no other clear benefit to him. The trimming of the pubic and axillary hair would serve no other purpose. I am anxious that IH should be spared additional stresses in his life, and wish to protect him and the staff from the risk of harm – an approach which itself has the endorsement of Islamic teaching'."

Discussion

The judgment included consideration of Islamic bioethics in its decision-making and specifically that ‘No hurt no harm’ was a cardinal principle of this approach. The judgment opined that it would be wrong to create a situation whereby observance of Islamic custom could or would cause harm to the person or their carers. Islamic bioethics is an extension of Shariah (Islamic Law) and is intimately linked to the broad ethical teachings of the Qur’an.⁴ It teaches that the patient must be treated with respect and compassion, and that the physical, mental and spiritual dimensions of the illness experience should be taken into account. The principlist approach to biomedical ethics⁵ as a culturally sensitive approach is broadly accepted and has been discussed among Muslim scholars.⁶ The four general principles of this are: (1) respect for autonomy, (2) beneficence, (3) non-maleficence, and (4) justice. Justice is often regarded as being synonymous with fairness – it can be seen as the moral obligation to act on the basis of fair adjudication between competing claims.⁴ Gillon⁷ subdivided the obligations of justice into: (1) fair distribution of scarce resources (distributive justice); (2) respect for people’s rights (rights based justice); and (3) respect for morally acceptable laws (legal justice). In this way, it can be seen that the MCA and the doctrine of best interests can readily be applied to individuals of the Islamic faith, and that Islamic bioethics underpins such an approach. Other legal cases involving various aspects of the Islamic faith include adoption,⁸ child care orders and immunisations,⁹ capacity to marry,¹⁰ capacity to marry and to have sexual relations^{11,12} and circumcision of a child.¹³

While this case centred on the Islamic faith, a similar approach can be taken in best interests cases for people of all faiths. Where needed, obtaining clarity from experts within a particular faith will be vital. Also, systematically applying the whole MCA rubric for s.4 Best interests decisions is of course paramount – the best interests checklist as advised by the MCA Code of Practice¹⁴ (Para 5.32) being vital for this. Within this assessment, it is important to establish a person’s reasonably ascertainable past and present wishes and feelings, and the beliefs and values that would be likely to influence their decision if they had capacity (s.4(6)). Similarly, where practicable and appropriate, it is important to gain the views of significant others as to the decisions at hand (s.4(7)). While such collateral history can be invaluable, the intricacies of balancing and weighing such information can be complex, as was seen in a case involving the potential cessation of clinically assisted nutrition and hydration from an elderly Christian man with end-stage dementia.¹⁵ In needing to obtain history from the family for this best interests decision, the court noted that it was ‘important that the strength and conviction of their views is not allowed to detract from a steady appreciation of the welfare of the individual concerned’.

There has been a rapidly developing body of best interests case law in recent years emanating from the Court of Protection. This has included cases involving best interests decisions containing a significant religious or faith-based element (*Box 4*). The case of *Re BM*¹⁷ suggested an approach to the weighing up or balancing of elements within best interests decision-making. This approach, which could be applied as part of a balance sheet approach or used as free-standing, involved identifying ‘the factor of magnetic importance’ – this factor being the one that tips the balance and determines the eventual outcome. Although not finally accepted by the judge, counsel had proposed that it was BM’s ‘very deep faith’ that was the magnetic factor in his case. *Box 4* Examples of best interests cases involving a religious or faith-based element 1. *Sandwell Metropolitan Borough Council v RG & Ors* [2013]¹⁶ – annulment of a marriage for a Sikh man with a learning disability. 2. *BM, Re* [2014]¹⁷ – the appointment of a deputy for property and financial affairs in a man of Christian faith who suffered an extensive cerebrovascular accident. 3. *The London Borough of Tower Hamlets v TB & Anor* [2014]¹⁸ – the assessment of where to live and capacity to consent to relations for a married Bangladeshi woman with moderate learning disabilities. 4. *P, Re (capacity to tithe inheritance)* [2014]¹⁹ – the capacity of a man with a chronic schizoaffective disorder to make a ‘tithe’ donation of 10% of an inheritance to a church. 5. *Wye Valley NHS Trust v B* [2015]²⁰ – the potential amputation of a foot in a man with chronic schizophrenia in whom religious delusions and auditory hallucinations had become so entrenched as to become an ‘intrinsic part of who he is’. This case has arguably been at the forefront of a sea change in how courts apportion weight to a person’s views and beliefs as part of any best interests assessment. 6. *N, Re* [2015]²¹ – the determination of whether it was in the best interests for a Jewish woman with multiple sclerosis and in a minimally conscious state to continue to receive life-sustaining treatment by means of clinically assisted nutrition and hydration (CANH). *The above judgments, and all within this article, can be found via www.bailii.org

The Law Commission review of Mental Capacity and Deprivation of Liberty law²² has recommended a legislative addition to s.4(6) MCA such that decision makers should ‘give particular weight to any wishes or feelings ascertained’. The Government response²³ has accepted that this recommendation ‘should be enshrined in law’, noting that as part of

a person-centred approach the principle of taking past and present wishes and feelings into account already represents good care practice.

We thank Dr Farooq Khan (Consultant in old age psychiatry, Birmingham and Solihull Mental Health NHS Foundation Trust) for advice on Islamic faith aspects of the article.

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1.4.18 Using Twitter to assess attitudes to schizophrenia and psychosis

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Abstract**Aims and method**

Schizophrenia is a psychotic disorder that is stereotypically stigmatised as untreatable and associated with violence. Several authorities have suggested that changing the name, for example to psychosis, would reduce such stigmatisation. We aimed to compare attitudes to schizophrenia and psychosis on Twitter to see if psychosis was associated with less negative attitudes. Tweets containing the terms 'schizophrenia', 'schizophrenic', 'psychosis' or 'psychotic' were collected on www.twitter.com and were captured with NCapture. On NVivo, tweets were coded into categories based on user type, tweet content, attitude and stigma type by two independent raters. We compared the content and attitudes of tweets referring to schizophrenia/schizophrenic and psychosis/psychotic.

Results

A total of 1120 tweets referring to schizophrenia/schizophrenic and 1080 referring to psychosis/psychotic were identified over two 7-day periods; 424 original tweets for schizophrenia and 416 original tweets for psychosis were included in the analysis. Psychosis was significantly more commonly included in tweets expressing negative attitudes ($n=131$, 31.5%) than schizophrenia ($n=41$, 9.7%) ($\chi^2 = 237.03$, $P < 0.0001$). Of the personal opinions or dyadic interactions, 125 (53.4%) in the psychosis data set were stigmatising, compared with 33 (24.6%) of those in the schizophrenia set ($\chi^2 = 44.65$, $P < 0.0001$).

Clinical implications

The terms psychosis/psychotic are associated with a significantly higher number of tweets with negative content than schizophrenia/schizophrenic. Together with other evidence, this suggests that changing the name of schizophrenia to psychosis will not reduce negative attitudes toward the condition.

Declaration of interest

S.L. has received personal fees from Otsuka and Sunovion, and personal and research fees from Janssen.

Contents

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Schizophrenia and stigma

Schizophrenia is the prototypical psychotic disorder and is characterised by the psychotic symptoms of hallucinations, delusions, disorganised speech, grossly disorganised or catatonic behaviour, and negative symptoms.¹ Typically, people with schizophrenia suffer from social or occupational dysfunction, such that only a minority will be able to live independently and obtain paid employment.² Nevertheless, around half of those with schizophrenia can be regarded as having a relatively good outcome³ and most will derive some benefit from antipsychotic medication.⁴

People with schizophrenia face a great deal of stigma, which is defined as a ‘negative attitude (based on prejudice and misinformation) that is triggered by a marker of illness’.⁵ This affects their social life, occupation, self-esteem, confidence and ability to seek help and succeed with treatment⁵. Stigma may even be ‘the main obstacle to the success of programmes to improve mental health’.⁵ For example, young people with schizophrenia are likely to delay seeking treatment because of perceived stigma and the concerns that it would harm their chances of getting jobs, they would not be taken seriously and would be seen as weak.⁶ Indeed, the way that members of healthcare teams treat patients with schizophrenia is affected by stigma; for example, in reducing the willingness and confidence of pharmacists to

provide medication counselling to people with schizophrenia.⁷ Further, people with the diagnosis of schizophrenia often stigmatise themselves in that they regard themselves negatively, and such ‘self-stigma’ is associated with poor neurocognitive function.⁸

Changing the name of schizophrenia

There has been debate as to whether renaming schizophrenia would reduce the negative attitudes expressed about people with the condition. A narrative literature review concluded that the advantages of a name change would outweigh the disadvantages and suggested that an eponym be used,⁹ although this conclusion was based largely on expert opinion. A recent systematic review found that in countries that have adopted a name change, the results have been inconclusive.¹⁰ The names changed from and to are likely to be important. For example, in Japan, what was called mind-split disease (a literal translation of the Greek origins of the word schizophrenia) was renamed integration disorder.¹⁰ Koike *et al*¹¹ found that this name change ‘had a limited effect’, whereas Aoki *et al*¹² found some improvement in reducing the frequency of reporting an association with violence.

In the English-speaking world, many authorities are beginning to abandon the use of the term schizophrenia both in clinical practice and in the academic literature, and increasingly refer to the condition as psychosis (e.g. Sami *et al*¹³). For example, the former *Schizophrenia Bulletin* recently changed title to *Schizophrenia Bulletin: The Journal of Psychoses and Related Disorders* in a bid to acknowledge the changing ideas about the diagnosis of schizophrenia.¹⁴ In 2016, van Os suggested a name changed to psychosis susceptibility syndrome and that the ICD-11 should remove schizophrenia as a term.¹⁵ The authors of the British Psychological Society’s report *Understanding Psychosis and Schizophrenia* debated whether even to use the word schizophrenia in the title of their report.¹⁶⁻¹⁷ They argued that symptoms of schizophrenia and psychosis are not necessarily mental illness, and labelling all patients who fulfil diagnostic criteria for schizophrenia as having a mental illness can be detrimental and cause more harm than good because of stereotypes and stigmatising views from patients themselves and society. They argue ‘schizophrenia is essentially an idea’ and does not explain the aetiology or likely outcome for a patient.¹⁶ The move to psychosis appears to be based on the assumption that this term will carry less of the negative connotations with severity, chronicity, untreatability and violence associated with schizophrenia. For example, it has been shown that the chances of recovery for a patient diagnosed with schizophrenia (13.5%) may be less than for those who have experienced only first-episode psychosis (38%).¹⁸⁻¹⁹ To our knowledge, this assumption of a reduction in stigma has not been tested. Therefore, we wished to examine if and how the word psychosis and the related term psychotic are used. If it was found that people talk less negatively about psychosis than schizophrenia, it would provide some support for the view that making such a change in official documents, scientific papers and clinical services would reduce stigma.

The role of social media

One way of assessing how different conditions are referred to and discussed is to examine the usage of various terms on social media. Many people use social media as an outlet for opinions and as a resource for information about mental illness.²⁰ Social media brings people from different parts of the world together for debate and discussion and the dissemination of information, and influence attitudes and health behaviour.²⁰ Twitter is a micro-blogging platform allowing users to write tweets up to 140 characters in length. On Twitter, one can access a vast amount of data in a limited amount of time, compared with other social media outlets such as Facebook and YouTube, and people’s tweets are easily accessible without a reader having an account. Previous studies have investigated how schizophrenia is discussed on Twitter, finding a significant association with negative attitudes and opinions compared with depression and diabetes.²¹⁻²² However, as far as we are aware, no study has compared how schizophrenia and psychosis are discussed.

Aims

Therefore, the primary aim of this study was to investigate the use of schizophrenia and psychosis on Twitter and compare the relative proportions of negative use of the two terms. We tested the null hypothesis that there is no difference in the stigmatisation of psychosis compared with schizophrenia on Twitter.

Method

To identify tweets for the study, Twitter's advanced search tool was used on www.twitter.com to find tweets that contained the words 'schizophrenia' or 'schizophrenic', and 'psychosis' or 'psychotic' (we henceforth refer to these as schizophrenia/c and psychosis/tic) and were captured with NCapture (NCapture for Chrome, QSR International, Victoria Australia, available for download at <https://www.qsrinternational.com/nvivo/support-overview/downloads#Download-NCapture-and-other-NVivo-add-ons>). On NVivo (NVivo 12 for Mac, QSR International, Victoria Australia, available for download at <https://www.qsrinternational.com/nvivo/support-overview/downloads#Download-NCapture-and-other-NVivo-add-ons>), using an inductive coding method suggested by Reavley and Pilkington,²¹ tweets were coded based on the degree and nature of stigma toward schizophrenia/c and psychosis/tic as well as coding for user type and tweet content. Exclusion criteria were as follows: (a) Lack of context: where the tweet was unable to be understood by the reader or the tweet was a spam tweet with no meaning behind it. (b) Non-English: where all or the majority of the tweet was not in English. (c) Repetition: where the tweet was exactly the same as another tweet in the data-set. (d) Retweet: a reposted or forwarded tweet that was originally posted by another user.

If included, each tweet was coded into three or four categories, as follows: (a) User type: individual, consumer, health professional, organisation and advocate. (b) Tweet content: personal experience of mental illness, awareness promotion, research findings, resources for consumers, advertisement, news media and personal opinion/dyadic interaction. (c) Attitude: stigmatising, personal experience of stigma, supportive, neutral and anti-stigma. (d) (If category (c) indicated stigma) Stigma type: social distancing, dangerousness, snap out of it, personal weakness, inaccurate beliefs, mocking or trivialising and self-stigma. G.L.P. and J.E.H. initially coded 100 tweets, using the categories and definitions from Reavley and Pilkington.²¹ Any tweets that were hard to categorise were discussed and resolved before J.E.H. and G.L.P. both coded 10% of the identified tweets to confirm the interrater agreement. The overall agreement was 87.6%, illustrating that the coding method had high reliability. G.L.P. then coded all tweets from two 7-day periods: 16–22 April 2017 and 21–28 September 2017. Fig. 1 Proportion of all tweets coming from each type of Twitter user.

To analyse the data, χ^2 -tests were manually calculated to compare the proportions of the different types of tweets about schizophrenia/c versus psychosis/tic. These were compared with a χ^2 table to determine the *P*-value, with a value of *P* < 0.05 deemed significant.

We did not seek ethical approval for this study as it concerns the use of previously published material in the public domain. Fig. 2 The proportion of all tweets in each 'tweet content' category. Fig. 3 The proportion of all tweets in each 'attitude' category.

Results

Examples of tweets in each category are shown in *Appendix 1*.

Inclusion and exclusion

The total number of schizophrenia/c tweets over the two 7-day periods was 1120 and the total number of psychosis/tic tweets was 1080 over the two 7-day periods. We excluded 696 (62.1%) schizophrenia tweets and 664 (61.5%) psychosis tweets from the data-set based on the criteria above, leaving 424 (37.9%) schizophrenia tweets and 416 (38.5%) psychosis tweets in the analysis.

For schizophrenia/c, 490 (70.4%) of the excluded tweets were retweets, 157 (22.6%) were repetitions, 27 (3.9%) were excluded because of lack of context and 22 (3.2%) were not in English. For psychosis/tic, 560 (84.3%) were retweets, 78 (11.7%) were repetitions, 15 (2.3%) were excluded because of lack of context and 11 (1.7%) were not in English. Fig. 4The percentage of tweets that were stigmatising within each 'tweet content' category.

User type

For schizophrenia/c, individuals ($n=188$, 44.3%) and organisations ($n=186$, 43.9%) tweeted the most. This was followed by consumers ($n=22$, 5.2%), health professionals ($n=18$, 4.2%) and mental health advocates ($n=10$, 2.4%).

For psychosis/tic, individuals tweeted the most ($n=275$, 65.9%), followed by organisations ($n=108$, 25.9%), health professionals ($n=28$, 6.7%), mental health advocates ($n=5$, 1.2%) and consumers ($n=1$, 0.2%).

Tweet content

For schizophrenia/c, the tweets were most commonly personal opinions/dyadic interactions ($n=134$, 31.5%). This was followed by research findings ($n=105$, 24.6%), experience of mental illness ($n=76$, 17.8%), awareness promotion ($n=37$, 8.7%), advertisement ($n=35$, 8.2%), news media ($n=29$, 6.8%) and resources for consumers ($n=10$, 2.3%).

For psychosis/tic, the majority of tweets were also personal opinion/dyadic interaction ($n=234$, 56.1%). This was followed by experience of mental illness ($n=59$, 14.1%), research findings ($n=49$, 11.8%), advertisement ($n=38$, 9.1%), awareness promotion ($n=20$, 4.8%), resources for consumers ($n=10$, 2.4%) and news media ($n=7$, 1.7%).

Attitude

For both schizophrenia/c and psychosis/tic most of the tweets were neutral ($n=334$, 78.6% and $n=266$, 63.9%, respectively). However, there was a significant difference in the number of stigmatising tweets: 41 (9.6%) of the schizophrenia/c tweets were stigmatising, whereas 131 (31.5%) of psychosis/tic tweets were. ²-testing revealed a significant difference with a ² value of 237.03 (1 d.f., $P < 0.0001$).

For schizophrenia/c, 35 (8.2%) were anti-stigma, 10 (2.4%) were supportive and 5 (1.2%) were recounting a personal experience of stigma. For psychosis/tic, 15 (3.6%) were anti-stigma, 2 (0.5%) were supportive and 2 (0.5%) recounted a personal experience of stigma.

When analysing the stigmatising tweets, it was found that for schizophrenia/c, 35 (85.4%) came from individuals, 5 (12.2%) came from organisations and 1 (2.4%) came from a consumer. The vast majority of the stigmatising schizophrenia/c tweets were personal opinions/dyadic interactions ($n=33$, 80.5%). Six (14.6%) were from news media and two (4.9%) were about experience of mental illness.

In the stigmatised psychosis/tic tweets, 123 (94.6%) came from individuals and 5 (3.8%) came from organisations. Mental health advocates and consumers made up the other users, each tweeting one (0.8%) of the stigmatising psychosis/tic tweets. Finally, 125 (95.4%) of the stigmatised psychosis/tic tweets were personal opinion/dyadic interaction, 3 (2.3%) were about experience of mental illness, 2 (1.5%) were advertisements and 1 (0.8%) was news media.

For schizophrenia/c, 33 (24.6%) of personal opinions/dyadic interactions were stigmatising and 6 (20.7%) of the news media tweets were stigmatising. Two (2.6%) of the schizophrenia/c tweets about experience of mental illness were stigmatising. For the other categories of tweet content, none of the tweets were stigmatising.

For psychosis/tic, 125 (53.4%) of personal opinions/dyadic interactions were stigmatising. One (14.3%) of news media tweets was stigmatising, two (5.3%) of the advertisement tweets were stigmatising and three (5.1%) of tweets about experience of mental illness were stigmatising. The other categories did not contain any stigmatising tweets. Comparing the percentage of personal opinions/dyadic interactions that were stigmatising demonstrates a statistically significant difference, with a χ^2 value of 44.65 (1 d.f., $P < 0.0001$).

Stigma type

Of the stigmatising schizophrenia/c tweets, 22 (53.7%) were mocking or trivialising schizophrenia/c, 10 (24.4%) were categorised as dangerousness, 4 (9.8%) as social distancing, 3 (7.3%) as inaccurate beliefs and 2 (4.9%) as self-stigma.

For psychosis/tic, 93 (69.4%) were categorised as mocking or trivialising, 36 (26.9%) as dangerousness, 3 (2.2%) as inaccurate beliefs and 2 (1.5%) as self-stigma.

Discussion

The aim of this study was to assess any difference in views expressed about schizophrenia compared with psychosis on Twitter to assess the potential effect of a name change of schizophrenia. We found that the terms psychosis/tic were more commonly included in tweets expressing negative attitudes to these conditions than tweets referring to schizophrenia/c. Most of the stigmatising tweets were tweeted by individuals in the format of personal opinion/dyadic interactions. The most common forms of such stigmatisation were mocking, trivialisation or making associations with dangerousness. For both schizophrenia/c and psychosis/tic, however, the majority of tweets were non-stigmatising and provided potentially useful information, often about new research, normally broadcast by organisations. Fig. 5 Proportion of 'stigma type' in all stigmatising tweets.

Comparisons with previous studies

As far as we are aware, this is the first study to assess attitudes to schizophrenia compared with psychosis on Twitter or any other social medium. However, there are some previous studies that have compared attitudes to schizophrenia and other conditions on Twitter and on other social media. Reavley and Pilkington²¹ compared schizophrenia with depression on Twitter and found that there was a significantly greater stigmatisation toward schizophrenia: 5% of the schizophrenia tweets they identified ($n = 451$) were stigmatising. Joseph *et al*²² examined the use and misuse of schizophrenia on Twitter compared with diabetes and found a significantly greater proportion of schizophrenia tweets contained negative attitudes. Approximately one-third of their schizophrenia tweets had negative connotations ($n = 685$). Our figure of 9.35% ($n = 424$) falls in between what these two studies found. The difference in the percentage of schizophrenia tweets rated as stigmatising at different times could reflect coding differences but may be because of the effect of short-term changes in discussions about schizophrenia on Twitter.

There is some literature on the stigmatisation of schizophrenia and psychosis in entertainment media. A content analysis of Finnish and Greek videos on YouTube found that 83% of 52 videos portrayed schizophrenia in a negative way.²³ Similarly, Nour *et al*²⁴ found that most videos presenting schizophrenia on YouTube inaccurately portray the condition. Goodwin²⁵ examined the stereotyping of characters experiencing psychosis in 33 psychosis-related horror films released before the study was conducted. He concluded that 78.8% portrayed a homicidal maniac and 72.7% portrayed a pathetic or sad character. This is in keeping with our finding that psychosis is heavily stigmatised.

News media are also a focal point for the stigmatisation of mental health conditions. Vilhauer²⁶ analysed 181 USA newspaper articles mentioning the auditory verbal hallucinations that are diagnostic features of schizophrenia and other psychotic disorders. They found that about 50% of the articles associated auditory verbal hallucinations with criminal behaviour and violence. These findings are broadly in keeping with a more recent study that concluded that over half of all UK newspaper articles about mental health ($n = 200$) are negative and 18.5% indicate an association with violence.²⁷

Strengths and limitations

The main strength of this study is its ability to assess peoples' uncensored views about schizophrenia and psychosis without the need of a survey, the results from which could be affected by social desirability bias. The nature of Twitter means that, once published, a tweet is accessible to anyone without further permission from the tweet's author. Relevant tweets were easy to access on www.twitter.com with the advanced search tool and the process of coding was relatively time-efficient and simple using NVivo.

There are, however, a few limitations of this study. First, capturing data for two arbitrarily chosen 7-day periods means that external events and news cycles may have affected the way people discuss schizophrenia and psychosis, perhaps reducing the generalisability of the data. Of note, there were news stories about USA's response to North Korean nuclear missile testing in the April 2017 observation period,²⁸ and September 2017's period was soon after a bomb injured 30 people in London, England.²⁹ A further study could look in detail about how news media and current affairs influence people's expression of mental illness on social media. A longer period of study could examine detail how current affairs influence people's discussion of mental illness on social media, and potentially highlight trends in how people discuss schizophrenia and psychosis.

Another limitation is that spelling mistakes, abbreviations and colloquial terms for the searched terms may be used in tweets. By searching for only 'schizophrenia', 'schizophrenic', 'psychosis' and 'psychotic', tweets containing mistakes, abbreviations and colloquial terms will not have been captured in the search. We decided not to include abbreviations and colloquial terms in the search because it may not be clear whether tweets would actually have been about schizophrenia and psychosis. An example would be the abbreviation 'psycho', which could refer to psychopath, rather than psychosis. However, if anything, it is more likely that spelling mistakes, abbreviations and colloquial terms may have higher rates of stigmatisation. In a similar vein, future studies could map the different definitions of schizophrenia/c and psychosis/tic used by lay individuals and professionals as this may influence the degree of stigmatising attitudes.

Both the 7-day window convenience sampling and the ability of users to privatise their Twitter accounts could have contributed to selection bias within the study. Content from private accounts would not be visible to our searches, and it would be an interesting but technically challenging study to assess whether private and public accounts have different levels of stigma. Selection bias is an often-encountered issue when conducting research on internet-based communications, and although an attempt to mitigate this was made by analysing all tweets from within the time frame, this may reduce the external validity of the conclusions.³⁰

Finally, this study only looked on www.twitter.com and there are other social media platforms that could be assessed. Facebook data may be hard to access as the average person is likely to have their profile on a private setting, but it would be interesting to see if psychosis content on YouTube is as negative and inaccurate as it is for schizophrenia. Future work could also compare the stigmatisation of different psychoses on Twitter and other social media.

In conclusion, on Twitter, psychosis is more stigmatised than schizophrenia. This suggests that the term psychosis should not be used if schizophrenia is to be renamed with the aim of reducing stigma. Further, given that different psychotic disorders have particular treatments and varying prognoses,³¹⁻³² such a move to a more generic term may do more harm than good.

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Appendix 1 Table of category definitions and example tweets
 Category Definition of category (adapted from Reavley and Pilkington²¹)
 Example tweet
 Schizophrenia/schizophrenic
 Psychosis/psychotic
 Tweet content
 Personal experi-

ence of mental illnessThe user expresses their personal experience of having a mental illnessAs a #schizophrenic, my social brain is not all what it could be. Twitter seems like an avalanche of media frenzy 24/7 but maybe I'm nub :/Having a rough time lately with my #mentalhealth Feeling exhausted and just not myself #depression #anxiety #psychosisAwareness promotionThe user promotes awareness about schizophrenia or psychosis by providing information or pointing readers in the direction of where they can find informationSchizophrenia truth and myths <https://t.co/wGYFtMBNRa> #schizophrenia #mentalhealthRecognizing the symptoms is crucial in order to help those suffering from #psychosis in #mania <https://t.co/W40srtD86J>Research findingsThe user details outcomes in research by summarizing or linking to publications and articles#Mental problems such as #schizophrenia and #bipolar disorder could be linked to a yeast infection in the #gut <https://t.co/v1u1CBQZod>Young people with #psychosis have a 24x greater risk of death than their peers: <https://t.co/KnGBZjMZZA>Resources for consumersThe user points someone with a mental illness in the direction of helpful resources or provides adviceDid you check out our video library yet? It's full of helpful resources about #schizophrenia & #psychosis <https://t.co/CMuFhZb9QCT>Take a look at SMART - a new mental health website for people who have experienced psychosis! #psychosis #recovery... <https://t.co/7Yk2Hh7Yas>AdvertisementThe user advertises events or products and services for saleApplications close soon: Neuroscience PhD Projects in our lab (School of Medicine, Uni of #Wollongong #Australia) <http://bit.ly/2y2D7Fs> #uow #neuropharmacology #MedicinalCannabis #cannabinoids #depression #schizophrenia #cognition #microbiota #FindAPhD #PhD #DoSomethingAmazingDon't miss HOAX Our Right to Hope @HoaxOrth Award-winning trilogy of art on #psychosis Liverpool & Salford <https://t.co/apUVQRNEYP>News mediaThe user tweets a summary of, or hyperlink to, a news storyMental health trust is asked to take action after death of Norwich man at hospital unit #schizophrenia #bhive <https://t.co/eZ51APnuCg>Antiques Roadshow expert died after psychotic episode, inquest hears -#postpartum #psychosis <https://t.co/lppuWm3N6O>Personal opinion/dyadic interactionThe user in conversation with someone or expressing their own personal opinion or viewReading Bleed Through by Adriana Arrington - this is one tough read #Schizophrenia@donnabrazile and, now he's using the moab to divert attention w NKorea. #psychosis ya think?AttitudeStigmatisingA tweet that expresses a negative attitude toward schizophrenia or psychosisAs a woman, I'm laughing at this, because I think these things are only things you've ever heard inside your own head #Schizophrenia much?@realDonaldTrump Your level of #psychosis and #sociopathic tendencies is truly the only way you sleep at nightPersonal experience of stigmaThe user describes a personal experience of being stigmatised because of schizophrenia or psychosisBeing #Schizophrenic, on a down phase, relating traumas to therapist, they like to tell me I'm a coldblooded emotionless sociopath. [No! #BipolarMoving account of how an experience of #psychosis and the #stigma that surrounds it, changed a life forever <https://t.co/yjkg3qAVbSS>SupportiveThe tweet is supportive to those with schizophrenia or psychosisI love the insight into #psychosis wish everyone suffering could have access to successful treatment #moneyformentalhealthTy for your kindness. I also want to send love and support to all those suffering #schizophrenia or #SchitzoAffective as well as family membersNeutralThere is a neutral attitudeLife goal achieved today! Writing for The New York Times! <https://t.co/pfz6757QRc> #Schizophrenia #mentalhealth #workingfromhomeLet's do a Scottish sequel: Surviving #Psychosis <https://t.co/IGufn98Wz9>Anti-stigmaThe tweet promotes a reduction in stigma toward those with schizophrenia or psychosis@pfrench123 Always great to see novel and engaging ways to break down #stigma in #psychosis. We hope the project does very well-MIND MATTERS: Mental illness doesn't always lead to #violence <https://buff.ly/2hsyzBn> #schizophrenia #bipolar #treatment #getthefactsStigma typeSocial distancingThe user expresses the wish to have no contact with someone with schizophrenia or psychosis#IfYouSeeMeInRealLife you're not a schizophrenic. If not go to your nearest psychiatrist now! #Schizophrenia #MentalHealthAwarenessN/ADangerousnessThe user implies that someone with schizophrenia or psychosis is dangerous and may cause harmSchizophrenic Canadian who beheaded bus passenger walks free, won't be monitored <http://medicalnews.drifterup.com/News/Details/40640> ... #Schizophrenia @MedicalNewsLHAny excuse for #war. #American politics has truly been taken over by #psychotic #warmongers at the detriment to #humanity. #HandsOffSyriaSnap out of itThe user implies that the person with schizophrenia or psychosis can 'snap out of it' by choiceN/AN/APersonal weaknessThe user implies that schizophrenia or psychosis are because of personal weaknessN/AN/AInaccurate beliefsThe tweet indicates the user has a lack of knowledge or inaccurate beliefs about schizophrenia or psychosisThe US Government is a split personality... #Schizophrenia@ddanielsen you did all you could @F1abraham can't be fixed, there's no fixing a person who is that #psychotic. @MTV you made her fix itMocking or trivialising(a) The user is rude, insulting or trivialising toward someone with schizophrenia or psychosis; (b) The user uses schizophrenia or psychosis as an insultSome people follow you, when you follow back, they unfollow. #Twitter #schizophrenia@Pamela_Moore13 What kind of drugs is this POS on #psychoticSelf-stigmaThe tweet implies the user has internalised a stigmatising attitude toward schizophrenia or psychosisI'm going mad today though I've been officially diagnosed as a crazy person. Schizophrenia is a real downer #Schizophrenia #hearingvoicesI think

I'm starting to realize that everyone around me is a lot more in touch with reality than I am. #psychosis #mentalillness

User type Individual A user who does not specify whether they suffer from a mental illness N/AN/A Consumer A user who states on their profile, or within the sample tweet, that they suffer from a mental illness N/AN/A Organisations A user who states on their profile that they are an organisation, or group of people N/AN/A Health professionals A user who states on their profile, or within the sample tweet, that they are a healthcare professional N/AN/A Mental health advocate A user who states on their profile, or within the sample tweet, that they are a mental health advocate N/AN/A

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1.4.19 Against the stream: intermittent nurse observations of in-patients at night serve no purpose and cause sleep deprivation

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date

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Abstract

This paper argues that intermittent nursing observations of in-patients at night do not reduce the risk of suicide or severe self-harm. Suicides between 23.00 h and 07.00 h are rare, and these overwhelmingly occur under intermittent observations. Such observation is purely a defensive intervention to document that a patient is safe at a particular time, as there is no engagement. For the large majority of in-patients, it has the unintended consequence of causing sleep deprivation. The intervention may cause harm to in-patients by making their disorder worse and increase their risk during the day. If patients are judged to be at immediate risk, then they should be placed on constant observation. If they are not, then optimising sleep is important for treating a psychiatric disorder and they should be placed on general observations.

Declaration of interest

None.

Contents

- *Against the stream: intermittent nurse observations of in-patients at night serve no purpose and cause sleep deprivation*

Nursing observation is defined as ‘... regarding the patient attentively, minimizing the extent to which they feel they are under surveillance, encouraging communication, listening, and conveying to the patient that they are valued and cared for ...’.¹ National Institute for Health and Care Excellence guidelines² define various levels of observation determined by a risk assessment, especially for severe self-harm, suicide, violence and absconding. These include *continuous* observation by one or more staff; low-level *intermittent* observation (usually a frequency of once or twice an hour); and

high-level *intermittent* observation (usually two to four times an hour). The term *general* observations usually refers to a frequency of once or twice in a staff shift. The importance of ‘engagement’ (that is, emotional and psychological containment of distress and giving of hope) is emphasised as a genuine (not just linguistic alternative) to observation.³ National guidance and local policies assume that nursing observation operates over 24 h. As I shall explain, this is where the problem lies: ‘engagement’ is not required at night when a patient needs to sleep and to be kept safe.

It is up to the nursing staff to determine what fulfils ‘reasonable’ observation when patients are sleeping at night. A variety of practices and frequency of observations are used at night to document that a patient is safe at a certain time. Policies usually require the staff member to clearly see the patient is breathing. At night this typically involves either opening the window hatch in the door or entering the bedroom and shining a torch on the patient’s face or switching on a light or waking the patient by shaking them to see that they are still breathing. There are many complaints by patients on the practice as it disturbs their sleep and they are frequently unable to get back to sleep. However, the documentation of a patient’s safety has become the only metric of importance to regulators and managers. No research or discussion has ever been published into the effectiveness for risk management of nursing observations at night. However, I will argue that the process of documentation by intermittent observations at night has many unintended consequences.

Surveys of psychiatric in-patients find that the large majority experience insomnia because of the noise and light on the ward and from nursing observations.^{4,5} There is a bidirectional relationship so that insomnia is not just a symptom of psychiatric disorder – intermittent sleep deprivation makes most psychiatric disorders worse.⁶ Importantly, sleep duration is negatively correlated with subsequent length of time in hospital⁷ and is associated with a range of physical and mental health problems.⁸ Specifically, sleep deprivation leads to negative changes in the neuroendocrine, immune and inflammatory systems, as well as hypertension. Furthermore, evidence from correlational and experimental studies have demonstrated that reduced sleep has a severe effect on emotional regulation.⁹ Paradoxically, it would be better to have one night of continuous sleep deprivation, followed by advancing the time of sleep over 3 days combined with bright light in the mornings (called ‘triple chronotherapy’). This resets the circadian rhythm and can lead to a rapid improvement in risk of suicide and improvement in mood.^{10,11}

Sleep deprivation and worsening of symptoms for the many might be justified if it significantly reduced the frequency of suicide or severe self-harm. However, the effectiveness of intermittent observations at night in preventing suicide is highly questionable. The most recent National Confidential Enquiry into Suicide and Homicide¹² reported that there were 114 suicides by in-patients in the previous year (compared with 1600 suicides *per annum* by people known to psychiatric services and about 6200 people *per annum* in the community who are not known). About one-third of the in-patient deaths occurred during busy periods on the ward (e.g. 07.00–09.00 h, 13.00–15.00 h and 19.00–21.00 h), hours during handover or when staff had multiple duties to attend to.¹² I requested a further search from the National Confidential Inquiry on the numbers of in-patients who died between 23.00 h and 07.00 h. Between 2011–2016, there were 464 in-patient suicides. Of these, 54 out of 338 (16%, excluding unknowns) died at night (about half on the ward, about half off the ward). There are no statistics collected on the frequency of severe self-harm. However, it would be surprising if the pattern of self-harm were very different to the reduced risk of suicide between 23.00 h and 07.00 h.

What is also known is that 91% of in-patient deaths by suicide occur under *intermittent* rather than constant observation.¹³ This is not really surprising. If you were determined to end your life or self-harm while being observed intermittently, you would choose a time just after you have been observed and then act. The rate of suicide is 13.7 per 10 000 admissions (0.14%).¹⁴ Therefore, about two out of 10 000 admissions die at night between 23.00 h and 07.00 h, and these are overwhelmingly under *intermittent* observation. It is true that because there are no randomised controlled trials (RCTs) we do not know how many deaths were prevented (or delayed) by intermittent observations. Owing to of the very low rate of suicide at night (two per 10 000 admissions), there will never be a RCT of, say, intermittent *v.* general observations at night with mortality as the primary outcome, because the numbers required would be about 250 000 to demonstrate non-inferiority between two groups.

My conclusion is that intermittent observations at night currently cause sleep deprivation for the majority of in-patients. They appear to do little to prevent suicide and are just as likely to be increasing risk during the day and prolonging in-patient stays. The best way of managing risk is to treat the disorder, and this includes insomnia. When I discuss this with colleagues, I find a widespread view that the practice stems from institutions’ fear that something may go wrong, and that the staff or hospital may be criticised by a coroner or regulator. When a serious event occurs, the monetary as well as the human costs can be large, and thus the best defence against possible negligence claims is for staff to follow local policies or national guidelines. However, guidelines that assume the same frequency of intermittent observations

during the day or night do not make sense because (a) staff are not expected to engage a patient at night; (b) suicide is much less common at night; and (c) when suicide does occur, it is generally under intermittent observations. Night-time observations thus cannot be justified on the grounds of keeping patients safe and may increase risk over the following days by causing sleep deprivation.¹⁵

If a patient is assessed as an immediate risk to themselves or others, then they should of course be put under *constant* observation at night – I do not have a problem with this, with the caveat that deciding who is at ‘immediate risk’ is unreliable at predicting suicide. There is no evidence for differentiating between low, medium and high risk in psychiatric in-patients.¹⁶ In brief, there is an overwhelming number of false positives from those rated as having a high risk and just as many suicides from those rated as a low or medium risk. This is important because such ratings determine the level of observations during the day *and* at night. Balancing reasonableness and proportionality are crucial issues in observations at night. Thus, a policy of placing a patient under intermittent observations at night because they are rated as low or medium risk allows an institution to feel they are doing something to manage risk and protect themselves from criticism from regulators or negligence claims.

I would like to see several areas of change. First, observations should be routinely called ‘engagement’ during the day and ‘observations’ by night. Second, national guidelines on engagement and observation should take into account that only a minority of suicides occur at night. Then it should be possible to have a personalised care plan so that the frequency of engagement during the day and observations at night can be varied if the risk is assessed as differing according to context. Thus, patients who are on intermittent once-an-hour engagement during the day may be put on general observations at night. This should not stop staff being inquisitive and vigilant when they believe something is ‘not right’.¹⁷ Last, I would like sleep on an in-patient ward to be taken seriously, and the principles of sleep hygiene and cognitive-behavioural therapy for insomnia, adapted for a psychiatric ward, to be implemented.¹⁷ This means focusing the culture and environment of a ward on optimising sleep at night and therefore managing risk by treating the disorder through improving sleep. We need to listen to patients and develop innovative solutions to improve care at night. Finally, duration of stay, global severity of psychiatric disorder and quality of sleep should be important indicators for RCTs, single case experimental designs and quality improvement projects on observations.

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How can we understand psychosis without experiencing it ourselves? How can we convey such a complex, bizarre and (as Jaspers would have it) *un-understandable* experience to others, particularly those new to psychiatry? It is a difficult task.

Karin Fossum, the respected Norwegian crime writer, does not shy away from confronting the more unpalatable aspects of the human mind. Her portfolio has included an exploration of the psychological motivation of paedophiles, elder abusers, and vulnerable people who are drawn into crime. Her focus is not on what, but why.

The Whisperer centres on the unremarkable, quiet, middle-aged Ragna Reigel, who, after surgery, was left with a disability that means she cannot talk above a hoarse whisper. Isolated and ignored, no-one notices (or particularly cares) when her thoughts and behaviour start to change, until it is rather too late.

Fossum has used her talent for drawing us into the minds of the misunderstood to powerful effect. Through the format of a sensitively conducted police interview, we are carried alongside Reigel as she develops psychosis. It is an unsettling and disorienting experience.

The book captures the sense of unease and apprehension that come with delusional mood. This progresses into more defined delusions and paranoia that permeate every aspect of Reigel's life. The loss of her sense of agency and experience of perplexity and distorted perceptions is well described. "...her overview was slipping...her body had been knocked out of its natural measured rhythm...life was no longer safe...external powers were taking over." "The night was no longer silent, she could hear the seven billion people who lived on this earth. They were breathing like an enormous beast, cackling and screaming and wailing."

The language changes subtly as Reigel deteriorates, reflecting her increasingly disordered thoughts as she struggles to make sense of what is happening to her.

Through Reigel's isolation and loneliness, the book raises broader questions about how we as a society care for the vulnerable and marginalised. The effect of disability and impaired communication on mental health is considered, as is the humane treatment of offenders with mental disorders.

The book's great strength is its accessibility. It can be enjoyed on its own merits as a work of fiction; yet it also communicates an experience of psychosis in a way no textbook can. I would recommend it to medical students and trainee psychiatrists, but even seasoned psychiatrists could gain a great deal from it. Empathy starts with understanding the experience of those we care for, and *The Whisperer* – quietly, unassumingly and unnervingly – helps us to do just that.

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1.4.20 How long is (too) long?

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Abstract

Forensic psychiatric services care for patients who present with a mental disorder as well as a risk to themselves or others, and have usually been convicted of an offence. Their needs are complex and the length of stay (LoS) in forensic settings is long. LoS is affected by patient factors as well as legal and policy issues. Owing to the considerable economic and ethical issues surrounding lengthy stays in highly restrictive settings, it is crucial that a strategy is developed for how to deal with this patient group.

Declaration of interest

None.

Contents

- *How long is (too) long?*
 - *Methodological issues*
 - *What we know about LoS in forensic settings*
 - *Service provision*
 - *International perspective*
 - *Recommendations*

Earnshaw *et al*, in this issue, describe a study looking at the length of admissions in a medium secure unit in England over a period of nearly 30 years. They show a significant increase in length of stay (LoS) in the most recent cohort, as well as far more discharges to other psychiatric settings and fewer to independent living, with the diagnostic composition of the cohorts remaining largely unchanged. The paper is a welcome addition to the literature on LoS in forensic settings. Evidence on LoS is scarce, despite its obvious ethical and economic relevance. This editorial summarises the research on LoS to date and considers ideas to improve service organisation for this group of patients.

Methodological issues

There are a number of ways to investigate LoS:¹ (a) admission samples (i.e. considering all patients admitted during a particular period with LoS calculated from admission to discharge); (b) cross-sectional samples (the sample consisting of all patients resident in the particular unit of interest on a particular date with LoS calculated from date of admission to this time point); and (c) discharge samples (all patients discharged during a particular period with LoS calculated from date of admission to this date). Which method is the best depends on the questions to be answered. Earnshaw *et al* use admission samples, which has the advantage that the political and service provision context is likely to be the same for all patients in the sample at point of admission. What this method cannot capture is those patients who have not been discharged at the time of data collection, as their length of admission cannot be known at this point, thereby underestimating LoS. Another, and more significant, limitation of most research to date, regardless of which of the three approaches is used, is that it only considers a relatively short period in the patient's care trajectory, the admission to a single unit. In reality, patients' pathways are complex and an individual may be admitted to a number of secure units consecutively, adding to their overall LoS in secure care.

What we know about LoS in forensic settings

Concerns that some patients stay for too long in too high a level of security were first raised following studies in high secure settings in the 1990s involving assessments by the patients' own teams as well as independent multi-disciplinary reviews. These suggested that between one-third and two-thirds of patients did not require that level of security.²⁻⁵ Inadequate provision of beds in less secure settings and inefficiencies in the system of transfer and discharge were thought to be significant factors in the delayed transfer to a more appropriate level of security. These findings led to the 'accelerated discharge programme',⁶ aimed at reducing patient numbers in high secure care while bed numbers in medium and low secure settings increased. At the beginning of the 1990s, there were 1700 high and 600 medium secure beds,⁷ while in 2015 there were just under 800 high and about 3200 medium secure beds.⁸ Although the reduction of high secure beds is a welcome development, the increase in the overall number of patients detained in secure settings is worrying. In addition, while I am not aware of any published research in this area, anecdotally, restrictions have increased in medium secure settings, e.g. with regards to leave and handcuffing during leave.

Maybe somewhat surprisingly, there is no agreement or guidance as to how long patients should stay in high secure settings in the UK. For medium secure care, the original guidance from government, based on the recommendations in the Glancy and Butler reports,⁹ suggested an upper limit of 2 years; however, a number of studies have demonstrated that this LoS is far exceeded in a large proportion of cases.¹⁰ In a multicentre study in the UK, including all three high secure hospitals and 23 medium secure services, both within the National Health Service and the independent sector,¹¹ we found that 23.5% of high secure and 18.1% of medium secure patients fulfilled our criteria for ‘long-stay’. We defined ‘long-stay’ as having been in a high secure setting for more than 10 years, in a medium secure setting for more than 5 years or in a combination of both for more than 15 years. These figures were based on pilot work showing that these thresholds would identify a population large enough in size to provide meaningful conclusions for service developments, but not so large that a substantial proportion of the total patient population would be captured. Whether there has been an actual increase in LoS, however, remains unclear – the paper in this issue of the *Bulletin* is the first to investigate this question.

Research identifying factors associated with long stay is limited. In the UK, one early study at one of the three high secure hospitals¹² identified severity of index offence as the most important factor for personality disordered patients, while for those with mental illness psychopathology was a more relevant predictor of LoS. Studies in medium secure settings have identified severity of psychopathology, psychiatric history, seriousness of offending, patients being on ‘restriction orders’ (requiring Ministry of Justice permission for transfer), non-engagement in interventions, dependency needs and lack of step-down facilities as factors associated with long stay. A review of the international literature¹ similarly found that the factors most frequently associated with longer stay were seriousness of index offence, longer previous prison sentence, psychotic illness, symptom severity and having no close relationship.

Patient perspective has thus far been largely neglected in research on long stay in forensic settings. A qualitative study which formed part of the multicentre study described above¹² and included 40 patient interviews investigated patients’ perspective on reasons for long stay, their current situation and the prospect of moving on. Based on the emerging themes – attribution, outlook, approach and readiness for change – four overall ‘stances’ could be identified. Patients in the ‘dynamic acceptance’ group attributed their long-stay to themselves; they felt overall positive about therapy and being in secure care but felt they were ready to move on. Patients in the group we labelled ‘static acceptance’ attributed the reason for long stay internally and externally, were somewhat less positive about therapies and did not believe they were ready to move on. Those in the ‘dynamic resistance’ and ‘static resistance’ categories attributed their long-stay to external factors and were largely negative about their placement and interventions. Whereas the former group still believed they would move on eventually, the latter had largely given up on the prospect of moving on, despite their belief that they did not need to be in secure care.

Service provision

Service provision in secure care is complex, entailing different levels of security with vague entry and even vaguer exit criteria. For example, those admitted to high secure care should present a ‘grave and immediate’ danger, obviously words that leave a lot of room for interpretation. Maybe somewhat surprisingly there is no agreement that those having entered high secure care presenting such a danger should then move on or be discharged if they no longer do so. In addition, how does one measure progress, e.g. of a patient having committed sexual offences against children? Such a patient might be very well adapted in any setting not giving access to children, but what should be the criteria to decide which level of security is the right one and when to move on after years of settled behaviour? The debate around the poor to moderate accuracy of risk assessment instruments for long-term predictions is also pertinent here.¹³ Unfortunately, in the UK there seems to be little appetite to tackle these complex questions nationally. Instead, each responsible clinician makes their own judgement, and in many cases has to fight individual battles with the next unit, trying to ‘sell’ their patient.

Little is known about the complex pathways forensic patients take. In theory, they move from higher to lower levels of security in accordance with the lowering of their risk and progress in therapy. In practice, such ideal pathways are rarely achieved. For instance, we showed in our study¹¹ that less than one-third of the sample of long-stayers had stayed in their current secure unit only, while about 40% had stayed in three or more settings. More than 50% of long-stay medium secure patients had been admitted from another medium secure unit. This may be good practice in order to try a different approach in individuals with limited treatment gains. Nevertheless, it is clear that rather than moving *on*, a

large number of patients seem to be moving *around*. It is difficult to see how this unfortunate state of affairs could be changed without taking a longitudinal view and without the development of national policy for this patient group.

Considering their pathways, the group of long-stay patients probably consists of three subgroups: (a) those who are still on a trajectory of positive, albeit slow, progress; (b) those who are 'stuck' currently but might move to less secure conditions under certain circumstances; and (c) those who require secure care for life. The first group is of least concern. The second might benefit from improvements in service organisation and advancements in psychotherapeutic and pharmacological therapies. The third group is most controversial. In our own study, consultants predicted that more than 40% of long-stay patients currently resident in high secure care would still be there in 5 years' time. Even for long-stay patients in medium secure care at the time of the study, only a minority of patients were expected to achieve independent living in the next 5 years.

Nevertheless, interviews with professionals in the UK demonstrated that staff working in secure units still conceptualise the process of care along the lines of 'admission, treatment, rehabilitation, cure', in denial of the actual situation of most patients.¹⁴ Staff felt uncomfortable with the idea of dedicated 'long-stay units', which they saw as warehousing. Many did not consider long periods of detention to be problematic as long as treatment was still offered, despite the fact that such treatment did not seem to make a difference to the patient's chances of moving on. Although these sentiments are understandable, not openly recognising long stay as a problem is likely to act as a barrier to considering service improvements for this patient group.

International perspective

A number of countries have started to recognise the problem of long stay in forensic psychiatric hospitals, resulting in a range of legal and service provision developments.¹⁵ Croatia, Italy and Portugal now have legal provisions such that detention in hospital can no longer exceed the length of a prison sentence the individual would have been given had they been convicted as a non-mentally disordered offender. While not going that far, in Germany the constitutional court ruled that the length of detention has to be proportionate to the index offence and that the longer detention lasts, the more the individual's right to freedom weighs in relation to the protection of the public. While this principle has long been established in the case law of the German constitutional court, the new Criminal Code additionally specifies that after 6 years of detention in a forensic psychiatric hospital, detention has to be terminated unless there is a risk that further offences will be committed that will cause 'serious' physical or psychological harm to a victim; after 10 years such risk has to be 'grave'.¹⁶

Other countries have developed policies and services specifically for long-stay forensic populations. One example of particular interest is service provision in The Netherlands. There patients can be given 'long-stay status' by a court on the application of their treating team. Criteria for this status are: •having been an in-patient in a forensic institution for at least 6 years;•having been a patient in two separate forensic hospitals;•having completed relevant treatment programmes but with little discernible progress (or consistently refusing to participate in such programmes);•no reduction in risk in the foreseeable future expected.

Individuals with long-stay status are diverted to specific long-stay units, where the emphasis is on quality of life rather than risk-reducing interventions. Crucially, an open discussion is held with the patient about this process and they are fully aware of their new status. Importantly, from a human rights point of view, this status is not a dead end; rather, patients can move back into mainstream provision if it is clinically indicated.

Recommendations

Given the significant ethical and economic consequences of long stay in forensic care, it is essential that a national strategy is developed to deal with this complex patient group. Issues to consider in such a strategy are: •taking a whole pathway approach;•clear entry and exit criteria for services;•cut-off points for the definition of ‘long stay’ in the different levels of security;•independent reviews of long-stay patients;•exploration of interventions designed to reduce LoS;•improvement of the efficiency of pathways for this group;•incentives to move patients on (e.g. through the Commissioning for Quality and Innovation framework, as is already happening in some trusts);•flexibility in moving between services with prolonged transition periods;•introduction and evaluation of pilot services for long-stay patients.

To develop such a strategy, wide consultation including patients and carers is required to capture relevant perspectives and concerns.

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This is an insightful and extremely valuable book depicting a man’s journey through depression and anxiety. It is based on Brent Williams’ experiences and is a deeply personal account, but is also based on sound medical science. Williams’ personal experiences and the unusual graphic novel format make the book very accessible, allowing the reader to understand the experience of depression and anxiety. It is beautifully illustrated by Korkut Öztekin, with pictures which often ‘say’ so much more than words in terms of evoking the atmosphere and man’s mood.

We journey with the man from a period of deep depression to recovery, passing through multiple steps on the way—including trying to recover alone, resisting help and later becoming open to help. The book offers an explanation as to how and why one might be feeling depressed and anxious, as well as enabling the reader to learn about the symptoms of depression and anxiety.

Importantly, the story shows the reader how to take the steps towards recovery. The man is told, ‘[y]ou need to break the downward spiral . . . by doing lots of small and manageable things’. The reader is exposed to breathing techniques, mindfulness and the importance of nature, learning, human contact and exercise amongst other practical steps which help promote recovery.

The book also demonstrates a realistic recovery path with the ups and downs which are so typical. Most significantly, by charting the man’s recovery it offers hope and demonstrates a way forward which will be helpful and comforting to those with similar problems. There are elements of the narrative which are perhaps a little alien to the National Health Service culture. Nevertheless, this is a much-needed book which will be very useful to patients and their families/friends as well as a great help to general practitioners by supporting the messages we give.

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1.4.21 Functional non-epileptic attacks: essential information for psychiatrists

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Abstract

Functional non-epileptic attacks (FNEA) are seizure-like events occurring in the absence of epilepsy. Having had many different names over the years including dissociative convulsions and pseudo-seizures, they now fall in the borderland between neurology and psychiatry, often not accepted by either specialty. However, there is evidence that there is a high rate of psychiatric comorbidity in these patients and therefore it is likely that psychiatrists will come across patients with FNEA and they should know the broad principles of assessment and management.

We have provided a clinically based overview of the evidence regarding epidemiology, risk factors, clinical features, differentiation from epilepsy, prognosis, assessment and treatment.

By the end of this article, readers should be able to understand the difference between epileptic seizures and FNEA, know how to manage acute FNEA, and understand the principles of neuropsychiatric assessment and management of these patients, based on knowledge of the evidence base.

Consent statement

Informed consent was obtained from the patient for publication of *Box 1*.

Declaration of interest

None.

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- *Functional non-epileptic attacks: essential information for psychiatrists*
 - *Clinical scenario*
 - *Evidence base in FNEA*
 - *Assessment of FNEA*
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Clinical scenario

You are a core trainee in a community mental health team, working in an out-patient clinic. You come out to call your next patient when you see a 40-year-old woman lying on her back on the ground with her eyes closed in the waiting room, with people crowding around her. The receptionist informs you that she arrived a few minutes late in a distressed state and was asked to take a seat. Within a minute she was seen slumping in her chair and then sliding down to the ground, jerking all four limbs while crying. When you approach her and try to talk, she responds to your questions and soon opens her eyes and her shaking stops, but she then slips back into jerking all four limbs again. You see on her wrist that she has a medical alert bracelet, which reads ‘medical alert: non-epileptic attacks’.

- What would be your immediate management of the situation?
- What are the principles of assessment and management in functional non-epileptic attacks (FNEA)?
- What are the differences between epileptic seizures and non-epileptic attacks?

Evidence base in FNEA

FNEA are when people present with what looks like epileptic seizures but they do not have epilepsy or associated electroencephalogram (EEG) changes or a physiological condition that may mimic seizures such as syncope. This condition is also known as psychogenic non-epileptic seizures (PNES), non-epileptic attack disorder (NEAD), psychogenic seizures, hysterical seizures and so on. In ICD-10 (1992) they are classified as ‘dissociative convulsions’, in ICD-11 (2018) as ‘dissociative neurological symptom disorder’ and in DSM-5 (2013) as ‘functional neurological symptom disorder – with attacks or seizures’. The change in terminology over the years reflects the changes in theoretical underpinning and clinical understanding. FNEA have been described in multiple cultures without a specific diagnostic label for 4000 years, the term hysteria was then used for the next 2500 years,¹ followed by conversion, dissociation and now FNEA, which is theoretically neutral from a psychological standpoint and considered to be acceptable to patients.²

FNEA are commonly seen in neurological and accident and emergency (A&E) settings. Up to one in five patients in epilepsy clinics present with FNEA and 20–40% of patients in epilepsy-monitoring in-patient units have FNEA.³ These patients or their carers will often initially call an ambulance and present to A&E departments. Indeed, nearly a quarter of FNEA patients report an episode of FNEA status,⁴ which may in some cases even lead to intubation in the intensive treatment unit. The estimated prevalence of FNEA is 2–30/100 000 in the general population⁵ and population incidence has been estimated to be 1.4–4.9/100 000/year.³ By contrast, the median estimated population incidence of multiple sclerosis is 4.2/100 000/year and that of epilepsy is 48/100 000/year.⁶ FNEA most commonly present in young adulthood and in women, but can occur in children, older adults and men.³

The aetiology of FNEA, as with functional neurological disorders in general, is thought to be multifactorial. Risk factors include female gender, childhood abuse and neglect, avoidant coping styles, previous functional disorders and somatisation, and recent stressful event which may itself be ‘organic’ – such as a head injury or syncope.⁷ In addition, FNEA are associated with neuropsychological deficits and alexithymia.⁷ Often overlooked is a family history of functional disorders, although there have been no positive genetic findings to date.⁸ There is an association with personality disorder, especially cluster B and cluster C personality disorders,⁹ and a number of patients have other psychological comorbidities such as affective disorders and anxiety disorders,¹⁰ which may act as predisposing, precipitating or perpetuating factors. Symptoms of panic and dissociation are common leading up to an attack, and patients may even ‘bring on’ an attack to rid themselves of these symptoms.¹¹

Distinguishing epileptic from non-epileptic attacks can be difficult, and it is important to remember that there are no clinical signs that *never* occur in epilepsy, and the only certain diagnostic feature of epileptic versus non-epileptic attacks is video EEG (vEEG) confirming epileptic or non-epileptic seizures.¹⁰ If this shows the *absence* of epileptiform activity in the *presence* of the patient’s typical attacks, it confirms the diagnosis of FNEA. vEEG is of course only diagnostic if the attack occurs during monitoring and can be falsely negative on scalp EEG if there is an ictal focus deep in the frontal lobe. However, vEEG is expensive and is carried out in only some cases. Diagnosis is largely clinical, based on good history and clinical observation of an attack, ideally supplemented by clinician-viewed video of the attack. *Table 1* helps distinguish clinical features of epileptic versus non-epileptic attacks, but should not be used in isolation to make a diagnosis either way. *Table 1* Distinguishing clinical features in FNEA and epilepsy.

Feature	FNEA	Epilepsy
Onset in certain situations	Sometimes	Rarely
Gradual onset	Commonly	Rarely
Over 2 minutes duration	Commonly	Rarely
Asynchronous limb movements	Commonly	Rarely
Purposeful	Rarely	Purposeful

movements Sometimes Very rarely Thrashing, violent movements Commonly Rarely Side-to-side head movements Commonly Rarely Tongue biting of tip Sometimes Rarely Tongue biting of side Rarely Commonly Eyes closed Very commonly Rarely Resistance to eye opening Commonly Very rarely Pupillary light reflexes Commonly retained Commonly absent-tictal crying or vocalisations Sometimes Very rarely Incontinence Sometimes Commonly Post-ictal rapid reorientation-Commonly Uncommonly Absence of cyanosis Commonly Rarely¹

Confusingly, some patients with epileptic seizures may also have non-epileptic attacks. What is important in this case is the semiology (clinical features of the seizure) and whether it is different from the patient's normal epileptic seizures. Epileptic seizures tend to be short, stereotyped and highly consistent, although of course they can take different forms in the same patient, e.g. simple and complex. However, in the case of the emergence of a new seizure type in a patient with stable epilepsy, FNEA should be considered.

In terms of prognosis and outcomes, data suggest that 4 years after diagnosis around a third of patients will be attack free.¹⁴ However, being attack free alone does not result in greatly improved levels of psychopathology or recovery of social function, as nearly half of patients who are attack free are still in receipt of state benefits.¹⁴ These data suggest that social interventions aimed at recovery of social function, e.g. going back to work, may be efficacious in improving quality of life more than aiming for patients to be attack free; however there are no studies examining social interventions alone and this is a gap in the literature. Furthermore, there is a general lack of long-term follow-up studies of patients with FNEA. Features associated with a favourable prognosis include lack of past psychiatric history, identifiable recent stressor, short duration of FNEA, higher socioeconomic class, normal IQ, lower age, less vigorous seizures, absence of comorbid epilepsy and no ongoing use of anticonvulsant medication.^{7,12}

Multiple treatments have been trialled including cognitive-behavioural therapy (CBT) (both individual and group based), paradoxical treatment, psychodynamic therapy, group therapy, family therapy, case management, eye movement desensitisation and reprocessing, acceptance and commitment therapy and multimodal approaches.^{7,12,15-18} However, the evidence base is hampered by lack of control groups, small numbers of patients in trials and also the highly variable population and presentation of FNEA. We would suggest that the individualised treatment approach as described in 2014 by Agrawal *et al*¹⁸ helps address this problem of the high variability in FNEA patients.

The problem of small numbers in treatment trials is also being addressed: The largest randomised controlled trial (RCT) to date is in CBT. Goldstein *et al*¹⁹ conducted an RCT of CBT versus standard medical care (SMC), with 33 patients in both arms, and seizure frequency reduced significantly in the CBT arm. However, the statistical power reduced significantly ($P = 0.086$) due to patients being lost to follow-up. This CBT trial was extended and repeated and is currently evaluating data as the 'COgnitive behavioural therapy versus standardised medical care for adults with Dissociative non-Epileptic Seizures' (CODES) trial.²⁰ It aimed to allocate around 150 patients to each arm – SMC and SMC with CBT – and is due to report.

Only one double-blind placebo RCT of treatment has been published in FNEA, and this was of sertraline versus placebo.²¹ A total of 33 patients were assessed and a non-significant reduction in seizure frequency was found in the sertraline versus placebo group. This was a feasibility study for a larger RCT which, to date, has not been undertaken.

1

Adapted from Reuber & Elger¹² and Mellers.¹³ FNEA, functional non-epileptic attacks.

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Assessment of FNEA

There are some key elements to the assessment of FNEA that should never be forgotten. (1) A clear history from both patient and an informant, ideally supplemented by video of the attack itself, is invaluable. Patients with non-epileptic attacks tend to talk about attacks in a different way to those with epilepsy (for example, talking about seizures by total negation and without context, i.e. 'I feel nothing', 'I don't know anything has happened'), whereas those with epilepsy try to give detailed explanations of what they did experience before or after.²² It is important to get a clear understanding of how the family react when a non-epileptic attack occurs as, in some cases, they may inadvertently be reinforcing or maintaining the attacks. (2) A good history is essential, especially for any recent stressful events. Some patients' attacks are clearly temporally related to a stressful event, although this is no longer required for diagnosis. (3) A full psychiatric history is required, assessing both past and current mental illness. Both patients with epilepsy, and with FNEA are more likely than the general population to have higher rates of depression and anxiety.¹⁰ Treatment of any comorbidities is an important part of treatment for FNEA as – although the data are limited by small numbers – comorbid prevalence rates of 63% with affective disorders, 46% with personality disorders, 32.5% with somatoform disorders, and 19% with both anxiety disorders and post-traumatic stress disorder (PTSD) have been reported.²³ (4) A thorough general medical history must be taken. Patients with non-epileptic attacks have been found to be more likely than patients with epilepsy to have functional or medically unexplained symptoms in different organ systems, such as fibromyalgia, chronic pain and irritable bowel syndrome.²⁴ The most common symptom combination distinguishing FNEA from epileptic seizures in one tertiary centre study was chronic pain, migraines and asthma in FNEA compared with diabetes and non-metastatic neoplasm in epilepsy.²⁵ (5) Determine the personal and social history of the patient. Patients with non-epileptic attacks are much more likely to report a history of abuse or neglect in childhood, and this should be sensitively asked about along with usual information such as birth trauma, developmental milestones, head injuries and details of schooling and relationships. Importantly however, some will not have this history of abuse or neglect. In some cases this may need to be asked about after developing rapport with the patient. They should also be asked whether they are still driving. (6) The premorbid personality should be ascertained. Patients with non-epileptic attacks are more likely to have a personality disorder than the general population, especially cluster B and cluster C personality disorders, although there are methodological problems with much research in this area.^{9,23} (7) The patient's illness beliefs, concerns, wishes and expectations should be ascertained. Research has shown that patients who are confident in the diagnosis of FNEA have a better outcome.²⁶ Lasting doubts about epilepsy should be dispelled and it must be emphasised that this condition is treatable and many patients fully recover. (8) Finally, a biopsychosocial formulation encompassing the above factors should be composed, using predisposing, perpetuating, precipitating and protective format. This will guide management.

Box 1 Patient experience of functional non-epileptic attacks

My dissociative seizures (NEAD) were precipitated by an episode of moderate depression and its treatment with Sertraline on transition to university. I also was experiencing panic disorder, GAD and depersonalisation–derealisation disorder. Everyone was very panicked by my first seizures. I visited several A&E departments, had numerous ambulance visits and was bounced between psychiatric liaison, the A&E staff and the CMHT, even having an overnight stay in AMU. No one could give me a concrete diagnosis, or know where to refer me. I was dosed up on benzodiazepines, which did not stop the seizures, and just made the experience harder to cope with. I experienced PTSD following the traumatic nature of these interventions; and they were completely needless. Psychiatrists at CMHT seemed very worried, even more so than I was, and this compounded the stress that was prolonging my condition. They were, however, helpful in sourcing CBT to treat my anxiety and depression. Six months after my first seizure, I was officially diagnosed with dissociative seizures. The reassurance of a diagnosis itself, along with further research into the condition, was enough alone to cause a noticeable decrease in the severity of my seizures. I then saw Dr Sheldon & Dr Agrawal at St George's. Dr Agrawal drew a diagram explaining how stress can build to cause my seizures, and I used a CBT diary to identify triggers over two months. I surprised myself with the diversity and number of my triggers on reviewing my diary, which I now manage. A greater understanding of my condition gained through psychoeducation, and the use of grounding, distancing and distracting techniques, have all been instrumental in my recovery. I am now discharged, and almost seizure-free. I wonder how much better my experience could have been if doctors had known how to treat my acute presentation?

A&E, accident and emergency; AMU, acute medical unit; CBT, cognitive–behavioural therapy; CMHT, community mental health team; GAD, generalised anxiety disorder; NEAD, non-epileptic attack disorder; PTSD, post-traumatic stress disorder.

Management

The management for all patients will naturally be different due to the different nature of their attacks and their individual triggers, but there are important overarching principles. These include making the diagnosis clearly and early (and ideally soon coming off anticonvulsants); biopsychosocial formulation including the role others play in reaction to attacks; psychoeducation about non-epileptic seizures; the management of comorbidities; the development of personal insight and understanding triggers to attacks (which can be achieved by things such as attack diaries); offering trauma-focused therapy if appropriate; and the personal testing and utilisation of different techniques such as grounding, relaxation and mindfulness. The use of benzodiazepines and anticonvulsants can be harmful both in the short and longer term. An overview of one such pragmatic, individualised treatment pathway is provided in Agrawal *et al.*¹⁸

The diagnosis should in most cases be made by a neurologist. However, many patients will benefit from neuropsychiatry-led sensitive and detailed exploration of illness beliefs, further explanation of the diagnosis and psychoeducation about triggers and management strategies. In some cases, patients will have been on anticonvulsants and will have lived with negative side-effects for years, not to mention the stigma of epilepsy and practical handicaps from the condition, such as being unable to drive. Some patients may only require a clear, sensitive diagnosis for the FNEA to stop; however, these patients are thought to be in the minority. In any case, the way a diagnosis is made is important (*Box 1*).

Four models about conveying a diagnosis have been published.^{13,27–29} However, what is common between models are the principles of reassurance; discontinuation of anticonvulsants; providing a type of model for how FNEA come about – including the relationship with emotions; and that although symptoms are not consciously controlled, patients can learn to identify triggers for seizures and learn to intervene.

People with FNEA will ideally be seen by a psychiatrist with experience of the assessment of FNEA and epilepsy, i.e. a neuropsychiatrist. The multidisciplinary team is often helpful, for example in discussing difficult formulations, and the team can offer individual therapy tailored towards the FNEA or underlying factors as appropriate. Enough time should be set aside in clinic to explore symptoms and history as well as management. The clinic letter can itself be a useful tool to explore illness beliefs at the next consultation.

Whether or not patients should remain on the neurological caseload is an interesting topic and how helpful this is has not been explored prospectively. Given some of the similarities in interpersonal interactions with borderline personality disorder and patients with FNEA, some believe that consistency is key and patients should be kept in follow-up and that discharge should be slow and gradual.⁹ Indeed, patients with FNEA often struggle to fit in within both neurology and psychiatry services and they bounce between teams with clinicians reluctant to take responsibility, similar to those with personality disorders in psychiatric services.

In an acute situation such as the above, the importance is in differentiating from an epileptic seizure. First, getting people to stand aside and leave the area is important to be able to assess the patient and manage the scenario. If your assessment is that this is a non-epileptic seizure, which from the description is likely, then some techniques can be used to arrest the seizure. For example, if a small mirror (or the front-facing camera on a smartphone) is brought to the patient's face, observe if the pupils converge on it (this is highly unlikely in an epileptic seizure). This mirror technique can in some cases stop the FNEA.¹³ However, if this is unsuccessful, it does not mean that this is *not* a functional seizure. If the patient's eyes are closed, it can be helpful to open their eyes to see if they resist eye opening, which would be very unusual in an epileptic seizure. If the patient can be spoken to and they respond emotionally to your voice (which, again, is common in FNEA), then you can talk to them and calm them. You could try asking them to tell you the day of the week, and to open their eyes and look at something in the room and describe it in detail. An example of such a grounding technique might be: 'tell me three things you can see, two things you can hear, one thing you can smell'. If the situation continues despite your best efforts, then be reassured the FNEA will stop eventually. It would be helpful to still see the patient despite the attack in the waiting room, if time allows. What is key is that the ambulance should not be called – unless the patient has seriously injured themselves – as a result of the FNEA and no acute pharmacological treatment is indicated.

Such acute treatment may not only reinforce a need for benzodiazepines or anticonvulsants, but has the potential to increase levels of dissociation by reducing alertness. Indeed it has been postulated that the variation in FNEA symptoms is due to the effect of anticonvulsants³⁰ and that other drugs inducing altered awareness states, such as anaesthetic agents, can induce FNEA.³¹

Patients may ask about driving. Current Driver and Vehicle Licensing Agency (DVLA) guidance in the UK dictates that people with FNEA should cease driving and inform the DVLA of their condition. To resume driving, people with FNEA should have episodes that are ‘sufficiently controlled’ for 3 months as long as there are ‘no mental health issues’. If there are ‘high-risk features’ then 6 months of control and a ‘specialist opinion’ is required before resumption of driving. This is the case for both group-1 and group-2 licences.³²

Conclusion

We have discussed the acute and chronic management of a patient with FNEA, highlighting the importance of individualised assessment and management based on biopsychosocial formulation. We would recommend that all patients with FNEA are referred to neuropsychiatric services, but also appreciate that due to service provision and funding gaps this is not always possible, and furthermore many patients have significant psychiatric comorbidity requiring the skills and resources of general psychiatry. Patients with FNEA can often seem as if they do not fall neatly within the responsibility of neurology or psychiatry; however a joint approach is likely to be the most productive given the degree of comorbidity. Their often-arduous journey towards diagnosis and treatment demonstrates why neurologists and psychiatrists should work, and train, in collaboration.

The extensive gaps in the literature that have been mentioned include the paucity of comparative studies between other episodic psychiatric syndromes such as panic attacks and FNEA (with these studies tending to compare FNEA patients with epileptic seizure patients), the lack of large-scale neuroimaging studies and genetic studies. The difficulty of establishing what abnormalities in studies are related to childhood trauma, comorbid psychiatric illness or the effect of chronic functional symptoms makes such studies difficult to perform. Studies assessing interventions focusing on purely social function are missing, as are large epidemiological studies, large personality disorder studies and studies examining the effect of being on or off a neurological caseload. Double-blind RCTs are extremely few in number, although this is not surprising as most studies are of psychological interventions which cannot provide a true placebo.

The earlier the diagnosis is made and biopsychosocial assessment and management put in place, the better the outcome, including a full resolution of symptoms. A neuropsychiatrist is ideally placed to do this, but a general psychiatrist, if following the basic principles discussed, can achieve good outcomes with these patients.

The authors thank Rowan Munson for his contribution to this article.

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1.4.22 Queering the Mental Health Model

Andrew Camden

date

2019-8

Contents

- *Queering the Mental Health Model*

I have been involved in a project run by the artist La JohnJoseph (JJ) on ‘Queering the Mental Health Model’. JJ’s interest in the area was sparked by their experience visiting an ex-partner who was detained on a psychiatric ward, where ‘queerness’ often seemed to be conflated with illness by ward staff. JJ observed the difficulty of maintaining individuality in the confines of the ward environment; they noted that an attempt to do so was at times interpreted by staff as a sign of pathology.

JJ led 10 sessions over 12 months around the UK, to which people who self-identify as queer were invited to talk about their experience of psychiatric services. There was a general sense that people felt poorly understood outside specialist services, which are difficult to access; participants described a sense of having to fight their way through the system. There was, however, a multitude of positive feedback from people who had felt able to access a small number of appropriate specialist services.

‘Queer’ tends to be used now as an umbrella term to describe non-cis or non-heterosexual people. Historically derogatory, from the early 1990s, queer was reclaimed as a self-affirming term, originally by the gay rights movement. Queer challenges our tendency towards conventional categorisation into defined groups and helps remind us of individuality and the diversity of identity. As part of the LGBTQ community, it is known that people who self-identify as queer suffer higher rates of mental distress than the population at large.¹ JJ’s project will shed some light on the reasons for this.

There is a dearth of literature on this topic. A literature search by Reay House Library (based at Lambeth Hospital in London) on the ‘experience of psychiatric/mental health services of people who self-identify as queer’ found a total of 33 articles, of which four were by UK authors. None of these had a specific focus on people who identify as queer; they described experiences of the UK LGBTQ community in general. Two articles have an historical focus. Hughes *et al* have published two recent articles, one looking at the experiences of LGBTQ youth (ages 16–25) of suicidality and help-seeking² and one on the perceptions and practice of mental health staff of this group.¹ There is clearly scope to further examine the experience of psychiatric services of people who identify as queer, to help inform how these might better meet demand and reduce feelings of distress and marginalisation.

JJ’s performance piece based on their experiences on the psychiatric ward, *A Generous Lover*, will tour the UK in September. There is further information at www.lajohnjoseph.com.

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1.4.23 Telepsychiatry in intellectual disability psychiatry: literature review

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Abstract

Aims and Method

The aims of this review were to explore the effectiveness and patient and provider acceptability of telepsychiatry consultations in intellectual disability, contrasting this with direct face-to-face consultations and proposing avenues for further research and innovation. Computerised searches of databases including AMED and EMBASE were conducted.

Results

Four USA studies of intellectual disability telepsychiatry services have been reported. The majority (75%) focused on children with intellectual disability. Sample sizes ranged from 38 to 900 participants, with follow-up from 1 to 6 years. Outcome measures varied considerably and included cost savings to patients and healthcare providers, patient and carer satisfaction and new diagnoses.

Clinical implications

The innovations summarised suggest a requirement to further explore telepsychiatry models. Despite some promising outcomes, there is a relative dearth in the existing literature. Further studies in other healthcare systems are required before concluding that telepsychiatry in intellectual disability is the best approach for providing psychiatric services to this population.

Declaration of interest

None.

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Background

In provision of psychiatric services to people with intellectual disability, several factors result in patients and carers experiencing difficulty in attending out-patient appointments.¹ As intellectual disability services often cater for large geographical areas, these factors include inconvenient travel.²

In the UK, there is an emphasis on finding efficiencies and providing cost reductions to address the political austerity agenda.³ The Transforming Care report⁴ for people with intellectual disability itself cited cost savings for patients returning to the community. Additionally, there is a growing movement towards a more environmentally conscious provision of service.⁵⁻⁷ Telepsychiatry⁸ consultations, on the surface, would appear to aid with these issues.⁹⁻¹¹

Telepsychiatry has been broadly defined as the use of information and communication technology to provide or support psychiatric services across distances.¹⁰ The General Medical Council¹² and the American Psychiatric Association¹³ have produced guidance on the fields of telemedicine and telepsychiatry, respectively. Notably, issues such as practicalities (including security, confidentiality, patient and provider identification, logistics, patient selection, prescribing responsibilities and reliability of equipment), as well as ethical issues including appropriate ability to escalate emergencies, are highlighted as important in such a modality.

Several reviews have focused on telepsychiatry and autism.¹⁴⁻¹⁶ Many people with intellectual disability have comorbid autism; however, the reverse is not always the case.¹⁷ Therefore, extrapolation of studies in telepsychiatry with autism, unless intellectual disability is explicitly stated, may mask the underlying needs of those with intellectual disability. Although a brief review of intellectual disability in telepsychiatry exists in the literature,¹⁸ this was methodologically flawed, as searches were limited to PubMed, resulting in omission and limited synthesis with inclusion of student teaching rather than telepsychiatry (patient-directed care).

Several innovative telepsychiatry services have been developed for use in adult, forensic, and child and adolescent mainstream (i.e. non-intellectual disability) mental health services.¹⁹⁻²² These, however, do not focus on the key issues encountered by the intellectual disability patient group and the specialist psychiatric services that serve them.

Aims

The aims of this review were to explore the effectiveness and patient and provider acceptability of telepsychiatry consultations in intellectual disability, contrasting this with direct face-to-face consultations and proposing avenues for further research and innovation.

Methods

Search strategy

A computerised search was undertaken on 10 June 2018 using the following databases: Cochrane Library, AMED, BNI, CINAHL, EMBASE, Medline, PubMed and PsychINFO. The search was of English language, peer reviewed journals for all dates available published in the respective databases.

Search terms were kept broad, to include as many studies as possible and account for the different terminology used internationally and over time for intellectual disability. The grey literature (opengrey.eu) was also searched to avoid missing relevant publications. References from papers that were selected by the search were also included if suitable studies were encountered.

The search terms for title and abstract were: (telepsych*) AND (mental* OR intellect* OR development* OR learning*) AND (deficien* OR disabilit* OR disabl* OR retard* OR disorder* OR impair* OR handicap*).

Study selection

Papers considered eligible for inclusion in this review included those where: (a) the participants were mental healthcare patients (adults or children) who were classified as having an intellectual disability; and (b) the intervention described was telepsychiatry, i.e. live synchronous or asynchronous videoconference-based clinical psychiatry. English abstracts of non-English articles were reviewed where available.

Papers were excluded where participants did not have an intellectual disability, there was no telepsychiatric intervention, or they were general review papers on telemedicine.

The titles and abstracts of reviews were identified, screened and classified for extraction of full review for further analysis by the author.

Results

A record of the searches is provided in *Fig. 1*. A total of 472 records were identified by database searches. A further 12 were retrieved by hand-searching from references. Of the 472 studies, 185 were duplicates and the remaining 299 were screened with abstracts reviewed by the author. The majority of exclusions were on the basis of the article having no clear reference to people with intellectual disability. At this stage, 107 articles were selected, including several involving participants with autism where further information was required to determine whether an intellectual disability was also present. *Fig. 1* Results of literature review search strategy.

Upon reviewing the full text of these studies, a further 103 were excluded. In these cases, the articles were opinion, commentary or editorial pieces, primary research, or addressing autism but not concerning patient groups with intellectual disability. Four studies were included in the qualitative synthesis; a summary is provided in *Table 1*. *Table 1* Characteristics of included studies

Study ID	Subjects	Study location	Intervention	Outcome	Funding	Gentile <i>et al</i> (2017)
22	900 patients,	Ohio (64 out of the 88 counties), USA	Synchronous telepsychiatry appointments with upper level residents and faculty physician partners. Various locations including homes, schools	Follow up: 4 years Data compared with year preceding intervention	Improved access to care, reduced emergency visits/hospital admissions. Cost savings, reduced travel and medical expenses	Reduced long-term services and support costs Grants from Ohio Department of Developmental Disabilities and Ohio Department of Mental Health and Addiction Services
23	Four groups of children, including one group of children with developmental disorders and severe behavioural disorders within the total of 100 participants.	Iowa, USA	Synchronous cable system connected to two public school sites and a small regional hospital from the hospital-based Center for Disabilities and Development	Two of the sub-projects included: (a) Telepsychiatry consultation – a real-time, two-way video conferencing psychiatry service for rural clients; and (b) specialised interdisciplinary consultations – a real-time, two-way video conferencing service for children with special health and behavioural needs in rural Iowa communities	Follow up: 1.5 years Phone-based interview for families and professionals	Outcomes specific to children with ID and severe behavioural disorders were not described separately.
24	Approximately 200 children with developmental disorders	Four case studies described, one involving clear behavioural or mental difficulties with an ID	Two rural counties in North Ohio, USA	Asynchronous telemedical care	School-based telemedicine program	Primarily uses store-and-forward technology to connect children with ID to their own primary care physician
				Follow up: 1 year	Post-visit survey and parent-reported outcomes	

High level of parent satisfaction, with 100% opting to continue to use service; 84% of children remained in school Grant from the Office for the Advancement of Telemedicine/HRSA (H2ATH07764) and a grant from Akron Children's Hospital Foundation Szeftel *et al* (2012) 25126 patients; 45 of these evaluated, of which 84% had an ID and 69% were children California, USA Synchronous care Collaborative-care model: primary care provider provides long-term care at the local clinic; child psychiatrist provides evaluation and recommendations at a distant clinic through videoconferencing Follow up: 3 years Retrospective chart review Prior to initial assessment, no patients were diagnosed with anxiety or mood disorders Approximately one-third of patients received one of these diagnoses in the telepsychiatry clinic Patients seen six times on average in first year and three times in the second and third years Telepsychiatrist recommended a change in patient's medication for 82% of patients at initial assessment, 41% at year 1 and 46% at year 3 Unclear¹

Study location

All studies took place in North America. Two of the studies took place in Ohio but were run by separate teams in different locations. The telepsychiatry care was provided in schools, hospitals and homes. All studies appeared to be funded by non-commercial sources.

Study designs

There were no randomised controlled trials identified. The Harper study used control groups that were evaluated on site rather than through a telepsychiatry modality and were matched using age, gender, socioeconomic status and problem type. The Langkamp study provided access to a primary care physician; while this was not a study of a psychiatric service, it was included as the cases described illustrated patient types likely to be seen in a UK intellectual disability service.

Study populations

Most studies (three) focused on children with intellectual disability, while the remaining study (Gentile23) included both children and adults with intellectual disability.

¹

ID, intellectual disability.

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Sample size

Sample sizes of people with intellectual disability were unclear in two studies (Harper²⁴ and Langkamp²⁵); however the sample sizes of the others ranged from 38 to 900 participants.

Interventions

Broadly categorised, the interventions in this review included psychiatric assessment and psychiatric follow-up, provided using a telepsychiatry service. Prior to the development of the telepsychiatry service, consultations were provided in a standard face-to-face model. Studies included in this paper used both asynchronous and synchronous connections, with the latter being more common (three studies). Synchronous services provide live, two-way interactive transmission at geographically separate locations,¹⁰ thereby simulating face-to-face interviewing. Asynchronous services, by contrast, do not require the presence of both parties at the same time, and have the advantages of being relatively inexpensive and not requiring any special hardware support. The information can be transferred in the form of data, audio, video clips or recordings, and can be done by email or web applications for review by a specialist at a later date.

Length of follow-up

Follow-up length varied from 1 to 6 years.

Outcome measures

Outcome measures varied considerably across the research studies and included cost savings to both patients and healthcare providers, patient and carer satisfaction, new diagnoses and medication changes.

Notably, there was a 96% decrease in emergency room visits (Gentile²³) in the 12 months following treatment via the telepsychiatry model compared with the preceding 12 months. The authors of that study suggest that teams have access to nursing and medical staff between appointments to assist in problem-solving in real time when issues occur between appointments. They also discuss how staff provide education on de-escalation techniques and options when patients exhibit behavioural change. Although a remarkable 96% decrease was noted, one would question the practice that existed prior to the telepsychiatry model. It is likely that, as there was limited access to local professionals before, the patients and carers may have been able to access professionals remotely. Further information on this would have been useful to balance the use of high-cost medical services with multiple accesses to lower-cost services.

Gentile described hospital admissions decreasing by 85%. The authors also noted that of their first 120 subjects, none had been admitted or readmitted to state-operated institutions. They estimated the state of Ohio saving approximately US\$80 000 per person per year in support costs. As above, more information on the frequency of contacts would have been useful. Although the study highlights several patients historically having had to use state-operated institutions, it cannot necessarily be concluded that the telepsychiatry intervention was the only reason there were no admissions or readmissions.

Harper²⁴ noted a positive attitude to their telemedicine group, with 98% stating that the experience was the same or more positive. Some parents (12%) reported technical problems such as poor audio and camera movement. Professionals rated the consultations as comparable to face-to-face consultations. There were no significant differences in consultation time. Over the time period, the authors evaluated costs including time, travel and mileage. They concluded that the average saving to the local district (professional and patterns) was US\$971 per telemedicine session. Additionally, the average saving for parents was estimated to be US\$125 per session, and fewer parents missed work.

Although there was no breakdown of cases in the Langkamp²⁵ study, the case studies included one illustrating a 10-year-old girl with intellectual disability and agitation. The authors comment that her parents were absent from work for healthcare visits less often as a result of using the telemedical link. The parents also reported appreciating their child receiving quality medical care without becoming excessively distressed.

Szeftel²⁶ and colleagues reported their patients as being seen six times on average in the first year, and three times per year in the second and third years. Severity and number of symptoms were noted to have decreased over the three years, with fewer visits as treatment progressed and fewer medication changes. The authors noted that changes in medication, either in dosage or type, tended to take place in the first rather than in later appointments, with 82% of patients having a recommended medication change at the initial assessment; this may suggest an emphasis on a biological rather than a holistic approach.

Discussion

This study is the first review to undertake a comprehensive synthesis of telepsychiatry in intellectual disability. There were two major findings: (a) very few reports of such studies exist; (b) all studies took place in North America. Unfortunately, it is therefore difficult to draw firm conclusions about the benefits and constraints of such a modality in this population group. The majority of the studies had relatively low sample sizes and focused on a single nation's health infrastructure (USA); hence, extrapolation to other populations and to other countries is potentially erroneous.

Unsurprisingly, most studies focused on children, given the relative ease of implementing such systems in children's services (as children attend schools and are more likely to have parents as guardians). It is therefore difficult to extrapolate satisfaction levels of parents to those of adult patients receiving such services. Information on exact numbers of patients with intellectual disability and mental illness or challenging behaviour was missing in half the studies. None of the studies discussed any legal implications of using remote services and storage of video data, nor how to escalate difficulties if and when they arose.

The absence of randomised controlled trials, the gold standard in research study design, was a major flaw in these studies – and, in fact, in telepsychiatry research as a whole.²⁷ Furthermore, it is possible that there are commercial intellectual disability telepsychiatry services who have not published their data for economically sensitive reasons and have therefore been missed by the searches.

However, despite these limitations, it would be irresponsible to dismiss this body of evidence when taken in the context of the telepsychiatry and general telemedical literature. Most notably, several reviews of telepsychiatry in autism^{14–16} have been conducted; these offer some overlapping features that could benefit those considering setting up telepsychiatry services in intellectual disability in other countries. There are potential legal and technological issues that could restrict the development of this field, and contextualising other non-intellectual disability studies could benefit such service innovators. Greenhalgh²⁸ and colleagues recently conducted a mixed-method study on video out-patient consultations, in which it was concluded that despite such consultations appearing convenient, safe and effective, this was only in patients judged clinically appropriate and was a fraction of the overall clinic workload. The paper also highlights that the National Health Service appears to be a difficult setting in which to introduce technologies that imply major changes in service models.

The studies overall suggested positive effects of the telepsychiatry model for intellectual disability patients. Notably, an often-considered concern from professionals regarding remote consultations is the loss of subtleties and direct relationships that are built with face-to-face appointments. These studies and the literature as a whole²⁹ do not support this. In fact, there is even evidence that children with severe anxiety and autism can be more engaged during a telepsychiatry consultation.³⁰

In addition, there are notable savings to services, both directly and in prevention of future hospital admissions, which are likely to appeal to service providers. When this is taken in the context of the positive patient and carer satisfaction results noted in the studies, it is surprising there has not been a larger uptake of telepsychiatry services in intellectual disability. If they develop sufficiently, such services may eventually be classified as a reasonable adjustment as per the UK Disability Discrimination Act. In fact, the most recent National Institute for Health and Care Excellence guideline³¹ for care and support of people growing older with learning disabilities includes specific advice to 'consider the use of technologies such as telehealth and telecare to complement but not replace the support provided by people face to face'.

All studies identified were conducted in North America; no published UK or European studies were found. This is surprising, as the UK has a faculty of intellectual disability at the Royal College of Psychiatry (<https://www.rcpsych.ac.uk/workinpsychiatry/faculties/intellectualdisability1.aspx>) and a well-established training scheme for psychiatrists

to specialise in intellectual disability psychiatry,³² as well as highly active patient advocate groups such as Mencap³³ and the Challenging Behaviour Foundation.³⁴ However, psychiatric services are generally be closer to patient populations when compared with the USA. Of the locations mentioned in the studies identified, Iowa is significantly low in population density (21/km²) when compared with California and Ohio (93 and 109/km², respectively),³⁵ although it is recorded as having more urban than rural population. In the UK, the population is more dense (271/km²)³⁶ overall, with an estimate of 83% of the population living in an urban setting.³⁷ However, it is notable in the UK that many on-call rotas are non-residential, covering large geographical regions; thus, the application of telepsychiatry could benefit both patients and a significant proportion of psychiatrists who work with intellectual disability patients.

Nevertheless, despite the identified studies focusing on intellectual disability services for children, the transition period from child and adolescent mental health services to adult services could be a positive avenue of research. Collaborative multi-professional appointments may in fact ease the transition, and research involving telepsychiatry could help to determine whether this is the case.³⁸⁻³⁹ This is often a difficult period for patients, carers and professionals, particularly for those with intellectual disability.

More research in this field would be welcomed for less-developed and more geographically spaced-out healthcare systems. Implementing both synchronous and asynchronous remote consultations using some of the more accessible, encrypted and mainstream video streaming services with intellectual disability population groups is likely to become more feasible, given that broadband services (and reductions in costs) have permeated much of the globe, including geographically isolated areas. Further research in less-developed countries as well as in other healthcare systems would help to build a more robust literature and facilitate innovation in this field. The rolling out of broadband services across other nations, including the UK, has been relatively slow in comparison with the USA; this may partly explain the lack of telepsychiatry services, which require reasonable connection speeds.

Additionally, as costs of technology such as secure smartphone devices and cheap encrypted applications decrease and data connection speeds increase, it is likely that more healthcare providers internationally may consider both implementing telepsychiatry services and sharing their outcome data in the peer-reviewed literature. Integrating the findings would therefore enable best practice guidelines to be developed, for example.

None of the studies in this review mentioned the use of interpreters; their incorporation into telepsychiatry, whether for Makaton, other forms of signing or in fact more mainstream language translation, is another potential avenue of research.⁴⁰⁻⁴¹

It is feasible that access to expertise via international collaborations using asynchronous methods or taking advantage of time zone differences for synchronous methods could enable, for example, vulnerable intellectual disability populations in underserved areas to access specialist intellectual disability psychiatric care to aid in reducing mental distress. Additional health economic and environmental evaluations in differing healthcare systems could also clarify whether similar models of care are transposable to such systems. Specific evaluation of environmental benefits or effects would also be a useful outcome to evaluate in further research.

Conclusions

This study identified four telemedical psychiatric consultation studies in intellectual disability, mainly limited to children. While there is some evidence of cost-effectiveness, improvement in patient and carer satisfaction, and convenience, the fact that there were relatively few studies limited to North America would suggest there is a need to explore further these novel methods of enhancing current psychiatric services.

Telepsychiatry models appear to aid in the empowerment of this patient group, as well as providing cost savings. However, further studies are required in other countries and across a wider age range before concluding that telepsychiatry in intellectual disability is an effective, acceptable and satisfying approach for providing psychiatric services for this underserved population group.

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This is a comprehensive resource for professionals working with students in higher education. Subsections of the book address in turn the student experience, caring for students with mental health issues and how to foster mental health in

distinct student populations. The book takes an academically robust approach to supporting student self-care, wellbeing and development of resilience.

Individual chapters go on to address key presentations around substance misuse, suicidality, mood and anxiety disorders, psychotic illness, autism, ADHD, trauma, sleep and eating disorders. There is also an important focus upon the role of university mental health services for students who have faced sexual violence, those from military backgrounds and first generation university attenders, as well as students identifying as part of the LGBTQ community. It is in the last chapter where the challenges for ‘medical students, residents and fellows’ are explored, albeit somewhat briefly. The writers identify the unique stressors for this group and reflect upon the obstacles to seeking help such as stigma and confidentiality. It is noteworthy that all medical students in the American system are postgraduate and therefore usually older than British students, most of whom enter medical school straight from sixth form/college and are less prepared for the expectations of professionalism at this early stage of their development.

Although written from the perspective of the American educational system, in general the content is still eminently transferrable to UK institutions. Throughout the book, its contributors make few assumptions as to prior knowledge, detailing everything from the risk-taking behaviours that develop during ‘emerging adulthood’ to the descriptive psychopathology for different major mental illnesses. Each chapter’s utilisation of ‘key concept’ bullet points and case examples further increase its accessibility to the reader.

Ultimately the book makes recommendations not only on how student health programmes can achieve excellence by successfully managing students with major mental illness, but also on how all students can be supported to reach their full potential. It is a valuable resource for teachers in higher education.

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1.4.24 Unheard voices: outcomes of tertiary care for treatment-refractory psychosis — ADDENDUM

S. Neil Sarkar Derek K. Tracy Maria-Jesus Mateos Fernandez Natasza Nalesnik Gurbinder Dhillon Juliana Onwumere Anne-Marye Prins Karen Schepman Tracy Collier Thomas P. White Anita Patel Fiona Gaughran Sukhwinder S. Shergill

date

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1.4.25 Harold Bourne, MB BS, DPM, FRANZCP, FRCPsych

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date

2019-8

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Formerly Senior Lecturer in Psychiatry, Otago University, Dunedin, New Zealand; Consultant Child and Adolescent Psychiatrist, Charing Cross Hospital, London, UK Harold Bourne at 94

Those who pioneer new treatments in psychiatry are usually held in high esteem. Those who successfully question established but potentially harmful interventions, though equally important, are often forgotten. This has been the case with Harold Bourne, who died recently at the age of 95 in London. In the early 1950s, while working at Netherne Hospital (a 2000 bed mental hospital in Surrey), Bourne began to question the use of insulin coma in the treatment of early schizophrenia. He wrote a notable paper, 'The Insulin Myth',¹ published in *The Lancet* in 1953. It was a review of the evidence for the effectiveness of insulin coma for schizophrenia and it concluded that the treatment was ineffective. Insulin coma, sometimes enhanced with electroconvulsive therapy during the coma, was the standard treatment for schizophrenia from the early 1930s until the late 1950s and all mental hospitals had insulin units to administer it. For a 30-year-old junior doctor this was a courageous act which challenged the authority of the profession's leaders. In 1957 (4 years after the publication of Bourne's paper), Brian Ackner and colleagues published the results of a controlled trial showing there was no difference in outcome between barbiturate-induced coma and insulin coma.² Shortly afterwards, all insulin units began to shut and this dangerous treatment went out of use.

Two other papers deserve mention. Bourne's paper on convulsion dependence³ described persistent psychoses which remained in remission only with long-term electroconvulsive therapy. This was before depot phenothiazines became available. Further, from his experience at the 600-bed Fountain Hospital for the severely mentally handicapped came his neologism 'protophrenia', a term for the dwarfing effect on mental development in children due to socially impoverished child-rearing, which could be mistaken for mental handicap caused by neuropathology.⁴ This latter observation preceded the description of psychosocial short stature or deprivation dwarfism by some 15 years.

Harold was the elder son of Jack Baum and Rachel, née Oster, and born in 1923 into a traditional London East End Ashkenazi Jewish family. His father was a tailor from Poland; his mother a school teacher. She was born in London, the daughter of Jewish migrants from Eastern Europe. Her brother was a family doctor which may have influenced Harold in his choice of career. The family anglicised their name to Bourne in 1934 but Harold always remained proud of his Jewish heritage.

Harold, known as 'Boy' in his family, won a scholarship to a grammar school in Islington, Dame Alice Owen's School. He then read medicine at University College London. His life-long interest in psychoanalysis which had begun at school was developed through his friendship with Charles Rycroft (1914–98), a contemporary at University College Hospital. Rycroft, 10 years older, was then completing his own analysis while studying medicine.

Following qualification, after 2 years of National Service at a 400-bed military psychiatric unit at Banstead Hospital and posts at Netherne and the Fountain Hospital, in 1955 Bourne was appointed Lecturer in Psychiatry in the Faculty of Medicine at the University of Otago, ultimately becoming Senior Lecturer and Senior Psychiatric Physician at Dunedin Hospital. The move to Dunedin, so he said, was to distance himself and his family from the European nuclear war he saw as imminent.

Bourne was a breath of fresh air in Dunedin, then an inward-looking academic community isolated by distance from its parent culture. He introduced the ideas of Freud and the belief that psychoanalysis could explain the causes of mental disorder and provide a treatment for them. In the absence of staff to provide this specialised treatment he used electroconvulsive therapy and drugs.

Bourne's charm, intellect and capacity for friendship influenced students and junior doctors to consider psychiatry, which was then a neglected and stigmatised specialty. He was an inspiring teacher of psychiatry with many protégées. Among those he influenced and who had careers in psychiatry in England were John Denford, Margaret Rich, John Steiner and myself. At least ten others had careers in Australia and North America.

In 1974 Bourne returned to London to a National Health Service child and adolescent psychiatry post at Charing Cross Hospital. He also established a therapeutic community at St Bernard's Hospital.

On retirement at 65 years of age in 1988 he became a psychotherapist to the expatriate anglophone community in Rome. Infirmary compelled a return to England in 2014 where he lived in a Jewish old people's residential home in Golders Green until he died.

Bourne married three times. In 1945 he married Winifred Hickson, known as Freddie. They divorced in 1980. In 1981 he married Niloufer Hickman-Fitter, divorcing in 1988. In 1989 he married Flavia Donati; they separated in 1998. With Freddie he had five children, with Niloufer one and with Flavia two. He is survived by Niloufer, Flavia, eight children, nine grandchildren, two great-grandchildren and his brother Stanford (known as Sandy) – a London psychoanalyst.

Harold Bourne was born in London 9 April 1923 and died in London 6 November 2018.

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1.4.26 Addressing shame in medical professional identity: is there such a thing as a good enough doctor?

Norella Broderick Roisin Vaughan

date

2019-12

Contents

- *Addressing shame in medical professional identity: is there such a thing as a good enough doctor?*

The author of 'Addressing shame in medical professional identity'¹ is to be congratulated for bringing this topic to the fore of our consciousness. It is welcomed along with the recent surge of popular literature focusing on the emotional challenges of medical practice (particularly among trainees), including Adam Kay's *This is Going To Hurt* and Danielle Ofri's *What Doctors Feel*.

We know that shame affects the self-care of doctors; it increases the risk of mental health problems by making us less likely to access support when needed. Mental health is currently a critical issue, especially among junior doctors, who have higher levels of clinically significant mental health problems than the general population;^{2,3} junior trainees are less likely to disclose mental distress,² and the more junior a doctor is, the less likely they are to know how to access

support.³ Further, failure to disclose mental distress and access help perpetuates stigma. There remains a high rate of presenteeism,² probably mediated by shame.

We also know that shame affects patient care experiences. The author notes that shame leads to reticence among doctors to disclosure errors. This means that teams are less able to learn from the mistakes of members, and the service does not have the opportunity to improve.

The author discusses what is not helpful in addressing shame (mandated reflective writing) but is vague on practical solutions – although there is a citation of Brown, reflecting that self-compassion is the antidote to shame. To our minds, this notion comes from Prof. Paul Gilbert's school of thinking and his team's extensive research on compassion-focused therapy (CFT) to address shame in a variety of clinical settings. They found that CFT training (a three-day workshop) for healthcare providers increased self-compassion and reduced self-critical judgement in clinicians.⁴

We suggest that CFT training could be provided to doctors as part of our suite of regular training courses. Hand hygiene training is ubiquitous, and we propose that mental health hygiene training is equally important. This could be accessed through the training colleges or from employers directly, like hand hygiene education.

In considering self-compassion as a profession, we encourage doctors to view themselves as 'good enough'. Drawing on the work of Winnicott⁵ in finding that 'good enough mothers' are what babies need, we suggest that 'good enough doctors', rather than perfectionist, shamed doctors, are what patients need.

Shame can only be addressed as above if we try to commit to a culture of disclosure and of self-compassion among doctors. As the author above describes, shame is endemic in medicine. As a step towards openness, and towards addressing shame, we ask readers to consider: can I (let myself) be a good enough doctor?

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1.4.27 The effect of integrated care on self-management and emergency department attendance

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date

2019-6

Abstract

Aims and method

The Frequent Attenders Programme is a joint initiative between Hertfordshire Rapid Assessment, Interface and Discharge service and the Emergency Department of the West Hertfordshire NHS Trust, which aims to divert frequent attenders from the emergency department by addressing their unmet needs. This paper describes the range of interventions put in place from the time that the service was set up in 2014 until the introduction of the new national Commissioning for Quality and Innovation 2017–2019, which tasked National Health Service trusts to improve services for people with mental health needs who present to Accident and Emergency. The terms emergency department and Accident and Emergency are used interchangeably, reflecting the practice in policy documents. A subsequent article will report on the impact of the Commissioning for Quality and Innovation in Hertfordshire.

Results

Analysis of the interventions indicated a highly significant ($P < 0.0001$) mean reduction in attendances. Lower gains were made in patients whose primary presentations were alcohol-related. A failure to effect change in two patients led to a significant revision of their respective care plans, resulting in a subsequent reduction in their attendances.

Clinical implications

An integrated approach to patients with complex presentations was associated with high levels of both patient and referrer satisfaction. It is hypothesised that dismantling the barriers between physical and mental health may lead to similar successes in frequent attenders in other in-patient and community medical and psychiatric services.

Declaration of interest

None.

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- *The effect of integrated care on self-management and emergency department attendance*
 - *Rates of frequent attendances to UK emergency departments*
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 - *Discussion*
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In 2014, there were approximately 21 million visits to hospital emergency departments in England; in 2016, this number had increased to 23.57 million. The increase between 2015 and 2016 was 5.2%, equivalent to an average of 3216 more people attending each day.¹ Among these, there is a small population of patients who attend on a frequent basis, despite not experiencing a medical emergency. Analysis of the data in Hertfordshire consistently indicates that more than 80% of these patients are either currently open or known to mental health services, a figure that underscores a strong relationship between mental health difficulties, unmet needs and a search for urgent help. The lack of an integrated approach to mental health has been implicated in the significantly reduced life expectancy of those suffering mental illness.²

Rates of frequent attendances to UK emergency departments

The definition of a frequent attender varies, with some National Health Service (NHS) trusts focusing on the admission rate of repeat attenders, and others focusing on the inappropriate attendance rate. In Scotland, a frequent attender is defined as someone who attends the emergency department 10 times or more in a 12-month period, or more than 5 times in a 3-month period. In England, in 2012–2013, 12 000 people made more than 10 visits in a 12-month period to individual emergency departments, with just over 150 attending on more than 50 occasions; some individuals attended nearly 250 times in 1 year.

Official concern about these rates coincide with the release of official figures in early 2015 that recorded the NHS's worst performance in emergency department for a decade, with 8.4% of patients forced to wait for more than 4 h after arriving at hospital. In February 2015, the *London Evening Standard*, using information obtained under the Freedom of Information Act, reported that 'hundreds' of patients are visiting London hospitals on more than 20 occasions each year.³ In February 2016, the London Ambulance Service disclosed that they currently had 47 768 'non-managed' frequent callers in the capital, resulting in an excess of 183 000 conveyances to hospital.⁴ In June 2017, the *Quarterly Monitoring Report* of The King's Fund, reported that in the previous 12 months, 2,500,000 people in the UK had spent more than 4 h in emergency departments, and that the finance leads of the Clinical Commissioning Groups stated that the pressures on emergency departments are their highest operational concern.⁵

Hertfordshire initiative to improve care offered to frequent attenders

The awareness of the widespread negative consequences of inappropriate attendances at emergency department led to the creation of The Hertfordshire Rapid Assessment, Interface and Discharge (RAID) Frequent Attenders Programme. This paper describes the development of a joint initiative between Hertfordshire Partnership University NHS Foundation Trust and Watford General Hospital to offer standardised care to frequent attenders. Both the successes and the challenges of implementing individualised and co-produced care plans are discussed, and are followed by reports of the outcome data for the first 2 years of the programme.

The pathway reflected the shared understanding that patients suffering mental health problems face long waits in environments not suited to prevent crisis escalation; many self-discharge before receiving a mental health assessment. Additionally, individuals may face negative attitudes from general hospital staff toward people experiencing a mental health crisis, particularly toward those who self-harm.⁶ Consequently, their needs continue unmet and their attendances persist. At the same time, resources are diverted from patients requiring medical treatment.¹

¹ Hertfordshire RAID is currently working with the police to harmonise the risks assessments that the NHS and the police use to determine the most appropriate course of action when a patient leaves the emergency department before assessment.

Method

The West Hertfordshire Frequent Attenders Pathway

Aims

The West Hertfordshire Frequent Attenders Pathway was set up in early 2014, expanding on an earlier RAID initiative that solely focused on frequent attenders to Watford General Hospital who were also known to mental health service. The revised remit extended to include prolific attenders either not known or not currently open to services. This reflected the finding that in the absence of a bespoke care plan, the frequency of patients' attendances either remained consistent or increased over a 12-month period. A core group comprising the RAID Consultant Psychiatrist and Consultant Psychologist, an Emergency Medicine Consultant and Senior Sister from the Emergency Department at Watford General Hospital and liaison workers from the country drugs and alcohol service Change, Grow, Live, initially met on a monthly basis (now bi-weekly) to identify patients who had attended the emergency department more than 15 times in a 12-month period, or who showed a recent escalating pattern of attendance (*Fig. 1: 2009–2013*). *Fig. 1* Presenting complaints of frequent attenders to Watford General Hospital.

Method: from single intervention to biopsychosocial assessment and multiagency meetings

Before the 2017–2019 Commissioning for Quality and Innovation (CQUIN), which tasks NHS trusts to achieve a 20% reduction in attendances of patients with mental health difficulties to Accident and Emergency (A&E) departments, referrals were accepted from clinical navigators in the acute general hospital and all staff working in the emergency department and the RAID teams. Cases were prioritised according to clinical need, and individual interventions put in place as appropriate. In some cases, this was as simple as sending an email to a specialty consultant asking for a review of the patient's condition, or involving district nurses in ongoing care of patients' daily needs.

Patients with comorbid physical and mental illness, or only with mental health difficulties, were invited to an assessment with the consultant psychologist. The key features of the assessment were its comprehensive evaluation of all areas of the patient's life (domestic, social, occupational), whether problematic or not, and the lack of time constraint. This enabled the clinician and the patient to achieve a joint understanding of the precipitating and maintaining factors for the frequent emergency department attendances, and formulate a bespoke and dynamic care plan, which could be modified as the patient's circumstances changed.

Patients with more complex presentations, for example, with multiple comorbidities and/or psychosocial difficulties, were discussed at a multiagency meeting, with the patient's general practitioner (GP) playing a pivotal role. To maximise attendance of involved professionals, invitations were sent out 2–3 weeks in advance, and followed up by a telephone call. Meetings were often arranged to take place at the patient's local surgery to accommodate GP clinic schedules; alternatively, conference call facilities were arranged. Participating agencies included the emergency services (the police, the east of England ambulance service, and – on occasion – the fire service), social services, specialty consultants, pain nurses, housing associations, children and family services, community mental health services, service managers and representatives of the two trusts' respective legal departments. In cases when key stakeholders were unable to attend or contribute by telephone, the findings, together with the meeting's draft care plan, were mailed to them.

The care plan

The patient's and/or carer's involvement in the planning meeting varied between individuals. In cases where guardianship is discussed, family/carers are routinely invited; where there are known engagement difficulties, the patients and their families (if they so wished) were invited to join the second part of the meeting, which would typically be attended by fewer clinicians to reduce potential stress for the patient. Following the agreement with, or at least the acceptance of the draft plan by all stakeholders, it was signed by the patient and a nominated health professional (usually the patient's care coordinator) and then distributed to all agencies and services, including the Mental Health Helpline. A copy of the care plan, including its review date, is kept in the patient's emergency department folder, so that it can be accessed whenever they attend, including out of hours, when junior doctors often come under pressure from patients to provide inappropriate treatments.

A more flexible approach was adopted with patients whose lives tended to be more chaotic often because of psychosocial issues such as homelessness and addiction. The Multi-Disciplinary Team discussion of the needs of these individuals would typically end with an agreement that if they attended the emergency department, the RAID psychologist would be advised so that (if possible) an on-site assessment could be conducted. If this was not possible, the patient would be invited to a biopsychosocial assessment. If the patient did not attend, an attempt was made (with the patient's consent) to meet at their GP surgery. Assessments have also been conducted at a homeless hotel, an intervention dependent upon both the assessor's availability at the time the patient presented and the patient's state of sobriety.

In all cases, emphasis is placed on the therapeutic ethos of the care plan: professionals attempt to balance what is given to the patient (for example, a referral to psychological therapy or access to community activities) with what is taken away from the patient (for example, ambulance conveyance to the A&E department on demand). If the patient's circumstances change, an earlier review meeting may be called.

Non-engagement

Patient non-engagement with services does not preclude the implementation of a multiagency care plan. It may change, however, the nature of the interventions. *In extremis*, the emergency services (both the police and the ambulance service) imposed a malicious telephony fine for wasting emergency services' time or, on very rare occasions, made an application to the court to demote the security of tenancy or evict a tenant whose frequent calls and troublesome behaviour significantly affected the mental health of vulnerable neighbours. The Frequent Attenders Programme trialled a collaboration with an organisation that worked with those with chaotic lifestyles (typically homelessness and substance misuse) who cost the NHS in excess of £75 000 *per annum*. The organisation, Reducing Chaos, provided transport to patients to support them to attend medical appointments, benefits interviews, addiction groups and meetings relating to their housing.

Data confidentiality

Terms of Reference for the Frequent Attenders Programme are sent to the Caldicott Guardian of all participating agencies and services to enable the sharing of information on a need-to-know basis.

Results

In demographic terms, the largest number of frequent attenders were women in the 26–39 years age group. In terms of cost to the NHS, the most expensive group were the over 65 years age group of both genders. These patients typically lived alone, had limited social networks and appeared to derive considerable comfort from the care and attention they received in the emergency department. Young adults (18–25 years) were disproportionately represented in the cohort, highlighting both the lack of good transition services between child and adult mental health services, and the need for improvement in treatments for those with emerging personality disorders.

In the first 2 years of the Frequent Attender Programme, 126 patients were referred to the Frequent Attender Pathway, 90 of whom were deemed appropriate. Of the 36 not accepted, 12 fell below the threshold rate for inclusion on the

Pathway; 24 patients reduced their attendances before an intervention was put in place, reflecting an improvement in their housing status. The number includes some out-of-area patients and a small cohort not been previously known to mental health services. Notwithstanding, the majority (>70%) are or have been open to community mental health teams in the county. As expected, most of these patients present with complex needs, including dual diagnosis (mental illness and substance misuse) or dual diagnosis together with a physical health problems. The primary diagnosis of the Hertfordshire frequent attender population is represented in *Fig. 1*, although it should be emphasised that there is considerable overlap between most of the conditions.

Results for the first 40 patients to complete 12 months after the RAID intervention, whether in the form of a biopsychosocial assessment and simple care plan for a new frequent attender or a multidisciplinary care plan for a patient with chronic and more complex needs, showed a substantial reduction in attendances for just under 90% of patients. In the 12 months pre-intervention, the mean number of attendances was 19.9 (mean, 19.88; s.d. 14.49); this figure dropped to a mean of 6 (mean, 6.00; s.d. 9.95) in the 12 months post-intervention ($t(40) = 6.32, P < 0.0001$). The mean associated cost similarly reduced from £7557 (mean, 7557.58; s.d. 5545.79) 12 months pre-intervention to £2097 (mean, 2097.29; s.d. 3904.20) in the 12 months post-intervention ($t(40) = 6.12, P < 0.0001$). The reductions in both attendance and cost are highly significant ($P < 0.0001$).

In terms of attendances, the highest number for any individual in the 12 months before the RAID intervention was 61; this patient has only attended once in the subsequent 24 months (*Table 1*). In financial terms, the cost of the most expensive patient on the Pathway was £21 567. The average cost of attendance was £354, as compared with a minimal intervention cost of £67.00 (advice only) and the next level of intervention, which costs £87.00 (advice plus painkillers).² In another case, a patient attended 34 times before the care plan and 4 thereafter. *Table 1* Patient vignettes Vignette 1 Vignette 2 Vignette 3 Presenting factors 45-year-old male malingerer; long forensic history 67-year-old woman with history of childhood sexual abuse and social deprivation made multiple daily calls to ambulance service;

asked ambulance crew to stop at Costa on the way to hospital; asked for sandwiches on arrival at A&E 50-year-old man relapsed 2 months after leaving a private alcohol rehabilitation programme; because of the risk he posed to his children, he was obliged to leave the family home, and ended up sleeping on the streets Rate of attendance 45 attendances throughout A&E departments in South-East England 45 A&E attendances to West Herts 11 A&E attendances to West Herts Care plan RAID psychiatrist worked with the police to place him on the Police National Computer, and negotiated a high threshold for detention under section 136 to avoid reinforcing maladaptive behaviours Following a professionals meeting, and with her agreement, she was rehoused in supported accommodation Urgent intervention, facilitated by the Hertfordshire FAP, the emergency department Medical Registrar, CGL and the Crisis Team found him a crisis bed in a residential placement, where he completed a community detox with chlordiazepoxide Outcome and new rate of attendance One in the 24 months following the plan Zero in the 24 months following the plan Zero in the 24 months following the plan³

As shown in *Fig. 1*, alcohol is the primary presenting issue in 34% of referrals. Patients with alcohol dependence often lead chaotic lives and tend to present to the emergency department only when drunk, making a meaningful assessment difficult. They also tend to ‘disappear’ for extended periods of time, either because they move between counties or because they are sentenced to prison sentences, typically for theft of alcohol. Their attendances also trace a different

² Figures do not include unscheduled GP attendance or East of England triage (£97 for ‘hear and treat’; £237 for conveyance). The costs of residential care placements are similarly excluded.

³ A&E, Accident and Emergency; West Herts, West Hertfordshire hospitals; RAID, Hertfordshire Rapid Assessment, Interface and Discharge service; FAP, Frequent Attenders Programme; CGL, Change, Grow, Live service.

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pattern to other frequent attenders: typically, they have cycles of abstinence alternating with cycles of relapse.

Discussion

Analysis of the results of the Hertfordshire Frequent Attenders Programme underscores that the most effective way of reducing inappropriate attendances and enhancing patient self-management is locating the frequent attender at the centre of the care plan. The Programme demonstrates that close collaboration between RAID and the emergency department, an integrated multiagency approach and a holistic assessment of the patient's needs improve outcomes. Although individualised care plans can, at least in theory, be drawn up by the Multi-Disciplinary Team in the absence of the patient, the patient's involvement, which may range from a brief assessment in the emergency department up to active co-production, is associated with a greater reduction in attendances. In complex cases, co-production demands a high level of flexibility on the part of the RAID team, including the willingness to offer an outreach service if required. Giving the patient the time they need to explain their difficulties is, unsurprisingly, reflected in individual behavioural change.

The Hertfordshire initiative, as well as programmes set up by other NHS mental health trusts, highlights that many patients who are frequent attenders to their hospital emergency departments have received suboptimal care or simply fallen through a gap in service provision. It is clear that the reasons for non-emergency attendances are complex, and multifactorial. Further, mental illness may or may not be involved in patients' presentations: 24% of the frequent attenders referred to the North-West London local CQUIN (2013–2014) were reported to have complex psychiatric morbidities. Geographical variations reflect different socioeconomic demographics and patterns of migration. What emerges equally clearly is the close relationship between patients receiving suboptimal care and the lack of integration both within and between NHS trusts, and between the health and social care systems. The outcome is either silo provision, gaps in care or duplication.

Several factors are implicated in the failure to provide comprehensive integrated care. Separate commissioning arrangements for substance misuse (a common reason for frequent attendance) and mental health result in disjointed service provision for patients. A lack of communication both between agencies, such as social services, the police and the acute general hospital, and between community and acute teams, forestalls any attempt of a seamless service provision. The problems of commissioning and communication (service factors) are exacerbated by the sizeable number of frequent attenders, often with dependency issues, who access urgent care centres or attend hospitals outside their own trusts (patient factors). In the first scenario, they may provide an alias, or simply not give their full details. In the second case, there is, to date, no communication between trusts unless a dedicated and savvy emergency department consultant alerts colleagues in neighbouring trusts. Requests from neighbouring trusts for information related solely to the number of attendances of an individual are often delayed or even lost in information governance systems. It seems highly probable the current figure of the 200 000 annual unscheduled frequent attendances are an underestimation.

It may be significant that frequent attenders typically make a high number of complaints about the medications and investigations offered, and/or their perceived treatment by emergency department staff. Some inappropriately request admission; others self-discharge prematurely. Many are angry; most are lonely. Those with limited psychological insight may project their frustration with their lives on to the emergency department. The experience of the Hertfordshire Frequent Attender Programme underscores that a multidisciplinary and, where appropriate, multiagency approach helps professionals manage their own emotions and enables patients to reflect on their own difficulties and make meaningful change. The strong therapeutic ethos of care-planning and individual interventions deepens stake-holders' understanding of the interplay between the medical, social, psychiatric and biological vulnerabilities of patients, and is reflected in the positive feedback from both patients and referrers. Exploring the reasons for inappropriate attendances at the emergency department in an unhurried manner, with compassion and an absence of judgement, helps identify not only the predisposing and presenting factors in an individual's maladaptive coping strategies, but also the biopsychosocial perpetuating factors. Once the problem has been clarified, it becomes possible to look for solutions.

Other frequent attender programmes and future directions

Early work with frequent attenders in 2012–2013, undertaken by the West London Mental Health NHS, led to the development of a local CQUIN in Central North-West London. Building on the work undertaken by the West London Mental Health NHS Trust in 2013–2014, a local CQUIN initiative was developed to identify the most frequent attenders in each of the nine A&E departments, and to create a sustainable model to reduce their unscheduled attendances. The most common primary reason for presenting at an A&E department in this cohort of 128 patients was substance misuse and attendant problems (34%), followed by long-term medical conditions, either with or without a comorbid mental health condition (27%). The elderly frail with globally deteriorating physical health accounted for 15%, and the remaining 24% mainly comprised complex psychiatric morbidity.⁷

A smaller pilot project ($N = 20$) targeting frequent attenders in the Royal Bournemouth Hospital in 2013 reported that, ‘in many cases’, medically unexplained symptoms drive unscheduled presentations to the A&E department.⁸ This finding may be contextualised in light of the report by Bermingham *et al* into the cost of somatisation among the working population in England and Wales in 2008–2009 which found the cost to the Exchequer of patients with medically unexplained symptoms to exceed £18 billion, a figure that may be compared with the cost of caring for people with dementia.⁹ Costs to the NHS (investigations, treatments, consultations) amounted to £3 billion, with the rest being accounted for by benefit payments, loss of productivity through unemployment and reduced quality of life. In the time since the publication of the report, these figures have increased (Senior Policy Advisor, Centre for Mental Health, personal communication, 2016).

Further analysis was provided by Clifford Mann, President of the College of Emergency Medicine, who identified two cohorts of inappropriate frequent attenders at the emergency department: those unwilling to wait for a GP appointment and migrants, unfamiliar with the English system of healthcare.¹⁰

The initiatives outlined above together with the work in Hertfordshire indicates that the scope for developing the model is considerable. An assertive outreach pathway is already being trialled by the Watford RAID service. The pathway could additionally be extended to include frequent attendances to GPs and to primary and secondary community services, as well as to admissions to the acute general hospital. Integrated commissioning with other projects that target unmanaged complexity and frequent service use is already under discussion. The potential both for sharing good practice, training and education at a local, regional and national level is considerable. Helping people improve their quality of life through self-management, as well as bringing about significant savings to health and social care economies, benefits individuals and the wider society.

Limitations

The limitations of the study relate to both internal and external validity. The study design does not allow causality to be established between the intervention (the care plan) and the outcome (the frequency of attendances). Aware that the use of a control group or a randomised methodology were both ethically problematic, the researchers compensated by collecting both retrospective and prospective data. Future studies will seek to establish internal validity by increasing the size of the population studied and extending the follow-up period to 3 or 5 years.

The regional focus of the study limits its generalisability. Relative to London, Yorkshire and North-East England, Hertfordshire (and other regions of the East of England) has a small refugee and migrant population. Comparing interventions and outcomes with the results in areas with large populations of asylum seekers and migrants, who typically use the emergency department as their first port of call, will improve the level of evidence, perhaps leading in time to the development of a national protocol for improving the lives of frequent attenders.

We would like to thank Dr Niall Galbraith for his invaluable support, expertise and kindness as a mentor under the *BJPsych Bulletin* author mentoring scheme.

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1.4.28 Correcting inaccurate assumptions underpinning Transforming Care in England

Jean O'Hara

date

2019-6

Contents

- *Correcting inaccurate assumptions underpinning Transforming Care in England*

John Taylor¹ is an experienced responsible clinician looking after offenders with intellectual disabilities and/or autism presenting with complex needs. I can accept the perceptual position he has taken on some of the challenges outlined in his editorial. However, his assertion that underpinning Transforming Care is an assumption 'that the hospital is always bad, and community is always better' is inaccurate. We have explicitly said that some people will need specialist in-patient care, treatment and support at times. When this is needed, we should strive to deliver better quality care, a reduction in restrictive practices, therapeutic environments, improved patient experience and reduced lengths of stay. At the start of the national learning disability programme, we had a five-fold variation in the 'need for admission' to a mental health/learning disability bed across the country. This has now reduced to a three-fold variation. The National Health Service (NHS) Long Term Plan (www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf) is explicit about its focus on increasing investment in intensive, crisis and community support and improving the quality of in-patient care across the NHS and independent sector.

I am the clinical lead for the national learning disabilities programme in England

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1.4.29 Care programme approach – time to move beyond?

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date

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Abstract

The Care Programme Approach (CPA) has been instrumental in embedding principles of holistic collaborative assessment and management into mental health care. Initially, its implementation was assisted by targeting those at greatest need. However dichotomising patients into more and less

severe is now considered unhelpful and has been demonstrated to be unreliable. Division of patients into severe and not severe categories is no more logical than such a division of patients with physical health problems. CPA principles are now applied to all patients in mental health services and practice needs to move to individualised care, focusing on meeting quality standards and achieving positive outcomes. A system based on evidence-based clinical pathways and reliable measures of severity and need should replace the current approach.

Declaration of interest

None.

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- *Care programme approach – time to move beyond?*
 - *CPA and clinical pathways*
 - *Do we need CPA?*

The Care Programme Approach (CPA) was established in 1991 in England to ensure that a safety net of care was provided for people with severe mental illness.¹ It set out requirements for health and social care assessment, including risk assessment, involving patients, carers, the multidisciplinary team and other agencies. It was a response to the Spokes inquiry into the death of Isobel Schwarz, a social worker whose death, it concluded, resulted from a lack of effective coordination of the care of a person who was severely mentally ill.² Patients accepted by mental health services were required to have a key worker, a care plan and a review date. The policy described two levels, basic and enhanced. In practice, this generally meant that patients on a basic CPA were seen by a single practitioner, often a doctor in the case of out-patients, while those on an advanced plan saw a doctor, a non-medical mental health professional (later designated as a care coordinator) and, where involved, other agencies.

In 2008, the CPA was refocused on the enhanced level, although the previous requirements remained for all those under mental health services.³ The impetus for this ‘refocusing’ came from the recognition that allocation to CPA was inconsistent, and that there was a need to improve care coordination and reduce bureaucracy. A set of criteria were introduced to determine eligibility for ‘new CPA’, and principles for working with patients on CPA were described in detail.

CPA was therefore revised to describe a group of patients with more severe mental illness. Targets have been set by the government (Monitor and now NHS Improvement) for all CPA patients to have a care plan reviewed every year and, under the National Commissioning for Quality and Innovation payments framework, to receive at least an annual physical health check. The number of people on CPA is also sometimes used as a proxy for the severity of illness of individuals in services and on caseloads, and for use in service redesign.

Services have now progressed such that the broad principles of CPA are fully accepted by professionals and regulatory bodies (*Fig. 1*). However, there is no evidence as yet that CPA criteria are applied consistently across services, or that this has improved over the years:⁴ current figures range from 1.7% to 23.5% of patients allocated to CPA,⁵ which is not proportional to morbidity. Similarly, there is no sign that the quality as opposed to quantity of care plans or health checks and interventions is adequate. The CPA definition is broad and subjective, and applying a ‘tick box’ approach to care plans and physical health checks is at best only a first step towards improving their application. Dichotomising patients into CPA or not is overly simplistic and allocation of resources has not explicitly followed, although managers probably give consideration to providing increased resources and time for increased need (whether on CPA or not). It has also contributed, despite the emphasis on its being primarily a clinical process, to an administrative rather than a person focus: ‘Care plans were described as administratively burdensome and were rarely consulted. Carers reported varying levels of involvement. Risk assessments were central to clinical concerns but were rarely discussed with service users. Service users valued therapeutic relationships with care coordinators and others, and saw these as central to recovery’.⁶

Fig. 1 Care programme approach.

When it was introduced, CPA was intended to lead to a prioritisation of service delivery to people according to their needs. The allocation to enhanced CPA can be argued to have initially achieved this, and refocusing on CPA provided further reinforcement. Such prioritisation remains necessary, but allocation to CPA is a blunt instrument. In practice, applying targets to CPA and the bureaucracy that has often developed have also been disincentives to allocating patients to it.

An option to remedy this might be to seek to improve reliability of allocation to CPA by using outcome measures which profile severity, such as the Health of the Nation Outcome Scales (HoNOS). Symptom and/or social measures on HoNOS or Clinical Outcomes in Routine Evaluation (CORE)⁷ and risk ratings could be used in combination, for example, all patients rated as having severe mental illness (i.e. high symptom scores, or moderate with significant disability) and a medium or high risk rating according to national guidance⁸ for more than a month could be included. The criteria also might include consideration of a range of other issues, for example, multi-agency involvement and carer stress, but these would be more difficult to quantify reliably.

CPA and clinical pathways

The principles of CPA have therefore been accepted as an essential foundation on which improvement of the quality of community services has been based, and broad consensus has been reached that it should be applied. However, CPA may no longer be assisting in moving services towards systematic application of the evidence-based clinical guidelines and quality standards which have been developed since it was instigated. The National Institute for Health and Care Excellence (NICE) has described these for a range of clinical conditions, and they have been operationalised into care pathways describing ‘what should happen when’.⁹ This requires individuals to be allocated to care pathways in accordance with their needs, which go beyond ‘severe’ and ‘less severe’ categories. These quality standards and outcome measures are relevant to pathways and need to be systematically implemented and monitored. Clinical measures such as the HoNOS and patient-rated measures such as DIALOG¹⁰ support this and are relatively simple and quick to use. DIALOG asks how satisfied the person is about key issues in their lives: not just mental and physical health, but accommodation, leisure, safety and relationships. It profiles need and clinical state, provides a patient-rated experience measure and links directly to care plans by eliciting the specific issues with which the individual wants help (*Fig. 2*). *Fig. 2* Pathways, outcomes and standards.

Such outcome measurements can allow the development of definitions of recovery, meaningful improvement, stability and deterioration. These may be more complex than those used for Improving Access to Psychological Services, but, in practice, it is feasible to set service definitions using these measures and other available information, e.g. relapse or disengagement from services. Recovery or improvement can be reflected by using a balance of increased satisfaction levels, symptoms, functioning and lower needs. Quality and outcomes can be improved and payment systems developed to replace block contracts, which have been blunt and ineffective instruments to fund services and are very vulnerable to arbitrary cuts. Subdivision into costing groups will become possible as data develops with greater clinical validity and reliability than the current ‘clustering’ system.¹¹ These costing groups can use some of the principles and practice used in ‘clustering’, but by using condition pathways and severity scores linked to clinical guidelines and quality standards.

A starting point, therefore, is allocation to pathways, e.g. psychosis, affective, emotionally unstable personality and organic mental disorders, using broad NICE clinical guidelines which can be expanded to the further pathways, e.g. within affective disorders, bipolar, depressive and individual anxiety disorders, as these are embedded in services and reach across the lifespan. Although patients may have multiple conditions, primary pathways can usually be allocated in practice. HoNOS and other measures can then be used to determine symptom severity to provide groupings and weightings for physical health issues, and social needs can be incorporated. Use of pathways and severity can lead to more meaningful prioritisation than attempting to allocate to CPA or non-CPA across all patients with mental illness. Prioritising within each pathway in terms of need and risk is more meaningful for measuring whether standards are being met and directing evidence-based care.

Our experience with replacing clustering with allocation of pathways, DIALOG, HoNOS and standards assessment with an algorithm for severity/pathway ‘clusters’ has been positive, with ready acceptance by mental health staff (over 5000 allocations made within the first 3 months). This algorithm is now providing clinically relevant data to redesign, support and manage services, and is being developed with local clinical commissioning groups for costing purposes.

Do we need CPA?

So do we need to retain CPA? 'Allocation to CPA' is currently a means of defining a level of severity, but allocation to clinical pathways and use of outcome data to profile groups is a much richer and more reliable approach to identifying and quantifying need. Clinical practice is not dependent on whether someone is on CPA or not, but is an individualised process. CPA has been invaluable in setting principles and practice to follow as services in the community have developed, but mental health services now need to move beyond it. CPA might possibly have a role in differentiating those with greater risk and need from those with less risk, but is this really helpful in clinical practice, service design and benchmarking?

Why should NHS Improvement, as currently, expect 12-month reviews of care plans only for people on CPA? Isn't this relevant to all people in mental health services, although the complexity and length of a care plan will vary according to the needs addressed? Is the physical healthcare of people on CPA, another target, more important than that of those who are not? There is certainly an issue of prioritising resources to ensure the most effective care, but isn't a person who is not on CPA with diabetes at least as in need of linking with primary care as one who is on CPA but lacks a physical health problem? CPA has done an invaluable job, but time has passed and more individualised and sophisticated pathway-based systems should now be adopted.

I acknowledge the Southern Health NHS FT/Hampshire CCG CPA and care planning group and the UK Routine Clinical Outcome Measures group, whose comments have contributed to this article.

David Kingdon is a professor of Mental Health Care Delivery at the University of Southampton, and Clinical Director (Adult Mental Health) and honorary consultant psychiatrist to Southern Health NHS Foundation Trust. Rehabilitation services in Hackney, London, led by John Reed (then senior psychiatrist in the Department of Health), and in Bas-setlaw, Nottinghamshire where David Kingdon was clinical director, were the inspiration for the CPA policy after the professional bodies at that time had been unable to agree a way forward. After moving to work in the Department in 1991, dissemination of CPA was a key part of the role as a senior medical officer. David Kingdon's interest in the CPA process and development has continued since appointment as a professor of mental health service delivery and through involvement in many policy, research and management initiatives, and in developing and implementing evidence-based practice for severe mental illness.

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1.4.30 Provision of weight loss programmes and their influence on weight after 1 year: follow-up survey of usual care in the STEPWISE study

Lizzie Swaby Richard Holt Rebecca Gossage-Worrall Daniel Hind

date

2019-10

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- *Provision of weight loss programmes and their influence on weight after 1 year: follow-up survey of usual care in the STEPWISE study*

In 2014, the National Institute of Health and Care Excellence (NICE) recommended that people with psychosis, especially those taking antipsychotic medication, should be offered a combined physical activity and healthy eating intervention.¹ Moreover, from 2014, Commissioning for Quality and Innovation (CQUIN) supported these recommendations by introducing annual financial incentives to mental health trusts in England to improve their provision of physical healthcare.² However, our previous survey conducted in 2015 of ten UK National Health Service mental health trusts participating in the STEPWISE trial³ highlighted that such interventions were largely unavailable, and where programmes were offered these were variable and not always widely accessed.⁴

As a follow-up to our previous survey,⁴ and in conjunction with the STEPWISE study,³ we investigated changes in usual care provision of physical activity and/or healthy eating programmes during the course of the STEPWISE trial. As with the initial survey, mental health professionals completed the survey on behalf of the same ten participating STEPWISE sites.

The number of trusts offering trust-led lifestyle programmes declined from eight to four out of ten during the study. In those trusts not offering programmes, patients were often signposted to externally run services, such as council or voluntary-sector programmes, which was also the case in the first survey.

Seven sites reported changes in services since the previous survey. These included an increased awareness of the need for physical health monitoring; expansion of existing services such as dietitians, healthy living services and gyms; and new provision of services, for instance, one trust had formed a planning group to develop a trust-led programme.

More trusts reported offering support to stop smoking than in the first survey (60% v. 30%), with three trusts either being or becoming smoke free since baseline, and more sites providing access to smoking cessation advisors.

A similar number of surveyed trusts reported recording biomedical measures prior to starting antipsychotic medication, but more trusts reported ongoing monitoring of physical health measures at 1 year than in the first survey, indicating a move towards compliance with the NICE guidelines.

This follow-up survey suggests that trusts are beginning to implement some aspects of NICE physical health recommendations, but the availability of lifestyle programmes offered to patients remains limited. Possibly reflecting the influence of the national CQUIN programme, awareness of the importance of physical health in mental health is increasing, and staff are reportedly more knowledgeable about the services that are available to patients within their trust, including programmes and facilities offered by external services.

Further research would be needed in order to generalise these findings to all UK mental health trusts, as only STEPWISE participating sites were surveyed, which may have resulted in a biased sample. In addition, a longer-term follow-up may have revealed more substantial changes by allowing more time to overcome barriers and implement processes.

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1.4.31 Praxis makes perfect?

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Abstract

Cate Bailey outlines the origin and goals of the new trainees' section of the *BJPsych Bulletin*. 'Praxis' will involve two components. The first will be clinically inspired and problem based. Trainees will have an opportunity to collaborate with experts from different disciplines to examine how existing literature and knowledge can be applied to practice, with a clinical scenario forming the basis for discussion. The second component will be made up of commissioned or proposed editorial-type articles on subjects which fall broadly under the heading of personal and professional development. This will offer a space for reflection on relevant contemporary topics such as resilience, burnout, supervision, and patient involvement and co-production.

Declaration of interest

C.B. is editor of the *BJPsych Bulletin* trainees' section.

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- *Praxis makes perfect?*

It was a surprising, not to mention slightly terrifying honour to be offered the role of Editor of the new trainees' section of the *BJPsych Bulletin*. Three years after achieving my membership of the Royal College of Psychiatrists, I find I have stumbled into the heart of the institution itself. So perhaps I am justified in experiencing an episode of acute (on chronic) imposter syndrome. Each of the RCPsych journals were, to my colleagues and I training in Australia, the most esteemed publications one could imagine. Until now, my own attempts to grace these pages had been limited to poetry – though those two small references, I think, have added significant gravitas to an otherwise relatively slim academic CV.

The *BJPsych Bulletin* has a long history of offering trainees opportunities where they can gain editing experience. Since 1999, the *Psychiatric Bulletin*, as it was formerly known, held posts for trainees to sit on the Editorial board, engage in peer reviewing and develop an individually selected project during their three-year tenure.¹ This new post, however, represents a unique challenge to create an entirely new section focusing on trainees and education. It is already apparent that the *Bulletin* regularly publishes on topics of education and training, and on clinical issues relevant to trainees. This is perhaps why it is one of the most frequently read journals among trainee psychiatrists in the UK.² So, how to take this further?

While preparing for the interview for the post, I allowed my mind to run wild with all the things I would like to read about: issues I felt were pertinent to the trainees of today, and the psychiatrists of tomorrow, in the current climate of uncertainty and austerity. These are strange times indeed. Core trainee recruitment is up by a third, at least in part thanks to the RCPsych #choosepsychiatry campaign, which aimed to challenge the perceptions that patients with mental health conditions don't get better, and portrayed the specialty as a unique chance to understand a person from multiple perspectives.³ These figures are more impressive still, given that applications to specialty training are falling overall and junior doctors are apparently leaving in droves.⁴ However, the life of psychiatry trainees is far from rosy, as eloquently outlined in the trainee-led review into morale and training in psychiatry, aptly titled 'Supported and Valued?'.⁵

The new section, is of course, a work in progress and will no doubt evolve in response to the limits of reality, time and what is achievable in the medium of print. Having said that, one of my goals is to find ways to engage readers beyond the

traditional journal form, through online content, Twitter discussions and podcasts. Although a reluctant millennial, and generally inept user of social media, I've been inspired in this area by my enthusiastic geriatrician colleagues @MDT_podcast, and by psychiatrists Katherine Adlington (clinical editor @bmj_latest and @Kateadlington), Derek Tracy (@Derektracy1; Editorial board member and social media leader @TheBJPsych) and none other than the Twitter queen herself: our distinguished president Wendy Burn (@wendyburn). These represent a handful of the growing number of clinicians and researchers who are connecting creatively, finding novel and inclusive ways of sharing, discussing and debating information. The Bulletin will be regularly tweeting updates including news about the trainees' section via #BJPBulletin.

Naturally the first task when developing any new section (after buying fresh stationery) is to think of a snappy name. Inspired by phenomenology and psychopathology, I found myself immediately searching for German words. It was tempting to settle upon 'weltschmerz' (meaning world weary, or 'mental depression or apathy caused by comparison of the actual state of the world with an ideal state').⁶ Though perhaps a little too sullen, it did capture something of the zeitgeist and the mood of many junior doctors. Other contenders, although clever, were slightly esoteric, e.g. 'verstehen' ('empathic understanding of human behaviour').⁷ Perhaps if I had been more Twitter-savvy I would have conducted a poll. But the aforementioned limits of reality (particularly time) meant it had to be an executive decision. And so we came upon 'Praxis'.

Derived from Greek, praxis means 'the exercise or practice of an art, science, or skill' or 'practical application of a theory'.⁶ In a more occupational or neurological sense, it is the ability to plan or execute movement (<https://medical-dictionary.thefreedictionary.com/>). It also has further connotations in educational theory. Paulo Freire, one of the most influential thinkers about education in the late 20th century, regarded praxis as more than an action based on prior knowledge. Rather, he described a dedication to human well-being, truth, and a perpetually shifting interaction between question and answer: the application of knowledge to action for change.⁸ That sounds a lot like psychiatry, and what I hope we can achieve in some small way with this section.

The section will involve two components. The first has been modelled on *BMJ* Endgames, and is clinically inspired and problem based. This section aims to capture the fertile discussion of local case presentations with more comprehensive analysis and varied perspectives. Psychiatric presentations sit at the intersection of the biomedical, social, cultural, and interpersonal, the past and the present. This section will explore these often knotty and interconnected aspects, with a clinical scenario forming the framework for discussion.

Trainees will have an opportunity to collaborate with experts from different disciplines to examine how existing literature and knowledge can be applied to practice. In any given scenario, possible avenues for discussion could include neuroscience, diagnosis, formulation, treatment, transference and countertransference, practicalities, real-world service provision, and ethical and legal considerations.

The College is in the process of developing a new curriculum, and the collaboration with the Gatsby Foundation and the Wellcome Trust has already seen 'Brain Camps' being held around the country.⁹ This new section may be a place where new neuroscience can be woven into a holistic approach. Patient involvement will be strongly encouraged, and we have been helpfully guided by the *BMJ* in this regard.¹⁰ A template for these clinical types of paper will be available on the website shortly.

The second component will be made up of commissioned or proposed editorial-type articles on subjects which fall broadly under the heading of personal and professional development. This will offer a space for reflection on relevant contemporary topics. Subjects I hope we can explore include psychodynamic and systemic approaches to resilience and burnout, consideration of what supervision should entail, trainee experiences of organising their own personal therapy, the experience of discrimination in psychiatric training, and what meaningful patient involvement and co-production looks like in practice and education. In commissioning for this section, I propose to work closely with the Psychiatry Trainees' Committee and the College to ensure we are responding to the needs of trainees.

As Dr Poole has said in his editorial, the future of the journal depends on you.¹¹ The success of the trainees' section depends on trainees and trainers pitching ideas for articles. If you're facing a complex clinical scenario, the chances are that someone else is too. And if you think you might never see your name in this journal – believe me, I've been in your shoes. Praxis is about dialogue, so get in touch. As Freire said, 'knowledge emerges only through invention and reinvention, the restless, impatient, continuing, hopeful inquiry beings pursue with the world and with others'.¹²

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1.4.32 Against the stream: early diagnosis of dementia, is it so desirable?

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Abstract

The Prime Minister's challenge on dementia called for improved dementia diagnosis rates, based on assumptions of benefit to individuals and those who care for them. Subsequent policies have led to increased target drives for clinical practice to achieve early diagnosis of dementia through intense case identification. However, the current evidence base and treatment options do not support screening for dementia, and there is little empirical evidence that such intensive case identification and early diagnosis for dementia is justified without a better understanding of the benefits, costs and potential harms to individuals and services.

Declaration of interest

None.

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- *Against the stream: early diagnosis of dementia, is it so desirable?*

'Of course,' many would respond to the question in the title of this paper. The same response would be heard for any chronic disease. Surely it must be better to detect a serious condition as early as possible. Even to question this response could be interpreted as somehow unethical or immoral. It stands to reason that the earlier a health condition is detected, the more effective any intervention will be. Such is society's starting point, endorsed by the successes and widespread promotion of national population screening programmes such as screening for breast, cervical or colon cancer.

In the case of dementia, following this reasoning, early diagnosis would allow earlier treatment. The individual and his or her family would be able to plan more effectively for the future, for example, to access care and support and by making advanced decision plans.

To begin with, what is meant by 'early diagnosis' along the clinical pathway of dementia? There is evidence that dementia goes through an asymptomatic stage where there may be no clinical symptoms but precursor biological and neurological changes. This may progress to an early symptomatic stage, for example, with subjective memory complaints or mild cognitive impairment (MCI), before moving on to a later symptomatic stage where there is a clear effect on daily living with further progression to advanced dementia.^{1,2} Dementia is a complex syndrome with a gradual

evolution. In some people with dementia, however, these stages may not be consistent or clearly defined. For example, MCI has been defined as the grey area between intact cognitive functioning and clinical dementia,³ but not everyone with MCI will progress to a full diagnosis of dementia.^{4,5}

Further, there is a distinction between: population screening, that is, screening everyone at a population level, including healthy or asymptomatic individuals, with the aim of very early identification; applying a 'screening' test in a clinical setting, where a clinician detects symptoms during routine attendance; and using a 'screening' test in people who are theoretically at high risk but where there is no other concern for the clinician, the patient or family members.

This still leaves the question of what is meant by 'early'. The Oxford English Dictionary definition includes 'in good time', 'before the usual time', and 'prematurely'. Each of these definitions requires a different type of evidence. 'In good time' suggests a time that is appropriate for that individual within their context; 'before the usual time' suggests a pre-emptive or screening process without implication of benefit or harm; while 'prematurely' suggests the possibility of harm.

David Cameron's Prime Minister's challenge on dementia called for improved dementia diagnosis rates.⁶ However, it is unclear whether this challenge reflected a push for diagnosis earlier along the clinical pathway or a concern that much more advanced cases of dementia, were being missed. Whatever was intended, subsequent policies and rhetoric have led to strong, target-driven pressure for clinical practice in England to achieve greater levels of 'early' diagnosis of dementia through increased case identification. This drive for increased early diagnosis assumes it is beneficial for all people with dementia, without concern for the possibility that this might divert resources from other services.

A drive for diagnosis earlier along the pathway requires (1) screening and diagnostic methods with high sensitivity and specificity; (2) adequate support and follow-up to confirm the diagnosis; (3) the availability of effective treatment and support; and (4) the availability of sufficient services to provide diagnosis, treatment and support. There is an implicit assumption here that evidence-based intervention provides a positive change in prognosis for individuals and/or the well-being of those around them. Although this assumption is justified for the national cancer screening programmes described previously, this is not the case for dementia.

At the present time, population screening for dementia for all people aged over 65 is not recommended by the UK National Screening Committee,⁷ despite regular revisiting of the evidence. The UK's Committee concluded that the current best screening test for dementia does not accurately identify those people who have dementia and those who do not. For every 100 people aged 65 tested, 18 would test positive, but only six of these would have dementia and one case would be missed.⁷ A substantial proportion of those tested would therefore be 'false positives'. Crucially, in order to recommend screening, treatments need to be available that would slow or even prevent dementia. The Committee concluded that such treatments do not exist for dementia at present.

Additionally, for population screening programmes to be introduced, population-relevant evidence, usually in the form of trials conducted in relevant populations, is required. For those conditions where national screening has been introduced, the benefits to the population have been tested and estimated and there are effective treatments available.

Thus, to justify the introduction on a national basis of intense case identification, a robust and rigorous evidence base is required.⁸ To date, no trial of intensive case identification for dementia has examined the likely effects, benefits and harm. The only evidence that is currently available is from those people who have been identified through existing identification approaches, with no systematic attention to any harm that might have been experienced.

Individuals identified through intense case identification and screening will have different natural histories from those identified through services. They are more likely to be wrongly diagnosed or, if accurately diagnosed, to have a benign course. In the absence of a well-designed trial, the benefits assumed from early diagnosis, such as support and service provision, are inevitably exaggerated. While assumed benefits of early diagnosis include planning support and services, reducing crises and family stabilisation, a number of adverse effects such as anxiety, depression and uncertainty about the future have been reported.⁹ Excessive health anxiety can also be created by screening, particularly when findings are equivocal, leading to additional suffering and abnormal internet use (cyberchondria). There is also potential for diagnostic errors and diversion of resources and services from those clearly manifest cases of dementia where individuals and their families have sought help. Anxiety, depression and concern about the future have similarly been reported following a diagnosis of MCI.¹⁰

The process of diagnosis of dementia has been described as a 'collective, cumulative, contingent process'¹¹ that often

develops over time. A diagnosis of dementia affects not just the person with dementia, but also their family members and the services around them. Reactions to a diagnosis and readiness for a diagnosis vary between individuals with dementia and their family/carers,¹² so it is important that the diagnosis of dementia is ‘timely’ or ‘in good time’ both for the person with dementia and the people around them. This concept of timely diagnosis means disclosure of the diagnosis at the ‘right time for the individual with consideration of their preferences and unique circumstances’.¹³

The pathway from early identification of suspected symptoms usually involves referral to specialist secondary care assessment, often to memory clinics. The number of patients referred to memory clinics increased by 31% from 2013 to 2014,¹⁴ and those people with dementia estimated to have received a formal diagnosis increased from 42% in 2012 to 62% in 2015.¹⁵ However, confusion about complex referral criteria resulting from the drive for early diagnosis to memory clinics may have resulted in delaying referral, with a resulting negative effect on timely diagnosis.¹⁵

It has also been argued that relying solely on opportunistic diagnosis may lead to avoidable harm. For example, it is often stated that late diagnosis results in higher rate of falls of people with unrecognised dementia, or confusion after hospital admissions. Late diagnosis may leave people insufficient time to plan for the future. Diagnoses are still too often made after a crisis. However, these claims are difficult to test empirically – people who already have a diagnosis also experience these problems; it remains uncertain whether diagnosing dementia at an ‘earlier’ stage would have made a difference to an individual.

Research is needed to address these uncertainties, including experimental designs in the introduction of service changes. The introduction of major initiatives for vulnerable populations without evaluation is extremely costly and has an inevitable harmful effect on already overstretched services.

Currently, clinical efforts should be focused on achieving a *timely diagnosis* defined as when people with dementia and those around them are ready for and will benefit from it. Until there are effective treatments for dementia, and the benefits of early diagnosis to individuals and the effects of adequate support on individuals and services have been rigorously evaluated, the benefits, costs and potential harms of early diagnosis remain uncertain.

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1.4.33 Still room for improvement: standardisation of clinical correspondence and experience in a rural crisis and home treatment service

Daniel Robinson Samuel Dearman

date

2019-6

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- *Still room for improvement: standardisation of clinical correspondence and experience in a rural crisis and home treatment service*

The communication of important clinical information in the management of our patients continues to occur in the large part through clinical letters, electronic or otherwise. Poor letter writing which misses important information and does not highlight key considerations leads to suboptimal care. This is certainly true in the crisis and home treatment team environment, where patients present with increased levels of risk and are often discharged solely to the care of their general practitioner (GP). Unfortunately, omission of information often occurs. A study of letters from mental health services in London found a mismatch between what GPs felt they needed to know and what was being included; for example, only 17% of the letters in this study included a diagnosis.¹ Evidence suggests that structured letter formats take no longer to read, are preferred by GPs, improve comprehension of letters and reduce the risk of omission of information by the author and reader.²

Anecdotally, we observed variation in our medical

Correspondence

our

GP colleagues and thus undertook a quality improvement project looking at improving the quality and consistency of letters produced by our team. This project was used as a developmental opportunity for one of our trainees under consultant supervision to learn more about the quality improvement process and to solidify trainees' understanding of the psychiatric history, mental state examination and risk assessment as core psychiatric competencies. We determined clinical letter standardisation by including widely recognised components of the psychiatric history and the requirements of our service operational policy. We included diagnosis with ICD-10 code, formulation, risk assessment plan and capacity to consent to the care plan.

In phase 1, using our standardised template, we examined all existing letters from a randomly selected period (January and February 2018) within the service. Of these, 44% included past psychiatric history, 38% included past medical history, 19% included personal history and none included forensic history. Mental state examinations also contained omissions, with 62% documenting speech, 56% documenting thoughts and 63% documenting perception. From the perspective of a crisis and home treatment service, it was noteworthy that history of self-harm was included in 38% of letters, risk of suicide in 81%, harm to others in 50%, risk to dependants in none, and risk of self-neglect and vulnerability documented in 25% each.

The standardised letter template was developed collaboratively, communicated to and agreed with all medical practitioners of all grades in the service. It was universally implemented and allowed to be used for 6 months. After this we again assessed the content of medical letters, including all those produced for a second randomly selected period (September and October 2018). A significant improvement was seen. Following implementation of the template all aspects improved: past psychiatric history (96%), past medical history (92%) and forensic history (67%). It was reassuring that documentation of risk of suicide increased to 100%, self-harm to 96%, harm to others to 96%, harm to dependants to 80% and vulnerability to 84%. Regarding the mental state examinations, speech was documented in 92%, thoughts in 100% and perception in 96%.

Overall our results demonstrate that standardisation of doctor's letters continues to be an area for improvement within psychiatric services, but that relatively simple methods and collaborative efforts can lead to significant quality improvements. We hope our approach warrants consideration from the wider pool of colleagues as we meet our duties to improve the quality of services³ and especially commend engaging trainees in the process as a learning opportunity in an attempt to add as much value as possible.

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1.4.34 Abuse of psychiatry in Iran

Giuseppe Spoto

date

2019-10

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- *Abuse of psychiatry in Iran*

In the past, the Royal College of Psychiatrists has been very active challenging abuse in relation to psychiatry; I distinctly remember, for example, Dr S. Bloch and others successfully exposing abuse of psychiatry in the former Soviet Union in the 1970s.

Why is the College silent about the antediluvian treatment recently endured by Nazanin Zaghari-Ratcliffe in Iran? Simply by exposing such barbaric practice on the international stage and using its authority, the College may succeed where others have failed, namely in ensuring her immediate release.

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1.4.35 Response to Dr Spoto

Wendy Burn

date

2019-10

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- *Response to Dr Spoto*

Dr Giuseppe Spoto asks why the College has not made a statement about the treatment of Nazanin Zaghari-Ratcliffe in Iran and remembers that in the past it has spoken out against abuse of psychiatry in the former Soviet Union in the 1970s.

We remain active in responding to cases where we believe there has been abuse of human rights. We have to be very cautious about making public statements on these issues; we never act until we have taken advice from those working closely with the family and supporters of the individual concerned and from agencies such as Amnesty International. It would be easy to unwittingly make the situation worse for the people involved.

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1.4.36 Suicide and the psychiatrist

: Commentary on... Effects of patient suicide on psychiatrists

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date

2019-10

Abstract

Research into patient suicide indicates that it has an impact on the psychiatrists involved, but leaves a number of unanswered questions about which elements of the experience are most likely to cause problems, who is most at risk, what is the clinical or professional significance of any effect on the psychiatrist and how other professionals are affected. Despite these uncertainties, it is clear that a response is needed, with three bodies responsible in different ways for coordinating one: the relevant mental health trust, as employer; the Royal College of Psychiatrists, as the professional representative body; and the National Confidential Inquiry into Suicide and Safety in Mental Health, as mediator of social and professional impact.

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 - * *The nature of the experience of patient suicide*
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 - * *What about other mental health professionals?*
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¹ Declaration of interest: None.

²

See this issue.

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Something like one in four of all those who die by suicide in the UK have had recent contact with mental health services, so it is not surprising that many psychiatrists will have close experience during their career of this worst of all outcomes. Neither is it surprising that there are emotional and practical consequences of such an experience for the psychiatrists involved.¹ A paper by Gibbons and colleagues in this issue² describes the findings from a survey of psychiatrists about their experiences of patient suicide and serves as a useful reminder of the importance of this aspect of psychiatric practice; at the same time the results raise a number of questions about the specifics that lie behind these apparently self-evident truths.

The nature of the experience of patient suicide

What we are considering here is the idea of patient suicide as a life event for the psychiatrist. That is, it is an occurrence that directly impinges on the individual practitioner and has the potential to provoke a response that may be transient and unremarkable or may reach the level of intensity and duration that amounts to a disorder. What exactly is the nature of the exposure being considered?

In life-events terms, patient suicide is a complex event. That is, it has a number of more-or-less essentially interrelated features. There is the death itself and its immediate circumstances; inevitably, there is a formal inquiry (or more than one) in which the psychiatrist is likely to be asked to account for their own involvement; colleagues and close others make their own responses; finally, there is likely to be media coverage.

In relation to the first element of this complex – the death itself – the mention of post-traumatic stress disorder (PTSD) raises a question about level of exposure and proximity to the event. The UK's National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) has defined recent service contact as being within the 12 months before death;³ the survey reported here asked about suicide of a patient the psychiatrist had 'been working with', which suggests, without being specific, a more immediate connection (proximity). Surely the death of an in-patient in which staff are directly involved with attempts at resuscitation will have different effects from the death of somebody seen as an out-patient weeks or months before it occurred? The question is – should we, in the name of efficiency, focus more on the effects of some suicides (or the suicides of some people) than of others or should we accept that all suicides merit a staff-support response?

Life-events research tells us that external events are not just shocking in some non-specific way, they have a meaning that shapes the response we make – loss causing depression, threat causing anxiety and so on. While it is not difficult to understand the patient's death itself as uncomplicatedly negative – with perhaps an element of loss, threat and (under certain circumstances) the existential threat that constitutes trauma – the other elements of the exposure outlined above are less clear cut. They may be negative – critical, blaming, inducing guilt – or they may be positive – conveying support, affirmation, exoneration. It is difficult to see that these other aspects of the experience can be avoided, so the question is – can they be moderated either by direct influence on other parties or by support for the involved psychiatrist?

Who is most at risk?

Life-events research has produced a certain amount of ambiguity about the cumulative effect of multiple events. If one event is not severe enough to cause an emotional problem, what about several subthreshold events, are they additive? One of the more surprising (to me) findings from the present study¹ relates to the number of respondents who had experience of multiple patient suicides. Is this a question of age (years of exposure)? Area of work? What difference does it make? Is this a situation where multiple exposure sensitises or desensitises? This sort of accumulated experience of patient suicide is not likely to be picked up by suicide review, where the focus is on the patient and their care. Rather, it raises a question about staff review and how uncommon but important events can be monitored over time.

What exactly are the effects?

One of the inevitable weaknesses of questionnaire surveys is that they leave certain questions underexplored, and in this case it is difficult to judge exactly how severe the reported responses were. Clearly, the emotional effect of such an event can be significant, but in clinical terms even in a selected sample only a very small number took time off work or thought they were ill. It is not clear how many respondents sought professional help for their mental health, although about a quarter said that some form of counselling or therapy would be a good idea. In conventional psychiatric terms most of this would be described as no more than mild or moderate disturbance and would be unlikely to be accepted for treatment following referral to the average community mental health team. Is this a matter for occupational health or for the marshalling of personal resources? The majority of respondents in this study acted as if they thought the latter, whereas the authors conclude that the answer ought to be more towards the former.

An intriguing question not raised by the authors is the degree to which the response to patient suicide might have a positive dimension. There is a substantial literature on personal growth consequent upon adversity, and another possibility is raised by the observation that women reported a greater sense of responsibility and effect on their clinical confidence. There is evidence from other areas of medicine that female doctors tend to practise differently, with better outcomes,⁴ raising the question of whether the problem in medicine is female diffidence or male overconfidence. A worried sense of responsibility and questioning of our competence may be stressful, but it is not necessarily bad for our patients if it leads^{1,5} to more vigilance and desire for involving others when managing patients perceived to be at risk of suicide.

What about other mental health professionals?

Most mental health practice involves multidisciplinary teams – ward teams, crisis teams, home treatment teams, community mental health teams. Even in out-patient services, the patient who sees a psychiatrist is quite likely to have contact also with a community psychiatric nurse or other professional. It is a striking feature of the present study – and a number of the others cited – that these other professionals are not mentioned. One wonders whether some part of the psychiatrist's involvement had been to contribute to team discussions about the implications of a patient suicide, or to offer support to a non-medical colleague? Certainly, there is no reason to believe that doctors alone are vulnerable to the stresses of clinical work.⁶

As a mild digression, it is interesting to note how little literature there is on the effects of patient suicide in clinical psychology and improving access to psychological therapies (IAPT). These services have a reputation for reluctance to take on patients perceived to be at risk of suicide, but even so it must be the case that some suicides occur while the patient is 'working with' or has had recent contact with the relevant professionals. For example, the wider impact of suicide is discussed in a recent British Psychological Society publication,⁷ but the effect on professionals is not covered. The implication is that, as in psychiatry, the expectation is for individual practitioners to manage for themselves.

A final question: what are the implications?

Gibbons and colleagues, no doubt wishing to avoid wandering too far from their data, make few recommendations about what should happen next. Nonetheless, there are implications of their findings.

First, patient suicide is a complex event with a number of components that represent relatively predictable challenges for the mental health professional. The most common perceived needs in the present survey were for instrumental and informational support in facing these challenges. It is surely the employing organisation's responsibility to provide such support, organised via the medical director. It would be helpful if the Royal College of Psychiatrists were to provide practical guidance. The NCISH could also have a role here. Researchers are expected to indicate to research ethics committees how they will ensure that participants from whom they collect information are aware of how to access help; the NCISH could act as a useful conduit for independent (from the employing trust) guidance to psychiatrists faced with the death of a patient on whom they are providing data.

Second, the 'exposure' in patient suicide varies in intensity and proximity, and the emotional and social impact also varies. This argues against, as does much other work in trauma response, a global approach to preventive intervention

at an individual level. Follow-up of staff at (say) 6 months after a patient suicide could readily be incorporated into staff review and support – especially for those in high-risk subspecialties or with multiple experiences of patient suicide.

Finally, we should embrace multidisciplinary in this as in other areas of practice. It would be a useful collaborative exercise for the College to convene a working group with other official bodies, to include at least the British Psychological Society and Royal College of Nursing, with the aim of producing a common set of guidelines on staff support after patient suicide – a small but important part of the larger question of health and well-being in the NHS workforce.

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1.4.37 2.5 years on: what are the effects of a ‘frequent attenders’ service in the Emergency Department?

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2019-6

Abstract

This study focused on an evaluation over 2.5 years to establish if a frequent attenders’ service in an Emergency Department (ED) impacted on the overall number of patients attending as well as the numbers of their attendances. For this, three patient lists from April-September 2015 and three lists from a matched period in 2017 were randomly selected and the two samples compared. Results showed both a reduction in the number of total patients identified as frequent attenders as well as a reduction on the number of attendances to ED. The study suggests that the implementation of a frequent attenders’ service is associated with benefits, not only for the individual attendances per patient, but also in an overall reduction of the number patients classed as frequent attenders.

Declaration of interest

The authors have no conflict of interest to declare regarding this manuscript.

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 - * *Descriptive analysis of age, gender and clinical presentation to ED*
 - * *Analysis of outcomes for patients across the 2.5 year period of the study*
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Patients who frequently attend the Emergency Department (ED) have been characterized as a heterogeneous group,^{1,2} often with complex healthcare needs who are at least as sick as non-frequent attenders^{2,3} and have been associated with a higher expected mortality rate.^{1,4} A recent national Commission for Quality and Innovation (CQUIN) aimed to improve the way services manage these patients. This was based on the Cambridge study⁵ which highlighted that there should be services designed to integrate physical and psychological needs of these patients at the ED interface. In the current CQUIN, a cohort of patients who attend frequently is identified, and the pre and post intervention attendances across the cohort are compared with a 20% reduction in attendances required to achieve the target.

However, in the UK, the longer term effect of a frequent attenders' (FA) service has not been evaluated in terms of whether such a service has an impact on the overall number of patients attending ED who are classed as 'frequent attenders'.

In Durham and Darlington a FA's service has been running since 2014 following the implementation of a local CQUIN with County Durham and Darlington National Health Service (NHS) Foundation Trust in 2014/2015 which aimed to reduce attendances in those attending the Emergency Department (ED) 20 times a year or more. Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust was also involved in providing mental health support via the Psychiatric Liaison team, and the North East Ambulance service were the third partner in this project. This CQUIN was commissioned in response to guidelines from the Royal College of Emergency Medicine (August 2014).⁶ Due to the relatively small numbers of patients attending over 20 times a year the service saw all patients attending 15 times a year or more.

The initial local CQUIN demonstrated a 46% reduction in attendances in the cohort over a 12 month period compared to the previous 12 months and every patient demonstrated a reduction in attendance. Similar outcomes have been showed in other studies.^{7,8}

This service has been in place 2.5 years at the time of this study and an evaluation of its impact over this time period was conducted. This evaluation aims to establish if a FA's service impacts on the overall number of patients attending frequently as well as the overall frequency of their attendances to the ED.

Methods

The Frequent Attenders Service has been set up between the ED of the University Hospital of North Durham in Durham and the Liaison Psychiatry team. Patients are identified as frequent attenders by the ED if they attend 15 times a year or more. Each month a list is produced from the ED of all these patients. The list will have on it any patient who has attended the ED department 15 times or more in the previous year with no other exclusion criteria applied. The patients on the list are discussed at a monthly Multi-Disciplinary Team (MDT) meeting with ED, Liaison Psychiatry and the North East Ambulance Service (NEAS). The number of patients in the list for each month is dynamic as each month there will be new patients who meet criteria, some patients will be discharged as they have reduced their attendances and others who will continue on from the preceding month's list.

For some patients already involved in services, liaison with their established care providers is undertaken as often those providers are not aware of the ED attendances and are able to address the situation with the patient effectively within current care provision. For other patients a letter is sent offering them an appointment with the Liaison Psychiatry team, sometimes in collaboration with a different team – e.g. a joint consult with the respiratory nurses and Liaison Psychiatry. Plans of care are put in place for all patients with contributions from the MDT and the patient, if the patient chooses to engage. If the patient does not engage, a plan is put in place anyway if there are sufficient concerns about risk e.g. a plan may ensure that a patient with health anxiety does not receive iatrogenic harm from unnecessary tests. Education is also done with ED clinicians to look at approaches to talking to patients who frequently attend and potential management strategies. Two liaison clinicians (consultant psychiatrist and advanced nurse practitioner) coordinate the service and contribute 1 session a week between them on average.

This evaluation was conducted by randomly selecting three patient lists between April-September of the year 2015 and comparing this data to three randomly selected patient lists from a similar period in 2017. This was done to ensure that the result was representative and not skewed by a single particularly good or bad month. Therefore, the total number of patients for each list was obtained and their average number calculated.

Other data collected to compare the two cohorts was: age, gender, and most common clinical presentation. One list from each year only was used for this extra information. During the evaluation we followed up the patients who had

attended in 2015 to analyse how many were still attending frequently in 2017. During this we noted how many had died and what their original reason for attending was. This mortality data is also presented in the results.

The data was collated and analysed using Microsoft Excel 2010. Consent from patients and ethical approval was not sought given that the study was a service evaluation of an established service and no patient identifiable information is presented.

Results

Analysis of the average number of patients attending 15 times a year or more

Considering the period between April-September 2015, an average of 43 patients were attending ED 15 times a year or more, whereas this number reduced to an average of 17 patients in 2017 as shown in *Table 1*. This equates to a reduction of 60% in the average number of patients attending 15 times a year or more over the period of 2.5 years. *Table 1* Total number of patients per list and respective descriptive analysis and t-test result

Month (List)	2015 Mean	2015 SD	2017 Mean	2017 SD	95% CI for Mean	T	Df	Sig. (2-tailed)
141	43.33	4.04	13.16	6.75	5.11	5.71	37	0.0025

An independent sample t-test was conducted to compare the means of the samples for 2015 and 2017. There was a statistically significant difference between the means of the number of patients per month in 2015 when compared to 2017 ($t(4) = 6.76, P = 0.0025$).

Analysis of the average number of total attendances amongst the frequent attenders over preceding 12 months in 2015 compared to 2017

As can be seen in *Table 2*, the average number of total attendances over preceding 12 months by patients attending 15 or more times a year reduced from approximately 833 to 437 which is 396 fewer attendances. This amounts to a 48% reduction on the total number of attendances across the 2.5 years of the study. This difference was shown to be statistically significant ($t(4) = 6.38, P = 0.0031$). *Table 2* Number of total attendances amongst the frequent attenders and respective descriptive analysis and t-test result

Month (List)	2015 Mean	2015 SD	2017 Mean	2017 SD	95% CI for Mean	T	Df	Sig. (2-tailed)
173	1833.33	89.97	393	436.67	59.16	22.04	569	0.0031

Descriptive analysis of age, gender and clinical presentation to ED

As stated in the methods section, for this part of the analysis only one random list of each year was considered. For both years, each list considered showed a small majority of female patients (55% in 2015 and 57% in 2017). The median age of patients in 2015 was lower than in 2017 (36 v. 43 years old) (IQR 28.5–53 v. IQR 33–65).

Both samples also showed a similar distribution for clinical presentation to ED. Personality disorders and alcohol and substance misuse lead the most common clinical presentations followed by pain, undiagnosed dementia and chest problems (most commonly patients with respiratory problems) as it can be observed in *Fig. 1*. The Figure also shows the general reduction in the number of patients attending ED. However, this reduction is not the same across the different clinical presentations with the categories of undiagnosed dementia, children under 18, complex physical health needs and other remaining unchanged from 2015 to 2017. On the other hand, a reduction is seen in patients attending with alcohol and drug misuse problems, respiratory problems, pain and borderline personality disorder. *Fig. 1* Clinical presentations to ED in absolute numbers. A/S misuse, alcohol and/or substance misuse; BPD, borderline personality disorder; HA/MUPS, health anxiety/medically unexplained psychiatric symptoms; PH, physical health.

Analysis of outcomes for patients across the 2.5 year period of the study

It was also observed that all the patients who had been identified as frequent attenders in 2015 reduced their number of attendances to less than 10 per year by 2017 (some were not attending at all) and consequently they were no longer on the FA list, with the exception of a single patient (Patient A). Patient A is the only patient to be present in the FA's list in 2015 and 2017 and has also the highest number of attendances per year of both groups.

Of 13 elderly patients who presented as FA throughout the 2.5 period analysed, 11 had a previously undiagnosed dementia and almost all of those eventually required residential care.

It was noted that of the patients who attended in 2015, 9 had died 2.5 years later. Of these 2 were elderly patients who died of natural causes, one was a patient with a terminal illness and 5 were patients with substance abuse, 4 of which were alcohol related. In fact, when examined more closely, of the 8 original patients with alcohol presentations in 2015, 4 died within 18 months of identification as being a frequent attender. Also, of note, none of the patients in 2015 who presented with a primary presentation of self-harm or suicide attempts had died in the following 2.5 years.

Discussion

The implementation of a MDT approach to reduce attendance to ED services by frequent attenders has been suggested as effective by a number of studies^{7,8} and has therefore been recommended by the College of Emergency Medicine. However, a significant number of studies regarding this have been done outside of the UK which has implications on how much information can be extrapolated towards the UK population given significant differences in the national health care systems.

This study observed that since the implementation of the FA's Service, a marked reduction of the number of patients classed as 'frequent attenders' occurred from an average of 43 patients falling into this category each month in 2015 compared to an average of 17 patients in 2017. The average number of attendances of these patients for the preceding 12 months also reduced from approximately 833 to 437. Both reductions were statistically significant.

The reduction in the number of patients on the monthly frequent attenders list from implementation of the service was unexpected. A number of factors might have contributed to this result. As it was presented in the results, with exception of patient A, all patients clustered as frequent attenders in 2015 reduced their number of attendances and did not qualify for this category by 2017, which means that the 2017 patients' list (with the exception of patient A) was made of new patients. This means that there isn't a cumulative effect by which the list expands year after year as new patients are added. This has also been discussed by other studies. In two studies^{2,8} it has been demonstrated that some patients will qualify as FA during a period of crisis which is not a situation that repeats year after year. Therefore, each cohort tends to have a new set of patients while others are removed from the list.

Another potentially contributing factor to this result is the educational component of the project in which ED clinicians are encouraged to identify patients earlier and utilise more effective management strategies thereby reducing the potential of the patients to become frequent attenders.

The reason why early identification of these patients contributes to reduction in their attendance could be related to early addressing of potential conditioned responses that some patients develop by going to ED. For example, in acute exacerbations of chronic pain, the patient learns that ED will provide IV analgesics which will be more effective than oral therapy due to associated immediate euphoria and deep relaxation rather than just the analgesic effect. Hence during acute exacerbations of chronic pain coming to ED becomes the learned response. There is also an association of hospital in general as a place of safety and comfort which has been referred to as the "brick mother" by psychotherapist Henri Rey. Therefore, the patient learns that his fear, which will greatly impact on pain, will be more favourably managed in hospital than at home and this gives rise to a further conditioned response. By acting early, this response can be addressed before it becomes deeply entrenched and therefore patients can be better managed in the community e.g. in conjunction with support from the pain team. Overall practice has changed as well, with fewer clinicians prescribing IV analgesics for acute exacerbations of chronic pain and there have been fewer patients attending with acute exacerbations of chronic pain as can be seen in *Fig. 1*.

Another way behavioural reinforcers have been addressed is by taking a positive risk approach to physical health presentations, in particular in patients with health anxiety. This has been done by minimizing the number of investigations carried out in patients who have been appropriately investigated and who do not present with new symptoms. This has benefits for the system as it reduces the cost of the emergency episode but also for the patient as it reduces iatrogenic harm by repeated exposure to unnecessary procedures and harmful ionising radiations. A consistent approach to this also helps stop the chain of reinforcement.

It has been noted that for some patients, simply being sent a letter informing them that they are a frequent attender and offering help to address this seems enough to stop them attending. For others it is about getting the relevant community services to work better for the patient – e.g. often mental health services will not be aware that a patient is attending ED frequently and this can be addressed through crisis plans. Working with the community respiratory team has been highly effective in helping patients who repeatedly present with respiratory concerns, or referring patients to the pain clinic to come up with innovative community ideas for managing acute exacerbations of chronic pain have helped. These interventions appear to be the most likely explanation to the difference in the reduction of different clinical presentations seen in *Fig. 1*, with the highest reductions in pain, respiratory problems and borderline personality disorder presentations.

In this study, female gender was predominant, whereas a number of studies^{3,9-11} have showed higher prevalence of males in groups of frequent attenders. The mean age of patients in the second cohort was 7 years younger and generally this study presented lower mean ages than other studies⁹⁻¹¹. Some studies¹⁻¹⁰ have also suggested that the age distribution is bi-modal with peak ages in younger patients (<40 years old) and old age (>65 years old).

Two unexpected groups emerged that warrant further research: firstly, older people who attended ED frequently often had undiagnosed dementia and potentially older people frequently attending ED could be a red flag for considering this. Secondly, substance misuse patients in this study have a very poor prognosis. Half of the 2015 patients identified as FA with substance misuse problems have now died. This has serious implications for how these patients are cared for – they often do not engage in usual substance misuse services and this warrants further consideration as to what services models are needed to best support these high risk patients.

Regarding the costs of frequent attenders to ED: Considering the distribution of common presentations to ED in our sample, it is likely that basic investigations such as blood analysis or an x-ray are done which means that the cost per presentation will be around £127.¹² If a more specialized investigation such as a computerized tomography (CT) or ultrasound scan is done, the cost further increases to around £207.¹² This calculation does not take into consideration inpatient admissions (average cost £400 per night), or the use of ambulances (average cost of £254 per attendance).¹³ More than this, though, are the costs related to excess mortality and morbidity in this group of patients, whose underlying conditions are not being optimally managed, potential iatrogenic harm from unhelpful tests, investigations and treatments, poor patient and clinician experience and the disproportionate amount of time these patients take up in the ED due to their complexity. Of note, in the original CQUIN of patients attending over 20 times a year, there was a reduction of 170 inpatient admissions to the acute trust in the 12 months prior to the intervention compared to the 12 months post intervention.

There are a number of limitations to this evaluation and results should not be interpreted too broadly. The sample was collected from the area covered by County Durham and Darlington NHS Foundation Trust hospitals which covers a population with its unique characteristics that differ from other areas. Moreover, the sample for the study was small and therefore limits generalization into the general population. Another important issue, as mentioned above is the availability of other services which conditions the type of patients presenting to ED. That said, most literature reviewed concentrated on the effects of service implementation and therefore focused on assessing a single cohort of patients pre and post intervention and analysis of those individual's reduction of attendance whereas this service evaluation was able to show broader benefits in terms of actually reducing the number of frequent attenders rather than only the number of attendances per patient.

In conclusion: a frequent attenders' service can be effective in reducing the overall number of patients attending ED 15 times a year or more. This has led to the service being able to see patients attending 10 times a year or more. The most effective elements of the service are hypothesised as being: the psychoeducation of clinicians; working with patients and other relevant agencies to help them manage their condition in the community more effectively; identifying and breaking the cycle of the conditioned response these patients show to emergency services and the liaison between different services.

Case study

Ms D had a long history of COPD exacerbated by anxiety and previously attended ED over 40 times a year. Following a period of brief intervention with the frequent attenders' clinic which involved: joint work with the respiratory community team; a plan with the ambulance service to differentiate between an anxiety episode and COPD; a management plan for ED; the patient becoming involved with a community support group with the respiratory team; support with the local housing and social support team. Since this intervention was put in place Ms D has attended ED only once a year in the last 2 years (both appropriately) and has had one additional ambulance call where the crew managed the presentation at home.

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1.4.38 Section 12 approval: fit for purpose?

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2019-12

Abstract

In light of the increasing numbers of detentions of mentally unwell patients in the UK and the recent review of the Mental Health Act, this editorial seeks to analyse the process of Section 12 approval of doctors from a medical educational perspective. We compare the approval mechanisms with assessments in other specialities and suggest evidence-based improvements. We believe that a rethinking

¹

Declaration of interest None.

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of the Royal College of Psychiatrists' learning objectives for Section 12 approval and the introduction of a summative assessment would improve the knowledge and skills of clinicians performing an important and scrutinised role within our society.

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 - *The current state of affairs*
 - *Analysis*
 - * *What are the learning objectives?*
 - * *How does the training meet these learning objectives?*
 - * *How is it assessed?*
 - *Our solution*
 - *Conclusion*

In recent years there has been a dramatic increase in compulsory in-patient psychiatric treatment in the UK. In 2016, National Health Service (NHS) Digital reported a 47% increase in the number of detentions under the Mental Health Act over the preceding decade.¹ The reasons for this are multifactorial and include reduced access to social care, changes in the provision of psychiatric services and reductions in the number of psychiatric beds. Another factor that must be considered is the Mental Health Act assessment itself. Approval under Section 12 of the Mental Health Act confers the ability to deprive individuals of their liberty and curtail their human rights. This is one of the most life-altering powers a doctor can hold.

There is a danger that clinicians are not equipped with the knowledge and skills to wield this power safely and effectively, which could have a marked effect on the number of detentions under the Mental Health Act. In light of the recent independent review into the Mental Health Act and consequent discussions about what modern mental health legislation should entail, it is imperative that we scrutinise the process for training and approving the clinicians who carry out these assessments. Although the specifics of mental health law vary widely across the world, there are shared fundamental principles and an examination of the training, skills and assessment of professionals carrying out detentions of mentally ill individuals is an important process for psychiatrists to consider.

This article seeks to evaluate these training, approval and revalidation processes for Section 12 doctors and suggests evidence-based improvements.

The current state of affairs

Under current legislation in England and Wales, the Secretary of State can grant approval under Section 12 of the Mental Health Act, provided the clinician meets the requirements set out in the Act. This responsibility is delegated to local Section 12 panels, which also hold responsibility for the accreditation of induction and refresher courses. A clinician can be approved for a period of up to 5 years; at the end of this period they can apply for revalidation,^{2,3} which is contingent on participation in a section 12 refresher course.

We sent a questionnaire to all 23 providers of Section 12 courses and obtained only 5 responses. Although this is a low response rate, we triangulated this information with other sources to acquire information about key features of the courses. Section 12 induction courses and refresher courses typically last 2 days and 1 day, respectively. The cost of an induction course will range between £200 and £400. Attendance is generally monitored using a sign-in sheet, with no verification of identity. The courses consist of a series of lectures covering the nationally mandated learning objectives (see *Box 1*). Some courses will include an interactive component such as a case discussion or a quiz. There is no requirement to summatively or formatively assess whether the learning objectives have been met. *Box 1* Section 12 course learning objectives³ To have a broad understanding of the provisions contained in Part 2 of the Mental Health

Act relevant to the initial detention of a patient under Sections 2, 3 and 4. Be able to describe the role of a Section 12(2) doctor and that of others when undertaking a Mental Health Act assessment. Understand the meaning of, and be able to refer to, the criteria for detention under Part 2 when making a medical recommendation. Be able to describe the guidance contained in the Code of Practice relevant to the role and responsibilities of a Section 12(2) doctor when undertaking a Mental Health Act assessment. To use knowledge of the impact that an assessment may have on patients and their carers to inform the approach to an assessment. Be able to complete the statutory forms lawfully.

This lack of formative assessment is particularly concerning considering that there is evidence to indicate that there are inadequacies in many psychiatrists' understanding of the relevant legislation. When a random sample of Section 12-approved clinicians in the West Midlands were interviewed, none of them were able to define 'mental disorder' as it appears in the Mental Health Act.⁴ In a similar study in Scotland, only 10% of consultant psychiatrists were able to give the statutory definition of mental disorder.⁵ This raises questions about the training, approval and revalidation processes.

On completion of the induction course, prospective Section 12 doctors must undergo an approvals process whereby they must provide two referees, with the requirement that one of the referees is an NHS consultant psychiatrist familiar with the work of prospective Section 12 doctors. In theory, this is an additional check that the prospective clinician has the required knowledge and skills. In practice, there is no framework for how a referee should assess whether the prospective clinician has the complex skills specific to Mental Health Act assessments. Furthermore, it is likely that clinicians seeking Section 12 approval will choose consultants who are also their line managers as referees. Therefore, it would be equally unlikely that the referee would have witnessed the aspiring Section 12 doctor complete a Mental Health Act assessment because of the Mental Health Act's need for an independent doctor.

Analysis

When analysing the educational effect of these training courses, three questions must be considered: What are the learning objectives? How does the training meet these learning objectives? And how are they assessed?

What are the learning objectives?

Miller⁶ described the assessment of clinical skills and competencies as four levels of increasing complexity as shown in *Fig. 1*. Taking the example of venepuncture: knowing what a blood test is and its indications would satisfy the lowest level of the pyramid. Being able to describe how to take blood would show that the clinician 'knows how' to perform the task. Assessing the individual performing a simulated blood test on a manikin would satisfy the third level of the pyramid and observing the competency being performed on a patient would demonstrate proficiency of the highest level on the pyramid. *Fig. 1* Miller's pyramid⁶ a framework for classification of assessment in medical education, can be used to align assessment with learning outcomes. EMQ, extended matching question; MCQ, multiple choice question; OSCE, objective structured clinical examination.

Biggs and Tang⁷ have aligned the imperative words used to describe learning objectives to levels on Miller's pyramid so that words such as 'identify', 'define' and 'describe' refer to learning objectives at the bottom of the pyramid and 'perform' and 'demonstrate' are associated with the highest level on the pyramid. By this analysis, the current learning objectives for Section 12 approval courses are only assessing the lowest levels of the pyramid. Indeed, the only practical skills required are 'completion of the statutory paperwork' and 'rectification of errors'. There appears to be a presumption that the clinician will develop the necessary skills elsewhere. This is not necessarily the case; for example, clinicians who have achieved membership of the Royal College of Psychiatrists are eligible to apply for Section 12 approval, but as an international examination, the MRCPsych does not assess UK mental health law.

Performing a Mental Health Act assessment is a complex skill requiring the ability to apply the principles of mental health law to challenging clinical situations; this is not reflected in the current learning objectives, which focus on simple knowledge and skills with relatively little emphasis on higher-order learning.

How does the training meet these learning objectives?

To motivate prospective Section 12 doctors and support them to achieve these higher-order learning objectives, the learning activities should be closely aligned with these objectives.⁸ At present, Section 12 courses rely heavily on lecture-based teaching, with a focus on conveying large volumes of factual content. This may be problematic because although lectures can be a useful didactic method for imparting factual knowledge, they are less effective at changing attitudes and behaviours. For teaching complex skills, the evidence base supports the use of active learning activities to engage learners in more effective and more sustained learning.⁹

How is it assessed?

There is an absence of any mandatory assessment in the Section 12 approval process, and this has significant implications. Assessment serves two distinct educational functions: it is used to evaluate whether the learning objectives have been achieved and it is used to drive learning.¹⁰ The widely held belief that ‘if it’s not assessed, it’s not important’ is backed up by substantial evidence demonstrating that trainees learn more effectively when they know they will be assessed.¹¹ If they are not formally assessed, they will not achieve the learning objectives. The ability to perform a Mental Health Act assessment is a complex skill, requiring a sound knowledge base and extended abstract thinking, and this needs to be reflected in the learning objectives, learning activities and assessment process.

Our solution

To optimise their educational effect, the design of training courses should be guided by the evidence base. Appropriate learning objectives should be created based on the knowledge and skills required of a Section 12 doctor, and the learning activities should be aligned with these objectives. We propose a teaching model similar to that used in Advanced Life Support (ALS) training run by the UK Resuscitation Council, whereby prospective Section 12 doctors would be given standardised educational material before the course, either as written material or as a series of e-learning modules. This could employ a variety of formats to suit different learning styles, and would allow clinicians the flexibility to work through the material at their own pace. A pre-course self-assessment quiz would allow them to test their level of understanding and identify learning needs, as well as ensuring engagement with the pre-course material.

Instructors should therefore have more confidence that the doctors will have decent levels of working knowledge of the Mental Health Act to build upon during the course. The face-to-face training course would then have scope to focus on higher-order skills such as applying their knowledge of the pre-course material to ‘real-life’ scenarios. Instructors would have flexibility to make their training course unique; for example, by using role play, case discussions and simulated Mental Health Act assessments.

Rather than simply signing an attendance sheet, there should be a formal identification check at the outset of the course. Furthermore, sign-off should be contingent on an end-of-course summative assessment with two key components: a written multiple choice test and a practical assessment such as a case discussion with the instructor. Concerns about failing a substantial number of prospective Section 12 doctors are understandable, but these fears are misplaced: if the assessment is criterion-referenced and aligned with the learning objectives, and the pass mark is determined by an appropriate methodology such as the Angoff¹² method, the assessment will uphold the minimum standard without failing candidates unnecessarily. For context, only 3.4% of candidates fail their ALS training.¹³ With something as important as Section 12 approval, minimum standards must be upheld and summative assessment is the only way to achieve this.

Of course, there are practical and cost considerations when implementing such an assessment. The development of a question bank and determination of an appropriate pass mark would be resource-intensive; nonetheless, it is still feasible and the advantages of incorporating assessment into the training far outweigh the disadvantages. The cost to the delegate of attending a Section 12 approval course are similar to those attending ALS. Therefore it is likely to be financially feasible to implement these changes.

We also propose a modification to the learning objective for Section 12 approval courses to reflect the changes in assessment and the complex nature of the Mental Health Act Assessment as detailed in *Box 2*. *Box 2* Proposed Section

12 course learning objectives aligned with assessment methods **Outline** the provisions contained in Part 2 of the Mental Health Act relevant to the initial detention of a patient under Sections 2, 3 and 4 of the Mental Health Act. With reference to the Mental Health Act Code of Practice, **describe** the role of the Section 12 doctor and other participants in a Mental Health Act Assessment. **Explain** the criteria for detention under Part 2 of the Mental Health Act. **Perform** a holistic assessment of a patient's history and mental state in the context of a Mental Health Act assessment. Based on a holistic clinical assessment, demonstrate sound and lawful **application** of the statutory criteria for detention under the Mental Health Act and **justify** the chosen course of action. **Demonstrate** lawful and accurate completion of statutory forms. **Reflect** on the patient's experience of a Mental Health Act assessment, and how this might affect their mental state and engagement with healthcare services.

Conclusion

The authority to detain someone against their will is one of the greatest powers that can be granted to our profession, and it is a responsibility that should be taken seriously. Future legislation (and indeed the Royal College of Psychiatrists) should revise the learning objectives of Section 12 courses to mandate a more appropriate standard than the bare minimum set out in the current format of the learning objectives. Efforts should be taken to ensure that this training is evidence-based, developed from sound educational principles and reinforced by appropriate assessment.

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1.4.39 Changes in smoking status, mental state and plasma clozapine concentration: retrospective cohort evaluation

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date

2019-12

Abstract

Aims and method

To investigate the percentage of patients who commenced smoking after transferring out of a non-smoking forensic psychiatric unit, the corresponding clozapine dose adjustments, the effects on plasma clozapine/norclozapine concentrations and observed changes in mental state. We reviewed the notes and plasma clozapine/norclozapine concentrations of 46 patients transferred to medium secure units between July 2008 and December 2013.

¹ Declaration of interest None.

Results

Thirty-five patients commenced smoking. Their median clozapine dose was increased by 50 mg/d. In the non-smokers, the median clozapine dose remained unchanged. Plasma clozapine/norclozapine concentrations were significantly reduced in smokers despite dosage adjustment. Eighteen patients experienced deterioration in mental state after transfer; almost all these patients were smokers.

Clinical implications

Approximately three-quarters of patients who were non-smokers by virtue of being in a secure non-smoking environment commenced smoking after transfer. Monitoring of clozapine serum levels and assessment of mental state in the immediate period after a change in smoking status is indicated.

Contents

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Clozapine use in schizophrenia

Clozapine is the only antipsychotic licensed for use in patients with treatment-resistant schizophrenia. It has a narrow therapeutic index and pre-dose plasma clozapine concentrations between 0.35 and 0.60 mg/L are associated with optimal response, although patients may show such a response at lower or indeed higher plasma concentrations.¹ Adverse effects are more likely at plasma concentrations above 0.6 mg/L.²

Clozapine metabolism

Clozapine is primarily metabolised to its principal plasma metabolite *N*-desmethylclozapine (norclozapine) by the cytochrome P450 (CYP) isoenzyme CYP1A2, with possible additional contributions by CYP2C9, CYP2C19, CYP2D6 and CYP3A4.^{3,4} There are significant differences in plasma concentrations of clozapine between patients receiving the same dose, owing to factors including age, gender and exposure to tobacco smoke.^{5,6} The magnitude of the effects of the polycyclic aromatic hydrocarbons in tobacco smoke in increasing CYP1A2 activity are second only to dose on plasma clozapine concentrations.⁷ A systematic review of the effects of smoking cessation on plasma clozapine concentrations found clozapine dose reductions of between 30 and 40% were required to achieve pre-cessation concentrations.⁸ Neither the nicotine in cigarettes nor nicotine replacement therapy products have an effect on clozapine metabolism.⁸

Schizophrenia and smoking

Patients with schizophrenia are more likely to smoke cigarettes, and in greater quantity, than the general population.⁹ An evaluation from a UK forensic psychiatric medium secure unit found 84% of in-patients were smokers before the introduction of a smoking ban, and cessation rates after smoking reduction programmes are less than 7%.^{10,11}

Ashworth Hospital is a high-security psychiatric hospital serving the population of Northern England and Wales. The hospital has approximately 200 male in-patients who are detained under various sections of the Mental Health Act 1983; none have unsupervised community leave. The hospital became a non-smoking unit on 1 July 2008. Tobacco products are not permitted in the hospital. This is a policy that is effectively implemented as all hospital staff, patients and visitors are subject to rigorous security measures, including searches in and out of the hospital and x-ray scanning of personal possessions. Patients no longer requiring treatment in a high secure unit are transferred either to prison or to medium secure units. At the time of this evaluation, all the medium secure units to which patients were transferred permitted smoking.

Clozapine and smoking

We could find no published study that documented changes in smoking status and clozapine dose requirement after transferring out of a non-smoking psychiatric unit. We decided to investigate the percentage of patients who commenced smoking after transfer, the corresponding clozapine dose adjustments performed, the associated effects on plasma clozapine and norclozapine concentrations and observed changes in mental state.

Method

The service evaluation was registered within Mersey Care National Health Service (NHS) Foundation Trust. We identified patients prescribed clozapine who were discharged to medium secure units (both NHS and independent) from Ashworth Hospital from July 2008 to December 2013. Patients transferred to a medium secure unit on trial leave remain under the nominal care of the Responsible Clinician at Ashworth hospital and are routinely reviewed by clinical staff from Ashworth Hospital; trial leave is for a minimum period of 6 months and can be longer, allowing an opportunity to review case records and changes in smoking status. From the clinical notes we collected data on clozapine dose, plasma clozapine and norclozapine concentrations, smoking status and mental state in the 6 months pre-transfer and up to 12 months post-transfer. Patients who were either discharged without a period of trial leave, or remitted directly to court or prison were excluded. Plasma clozapine and norclozapine concentrations were monitored as necessary to help guide clozapine dose adjustment. The last clozapine plasma measurement on file was used as a measure of post-transfer plasma clozapine and norclozapine. Information routinely recorded when requesting plasma clozapine assays include the time and date of sample, time and date of last clozapine dose, clozapine dose (milligrams per day), mode of administration (tablets or suspension), duration of clozapine treatment, age (years), gender, body weight (kilograms), smoking status (yes/no) and other relevant information that could aid interpretation of the result, such as co-prescribed drugs and the reason for the assay request.

Statistical significance of analysed data was calculated using paired *t*-tests and Fisher's exact test as appropriate.

Ethical approval

The service evaluation was registered within Mersey Care NHS Foundation Trust. Ethical approval was not required; no individual patient is described.

Results

Forty-six male patients with complete data were identified. All had a diagnosis of schizophrenia (ICD-10 F20).¹² Ethnicity was White British ($n = 27$), White Irish ($n = 2$), Black Caribbean ($n = 3$), Black African ($n = 2$), other Black background ($n = 4$), Pakistani ($n = 2$), Indian ($n = 1$), other Asian background ($n = 1$), and other mixed background ($n = 4$). The median age at the start of trial leave was 37.1 years (range, 24.8–56.0 years).

Plasma clozapine and norclozapine concentrations had been measured in all patients before transfer (median time before transfer, 89.5 days; range, 1–315 days). The median number of plasma clozapine assays performed after transfer to a medium secure unit was 2 (range, 1–9). Plasma clozapine was first measured on average 45 days post-transfer (range, 2–345 days). A total of 72% of patients had plasma clozapine and norclozapine measured within 1 month of starting trial leave; this increased to 87% of patients at 3 months post-transfer.

Thirty-five patients (76%) commenced smoking after transfer and eleven (24%) remained non-smokers (*Table 1*). The average duration of follow-up was 6.6 months in both the smoking and non-smoking groups. *Table 1* Comparison of pre- and post-transfer data: clozapine dose (mg/d) and clozapine concentration (mg/L)

	Smokers ($N = 35$)	Non-smokers ($N = 11$)	P -value ^a
Pre-transfer	275 (150–550)	250 (125–500)	
Post-transfer	350 (175–750)	250 (200–400)	
Mean (s.d.) clozapine dose (mg/d)	306 (101)	376 (133)	<0.01
Mean (s.d.) plasma clozapine concentration (mg/L)	0.58 (0.20)	0.43 (0.15)	<0.01
Mean (s.d.) plasma norclozapine concentration (mg/L)	0.34 (0.12)	0.28 (0.12)	<0.01

^aTwo-tailed paired t -test.

In the smoking group the median clozapine dose before transfer was 275 mg/d and this increased to 350 mg/d after transfer; an increase of 27%. The median dose increase was 50 mg/d (range, 75 mg/d decrease to 375 mg/d increase) and there was a statistically significant decrease in both plasma clozapine concentration and plasma norclozapine concentration after transfer in the smoking group. In the non-smoking group the median prescribed dose before transfer was 250 mg/d and this remained unchanged after transfer (range, 100 mg/d decrease to 125 mg/d increase). We found no plasma clozapine concentrations >1 mg/L in either the smoking or non-smoking group post-transfer.

Mental state deterioration was defined as either a worsening of residual symptoms after transfer or emergence of new psychopathology. Eighteen (39%) patients showed evidence of deterioration in their mental state and of these, all but one were in the smoking group ($P < 0.05$; Fisher's exact test). The median time to mental state changes was 54.5 days after transfer as recorded in the clinical notes (range, 6–175 days). Ten patients, all within the smoking group, experienced an exacerbation of psychotic symptoms (*Table 2*). For three patients who experienced increased psychotic symptoms, the trial leave period was extended as a consequence. Notably, no patients in the non-smoking group experienced either a worsening of psychotic symptoms or emergence of new psychopathology. The remaining eight patients, seven of which were in the smoking group and one in the non-smoking group, experienced non-psychotic changes in mental state, including increased self-harm, sexual disinhibition, amotivation, agitation and anxiety. In all cases ($N = 18$), the mental states of these patients improved with an increase in clozapine dose and no patients required readmission to the high-security psychiatric hospital as a consequence of a change in their mental status. *Table 2* Symptoms experienced after transfer

Psychotic symptoms (10 patients)	Paranoid delusions 7	Auditory hallucinations 3	Religious delusions 1	Delusional memory 1
Non-psychotic symptoms (8 patients)	Agitation 3	Anxiety 3	Amotivation 1	Worsening self-harm 1
	Sexual disinhibition 1			

²

Two-tailed paired t -test.

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Discussion

A not unexpected finding was that most patients commenced smoking despite being provided with nicotine replacement therapy and smoking cessation advice both before and after transfer. Studies have shown that enforced tobacco abstinence in secure environments has little effect on post-release smoking status.^{13,14}

There is an established association between tobacco smoking and the pharmacokinetics of clozapine, with higher clozapine doses generally required in smokers when compared with non-smokers. A previous evaluation of plasma clozapine concentrations before and after implementation of a hospital-wide smoking ban found a mean increase in plasma clozapine of 36% in non-smokers when outliers were excluded.¹⁵ We found a mean clozapine dose increase of 23% (median increase, 27%) occurred in smokers prescribed clozapine and this is less than the 40% dose increase recommended where one or more packs of cigarettes are used per day¹⁶ and less than the recommendation to increase the clozapine dose by a factor of 1.5 over a period of 2–4 weeks.¹⁷ This difference may be because of the effect of restricted time periods off the ward for patients in our sample, who were in a medium secure unit, which is likely to have limited their consumption of tobacco. However, it may also be that clinical teams were cautious in increasing clozapine doses, or patients were reluctant to take more clozapine, given the observed changes in mental state in the smoking group.

We found that receiving clinical teams were aware of the association between plasma clozapine and smoking status and the need to proactively monitor and adjust doses accordingly. As noted earlier, 72% of patients had plasma clozapine and norclozapine measured within 1 month of starting trial leave and this increased to 87% of patients at 3 months post-transfer. There were nevertheless adverse changes in the mental state of almost half of patients who had recommenced smoking. It is possible these symptoms were secondary to the observed reduction in plasma clozapine concentrations. Previous studies investigating the effects of smoking on mental state have focused on patients with neurosis rather than psychosis.¹⁸ We found that most patients experiencing changes in mental state had psychotic symptoms, although this may reflect the symptoms of this particular population from a high secure psychiatric unit. However, structured rating scales were not used in our survey given the nature of this evaluation.

Our study population was of a modest size and data were collected over a minimum follow-up period of 6 months, allowing ample time for changes to clozapine dosing schedules and changes in mental status to have been observed. A limitation of this study is our use of case notes as a source of patient data as case notes do not always include all data that would otherwise have been collected systematically via a structured interview. Our recording of patient mental status before and after smoking resumption is therefore open to assessment bias. Additionally, the post-transfer plasma clozapine and norclozapine concentrations used in this study were not necessarily performed before the recorded dose adjustments. Given the nature of this study (i.e. a service evaluation), we did not control for clozapine dose when measuring the effect of smoking on clozapine and norclozapine plasma concentrations. It should be noted that the non-smokers had a statistically significant lower norclozapine plasma concentration after transfer; we are unable to explain this finding. Finally, we cannot be certain that the non-smoking patients were entirely abstinent as we relied on patient notes to classify smoking status; we did not measure plasma or urine cotinine to confirm smoking status.

This evaluation is a reminder to clinicians that changes in smoking status may cause marked changes in clozapine plasma concentration, and require substantial adjustments in clozapine dosing. We anticipate this evaluation will assist clinicians in the management of patients prescribed clozapine who commence smoking after a period of abstinence and advocate close monitoring of plasma clozapine concentrations, clozapine dose and mental status in patients who change their smoking status, to minimise the risk of relapse.

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1.4.40 Author reply

John L. Taylor

date

2019-6

Contents

- *Author reply*

Jean O'Hara is correct in saying that I am a responsible clinician working with people with intellectual disabilities with offending histories and complex needs – in both in-patient and community settings. As such, my experience of the impact of the Transforming Care national plan is concrete and real rather than 'perceptual'.

It is nonetheless encouraging to learn that NHS England recognises that some people with intellectual disabilities and/or autism need high-quality in-patient care and treatment at times. The question is, post Transforming Care, where are they going to receive it given the wholesale closure of specialist NHS services – including some rated by the Care Quality Commission as outstanding? The options would appear to be either the profit-focused private sector, or acute mental health in-patient units where the specialist care and treatment required is not available.

I note that Dr O'Hara doesn't refer to the data that indicate clearly that the Transforming Care national plan has failed to significantly reduce the number of people with intellectual disabilities and/or autism in in-patient facilities. Rather, she introduces a new metric of the 'need for admission'. This is not defined but seems to refer to admission rates. It is suggested that the national plan has been successful in reducing the variation in the 'need for admission' across the country. Given that a reduction in the geographical variation of admission rates could be achieved by closing beds in some areas whilst maintaining (or increasing) bed numbers in others, with no overall reduction in the number of beds across the country, one might wonder whether this is another case of smoke and mirrors?

Three-and-a-half years on, the Transforming Care programme has failed to invest the tens of millions of pounds in community services in England promised in the national plan. Can we then be comforted by the news that the NHS Long Term Plan 'is explicit about its focus on increasing investment in intensive, crises and community support', or is this just another example of 'jam tomorrow and jam yesterday, but never jam today'¹ for people with intellectual disabilities?

I am employed by Northumberland, Tyne and Wear NHS Foundation Trust; however, the opinions expressed in this response are my own and do not reflect the views of the Trust.

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1.4.41 Do patients get better? A review of outcomes from a crisis house and home treatment team partnership

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2019-6

Abstract

Aims and method

The Tower Hamlets Crisis House (voluntary sector), in partnership with the local home treatment team, offers a brief residential alternative to psychiatric hospital admission. Here, we review clinician-reported (Health of the Nation Outcome Scales; HoNOS) and patient-reported (DIALOG) outcome scores collected from successive admissions between June 2015 and December 2016, to assess the effectiveness of the service model. We identified 153 successive admissions, and of these, 85 (55.6%) and 91 (59.5%) patients completed both admission and discharge DIALOG and HoNOS questionnaires, respectively. We analysed ten out of twelve HoNOS domains and eight patient-reported outcome measure DIALOG domains.

Results

We found a statistically significant improvement in nine out of ten domains of HoNOS and three out of eight domains of DIALOG.

Clinical implications

A partnership between a home treatment team and crisis house can result in positive outcomes for patients, as determined by both clinicians and patients.

Declaration of interest

None.

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What is a crisis house?

Over the past decade, a nationwide drive to reduce and consolidate in-patient psychiatric beds across the UK National Health Service (NHS) has resulted in a concomitant growth in alternative models of intensive care in community settings, including an increase in the number of crisis houses.¹ A crisis house offers provision for people who find themselves in a mental health crisis as a community-based alternative to hospital admission.² The Tower Hamlets Crisis House (THCH) offer a short-term, community-based service for people who find themselves in significant mental distress, which is recognised to be potentially less stigmatising, coercive and institutionalised.³ A mental health crisis may be because of a variety of reasons, ranging from suicidal behaviour with or without intent, panic attacks or extreme anxiety, psychotic episodes or other behaviours that can potentially endanger the patients themselves or others.⁴

Outcomes in Mental Health

Healthcare outcomes are the results of care in terms of patients' health over time.⁵ Outcomes can be assessed by the patient, in the form of a patient-reported outcome measure (PROM), or by the clinician, in the form of a clinician-reported outcome measure (CROM). Over the past decade, increasing emphasis has been placed on medical interventions that yield high value for patients, with value defined as the health outcomes achieved per unit currency spent.⁵ If value improves, both patients and commissioners can benefit as the economic sustainability of the healthcare system increases. Although home treatment team (HTT) services are known to have inexpensive resource utilisation and foster better patient experiences,⁶ there is little research exploring their outcomes, particularly PROMs. The DIALOG intervention is an 11-item PROM that assesses patients' well-being on a 7-point Likert scale. Only the first eight questions of the DIALOG intervention assess patient-reported outcomes, whereas the last three domains assess patient experiences. The Health of the Nation Outcome Scales (HoNOS) intervention is a 12-item CROM intervention assessing four domains on a five-point Likert scale (0–4): behavioural problems, impairment, symptomatic problems and social problems.

Aims

To our knowledge, there is a paucity of agreed methodology for the analysis of CROM data.⁷⁻⁸ Similar challenges exist in analysing PROM data, given no nationally agreed methodology exists to assess these outcomes. The aim of this study was to measure the effectiveness of the THCH, using routine collection of PROM and CROM data.

Method

Data were collected as part of a routine service key performance indicator by the voluntary sector provider in partnership with the NHS trust and reported to the commissioners. The study received ethical approval as a service evaluation from the East London NHS Foundation Trust because the process did not involve any additional data collection or patient contact.

In this retrospective case series, we reviewed HoNOS and DIALOG data from successive patients admitted to the THCH at both admission and discharge (two-point data), between June 2015 and December 2016. Data were collected from quarterly reports submitted as a part of quarterly reporting. To avoid double-counting, e.g. in patient episodes that spread over more than one quarter, data were reconciled to ensure patients who were admitted and discharged over two different quarters were identified as single patients and double-counting was therefore avoided.

For the analysis, the authors compared HoNOS (CROM) and DIALOG (PROM) ratings at admission and discharge. Therefore, we did not analyse the three patient-reported experience measures in the DIALOG intervention (questions 9–11). This study did not assess domain four (cognitive problems) of the HoNOS, as most of the patients presenting to the THCH did not have cognitive difficulties. We also decided not to assess domain eight of the HoNOS intervention (other mental and behavioural problems: specify A, B, C, D, E, F, G, H, I or J, where A is phobic, B is anxiety, C is obsessive–compulsive, D is mental strain/tension, E is dissociative, F is somatoform, G is eating, H is sleep, I is sexual and J is other, specify) because of the heterogeneity of conditions that are assessed in this domain. As a secondary outcome measure, the number of patients who required acute hospital admission or terminated their treatment in an unscheduled manner over this period were noted.

Results are displayed as the means \pm s.e.m. Statistical significance between the two-point PROM and CROM data-sets were determined by a paired *t*-test. All statistical tests were performed with GraphPad Prism, version 6.0d for MAC OS (GraphPad Software Inc., San Diego, CA, USA). Statistical significance was assumed when differences were at $P < 0.05$.

Results

There were 153 admissions during the time period. Two-point DIALOG and HoNOS data were available for 85 (55.6%) and 91 (59.5%) admissions, respectively. Among those for whom two-point DIALOG data were unavailable ($n = 68$): 47 customers did not complete the discharge PROM but had a planned discharge, 6 customers did not complete the discharge PROM as they were either admitted to hospital or abandoned occupancy, and for 15 patients there was no admission or discharge DIALOG score (see *Fig. 1*). Two-point and one-point HoNOS data were available for 91 (59.5%) and 62 patients (40.5%), respectively. There was >85% matching in the cohort of patients who completed the two-point DIALOG and HoNOS interventions. For HoNOS scores, we show a statistically significant improvement in nine out of ten assessed domains, where domain five (physical illness or disability problems) was the only outcome that did not reach statistical significance (see *Fig. 2*). Among the eight DIALOG scores assessed in this analysis, we show a statistically significant improvement in domains one (mental health), five (leisure activities) and eight (personal safety) (see *Fig. 3*). Comparing similar domains in the HoNOS and DIALOG (see *Table 1*), we show some degree of mirroring in the clinician and patient responses, although there is some discrepancy, e.g. comparison numbers four, seven, nine and ten. *Fig. 1* A flow diagram of patients in the study. CROM, clinician-reported outcome measures; DIALOG, PROM, patient-reported outcome measures; HoNOS, Health of the Nation Outcome Scales. *Fig. 2* Outcomes of the HoNOS (CROM) score ($n = 91$). A lower mean score indicates a better psychiatric profile. The mean has been plotted along with \pm s.e.m. CROM, clinician-reported outcome measures; HoNOS, Health of the Nation Outcome Scales. $*P < 0.05$, $**P < 0.005$. *Fig. 3* Outcomes of the DIALOG (PROM) score ($n = 85$). A higher mean score indicates a better psychiatric profile. The mean has been plotted along with \pm s.e.m. DIALOG, PROM, patient-reported outcome measures. $**P < 0.005$. *Table 1* A comparison of similar domains in the HoNOS and DIALOG interventions. Comparison number Domains assessed in the HoNOS intervention *a* HoNOS *P* value Domains assessed in the DIALOG intervention *b* DIALOG *P* value Relationship between HoNOS and DIALOG scores

1 Domain one:

Overactive, aggressive, disrupted or agitated behaviour $*$ Domain eight:

How satisfied are you with your personal safety?

Domain one:

How satisfied are you with your mental health? $**$

$**$ Yes 2 Domain two:

Non-accidental self-injury $**$ Domain eight:

How satisfied are you with your personal safety? $**$ Yes 3 Domain three:

Problem-drinking or drug-taking $**$ Domain one:

How satisfied are you with your mental health? $**$ Yes 4 Domain five:

Physical illness or disability problems Domain two:

How satisfied are you with your physical health? No 5 Domain six:

Problems with hallucinations and delusions $**$ Domain one:

How satisfied are you with your mental health? $**$ Yes 6 Domain seven:

Problems with depressed mood $**$ Domain one:

How satisfied are you with your mental health? $**$ Yes 7 Domain nine:

Problems with relationships $**$ Domain six:

How satisfied are you with your friendships?

Domain seven:

How satisfied are you with your partner/family? No 8 Domain ten:

Problems with activities of daily living $**$ Domain five:

How satisfied are you with your leisure activities? $**$ Yes 9 Domain 11

Problems with living conditions**Domain four:

How satisfied are you with your accommodation?No10Domain 12

Problems with occupation and activities**Domain three:

How satisfied are you with your job situation?No¹²³⁴

Discussion

Over the past decade, commissioning in health has rightly turned its focus from commissioning for activity towards commissioning for outcomes. The Five Year Forward View for Mental Health stresses the importance of funding psychiatric services that have transparency around quality and outcomes, and suggested these should be in place by 2017–2018 for adult mental health services.⁹

In recent years, the patient–doctor relationship has evolved: from a paternalistic approach to one that is more collaborative with increased respect for patient autonomy.¹⁰ Given this evolution in the healthcare model, there is increasing recognition of the importance of involving patients in the development and evaluation of healthcare service delivery and quality improvement. PROMs are the tools that have been developed to ensure both a valid and reliable measurement of patient-reported outcomes. PROMs are directly reported by the patient without interpretation of the patient’s response by a clinician or anyone else and pertain to the patient’s functional status associated with healthcare or treatment.¹¹ Capturing both PROM and CROM data in clinical practice provides a more complete understanding of the impact of a healthcare intervention.

HoNOS is mandated as the nationally recommended generic CROM, to be administered by mental health professionals.⁹ Although HoNOS has been around for 20 years,¹² currently no universally agreed methodology for analysing this score exists in the literature.⁸ The DIALOG intervention was developed as part of a multicentre trial developed from Mensa, and then further developed as a solution-focused therapy tool.¹⁴ The DIALOG intervention is suggested by NHS England as an effective PROM intervention, but there are several alternatives, including the Questionnaire about the Process of Recovery and Short Warwick & Edinburgh Mental Well Being Scale.⁹ The analysis of PROM scores around DIALOG is in its infancy.

To our knowledge, this is the first report to systematically compare outcomes of the HoNOS and DIALOG interventions in a crisis house and HTT partnership. Given no standardised approach to analyse HoNOS and DIALOG data-sets exists in the literature, we analysed each item in the HoNOS and DIALOG interventions individually to achieve maximum granularity of data, as well as to allow us to compare similar fields in DIALOG and HoNOS, which would permit a degree of triangulation of clinician and patient perspectives. Our study shows that improvement in CROM scores is not always reflected by an improvement in PROM scores.

It is encouraging that mental health (DIALOG domain one) and personal safety (DIALOG domain eight) – the domains in which a mental health crisis service would be expected to have maximum impact – both feature statistically significant improvement in PROM scores. This finding is supported by statistically significant improvement in similar CROM scores assessing overactive, aggressive, disrupted or agitated behaviour (HoNOS domain one); overactive, aggressive,

¹ DIALOG, PROM, patient-reported outcome measures; HoNOS, Health of the Nation Outcome Scales.

² This study did not assess domain four (cognitive problems) or domain eight (other mental and behavioural problems: specify A, B, C, D, E, F, G, H, I or J, where A is phobic, B is anxiety, C is obsessive–compulsive, D is mental strain/tension, E is dissociative, F is somatoform, G is eating, H is sleep, I is sexual and J is other, specify; all items are scored on a range from zero to four).

³ This study did not assess domain nine (How satisfied are you with your medication?), domain ten (How satisfied are you with the practical help you receive?) or domain 11 (How satisfied are you with the consultations with mental health professionals?). All domains are assessed on a range from one to seven.

⁴
 $P < 0.05$, $**P < 0.005$.

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disrupted or agitated behaviour (HoNOS domain one); non-accidental self-injury (HoNOS domain two); problem-drinking or drug-taking (HoNOS domain three); problems with hallucinations and delusions (HoNOS domain six) and problems with depressed mood (HoNOS domain seven).

Broadly speaking, there are four models of community base community-based crisis services:³ (a) clinical crisis houses, providing residential services with staff onsite through the night and have a high level of clinical staff involved in providing onsite care; (b) specialist crisis houses, which share similar features to clinical crisis houses but are aimed at specific groups such as women and people with early psychosis; (c) crisis team beds, which provide a small number of beds aimed at short stays and are fully integrated with Crisis resolution and home treatment (CRHT) teams and (d) non-clinical alternatives, which are mainly managed by the voluntary sector with few clinical staff but many have also forged strong links with CRHT teams. Not all crisis houses have the same degree of collaboration with CRHTs, nor do they all offer residential support; for example, the Dial House in Leeds, UK.¹⁵ The THCH, established in 2010, is a partnership between the voluntary sector provider Look Ahead and East London NHS Foundation Trust (ELFT). The THCH service is embedded within the HTT, which ‘gate-keeps’ all admissions to the accommodation. There were initially five beds in the facility, which expanded to a ten-bed service in 2012. We would consider our model a hybrid of model (a) and (c) and our results indicate that such a model is effective in facilitating patient recovery. Given the heterogeneity of crisis house models, our outcomes cannot be generalised to other models of crisis house.

Our study is not without limitations, one being the limited sample size. Indeed, patients have a right to refuse to complete the DIALOG questionnaire, which explains the relatively little DIALOG data compared with HoNOS (85 v. 91). Although we attempted to administer the HoNOS scale to all patients, this could be done more predictably at admission: unscheduled discharges or very short admissions limited the opportunity to obtain discharge, and consequently, two-point data.

Unfortunately, the data used to analyse CROM and PROM outcomes did not include demographic details or ICD-10 codes. This information would have clarified the groups of individuals who most benefitted from the crisis house intervention. A previous multicentre study comparing the crisis house model to an in-patient psychiatric service noted that patient populations using both services were different with regards to gender, ethnicity and ICD 10.¹⁶ This dissimilarity could mean crisis houses are not a ‘true’ alternative to hospital admission, as the crisis house service could be treating patients who are not as unwell. This is an issue that does not affect the THCH: in a separate analysis performed by our group in 2015, we reviewed the patient profiles of crisis house clients ($n = 299$) and compared these with admissions to an acute in-patient ward ($n = 677$), and found that patients matched on gender, ethnicity and ICD-10 code (results were presented as a poster at the RCPsych International Congress¹⁷).

For (the majority of) patients who demonstrated an improvement in HoNOS and DIALOG scores, we are unable to comment on the precise intervention, or indeed the interplay of interventions, that facilitated improvement in their mental health. Was it being in a safe environment, the therapeutic relationship, pharmacotherapy, practical support or natural resolution of their social crises? In the absence of specific documentation of diagnoses, interventions offered and a ‘control’ group (e.g. an in-patient population), we are unable to discern the elements of the crisis house admission that were effective. It is also possible that this study has overestimated the impact of a crisis house intervention in the HoNOS and DIALOG scores, given patients for whom two-point data is available are more likely to have had a favourable course of treatment, as they would have been more engaged with staff and not made an unscheduled departure or required acute hospital admission.

In conclusion, we report evidence that a crisis house and HTT partnership can result in favourable results particularly around patients’ mental health and safety as assessed by both the patient and clinician. Our findings support the effectiveness of a novel partnership model, supporting its continuance, and providing data to help mental health commissioners elsewhere in determining their local model of crisis care. Despite the study’s limitations, its findings are worth disseminating, given that the evidence base for HTTs is inadequate and is even less established for crisis houses. Furthermore, the routine use of clinical outcome measurements in adult mental health remains patchy, despite significant national drivers. Our findings make a sizeable contribution to the limited literature describing the crisis house service, which is often poorly understood and infrequently commissioned. We hope this study encourages similar services to routinely collect and analyse PROM and CROM scores to develop a rich evidence base in this field.

Mohsin Faysal Butt is a medical student at Barts and The London School of Medicine and Dentistry, UK. **David Walls** is manager of Tower Hamlets Crisis House service, Lookahead Housing, UK. **Rahul Bhattacharya** is a consultant psychiatrist with the Tower Hamlets Home Treatment Team and clinical lead for Crisis House, East London NHS

Foundation Trust, UK.

1.4.42 Personal resilience for psychiatrists: systematic review

Francis Stella Sophia Senthil

date

2019-12

Contents

- *Personal resilience for psychiatrists: systematic review*

I read with interest this article¹ which explores the factors that promote and maintain psychiatrists' well-being, particularly personal, workplace and non-work-related factors such as increased self-awareness, extending job roles, discrete work activities, and/or support from family or social environment.

John. D. Yoon and Brendan M. Daley, studying the association between a sense of calling and physician well-being,² reported that a higher sense of calling in primary care physicians and psychiatrists was associated with an increased level of job satisfaction and resilience from burn-out. This reflects the deeper sense of meaning and purpose that work can bring, which generates and even sustains motivation and enables working with vision. However, there are reported challenges relating to the bureaucratic and technological demands that physicians experience, which mean the sense of calling can be hard to sustain.

A report from the Association of American Medical Colleges published in February 2019 highlights the misalignment between practitioners' values and practices and those of organisations, which can contribute to burn-out and diminished well-being.

Authors Adam M. Brenner and John Coverdale, in their update on trainee wellness,³ report on voluntary resident-led peer group reflective practice for medical students as an intervention for social connectedness. Although the study was of small sample size and lacked a control group, social belonging appeared to be a positive predictor of well-being, diminished imposter syndrome and tolerance of diverse perspectives, suggesting that this model deserves further attention as a potential means of improving resilience in trainees and professionals or psychiatrists.

The authors quote in their update Winston Churchill's famous saying: 'Now this is not the end. It is not even the beginning of the end. but it is, perhaps, the end of the beginning'. These words express hope for momentum towards victory; we are still in the early stages of addressing burn-out and improving well-being, but perhaps we are moving in the right direction.

Christine Montross, in her book *Falling Into the Fire: A Psychiatrist's Encounters with the Mind in Crisis*,⁴ describes 'patients who are so difficult to diagnose or treat – uncertainty it arises', 'I hold my trust in medicine up to the light, I see that it is full of cracks and seams. In some places it is luminous. In others it is opaque. And yet I practice'. She discusses how over time she has developed trust in the daily work of talking, treating and attempting to heal: 'you have to be anchored to the shore – to the people and things that are central to your own life'.

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1.5 2018**1.5.1 41. RECONSIDERING THE EVIDENCE FOR CLOZAPINE FOR TREATMENT REFRACTORY SCHIZOPHRENIA**

James MacCabe

date

2018-4

Abstract

Overall Abstract: The superiority of clozapine for treatment refractory schizophrenia was, until very recently, seen as one of the few unshakeable truths in psychiatry. But the pre-eminence of clozapine has recently been called into question by meta-analyses. What are we to make of the fact that meta-analyses of clinical trials, supposedly the pinnacle of evidence based medicine, fail to show an effect which seems clearly evident to most clinicians, and on which many of our guidelines are based? Have we believed in a fairytale for the past three decades? Or do biases in RCTs and methodological limitations of meta-analyses explain the results? These questions will be discussed by Dan Siskind.

Another way to address the question of efficacy is to examine the pharmaco-epidemiological evidence using population-based registers. Jari Tiihonen will present data from his seminal studies of mortality and readmission rates under clozapine treatment versus other antipsychotics, as well as other data. These data seem to show powerful positive effects of clozapine at the population level. Furthermore, more recent evidence suggests a role for clozapine in reducing rates of violent offending, with new data presented for the first time by Vishal Bhavsar.

Finally, despite clinical guidelines recommending the use of clozapine, the actual rates of clozapine use are much lower than expected, with large regional and international variations. There is evidence that the burden of blood monitoring deters physicians from prescribing clozapine. Yvonne van der Zalm will present new data from a cluster randomised trial testing the efficacy and safety of an intervention to increase rates of clozapine prescribing by employing nurse practitioners trained in the initiation and monitoring of clozapine.

John Kane, author of the first, seminal RCT of clozapine in 1988, will lead the discussion.

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- *41. RECONSIDERING THE EVIDENCE FOR CLOZAPINE FOR TREATMENT REFRACTORY SCHIZOPHRENIA*

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1.5.2 41.1 WHAT DO META-ANALYSES TELL US ABOUT CLOZAPINE'S EFFICACY AND EFFECTIVENESS FOR TREATMENT REFRACTORY SCHIZOPHRENIA?

Dan Siskind Steve Kisely Rachel Land Lara McCartney

date

2018-4

Abstract

Background

Clozapine has long been considered the gold standard antipsychotic for treatment refractory schizophrenia (TRS). There have been a number of recent meta-analyses of efficacy of clozapine on psychotic symptoms and effectiveness in reducing hospitalisations that have sparked debate on the role of clozapine.

Methods

Current literature regarding the efficacy of clozapine for TRS, including pair-wise and network meta-analyses of RCTs with reported outcomes of total psychotic symptoms, positive symptoms and negative symptoms were reviewed. We also examined the results of a meta-analysis of the effectiveness of clozapine on reducing hospitalisations based in RCTs and observational studies.

Results

Two recent meta-analyses: Samara et al (2016), a network meta-analysis in JAMA Psychiatry; and Siskind et al (2016) a pairwise meta-analysis in BJPsych, found similar equivocal results for total psychotic symptoms. However, Siskind et al (2016) found clozapine to be superior to other antipsychotics for positive symptoms. Factors influencing the difference in results included pair-wise vs network methodology and sensitivity analyses of pharmaceutical industry support. Of note, only 40% of people with TRS responded to clozapine. Clozapine's effectiveness for reducing hospitalisations was significant, with a relative risk of 0.74 (95%CI 0.69–0.80).

Discussion

There are a lack of recent non-industry funded randomised control trials of clozapine compared to SGAs, which hinders an equivocal statement about the superiority of clozapine for total psychotic symptoms. However, there is evidence to suggest that clozapine is superior to other antipsychotics, including SGAs, for positive symptoms. In terms of effectiveness, initiation of clozapine can reduce the proportion of people hospitalised and reduce bed days. Use of clozapine needs to be balanced against its adverse drug reaction profile. There remains a need for more effective treatments for TRS, and biomarkers to identify TRS.

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- *41.1 WHAT DO META-ANALYSES TELL US ABOUT CLOZAPINE'S EFFICACY AND EFFECTIVENESS FOR TREATMENT REFRACTORY SCHIZOPHRENIA?*

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1.5.3 40.4 LOW-DOSE RISPERIDONE TREATMENT IN ADOLESCENCE PREVENTS THE DEVELOPMENT OF NEUROINFLAMMATION IN THE MATERNAL IMMUNE ACTIVATION MODEL

Ina Weiner Shani Pery Jasbeer Dhawan Anat Biegon Yael Piontkewitz

date

2018-4

Abstract

Background

Postnatal consequences of prenatal immune activation mimic a broad spectrum of neuro-psychopathological features phenotypic of schizophrenia (SCZ). We previously showed that SCZ-relevant behavioral and brain structural abnormalities emerging in adult offspring of moms exposed to the viral mimic polyI:C, are prevented by treatment with the atypical APD risperidone (RIS) in adolescence, prior to the emergence of structural and behavioral abnormalities. Given the increasing centrality of neuroinflammation in SCZ and its treatment and/or prevention, here we assessed whether adolescent RIS is able to prevent neuroinflammation in the polyI:C offspring.

Methods

On gestation day 15, pregnant Wistar rats were injected IV with polyI:C (4 mg/kg/ml) or saline. Pups were weaned on postnatal day (PND) 21. Preventive treatment with RIS (Janssen, Belgium; 0.045 mg/kg) was administered daily on PNDs 34–47. Offspring were sacrificed on PND48, prior to full spectrum of structural and behavioral abnormalities, or on PND90, after the emergence of structural and behavioral abnormalities. Microglial activation was assessed in ten regions (nucleus accumbens, striatum, substantia nigra, frontal, anterior cingulate and occipital cortices, dorsal hippocampus (sub-regions CA1, CA3 and dentate gyrus [DG]) and ventral hippocampus (vHPC), using quantitative [3H]PK11195 autoradiography. Another cohort of offspring underwent behavioral testing and imaging.

Results

ANOVAs of [3H]PK11195 binding in offspring sacrificed on PND48 revealed no significant effects of prenatal polyI:C in any of the regions assessed. In adult male offspring, [3H]PK11195 binding was significantly increased in the CA1, CA3 and DG hippocampal subfields as well as in the frontal and occipital cortices, compared to controls. No such increases were observed in polyI:C offspring treated with RIS in adolescence (significant prenatal x preventive treatment interactions, and significant difference in [3H]PK11195 binding between polyI:C-VEH and saline-VEH but not between polyI:C-RIS and saline-VEH offspring in post-hoc analyses, in each of the regions). In females, [3H]PK11195 binding was significantly increased only in the vHPC, occipital cortex, and nucleus accumbens. Such increases were not observed in polyI:C female offspring treated with RIS in adolescence. In a second cohort of offspring, prenatal poly-I:C led to structural abnormalities in the hippocampus, striatum, prefrontal cortex and lateral ventricles, as well to deficits in selective attention, executive function, working memory and social interaction, all of which were prevented by RIS.

Discussion

Increased [3H]PK11195 binding in the brains of adult poly-I:C offspring is consistent with increased uptake of [11C]PK11195 in patients with SCZ, measured in-vivo by PET. Microglial activation emerged in adulthood, with no such activation in young (PND48) offspring. Late emergence of microglial activation parallels the developmental course of behavioral and brain structural abnormalities in poly-I:C offspring (Piontkewitz et al, 2011a, 2012a; Piontkewitz et al, 2009), suggesting that these late-emerging abnormalities are linked. The latter is supported by the fact that RIS in adolescence prevented the emergence of behavioral and brain structural abnormalities as well as microgliosis in the adult offspring. These data suggest that prevention of adult microgliosis is one of the mechanisms underlying RIS capacity to prevent polyI:C-induced behavioral and neuroanatomical deficits, however, a causal relationship remains to be established.

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- *40.4 LOW-DOSE RISPERIDONE TREATMENT IN ADOLESCENCE PREVENTS THE DEVELOPMENT OF NEUROINFLAMMATION IN THE MATERNAL IMMUNE ACTIVATION MODEL*

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1.5.4 Abstracts for the Sixth Biennial SIRS Conference

date

2018-4

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- *Abstracts for the Sixth Biennial SIRS Conference*

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1.5.5 Implementing National Institute for Health and Care Excellence smoke-free guidance in a secure facility: an evaluation of the prescribing costs in clozapine users

Stephen Noblett Jane Beenstock James Noblett Joanne Ireland Sarah Ormiston

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Stephen Noblett

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date

2018-4

Abstract

Aims and method

The increased rates of smoking in people with mental illness is well documented, and establishing smoke-free mental health environments has been emphasised over recent years. This article examines the financial costs of implementing smoke free guidance and assesses the cost associated with patients who were prescribed clozapine and who committed to stopping smoking cigarettes for the duration of the study period.

Results

Patients (38) who were prescribed clozapine were included in the study. A moderate reduction in dose was noted with a moderate reduction in prescribing costs. The total increase in cost for the whole group, however, was £17 624, largely due to the use of nicotine replacement therapy and an increase in the number of clozapine assay tests.

Clinical implications

Further studies on implementing this important policy change are needed. The positive effects must be balanced with increased financial pressure on Mental Health Trusts.

Declarations of interest

None.

Contents

- *Implementing National Institute for Health and Care Excellence smoke-free guidance in a secure facility: an evaluation of the prescribing costs in clozapine users*
 - *Cost of smoking*
 - *National Institute for Health and Care Excellence guidance*
 - *NRT and the associated costs and savings*
 - *Aim*
 - *Method*
 - * *Setting*
 - * *Context*
 - *Results*
 - *Discussion*

Cost of smoking

Smoking imposes a huge economic burden on society. Action on Smoking and Health has concluded that the costs to society in England are approximately £13.9 billion per year. Around £2 billion of this is the cost to the National Health Service (NHS) of treating diseases caused by smoking.¹ For adults with a common mental disorder such as depression and anxiety, smoking rates are almost twice as high compared to adults who are mentally well, and three times higher for those with schizophrenia or bipolar disorder.² Smoking is thus a key contributor to the health inequalities that exist between people with a mental health disorder and the general population, which result in a difference in life expectancy of 15–20 years.^{3,4} Nationally there has been a growing recognition that providers of mental health services should be smoke free and support patients with nicotine addictions to stop smoking.^{5–7}

National Institute for Health and Care Excellence guidance

In particular, National Institute for Health and Care Excellence (NICE) guidance⁵ advocates that all NHS settings should be smoke free because of the health benefits to the individual, the wider community and healthcare providers. They emphasise that healthcare providers should promote healthy environments for their staff and patients. In this Trust the guidance was implemented through a nicotine management policy as, learning from other Trusts, the focus was on supporting people who have a nicotine addiction rather than banning smoking. The policy contents are similar to smoke-free policies in other Trusts: admitted smokers may no longer have smoking breaks and should manage their nicotine addiction through the use of nicotine replacement therapy (NRT) with behavioural support. Consequently, people admitted to smoke-free mental health units need to be supported to cease smoking tobacco cigarettes during their admission. Ideally, this would lead to permanent smoking cessation. *Table 1* summarises some of the consequences in terms of cost or benefit to the individual and to the wider organisation. *Table 1* Summary of the costs and benefit consequences of smoking cessation following the introduction of a smoke-free policy in a mental health provider unit

Consequence	Cost or benefit?
Smoking cessation aids such as nicotine replacement therapy (NRT) and medications such as bupropion	Cost
Behavioural support	Cost
Increase in number of clozapine assay tests required	Cost
Reduction in amount of antipsychotic medication required, with opportunity for fewer side effects from the medication	Benefit
Reduction in staff time spent supervising smoking breaks	Benefit
Improvement in mental health	Benefit
Reduction in premature mortality and in levels of morbidity	Benefit
Potential lower costs of prescribed antibiotics for lung infections or other smoking-related physical health problems	Benefit

Public Health England estimates the long-term quit rate for long-term patients is 40%, and 25% for short-term patients

Intervention	Cost	Benefit
Public Health England estimates that the intervention could cost approximately £1430 per annum to the health and care system on average over 10 years	Cost	Benefit
Public Health England estimates net savings of approximately £1460 per annum per person to the health and care system on average over 10 years	Benefit	Benefit

NRT and the associated costs and savings

NRT provides nicotine to the body without using cigarettes. The aromatic hydrocarbons found in cigarette smoke are known to increase the metabolism of some drugs due to induction of the cytochrome P450 enzyme system.¹⁵ NRT does not influence these metabolic enzymes.¹⁶ Plasma levels of clozapine are altered in the absence of tobacco smoke. Therapeutic-drug monitoring of clozapine is therefore useful with a recognised therapeutic range to regulate the required prescribing dose. Failure to monitor plasma levels in the context of stopping smoking may result in prescribing the incorrect dose. Following smoking cessation, clozapine doses may be reduced, decreasing the medication cost for the NHS in mental health. Smoking cessation could be financially beneficial to the NHS because the resources used to supervise smoking could be used elsewhere to improve health and well-being. This, however, may be offset by increased requirements for therapeutic-drug monitoring and the cost of NRT. Whereas there is extensive published literature demonstrating the long-term benefits of smoking cessation, in both the general population¹⁷ and in the population of people with a mental health disorder;¹⁸ there is limited published work describing the short-term costs and benefits.

Aim

This project aimed to review the costs of providing NRT, clozapine and clozapine assay testing in the context of the new nicotine management policy within a secure mental health population. In January 2015, the secure mental health service implemented a nicotine management policy (NMP) in response to the publication of the NICE public health guidance 48.⁵ This evaluation focused on the costs and savings relating to clozapine and NRT because these are the two most direct expenditures from supporting people who smoke to manage their nicotine addiction without smoking tobacco cigarettes. NRT is required to manage the nicotine addiction and clozapine is commonly prescribed in the specialist services. Patients on clozapine who stop smoking are likely to have lower prescribing costs because of the need for lower dosages of medication when stopping smoking.¹⁹

Method

Setting

Guild Lodge is a secure mental health facility which provides care for 164 male and female patients within medium, low-secure and step-down ward environments. It also provides regional medium and low-secure care for males with acquired brain injury. The service provides a seamless transition of care between different levels of security in preparation for support in the community. The service is made up of 12 in-patient wards, 3 of which care for a total of 24 women. Ethical approval was not required as no patient information was identified. Advice was sought through the audit department within the Trust.

Context

The study looked at a cohort of patients who were prescribed clozapine for a 12-month period at the time the NMP was implemented at Guild Lodge in January 2015. These people stopped smoking cigarettes at this time and maintained their smoke-free status for the duration of the study. This was monitored in the context of the secure in-patient and hospital grounds smoke-free environment. Prior to the implementation date, data was collected in an effort to try to anticipate where there may be particular risks due to elevated clozapine plasma levels for individual patients. Data included clozapine dose, plasma level (with current dose) and if any anticonvulsant medication was also prescribed.

The 6 month period prior to the implementation in January 2015 was considered in terms of dosage of prescribed clozapine and the number of clozapine assay tests undertaken. In the following 6 months, until July 2015, information relating to the dose of prescribed clozapine, number of clozapine assays and prescribed NRT was collated.

The total financial cost for this group, in the 6 months before and after implementation of the NMP, was calculated based on the cost to the organisation of clozapine, clozapine assay tests and specific NRT, including patches, lozenges and inhalators.

Results

A total of 38 patients were included in the study, representing 23% of the total in-patient population. Of these, 8 were women (21%) and 30 were men (79%). Data was obtained from each of the 12 wards within the service. In total, 48 out of 164 patients were prescribed clozapine in the service at the time. Ten of these were non-smokers and were therefore not included in the study. At the time of the study, the hospital site became a smoke-free environment, although there was occasional evidence of illicit smoking within the secure setting.

The results demonstrated a small reduction of 6.5% in mean clozapine dose from 381 mg to 356 mg in the 6 month period following the NMP implementation. However, the number of clozapine assays carried out in this period increased by 200%, with the mean number of assays rising from one to three. The increased number of clozapine assays had a significant financial effect (*Table 2*), although the number of required assays is likely to reduce as plasma levels stabilise following smoking cessation. *Table 2* Total cost before and after implementation of National Institute for Health and Care Excellence smoke-free guidance

	Total cost of clozapine dose before intervention (£)	Total cost of clozapine dose after intervention (£)	Total cost of assays before intervention (£)	Total cost of assays after intervention (£)	Total cost of nicotine replacement therapy (£)	Total cost before intervention (£)	Total cost after intervention (£)	Total difference in cost after 6 months (£)	Total cost for service
	7489.41	6991.44	878.75	228016	818.96	8368.16	26 090.40	17 623.66	Mean cost per patient
	197.09	183.99	23.13	60442.60	220.21	686.59	463.78	Range of individual costs	77.61–362.18
	77.61–362.18	77.61–362.18	71.25	23.75–142.50	0–871.92	101.36–385.93	127.23–1184.25	0–930.24	

Table 2 demonstrates the specific prescribing costs for medication and for clozapine assays for the service, as advised by the pharmacy department. These figures are based on the costs of clozapine over the two 6 month periods for the organisation, costs for each assay test and total cost of NRT. Costs did not include any additional phlebotomy or laboratory costs.

A total of 5 out of the 38 patients had no clozapine assay tests taken in the 6 month period prior to stopping smoking, which may have represented clinical stability and consistent dose prescribing in this group. A total of 28 patients (74%) were prescribed NRT throughout the 6 month period with the majority using patches (53%) and inhalators (45%). This resulted in a cost of £16 819 for the 6 month period.

There was only a moderate reduction in the cost of prescribed clozapine because of limited dosage change, but also due to the relative in-expense of clozapine itself. For 18 out of the 38 patients, the cost of clozapine remained the same, indicating that the dose was unchanged during this period. Although the patients had committed to stopping smoking, it is possible that they continued to smoke cigarettes at times, leading to an increased cost of prescribed NRT, as this may have had little clinical benefit for these individuals.

For 35 patients, representing 92% of the sample, there was an increased cost in the 6 month period following the implementation of the NMP, with a total cost of £18 641.66 for the whole group during this time.

Discussion

This study showed that in the 6 months following the introduction of the NMP in this unit there was a slight decrease in the costs from prescribed clozapine, and increased costs generated by more assay tests and the use of NRT.

These results will have been influenced by the take-up rate of NRT patients, and the extent to which they were compliant with not smoking cigarettes during the 6 month period. This will have affected the amount of NRT prescribed and the consequent impact on clozapine plasma levels. Current and future costs will also be affected by the number of patients who use e-cigarettes.

The current culture and practice around smoking has been evolving since the 6 months reviewed in this study. Recently, the use of e-cigarettes has been piloted and a much more robust approach to implementing the NMP has affected attitudes and behaviours in relation to the NMP. In addition, patients have been given less time in the grounds where they have been likely to smoke cigarettes, especially when they have access to the community on leave. This may begin to change the culture of leave within the grounds to be more therapeutic and less about gaining access to cigarettes.

This study has not included all the financial costs that could be affected by the introduction of the NMP, such as prescription costs for physical health problems related to smoking, and staffing costs for supervising patients who have smoking breaks.

Although there is good evidence that the overall benefits of smoking cessation are greater than costs for both individuals and society in the longer term, in the short term there are some immediate financial pressures generated for Mental Health Trusts. Further work is needed to understand if these results are likely to be the same for other Trusts implementing this important policy change that is needed to improve the mental and physical health of people using mental health services. Smoke-free policies challenge the culture in mental health units,²⁰⁻²³ but the financial pressure involved should not derail the ambition to be smoke free because it is consistent with national policy and is of significant benefit to people with a mental health disorder.¹⁸

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1.5.6 Choice of provider for out-patient treatment is not working

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Abstract

In 2012, the coalition government introduced the legal right for National Health Service (NHS) patients in England to choose their mental healthcare provider for out-patient treatment. This was a significant step towards parity of care between mental and physical ill health, and NHS Improvement and NHS England have provided sensible guidance on its implementation. However, several factors prevent the system from working as it was intended: lack of awareness of the principle of patient choice for out-patient treatment; complacency from some trusts and commissioners; mental health trusts operating outside the e-referrals system; misuse of care pathways; lack of direct access by many general practitioners for out-of-area referrals; and delays in authorisation for funding. I describe how I have come to this conclusion and suggest some solutions.

Declaration of interest

The author is employed by a trust that potentially benefits from ‘patient choice’.

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The Royal College of Psychiatrists has campaigned for parity of care between mental and physical ill health and has secured some notable success in raising awareness and pushing mental health up the political agenda. One issue in parity of care, which remains problematic, is the right of patients to choose their out-patient provider in defined circumstances. Thus, if you visit your general practitioner (GP) with a cancer, you can choose your treatment provider, using a variety of criteria such as reputation, outcomes, waiting times and location. Paradoxically, choice is not often a

priority in physical healthcare.¹ When surveyed, people most value proximity, a short waiting list and ease of transport to healthcare. This is perhaps because the quality of physical healthcare is more similar across providers compared with, say, the delivery of a protocol in cognitive-behavioural therapy (CBT) for a particular disorder.

Background

In 2012, the Rt Hon. Norman Lamb and the coalition government introduced the legal right for National Health Service (NHS) patients in England to choose their mental healthcare provider for out-patient treatment.² This was a significant step towards parity of care and allowed patients suffering mental disorder to choose their *out-patient* provider, in the same way as they could if suffering from a physical condition, without the need for discussion at a funding committee. Older readers will remember that choice for mental health out-patient treatment used to be available on the NHS up until the early 1990s.

The way the change in law is interpreted is outlined in the document *Choice in Mental Health*, published by NHS Improvement, who are now responsible for the regulation of patient choice.³ NHS England have also published some helpful documents and guides on patient choice, from which some of this article is drawn.⁴⁻⁶

The guidance by NHS Improvement and NHS England is clear. Nevertheless, introduction of the change is being hampered by several factors: lack of awareness on the part of both professionals and the community; poor commitment by trusts and commissioners; and various loopholes that I will go on to describe. As it remains cheaper for a patient to be treated by a block contract with a local provider, some of the apparent lack of compliance may flow from an effort to contain costs. To follow the guidance for patient choice, out-patient treatment needs to follow a typical package of care at a service that has a standard NHS contract. This can be at two levels of stepped care.

Primary care – Improving Access to Psychological Therapies (IAPT)

This consists of a psychological therapy with no consultant involvement. Thus, legally the GP and patient may decide they wish to go to a different provider even if a clinical commissioning group (CCG) has a block contract with a local IAPT service.

Secondary care – consultant-led service

Where a patient with moderate to severe symptoms requires a more experienced therapist and medication advice in a consultant-led service, this can also be accessed under patient choice by a GP. The treatment must be *clinically appropriate*, without the need for local community mental health team (CMHT) involvement or integrated social care. Here, the service acts as the secondary care provider. Again, under patient choice, the existence of a care pathway with a block contract for a local CMHT or psychological therapy service is irrelevant if the GP and patient decide they wish to go to a different provider. Clarity over the right of patients to choose may be particularly important where there is a need for assessment or treatment in one of the many ‘Cinderella’ services in psychiatry, such as anxiety disorders and trauma, attention-deficit hyperactivity disorder (ADHD), chronic fatigue or medically unexplained symptoms, where local services may not be well developed. It might involve out-patient child and adolescent services if other local services are not required. However, there is no obligation on the provider of a CMHT to travel to the patient; in effect, choice depends on the patient traveling to an out-patient provider.⁵

In brief, NHS England⁵ state that a patient is *not* entitled to choose where to be referred in the following cases. ¹The patient’s needs cannot be addressed by a typical package of care that lies outside National Institute for Health and Care Excellence (NICE) guidance or is not routinely commissioned on an ongoing basis through a NHS standard contract. An example for which choice of provider does not exist might be repetitive transcranial magnetic stimulation for depression, because it is not routinely commissioned. An example of where choice would exist is CBT for post-traumatic stress disorder (PTSD), which would be commissioned to be treated at a local IAPT or secondary care service.²The patient’s needs mean that an outside referral is *not* clinically appropriate. For example, urgent care for a patient with significant risk factors (such as self-neglect or a risk of suicide), which are best served by local CMHT involvement. Patients cannot choose their level of care (such as residential or in-patient over out-patient care) unless it is clinically appropriate (for

example, intensive CBT on a residential unit for severe obsessive–compulsive disorder). Nor are patients entitled to choose a non-local provider if treatment is likely to need integrated care with social services or a CMHT because of the level of risk. These are examples of where it is not clinically appropriate for a GP to refer that patient to an out-patient service. If patients need a local CMHT, then the GP cannot refer to a specialist service. If appropriate, the CMHT will make an individual funding request to a CCG for assessment or treatment at a national specialist service as part of tertiary care.

The principles developed by NHS Improvement and the Patient Choice department of NHS England⁵ are sensible, but parity of care is not working in practice. I highlight some of the key problems and possible solutions below.

Lack of awareness of patient choice on the part of patients and GPs

Patients and GPs remain broadly unaware of patient choice. It seems very strongly embedded in the culture that mental healthcare is differently regarded from physical care and that only in exceptional cases can patients be referred out of area. I have read refusals for funding from commissioners in mental health, which cite unapologetic expectation that routine patients be treated in a locally commissioned service. I have lost count of the patients who report that their GP swiftly dismissed any suggestion that an out-of-area referral is possible other than in exceptional circumstances (i.e. a tertiary care option) or where ‘local resources have been exhausted’. On the NHS Choices website, psychiatric hospitals are commonly listed as providing a service for their local population. There is no listing of, say, a clinic for anxiety disorders, ADHD or eating disorders that will accept referrals from GPs all over England.

Linked to this problem, the NHS Choices website specifies no waiting times, or details of outcomes, awards or patient feedback for any individual clinic. Neither do hospital or IAPT websites make clear when a service can receive a direct referral from a GP from around the country or when it requires a CMHT to make the referral. Where patient-reported outcome measures (PROMs) are available, presentation is very patchy (and tends to refer to an IAPT service in one borough, rather than a service like our own at the Centre for Anxiety Disorders and Trauma which accepts a selection of patients across different IAPT services). There appears to be little desire by trusts to develop special interests, and so trusts that do provide a ‘specialist’ service appear to regard them still as only available in complex cases or for tertiary care, for which patient choice does not apply. This is not the case. Services such as our own not only have funding streams for treating patients with severe cases in tertiary care but also treat patients within primary care (IAPT) and secondary care as described above. NHS Improvement published further guidance earlier this year in user-friendly language. The leaflets⁵ were sent directly to all CCGs.² Although Mind and other mental health charities also publicised the initiative, the message is still not getting through to GPs or patients who would like the option of choice for out-patient treatment where it is clinically appropriate.

It would undoubtedly help if NHS Digital and providers were to publicise on their websites those services that are directly available to GPs, accompanied by clear data. At present, NHS Choices tends to describe the hospital but not individual clinics, although I acknowledge they are dependent on the information provided. NHS Choices does, however, provide a list of private therapists, which seems odd on an NHS website. ‘Specialist’ services on hospital websites appear to be solely relevant for tertiary care rather than open for GP referrals. The NHS Choices and individual hospital websites need to encourage the reporting of standard PROMs and other meaningful information such as waiting lists for individual clinics. Patients find it difficult to make choices unassisted and currently seem to rely mainly on reputation and charity helplines. This is not good enough.

Mental health foundation trusts are not part of ‘e-referral’ systems on GPs’ computers

Only a small number of mental health providers have joined e-referral (or the old ‘Choose and Book’ system) in the same way as physical care providers do. This prevents GPs from using the system as intended, while feeding the misperception that they are obliged to use the local service. Thus, if you have a physical health problem, your GP can book you into a clinic of your choice on his/her computer. Waiting times are generally known for competing hospitals providing physical healthcare. Mental health trusts appear to prioritise their CMHT services over implementation of e-referrals and other mechanisms to assist with the guidance.

Misuse of care pathways

A 'care pathway' is a way of describing *how* a patient is assessed and treated for a specific problem. Many hospital trusts and CCGs have care pathways which are helpful. They are generally based on NICE guidance, although there are often areas in which there is not sufficient evidence and a pathway is based on other evidence and expert opinion. Care pathways are sensibly used for long-term physical conditions such as diabetes, which require local joined-up solutions. However, care pathways in mental healthcare are often misused; they may state *the location* of a local service without highlighting the need to discuss patient choice when there are no significant risk factors or any need for local social services or a CMHT (as required by NHS Improvement). Other misuses of care pathways include referrals for a patient with a certain condition (e.g. chronic fatigue) being directed to a specific care provider that has a block contract, with no discussion about choice.

My view is that NHS Improvement needs to ensure that, when a patient does not have significant risk factors (e.g. suicide, neglect) or any need for integrated social services, a local care pathway includes a discussion of choice and relevant documents are easily available on a local website (rather than, for example, obtained under the Freedom of Information Act). Here, NICE could highlight the role of choice in out-patient treatment for problems that do not require local CMHT or social services.

Lack of direct access by GPs to IAPT providers out of their area

Increasingly, CCGs prevent their GPs from directly referring to a non-local IAPT provider. GPs may refer to a local IAPT service, but anything else is directed to a local triage assessment or to a funding panel. In other words, not all providers are treated equally, and delays are created for patients referred to triage or a funding panel. Triage can be helpful when a patient is likely to need a local CMHT (for example, if a patient has significant risk factors or is likely to need mental healthcare integrated with social services). An IAPT patient by definition does not have significant risk, so this is an example of inherent bias (or lack of parity). Triage is not required for referral to a local IAPT level of service, but it may be required to determine whether the patient needs to be referred to a CMHT. Indeed, people are entitled to self-refer without even needing to involve a GP, yet if they have the temerity to go out of area, they have to be triaged to discuss the benefits of the local IAPT service, thus delaying treatment.

At present, NHS Improvement allows CCGs to set up care pathways as they see fit. They believe that a triage assessment can be used to determine whether the referral is clinically appropriate, so long as choice is discussed. However, local triage services do not collect the relevant PROMs or waiting times, or keep a current list of specialised clinics of other IAPT providers around the country. Sample documents have shown that it is not normally part of the policy to discuss choice of provider (and certainly choice of IAPT provider). Many CCGs just ban their GPs from referring out of area, and such requests have to go to a funding panel where the GP is required to request special circumstances, which is inconsistent with patient choice. In practice, patients conduct their own research and discuss it with their GP or hope that the GP has specialist knowledge and can advise them. IAPT services are perfectly capable of saying when treatment with them is not appropriate, without local CMHT involvement. Patients do not need another triage assessment – otherwise they would not be allowed to refer themselves directly to a local IAPT provider.

In summary, IAPT represents the lowest level of stepped care. Patients are often entitled to self-refer. The principle of a triage service for IAPT patients who wish to be referred to an out-of-area provider is therefore nonsense. In my view, NHS Improvement needs to ensure that IAPT patients can be assessed at the provider of their choice. Referrals to non-local providers need to state clearly which service is sought (for example, IAPT rather than secondary care).

Lack of direct access by the GP to a secondary care provider

By secondary care provider we mean a consultant-led service which deals with more complex problems than IAPT does or where medication advice may be required. Again, GPs are often prevented from directly referring outside the area or are restricted in doing so until after triage by their local provider. Local triage services are appropriate when local CMHT or social services involvement is likely to be required. Again, NHS Improvement does not define how referrals should be managed *so long as choice is discussed* at a triage service. As we have seen above in discussing IAPT services, this is naïve: triage services do not have regular access to information about other services, relevant PROMs and care pathways. In practice, despite the guidelines, triage services do not discuss the importance of patient choice in their policy documents, and not all providers are treated equally. Alternatively, such referrals are just blocked at funding panels, and the patients and GPs are unaware of their rights.

In my view, NHS Improvement needs to ensure that all triage services include a full discussion of choice in their policy documents or care pathways, and that they can provide details of other relevant services. In addition, such cases should not be discussed at funding panels. Referrals to providers need to state clearly that they are seeking a secondary care service rather than IAPT, and that they require assessment and treatment by a consultant's team.

Delays in authorisation of funding for assessment

When a patient is finally referred, there must be pre-authorisation for funding by the CCG. Referrals for mental disorders out of area are still widely treated as something unusual, and the funding panels question why the patient cannot be treated locally or use a care pathway that states where a patient must be referred (because that is where there is a block contract). There are many examples at my own service of patients referred by their GP who wait several months, even a year, for applications to be ignored, and then find that funding is never authorised. About 50 patients who have been referred by their GPs to my department at the Centre for Anxiety Disorders and Trauma are waiting for authorisation for funding from CCGs, either for an assessment or, when they have been assessed, for treatment. Of the 50 I recently audited, seven have been waiting more than a year, 13 for more than 36 weeks, 25 for more than 24 weeks, 38 for more than 12 weeks, and the rest for more than 4 weeks. The picture has been similar in previous years. We recently reviewed our list and found that some patients had given up: some accept local treatment; some seek private care they can't afford. The people who can choose the location of their treatment are either lucky (depending on their postcode), or extremely persistent and articulate, or helped by an advocate. Once a patient has been assessed by a provider and treatment is recommended, there may then be delays obtaining funding for treatment. This is wrong, because the guidelines direct that in such cases, the CCG concerned cannot then require the patient to switch to its own provider for treatment. Although the NHS Improvement guidance on this does appear clear, the message is still not getting through to CCGs. My own trust has hundreds of outstanding requests for authorisation of GP referrals for assessment or treatment (not just for our department). Much time is wasted by the trust and by patient advocates in chasing CCGs, and patients experience delays in treatment, resulting in avoidable distress to patients and their families. If these same patients were suffering a physical health problem and required out-patient treatment, no authorisation for funding would have to be made: an invoice for activity would just be presented at the end of a treatment episode. Funding should only be refused if the treatment is not clinically appropriate (and not, for example, because the applicant should be treated in the local care pathway), and any such process should not unduly delay assessment or treatment. GPs and patients can complain directly to the regulator at NHS Improvement (<https://improvement.nhs.uk/contact-us/>) if they feel they are being denied their rights.

Conclusions

Some patients want to be able to choose their treatment provider for out-patient treatment. This will mainly affect more 'specialist' services such as anxiety disorders, chronic fatigue and ADHD, where a local service may be less well developed. They have a legal framework and guidelines from the regulator to support them. However, more than 4 years after the system was introduced, it is not working effectively to deliver the care intended.

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1.5.7 The alignment of law, practice and need in suicide prevention

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Abstract

Help-seeking is important for patients with suicidal ideation. Currently, a risk management paradigm is used with patients who express suicidality; however, this may limit support and increase stigma, reducing future help-seeking. Coping planning is proposed as a paradigm shift that overcomes these problems by focusing on patient needs and strengths.

Declaration of interest

None.

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- *The alignment of law, practice and need in suicide prevention*

There has been a plethora of research related to help-seeking and mental illness; for example, a Google Scholar search for 'help-seeking and mental health' provided 2.17 million results. Perhaps this is not surprising in light of the considerable efforts that have been undertaken to raise awareness of mental illness and promote help-seeking. But an important question is: why would someone with a mental illness seek professional assistance to begin with, and what is the need

when he/she asks for help? Although help-seeking is an important first step in accessing all treatment, here we will focus on help-seeking from the perspective of the patient disclosing suicidality.

Suicidal ideation can be seen as a coping strategy, occurring when the person has inadequate healthy and other unhealthy strategies to cope and starts to wonder whether suicide is a solution for his/her distress.^{1,2} Disclosing suicidal ideation – rather than acting on it or ruminating about it – is a healthy coping strategy. The main message that a person who is confiding suicidality is saying is, ‘I’m having trouble coping right now. I need you to help me.’ Seen in this way, the need from help-seeking is immediate support. The disclosure comes with trust that the confidante can and will help, providing minimally-sufficient support – that supports coping, but does not undermine a person’s strengths and autonomy – until the person can cope independently again.³

However, this message is not always what the health professional may hear, or is trained to hear. Rather, what may be interpreted instead when a person discloses suicidality is, ‘I am at risk of harming myself – now that I have disclosed this risk, you are responsible to stop that from happening.’ Managing this risk is the dominant paradigm in responding to suicidality.^{4,5} Its focus is on ensuring the patient’s safety and preventing death. A risk perspective reflects a society that is motivated by a commonality of anxiety about the future, rather than a commonality of need in the present.⁴ Legally, this is reflected in mental health acts, which allow the detention of people who are judged to be at risk of harm to themselves, including suicide. The risk-focused response of the clinician, then, is to assess symptoms and manage or mitigate risk, which includes assessment of suicidal thoughts and other risk factors and safety planning (e.g.⁶⁻⁸). Within an emergency department setting, disclosure of suicidal ideation is met with a triage system that prioritises externalising behaviours and the severity of suicidality to determine the risk of harm and the urgency of treatment.⁹ Assessment of risk relates to the potential for harm without treatment, not the needs for support. Thus, the law and clinical practice are aligned.

In this common scenario, however, the needs of the patient, as expressed through seeking help and disclosure, have been neglected. Moreover, a risk management approach to assessing suicide risk actively harms the patient through stigma. Stigma is a mark of disgrace – one that reduces a person in their social status to being tainted and now shamed by society – such as through presumed dangerousness or contagion of disease.¹⁰ Stigma affects people with mental illness broadly, including those with suicidality; for example, people who have attempted suicide describe experiencing a range of stigmas, including being seen as contagious, attention-seeking ‘drama queens’, manipulative, incompetent, weak, dangerous and hopeless.¹¹ By responding to a disclosure of suicidality with an assessment of an individual’s dangerousness to himself/herself and considering coercive and isolative treatment, professionals who use the risk management approach are making efforts to keep the individual safe. However, in so doing they risk begetting or promoting these stigmas, as setting these individuals apart from others implies social unacceptability. Consistent with this concern, people who have attempted suicide in the past describe being stigmatised by health professionals. By reacting to disclosures using a risk management approach, health professionals were seen to lack empathy for and dismiss their distress, and instead overreact to the potential for danger.¹¹ Not surprisingly, these individuals describe feeling mistrusted and full of shame after disclosing suicide, and are often motivated to hide any future suicidality from professionals.¹¹⁻¹² Thus, patients who disclose and feel stigmatised through being dismissed, labelled as hopeless or considered dangerous may be likely to conceal future suicidality.

Clinicians in all professions often report feeling ill-prepared to work with people who are experiencing suicidality (e.g.¹³). The cause of this anxiety and fear may be the futility of the task – risk and protective factors that clinicians have long based their assessments on have been shown to be poor predictors of death by suicide.¹⁴ Additionally, risk is only associated with the probability of negative outcomes and with assigning blame,¹⁵ which creates additional fear in many clinicians. Through the concept of ‘otherness,’ that is, conceptualising another person as substantially different from the self,¹⁶ the risk approach also discourages clinicians who may be feeling distressed or suicidal from seeking help, as doing so might mean that they are seen as no longer capable of being the professional. Thus, the risk management approach has the potential to harm the clinician as well as the patient.

It is time to make a change to how we approach suicidality. An alternative paradigm that has been proposed is coping planning.¹ This is a paradigm shift from a future-focused, risk approach to a present-focused, needs approach. Coping is a universal human behaviour. Feeling suicidal ideation is a normal human coping strategy to overwhelming distress. Rather than trying to determine the incalculable risk of a single endpoint (suicide), coping planning focuses the clinician’s attention on the needs of the patient (i.e., helping them cope with their distress). This involves: (1) caring; (2) collaborating; and (3) connecting.³ The first step involves just listening and attending to the person’s distress. The sec-

ond step is to collaboratively identify the person's existing coping strategies and help them strengthen their coping plan by including additional strategies or professional support. The final step is connecting the person with higher intensity support, if needed. The needs assessment could show that the patient has: (1) low needs, being able to cope independently after talking about their problems; (2) moderate needs for additional professional support that may include having *ad hoc* supports in their coping plan, such as telephone helplines or their general practitioner; or (3) high needs, requiring immediate more intensive supports.¹ The triage system for suicidality cannot be based on the same criteria as physical illnesses.¹⁷ The response received at disclosure can affect the progression of the distress. Attending to distress at this point needs to be a priority to meet the needs of patients presenting for problems with coping to prevent subsequent harm.

Responding to disclosures of suicidality with coping planning has real potential to overcome some of the stigmas towards people who experience suicidality. Coping is a universal experience, including for those who experience suicidality.¹ Attending to distress, rather than moving to the practitioner task of risk assessment, can be a minimally sufficient intervention for many people.³ Unlike assessments of risk for danger and the potential need for coercive treatment, viewing disclosure of suicidality as an invitation to support a patient sends a socially inclusive message that the person is capable and cared about, and that they should not feel ashamed. With the focus on caring, listening and supporting, and away from assessment of future danger, there is the potential for professionals to feel competent, rather than ill-equipped and fearful. Moreover, collaborating with the patient using the coping planning approach eliminates the 'otherness' that is endemic to risk management, which may also improve the help-seeking of the helpers when needed.¹⁸

In summary, although current practices align with the risk assessment and management work of mental health acts, neither meet the needs of patients. Practice needs to focus on meeting the needs of patients when they disclose distress to promote help-seeking and prevent stigma and suicide. Consistent with our current health practices that aim to be patient-centred, coping planning provides a strengths-focused framework to respond to patients in distress who are seeking professional support. Mental health legislation needs updating to reflect current knowledge about risk and to place patient needs at their core.

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1.5.8 Known but unpredictable – an argument for complexity

Martin Plöderl Clemens Fartacek

date

2018-4

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- *Known but unpredictable – an argument for complexity*

Since the seminal paper of Pokorny in 1983,¹ the prediction of suicides has not improved, as Large *et al* have pointed out in their current paper² and in previous meta-analyses.³⁻⁷ In opposition to most current recommendations in suicide prevention, which still require clinicians to formulate levels of suicide risk,⁸ Large *et al*² suggest that clinicians should

give up risk formulation and instead focus directly on the individual needs of patients to deliver optimal care. They argue that uncertainty in the prediction of suicide is largely aleatory (dependent on random processes) and also epistemic (lacking knowledge). We think that one important explanation is missing: complexity.

Complexity refers to behaviours produced by nonlinear dynamic systems, which cannot be predicted in the long term, even if the generating system operates completely deterministically and is known in detail. The most prominent type of complex dynamics is deterministic chaos, which became familiar as the ‘butterfly effect’. During chaotic dynamics, even the smallest differences in initial conditions lead to a massive divergence of trajectories over time. Owing to complex behaviours such as chaos, from a nonlinear dynamical perspective, the failure of long-term predictions of suicidal behaviour could be a consequence not only of incomplete epistemic knowledge (e.g. unspecific or unknown risk factors) or aleatory processes (random noise), but also of the inherent complexity of the underlying system.

Are there any alternatives for predicting suicidal behaviour from a nonlinear dynamical perspective? Natural sciences (e.g. geophysics) have developed methods for the short-term prediction of extreme events (e.g. tsunamis), based on continuous monitoring of appropriate signals and identification of nonlinear dynamical precursors.⁹¹⁰ This might be a promising approach for suicide research as well. Given the recent improvements of scientific methods, an empirical application of complexity theory in suicide research seems realistic.¹¹¹² However, it still has to be demonstrated that such novel approaches are feasible in clinical practice and that they can in fact improve the prediction of suicides.

We believe that suicidology needs to take complexity theory into consideration. If not, much time, effort and money will continue to go into approaches that, from the viewpoint of complexity theory, lead to a dead end. This includes the search for novel risk factors or combinations of risk factors (e.g. by applying machine learning) without acknowledging the underlying complex processes.

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1.5.9 Against the Stream: Generalised anxiety disorder (GAD) – a redundant diagnosis

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date

2018-4

Abstract

The diagnosis of generalised anxiety disorder is a distraction of no value. It is highly unreliable, co-occurring with many other disorders of firmer diagnostic status, and has intrinsic connections to personality dysfunction. It is argued that classification would be heartily relieved to rid itself of this unnecessary appendage and for the symptom of anxiety to remain as a descriptive term only.

Declaration of interest

None.

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Generalised anxiety disorder (GAD) describes an excessive and disproportionate anxiety or worry about minor matters that would not trouble most people. In addition to mental tension, consequent muscle pain and inability to relax, people with GAD almost always have bodily symptoms such as shaking, nausea, tingling sensations, a variety of gastrointestinal symptoms covering the full extremity from mouth to anus, sweating, palpitations, breathlessness and other respiratory symptoms. It is a recurrent disorder and often lasts for many years. This is an easily recognisable syndrome that is found to be one of the most common in population epidemiological surveys.

So why do I suggest that the letters GAD would better stand for godawful diagnosis? It is because all the characteristics that make a diagnosis useful in psychiatry – clear and reliable presenting symptoms, predictable outcome and treatment response – are lacking. Each of the components of the diagnosis has been systematically stripped away, leaving an ill-defined core of excessive worry only, which makes the diagnosis so grossly comorbid as to be useless. Let us take each of these elements in turn.

Excessive and disproportionate anxiety

If there is sudden and dramatic anxiety occurring without obvious reason, particularly when accompanied by bodily symptoms such as palpitations and shortness of breath, the condition is described as panic disorder. There is no difference between the symptoms of panic disorder and GAD; only their speed of onset separates them. Panic disorder is like an overpowered car that can go from zero to 60 mph in 5 s, while GAD is like a reconditioned Morris Minor that takes at least a minute to get to 60 mph and then groans with it and about it, for years. The removal of panic makes GAD into worry only.

Bodily symptoms

Mid-gastrointestinal – irritable bowel syndrome

Irritable bowel syndrome is now so well known that even the general public refer to it as IBS. Most people with IBS are anxious¹ and often have other bodily symptoms of anxiety, but these are subjugated to the gastrointestinal ones. There are now a number of specific and effective treatments for IBS that either ignore the generalised anxiety components or describe them in terms that are specific to the organ system concerned.

Muscular pain and tension – fibromyalgia

Fibromyalgia is a complex word, but pain and tension are the most prominent symptoms. There are many who doubt the value of this diagnosis, but few can deny that it has taken two important symptoms away from GAD.

Other bodily symptoms – somatic symptom and somatoform disorders

There are many other bodily symptoms that have been given formal titles in general medicine – non-cardiac chest pain, respiratory distress syndrome, functional dysphagia – but they all are selective in picking out one of the symptoms of GAD and ignoring the others. Somatoform disorders are ripe for justified criticism,² but they are overshadowed by a proto-diagnosis that is not liked for its aetiological nihilism, ‘medically unexplained symptoms’; it gets a great deal of interest and attention, especially in primary care, again taking a chunk away from the GAD superstructure.

Worry about health matters

People with the symptoms of GAD whose main symptom is worry about their health are now diagnosed with illness anxiety (in the USA) or health anxiety (outside the USA), but as these describe the same condition we should not get too concerned. In health anxiety, minor worries about health are amplified into a full anxiety syndrome that includes all the symptoms of GAD. One of the core parts of treatment is for the patient to learn to appreciate that these ‘minor matters’ should remain minor, so chipping away at another GAD limb.³

Recurrent disorder that may be lifelong

Anxiety is a personality trait as well as a symptom, and it has been appreciated for many years that anxious or avoidant personality features are very common in people with GAD. ‘I’ve always been a worrier’ and ‘I come from an anxious family’ are very common spontaneous comments made by patients at assessment. So, when patients with GAD construct a life chart of their anxiety, it is easy to identify a range of outcomes from one episode only to dozens of clear-cut episodes over time, with many others that may not reach the threshold for GAD. The patient often does not make much of this diagnostic distinction, as the handicap created by the symptoms at different times is very similar. But it makes prognosis extremely difficult to determine.

There is so much overlap between personality status and GAD that a strong case can be made for a condition called the ‘general neurotic syndrome’ (or the ‘general nervous syndrome’ for those who abhor the word ‘neurotic’), in which certain personality features such as obsessiveness and dependence, as well as anxiousness, contribute to the biaxial diagnosis.⁴

Mixed anxiety–depression (cothymia)

“‘The study of anxiety and depressionTeaches us one important lessonThough their separate study often pleasesWe must remember they are not diseasesLike wind and rain in stormy weatherThese symptoms always come together’5”

This is the real cruncher that fells GAD completely. Nosologists have tried desperately for years to keep anxiety and depression apart, insisting that they are distant relatives, not siblings, but the family bonds are too strong and the two always hover together threateningly at diagnostic gatherings. The analogy is appropriate, as the genetic evidence has shown repeatedly that anxiety and depression have a common genetic structure⁶ and so should be thought of together, despite the obvious differences in symptomatology.

Despite the valiant efforts of David Goldberg⁷ and several others, there has been great reluctance to accept mixed anxiety–depression as a full syndromal diagnosis in either the DSM or ICD classifications. If this was agreed, and it is becoming increasingly likely this will happen, the separate diagnosis of GAD would be weakened severely.

Unreliability of diagnosis

Some of these criticisms could be overcome if clinicians were pleased with the criteria for the diagnosis and used them consistently. But they do not. In the recent field trials of DSM-5, the interrater reliability of GAD was 0.20,⁸ which the authors regard as ‘questionable’, but which most clinicians would regard as unacceptable.

Replacement of GAD

If we abandoned GAD, what would replace it? There are three possibilities here. The first is to elevate mixed anxiety–depression to a more robust diagnosis instead of an apologetic afterthought. But of course, some would argue correctly that generalised anxiety can occur in the absence of depression. The second is to be really bold and join up the common personality characteristics of anxiety, dependence and obsessionality with the mood disturbance to constitute a ‘general neurotic syndrome’. This is a condition, usually combined with depression, that runs a chronic course and has a worse long-term outcome than either anxiety or depressive disorder alone,⁴ especially when the personality disorder is more severe.⁹ The third option is to think of GAD as an adjustment disorder.

Adjustment disorder

Many people receive a diagnosis of GAD when they are somewhat anxiety prone and then experience a major life event, especially one that is perceived as threatening. Although for many years adjustment disorder had been thought of as a subsyndromal diagnosis, and as a consequence largely ignored,¹⁰ it is now being examined more seriously as an important and measurable element of the trauma-focused disorders.¹¹ The importance of this in clinical practice is that these life event-precipitated forms of GAD could be treated by relatively brief psychological therapies and be less likely to lead to long-term iatrogenic disease.

Conclusions

The old concept of ‘anxiety neurosis’ has gone and been replaced by a host of different labels. In the course of this process, the original core of free-floating anxiety coming from out of the blue and surrounding each patient with a mist of uncertainty and threat has become redundant. It is persistently comorbid with other conditions and has no central elements that deserve separate classification. It should be quietly laid to rest and little mourned.

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1.5.10 A review and update of the Health of the Nation Outcome Scales (HoNOS)

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Abstract

Aims and method

The Health of the Nation Outcome Scales (HoNOS) and its older adults' version (HoNOS 65+) have been used widely for 20 years, but their glossaries have not been revised to reflect clinicians' experiences or changes in service delivery. The Royal College of Psychiatrists convened an international advisory board, with UK, Australian and New Zealand expertise, to identify desirable amendments. The aim was to improve rater experience by removing ambiguity and inconsistency in the glossary rather than more radical revision.

Results

Changes proposed to the HoNOS are reported. HoNOS 65+ changes will be reported separately. Based on the views and experience of the countries involved, a series of amendments were identified.

Clinical implications

While effective clinician training remains critically important, these revisions aim to improve intra- and interrater reliability and improve validity. Next steps will depend on feedback from HoNOS users. Reliability and validity testing will depend on funding.

Declaration of interest

None.

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- *A review and update of the Health of the Nation Outcome Scales (HoNOS)*
 - *Method*
 - *Results*

– Discussion

- * *Overarching HoNOS rating guidelines*
- * *Other issues*
- * *Implications*

The Health of the Nation Outcome Scales (HoNOS)¹ is a 12-scale clinician-rated measure developed by the Royal College of Psychiatrists to guide everyday clinical practice and measure health and social care outcomes in secondary care mental health services for working-age adults (18–65 years). The HoNOS was designed to: (1) be short and simple for routine use and acceptable to a range of mental health professionals (2) have adequate coverage of clinical and social functions (3) be sensitive to improvement, deterioration or lack of change over time (4) have demonstrable and acceptable reliability (5) have a known relationship with more established scales.² Over its 20-year lifespan, the HoNOS has demonstrated adequate reliability, validity, clinical utility^{2,3} and sensitivity to change.^{4,5} Subsequent to its development, a family of related measures have been developed for different age groups and clinical populations.^{6–8} The HoNOS has been translated into at least 12 other languages and is routinely used in clinical practice and research around the world. England, Australia and New Zealand, have also mandated the HoNOS for routine monitoring and outcome measurement across their mental health services at a national level.^{9–12}

Although the basic soundness of the instrument is recognised, two decades of training, routine use and analysis of the resultant data, together with substantial advances in psychiatry and mental health services, have shown that updates to the supporting documentation are required to improve use of the HoNOS.^{3,4,13} As copyright holder for the HoNOS family of measures, the Royal College of Psychiatrists elected to undertake a limited review (rather than a full redevelopment and revalidation) that aimed to use expert opinion to improve the utility of the HoNOS in contemporary mental healthcare, while remaining true to its original aims and maintaining comparability with existing HoNOS data-sets. This paper outlines the review process, its scope, the issues identified and the set of revised scales.

Method

In recognition of each country's mandated use of HoNOS at a national level,^{9–12} and to ensure their interests were incorporated, an advisory board (chaired by the Royal College of Psychiatrists' national HoNOS advisor) was drawn from representatives from England, Australia and New Zealand. Nominations from the respective national governments were made, with members being required to have extensive experience in either: HoNOS staff training; using HoNOS in practice; using HoNOS data at a macro level; or providing oversight at service, professional or governmental level.

Advisory board members were asked to use their professional networks to canvas widely for clinicians' opinions regarding aspects of the tool that required refinement. To facilitate this, a standard recording form, covering each scale (as well as the overall rating guidelines) was provided, which, when collated, acted as a review template (*Table 1*). The board also considered the evidence and recommendations previously prepared in the review by Trauer and Buckingham³ commissioned by the Australian Government Department of Health. *Table 1* Summary of issues raised

Scale/Section	Issues recommended for consideration
Overall rating guidelines	• Need additional guidance about incorporating cultural factors into ratings • Improve clarity of the scoring system in relation to clinical significance • Improve clarity regarding what is to be rated (i.e., most severe problem or usual level of difficulty in past 2 weeks) • Clarity about when the scales should be used
Scale 1. Overactive, aggressive, disruptive or agitated behaviour	• Ensure all four behaviours are considered and clarify how many need to be present • Clarify to what extent behaviours here should be related to mental health problems • Provide guidance about how to address relevant cultural factors and context • Consider adding expansive mood as underrepresented by Scale 8
Scale 2. Non-Accidental self-injury	• How to address relevant cultural factors and context • Clarify that this is not an assessment of risk • High-risk thoughts/intentions currently underrated relative to overall severity • Increase consistency of dimensions of risk considered at different levels.
Scale 3. Problem drinking or drug-taking	• Provide clarity on the rating of tobacco use • Clarify how behaviours associated with addiction are rated • Improve clarity of rating for binge drinking and the reference to social norms that can lead to subjective rating • Clarify how ratings should take into consideration people on substitution programmes (e.g. methadone)
Scale 4. Cognitive problems	• Clarify where formal thought disorder and a lack of insight should be rated • Perceived to be a large gap in severity between rating 2 and rating 3 anchor points • Descriptors focus primarily on dementias, not other

cognitive difficulties • Review problems associated with transient versus enduring cognitive impairments within this scale

Scale 5. Physical illness or disability problems • Glossary descriptions reported by many to be unclear and/or unhelpful, especially in comparison with the HoNOS 65+ descriptors

Scale 6. Problems associated with hallucinations and delusions • Clarify where body image disturbance related to eating disorders should be rated • Improve description of ‘odd or eccentric ideas’ • Clarify where ‘lack of insight’ should be rated

Scale 7. Problems with depressed mood • Clarify that this scale is about depressed mood rather than clinical depression, as other symptoms of clinical depression cause confusion in the field • Change examples used to clarify ratings, as these were not found to be helpful in the field (e.g. guilt or self-accusation)

Scale 8. Other mental and behavioural problems • Consider whether any changes could be made that would retain the current features of the scales while addressing the high levels of use of labels A and D in this scale • Relatively poor reliability for this scale • Consider the addition of an option for elated mood, as this is not represented elsewhere in the scales • Clarify whether stress should relate to general life stress or specifically acute stress reaction and post-traumatic stress disorder • Clarify where body image disturbance should be rated

Scale 9. Problems with relationships • Improve clarity about whether clinicians should score worst or usual level of relationship difficulties • Improve glossary examples to better ensure full range of relationship difficulties identified (e.g. destructive or unhelpful relationships, active or passive withdrawal)

Scale 10. Problems with activities of daily living • Improve instructions on how to combine assessment of deficits in basic and complex skills into a single rating • Clarify how clinicians should determine the effects of existing supports • Review and evaluate the perceived disproportionate jump in severity from rating 2 to rating 3

Scale 11. Problems with living conditions, and Scale 12. Problems with occupation and activities • High missing data rates from in-patient settings • Provide additional clarity regarding the use of the 2-week rule for these scales • Review the perceived inconsistencies between the descriptors for the different levels of severity • Provide more formal clarification about how to rate these scales for long-term in-patients and residential settings

Other matters • Review the terms used for patients, staff and carers • Explore the feasibility and desirability of trying to build consistency between the HoNOS and the HoNOS 65+

This review template formed the basis of a scale-by-scale review. Some suggestions for change were more radical than others; hence, the board developed criteria with which to gauge their viability. For a change to be supported, it needed to represent a tangible improvement (e.g. removal of anachronisms or ambiguities, or simplifying the instrument’s use) whilst also: (1) maintaining the original instrument’s integrity as much as possible (2) ensuring that individual and aggregated outputs were likely to remain comparable with existing data (3) supporting HoNOS as a summary of clinical assessment(s) (4) adhering to the HoNOS ‘core rules’ i.e. • each item is a behaviourally anchored 5-point scale • rate items in order (1–12) • use all available information to make a rating • do not include information already rated in an earlier item • rate the most severe problem/worst manifestation from the preceding 2 weeks • a problem is rated according to the degree of distress caused and/or its effects on behaviour • must be rated by a mental health professional trained in clinical assessment • rate problems regardless of cause.

2 Some changes identified had consequences/implications for other items, and hence an iterative process of minuted teleconference and email discussions evolved, between October 2014 and January 2016.

Following review of the HoNOS documentation, a review of HoNOS 65+ was also undertaken through to October 2016. This presented an opportunity to maximise alignment between the two versions of the instrument and yielded a number of additional refinements to both measures.

Results

After working through the issues set out in *Table 1*, and reviewing the HoNOS 65+, the advisory board produced a set of revised HoNOS scales (supplementary Table 1 available at <https://doi.org/10.1192/bjb.2017.17>). Each item’s original wording is also included (in greyed-out boxes) to aid comparison.

Discussion

Overarching HoNOS rating guidelines

Despite the agreed objective of keeping the instrument short and easy to use, based on considerable experience of training and routine clinical use, advisory board members universally agreed that the original rating instructions erred on brevity at the expense of clarity. They also recognised that the frequency, duration and quality of training varies significantly.^{3,14} Therefore, to improve interrater agreement (but not to replace formal training), existing training materials and protocols were reviewed and, in many cases, incorporated.

The first notable augmentation was to legitimise the informal training advice that ratings of 0–1 should be viewed as subclinical, whereas ratings of 2–4 indicate problems of a severity that would normally warrant care/treatment planning and intervention.

Second, the original guidance stipulated that behaviours/problems should be rated regardless of cause (i.e. irrespective of psychiatric disorder) but was silent on the rating of issues deemed normal in an individual's culture/subculture. Issues for which the ratings may be affected by cultural and contextual factors have been previously identified³ and include culturally sanctioned aggression (Scale 1), self-harm associated with religious ceremonies or periods of mourning (Scale 2), paranormal experiences associated with cultural beliefs or events (Scale 6), and the expression of sadness associated with bereavement (Scale 7). None of these are attributable to mental health problems and, if rated, would produce a misleading clinical picture. Therefore, although cultural competence remains a prerequisite to good-quality clinical assessment (and thus accurate ratings), there is now an explicit expectation that an individual's culture should be taken into account. This debate also raised a wider question for the advisory board about how attributable to mental ill health behaviours needed to be before they should be included, an issue that was carried into amendments to several individual scales.

Consideration was given to what terms should be used to describe people who use mental health services, their significant others, and staff. This, in part, reflected moves from the recovery perspective and the mental health consumer movement to minimise the extent to which language used is pathologising and pejorative.¹⁵ Discussion indicated that terminology varied between countries, over time and between groups within countries. Given the lack of consistency, the decision was made to retain the term patient to denote a person who uses mental health services, family for people who are significant others of that person, and staff for people who are paid to provide mental health services.

Scale 1 Overactive or aggressive or disruptive or agitated behaviour

It was recognised that while item 1 has a broader scope than most others, clinicians focus primarily on the aggressive elements of the scale.³ The case for creating a separate item for this aspect alone was judged to be a more fundamental change than the current review's scope could support. Instead, the item description was revised to emphasise the need to consider all four aspects. The issue of culturally sanctioned aggression in the context of ritual was felt to have been addressed in the overarching rating guidance, hence the scale remaining diagnosis-agnostic.

Scale 2 Non-accidental self-injury

Revisions here were intended to provide consistency of examples across the severity ratings (covering risks and thoughts as well as behaviours). Cultural influences (e.g. ritual self-flagellation commonplace in some religions¹⁶) continue to require a culturally competent clinician and reference to the overarching guidance.

Scale 3 Problem drinking or drug-taking

As with Scale 2, changes now provide consistent descriptions of key elements of addictive behaviours, with each level describing aspects of craving, dependency and behaviour that align to contemporary notions of severity (e.g. National Institute for Health and Care Excellence guidance¹⁷). The more subjective aspects of the original scales (e.g. ‘within social norms’ and ‘loss of control’) have been removed, and there is an increased emphasis on the psychological effects of drug and alcohol use. This ensures that, during periods of enforced abstinence (e.g. hospital admissions), the severity of addiction can still be captured.

Finally, the advisory board, while fully acknowledging the harmful effects of tobacco use,¹⁸ agreed to explicitly exclude smoking from this scale – a significant decision that warrants further explanation. First, as per the original text, the physiological consequences of smoking will continue to be captured by Scale 5. Second, the prevalence of smoking in people with mental health conditions is approximately twice the norm,¹⁹ creating a ‘shadowing effect’ that can detract from the scale’s clinical utility. There are, of course, more extreme scenarios where, for example, individuals render themselves vulnerable to exploitation through their attempts to obtain cigarettes. The new guidance therefore excludes dependence on tobacco unless there are severe and adverse consequences above and beyond the known detrimental effects to physical health.

Scale 4 Cognitive problems

Feedback suggested that Scale 4 was too heavily orientated towards dementia and, even then, some of the examples were deemed unhelpful. Revisions were therefore undertaken in two stages. Initially, with reference to other versions of HoNOS,^{8,20} the narrow focus on dementia was broadened to incorporate issues such as formal thought disorder and the ability to learn. Through this process, the reported ‘excessive jump’ between ratings of 2 and 3 was also addressed. Then, in parallel with the HoNOS 65+ review, the descriptions were adjusted further. This led to improved alignment between the HoNOS and HoNOS 65+ cognitive scales, but complete alignment was regarded as too radical a change.

Scale 5 Physical illness or disability problems

No changes to this scale were deemed necessary.

Scale 6 Problems associated with hallucinations and delusions

This scale only required minor linguistic changes.

Scale 7 Problems with depressed mood

The descriptors for ratings 2–4 are now consistent with the scale title (i.e. depressed mood rather than depression), thus removing ambiguity surrounding the inclusion/exclusion of other depressive symptoms. This point has also been reiterated in the scale’s initial bullet points. Training experience has shown that the original descriptors led clinicians to focus heavily on the concept of guilt at the expense of other manifestations of low mood. Consequently, as for Scale 1, a more consistent and balanced description of each severity rating (in this case including loss of interest, guilt and loss of self-esteem) has been created.

Scale 8 Other mental and behavioural problems

The frequency with which anxiety is rated within this scale³·10 has resulted in calls for its promotion to that of a scale in its own right. While this proposal has merit, it was deemed a substantial change and thus out of scope for inclusion in this work. The possibility of rating multiple issues on this scale was also discussed, but would again affect comparability with existing data, contradict the ‘rate the worst’ rule and overly complicate the rating guidance for relatively little benefit. As a result, these two proposals were reserved for a more extensive review should the opportunity arise.

HoNOS trainers reported frequently being asked where elated mood should be rated. There was a suspicion that it was often captured under the ‘other’ option in this scale, or rated by proxy in Scale 1 (although no empirical evidence was available). To improve consistency of rating, it was introduced as a specific option (‘K’) in Scale 8. (N.B. The letter J has not been reused to avoid potential confusion between data-sets collated from the use of the original HoNOS and this revised version).

Based again on training experiences, while options A–I have been retained, each has been supplemented with explanatory text. DSM-521 was the genesis for these additions, but descriptors have been heavily edited to ensure they described presenting needs/problems rather than merely reflecting diagnostic criteria. This clearly challenged the core principle of brevity but was felt to be outweighed by the benefits arising from improved clarity.

Scale 9 Problems with relationships

Changes to this scale were limited to modest rewording of descriptions, again intended to increase clarity.

Scale 10 Problems with activities of daily living

Additional introductory text has been added to reflect common training advice regarding how to ‘manage’ the effects of any existing support the patient is receiving. The considerably more complex and granular approach that might be required to accommodate the occasional problems experienced when rating patients whose complex skills are intact, but whose self-care skills are not, was also considered. The approach used by the tabulated version of the HoNOS 65+22 was suggested as a possible model to accommodate this, but was deemed to represent a substantial change and hence rejected.

Scale 11 Problems with housing and living conditions, and Scale 12 Problems with occupation and activities

The issues and solutions for the final two scales were very similar, and hence their discussion has been combined. First, experience from the field suggested that, without adequate training, Scales 11 and 12 are often used to consider aspects of the patient’s abilities (as in Scale 10) rather than to rate how well their current environment matches their needs in terms of accommodation or occupation and activity. Alternatively, these scales can be misused as global ratings of the quality of accommodation and occupation/activity. Either way, the conceptual complexity causes difficulty in routine use.²³ An additional bullet point now addresses these misconceptions.

Second, in recognition of the rating difficulties that can arise at/around the point of hospital admission and discharge,²⁴ a thorough review of supplementary advice provided in each country was undertaken. The option to vary the 2-week rating period for these scales was considered, but the board was uncomfortable breaching this core rule. Instead, a less radical solution was to highlight that ‘the patient’s usual . . .’ was to be rated and provide clearer guidance about how this should be dealt with in different living situations. Retaining this degree of clinical discretion was deemed both tolerable and more likely to result in clinically meaningful ratings.

Other revisions to these scales were less complex and primarily sought to update some of the terminology used and ensure all terms were acceptable to each participating country.

Other issues

In addition to the changes discussed, the review highlighted further areas for development that may be considered desirable. However, these constitute substantial changes that fall outside the scope of the agreed review. These would require the development of a new instrument but remain an option for future development pending sector agreement, as well as government interest and funding.

Implications

The Council of the Royal College of Psychiatrists considered the proposed changes to the HoNOS set out in this paper at its meeting on the 14 July 2017 and agreed to these recommended changes proposed by the advisory board. In doing so, the Council acknowledged that it is highly desirable that the perceived benefits of the changes be subjected to empirical testing through assessment of interrater reliability and revalidation of the measure in the field. Such testing will require funding and ideally the involvement of those countries that have heavily invested in the HoNOS to date; this is being pursued by members of the advisory board.

It is also acknowledged that there are likely to be issues that will affect the implementation of a revised version in the different jurisdictions involved in the review, as well as in other parts of the mental health community worldwide that have invested in the use of the HoNOS and translations of the original scales. One such effect might be on the programmes of training for clinicians; while the proposed changes are intended to improve the clinician experience of using the scales, they do not obviate the need for training in the use of the scales.

We thank the following members of the advisory board: **Prof. Mike Crawford**, Director of the College Centre for Quality Improvement, Royal College of Psychiatrists; **Adrian Worrell**, Head of Centre for Quality Improvement, Royal College of Psychiatrists; **Dr Clive Bensemam**, Director of the Mental Health & Addictions Healthcare Service Group, Auckland District Health Board, New Zealand; **Dr Arran Culver**, Deputy Director, Mental Health Ministry of Health, New Zealand; **Dr Mark Smith**, Clinical Lead, Te Pou, New Zealand; **Dr Rod McKay**, Chair, National Mental Health Information Development Expert Advisory Panel (NMHIDEAP), Australia; **Mr Tim Coombs**, Australian Mental Health Outcomes and Classification Network (AMHOCN), Australia; **Ms Rosemary Dickson**, AMHOCN and NMHIDEAP Coordinator, Australia; **Allen Morris-Yates**, Director of the Centralised Data Management Service, Australia.

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Supplementary material is available online at <https://doi.org/10.1192/bjb.2017.17>.

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1.5.11 The prevalence of constant supportive observations in high, medium and low secure services

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Abstract

Aims and method

We explored the prevalence and use of constant supportive observations (CSO) in high, medium and low secure in-patient services in a single National Health Service (NHS) mental health trust. From clinical records, we extracted data on the length of time of CSO, the reason for the initiation of CSO and associated adverse incidents for all individuals who were placed on CSO between July 2013 and June 2014.

Results

A small number of individuals accounted for a disproportionately large proportion of CSO hours in each setting. Adverse incident rates were higher on CSO than when not on CSO. There was considerable variation between different settings in terms of CSO use and the reasons for commencing CSO.

Clinical implications

The study describes the prevalence and nature of CSO in secure forensic mental health services and the associated organisational costs. The marked variation in CSO use between settings suggests that mental health services continue to face challenges in balancing risk management with minimising restrictive interventions.

Declaration of interest

A.B. and J.L.I. are both directly employed by the NHS trust in which the study was conducted.

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 - * *Prevalence of constant observations*
 - * *Distribution of CSO hours across patients*
 - * *Reason for commencing CSO*
 - * *Adverse incidents*

* *Organisational costs of observations*

– *Discussion*

Supportive observations involve the increased monitoring of mental health in-patients who are at an increased risk of harming themselves, harming others or absconding.¹ The practice involves clinical staff being assigned to an unsettled patient to engage with them therapeutically² and monitor their well-being.³ The National Institute for Health and Care Excellence (NICE) guidance on the short-term management of violent behaviour in in-patient settings⁴ outlines four distinct levels of observations, with the highest two levels (3 and 4) involving constant observation of the patient. Observations may also vary in terms of the number of staff assigned to conduct them – constant supportive observations (CSO) are commonly conducted on a one-to-one basis, but in more extreme cases multiple staff may be assigned to observations of the same patient (the most recent NICE guideline on the management of aggression has formalised observations involving multiple staff as a distinct category⁵).

Observations are the recommended approach for managing individuals deemed to be at risk,⁶ reflecting the competing demands of a mental health service – the provision of compassionate care while managing risk – but the rationale and efficacy of CSO is debated in the literature.⁷⁻⁹ However, there are no reports of the prevalence of supportive observations in mental health services, and so the extent to which supportive observations are being utilised in mental health services, and in what context, is unclear. This research therefore explored the prevalence and nature of CSO in a single National Health Service (NHS) mental health trust, comparing data from high, medium and low secure forensic mental health services within that trust.

Method

The data were gathered from a single NHS mental health trust in England for the 12-month period between 1 July 2013 and 30 June 2014. The secure division within this trust comprises a high secure service (HSS; 228 male in-patient beds), a medium secure unit (MSU; 58 male in-patient beds and eight female in-patient beds) and a low secure unit (LSU; 32 male in-patient beds). During the period of study, the mean daily occupancy levels were at 84% of capacity for high secure, 88% for male medium secure, 93% for female medium secure and 90% for low secure (not including beds assigned to patients on trial leave).

From clinical records, we identified all individuals who were resident on 1 July 2013 or admitted between 1 July 2013 and 30 June 2014 in each service. The clinical information for each individual was manually searched, and we extracted and collated data on all episodes of level 3 or 4 observations that took place within the review period. For each episode, the data recorded were: the level of observations (level 3 or 4), the start and end time/date of each episode of observation, the number of staff involved in each episode, and the reason for initiation of the episode. An episode of CSO was only recorded when there was a defined start and stop time recorded in clinical notes. Thus, where the CSO arrangement was flexible dependent on circumstances (e.g. level 2 in communal areas but level 3 when in their bedroom) and no start/stop time was recorded in the notes for the changing levels of CSO, it was not possible to record the data for those episodes. Data on all adverse incidents involving the individuals on CSO were collated and manually searched to establish the number of incidents that occurred while that individual was on CSO and not on CSO.

Results

During the review period, 239 individuals were resident in the HSS at different periods and 56 of these were placed on CSO at some stage during the year. In the female MSU ward, nine different individuals were resident during the year and eight of these were placed on CSO. There were 84 individual residents during the year on the male MSU wards, with 31 of these being placed on CSO. Eighteen of the 38 residents in the LSU during the year were placed on CSO. There were only a very small number of episodes of level 4 observations across the data-set (seven episodes in HSS, two episodes in MSU, and four episodes in LSU) and so for the purposes of analysis, these were combined with the level 3 episodes. A summary of the data extracted for each unit is shown in *Table 1*. Table 1

	Low secure	Medium secure	High secure	Total
Prevalence of constant supportive observations	18 (38)	31 (84)	8 (9)	56 (239)
No. of patients on CSO (no. of patients resident during the period)	18	31	8	56
Total patient hours spent on CSO	454	1862	272	6697

CSO14 96015 77014 02541 192 Total staff hours spent on CSO16 53718 66216 46847 628 Patient hours per 100
 OBD143.1084.67514.4959.03 Staff hours per 100 OBD158.18100.19604.1168.26 Estimated cost per 100 OBD, £
 (estimated total cost for unit, £) a3734 (390 370) 1811 (337 269) 10 802 (294 471) 1221 (851 636) Reasons for initiating
 CSO, % staff hours Aggression 47
 Self-harm 14
 Deterioration 0
 Env. change 2
 Other 37 Aggression 45
 Self-harm 34
 Deterioration 6
 Env. change 14
 Other 1 Aggression 8
 Self-harm 88
 Deterioration 1
 Env. change 3
 Other 0 Aggression 8
 Self-harm 52
 Deterioration 18
 Env. change 21
 Other¹²

Prevalence of constant observations

Across the secure division, patients were placed on CSO for a total of 85 947 h in the 12-month period of study. *Table 1* shows the prevalence of CSO in the three different units, both in terms of the number of hours that patients spent on CSO and the number of staff hours devoted to CSO. To allow comparison between units, occupied bed days (OBD; the sum of the daily number of occupied beds for the entire period) was used as the common denominator. *Table 1* shows the total number of hours of CSO per 100 OBD in each unit. The HSS recorded the lowest CSO levels (59 h per 100 OBD), while the highest level of CSO was in the female MSU (514 h per 100 OBD). Staff hours devoted to CSO were consistently higher than patient hours, owing to episodes of 2:1 or 3:1 observation, and the magnitude of increase in staff hours varied between 10 and 18% of patient hours (low secure: 10% higher; male medium secure: 18% higher; female medium secure: 17% higher; high secure: 15% higher).

Distribution of CSO hours across patients

CSO was not evenly distributed across the in-patient population; in all units, a small number of individuals accounted for a substantial proportion of staff time on CSO. In the HSS, five out of 56 individuals on CSO accounted for 54% of all CSO hours in the unit (one individual was on CSO for the entire 12-month period). On the female MSU ward, two out of eight individuals on CSO accounted for 57% of the CSO hours, while on the male MSU wards, four out of 31 individuals on CSO accounted for 56% of the CSO hours. Similarly, in the LSU, two out of 18 individuals accounted for 46% of the CSO hours.

¹ OBD, occupied bed days; CSO, constant supportive observations; Env. change, environment change.

² Estimates based on one-third of CSO conducted by staff in band 5, two-thirds conducted by staff in band 3.

Reason for commencing CSO

To aggregate the reasons for commencing CSO, the circumstance of each episode of CSO was extracted from clinical notes and placed in one of five categories. Reasons were categorised as ‘Aggression’ if the individual was placed on CSO because of an act of aggression (including violence) or threats of aggression, including verbal abuse. ‘Self-harm’ included actual self-harm as well as threatened self-harm and requests from the individual for extra support because they feared harming themselves in the near future. CSO was categorised as ‘Deterioration’ when individuals were placed on CSO because of a general agitation or deterioration in mental state that warranted additional support for them. CSO was categorised as ‘Environment Change’ when a specific change in environment preceded CSO and was the main reason for it, e.g. new admission, termination of a period of seclusion, ward change. CSO was categorised as ‘Other’ when there was a specific reason for placing an individual on CSO that did not fit the other categories, e.g. for safeguarding purposes in a situation where there was a high likelihood of exploitation, or for physical health purposes when an individual had recently returned from hospital after an operation and required support.

The proportion of staff hours devoted to CSO in each of the different categories in each unit is shown in *Table 1*, where it can be seen that the reasons for initiation of CSO varied between services. In HSS and the female MSU, self-harm (actual or risk of) was the main reason for CSO, while aggression was not often a reason to initiate CSO. In both the male MSU and the LSU, however, aggression was the predominant reason for initiating CSO. CSO to provide support in self-harm was also a frequent motive in the male MSU, while a large proportion of CSO hours were devoted to a specific other reason in the LSU. Further exploration of the LSU reasons indicated that a single individual was placed on CSO for a 6-month period for safeguarding reasons, leading to the unusually high proportion of CSO hours in the ‘other’ category.

Adverse incidents

To examine the effect of CSO on adverse incidents, we extracted data on the date/time of each incident and the incident category for every incident involving any individual on CSO during the period of study. By examining the date/time and circumstances of the incident, it was possible to categorise each incident as having occurred while the individual was either on CSO or not on CSO. Using data on the number of hours that all individuals spent on CSO within a unit, and also the number of hours for those same individuals during the 12-month period that were not spent on CSO, we computed the incident rates relative to a common denominator (per 100 h on CSO and not on CSO) to enable comparisons between incident rates.

Incidents are categorised in terms of nature and severity into four categories, A–D. Category A incidents are very serious incidents that may involve a death, serious sexual assault or hostage-taking. No individuals on CSO during the period of study were involved in any category A incidents. Examples of category B incidents include attempted hostage-taking, serious assault and attempted suicide; typical category C incidents may involve assault, moderate self-harm and threats; and examples of Category D incidents may include verbal abuse, minor self-harm and property damage. *Table 2* shows the number of adverse incidents (in each category) per 100 h of residence while those individuals were on CSO and not on CSO. *Table 2* Adverse incidents in each category and in total for each unit for patients involved in constant supportive observations (CSO) Incidents while on CSO Incidents while not on CSO

Category	Unit	BCD	Total	BCD	Total
Low secure	0.010.050.350.410.010.020.160.20	0.010.050.350.410.010.020.160.20	0.010.050.350.410.010.020.160.20	0.010.050.350.410.010.020.160.20	0.010.050.350.410.010.020.160.20
Medium secure – male	0.020.080.180.270.010.030.070.10	0.020.080.180.270.010.030.070.10	0.020.080.180.270.010.030.070.10	0.020.080.180.270.010.030.070.10	0.020.080.180.270.010.030.070.10
Medium secure – Female	0.010.070.530.610.000.040.120.16	0.010.070.530.610.000.040.120.16	0.010.070.530.610.000.040.120.16	0.010.070.530.610.000.040.120.16	0.010.070.530.610.000.040.120.16
High secure	0.00.430.621.060.010.120.220.35	0.00.430.621.060.010.120.220.35	0.00.430.621.060.010.120.220.35	0.00.430.621.060.010.120.220.35	0.00.430.621.060.010.120.220.35
High secure (without atypical patient)	b0.010.210.360.58 ³⁴				

³ Incidents are presented per 100 h of residence.

⁴

Atypical patient was on CSO for the entire 12-month period. Category B: serious incident (e.g. attempted hostage taking, serious assault, attempted suicide); category C: less serious incident (e.g. assault, moderate self-harm, threats); category D: minor incident (e.g. verbal abuse, minor self-harm, property damage).

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In all units, figures indicate that adverse incidents were more common for individuals on CSO than when those same individuals were not on CSO, with the highest overall incident rate for patients on CSO in the HSS (1.06 incidents per 100 h). Further examination of the records from HSS revealed that one individual was responsible for 251 incidents while on observations; because he was on CSO for the entire 12-month period, there were no instances of incidents while not on observations. When this atypical individual was removed from the incident figures, the incident rate for HSS patients while on CSO reduced to 0.58 incidents per 100 h.

The data in *Table 2* indicate that across all units, individuals were at least twice as likely to engage in an incident while on CSO compared with when they were not on CSO, and, in the case of the female MSU ward, almost four times as likely. Closer examination of the figures revealed that this was driven largely by an increase in category D incidents when on CSO.

Organisational costs of observations

The exact cost to the organisation of conducting CSO depends on the hourly rate of pay for the staff that conduct the observations. The identity of the staff who contributed to conducting each episode of CSO was not available in the clinical notes, and so the true costs could not be calculated. However, we estimated staff costs by using the 2013/2014 hourly rates for NHS band 3 (£16.07) and band 5 (£21.51), based on the informal estimate from hospital managers that one-third of CSO was carried out by clinical staff in band 5 and two-thirds by clinical staff in band 3. On this basis, we estimated the cost of CSO to be £851 636 for the HSS, £631 740 for the MSU and £390 370 for the LSU, noting that the female ward accounted for 47% of the total cost of CSO in the MSU (£294 471 for the female ward). When OBD is used as a common denominator, the relative costs of CSO in each service may be compared; the estimated figures in *Table 1* show that the cost of CSO in the HSS was £1221 per 100 OBD, compared with £10 802 in the female MSU.

Discussion

This paper represents the first published study of the prevalence of supportive observations in a UK mental health trust, reporting data from low, medium and high secure services.

In the literature, the organisational cost of observations is reported to be high. One economic analysis in 2008 estimated the annual cost of observations to the NHS at £80 m¹⁰ with £35 m spent on providing CSO. In the present dataset, our findings estimate that the cost to the organisation of constant observations alone was £1.8 m in 2013–14. Estimates suggest that between 3 and 20% of people admitted into mental health services will be subject to some form of intensive observation, and that up to 20% of the nursing budget for a hospital may be used in the provision of constant observations.⁷ In the current economic climate, where cost, value and effectiveness are increasingly important, it is appropriate to consider the use of finite staffing resources. Although constant observations remain fundamental to mental health nursing care, some researchers question the efficacy of the practice,⁸ particularly against the more contemporary background of reducing restrictive practices in mental healthcare, and clinical decisions on the issue of CSO remain a policy matter for individual mental health trusts.

A small number of individuals in each unit accounted for a disproportionately large amount of the time devoted to conducting CSO and thus a large proportion of the CSO costs to the organisation. In the MSU, for example, two patients out of 93 individuals who were resident on that unit accounted for 27% of the total CSO hours in the whole unit. Similarly, in the HSS, two patients out of the 239 individuals who were resident that year accounted for 31% of the CSO hours in that unit. In secure mental health services, it is not unusual for some patients to have high dependency needs, and assessing the balance between pro-active and defensive approaches to managing risk can be a challenge. As a result, some patients are subjected to constant observations for sustained periods of time; as all mental health trusts are motivated to employ the least restrictive interventions while maintaining safety, this is a difficult balance to strike, with some trusts potentially erring on the side of caution.

¹⁰The Authors own the copyrights to the individual articles.

The finding that patients were involved in adverse incidents more frequently when on observations than when not on observations could reflect closer surveillance of behaviour, but is more likely explained by different baseline presentations in the two contexts. Individuals are more disturbed and unwell when they are on observations than when they are not, and it is unsurprising that individuals engage in more adverse incidents when they are more labile and agitated than when they are stable and settled. What is not known from these data is what specific effect CSO had on adverse incidents; it is probable that had those patients not been on constant observations, the level of adverse incidents in such an unsettled group would have been much higher. One motivation for CSO is to manage risk with patients at risk of harming themselves or others, but assessing the extent to which CSO is successful in doing that can be problematic. One explanation of perpetrators' decisions to engage in aggression involves a calculation of the effect/danger ratio,¹¹ where an individual judges the costs and benefits of using aggression in any given situation, opting to use aggression only when the costs to them in terms of detection and reprimand are limited relative to the potential outcome. As such, less serious forms of challenging behaviour can occur as a result of this cost–benefit analysis, and, for individuals unable to manage their use of challenging behaviour, being on observations could encourage the behaviour least likely to elicit reprimand (e.g. more minor incidents such as verbal abuse and property damage). This may explain why the increase in incidents while on CSO was largely due to an increase in category D incidents, and a rational assumption is that the effect of constant observations may have been to deflect what was a potentially serious situation into a more minor incident.

Across the different units, specific concerns about aggression and self-harm were the reasons for initiating most of the CSO hours, but the balance between these reasons was markedly different in different settings. Aggression was most frequently the reason for constant observations in the male medium and low secure settings, but self-harm was the most prevalent reason for constant observations in the female MSU ward and in the HSS. In fact, nearly all instances of CSO on the female ward were motivated by actual, or risk of, self-harm. The dominance of self-harm as a driver of CSO in this setting may be partly related to diagnosis. The present data-set did not drill down into the specific diagnoses of patients in each unit, but a recent large-scale survey of forensic psychiatric in-patients in The Netherlands¹² found that, while around 75% of both male and female patients were diagnosed with both axis I and axis II disorders, 61% of female patients had a diagnosis of borderline personality disorder (BPD) and a further 21% presented with borderline traits. BPD diagnoses were much less prevalent in the male patients in their sample. A separate and equally valid explanation relates to clinician perception and response. There is recognition in secure psychiatric services that clinicians' responses to aggression frequently differ depending on whether the patient is male or female; aggression by men leads to more discussion by clinicians than aggression by women, and aggression generally is viewed as a male phenomenon in spite of the evidence that women may be equally aggressive.^{13·14} Similarly, the prevalent clinical view is that self-harm is more common in women than men, in spite of more equivocal evidence in the literature.^{15·16} Further exploration of this issue falls outside the scope of the current research, but the present data may support the view that a potential gender bias exists in clinical responses to challenging behaviours.

Although findings from these data should be viewed in the context of a single mental health trust (and a single female ward), they nevertheless present a picture of the prevalence and use of a cornerstone of clinical practice in mental healthcare.

Romi Eden, Leah Greenwood, and Rebecca Ozanne gave invaluable assistance in extracting data from clinical notes.

Katie Lambert, Research Assistant, Mersey Care NHS Foundation Trust; **Simon Chu**, Senior Lecturer in Psychology, University of Central Lancashire and Research Fellow, Ashworth Research Centre, Mersey Care NHS Foundation Trust; **Chris Duffy**, Assistant Psychologist, **Victoria Hartley**, Research Assistant, and **Alison Baker**, Senior Clinical Nurse, all at Mersey Care NHS Foundation Trust; **Jane L. Ireland**, Professor of Forensic Psychology, University of Central Lancashire and Consultant Forensic Psychologist, Mersey Care NHS Foundation Trust.

1.5.12 Profile: André Tomlin

Julia Bland

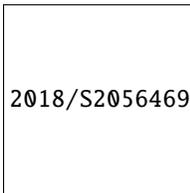
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- *Profile: André Tomlin*

Julia Bland meets André of the Elves, arch communicator and pretension buster, man with a mission: to get healthcare workers better informed so that they can provide higher quality care to patients



The Mental Elf is a charming woodland creature, smiling, intelligent, sensitive, balanced, with no beard, pointy ears, or a cap with a bell on the top.

In fact, he is André Tomlin, 45, information scientist, health blogger, educator, evidence-based practice guru, businessman with a genuine vision of improving the quality of healthcare, and father of three children under 8 years of age. He has over 50 000 followers of his Twitter account, and claims that the twitter community's outrage at Asda for selling mental patient costumes complete with axe and blood for Halloween, led to the removal of the offending items. He sees himself as embedded into an online community of people trying to make sense of their experience (he also has personal experience of anxiety and depression).

If you haven't heard of the National Elf Service (www.nationalelfservice.net), launched in May 2015, you may need an explanation.

This is an online subscription service that provides digests of the latest research in mental health, tailored to your interests, plus a host of interactive opportunities, like webchats, videos, and continuing professional development certificates, all 'gamified' with levels to achieve and gnomish cartoons dancing about. Actually, much less irritating than you might have expected.

Tomlin explained to me the genesis of the National Elf Service. He and his business partner Douglas Badenoch, worked for years at the digital end of evidence-based medicine, believing in the importance of the translation of research into practice, but were frustrated by the unappealing lumpiness of the website delivery vehicles.

They wanted to develop a user-friendly, highly accessible, but accurate and reliable online resource for the time-constrained front-line mental health worker.

Have they done this? And what else do they do? And how does it work as a business versus a piece of philanthropy?

I went to meet André Tomlin with an open mind, but holding a comment from a colleague with a key question: 'He seems to be dominating the social media side of mental health. Why has he become so successful with this and what are his credentials in dictating the agenda?'

The unique selling point of the Mental Elf is the combination of the serious with the playful. The antithesis of pompous. I was convinced of the underlying seriousness, even idealism, of the intentions: 'Accessibility, Usability, Reliability No bias, no misinformation, no spin', with a view to improving standards of mental health provision with a personalised feed of information to the smartphones of mental health professionals, (especially nurses) and of course, some of his subscribers are patients. His anti-silo, deliberate, democratising intention is to open up the debate around

mental health. He thinks that not only should patients and their families be listened to, but also non-health professionals; for example, schools, in relation to child mental health. Social media in the mental health field has a supportive and welcoming rather than aggressive tone, he claims. For example, when the Daily Mirror outed the Everton footballer Aaron Lennon as having been sectioned, there were over a hundred tweets supporting him and criticising the Daily Mirror.

The benign aspect of the Mental Elf is also illustrated by their work with charities like Rethink, Mind, and the Mental Health Foundation. He sees the work as partly public service, running tweet chats offering peer support on topics like suicide and severe mental illness with ‘twitter buddies’, usually clinical psychologists, who can take distressed individuals aside for a private ‘direct message conversation’, and can suggest appropriate action, for example, contacting the crisis team or going to an Accident & Emergency Department.

Of course, this is also a business, and he freely admits that the line between business and altruism is a ‘blurred boundary’. He and Badenoch, another ‘information scientist’, run Minervation (an evidence-based healthcare consultancy) plus the Elves empire. They conveniently believe in ‘coproduction’. As one expert invited to write for the Mental Elf put it bluntly, ‘We don’t get paid. We do the work, and he gets the money.’ Tomlin is frank: ‘Sometimes I help people, sometimes I push people towards my product, and sometimes I just have to do something to make money.’

Minervation, which ‘spun out of the university’ (i.e. the Oxford Centre for Evidence-Based Mental Health), also provides consultancy to big health players: the National Institute for Health and Care Excellence, Cochrane, and Bupa amongst them. They also specialise in building accessible websites for charities and other public sector organisations.

One of his favourite projects was for the General Medical Council. Five years ago, he developed a programme to help general practitioners provide better care for people with learning difficulties. They included a ‘forum theatre’ approach, where a play scenario is set up: a woman with Down’s syndrome and her sister present at Accident & Emergency. She has stopped eating and drinking. As the play evolves, the audience can challenge and participate, ‘why is the doctor talking to her sister and not to her?’. This can then be digitally broadcast and helps promote Mencap’s priority to improve communication by professionals with people with intellectual disabilities.

The Elves are accessed via subscription, and it’s the institutional subscriptions that are most lucrative (over £1000 for a year for group users v. £60 per year for individuals). He has signed up universities including Oxford and Manchester, and Mental Health Trusts such as University College London, hoping to include Kings and in particular, the Masters course at the Institute of Psychiatry, Psychology and Neuroscience soon. Institutions are provided with regular anonymised reports on how their staff are using the Elf system, such as the most popular blogs, the number of reflective practice entries and the research impact.

Subscribers get access to digests of new research with comments on clinical relevance by expert reviewers, connection to other experts via online discussion and journal clubs, and a personalised ‘gamified’ continuing professional development record.

Minervation also run a digital conference service called Beyond the Room, which prepares for, attends, live streams, blogs, and podcasts from your conference for a fee. They see the slides in advance, speak to the speakers, and then do live tweeting and blogging from the conference floor, putting up podcasts afterwards. All this enables a small number physical conference to reach a far larger potential audience.

They used to offer critical appraisal workshops, but have had greater uptake for workshops teaching psychiatrists and others to use twitter and blogs. He believes all this digital output needs to be researched itself with ‘alt metrics’. He fully accepts that numbers of hits don’t reflect quality: 3 years ago, the most popular blog was about dolphin semen, and he wants to improve the capacity of digital sites in ‘meaningful analytics’, which genuinely measure the effect of published articles.

Another Tomlin initiative is a public discussion with experts, every three months, linking Mental Elf, Lancet Psychiatry and University College London psychiatry. They have covered subjects like dementia, digital mental health, preventable harm and women’s mental health.

They have developed the Social Care Elf, Learning Difficulties Elf, Dental Elf, Lifestyle Elf and the Diabetes Elf, and are hoping to expand into Elder Elf, Public Elf, Economist Elf, Sexual Elf and Stroke Elf.

Tomlin’s background is interesting. His Dutch maternal grandfather, who just escaped being shot by Nazis twice

during the occupation of the Netherlands, took young André round the red light district of Amsterdam as a boy. His parents were active members of the Campaign for Nuclear Disarmament and he ‘hung around Greenham Common’, the extensive antinuclear missile protest site, as a child.

His adult politics remain broadly left of centre but he is no dogmatist.

After philosophy and English at university he became assistant librarian at the Institute of Health Sciences in Oxford in 1993. After a Masters in Information Science at the University of West London, he returned to Oxford to help psychiatrist Professor John Geddes establish the Centre for Evidence-Based Mental Health.

Although remaining an ardent supporter of evidence-based medicine, he describes his growing impatience with the inaccessibility of the main health information websites. He and Badenoch could see how newer technology can deliver much faster and more personalised information. He also sees the speed of blogging reactions as contributing to dispelling misinformation.

The example he gives is after a paper with negative findings, determining whether exercise was useful in the treatment of depression, was taken up by the newspaper headlines as ‘Exercise found to be no help in depression’. Tomlin immediately wrote a blog publishing the actual evidence, correcting the interpretation, pointing out that exercise may still be preventative in depression, alerted the Twittersphere, and the BBC. Later that day the newspaper headlines were changed.

The power of social media operating in the interest of accuracy (for once).

Another mission is in myth busting, with evidence, of potentially harmful treatments; for example, a recent review piece in *Mental Elf* by Edel McGlanaghy on the subject of the potentially harmful effects of psychological treatment, mainly online cognitive-behavioural therapy for anxiety.¹

We discussed the merits and demerits of ‘trans diagnostic’ approaches to mental healthcare, recently written about in relation to Child and Adolescent mental health by Miranda Wolpert and Peter Fonagy.²

They have looked at the limitations of diagnosis and evidence-based research, proposing focusing on the person rather than the diagnosis. They point to the long waits for Child and Adolescent Mental Health Services (CAMHS), and the unsatisfactory outcomes for a significant minority of patients. Wolpert recommends a practical, evidence-based coproduction approach, developing apps for young people to prepare for seeing psychiatrists.

In January 2017, the *Mental Elf* published a systematic review of digital interventions for young people with mental health problems. They concluded that evidence is uncertain for digital interventions and should extend rather than replace offline services, with more interdisciplinary research needed, designed with user input and involving computer scientists, and engineers as well as psychologists and psychiatrists.

This migration on Tomlin’s part from traditional psychiatric research towards the ‘groovy social science side’ is never going overboard, he reassures me. ‘I’ll stop in the safe middle ground’. He feels his education about psychiatry has been extended beyond ICD-103 via twitter contact with patients and nurses, reaching out into the wider waters of social care and psychology. But writing from the user perspective can become flaky, he admits, and although his personal philosophy is transdiagnostic, he fully supports psychiatrists who must treat patients on particular pathways determined by diagnosis.

He is also increasingly sceptical about the evidence-based medicine world, which he sees as ‘quite insular’, and even research more broadly, claiming that about half published research is methodologically unsound, and another half never reaches publication because of the bias against publishing negative findings. In fact, he goes even further in pointing to the gap between evidence-based medicine and ordinary practitioners, and states ‘we would have most impact if we just implemented what we know now.’

So, is he a breath of fresh modernising air that we psychiatrists should breathe in deeply, and are sorely in need of with our rushed lives, or is the *Mental Elf* a bit gimmicky or presumptuous in setting the tone and agenda for public debate?

You will need to visit the *Mental Elf* site (free month’s trial) and decide for yourself.

Julia Bland is an honorary consultant psychiatrist for South London and Maudsley NHS Foundation Trust and a consultant medical psychotherapist at DocHealth, British Medical Association, UK; email: julia.bland@hotmail.co.uk

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1.5.13 Debate: The concept of culture has outlived its usefulness for psychiatry

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2018-4

Abstract

Summary

This paper presents a debate in which the authors participated at the World Psychiatric Association conference in Cape Town, South Africa in November 2016. Professor van Staden acted as chair and here, as at the debate, provides a rationale for debating a topic that many of those involved in mental health believe to be decided. The discussion that ensued demonstrated, however, that while the arguments have moved on they have not ceased. Who won? Well that depends how you look at it. A few in the audience shifted position towards the motion but the majority remained opposed. What do you think?

Declaration of interest

None.

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 - *Against the motion, Abdi Sanati*

Introduction: Werdie van Staden

‘Preposterous’ or ‘high time’ may be the respective responses of antagonists and protagonists to the claim that the concept of culture has outlived its usefulness for psychiatry. Philosophical rigour, however, requires much more than an exclamation of sentiment. Such rigour is probably demonstrated best by articulating an argument that goes against one’s own sentiment, thereby unpacking and clarifying the issues at stake. This article follows suit, thus not committing our contributors beyond the remit of this article – an article that is about the ‘what’ (i.e. the content) as well as the ‘how’ (i.e. argument).

The topic is patently relevant considering the provisions for culture by the DSM-5,¹ specifically through cultural concepts of distress, the cultural formulation and the cultural formulation interview. In addition, connections between culture and mental health may variously and profoundly be found in the way culture affects the various mental disorders in their expression, experience, interpretation, course and outcome. One may assert that culture influences individual resilience, coping mechanisms and social response, which are all crucial for recovery from mental health problems. Anthropologically, one may assert that mental health practice involves the meeting of at least two cultural worlds: the clinician’s and the patient’s.²

A scholarly debate provides for consideration, if of good logical pedigree, of the differences as well as the similarities shared by both sides of the debate. As an introduction to the arguments of our pairs of protagonists and antagonists, two shared features are highlighted: ‘culture’ necessarily involves *practice* and *values*.

The first protagonist, Mohammed Rashed, raises the issue of the conceptual relation between cultural group identity and culture as a dynamic set of shared practices. Taking the latter rather than the former as constitutive of culture, cultural group identity is shown to be a conceptual derivative of shared practice rather than the (commonly assumed) converse. The premise also underpins the antagonist argument of Abdi Sanati below. Following Wittgenstein’s private language argument, he argues that without culture there cannot be language, and, hence, no psychiatry.

The premise that culture is constituted by shared practice thus features on both sides of the debate, with conceptual implications that are beyond the scope of this article. One example, nonetheless, may serve to enlighten their arguments. This premise unmasks the mistaken assumption that culture is necessarily confined to a geographical location (as does the DSM-5).² Examples of the contrary are found in shared practice: the internet culture, the renaissance culture, a scientific culture, a 21st century culture, a ‘Googling’ culture, etc.

An emphasis on values is shared by the arguments of the protagonist, Norman Poole, and the antagonist, Rachel Bingham. The inevitable cultural origins of values are underscored in Bingham’s argument, whereas Poole is concerned by the alienating and exoticising consequences of ascribing mental disorder to cultural values.

Space here does not allow for rebuttal, but the scene is set, no doubt, for further discussion.

For the motion, Mohammed A. Rashed

I am going to argue for this motion: I believe that the concept of culture has outlived its usefulness for psychiatry. I believe so not because I am a defender of a reductive, biological psychiatry – I am not – but because among the two definitions of culture that are, in my view, of relevance to mental health, the first is so general so as to dissolve into the concept of meaning, and the second is so unjustifiably homogenising as to require that we explore the patient’s beliefs and values without the assumption of a cultural group.

Culture has many definitions; I list four. 1Culture in the sense of activity: the tending of natural growth; to cultivate the land, to breed animals, and to await the growth of bacteria in a Petri dish.³ This meaning of culture is irrelevant to our debate. 2Culture also in the sense of activity, but instead of cultivating vegetables and bacteria, we cultivate our intellectual capacities and create civilisation. This meaning of culture lives today in the ‘culture’ section of newspapers.⁴ This meaning of culture, as well, is not relevant here. 3Culture as a noun, denoting groups of people united by shared beliefs and practices; for example, Maori culture, Muslim culture, and so on.⁵ This meaning of culture is relevant. 4Finally, culture as socially acquired and shared symbols, meanings and significances that structure experience, behaviour, interpretation and social interaction; culture ‘orients people in their ways of feeling, thinking, and being in the world’ (Jenkins & Barrett 2004, p. 5; see Rashed 2013, p. 4). This concept of culture is analytic in the sense that its introduction enables researchers and theoreticians to account for the specific nature of, and the differences among,

various social phenomena and people's subjective reports of their experiences. For example, a prolonged feeling of sadness can be explained by one person as the effect of a neurochemical imbalance, by another as the effect of malevolent spirits, and by another as a test of one's faith: these differences can be accounted for through the concept of culture.

Having identified two meanings of culture that are relevant to this motion, I want to show why we should abandon the term culture. Consider the final definition: culture as socially acquired meanings and significances. Here we are talking about interpretation and giving meaning to our experiences, to the experiences of others, to social events and to behaviour. For example, in many societies, there exists the phenomenon of the evil eye.² This is an innate capacity to do unintentional harm through a direct look when encountering abundance or beauty in situations that evoke genuine admiration and appreciation. It may affect animals, plants, material possessions and human beings. People for whom this notion is relevant regularly explain misfortune – for example, if a tree dies or a well dries – by saying that a person who visited recently had given a 'bad eye'. For other people, however, seeing a friend's new car is an occasion to say something like 'congratulations' and to ask for a drive, without worry that one might have, inadvertently, given the bad eye.

Now, both approaches to such a social encounter involve an interpretation and a related response, and this applies to all social encounters irrespective of where the involved individuals come from. But then what part does the term 'culture' play here? If everything is culture, in the sense that everything is subject to interpretation, then it would seem that we just need to attend to that without having to invoke an overarching thing called 'culture'. It could be objected that the term culture is helpful because it allows us to identify a certain set of interpretations that occur together regularly, and to give that a name. This brings us to the third definition of culture I mentioned earlier: culture as a noun denoting groups. So, for example, the benefit of using the term Maori culture is that we can refer to a set of interpretations and practices that Maoris do: a shorthand to refer to a whole group and ascribe to them certain beliefs and practices. This, however, is problematic. The idea that we can demarcate a group of people that believe this or that and do such and such has been debunked as an anthropological fiction belonging to the European missionaries and adventurers of the first half of the previous century. It downplays individual agency in favour of some homogenous thing called 'those people's culture'.³ Consider, again, the evil eye, a phenomenon which I studied in Egypt. No two people agreed on what it meant, on its importance, on the extent to which it is a genuine problem, or on the situations in which it can be harmful. In fact, the description I gave earlier is quite partial; people appropriated the notion and made it their own, and they had a unique sense of what it is and whether or not it is relevant to them.

The notion of a cultural group may be useful politically, but it's not useful for psychiatry. The clinical encounter must always involve a serious inquiry into the person's beliefs and values, and this has to occur every time irrespective of where the clinician and the patient come from; that is, irrespective of their presumed 'culture'. In fact, to continue to use the term culture to refer to a group can be detrimental in that it may make the clinician think that he or she understands the patient – that the patient is 'Muslim' or 'Maori' or 'Irish' – when that understanding may be no more than a stereotype and hence a further obstacle to engaging with the other person's worldview. To recap, the concept of culture is no longer useful for psychiatry; if we understand culture as meanings and significances, then we need to stay with those notions, the term 'culture' playing no useful part. If we understand culture as referring to bounded groups, we would be holding a discredited view of culture, and a view that may prevent genuine engagement between clinicians and patients.

Against the motion, Rachel Bingham

A central conceptual struggle in psychiatry is the question of how to define mental disorder, and thereby delineate the proper boundaries of psychiatric practice. The concept of culture may arise in various ways; for example, in drawing a distinction between religious experience and psychopathology,⁷ or between social deviance and mental disorder.⁸ Here, I will argue that the concept of culture is more useful than ever. My argument, briefly, is that the boundary between mental health and ill health is defined by values, and values arise from culture; therefore, mental health and psychiatric practice cannot be understood without attention to culture. Developing this, I suggest that not only do values depend on culture, but values and culture overlap, or partly constitute each other. Accordingly, to say something about a person's culture is to say something about her values, and vice versa. If so, the concept of culture should be considered vital to values-based practice.⁹

The concept of culture is used here to refer to socially acquired meanings that shape our experiences, our understandings

of our experiences, the behaviours of others and social events more broadly. These shared meanings may influence not only when I believe myself to be unwell and what response I consider is required, but may also shape my experiences, actually contributing to whether or not I feel unwell or in need of help in the given circumstances.⁷ It is important not to overstate the homogeneity of cultural meanings within a group. I may not endorse all supposedly shared beliefs and values of all contexts I inhabit, and it will be difficult to make predictions about my beliefs and values by surveying the community in which I live. Nevertheless, I will be affected by others' beliefs and values – whether I endorse them, unquestioningly go along with them, or even use my rejection of the beliefs and values of my community as a springboard from which to find my own way.

Values are integral to the concept of mental disorder, just as they are to the concept of culture. Attempts to define mental disorder in purely objective, factual terms have not been successful.¹⁰ Distinctions between mental disorder and mental health are irreducibly normative. Facts alone cannot tell us which statistically extreme deviations, such as genius or avarice, are pathological. Neither can facts alone tell us what is functional or dysfunctional, as functions themselves are relative to some valued outcome or purpose. Even if the neural correlates were described for every item in a list of diagnosable mental disorders, we would rely on values to decide the contents of that list. Otherwise, we would merely have a list of states involving changes in the brain, including, perhaps, love or criminality, with no further directions as to which are the proper business of psychiatry.¹¹

Values, then, are essential to the concept of mental disorder. And values, as discussed, are not only influenced by culture, but contribute to culture, and vice versa. But if so, why not abandon culture altogether, as redundant, and focus only on what people value? Yet, to focus only on values and not their context does not serve psychiatry well. Whether values, meanings and interpretations are shared or not may influence whether a particular experience is interpreted as illness, or as some other unusual or distressing but essentially normal state. For example, whether experiences such as fear or hearing voices are shared and understood contributes to whether an individual is considered to be gifted, possessed, well or unwell. In other words, the values and beliefs of our community may partly constitute our experience of illness. The extent to which these meanings are shared may even determine whether or not a diagnosis is made.

In conclusion, among many uses of the concept of culture, one important feature is to describe something other than scientific facts: something essentially about values. Yet, psychiatry cannot focus only on values, abandoning culture, because part of both the experience and the diagnosis of mental health problems depends on the context – the shared beliefs and meanings – in which values arise and develop. Accordingly we need to see the practice of psychiatry as part of a wider context, as happening in a time and place that influence how it proceeds. We need to see our clients, patients, colleagues and ourselves as coming from contexts that influence not only whether we experience distressing or disabling symptoms, but also whether these symptoms are interpreted as illness. Unless we can say this is really being done well, without the need for further theoretical work, we cannot dispense with the concept of culture.

For the motion, Norman A. Poole

As a neuropsychiatrically inclined psychiatrist, it might be assumed that my reservations stem from a preference for biological explanations in psychiatry. While there is something to be said for the role of neuroimaging and biological investigations in psychiatry – for example, the measurement of hippocampal volume and cerebrospinal fluid beta-amyloid concentration in early stage Alzheimer's disease – they do not satisfactorily address the motion, which, let us recall, is that culture has outlived its usefulness for psychiatry. This is not to argue that the focus on culture has hindered psychiatry. Indeed, the transcultural psychiatrists have, among others, helped us to see that biological reductionism is simplistic and wrong-headed. The diagnosis of mental disorder is at the normative level,¹² just as the culturally orientated psychiatrists claimed. Furthermore, transcultural psychiatry has shown that what is deemed pathological in one culture need not be viewed as such within another. Demon possession is considered abnormal in the West, but this does not generalise to all other situations. What is left to discuss? It appears I am at one with my opponents.

My reservation is that cross-cultural psychiatry prioritises difference at the expense of universality, thereby exoticising mental disorder and potentially alienating patients further. Those with so-called culture-bound syndromes appear in the literature like new species of tropical bird for the reader to gape and wonder at. Worse still is the tendency, familiar to anyone who has worked in areas of diversity, for clinicians with a smattering of mandatory 'cross-cultural training' to dismiss unusual behaviour as 'cultural'. I've heard this applied to new-onset domestic violence and social withdrawal; cases of frontal temporal dementia and schizophrenia, respectively, as it turned out.

Instead, I wish to present the view that what goes awry at the level of norms and values is more universal than the trans-cultural psychiatrists have supposed. Consider Pascal Boyer's notion of a folk psychiatry, which is parasitical on what is called intuitive psychology.¹³ That is, the tendency to understand one's own and others' behaviour through appeal to unobservable mental states such as beliefs, desires and emotions, including their relation to one another. Most of this is done at a level beneath conscious awareness; we become aware only of the outcome. And our intuitive expectations of one another are composed of domain-specific abilities rather than this being a general process. While there are differences in explicit psychological models around the world, the evidence from developmental psychology is that intuitive abilities are universal; the best-known being theory of mind, which occurs in all cultures studied to date.¹⁴ Other tenets of intuitive psychology include: mental states somehow represent or map the world as it is; behaviour is internally generated; memory is a store of past experience; communication follows tacit but constraining programmatic principles, with each party endeavouring to ensure the other's ongoing comprehension; a largely unconscious reading of others' subtle emotional cues; and so on. That these develop in infancy implies they are more universal than local. For instance, babies preferentially attend to objects that appear to interact with one another, such as the Heider and Simmel animation involving an 'aggressive' triangle and 'fearful' circle (<https://www.youtube.com/watch?v=VTNmLt7QX8E>). No one, with the exception of those with autism,¹⁵ has any trouble in attributing internal mental states to these shapes. Indeed, feelings of pity for the circle are frequently evoked.

The idea is that mental disorder is implied when behaviour, including verbal behaviour, contravenes one or more of our tacit expectations. People with schizophrenia exhibit disordered thought and speech that fails to follow the tacit rules of checking, repair, reducing ambiguity and so forth, which are apparent to carers and fill the psychopathology textbooks. It is important to note that this failure to meet the expectations of intuitive psychology are not mere violations of social norms – it is possible to behave in a socially unacceptable manner without there being a corresponding difficulty with its understandability. Repeat offenders are socially sanctioned, but few of us have trouble attributing a motive to their crimes. Intuitive psychology also seems to help sort the classic cross-cultural psychiatric cases, without recourse to culture. The belief that one is possessed by demons does not in the West seem to map or represent the world accurately. There are, however, other accepted means for the acquisition of belief; beliefs can also arise from the testimony of others.¹⁶ The belief that one is possessed by demons is accepted in some cultures, because the belief is acquired from authority, i.e. the rest of the group. This removes culture, because it is a fault with the mechanism of belief acquisition that triggers suspicion of dysfunction rather than the more general notion of a social norm being contravened.¹⁷

To conclude, culture has outlived its usefulness for psychiatry because it has misconceived the level at which things go wrong in mental disorder. Those with mental disorder are not identified merely for social deviancy but because some aspect of their behaviour fails to meet the intuitive and universally held psychological expectations of others. By focusing at this level, we are better able to appreciate what unites us, both in sickness and in health.

Against the motion, Abdi Sanati

In what follows, I aim to show that culture is inseparable from psychiatry, and that, in fact, psychiatry cannot be practised, or conceived of, without culture. One can think of different ways to link psychiatry and culture. One of the most basic ones is through language. First, let us focus on the relationship between language and psychiatry. One of the important, and in my opinion essential, elements of psychiatry and its practice is psychopathology. It provides the framework within which we define signs and symptoms of mental disorders and communicate them to others. And language plays a necessary part in this discipline. From an ontological point of view, I find it hard to imagine the existence of delusions, verbal hallucinations and obsessional thoughts without language. From an epistemological point of view, to say any enquiry about human emotions is impoverished without use of language is an understatement. Even describing purely behavioural signs needs a language.

Now, I shall consider the relationship between language and culture. Culture and society are inseparable. One of the integral elements in every society is communication. Language is one of the most complex means of communication and has enabled human society to achieve immense complexity. The increase in the complexity of language contributed to the increase in the complexity of the culture. The increase in complexities of culture, in turn, feed back to make language more complex. There are many other factors operating in this process; for instance, I cannot deny the impact of technology on both culture and language. However, there is a definite link between culture and language. One can argue that while there is a definite association between culture and language, this association is merely a contingent one and it does not necessarily have to be the case. In the next step, I shall argue that the association is indeed necessary; that

is, without culture we would not have language. Here, I rely on the work of Ludwig Wittgenstein, especially his private language argument. Wittgenstein explores whether there is a possibility of existence of a language which is logically private; that is, it could be understandable only by one person.¹⁸ To clarify, it is not the possibility of a language that someone like me can develop, which can be deciphered, but the possibility of a language by someone who has been separate from others since birth: a born Robinson Crusoe. This is different from development of a new language by someone who already is a language speaker. That person is already in possession of language skills, and the new language would follow accepted rules. The Crusoe-type person in question does not have any awareness of the rules of language and has to develop them from scratch. In other words, this language is developed *de novo* in an individual who has never been part of a community/culture. Wittgenstein concludes that ‘a language in principle unintelligible to anyone but its originating user is impossible. The reason for this is that such a so-called language would, necessarily, be unintelligible to its supposed originator too, for he would be unable to establish meanings for its putative signs’.¹⁹ Why would he be unable to do so? The answer lies in Wittgenstein’s description of language. According to Wittgenstein, to understand a word is not to have a mental process signifying it. It is knowing *how* to use the word. In other words, it is to know how to follow the rules of using the words in different linguistic activities such as questioning, asserting, joking, demanding, etc. Language is a rule-governed activity. And to follow a rule one needs public criteria, i.e. something outside oneself to objectively confirm that the rule is followed. By objective, Wittgenstein does not mean that the rules are in some way independent of our practice, something he asserted in his earlier philosophy, but that what constitutes a rule is our collective use of it. Rule-following is a general practice established by agreement, custom and training.²⁰ He argues that the concept of rule presupposes a custom. It is a cultural phenomenon. It cannot be imagined to happen individually, independent of ‘historical groups of individuals who are bound together into a community by a shared set of complex, language-involving practices’.²¹ There is a vital connection between language and the complex set of practices and activities that binds a community together. Language is interwoven into the activities of the people and is fundamentally cultural in nature. In other words, without culture there cannot be language and, hence, no psychiatry.

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1.5.14 Management of common mental disorders for psychogeriatric patients in Hong Kong: comparison of two clinics after 1 year of treatment

Mimi Mei Cheung Wong Pui-fai Pang Michael Gar Chung Yiu

date

2018-4

Contents

- *Management of common mental disorders for psychogeriatric patients in Hong Kong: comparison of two clinics after 1 year of treatment*

We would like to update the findings of our pilot study which compared the enhanced common mental disorder clinic (CMDC)¹ and conventional specialist psychiatric out-patient clinic (SOPC) in the management of common mental disorders (CMDs) for psychogeriatric patients in our hospital in Hong Kong. In our previous letter to the editor, different clinical factors were compared between the two groups 6 months post-treatment. This time, findings for 1 year post-treatment were available.

The CMDC is a 1-year programme with multidisciplinary involvement. There were 30 patients in each group. After 1 year of treatment, only 15 patients (50%) remained in the CMDC, while 23 remained in the SOPC ($P = 0.03$). Ten patients (33.3%) completed the CMDC programme and were successfully discharged from the CMDC. They did not require any medication for their CMDs. One patient refused to attend medical follow-up. One patient was transferred from CMDC to SOPC, as she was found to have dementia. Another patient was transferred to the general out-patient clinic for continuation of treatment for her mixed anxiety and depressive disorder.

Concerning psychological intervention, half of the patients in the CMDC group (50%) were referred to a clinical psychologist, and ten had good adherence to appointments. For the SOPC group, only three patients (10%) were referred to a clinical psychologist ($P < 0.05$).

Concerning antidepressant use, the rate at 1-year follow-up was 11 (36.7%) for CMDC v. 20 (69%) for SOPC patients ($P = 0.02$). Profiles of benzodiazepine and hypnotic use and prescription were similar prior to consultation, after the first consultation, 6 months post-treatment and 1 year post-treatment. Eight patients (26.7%) in each group did not require benzodiazepines or hypnotics after the first consultation. The reduction in benzodiazepines and hypnotics was statistically significant ($P = 0.04$). At 1 year after treatment, ten patients (33.3%) in each group were taking benzodiazepines or hypnotics.

In summary, psychiatrists of both clinics were able to reduce benzodiazepine and hypnotic use after the patients formally presented to the psychiatric clinic. Nearly half of the patients who were given a benzodiazepine or hypnotic did not require it afterwards. Instead, about two-thirds of them were treated with antidepressants. Significantly more patients did not require antidepressants at 1 year post-treatment in the CMDC group. There were also significantly more patients who did not require medical follow-up at 1 year for the CMDC group.

Remission of CMDs is possible for patients who have completed the 1-year CMDC. Its psychological and pharmacological components, as well as timely interventions, have contributed to its success. The treating team and the patients are aware of the time-limited nature of the programme and have expectations that suitable cases can be discharged from the programme upon its completion. This helps to ensure that the clinic is not overwhelmed by continual accumulation of cases. On the contrary, the SOPC does not have a specified duration of treatment and the doctors are less ready to discharge patients from the clinic if they are stable on medical treatment. It is not common to refer back stable cases to primary care. Enhanced collaboration between the SOPC and primary care in the management of CMDs can help to reduce the burden on the SOPC, so that it can have more capacity to deal with complicated and unstable cases.² The acceptability of psychological interventions is expected to be better if they can be more tailored to elderly patients; in fact, many older people expressed a preference for talking therapies.³

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1.5.15 Benjamin (Ben) Steinberg, MD FRCPsych

J. Guy Edwards

date

2018-4

Contents

- *Benjamin (Ben) Steinberg, MD FRCPsych*

Formerly Consultant Psychiatrist, Knowle Hospital, Fareham and Royal South Hants Hospital, Southampton, UK

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Ben Steinberg, who died recently at the age of 93 years, was regarded as one of Hampshire's most popular and well-respected psychiatrists. He had an encyclopaedic knowledge of many subjects, including psychiatry, world affairs, history, literature and the theatre, and was a most engaging conversationalist. He could debate controversies in a robust but sensitive way, and was a great listener. He had an unrelenting capacity to care. In his later years, he worked voluntarily for a charity providing emotional, legal and financial support for refugees and asylum seekers in Southampton and Winchester.

He served as chairman of the Medical Committee, was a member of the Management Committee and chairman of the Psychiatric Rehabilitation Committee at Knowle Hospital, was chairman of the Wessex Psychotherapy Society, and was also a member of the Southampton and District Community Health Council and chairman of its Mental Health Group. He taught under- and post-graduate students and assisted in a number of research projects.^{1,2}

He was an active member of the Labour Party and was elected chairman of the Romsey and Southampton North Branch and chairman of the Southampton and District Fabian Society.

Ben was born into a Jewish family in Latvia. In 1925, his family moved to Belfast where his father became an assistant Rabbi. He graduated in medicine from Queen's University, Belfast, in 1946 and obtained his MD in 1957. Following his preregistration training, he served in the Royal Army Medical Corps for 2 years and then undertook his psychiatric training (1949–1956). He was appointed Senior Hospital Medical Officer in Cardiff in 1956 and consultant at Knowle Hospital in 1958. After retiring he worked as clinical assistant in the Rehabilitation and Long-Stay Units at Knowle and Southampton for a further 9 years.

He and his late wife, Phyllis (a nurse from the Republic of Ireland), showered hospitality on his colleagues and many generations of trainees and their partners. Many overseas trainees showed their appreciation decades after returning to their native countries.

Ben remained youthful until near the end. His clinical skills, intellectual prowess, sense of duty, concern for patients and loyalty to friends and colleagues will remain as monuments to his memory. He will be sadly missed by all who knew him, but most of all by his family, to whom he was deeply devoted – his three children (David, Judith and Helen), ten grandchildren and two great grandchildren.

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1.5.16 ‘To know before hand is to freeze and kill’ Commentary on... Should psychiatrists write fiction?

Daniel Racey

Correspondence

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date

2018-4

Abstract

In this article I argue that fictional accounts of mental illness should be unethically unobliged. I suggest that art is not generated with conscious ethical intent and provide evidence that art proceeding from an ethical agenda is more likely to be poor art. I also consider ways in which a writer-doctor might need to compromise what they articulate to maintain a professional ethical integrity.

Declaration of interest

None.

Contents

- ‘To know before hand is to freeze and kill’ Commentary on... Should psychiatrists write fiction?

“For only after, can one nail down, examine, explain. To try to know beforehand is to freeze and kill. Self-consciousness is the enemy of all art, be it acting, writing, painting, or living itself, which is the greatest art of all. Ray Bradbury¹”

Beveridge² argued that fiction supports psychiatrists to imaginatively enter other lives to become more ethical and empathetic. The previous article³ changes the slant: psychiatrist/writers should enter the life of readers to encourage them to become more ethical and empathetic regarding mental health. Oyeboade, a poet/psychiatrist, sees literature as lacking conscious ethical intent, but argues that a secondary outcome of fictional investigations of psychiatry is to influence how society sees mental disorder and how politicians will tackle this area.⁴

Will Self has written many pieces of fiction with a recurring psychiatrist character, Zack Busner, who sometimes resembles Ronnie Laing, sometimes Oliver Sachs. For Self, psychiatry has become central to his writing, because: “... psychiatrists stand – whether they acknowledge it themselves [...] at the threshold between happiness and sadness and between sanity and madness [...] I’m thinking [...] in terms of priests who manage the transition from the phenomenal to the numinal.⁵”

In a secular age dominated by scientism, psychiatrists function as meaning-makers. Given this status, shouldn’t psychiatrists who write show an ethical loyalty to the project of psychiatry?

The way in which creativity proceeds and how art and psychiatry interact with each other can be approached using the framework of one of psychiatry’s foundational figures – Karl Jaspers. Jaspers identified two modes of knowing, which should weave together in the work of a psychiatrist: Verstehen and Erklären.⁶ Erklären tries to make explanatory sense of phenomena by finding the laws that govern them. The psychiatrist who engages in Verstehen tries to make empathetic sense of phenomena by looking for the perspective from which the phenomenon appears to be meaningful. Jaspers is describing the art and science of medicine, insisting that scientific explanations are necessary but not sufficient accounts of our patients.

Fiction attempts to subjectively understand the human condition – it is *Verstehen*. At the same time, fiction is not just a right-brained tapping of the unconscious. A writer gains by having authority over the subject matter: to be coherent, to be up-to-date, to teach us, to please us with erudition. We know the difference between well-researched and poorly researched novels. However, writing that is overly occupied by *Erklären* will fall dead from the womb.⁷ A Pulitzer Prize winner writes: “‘*What’s erroneous is the assumption that the thoughtful analysis and willful insertion of that in the work is the creative process [...] it’s the antithesis of the process [...] If you start perverting that with other motives to write, your ability to become an artist is severely hampered, if not destroyed.*’⁸”

In the accompanying piece, the authors simplify and rationalise the writing process, which they depict as ‘*Firstly, the writer gathers information through research. Secondly, a story framework, however loose or rigid that may be, is devised. Thirdly, a coherent narrative is constructed through putting the words onto paper.*’⁹ This strikes me as true when I write professionally or academically. I would suggest that the process of writing fiction is fundamentally different, that the authors misunderstand the writing process by assuming the ego’s fingers have a firm grip of the pen. Numerous writers have described the creative process as passive,^{8,9} for example, Paul Bowles states: “‘*If I am writing fiction, I am being invented. I cannot retain any awareness of identity. The two states of being are antithetical. The author is not at a steering wheel [...]*’⁹”

The creating artist may be caught in an unconscious dream, but Margaret Atwood does not allow so easy an abdication of moral responsibility: “‘*Why do authors wish to pretend they don’t exist? It’s a way of skinning out, of avoiding truth and consequences.*’¹⁰”

Ray Bradbury states: ‘*For only after, can one nail down, examine, explain.*’¹ This feels true to the writing experience: that creation is often unconscious, but the subsequent shaping of the material is conscious and where ethics become relevant. The poet Selima Hill describes the moral editorial step which occurs late in her creative process. She uses the following rubric to guide her: “[...] *the morals of the thing. Is it libellous? Is anyone’s reputation going to suffer? [...] Am I exploiting someone else’s work, or life? Or might it, on the other hand, have a positive (morally ‘good’) effect?*’¹¹”

The power dynamic in psychiatry is so asymmetric and the potential consequences of breaching confidentiality are so severe that when psychiatrists write about psychiatry, our policing needs to be rigorous. How we achieve this is another topic in itself.

Selima Hill concludes that the function of art is not that of *Erklären* but the subversion of *Erklären*. “‘*It is not the place of art to draw conclusions or even to understand. On the contrary, isn’t the whole point that it is non-judgemental? That it undermines the making of value judgements? It is modest, helpless, useless, but at the same time determined, and just. I think of Heaney’s phrase ‘to set the darkness echoing’ – where darkness is what it is, and we can neither flinch nor sink.*’¹¹”

Hill is arguing that art should be ambiguous, should avoid conclusions. Psychiatry is used to shades of grey in its epistemology, nosology and ethics. More than other branches of medicine, we require negative capability – the skill of sitting with uncertainty without irritably reaching after a simplistic explanation.¹² This is *Verstehen* – a different kind of understanding, one that does not make value judgements. To achieve such an end, the artist/psychiatrist will put aside *Erklären* and ethics. An activity that is ‘*modest, helpless, useless but just and determined [...] where [...] we [...] neither flinch nor sink*’ sounds like what most psychiatrists do, the kind of modest psychiatry we can believe in, the psychiatry that we actually practise in shabby clinics and battered wards ‘*where we set the darkness echoing*’.

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1.5.17 Should psychiatrists write fiction?

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Abstract

This paper looks at the relationship between fiction and psychiatry. Specifically, the idea of psychiatrists as fiction writers is explored, and reference is made to various fictional texts to illustrate the problems of stigma and negative imagery. These two main areas of focus are highlighted as ones that the practice of writing fiction might address, and some potential pitfalls are discussed. The paper suggests how psychiatrists might ameliorate the present problems by incorporating their unique clinical skills and knowledge into fictional narratives.

Declaration of interest

None.

Contents

- *Should psychiatrists write fiction?*
 - *Raising awareness*
 - *Correcting the image*
 - *Pitfalls*
 - * *Ethics*
 - * *'Medical' fiction*
 - *Conclusion*

In 2003, Allan Beveridge examined the idea of whether psychiatrists should read fiction.¹ This paper asks the related question of whether psychiatrists should *write* fiction? Chekhov did it, and so did Oliver Sacks, even if he did burn his first efforts. Femi Oyeode² notes the similarity in the tasks of the fiction writer and the psychiatrist, pointing out that they are both trying to make sense of human behaviour. This observation is pertinent to this paper, which will look at the connection between psychiatrists and fiction writing. Certainly, fiction can be powerful, but so can psychiatry. Garcia-Nieto³ says that there used to be a strong connection between literature and psychiatry, a connection that was severed during the 20th century. Psychiatrist/writers can help to restore that link.

Novelists write about the human condition, that much is evident. As Baker *et al*⁴ note, for writers 'madness has long been, and remains, a compelling preoccupation'. Fiction writers often write about psychiatry for dramatic effect, but not always faithfully. The result can produce stereotypical depictions of mental health and of the people who work in that arena. Writers also write about psychiatrists, often with the same result.

Patrick McGrath has done both; he has written about psychiatry and the experience of mental suffering (*Spider*), but he has also written about psychiatrists. In *Trauma*, his character, Charlie Weir, is a psychiatrist struggling to come to terms with his mother's death.

McGrath has also combined the two. In *Asylum*, set in a secure hospital in the late 1950s, McGrath writes about the experience of suffering, and about a young psychiatrist and his family.⁵⁻⁷

Drawing on experience is something that every writer does, but some knowledge of psychiatry is important for such genre writing. I want to suggest that writing fiction, as an avenue open to psychiatrists, presents a great opportunity to provide positive models of mental health. The understanding psychiatrists have for their patients is likely to encourage a more complete illustration of character and setting. So the answer to the question posed by this paper should be yes. The writing process essentially involves three stages. First, the writer gathers information through research. Second, a story framework, however loose or rigid that may be, is devised. Third, a coherent narrative is constructed through putting the words on to paper. When it comes to writing about psychiatry, it is plain that psychiatrists have a head start. Step one, where Sebastian Faulks, for example, spent 5 years researching his epic book about psychiatry, *Human Traces*, can be leap-frogged by psychiatrists. Similarly, the difficulty that Patrick McGrath⁸ talks about in drawing from psychiatry for fiction is largely circumvented by the closeness of psychiatrists to their subject matter and their ability to make sense of human experience.

Before the reader dashes away from the clinic armed with a notebook stuffed with observations and ideas for their new novel, I should introduce something by way of balance. The critics would suggest, for example, that somebody working therapeutically should not write, or that they may end up manipulating patients.⁹ Those in the ‘no they shouldn’t write’ camp might also caution against the danger of clinical narrow-mindedness and an overkill of technical psychiatric jargon. This pitfall will be examined below. For the moment, it should be sufficient to note that the skill of a writer is in creating a world *apart* from real-world experience. Paradoxically, though, this subtle shift from fact to fiction has the aim of *seeming* real. I therefore suggest that, beyond wishing to produce an entertaining product, psychiatrists should have two principal goals in mind when approaching the writing of fiction. These are: •correcting stigma by raising awareness, educating others and promoting good mental health•countering the negative image of psychiatry and the psychiatrist.

Raising awareness

The impact of media representations has major effects on the stigma experienced in mental health. That media portrayals of mental health and mental health professionals influence public perception is a well-documented phenomenon.¹⁰ ¹¹ As Stuart¹² notes, the media has a ‘vast store’ of negative images in relation to mental illness.

As Liam Clarke said, literature’s take on human behaviour ‘surpasses the descriptions of social and psychological sciences’.¹³ The potential power of the combination of fictional narrative and psychiatric insight could offer a potent formula of truth and wisdom resulting in enlightened understanding. The demystification of mental health services through the normalising effect of honest and informed writing cannot be understated. As Oyeboode¹⁴ suggests, these narratives influence ‘how wider society perceives mental illness’. It therefore follows that sensitive portrayals of psychiatry would encourage a more informed and sympathetic view of the work done by psychiatrists. Rightly or wrongly, psychiatry has always endured its critics. Many of these issues are still current, whether they relate to concerns about paternalism,¹⁵ over-reliance on medication,¹⁶ the use of ‘specialist’ knowledge in the maintenance of power,¹⁷ criticisms of biological models,¹⁸ or even debates about the value of diagnostic labels.¹⁹ ²⁰ Psychiatrists might, therefore, wish to respond to such commentary through writing fiction that points to a more eclectic nature in the profession and what they do.

The acknowledgement that psychiatrists can move to a more collaborative relationship with the service user movement²¹ would suggest one area where fiction could develop a stronger image for psychiatrists and patients alike. Such efforts are starting to show potential, as in the recent novel by Monica Starkman, *The End of Miracles*.

The other thing to bear in mind is that although fiction may be the poor relation to the medical textbook,²² fiction is more accessible, and people are more likely to read a fictional account than a research paper or the DSM-5.

Correcting the image

Psychiatry has had its periods of self-doubt. In fact, it would be hard not to see the problem as a perennial identity crisis.²³⁻²⁵ Fiction does little, it seems, to help. In her study of media representations of psychiatrists, Jacqueline Hopson claims that psychiatrists are ‘demonised’ by fiction. She asserts that psychiatrists are regarded with suspicion and fear, and that the portrayals in fiction, which are frequently related to power, are deleterious to the profession. She points to representations such as *The Snake Pit* and Antonia White’s *Beyond the Glass* in support of her thesis.²⁶ Psychiatrists are without doubt in a position of power, and the idea of using psychiatric treatment as a punishment is a popular theme in fiction. If we believe what we read, it is a short step from administering medication to using it to control and punish others. *The Bell Jar*, Sylvia Plath’s classic book, with its references to electroconvulsive therapy (ECT), self-harm and suicide, shows us the confusion depicted in the character of Esther Greenwood, confusion which is epitomised after her first ECT session, when she remarks: ‘*I wonder what terrible thing it was that I had done*’.

In *The Trick is to Keep Breathing*, by Janice Galloway, her character, 27-year-old Joy Stone, has doubts about her psychiatrists. Joy sets out a list of general ‘lessons’ she has learned about them, including her belief that psychiatrists are ‘devious and persistent. They always win in the end’. Such portrayals have significant consequences for those who work in mental health settings, just as they do for sufferers. For psychiatrists, negative imagery can lead to problems with recruitment,²⁷ difficulties with their public image,²⁸ and denigration from their colleagues in other branches of medicine.²⁹

With a more positive mindset, fiction can act as a beacon of truth. Andy Bickle³⁰ urges that we ‘should not underestimate the importance of literary and other media representation in creating the milieu in which we work’. In the same way that social worker Freya Barrington had the aim of raising awareness of her profession in her book, *Known to Social Services*,³¹ psychiatrist Monica Starkman relates her goal of showing psychiatry and psychiatrists as they are, and not as the stereotypes portrayed in books or films.³² So, a prime motivator for psychiatrists might be to adopt the ‘inform and entertain’ ideal in their approach to writing fiction, and tell readers what being a psychiatrist is *really* like. As I have already said, there are plenty of fictional psychiatrists, and they are by no means universally negative, despite what Hopson claims in her paper. In his latest novel, *Where My Heart Used to Beat*, Sebastian Faulks presents Robert Hendricks, a post-war psychiatrist who is a long way from the unpleasant stereotype Hopson bemoans. Nevertheless, there is potentially a different dimension to ‘psychiatrist point-of-view’ novels written *by* psychiatrists.

As well as correcting erroneous imagery, psychiatrists might wish to portray something of the conditions in which they work. The political dimension of psychiatry has been written about before, perhaps most strikingly in *One Flew Over the Cuckoo’s Nest*, but there are other books that use narrative as a form of commentary on the state of mental health or welfare services. *Poppy Shakespeare*, by Clare Allan, is set in a psychiatric day unit. This novel, which raises issues of institutional relationships and of benefits payments, is a notable example of how fiction can highlight current difficulties in service provision.

Pitfalls

Ethics

*The writer is a member of society and therefore has ethical and moral responsibilities. We need to take care in the construction of our own ‘make believe’ worlds.*³³ Ethical considerations are always prevalent in psychiatry. For psychiatrists writing fiction, there are issues of confidentiality and professional sensitivity to consider. There are always those who claim that fiction is simply fiction, but Gandolfo would disagree on the basis that fiction has the power to make a difference to people’s lives. He has argued that writers should ‘rigorously question both themselves and their writing’.³⁴ The fiction produced by psychiatrists might be governed not only by the desire to tell a story, it will also be tempered by the need to provide honest and realistic portrayals of the subject matter. Of course, the ethical dimension can be productive in itself. Beveridge³⁵ points out that writers might want to explore moral quandaries, a subject particularly prevalent in psychiatry. Issues of power, liberty, treatment and the like are fertile topics that do not have to be restricted to textbooks and non-fiction.

'Medical' fiction

Psychiatrist Monica Starkman asks whether psychiatrists write good novels. In attempting to answer her own question, she points out that psychiatrists have access to 'the deepest, most private thoughts and feelings of many people', which might lead one to assume that fiction writing should be easier for a psychiatrist. However, writing should be informed, but it should also be entertaining, and another obstacle for potential 'psychiatrist fiction writers' is technical language. Beveridge³⁶ suggests that writers are attempting to do crudely what modern psychologists do in a sophisticated manner. This is missing the point of fiction, but it is a point he later seems to correct. In 2010, he said that fiction can 'deepen our understanding of people with a mental illness' and divert from the narrow evidence-based approach to psychiatry.³⁷ Potential writers should always think about the reader, so psychiatrist/writers should resist the desire to overdo psychiatric terminology. As Crawford and Baker note,²² it should be remembered that fictional texts are *representations* of illnesses. They also reiterate the fact that fiction is not written for the purposes of diagnosis. To 'diagnose or not' is a consideration psychiatrist fiction writers will face. Oyebode¹⁴ points out that novels are not scientific studies of psychopathology; in a discussion I had with award-winning novelist Nathan Filer (*The Shock of the Fall*), Filer pointed out that, despite the protagonist in the novel having a strong psychotic dislocation, the term 'schizophrenia' was only used twice in his book. There are other writers, Nicola Barker, for instance (*Reversed Forecast*), who similarly convey a sense of suffering without resorting to psychiatric terminology.

Conclusion

Psychiatrists are dealt a rough hand by fiction. Despite more light-hearted depictions such as the satirical archetype produced by Will Self in a number of his novels (Dr Zack Busner appears in a succession of Self's novels and short stories, *The Quantity Theory of Insanity*, *Ward 9*, *Dr Mukti*, *Umbrella*, *The Book of Dave*, *Shark*), the work of the psychiatrist is depicted as mysterious at best and threatening at worst. Such imagery is only likely to have negative results. Not only does this affect the profession, but it filters down to the end-users of mental health services.

Although Bickle³⁰ suggests that fiction deals with the 'wrong type of data' to convey a comprehensive knowledge of mental illness, Bickle³⁰ makes the point that it offers the chance to step back from the world and to explore these issues, thereby helping psychiatrists reflect on their practice. The efforts of psychiatrist/writers in producing fiction presents an opportunity to correct some of these ills. If psychiatrists can avoid the pitfalls, then writing fiction can achieve a number of positive outcomes.

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1.5.18 Weekday and seasonal patterns in psychiatric referrals in three major London A&E departments, 2012–2014

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Abstract

Aims and method

To identify temporal and demographic trends in referrals made to psychiatric liaison services. Routine clinical data from 16 105 individual referrals from three central London accident and emergency (A&E) departments to psychiatric liaison services from 2012 to 2014 were obtained and analysed using the Clinical Record Interactive Search (CRIS).

Results

Referrals from A&E to psychiatric liaison services increased 16% over the 3-year study period. There were fewer referrals to psychiatric liaison services in winter months compared with other seasons. There were fewer referrals to psychiatric liaison services over the weekend compared with weekdays (average 15.4 daily weekday referrals *v.* 13.2 weekend, $z = 5.1$, $P < 0.001$), and weekend referrals were slightly less likely to result in admission to psychiatric hospital (11.3% *v.* 12.8%, respectively, $\chi^2 = 6.33$, $P = 0.01$).

Clinical implications

Psychiatric staffing in A&E and inpatient psychiatric wards requires planning to meet temporal and regional variations in the pattern of demand.

Declaration of interest

None.

Contents

- *Weekday and seasonal patterns in psychiatric referrals in three major London A&E departments, 2012–2014*
 - *Aims*
 - *Method*
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 - * *Trend in referrals year on year*
 - * *Seasonality of referrals*

* *Weekend referrals*

– *Discussion*

* *Limitations*

Accident and emergency (A&E) departments in the UK are getting busier, with an estimated 50% increase in demand over the past 10 years.¹ Approximately 5% of A&E attendances are for treatment of a mental disorder.² An estimated 8% of all A&E attendances are by ‘chronic repeat attenders’; the most common reason for frequent attendance is an untreated mental health problem.¹

The increased demands on A&E and the consequent impact on bed availability in acute trusts have been well studied, and a trend in peak pressures on A&E departments over the winter months has been established.^{3,4} Although it is acknowledged that A&E attendances are generally lower in the winter months, patients are likely to be more unwell, requiring admission that can lead to longer hospital stays and long waiting times in A&E – the ‘winter pressures’.⁵ This phenomenon has attracted injections of short-term funding of staff and resources in an attempt to encourage flow through the system – including to liaison mental health teams.

Public awareness of these pressures has led to a number of developments in recent years. These include the drive towards consultant-delivered care and, more recently, the ‘7-day National Health Service (NHS)’ proposals made by Bruce Keogh initially in 2013.^{6,7} These initiatives are now supported by government policy following suggestions that, further to the pressures on NHS services, there may be a weekend effect in terms of increased morbidity and mortality.⁸

A recent study by Patel *et al*⁹ investigated the mortality relating to *psychiatric* weekend admissions and found no correlation between weekend admission and increased mortality. However, the study identified that those admitted at the weekend had shorter admissions and higher readmission rates, leading to the suggestion that there is a different population who are more likely to be admitted at weekends. There is little or no work looking at the fluctuation in presentation at the gateways to psychiatric admissions – of which A&E attendance is a major source.

Anecdotally, it is said that ‘major’ mental illness, i.e. bipolar affective disorder and schizophreniform disorders, have bimodal peaks in presentation of spring and autumn;^{10,11} it might be assumed, therefore, that these would be peak admission times for psychiatric patients.

Here, we describe a study that analyses 3 years of referral data from three central London A&E departments to their psychiatric liaison teams, looking at seasonal variation and variation in weekday/weekend referrals, as well as some limited analysis of the demographics of those patients referred.

Aims

The aim of this study is to describe referral rates from three central London A&E departments to their respective psychiatric liaison services, to explore whether patterns of referral are similar to trends reported regarding general attendance to A&E, including the weekend and ‘winter pressures’ models reported nationally. The secondary aim was to compare weekend *v.* weekday referral trends, and whether these referrals were more or less likely to result in admission to inpatient services. The tertiary aim was to assess those presenting frequently to A&E services (3 times during the study period), and determine whether these patterns were more pronounced in this group of patients.

Method

Routine clinical data for this study was obtained from Camden & Islington (C&I) NHS Foundation Trust using the Clinical Record Interactive Search (CRIS) tool. CRIS is an application developed to enable routinely collected electronic health records to be used in research, using an explicit deidentification process.¹² C&I is a large mental health provider serving a geographic catchment area of two inner-city London boroughs, and approximately 440 000 residents. The database contains full but anonymised information from over 100 000 mental health patients.¹³ Studies using CRIS received ethical approval from the National Research Ethics Service (NRES) Committee East of England – Cambridge Central (14/EE/0177).

We conducted a retrospective cohort study of all A&E referrals to psychiatric liaison services across three London teaching hospitals (Royal Free Hospital (RFH) and Whittington Hospital (WH) in North London, and University College London Hospital (UCLH) in Central London) over a 3-year period (2012–2014), deriving a complete data set of 16 105 individual psychiatric referrals. These 3 years were chosen since complete electronic record data was available for all three sites.

Data collection on the 16 105 referrals was limited to fields that are well recorded on CRIS and encompassed the following: •day and date of referral from A&E to psychiatric liaison service•demographic details of referee – age, gender, ethnicity•discharge destination of referral, i.e. admission or discharge•admission, i.e. informal or under a section of the Mental Health Act.Data on diagnosis were not used for purposes of this study, as the majority of the patients referred to liaison teams are not allocated a recorded ICD-10 diagnosis, for instance, where no mental disorder is present after assessment.

Discharge destination of liaison referral being admission to psychiatric hospital was used as a ‘proxy of severity’ of presentation, in common with other similar studies.^{14–20}

Number of presentations of individual patients during the time period was also recorded, and those presenting 3 times in the study period were identified as ‘frequent attenders’ and analysed as a separate cohort within the study in an attempt to identify any differences in patterns of referral for this group.

Statistical analysis

Number of referrals per year was expressed as a proportion of referrals from the total population in the C&I catchment area (426 463 according to the 2011 census). Z-tests were used to compare the proportion of referrals between the different study years, seasons and days of the week (weekday *v.* weekend).

Descriptive statistics of all patients referred over the study period were examined.

The chi-square test of independence (²) was used to compare the number of referrals across seasons and days of the week.

Multilevel logistic regressions were used to account for multiple referrals of one patient and to examine the association between patient characteristics (sex, age and ethnicity) and weekend referral.

Finally, frequent attenders were compared to non-frequent attenders using the ² test for categorical variables and independent samples *t*-test for continuous variables.

Results

In the years 2012–2014, there were a total of 16 105 referrals from A&E services to psychiatric liaison teams in the study area (RF: 4575, UCLH: 6440, WH: 5090). These referrals represent a total of 10 049 individual patients referred. The total number of referrals per patient varied from 1 to 49.

Description of cohort

The average age of patients referred was 38.8 years (SD = 15.6); 92.6% were under 65 years of age. 51.2% of the cohort were male. Ethnicity data were missing for 17% of the sample. Of those with complete data, the majority of patients were of White ethnic origin (69.5%).

Frequent attenders (3 referrals over study period, $n = 1108$) did not differ from the rest of the cohort with regard to gender and age distribution, although there was a slightly higher proportion of people of White ethnic origin.

Trend in referrals year on year

As can be seen in *Table 1*, there was an increase of 16% ($z = 7.764$ $P < 0.001$) in total referrals over the 3 years across the three sites (RF +36%, WH +7%, UCLH +12%).

Site	2012	2013	2014	Total % increase 2012–2014
Royal Free Hospital	1229	1679	1667	36%
Whittington Hospital	1606	1769	1715	7%
University College London Hospital	2076	2040	2324	12%
Total	4911	5488	5706	16%

Referrals as proportion of population in catchment area: 1.15% 1.29% 1.34%—

Over the 3 years, 12.4% of referrals led to an inpatient psychiatric admission ($n = 2003$), 33.4% of those ($n = 654$) under a section of the Mental Health Act.

Seasonality of referrals

When the 16 105 referrals across the year were divided by season (defined as: winter, December to February; spring, March to May; Summer, June to August; Autumn, September to November) the only statistically significant finding was that, compared with all other seasons, the winter months saw fewer referrals ($z = 4.8$, $P < 0.001$; see *Table 2* and *Fig. 1*). This matched with the lowest percentage overall of admissions from all seasons. Peak admissions were seen in the spring – 13.1% or 546 admissions over the 3 years – however, the percentage of referrals resulting in admission did not differ significantly by season ($\chi^2 = 3.92$, $P = 0.27$). Similarly, there was no statistically significant difference between the percentage of referrals resulting in admission under the Mental Health Act by season ($\chi^2 = 0.30$, $P = 0.96$).

Season	Total no. of referrals (%)	Admissions from referrals (%)	No. of admissions under section of the Mental Health Act (%)
Winter	3715 (23.1)	474 (12.8)	157 (33.1)
Spring	4160 (25.8)	546 (13.1)	174 (31.8)
Summer	4162 (25.8)	496 (11.9)	165 (33.3)
Autumn	4068 (25.3)	487 (12.0)	158 (32.4)
Total	16 105	2003	654

Proportion of population (%) 0.87% 0.98% 0.98% 0.95%

Weekend referrals

Of the 16 105 referrals, there were fewer referrals to psychiatric liaison services at weekends compared with weekdays (0.48% v. 0.56% of the population; $z = 5.1$ $P < 0.001$).

Fewer weekend referrals resulted in inpatient admissions compared with weekday referrals (11.3% v. 12.8%, respectively, $\chi^2 = 6.33$, $P = 0.01$). Of the weekday referrals that resulted in admissions, 33.3% were under a section of the Mental Health Act. Of the weekend referrals that resulted in admissions, 30.6% were under a section. This difference is not statistically significant ($\chi^2 = 1.20$, $P = 0.27$).

Multilevel logistic regressions suggested that patients referred on weekends were more likely to be female, under the age of 65 and of White ethnic origin (Table 3). Table 3 Comparison of demographic data of all referrals to psychiatric liaison services; weekend v. weekday attenders

Total no. of referrals	Weekend referrals, %	Odds ratio (95% CI), P
Total referrals	16 105	
Gender		
Male	8330	2.8 (Reference)
Female	7775	26.61.11 (1.03–1.19), 0.006
Age		
Average (years)	39.36	<65 15 049
>65	1056	23.70.87 (0.71–0.96), 0.015
Ethnicity ^a		
White	10 116	26.7 (Reference)
Asian	686	21.60.75 (0.62–0.91), 0.004
Black	1778	24.20.86 (0.76–0.98), 0.02
Other	1535	25.70.95 (0.83–1.07), 0.40 ¹

Discussion

Referrals to psychiatric liaison services between 2012 and 2014 within three central London A&E departments echoed the national figures for A&E attendances, with increased overall attendance year on year. Our results also showed a seasonal trend similar to the A&E data, with decreased absolute referrals in winter months. However, in contrast to the general hospital population, these referrals appear to be for people with a lower severity of illness in the winter months (using the proxy outcome measure of an admission to inpatient psychiatric services resulting from those referrals). Our data showed increased severity of presentations (increased admissions) occurring outside the winter months, but there was no statistically significant variation in number of patients admitted informally or under the Mental Health Act throughout the year.

Weekdays were slightly busier in terms of average numbers of psychiatric referrals and admissions than weekends, in terms of both numbers of referrals and numbers of admissions to psychiatric inpatient beds (11.3% v. 12.8%, respectively, $\chi^2 = 6.33$, $P = 0.01$).

There is only limited evidence from this data set to support the concept of a defined seasonal variation in psychiatric presentation; despite the academic position that ‘major’ mental illness – bipolar affective disorder and schizophreniform disorders – have bimodal peaks in presentation of spring and autumn.¹ This phenomenon might, however, be able to explain the trend seen in our data of a shift in severity of illness when comparing the psychiatric population with the general acute hospital intake, with a peak of admission rates from winter to spring; however, there were no reliable data in this study on diagnosis.

This study demonstrates an increased presentation of mental health problems to A&E, and increased severity of those presentations, during the week rather than at the weekend.

Key points and implications for A&E and psychiatric liaison services from this study are as follows. •There was a significant increase in number of referrals from A&E to psychiatric liaison services year on year. •Winter was significantly different from the three other seasons (with lower referrals). •There were significantly fewer referrals per day (on average) on weekend v. weekdays, but the absolute difference was only 1–2%.

¹

a. Data on ethnicity missing for 1726 (17.2%) participants.

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Limitations

We looked at referrals to mental health liaison services, rather than totals for A&E mental health presentations. It is anticipated that a far higher proportion of patients with a primary psychiatric reason for presentation are managed by A&E staff and discharged without referral to mental health liaison services. It could be argued, therefore, that referral itself could be used as a proxy for severity of presentation.

This study looks at only one route of psychiatric presentation – through A&E – and does not include other routes of presentation, i.e. crisis teams, general practitioner, etc., and it is therefore not a comprehensive picture of fluctuation in need throughout the year.

Diagnosis was not reliably recorded in the data set and therefore not included in this study – a major limitation in discussion around seasonal variations in psychiatric illness presentation.

We have no data on timings of referrals and we are therefore unable to comment on ‘out of hours’ attendance other than weekday/weekend comparisons.

It is highly likely that there is a variety in threshold for referral between sites and at different times of year. For example, higher absolute summer referrals could possibly be accounted for by an influx of new doctors with lower thresholds for referral, resulting in an increase in summer referral rates but lower severity of presentation; however, we have used statistical tests in the data set in an attempt to mitigate the impact of these variables.

Use of psychiatric admission as a proxy for severity is not without its limitations: decisions to admit, particularly informally, may well be linked to bed pressures, abilities of home treatment teams locally, etc. The admissions under a section of the Mental Health Act should be less susceptible to these variables.

Although there are differences in the populations that the three hospitals serve, they are of similar size and location with equally diverse local populations, allowing for a good generalisability of the data. The e-record (RiO) is the only records system used by the psychiatric teams at all three sites and as such is a reliable representation of all patients seen.

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1.5.19 External validity and anchoring heuristics: application of DUNDRUM-1 to secure service gatekeeping in South Wales

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Abstract

Aims and method

Structured clinical judgement tools provide scope for the standardisation of forensic service gate-keeping and also allow identification of heuristics in this decision process. The DUNDRUM-1 triage tool was completed retrospectively for 121 first-time referrals to forensic services in South Wales. Fifty were admitted to medium security, 49 to low security and 22 remained in open conditions.

Results

DUNDRUM-1 total scores differed appropriately between different levels of security. However, regression revealed heuristic anchoring on the ‘legal process’ and ‘immediacy of risk due to mental disorder’ items.

Clinical implications

Patient placement was broadly aligned with DUNDRUM-1 recommendations. However, not all triage items informed gatekeeping decisions. It remains to be seen whether decisions anchored in this way are effective.

Declaration of interest

Dr Mark Freestone gave permission for AUC values from Freestone *et al.* (2015) to be presented here for comparison.

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Secure mental health services in the United Kingdom are designed to detain individuals who have severe mental ill health and are believed to pose a significant risk of harm to others.¹ Secure services in the UK are configured around three tiers (low, medium and high) in order to accommodate people in different levels of clinical security. The task of allocating individual patients to different security tiers is challenging. First, clinicians are expected to adhere to the principle of the *least restrictive option*,² and yet there are no clearly defined eligibility criteria for different levels of security, and no clear guidelines for their particular roles.³ Furthermore, consideration of a patient's clinical presentation, psychiatric history, diagnosis, comorbidity, developmental history, family history, employment history and ethnic/cultural background,⁴ and the patchy information about outcomes achieved by secure services, complicates and compromises gatekeeping decisions further still. The challenge for forensic gatekeepers in matching patients to appropriate security levels is apparent in the reported heterogeneity of cases admitted by both medium^{5,6} and low⁷ secure services.

The process of deciding who should/should not be admitted to specific levels of security requires consideration of a wide range of characteristics.⁴ Unfortunately, knowledge about associations between patient characteristics and relevant outcomes is currently restricted by a dearth of rigorously controlled outcome studies⁸ and by a range of confounding factors that include, but are not restricted to, diagnostic uncertainty, individualistic risks, individual needs and treatment responsiveness. At present, decisions regarding patient allocation to different levels of security must be extrapolated from an uncertain knowledge base, with inevitable uncertainty regarding likely outcomes. Apart from the weak knowledge base, it is important also to consider the inherent complexity of this form of decision process.

Under complex and uncertain circumstances, human decision-making typically depends upon heuristics. Heuristics describe the normal tendency for people to employ a range of strategies in order to reduce the burden on their finite cognitive resources.⁹ Heuristics are especially prevalent when decision makers are required to accommodate multiple or conflicting sources of information.¹⁰

Heuristic phenomena of particular relevance to forensic practice include representativeness bias, availability heuristics and decision anchoring.¹¹ The anchoring heuristic, which will be the focus here, describes decision processes that are biased toward initially received (or attended to) information.^{12,13} Anchoring describes a process where initially considered features disproportionately influence decisions, while later processed information is neglected and does not influence decision-making.¹⁰

When anchoring is present, decisions that are supposed to be based on a range of characteristics (i.e. should the patient be admitted to secure services?) will instead be based on a limited set of characteristics. Under these circumstances, the structure of assessments and/or the emphasis placed on specific characteristics will be more important than the bulk of the information that is intended to inform decisions. There is a risk, therefore, that patients may be inappropriately placed because of the neglect of information.

One of the objectives of structured clinical judgement tools is to increase the transparency and consistency in decision-making and to make sure that relevant factors consistently inform clinical decisions. Despite the availability and widespread knowledge of structured clinical judgement tools in forensic services, clinical opinion can still be more influential than formally assessed risk status in decisions to detain people in secure conditions.¹⁴

Clinical opinion has been criticised as error prone and too heavily dependent on heuristics.¹⁵ Heuristics have predominantly been associated with misdiagnosis, inappropriate treatment¹⁶ and (notably for forensic services) high-impact failures of case management that have resulted in fatalities.¹⁷ Heuristics are predominantly presented as a source of error; there is a widespread assumption that cognitive short-cuts are necessarily bad, but also a growing realisation that the efficacy of heuristics is open to debate.¹⁸ A counter argument has therefore arisen against the *a priori* assumption that heuristics are necessarily bad. This counter argument is that heuristics may have many practical benefits that counterintuitively can include accuracy, transparency and efficiency.¹⁹ Furthermore, it has been argued that heuristics in practice-based medicine drive the iterative refinement of decision-making and allow clinicians to learn to focus on outcome-relevant features through reflection on the consequences of clinical decisions that they observe directly over time.²⁰ The possibility that heuristics may have some value is particularly interesting to forensic practitioners who have become accustomed to the notion that clinical opinion is less reliable than actuarial or structured clinical judgement tools.²¹ The nature and extent of the use of heuristics in forensic practice, however, remain largely unknown, despite the substantial potential benefits and costs for these forms of decision-making.

Until recently, gatekeeping decisions have relied on clinical experience along with local definitions of security need.

Structured clinical judgement tools with robust psychometric properties are now beginning to influence gatekeeping practice and may be preferred because they promise increased transparency and uniformity in decision-making. Despite widespread knowledge of the DUNDRUM quartet²² among secure service personnel, the extent to which this tool has been adopted and implemented in gatekeeping decision-making is unknown and has only recently become a subject for evaluative investigation.²³

Kennedy²⁴ lists violence, immediacy of risk, specialist forensic need, absconding behaviour and public confidence as the assessment guidelines that should determine security placement of patients. The Dangerousness, Understanding, Recovery and Urgency Manual²² was developed as an aid to clinical decision-making, and includes a scale designed to assist psychiatric triage (DUNDRUM-1). The DUNDRUM-1 is an 11-item risk assessment tool that uses both scores on individual items and the distribution of those scores (a case should score mostly in one category) to inform judgement. The tool is reported to have excellent predictive validity, high internal consistency and good interrater reliability.²⁵ The DUNDRUM-1, therefore, has potential for assisting clinical decision-making regarding patient placement and for evaluating the correspondence between patient characteristics and secure service placement. The DUNDRUM-1 also has the potential to measure the influence of heuristic bias in clinical decision-making.²⁶⁻²⁷ The DUNDRUM quartet is a third-generation risk assessment tool, with items that are anchored in specific definitions of low, medium and high security that do not take account of the contextual factors within individual secure units (patient acuity, patient dynamics, workforce skill, philosophies of care and so on). Nevertheless, the DUNDRUM allows the initial quantification of the specific nature of anchoring that may underpin clinical decision-making in relation to allocating people to levels of security.

Aims and hypotheses

First, the current study was designed to extend examination of the external validity of the DUNDRUM-1 psychiatric triage tool to a sample that was different from the original validation sample,²²⁻²⁵ and also different from the first external demonstration²³ of the DUNDRUM-1 as a useful support for clinical decision-making. Significant alignment between DUNDRUM-1 scores and patient placement would confirm the external validity of the tool. The second objective of the current study was to use the DUNDRUM-1 as a ‘best practice’ framework in which to examine anchoring heuristics in secure service gatekeeping decisions. Anchoring would be apparent if, following regression, one (or a narrow set) of the DUNDRUM-1 items were able to explain a disproportionately large fraction of variance in patient placement.

Method

Sampling

The study was approved by the research ethics committee of Cardiff Metropolitan University’s School of Health Sciences, and as a service evaluation by the relevant local National Health Service (NHS) Health Board Research and Development department. All patient characteristics were extracted from written narrative reports that had been triggered by a referral requesting admission to secure services. In every instance, permission was sought from the original report author; no requests were declined.

Characteristics of the sample were extracted from the All Wales Secure Services database of immediate post ‘referral-to-service’ (gatekeeping) assessment reports between January 2010 and June 2013. This database is used in the management of Welsh secure service patient placements. Cases were selected if they had not previously been referred either for treatment or assessment by secure services. First-time referral was used as an inclusion criterion to control for possible confounding of assessment recommendations by previous placement of patients. The database was interrogated sequentially for cases where a psychiatric report was available and the destination of the patient recorded. A total of 121 assessment reports were present in the database for the sampling period.

Of the 121 cases, 50 patients were admitted to medium security, 49 were admitted to low security and 22 remained in open conditions. Reports included comprehensive details of the index offence, forensic history, Mental Health Act 1983 status, psychiatric history, diagnoses, previous non-criminalised violence and/or self-harm, and the gatekeeping recommendation for security level.

Design

The study used a between-subjects retrospective cohort design.²⁸ All cases involved first-time referrals for secure care to avoid biasing of placement decisions by previous secure referrals. Neither of the raters had any involvement in the referral process for any of the patients included in the current study. Both were also blind to the referral outcomes at the time of completing the assessments.

Materials

The Dangerousness, Understanding, Recovery and Urgency Model²² was used as the method for rating patient characteristics at the time of first referral. DUNDRUM-1 is the triage component of the DUNDRUM Quartet and consists of 11 items that rate patient triage features on a 0–4 scale, where 0 is very low severity and 4 is high severity. Kennedy *et al.*²² suggest that people who mostly score 4 (across the range of the items on the scale) will initially require conditions of high therapeutic security (i.e. Special Hospital). A person who mostly scores 3 is likely to need conditions of medium security, and a person who is mostly rated 2 will be best placed in conditions of psychiatric intensive care (acute low security). A patient rated as 1 on most of the items should be safely treated in an open setting, and a person mostly rated 0 may be cared for in a community setting.

The DUNDRUM-1 was selected on the basis of its psychometric properties. The DUNDRUM-1 has been reported to have acceptable validity and reliability.²⁵ For instance, the scale has been reported to have good internal consistency (Cronbach's α : 0.95) and also good interrater reliability; the kappa statistic could be rated for seven of the 11 items and was greater than 0.85 for each of these.

Procedure

The DUNDRUM-1 was applied to each report by one of 2 raters (D.L. & T.D.). Both raters had successfully completed reliability workshops for the Historical Clinical Risk Management-20 (HCR-20), Sexual Violence Risk-20 (SVR-20) and Psychopathy Checklist – revised (PCL-R); they had achieved high interrater reliability with HCR-20 assessment (kappa for both: 0.9) and were therefore assumed to be reliable in the application of other similar structured clinical judgement tools (DUNDRUM-1). For each case, each item of the DUNDRUM-1 was scored by either D.L. or T.D. in accordance with item score definitions published for DUNDRUM-1.²²

Methods of analysis

All statistical analyses were conducted using SPSS version 22 (IBM). The alpha criterion was set throughout at 0.05, and alpha was adjusted for multiple comparisons using the Holm–Bonferroni method.²⁹

The index of predictive validity reported here is the area under the curve (AUC). In both the current study and the comparison data²³ the AUC was used to determine the ability of the individual DUNDRUM-1 item scores (and total score) to discriminate between cases admitted to security (low or medium secure) versus those who were not admitted to security (open conditions). AUC values can range between 0 and 1 (0 = perfect negative prediction, 0.5 = no predictive validity and 1 = perfect positive prediction). Higher AUC values indicate increased predictive validity, 0.5 acts a reference and 95% confidence intervals are used to determine whether predictive validity is superior to chance; where the lower bounds of the 95% CI were below 0.5, the null hypothesis (predictive validity is no better than chance) was accepted. Similarly, where confidence intervals overlapped, there were no significant differences in predictive validity between DUNDRUM-1 items or samples.

The next set of analyses was designed to determine whether scores for DUNDRUM-1 items differed between patients allocated to each of the three tiers of security (open conditions, low security or medium security) in the current sample. Total DUNDRUM-1 scores and individual DUNDRUM-1 item scores for these three groups were compared using Kruskal–Wallis analyses, *post hoc* contrasts between specific pairs of groups used Mann–Whitney U, and alpha inflation was controlled using the Holm–Bonferroni²⁹ method.

The final set of analyses used multiple ordinal regression to explore the extent to which DUNDRUM-1 items might individually, or in combination, explain patient placement. Analysis used multiple ordinal regression because of the ordinal nature of the independent (DUNDRUM-1) and dependent (patient placement) variables. Models were designed using the enter method in order to explore possible structures in decision processes.

Results

For comparison, the results of the AUC analyses for the current sample and for the Freestone *et al.*²³ sample are presented in *Fig. 1*. Predictive validities of total DUNDRUM-1 scores for both samples were superior to chance, and the AUC values and confidence intervals were remarkably similar between the two samples. The picture for individual DUNDRUM-1 items was more complex and not wholly consistent between the two samples. The two samples yielded similar significant AUC results for the following five items: immediacy of risk, specialist forensic need, absconding and legal process. The two samples were also consistent in finding that neither self-harm nor suicide immediacy predicted secure admissions. The two samples yielded inconsistent AUC results for violence seriousness, preventing access, public/victim sensitivity, complex risk of violence and institutional behaviour. Violence seriousness predicted secure placement in the East London sample but not in the South Wales sample; the same pattern was observed for preventing access, public/victim sensitivity and complex risk of violence. The opposite pattern was apparent for the institutional behaviour item; this item showed significant predictive validity for the South Wales sample but not for the East London sample. The preceding analysis served as a means of assessing the predictive validity of the DUNDRUM-1 for discriminating between patients admitted to secure services versus those not admitted to secure services. The next series of analyses were concerned with whether either DUNDRUM-1 total scores or individual DUNDRUM-1 items differed significantly between three groups of patients in South Wales. *Fig. 1* Comparison of AUC for DUNDRUM-1 total and item scores between East London (Freestone *et al.*²³) and South Wales (current sample). AUCs reflect the validity of DUNDRUM-1 items for discriminating individuals admitted to secure services (low or medium secure) from those not admitted to secure services. Error bars indicate 95% confidence intervals. The hatched reference line at AUC = 0.5 indicates the line of no information.

External validity, total DUNDRUM-1 scores

Fig. 2 presents the mean total DUNDRUM-1 scores separately for the patients who stayed in open conditions and for those who were admitted to either low or medium secure care. The mean scores suggest appropriate alignment between DUNDRUM-1 criteria and clinical gatekeeping decisions; mean scores increased as the levels of therapeutic security increased. This impression of the total DUNDRUM-1 scores was confirmed by the association between patient placement and total DUNDRUM-1 scores, $H(n = 121, d.f. = 2) = 20.737, P < 0.000$. Furthermore, *post hoc* comparisons with Mann–Whitney and alpha adjustment revealed that mean total DUNDRUM-1 scores for each of the groups differed from the other two groups (open *v.* low, mean difference = 3.86, $P < 0.050$; low *v.* medium, mean difference = 5.78, $P < 0.005$; and open *v.* medium, mean difference = 9.64, $P < 0.005$). *Fig. 2* Mean DUNDRUM-1 scores for the patients allocated to open conditions, low and medium security. Error bars show the standard error of the mean (* $P < 0.050$; *** $P < 0.001$).

External validity, individual DUNDRUM-1 items

Fig. 3 presents the mean scores for individual DUNDRUM-1 items for three groups of patients referred to the South Wales Forensic Mental Health Service: those who subsequently remained in open conditions, those admitted to low security and those admitted to medium security. Between-group differences and successive increases in the mean scores for individual items indicated that patient placement had been consistent with DUNDRUM-1 criteria. Inspection of the data in *Fig. 3* suggested that patient placement was not consistently aligned with all of the DUNDRUM-1 items, for example, there was clear separation in mean scores between the groups for the legal process item but poor separation for the self-harm seriousness item. In order to explore this impression of the association between items and patient placement, a series of Kruskal–Wallis tests were conducted, one for each of the 11 items of the DUNDRUM-1. *Fig.*

3 Mean DUNDRUM-1 item scores for patients who stayed in open conditions, and those who were admitted to either low or medium security. Error bars show the standard error of the mean.

The results of the multiple Kruskal–Wallis analyses are presented in *Table 1*. The impression that some DUNDRUM-1 criteria fitted service placement more accurately than others was confirmed. Only seriousness of violence, immediacy of risk, specialist forensic need, legal process and institutional behaviour were significantly associated with patient placement. Placement was not associated with absconding risk, complex violent need, victim sensitivity/public confidence, preventing access, self-harm seriousness or immediacy of suicide risk. It is worth noting, however, that several items (absconding risk, complex violent need and victim sensitivity/public confidence), if tested individually, would have been regarded as statistically significant but were rejected here after alpha adjustment. *Table 1* Kruskal–Wallis analysis of individual DUNDRUM-1 items

DUNDRUM-1 item	Observed P -value	Adjusted alpha	Significance
Legal process	<0.0000	0.005	***
Immediacy of risk	<0.0000	0.005	***
Specialist forensic need	<0.0000	0.005	***
Seriousness of violence	<0.0000	0.006	***
Institutional behaviour	<0.0010	0.007	**
Absconding risk	<0.0500	0.008	ns
Complex violent need	<0.0500	0.010	ns
Victim sensitivity/public confidence	<0.0500	0.013	ns
Preventing access	>0.0500	0.017	ns
Self-harm seriousness	>0.0500	0.025	ns
Immediacy of suicide risk	>0.0500	0.050	ns

The above Kruskal–Wallis analysis was used to select predictor variables for regression modelling of gatekeeper decision-making and identified five significant potential predictor variables. The current sample of 121 cases with five predictor variables therefore exceeded the normal power convention (30) in standard regression analyses (104 + number of predictors = 109).

Analysis of heuristics

With an ordinal dependent variable, an ordinal regression was chosen. The distribution of the dependent variable was skewed towards the higher security levels (see *Fig. 2*), so the complementary log-log function was used.

The predictors for the model were those highlighted in *Table 1* by the Kruskal–Wallis analysis (seriousness of violence, immediacy of risk, specialist forensic needs, legal process and institutional behaviour). The model was a significant predictor of level of security assignment ($\chi^2 = 236.6$, d.f. = 5, $P < 0.001$), with estimates of variance accounted for ranging between 86% (Cox and Snell) and 98% (Nagelkerke). The goodness of fit tests (Pearson and deviance) were both non-significant ($P = 1.000$ for both). The test of parallel lines was also non-significant ($\chi^2 = 0.0$, d.f. = 5, $P = 1.000$). Parameter estimates are shown in *Table 2*. The two significant predictors in this initial model were legal process and immediacy of risk. *Table 2* Parameter estimates of variables predicting assigned level of security (whole model)

Estimates	e	Waldd.f.	P -value	Predictors
Seriousness of violence	0.060	190.111	>0.050	Immediacy of risk
0.360	174.701	<0.050	Specialist forensic needs	
0.240	201.471	>0.050	Legal process	
1.810	2842.221	<0.001	Institutional behaviour	
0.220	150.021	>0.050		

To examine the variance accounted for by different elements of the model, the analysis was repeated with only legal process and immediacy of risk (the elements that were significant in the initial model). Legal processes and immediacy of risk were significantly associated (Kendall's tau = 0.255, $P < 0.010$). The simpler model was a significant predictor of security assignment ($\chi^2 = 166.4$, d.f. = 2, $P < 0.001$); the estimates of variance accounted for were lower than when all five predictors were included in the model, between 75% (Cox and Snell) and 85% (Nagelkerke). The goodness of fit tests were both non-significant (Pearson $P = 0.940$, deviance $P = .530$), see *Table 3*. *Table 3* Parameter estimates of variables predicting assignment to level of security

Estimates	e	Waldd.f.	P -value	Predictors
Immediacy of risk	0.350	137.831	<0.005	Legal process
1.560	2540.731	<0.001		

The remaining three predictors (seriousness of violence, special forensic needs and institutional behaviour) were then considered without legal Process and immediacy of Risk, see *Table 4*. The resulting model was a significant predictor of security assignment ($\chi^2 = 34.9$, d.f. = 3, $P < 0.001$); estimates of variance accounted for ranged between 14% (McFadden) and 28% (Nagelkerke). The goodness of fit tests were both non-significant (Pearson $P = 0.200$, deviance $P = 0.080$). Specialist forensic need was correlated with both institutional behaviour (Kendall's tau = 0.342, $P < 0.001$)

¹ Alpha was adjusted for multiple comparisons using the Holm–Bonferroni method. DUNDRUM-1 items were sorted on the basis of observed P -value (reading down, lowest to highest). *** $P < 0.000$; ** $P < 0.001$; ns, not significant.

² Significant P values are highlighted in bold.

³ Significant P -values are highlighted in bold.

and seriousness of violence (Kendall's tau = 0.258, $P < 0.005$); however, institutional behaviour scores were independent of seriousness of violence (Kendall's tau = 0.025, $P > 0.050$). Table 4 Parameter estimates of variables predicting assigned level of security (initially excluded predictors) Estimates. e. Waldd.f. P-value Predictors Seriousness of violence 0.370.165.011 <0.050 Specialist forensic needs 0.300.135.261 <0.050 Institutional behaviour 0.330.136.261 <0.050⁴

Discussion

External validity of the DUNDRUM-1 triage tool

The weaknesses of unsupported clinical risk assessment have been the subject of debate for more than 30 years, and a growing number of tools have been designed with the intent of maximising consistency and transparency; however, the application of violence risk assessment tools has been extensively criticised.³⁰ The DUNDRUM quartet²² has been designed specifically as a support tool for clinical judgements at important junctures in patient care (admission to hospital, increasing/decreasing therapeutic security and discharge). One potential weakness of the DUNDRUM quartet is that it was developed in a specific service context, and its practical relevance depends heavily upon its generality. Currently, the validity of this tool rests upon work conducted predominantly by its authors; very little is known about how well the contents of the DUNDRUM quartet generalise to decision-making in other services.

Overall, the findings of the current study support the predictive and external validity of the DUNDRUM-1 triage tool as a clinical decision aid for first-time referrals to secure psychiatric services. Total scores on the DUNDRUM-1 differed between all three of our groups of patients (open conditions, low secure and medium secure), and scores increased as levels of security allocation increased. The main measure of predictive validity was the AUC, and our findings, along with those of Freestone *et al.*,²³ indicate acceptable discriminative power for the DUNDRUM-1; total scores on the DUNDRUM-1 yielded AUC values between 0.75 and 0.8, with lower bounds for 95% CIs that were comfortably above chance. It is notable, however, that these AUC values were lower than that reported earlier (AUC = 0.984) when the DUNDRUM-1 was used to discriminate between court cases in which individuals were admitted or not admitted to psychiatric care.²⁵ By contrast, all of the individuals in the samples reported by Freestone *et al.*²³ and here were referred to services, presumably because their offending and/or clinical presentation caused sufficient concern to prompt forensic assessment. It is therefore unsurprising that our AUC values were lower than those reported earlier, because any sample referred to specialist services will have been relatively homogenous compared with a 'randomly' selected and clinically heterogeneous court sample. This finding shows that the predictive validity of the DUNDRUM-1 depends to some extent upon the context in which it is being applied, and its external validity may therefore be constrained.

The pattern of findings for the predictive validity of individual DUNDRUM-1 items was not simple. First, both the current study and Freestone *et al.*²³ found that self-harm and suicide risk were not related to decisions following referral for possible admission to secure conditions. This finding suggests that secure admissions in South Wales and East London were not influenced by the severity of the risk that individuals posed to themselves. It is plausible that differences in service configuration (e.g. the degree of integration between secure and general services) between the UK and Eire could explain the restricted external validity of these two items. Alternatively, this could reflect a difference in emphasis on public protection between services in the UK and in Eire. Further research would have to be conducted in order to determine the source of this important difference.

As well as the differences between the two UK samples and the original validation sample for the DUNDRUM-1, there were also a number of differences between the two UK samples that may indicate local constraints on the validity of some of the tool's items. There was agreement in AUC analysis between the South Wales and East London samples for

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Significant *P*-values are highlighted in bold.

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six of the 11 DUNDRUM-1 items (including non-significant results for suicide and self-harm). AUC results therefore differed for five items, including seriousness of violence, preventing access, public/victim sensitivity, complex risk of violence and institutional behaviour. Therefore, the influence of these factors on secure admissions decision-making differed between South Wales and East London.

Overall, the above interpretation of the external validity of the DUNDRUM-1 triage tool raises some difficult questions. Are generic clinical judgement tools viable for applications across contexts, where there appear to be so many differences in emphasis between services and in the predictive accuracy of the tool? Might locally defined clinical judgement tools provide an alternative approach that would be more contextually relevant, especially in light of increasing devolution of health service configuration and governance between regions of the UK?

Anchoring heuristics in clinical decision-making

The emphasis in the forensic literature has been on the possible contribution of heuristic decision-making to preventable fatalities; however, only a minority of such events are in fact predictable, even when heuristics could have been minimised by the application of risk assessment tools.³¹ The current work makes a novel contribution, because it focused instead on characterising the nature of heuristics applied by gatekeepers when patients were allocated to different levels of therapeutic security at the point of first referral to secure services.

The information for rating all of the items of the DUNDRUM-1 was readily available in all of the patient referral reports that were analysed in the current study. The gatekeeping clinicians were therefore clearly collating and reporting patient characteristics relevant to all 11 of this tool's items, even though the gatekeepers were not using the DUNDRUM-1 in their decision-making. The DUNDRUM triage tool, therefore, showed excellent face validity with respect to the information gathering practices in secure triage assessment. In the following, we consider whether all of this information actually informed clinical triage decisions to the same extent, or whether gatekeeping decisions instead reflected the operation of heuristic bias.

The second objective of the current study was to use regression analyses of individual DUNDRUM-1 items and gatekeeping decisions to examine the nature of heuristics in the decisions made by clinicians in South Wales. Our analyses revealed the presence of anchoring¹² that was biased in favour of a subset of DUNDRUM-1 items. Two of the 11 (legal process and immediacy of risk due to mental disorder) explained a disproportionately large fraction (between 86% and 98%) of the variance in patient placement. When these two potent predictors were removed from the model, three further variables (seriousness of violence, specialist forensic need and institutional behaviour) were shown to predict security level but explained a more modest proportion (between 14% and 28%) of variance in decision-making. Taken together, the two regression analyses suggest a two-tiered, hierarchical heuristic (see *Fig. 4*) that was primarily anchored by two items, legal process (which reflected the least restrictive option acceptable to all parties) and immediacy of risk due to mental disorder; the secondary tier included consideration of seriousness of violence, specialist forensic need and institutional behaviour. *Fig. 4* Legal process and immediacy of risk served as heuristic anchors that may have acted as a heuristic frame for secondary consideration of seriousness of violence, specialist forensic need and institutional behaviour.

Our heuristic analysis rested on the assumption that each of the items of the DUNDRUM-1 tool should influence decision-making to the same extent. This is a common assumption in the construction of risk assessment tools (PCLR; HCR-20), but it often does not reflect the subjective weighting given to these characteristics by clinicians during assessments. Further application of regression methods with the DUNDRUM-1 and other assessment tools could further elaborate the extent and nature of anchoring heuristics in many aspects of clinical decision-making regarding people with mental illness.

Limitations

Anchoring and framing heuristics are closely interrelated,¹¹ and it is plausible that consideration of two or more of the patient characteristics may have interacted: consideration of some items may have acted as frames for subsequently considered items. Unfortunately, the design of the current study did not allow more detailed exploration of such interactive cognitive processes; the contribution of framing heuristics here must remain unknown.

Examination of the referral reports yielded information on a great many factors that did not form part of the items included in the DUNDRUM-1. Gatekeepers were therefore routinely collecting and assessing information beyond the scope of the DUNDRUM-1. Our analysis depended on applying the DUNDRUM-1 as a best practice framework, and it could not capture the possible contribution of these other factors to triage assessment decisions. We conclude that the heuristic in triage decisions was anchored on only two factors. It is possible that selection of the DUNDRUM-1 as the best practice framework for the current analysis may have artificially constrained the resulting heuristic and clinicians may have been basing their decisions on a wider set of factors.

The current study does not inform about any relationships between triage decisions and either health or forensic outcomes. Individual progress monitoring and aggregated data on outcomes for patients placed in secure mental health care (cf. Centre for Mental Health, 2011) remains underdeveloped in the UK.

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1.5.20 Against the stream: Antidepressants are not antidepressants – an alternative approach to drug action and implications for the use of antidepressants

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Abstract

Although antidepressants are regarded as effective and specific treatments, they are barely superior to placebo in randomised trials, and differences are unlikely to be clinically relevant. The conventional disease-centred understanding of drug action regards antidepressants as targeting an underlying brain process, but an alternative ‘drug-centred’ view suggests they are psychoactive substances that modify normal mental states and behaviour. These alterations, such as numbing of emotions, may reduce feelings of depression, and also create amplified placebo effects in randomised trials. Patients should be informed that there is no evidence that antidepressants work by correcting a chemical imbalance, that antidepressants have mind-altering effects, and that evidence suggests they produce no noticeable benefit compared with placebo.

Declaration of interest

The author is co-chairperson of the Critical Psychiatry Network.

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Antidepressants are by far the most commonly prescribed class of drug for mental disorders, and their use continues to rise.¹ Huge marketing campaigns have persuaded the general public that depression is a ‘chemical imbalance’ that antidepressants can help reverse. Professional organisations claim that antidepressants are an effective and specific treatment for depression, and that they are considerably more effective than placebo. The Royal College of Psychiatrists’ current information leaflet suggests that 50–65% of people who are given an antidepressant will show ‘much improvement’ within 3 months, compared with only 25–30% on placebo.²

The evidence base

Overall, randomised controlled trials show that depression ratings decrease slightly more with antidepressants than placebo. Studies are inconsistent, however, and differences are small, especially when unpublished trials are included. Reviews of the literature on tricyclic and older antidepressants concluded that ‘in well-designed studies, the differences between antidepressants and placebo are not impressive’.³ Meta-analyses of trials of selective serotonin reuptake inhibitors (SSRIs) and other modern antidepressants that include unpublished trials have found mean differences between antidepressants and placebo ranging from 1.80 to 2.55 points on the widely used Hamilton Rating Scale for Depression.^{4–6}

The clinical significance of such small differences is doubtful. The Hamilton scale has a total score of 54 points. A recent analysis comparing scores on the Hamilton scale with scores on the observer-rated Clinical Global Impression (CGI) scale suggests that a difference of three points on the Hamilton scale is equivalent to a rating of ‘no difference’ on the CGI scale, while a difference of eight points is required to obtain CGI scale ratings of ‘mild improvement’.^{7,8} Antidepressant/placebo differences therefore appear to fall well below levels required to make a noticeable difference in someone’s condition.

Antidepressant effects and severity

It is often suggested that antidepressants are more effective, or perhaps only effective, in severe depression, and that this can explain their poor performance relative to placebo in trials with mixed populations. Some meta-analyses have found a gradient between the size of the antidepressant/placebo difference and the severity of initial depression across trials,^{5,9} although differences in people with the most severe depression still fall well below those equating to ‘mild improvement’ on the CGI. Other meta-analyses have not identified a severity gradient.^{10,11}

Older evidence suggests that antidepressants are not particularly helpful for inpatients with depression. A Medical Research Council trial, for example, found little difference between imipramine, phenelzine and placebo.¹² Trials of antidepressants for the treatment of depression in people with bipolar disorder have also found no differences between antidepressants and placebo.¹³

Antidepressant effects and the drug-centred model of drug action

The accepted view of drug action in psychiatry is that psychiatric drugs work by targeting a putative underlying brain abnormality. I have called this the ‘disease-centred’ model of drug action. An alternative explanation is the ‘drug-centred’ model, which suggests that psychiatric drugs influence symptoms of mental disorder and distress through their psychoactive effects. ‘Psychoactive’ drugs, sometimes referred to as ‘mind-altering drugs’, include recreational drugs, drugs prescribed for mental health problems and some other medical drugs (e.g. steroids, anticholinergics). They modify normal thoughts, emotions and behaviours in characteristic ways. According to the drug-centred model of drug action, for example, antipsychotics reduce the symptoms of psychosis through their ability to produce a state of mental slowing and emotional restriction, a state they produce in animals and humans, regardless of the presence of psychiatric or behavioural problems. Anxiolytics reduce symptoms of anxiety through their well-known sedative and relaxant effects, which occur independently of any psychiatric disorder.

Elsewhere, I have outlined the lack of evidence for the disease-centred view of drug action for any class of psychiatric medication.¹⁴ The serotonin and noradrenaline theories of depression, which appear to explain the action of antidepressants in a disease-centred manner, are not supported by evidence or expert opinion.¹⁵¹⁶ Moreover, numerous randomised trials have shown that drugs that are not considered as antidepressants, and have actions on other neurotransmitter systems, including benzodiazepines, opiates, stimulants and antipsychotics, are as effective as recognised antidepressants in people with depression.¹⁵

The drug-centred model suggests that the mental and physical alterations produced by antidepressants account for the differences between antidepressants and placebo in randomised trials. The psychoactive effects of individual antidepressants vary in strength and character, depending on chemical class and composition. Tricyclic drugs are strongly sedating and impair psychological test performance.¹⁷ SSRIs have weaker and more subtle effects, but can induce a state of emotional numbing or restriction, lethargy, reduced libido and sexual impairment. They also occasionally produce a state of agitation and tension, especially in young people.¹⁸ Antidepressant-induced emotional numbness may directly reduce the intensity of people’s feelings, but mental and physical alterations may also produce an amplified placebo effect, by revealing to people participating in randomised trials that they are taking an active drug. The fact that drug/placebo differences are so small, however, suggests that antidepressant-induced alterations are not clinically useful, whether they act through pharmacological or psychological means.

Adverse effects

By emphasising that psychiatric drugs change the normal state of the brain and body, the drug-centred model highlights the likelihood of adverse effects. Although modern antidepressants are usually well-tolerated, there is mounting evidence of less common but serious effects, including increased suicidal thoughts,¹⁹ fetal malformations,²⁰ bleeding, a prolonged and severe withdrawal syndrome,²¹ and persistent sexual dysfunction after discontinuation.²² The widespread use of antidepressants may also produce nocebo effects by undermining people’s sense of self-efficacy, potentially setting them up for a lifetime of chronicity and dependence on services.

Conclusions

The public have been led to believe that depression is caused by a chemical imbalance that antidepressants help to rectify; however, there is no current evidence that any sort of drug specifically targets an underlying biological abnormality, and whether there is an underlying brain state or states specific to the experience of depression has not been demonstrated. Amplified placebo effects and the subtle emotional alterations produced by antidepressants may account for the small differences between antidepressants and placebo found in some randomised controlled trials, but these small differences are unlikely to translate into a clinically meaningful effect. Doctors need to share this evidence with patients who are considering taking an antidepressant. Doctors should also help people to consider the pros and cons of using a mind-altering drug, such as an antidepressant, in relation to each individual’s particular situation. This should include discussion of alternative ways of achieving desired outcomes, using strategies that do not carry the inherent risks of drug treatment.

Although the discovery of a specific antidepressant agent in the future cannot be ruled out, it is possible that we misunderstand the nature of depression, and that regarding it as a discrete and universal disorder may have raised false hopes about the chance of a generally applicable ‘cure’ or treatment. The alternative view of depression as part of the spectrum of meaningful human responses to the world suggests that drugs will only dull the experience. In the end, the situation that provoked the negative emotion needs to be addressed. Depression is a signal that change is needed in some aspect of life.

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1.5.21 Sharing quality and safety improvement work in the field of mental health

Amar Shah

date

2018-2

Contents

- *Sharing quality and safety improvement work in the field of mental health*

I welcome the findings of D’Lima, Crawford, Darzi and Archer¹ on the relative scarcity of publications related to mental health quality and safety improvement within reputable quality and safety journals.

I agree with the authors’ proposition that there is increasing interest in the application of improvement science within the mental health field. A large number of providers of mental health services in the UK and beyond are now starting to apply quality improvement methods at scale. The Royal College of Psychiatrists has established a quality improvement committee over the past year, and has recently appointed its first quality improvement lead. There is also an organically growing global mental health improvement network (#MHimprove), which meets twice a year and has begun to present and share knowledge at large international conferences.

As both the College quality improvement lead and the lead for quality at East London NHS Foundation Trust (ELFT), with perhaps one of the largest improvement programmes in the world within mental health services, my experience agrees with the conclusion of the authors that publishing mental health improvement work within reputable quality and safety journals is a struggle. Our efforts to share real-world improvement work have largely been unsuccessful in the high-quality journals within this field. My theory, both as a submitting author and a reader of these journals, is that the journals are still focusing more on the research and evaluation end of the spectrum, as opposed to real-world, messy improvement work in mental health services.

As an example, the use of Shewhart (control) charts to demonstrate improvement over time, which is seen as best practice by improvers across the globe, is still frowned upon by journals (both subject-matter specialist journals and quality and safety journals), who prefer enumerative statistics in the form of pre- and post-comparison of averages. This jars with the real world of applied science, where there is no pre- and post-state, but a gradual and iterative transition, fuelled by multiple tests of change with increasing degree of belief and reliability in the change package.

Despite these challenges, ELFT has published approximately 15 peer-reviewed articles over the past 4 years and has 3–4 articles continuously in the process of submission. All published papers are made available transparently to everyone through the ELFT quality improvement website (<https://qi.elft.nhs.uk>), which has now had over half a million hits in the past 3.5 years. Going even further, ELFT aims to share learning from all completed projects on its website, in acknowledgement of the fact that practising improvers and clinicians will always struggle to find time to publish all completed improvement work in peer-reviewed journals.

This brings me to the question: are journals still relevant in a world of fast-paced knowledge-sharing and acquisition, and with increasingly digital and connected networks? More than 500 leaders and clinicians from more than 50 different provider organisations have now been to visit ELFT to find out more first-hand about the quality improvement work taking place. At ELFT, we are also using the web and social media to share knowledge in real time and transparently with everyone, as we recognise our responsibility in helping to grow the field of knowledge within mental health improvement, and also to foster confidence in the use of quality improvement.

So, while my personal experience leads me to agree with the authors that publishing mental health improvement in journals remains challenging and often puts people off from even submitting, I would also suggest that there is much more active improvement work taking place and being shared by mental health services globally than might be apparent from looking at high-quality peer-reviewed journals alone.

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1.5.22 A lost cause

Anuradha Menon

date

2018-2

Contents

- *A lost cause*

On reading Dr Moorey’s earnest response to Dr Gipps’ views, I was struck by his description of the ‘depressive mode’.¹ This marvel of development, 100 years on from Freud’s classic paper,² is – in Dr Moorey’s view – a ‘complex neural network, including multiple relevant brain regions that are activated or deactivated during depression’. This, he argues, is the target of therapeutic practice in cognitive–behavioural therapy (CBT), where unconscious schemas are automatic, not repressed. It seems to the reader that in this dehumanised framework, grief and loss are merely ‘problems’ that face humankind, which need to be put on the CBT table to be sorted out openly between therapist and patient. The tools? Good old-fashioned common sense, an indefatigably optimistic therapist and well-positioned intelligence. As for the measures: specially designed scales that measure the very structure which they helped create.

I am writing this piece to explore how both Dr Moorey and Dr Gipps warily circle around a point which is never highlighted in its own right.

Freud’s theory of melancholia² posits an unconscious basis for the depressed patient’s dilemma. This theory holds true: the proof is in the analytic setting, and all contemporary psychoanalytic approaches which describe the transference find their roots in this classic paper.³ Freud writes about an identification of the ego with the abandoned object, saying

‘thus the shadow of the object fell upon the ego’. This is still pre-object relations. American psychoanalysis, which was evolving at the time, is well known to have been profoundly influenced by Freud.

In the 1950s, psychoanalysts around the world were working on extending early theories, and the Americans actively participated in this worldwide development. So, with respect, Dr Moorey’s point about Beck’s ‘perfectly acceptable masochism hypothesis’ is a bit like Lamarck chasing after amputated tails while Darwin was thinking about evolution!

The crux of the matter is that Beck moved into what is essentially the conscious realm when he developed his theory. Today, anyone who manages patients with depression will know that the latter is the easier and, dare we say, cheaper option. It’s all backed up by robust evidence, and supported by what is essentially an Orwellian⁴ environment. I hardly need wonder why patients are rarely asked what they prefer: an analyst who is interested in undiscovered aspects of their loss and is willing to explore themselves in the process, or one bent on pinning down the patient’s experience in prosaic terms.

This is why I take exception to the statement in Dr Moorey’s final paragraph, which is unreferenced and states that CBT ‘has given psychoanalysts methodologies they now use to evaluate their own theories’. This is outrageous, as no self-respecting psychoanalyst would turn to a two-dimensional construct to tell them whether they are tuned into their patient’s inner world. I think this is another example of the kind of empiricism that undermines a patient’s personal struggle with loss, ignores the depth in a poorly understood psychoanalytic theory and exposes a flawed theoretical argument. Why would psychoanalysis have any real use for a methodology that doesn’t even address its basic theoretical stance? Dr Moorey’s thesis is, unfortunately, a lost cause. So, to quote from the excellent choice of title for this debate:

‘I give you the mausoleum of all hope and desire [...] I give it to you not that you may remember time, but that you might forget it now and then for a moment and not spend all of your breath trying to conquer it. Because no battle is ever won he said. They are not even fought. The field only reveals to man his own folly and despair, and victory is an illusion of philosophers and fools’. (William Faulkner, *The Sound and the Fury*⁵)

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1.5.23 Completed audit cycle to explore the use of the STOPP/START toolkit to optimise medication in psychiatric in-patients with dementia

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date

2018-2

Abstract

Aims and method

To explore the use of the STOPP/START toolkit in older psychiatric in-patients with dementia. Clinical records and current drug charts were reviewed against STOPP/START criteria for all in-patients ($n = 86$) on six specialist dementia wards.

Results

Benzodiazepines, antipsychotics and opiates were most commonly prescribed inappropriately. The most common unprescribed medication groups were statins, calcium supplements and vitamin D supplements. There was an overall reduction of 7% in comorbidities and 8% in the number of prescriptions. t -test showed a significant drop in average comorbidities between both audits, $t(1) = 23.920$, $P = 0.027$, and in average prescriptions per patient, $t(1) = 28.808$, $P = 0.022$. There was no difference in the number of patients receiving polypharmacy, $t(1) = 7.500$, $P = 0.084$, or receiving medication with a high risk of adverse drug reactions, $t(1) = 6.857$, $P = 0.092$.

Clinical implications

The STOPP/START toolkit highlighted the importance of collaborative working between doctors, clinical pharmacists and nursing staff, and could provide old age psychiatrists with a structured tool to identify inappropriate prescribing of non-psychiatric medications.

Declaration of interests

None.

Contents

- *Completed audit cycle to explore the use of the STOPP/START toolkit to optimise medication in psychiatric in-patients with dementia*
 - *Methodology*
 - * *Agreed action plan following the first audit*
 - *Results*
 - *Discussion*
 - *Conclusion*

There are 10 million people in the UK over the age of 65. The latest projections suggest there will be an additional 5.5 million older people by 2036, and that the current number will have nearly doubled to around 19 million by 2050. Older people have a high prevalence of chronic and multiple illnesses and are likely to be prescribed multiple medications. Potentially inappropriate prescribing (PIP) is reported to be highly prevalent in this age group, and has been associated with adverse drug events (ADEs) leading to admission to hospital and death.¹ Inappropriate prescribing occurs when the risks associated with prescribing a medication outweigh the potential benefits of the medication in a particular patient. PIP may also occur when a patient does not receive a medication indicated for the treatment or prevention of a disease or condition.² Pharmacokinetics and pharmacodynamics may be altered by ageing or disease. This puts older people at a high risk of adverse drug reactions (ADRs), ADEs and drug–drug interactions.

Some of the drugs that are considered a high risk with respect to hospital admissions include: non-steroidal anti-inflammatory drugs (NSAIDs, including aspirin), diuretics, warfarin, angiotensin-converting enzyme inhibitors

(ACEIs)/angiotensin-II receptor antagonists (A2RAs), antidepressants, lithium, beta-blockers, opiates, digoxin, prednisolone and clopidogrel.³

The National Service Framework (NSF) for older people recommends that an older patient should have medication reviews to reduce medicine-related problems. Studies in general practices and care homes have demonstrated that pharmacists undertaking medication reviews can improve the quality of care, optimise the use of medicines and produce cost-effective savings.^{4,5}

The aim of the audit was to review all prescribed medication in psychiatric in-patients over the age of 65 with a diagnosis of dementia in the Cwm Taf University Health Board (UHB) area covering a population of 300,000, to determine the degree of inappropriate prescribing and to optimise medication.

Methodology

Cwm Taf UHB is responsible for providing healthcare services (hospital- and community-based services) to the population of Merthyr Tydfil and Rhondda Cynon Taf, estimated to be around 289 400 people. The Health Board is divided geographically into four sectors.

The audit included all mental health patients with a diagnosis of dementia who were in-patients on 1 December 2015. All psychiatric assessment wards (for those over the age of 65) and specialist dementia wards in Cwm Taf UHB were audited. We identified 47 patients in December 2015 and 39 patients in the re-audit in May 2016. A thorough past medical history and current medication history were established for each patient using the clinical records. All diagnoses were made using internationally agreed standard criteria, such as the National Institute of Neurological and Communicative Disorders and Stroke and the Alzheimer's Disease and Related Disorders Association criteria, by the consultant psychiatrist and their teams in either the community or in-patient settings. The dementia ranged from moderate to severe for all specialist dementia wards. For the purpose of this audit, polypharmacy was defined as more than five medications. The audit used the second version of the toolkit;⁶ the tool itself takes about 30 min to complete.

Some tools have been developed to identify older people at risk from adverse effects and to reduce the risk of initiating drugs likely to cause adverse events. These include the screening tool of older persons' potentially inappropriate prescriptions (STOPP) and the screening tool to alert doctors to the right treatment (START). The toolkit was not designed for mental health patients. However, the STOPP-START tool has been validated in patients aged 65 and over by a consensus panel of 18 experts in geriatric pharmacotherapy in Ireland and the UK.^{7,8,9} The panel included experts in geriatric medicine, clinical pharmacology, old age psychiatry, clinical pharmacy and primary care medicine. Interrater reliability of the STOPP ($K = 0.75$) and START ($K = 0.68$) criteria was tested in six different European countries.⁸ A further study¹⁰ found higher interrater reliability of STOPP ($K = 0.97$) and START ($K = 0.92$).

All prescribed medication was checked against the STOPP/START criteria. In the STOPP/START tool, STOPP comprises 65 clinically significant criteria for PIP in older people. Each criterion is accompanied by a concise explanation as to why the prescribing practice is potentially inappropriate. It emphasises potential adverse drug-drug interactions and duplicate drug class prescriptions. An example is the advice to stop NSAIDs in patients with a history of peptic ulcer disease or gastrointestinal bleeding because of the risk of peptic ulcer relapse. In addition, NSAIDs should be stopped with moderate to severe hypertension (moderate: 160/100–179/109 mmHg; severe: 180/110 mmHg) because of the risk of exacerbation of hypertension.

START consists of 22 evidence-based criteria and identifies potential prescribing omissions (PPOs), e.g. start levodopa in idiopathic Parkinson's disease with definite functional impairment and resultant disability.

A *t*-test was conducted to compare the means between the initial audit and the re-audit. Following the initial data analysis, the audit was presented to all involved teams and action plans were introduced.

Agreed action plan following the first audit

It was agreed that all teams would regularly review the medication charts along with the clinical pharmacist to optimise prescribing. Small pocket-sized smartcards/leaflets showing the drugs commonly meeting the STOPP/START criteria were also produced. Smartcards were placed alongside all medication charts on the wards. Training regarding the use of the STOPP/START toolkit was also incorporated into team inductions for junior doctors and nursing staff. A re-audit was completed on 1 May 2016 to determine the impact of these changes.

Results

Table 1 shows a summary of the demographics across both audit cycles. There was no significant difference in age between the two audits. According to the Mann–Whitney U test, the distribution of the female gender was the same across both audits, $P = 1.000$. There was no significant difference in the proportion of patients on specialist dementia wards in the two audits. There was no reduction of medications prescribed in the community for patients on the acute wards before those patients came into hospital. Table 1

Demographic	First audit	Re-audit
Number of patients	584	47
Age, years (mean \pm s.d.)	78.33 \pm 2.74	78.72 \pm 3.11
Female gender (%)	31 (53.5)	29 (63)
Diagnosis (n):		

AD

VAD

Dementia with Lewy bodies

Parkinson's disease/dementia

Head injury

Mixed

Unspecified

18

21

5

–

1

7

6

20

15

6

1

–

3

2 Average comorbidities per patient (mean \pm s.d.) 6.23 \pm 1.52 5.73 \pm 1.02 $t(1) = 23.920$, $P = 0.027$ 95% CI = 2.803–9.157

Average number of prescriptions per patient (mean \pm s.d.) 10.88 \pm 1.27 10.15 \pm 0.58 $t(1) = 28.808$, $P = 0.022$ 95% CI = 5.877–15.153

Number of patients receiving polypharmacy (%) 51 (88) 39 (85) $t(1) = 7.500$, $P = 0.084$ 95% CI = 31.237–121.237

Number of patients receiving medication with high risk of adverse drug reactions (%) 55 (95) 41 (89) $t(1) = 6.857$, $P = 0.092$ 95% CI = 40.943–136.943

Number of patients on specialist dementia wards (%) 48 (83) 39 (83) $t(1) = 9.667$, $P = 0.066$ 95% CI = 13.678–100.678

There was an overall 7% reduction in the number of comorbidities and an 8% reduction in the number of prescriptions. The t -test showed a significant drop in the average number of comorbidities between the two audits, $t(1) = 23.920$, $P = 0.027$, and a drop in the average number of prescriptions per patient, $t(1) = 28.808$, $P = 0.022$. The overall improvement in prescribing contributed to a 19% reduction in bed occupancy for specialist dementia beds.

However, there was no difference in the number of patients receiving polypharmacy, $t(1) = 7.500$, $P = 0.084$, or the

number of patients receiving medication with a high risk of ADRs, $t(1) = 6.857$, $P = 0.092$. There was also no significant difference in the number of patients in specialist dementia wards, $t(1) = 9.667$, $P = 0.066$.

Fig. 1 represents the STOPP part of the toolkit, while *Fig. 2* represents the START component. *Fig. 1* Inappropriate drugs prescribed according to STOPP. *Fig. 2* Drugs that should have been prescribed according to START.

According to the STOPP toolkit, 164 drugs were prescribed; of those, 118 (72%) drugs were prescribed for longer than a year. Forty-one (25%) drugs were considered to have been inappropriately prescribed and could be stopped according to STOPP (*Fig. 1*). The four main types of inappropriateness were long-term use, lack of clear indication, symptoms no longer present, and lack of clear documentation. The most common drugs inappropriately prescribed were benzodiazepines, antipsychotics and opiates.

According to the START toolkit, 145 drugs were prescribed; of those, 129 (89%) drugs were prescribed for longer than a year. Twenty-six drugs should have been prescribed according to the toolkit but were not (*Fig. 2*).

Discussion

When reviewing all geographical sectors, an improvement in the prescribing pattern was found between the audits. All teams were more conscious of inappropriate prescribing in older people. In some of the cases, we had little information on who prescribed the medications, why they were prescribed and when they were reviewed. Nevertheless, it is important to remember that the STOPP/START criteria were designed to highlight inappropriate prescriptions and prevent ADEs, especially those involving medications with a high risk of ADRs.

The audit showed an observed overall 24% reduction in polypharmacy and a 25% reduction in prescribing of medications with a high risk of ADRs. However, the difference between the audits was not statistically significant. The non-significance may be related to the reduction in number of patients from 58 to 47, or the reduction in drugs per patient may have been due to them having fewer illnesses.

According to the STOPP Toolkit, 164 drugs were prescribed in the 2016 audit. *This was a 25% reduction in prescribing since the first audit.* Seventy-five central nervous system (CNS) drugs were prescribed according to STOPP, a 40% reduction in prescribing since the first audit. According to the START toolkit, 145 drugs were prescribed at the time of the re-audit. *This was an 8% reduction in prescribing since the first audit.* There was no change in the total number of CNS drugs prescribed, according to the START toolkit. However, *there was less antidepressant prescribing across all sectors.* These results are also a proxy measure for improving care by optimising medicines in the elderly, i.e. reduced exposure to polypharmacy improves care and quality of life.

According to the toolkit, our CNS drugs will be mainly inappropriately prescribed because of long-term use (longer than a month). However, the nature of mental disorder and its associated behavioural and psychological symptoms will mean that it is appropriate for our patient groups to be on longer-term medication. The multiple comorbidities will also add to the complexity of those patients and their management.

Another important observation is that adequate documentation is very much needed to clarify the target symptoms and the rationale for prescribing. It is important for all the teams to review medications and their appropriateness as part of the weekly ward round and monthly clinical pharmacist input. It is important to continue to raise awareness of the STOPP/START tool and to encourage its use by doctors and pharmacists, in order to promote safe prescribing among older patients.

Prescribers should not feel overwhelmed when reviewing multiple medications prescribed for older people. The STOPP/START tool has been proven to be a useful framework.

The audit has provided the foundations of a good multidisciplinary relationship between medical, nursing and pharmacy staff, which has not only benefited the in-patients but also demonstrated how a multidisciplinary team can stop inappropriate prescribing in older patients. It is clear that we can improve the care and safety of such patients by optimising their medicines. This will also have a secondary economic impact by producing an annual cost saving. The additional cost benefits in preventing adverse effects and associated medical treatment should be included in any basic financial evaluation. These additional benefits are likely to be substantial in economic and human terms. The benefits of the medical and pharmaceutical perspectives working together as a team were both additive and synergistic.

The audit also highlighted the need to facilitate greater collaboration with a clinical pharmacist and the older person's physician/general practitioner to provide better care for older psychiatric patients. As the toolkit looked at the prescribing pattern, it does not include the patients' views or their families' opinion about drugs. However, shared decision-making should be always a priority for clinical teams. As the audit reflects a cross-section of old age psychiatry, we believe that the results are generalisable. It will be useful in the future for a well-designed research study to be conducted in old age psychiatry covering multiple areas or larger community and in-patient settings to test that assumption.

The small pocket-sized smartcards/leaflets showing the drugs commonly meeting the STOPP/START criteria proved useful on all wards. Introducing the toolkit at junior doctor induction has also been beneficial.

Conclusion

Inappropriate prescribing occurs when the risks associated with prescribing a medication outweigh the potential benefits of the medication in a particular patient. PIP may also occur when a patient does not receive a medication indicated for the treatment or prevention of a disease or condition. The STOPP/START criteria have been used to review the medication profiles in various settings worldwide. STOPP/START criteria are validated, reliable systems-based criteria for PIP. The STOPP criteria significantly predict ADEs, and the application of the STOPP/START toolkit improves medication appropriateness and probably reduces/prevents adverse events. The STOPP/START criteria are *not* the complete answer to preventing medication errors, but they help to optimise pharmacotherapy at the point of initiation and at routine medication review. The use of the STOPP/START toolkit can also have a positive impact by reducing prescribing errors. Sustaining these changes will require continued efforts to maintain prescriber awareness of the STOPP/START toolkit.

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1.5.24 Neurologists' detection and recognition of mental disorder in a tertiary in-patient neurological unit

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Abstract

Aims and method

Psychiatric disorders are common in neurological in-patients, but they are under-recognised and undertreated. We investigated the frequency of detection of mental disorder and referral to psychiatric services in a regional neuroscience centre. The results were compared with the expected prevalence. All in-patient referrals received in 2014 from the in-patient wards of the regional neuroscience centre and acute neurological unit were reviewed.

Results

A total of 129 ward referrals were identified; of these, 78 were from the regional in-patient neurological unit, which comprised 11.4% of the total of 679 admissions to that unit.

Clinical implications

A spectrum of neuropsychiatric conditions were recognised by neurologists, but overall rates of recognition were low. To address the problem of under-recognition, routine screening with validated assessment tools can represent a cost-effective and acceptable method to detect psychiatric disorders in an in-patient neurological setting.

Declaration of Interest

None.

Contents

- *Neurologists' detection and recognition of mental disorder in a tertiary in-patient neurological unit*
 - *Method*
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 - *Discussion*

Liaison neuropsychiatry is an important element of psychiatric care in neurological in-patients, given the severity and complexity of the cases involved.¹ Yet there is a dearth of information about consultation rates, presentation, diagnoses, and interventions that would improve access to services, facilitate evidence-based practice, and articulate the relationship between neurological and psychiatric disorders.²⁻⁴

Previous estimates of psychiatric comorbidity in neurological settings have revealed high prevalence rates. For example, the overall rate of psychiatric disorder in neurological out-patient clinics has been reported as 55.1%,⁵ the most frequent diagnoses being somatoform disorders, which represented 33.8% of the sample. Similarly, the prevalence in an acute in-patient neurological unit was 51.3%.⁶ It appears, therefore, that psychiatric comorbidity is high in neurological settings. This is to be expected, given the elevated rates of psychiatric comorbidity in neurological disorders. Patients with cerebrovascular and Parkinson's disease have prevalence of depression that ranges between 20 and 40%.⁷⁻⁸ Functional neurological symptoms are also common in neuroscience settings; it has been reported that 14% of consecutive neurological admissions had no so-called 'organic' bases for their symptoms, while another 24% had symptoms not fully accounted for by the underlying pathology.⁹

Neuropsychiatric conditions in neurological in-patients, if undetected or not adequately managed, are associated with poor quality of life, greater morbidity, mortality and poor psychosocial outcomes.¹⁰ Moreover, there are specific neuropsychiatric presentations associated with common neurological conditions that pose diagnostic, nosological and management challenges, which require the unique clinical skills of neuropsychiatrists. These conditions may include

schizophrenia-like psychosis of epilepsy, forced normalisation,¹¹ organic personality changes or organic mood disorders,¹² to name a few. This highlights the need for the development and implementation of structured care pathways for the neuropsychiatric comorbidities associated with neurological conditions.¹³

Despite these high rates of psychiatric comorbidity, surveys investigating referrals from neurology wards to neuropsychiatric liaison services have demonstrated unexpectedly low rates of referral. Fitzgerald *et al* and Jonge *et al* found that only 6% and 2.4% of neurology in-patients, respectively, were referred to liaison neuropsychiatry.^{14,15} The present study sought to investigate the rates of referral to an established neuropsychiatry service in a tertiary neurosciences centre, in order to better understand referral patterns and rates of recognition of mental disorder in neurological in-patients.

Method

This study was conducted at the Atkinson Morley Regional Neurosciences Centre at St George's Hospital, London, covering a population of 3 million residents of South West London and Surrey. All referrals made to the neuropsychiatry service at St George's Hospital over a 12-month period in 2014 were included.

We reviewed the referral forms and electronic patient records to extract information on demographics, reasons for referral, diagnoses, treatment plan, and number of contacts made. We identified the reasons for referral from the free text provided by the referrers. This requested information gives specific details about reasons for referral, presenting symptomology, referrers' suspected diagnoses, previous psychiatric history and interventions, and management difficulties. Reasons for referral were grouped into categories, and more than one reason for each patient was allowed. The patient electronic records system used to record every contact with patients was also searched to retrieve the primary ICD-10 diagnoses for each patient. These results were then compared against those available in the published literature on neuropsychiatry and adult liaison psychiatry services referral patterns.

Those referred to the neuropsychiatry service from the acute neurology ward were compared against admission data for that ward to establish rates of referral. This was then contrasted with results from previous studies of this ward investigating the prevalence and rate of detection of mental disorder by neurologists. All clinicians involved in this study work within the clinical team and had access to patients' records as part of their role. Anonymised data were analysed and compared with previously published data.

Results

A total of 129 referrals were identified in the year 2014. They were evenly dispersed across age groups, with a small peak in the age group 50–59. The female:male ratio for referral was 1.35:1 ($P = 0.09$). Almost 50% of the sample had a past psychiatric history. In terms of face-to-face contacts made, 32% received initial assessment only, 27% were seen twice, 15% were seen three times, and 10% were seen four times. The remaining 16% had four or more face-to-face contacts. The cumulative sum of all face-to-face contacts (first assessment and follow-up) was 311. Usually, the first assessments lasted 45–75 minutes and 90% were seen within 2 working days of the date of referral. The highest rates of referral were during the months March, June, October and December.

Sixty per cent of referrals came from the regional in-patient neurology ward, 15% from neurosurgical wards, 9% from the stroke units, and 4% from the neuro-intensive care unit (NICU). The remainder were referred from other wards. Only 7% were made as urgent referrals. It was documented on 75% of forms that the referrer had discussed referral with the patient.

The most frequent cited reasons for referral were depression (50%), functional neurological symptoms or functional overlay (27%), anxiety (22%), cognitive decline or confusion (17%), agitation/aggression (13%), suicidal ideation or behaviour (12%), and psychotic symptoms (12%). Often, more than one reason for referral was provided; hence, the percentages do not total 100%. As a reason for referral, 'agitation' was associated most with organic disorders, 'suicidal' with adjustment disorder and organic mood disorder, and 'depression' with mood disorders, adjustment disorder and 'no diagnosis'. Functional symptoms/overlay were invariably associated with a psychiatric diagnosis of dissociative/conversion disorders. Almost all (91%) of the referred patients met the criteria for a psychiatric disorder according to ICD-10. The most common primary psychiatric diagnoses were: mood disorder (22%); dissociative

disorder (18%); adjustment disorder (9%); delirium (5%); organic disorders (24%), including organic mood disorder (8.5%); and organic personality disorder (5%). In 9% of those referred, no mental disorder was established (*Fig. 1*). *Fig. 1* Distribution of patients per diagnostic categories.

Seventy-eight of the referrals were sent from the regional in-patient neurological unit, comprising 11% of the total of 679 admissions to that unit. The age of referred patients was distributed evenly across the decades of life, with a small peak in the 20–29 age group. The female:male ratio was 1.4:1. Initial assessment only was completed for 31%, while 27% were seen twice, 14% three times, and the remainder four times or more. Urgent referrals constituted 10% of all referrals from this ward, and 83% of referral forms had documented a discussion with the patient. Collectively, depression, anxiety and adjustment disorders represented the most frequent diagnoses (32%), followed by ‘organic’ disorders (31%) and then somatoform disorders (21%). Most of those referred (81%) had a past history of psychiatric disorder. The majority of those patients diagnosed with dissociative disorders (70%) attended out-patient follow-up with our service following discharge.

Discussion

This is a retrospective study of referrals from a regional neurology unit, which can come with its own limitations. Such a unit would generally have more complex neurological in-patients with a higher rate of neuropsychiatric comorbidity. However, the results of the present study and previously published papers are broadly comparable, suggesting no specific biases associated with our study population. The total number of referrals was small, despite the expected prevalence of psychiatric illnesses in neurological settings. This is in keeping with the low rates of identification of psychiatric comorbidity found in earlier prevalence studies. It may also suggest that neurology colleagues have a high threshold for referral to the psychiatric services. However, this implies that patients suspected to have psychiatric disorder were not referred to specialist services.

Our results show that patients referred to the team presented with a wide range of neuropsychiatric disorders (*Fig. 1*). The rates of mental disorder in our sample did not match those in community¹⁶ or general hospital¹⁷ settings, demonstrating the distinctive nature of neuropsychiatric samples. The most common categories in our population were mood disorders, organic disorders and dissociative disorders, while the most common reasons for referrals were ‘depression’ and ‘functional neurological symptoms’. Rates of disorder in our sample were close to those reported in previous studies,^{14, 15} with a few differences.¹⁷ One difference is that depressive disorder accounted for 40% of referrals reported by Guthrie *et al* to their general liaison service that serves a large teaching hospital, but only 20% of our referrals received this diagnosis. Nevertheless, as for Guthrie *et al*, ‘depression’ was the leading reason for referral to our service and the most common diagnosis in our sample. Schizophrenia and bipolar disorders constituted a small portion of our workload, while they comprised one-third for Guthrie *et al*. Other significant differences were found in the rates of somatoform disorders (18.6 v. 2.6), organic disorders (24 v. 1.7), substance use disorders (4.8 v. 1.55) and personality disorders (0.7 v. 3.8), as shown in *Table 1*. Not unexpectedly, perhaps, our neuropsychiatry team was referred a higher proportion of organic disorders compared with the general hospital liaison service of Guthrie *et al*. It might be that neurologists perceive neuropsychiatrists as more willing and/or able to manage patients with organic psychiatric disorders than a liaison psychiatric service, such as that of Fitzgerald *et al*. Alternatively, because the Atkinson Morley Centre is a tertiary unit which admits complex neurological cases, there may be a higher percentage of organic psychiatric disorder in the population we serve. Another difference was the higher rate of dissociative disorders compared with liaison psychiatry teams, which again likely reflects that a tertiary neurology centre admits the most complex functional cases for thorough investigation and intervention – especially as there is a dearth of neuropsychiatry services outside the London area. The unexpectedly low rate of substances misuse and personality disorders identified in our sample could reflect a reluctance to discuss these issues or an oddity of our population. Either way, this finding merits further evaluation. These variations will differentially influence the clinical expertise and practice of neuropsychiatrists and their colleagues in liaison psychiatry. *Table 1* Comparison of psychiatric diagnoses as a proportion of total number of referrals (%)
 Diagnostic categories
 Jonge *et al*, 2001 (neurological ward referrals to general liaison psychiatric service)
 Fitzgerald *et al*, 2008 (neurological ward referrals to general liaison psychiatric service)
 Dawood *et al*, 2016 (neurological ward referrals to neuropsychiatric service)
 Guthrie *et al*, 2016 (general non-neurological ward referrals to general liaison psychiatric service)

system ICD-10 DSM-IV ICD-10 ICD-10Mood disorders15.12421.746.5Somatoform disorder/dissociative disorders/

Medically unexplained symptoms19.32318.62.6Anxiety disorders/adjustment disorders15.51112.26.4Organic disorders, including dementia165245.2Delirium3.85.46.7Substance use disorders4.4201.554.7Psychosis/schizophrenia2.753.914.8Personality disorders0.773.8Others7.92.332No mental illnesses/differed15.1129.37.3Total100100100100

Regarding the acute in-patient neurological unit, our results demonstrated a referral rate of only 11.16%, although previous studies on the same ward have demonstrated substantially higher prevalence rates. Utilising a battery of screening questionnaires followed by psychiatric interview Jeffries *et al*⁶ identified a DSM-IV-defined mental disorder in 51.3% of 265 consecutive admissions during a period of 6 months. Of these, 18.7% fulfilled the criteria for two diagnoses, and 5.1% were diagnosed with three or more. Earls *et al*¹⁸ investigated rates of detection of psychiatric symptoms by neurologists on this same ward 3 months pre and post Jeffries *et al*'s screening period. This showed that neurologists recognised and documented symptoms of mental illnesses in 23.7% of all admissions, but referred fewer than half of these (10.4%), echoing our more recent findings (11.6%). Taken together, this demonstrates that 70–80% of neurological patients with a comorbid psychiatric disorder are not being referred to specialist services. Given the known impact of neuropsychiatric comorbidity on quality of life, duration of hospital stay, mortality, and cost of care, this may have a deleterious effect on those unable to access timely and effective psychiatric intervention.¹⁹ Of those who were referred, analysis of the reason(s) for referral indicated strong correlation with the eventual confirmed diagnosis. The small number of patients who did not receive any diagnosis points to a low rate of false positives. Thus, it appears that neurology referrers were specific but not sensitive to identification of cases. *Table 2* suggests that few patients with anxiety, adjustment disorders, personality disorders, and substance misuse disorders were referred, while referral was made for only a minority of those with depression and cognitive disorders. Appropriately, all those with psychotic disorders were referred, as were half the patients with somatoform disorders. Regarding patients with cognitive impairment, it may be that neurologists consider themselves capable of managing this patient group, as agitation was given as the main reason for the referral in all cases involving that problem. *Table 2* Comparison of psychiatric diagnoses/symptoms as a proportion of total admissions in the specific neurological in-patient unit (%)

Diagnostic categories	Jeffries <i>et al</i> , 2007	Earl <i>et al</i> , 2011	Dawood <i>et al</i> , 2016
Prevalence of psychiatric diagnoses DSM-IV	51.3	23.7	11.6
Psychiatric symptoms / problems detected by neurologist	23.7	10.4	11.6
Diagnoses referred by neurologists, ICD-10			
Mood disorders plus organic mood disorders	24.89	23	23
Delirium, dementia and cognitive disorders	17.76	70.88	12.72
Anxiety	12.72	20.73	4.600
Adjustment disorders	4.600	88	4.56
Somatoform disorders	4.56	42.5	30.1
Substance use disorders	30.1	20.29	20
Personality disorders	20.29	Disorders usually diagnosed in childhood	20.1
Other disorders that may be of clinical importance	20	Psychotic disorders	11.61
Eating disorders	0.50	Other organic disorders	1.1
No diagnosis	0.58	Total ^a	51.123.711.16 ¹

It is unclear how this under-referral affects the well-being of patients and the efficiency of neurological departments. Similarly, Jonge *et al* found that neurologists throughout Europe refer only a small proportion of the psychiatric patients on their wards. Possibly, their recognition of mental disorder is poor, or these comorbidities are considered irrelevant to their neurological care. Jonge suggested a referral procedure consisting of a short questionnaire to facilitate detection of caseness.¹⁵ Likewise, Jeffries *et al* concluded that psychiatric screening questionnaires have a high sensitivity and specificity, thereby representing a cost-effective and acceptable method for improving identification of psychiatric morbidity and comorbidity.⁶ The intervening years have not lessened the arguments for this approach. There is now a pressing need for strategic planning to develop neuropsychiatric provision, both nationally and internationally.^{20–22} Provision of prospective screening on neurological units and the impact of neuropsychiatric input would require prospective evaluation to evaluate their utility and efficacy.

1

a. Percentages add up to more than total because some cases had two or more comorbid psychiatric diagnoses.

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1.5.25 Vitamin D in patients with intellectual and developmental disability in secure in-patient services in the North of England, UK

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date

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Abstract

Aims and method

To assess the benefits of the introduction of routine vitamin D serum sampling for all patients admitted to a secure in-patient hospital in the North of England providing medium security, low security and rehabilitation services for offenders with intellectual and developmental disability. The vitamin D levels of 100 patients were analysed at baseline. Those with insufficient or deficient levels were offered treatment and retested after 1 year. Vitamin D levels were analysed in the context of level of security, seasonality of test and co-prescription of psychotropic medications.

Results

Eighty-three per cent of patients had suboptimal vitamin D levels at initial test (41% deficient and 42% insufficient). This was seen among established patients and new admissions. Regression analysis of baseline vitamin D levels revealed no differences for levels of security, seasonality, whether patients were taking antipsychotic or anticonvulsant medication, or length of stay. Patients with deficiency or insufficiency were all offered supplementation. Those who opted in had significantly higher vitamin D levels at follow-up, compared with those who declined treatment.

Clinical implications

Established and newly admitted patients in our secure mental health services had substantial levels of vitamin D insufficiency. In the light of the morbidities that are associated with deficient vitamin D levels, routine screening and the offer of supplementation is advisable.

Declaration of interest

None.

Contents

- *Vitamin D in patients with intellectual and developmental disability in secure in-patient services in the North of England, UK*
 - *Background*
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 - * *Study population*
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 - * *Follow-up and treatment effects*
 - *Discussion*

Background

Suboptimal levels of plasma 25-hydroxy vitamin D (25OHD) have been implicated in a number of morbidities, including musculoskeletal and cardiorespiratory diseases, diabetes and depression.^{1,2} A substantial proportion of vitamin D is obtained from ultraviolet-B light acting on the skin¹, although the relative amounts obtained from solar and food sources vary from study to study.³ There is, therefore, a greater potential for impaired vitamin D levels during the autumn and winter months.⁴ Public Health England currently advise a minimum of 10 µg of vitamin D per day for the general population, but give no separate advice for those at risk of minimal sunlight exposure, such as institutionalised individuals.⁵

It is estimated that approximately 50% of the population of Northern England have insufficient or deficient vitamin D levels.⁶ Based on National Health Service guidelines, in January 2013, a decision was made by the clinicians at Northgate Hospital, Northumberland, UK, to routinely screen for vitamin D deficiency and treat as necessary.⁷ Northgate Hospital has a range of levels of secure care facilities for people with intellectual and developmental disabilities (IDD) who offend, as well as providing specialised services for people with severe autism spectrum disorders.

This paper describes an evaluation of the results of screening for 25OHD at Northgate Hospital. It was hypothesised that patients in secure services would have suboptimal levels of 25OHD due to less exposure to sunlight, and as a possible consequence of medications prescribed for mental disorders. We were also interested in the effect of season of testing, and whether the decision to routinely screen for and treat 25OHD deficiency would lead to improvement in any such deficiencies.

Aims

1 To describe vitamin D levels in an ‘at risk’ population of offenders with IDD in secure care, across a range of levels of security; 2 To assess the effectiveness of screening for and treating any vitamin D deficiencies.

Method

Cohort 1

Between January 2013 and February 2014, all patients at Northgate Hospital were screened for vitamin D deficiency. These existing patients, who were having blood tests taken as part of their annual health checks over the year, had a serum vitamin D level added to the standard biochemistry request form with no additional venepuncture over and above routine testing.

Cohort 2

While existing patients were having their vitamin D levels checked as part of annual health checks, new admissions to the secure services were also being screened. Because we judged that there may be differences between the established patient group and new admissions (higher levels of sun exposure, dietary intake differences), new admissions from January 2013 onwards were considered as a separate cohort for the purpose of assessing baseline vitamin D levels.

Data were collected for the first 100 patients screened, from both cohorts. The results were classified according to standard biochemical reference ranges for total 25OHD (the sum of 25OHD₂ and 25OHD₃): •deficient (<25 nmol/L) •insufficient (25–49 nmol/L) •sufficient (50–75 nmol/L) •optimal (>75 nmol/L) vitamin D levels. Each result was stored with anonymised data about the patient’s age, length of stay prior to the initial test, co-prescribed psychotropic medications, level of in-patient security and the season the test was performed.

Following the initial test, all patients were offered appropriate treatment by the hospital’s physical health service if required, although not all patients accepted it. At Northgate Hospital, the supplementation protocol for vitamin D is based on guidance provided by the National Health Service Specialist Pharmacy Service.⁸ Those patients found to be deficient were treated with 20 000 units of oral colecalciferol twice weekly for 8 weeks and then maintained on 800 units daily. Those found to have insufficient levels were treated with a maintenance dose of 800–1600 units of oral colecalciferol daily. Patients’ 25OHD levels were then re-tested a year later as part of the next year’s annual health checks.

Data analysis

Baseline 25OHD data

Mean baseline 25OHD levels were analysed using a single multiple regression analysis. The regression model assessed the effects of the following categorical predictors on baseline 25OHD levels: season of testing, levels of security, prescription of antipsychotic or anticonvulsant medication, and the cohort tested. Data that were not normally distributed were transformed appropriately (using a log₁₀ transformation for 25OHD values).

Effect of treatment

Patient records were scrutinised to ascertain whether, following baseline testing, treatment to correct any deficiency was offered and/or taken. Follow-up testing data were collected, and the McNemar test of marginal homogeneity was applied to the pairs of non-adjusted 25OHD levels to assess differences in patients' 25OHD levels between baseline and follow-up.

Data were analysed using SPSS version 22.9 This service evaluation was registered with the Research and Development department of Northumberland, Tyne and Wear National Health Service Foundation Trust, in November 2013 (Registration number SER-13-018).

Results

Study population

Seventy-three established patents at Northgate Hospital had baseline 25OHD screening between January 2013 and February 2014 (cohort 1). Between January 2013 and July 2016, a further 27 patients had been admitted to the hospital and received baseline 25OHD screening on admission (cohort 2). The two cohorts are described in *Tables 1* and *2*. As expected, the median length of stay at baseline test was significantly greater in cohort 1 than in cohort 2 (36 months vs. 1 month; Mann–Whitney U: 34.5, $P < 0.001$) as new patients were tested soon after admission. There were no patients of Black and minority ethnic (BAME) origin among the patient group. Table 1 Description of cohort 1

N Mean age Sex Antipsychotics

n (%) Anticonvulsants

n (%) Season of test (*n*) MF Winter Spring Summer Autumn Medium security 2026.52009 (45) 8 (40) 5663 Low security 3938.230915 (38) 10 (26) 97167 Rehabilitation 934.0814 (44) 2 (22) 0153 Autism service 533.4502 (40) 2 (40) 2120 TOTAL 7334.1302216152913

n (%) Anticonvulsants

n (%) Season of test (*n*) MF Winter Spring Summer Autumn Medium security 1425.81403 (21) 2 (14) 2462 Low security 1135.7924 (36) 5 (45) 4124 Rehabilitation 150.0011 (100) 00100 Autism service 119.0101 (100) 00010 TOTAL 2730.5976696

Baseline vitamin D levels

The mean 25OHD level of the whole study population was 35.1 nmol/L (s.d. 28.1), and the median was 27.0 nmol/L, representing positively skewed values (Shapiro–Wilk: 0.699, $P < 0.001$). The regression analysis was therefore conducted using \log_{10} -transformed values. The statuses of 100 patients at baseline are represented in *Fig 1*, showing that the vast majority had either deficient or insufficient 25OHD levels. Fig. 1 Vitamin D status of 100 patients at baseline testing.

The regression analysis demonstrated no effect of season or level of security on the vitamin D status of the patient at baseline (*Table 3*). Furthermore, there were no differences between the two cohorts, or between those prescribed antipsychotic or anticonvulsant medication. Table 3 Single multiple regression analysis of between-subject effects on \log_{10} 25OHD levels at baseline

Factor \log_{10} 25OHD

type III sum of squares d.f. Mean square F P -value

Season 0.46330.1542.3540.077 Security 0.14730.0490.7460.527 Antipsychotics 0.17110.1712.6000.110 Anticonvulsants 0.17510.175

There was a trend for lower 25OHD levels among patients already prescribed antipsychotic medication, and marginally higher levels in those on anticonvulsant medication, although four of the 29 patients in the latter group had already been prescribed vitamin D supplements. Furthermore, 25OHD levels were statistically non-significantly higher in the

summer compared with winter (median 25OHD 33 nmol/L vs. 20 nmol/L), and in the rehabilitation service compared with the medium secure wards (median 25OHD 33.5 nmol/L vs. 27.5 nmol/L).

Follow-up and treatment effects

Follow-up data were available for 89 patients who were retested around 12 months after baseline screening. The mean 25OHD level was 66.3 nmol/L (s.d. 33.6) and the median was 62.0 nmol/L, which represented a less extreme but still significant positive skew (Shapiro-Wilk: 0.914, $P = 0.035$). The numbers of patients with sufficient and optimal 25OHD had improved substantially (see Fig 2). Fig. 2 Vitamin D status of 89 patients at follow-up.

Not all patients who received baseline 25OHD screening and/or treatment were tested a second time. Some patients were discharged from hospital in the interim, or their 25OHD level was not requested by the physical treatment service. A flowchart of all 100 patients is provided in Fig 3. Fig. 3 Flowchart of 100 patients who underwent baseline screening. Mean (s.d.) 25OHD levels are reported.

The regression analysis was repeated for \log_{10} -transformed 25OHD levels at follow-up testing. As in the baseline data, there were no effects for seasonality, security level, or the prescription of antipsychotic or anticonvulsant medication.

Discussion

This is the first study to report data from a specialist hospital for patients with IDD who offend, and those with severe autism spectrum disorders, with a number of levels of secure and non-secure wards and units. This paper describes routinely collected data on serum 25OHD levels obtained at baseline prior to clinical decisions to treat any vitamin D deficiency, along with follow-up serum levels after a year. The rationale for the implementation of this protocol was based on concerns that low levels of sun exposure, the secure environment and the prescription of psychotropic medication put in-patients in a 'high risk' category, with potentially serious long-term health sequelae.⁷

The data suggest considerable vitamin deficiency among this patient group. Furthermore, there were no clear differences in 25OHD levels between patients already in hospital when baseline screening took place and newly admitted patients. This might be attributed to deficiencies in the community, but, in a tertiary service, new admissions frequently transfer from other in-patient services. Limitations in the data available mean that further scrutiny is outside the scope of this paper. There appeared to be a trend for marginally lower 25OHD levels in secure wards compared with rehabilitation services, but there was no statistically significant variation.

Although no significant differences were found between patients taking psychotropic medication and those who were not, these factors remain of clinical concern with respect to bone health. A recent small-scale prospective study found that antipsychotics may inhibit vitamin D-metabolising enzymes, thereby causing a reduction in both calcium and 25OHD levels.¹⁰ This association is of particular concern given the known link between antipsychotics and osteoporosis risk via raised prolactin levels.¹¹

Patients with normal 25OHD levels at baseline who were already on supplements all opted to continue with treatment. Those with normal levels at baseline who were not already receiving treatment were advised by their general practitioner based on the clinical scenario. Neither the supplemented nor the non-supplemented group had significant changes in their 25OHD status at follow-up, but numbers here were small.

Patients with suboptimal 25OHD levels were all offered supplementation using a standard protocol. Those who opted for supplementation had significantly higher 25OHD levels at follow-up, whereas those who opted out experienced non-significant changes. As the data here reported are routinely collected, it is not possible to make any systematic inference as to what lay behind a patient's decision to accept or decline supplementation.

Although vitamin D deficiency was widespread among this group, it was not present among all patients. There is some evidence from genome-wide association studies that genetic factors also have a significant role in identifying those at increased risk, but this is beyond the scope of this evaluation.¹²

Our data are commensurate with a study of psychiatric in-patients in a Scottish high-secure hospital at a similar geographical latitude to Northgate Hospital. That study concluded that all patients in secure settings should be screened

and offered supplementation based on ‘significant and serious’ deficiency of 25OHD associated with bone demineralisation.¹³ Furthermore, such deficiencies do not appear to be limited to secure care. One study of people with IDD in institutionalised nursing care in Finland demonstrated significant 25OHD insufficiency, which was addressed by oral or intramuscular supplementation.¹⁴

The data in this study were routinely collected and not prospectively planned, leading to limitations in their interpretation. Serum parathyroid hormone and calcium levels were not routinely collected, nor were any bone mineralisation tests performed. No data on the content or vitamin D qualities of patients’ diets were collected. It is also not possible to comment on the longer-term health risks such as fractures without a larger, more specialised study. The patient group at Northgate is not ethnically diverse; all patients in this cohort were of white ethnicity. One study of a long-stay psychiatric in-patient facility found an association between low vitamin D levels and being of a BAME background, with improvements in 25OHD levels after treatment.¹⁵ Another recent study in Tier 4 adolescent psychiatric services showed similar numbers of white and BAME patients with 25OHD deficiency (46 vs. 53%).¹⁶

This raises the question as to whether all patients who are ‘high risk’ should be offered treatment. The long stays of patients within secure services, along with concomitant medication, would put these patients within this category. Current guidance by Public Health England recommends a minimum of 10 µg per day for the general population aged four and above, where diet alone is insufficient.⁵ However, the choice between simple supplementation or a deficiency protocol for patients such as these has not been fully established. Furthermore, it has not been established whether supplementation should be offered without suitable baseline screening. It should also be considered that the more general effects of vitamin D supplementation are far from certain. A meta-analysis of 18 randomised controlled trials (RCTs) suggested that there was a modest reduction in overall mortality for people taking standard doses of 25OHD supplementation,¹⁷ but a more recent umbrella review of systematic reviews and meta-analyses of observational studies and RCTs found little convincing evidence of a clear role for vitamin D in health outcomes.¹⁸

Nevertheless, this study has shown that in-patients with IDD appear to have deficiencies in vitamin D and that these are amenable to correction by oral supplementation in many cases. We recommend further research in this area, including prospective studies of the longer-term health sequelae.

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1.5.26 Joan Bicknell

Sheila Hollins

date

2018-2

Contents

- *Joan Bicknell*

Dorothy Joan Bicknell, psychiatrist, born 10 April 1939; died 12 June 2017

Brilliant clinician who was appointed professor of psychiatry of learning disability at St George's, University of London.

In 1980, Joan Bicknell, who has died aged 78 of cancer, was appointed professor of psychiatry of learning disability – the first British female professor of psychiatry – at what is now St George's, University of London. A brilliant clinician, she put the disabled person and their family at the centre of each consultation.

She was in constant demand to speak to trainees, parent groups and learning disability services about her vision of what could be done, and published dozens of papers for both clinicians and families. An article drawn from her inaugural lecture as a professor in 1981, *The Psychopathology of Handicap*, was published in the journal *Psychological Medicine*, and remains inspirational today.

In it, she described the emotional effect on parents and siblings of the diagnosis of learning disability in the family and also explored what it is like for children and adults living with a learning disability in terms of their own emotional inner world, their expectations for adulthood and the extent to which they were included or excluded from participating in daily life in the community. At the time, most people with learning disabilities lived at home with their families – unless the family could no longer support the person – and the alternative was usually a hospital admission.

Joan demonstrated that with specialist advice, community services could provide families with more support to care for longer, and the growing number of community homes and hostels could be supported to provide family-style care. This was unpopular with many medical superintendents of “mental handicap” hospitals, and she was never accepted by the medical establishment.

In 1978, a public inquiry into a scandal at Normansfield hospital in Teddington, south-west London, found the medical leadership seriously at fault. The nurses at Normansfield had gone on strike two years earlier complaining about how dysfunctional the organisation was, and the appalling conditions in which people with learning disabilities were living. The South West Thames regional health authority accepted the inquiry recommendations and appointed Joan to lead a taskforce to transform the care provided. It brought staff and relatives together to create an improvement plan, a new multidisciplinary management structure was put in place and money was provided to build more accommodation to reduce overcrowding.

It was against this background that Joan became professor, heading a new NHS-funded academic department to launch the specialty of psychiatry of learning disability at St George's, covering south-west London, Surrey, Sussex and Hampshire. St George's remains a leader in teaching medical students how to communicate effectively with people with learning disabilities, work that began in 1982, when Joan started involving her patients and their families in face-to-face teaching.

During her working day she met patients and families in the clinic or at home, supervised trainees, advised NHS and social service managers and fielded phone calls from people seeking advice. In the evenings and at weekends she would be booked as a speaker or for consultations all over Britain. She took early retirement in 1990 at the age of 50, having suffered from mental illness and severe asthma for the final three years of her career.

Perhaps the hardest thing for her to deal with had been the failure of NHS managers and of politicians to respond with meaningful action when she spoke up for the human rights of people with learning disabilities. She wrote in the Personal View column for the *British Medical Journal* about the men in a locked ward who were not allowed access to the kitchen or to drinking water and resorted to filling their shoes with water from the lavatory pan. Eventually a

water fountain was installed in the living room, only for it to be blocked up by staff using it to dispose of their cigarette ash. Confronting cruelty in such hospitals was yet another of the ways she contributed to the advance of enlightened disability psychotherapy and psychiatry.

Born in Isleworth, south-west London, Joan lived in the capital for most of the second world war with her mother, Dorothy (nee Smith), a solicitor's secretary and later a foster parent, and her older brother, Edward, who went on to become a teacher in Swaziland, where he later died. Her father, Albert Bicknell, a foreman bricklayer in peacetime, served with the Royal Engineers in bomb disposal.

From Twickenham County school for girls Joan went to Birmingham University, graduating in medicine in 1962. A Methodist missionary society needed a paediatrician urgently at the Ilesha Wesley Guild hospital in Oyo, Nigeria, so Joan interrupted her paediatric training to test her new medical skills in a very different setting. When the Biafran war began in 1967, Joan was rounded up with others at bayonet point and put on a plane to Sierra Leone. There she worked on the flying doctor service before returning home.

She took a post at Queen Mary's hospital, Carshalton, in Surrey, where her concern about the poor care given to severely disabled children was strengthened by her own family experience, when her mother fostered two brothers with learning disabilities. This was the new challenge she needed and five more years of clinical training followed.

Joan obtained the diploma in psychological medicine in 1969, and in 1971 completed an MD on the causes and prevalence of lead poisoning in institutionalised children. She was soon active in campaigning about the restricted and poorly supported lives that people experienced in long-stay hospitals.

In 1972 Joan became a consultant psychiatrist in mental handicap at Botley's Park hospital, Chertsey, where she later met Diane Worsley, a social worker. Their friendship and partnership stood the test of time, and after Joan retired they moved to Holnest, Dorset, and ran a farm, welcoming disabled children to work with the animals. Joan and Diane also built up the Longburton Methodist chapel, where they were worship leaders. In 2016 they sold the farm and moved to nearby Stalbridge.

The community team base at Springfield University hospital in Tooting, south-west London, where Joan did much of her pioneering clinical work, was named after her when she left. The Royal College of Psychiatrists instituted an annual essay prize in her honour.

She is survived by Diane.

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1.5.27 Psychiatry, not mental health

Richard Braithwaite

date

2018-2

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| <ul style="list-style-type: none">• <i>Psychiatry, not mental health</i> |
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Timms begins his article on solid ground, highlighting the serious problem of psychiatric jargon.¹ Sadly, it descends into a light-hearted list, focused on the gulf between manager and clinician in the British health service. Most importantly, he omits four gravely misused jargon terms prevalent in psychiatry.

First, the noun ‘depression’ and its adjective ‘depressed’. The noun has half a dozen dictionary definitions unrelated to medicine² and, as a word on its own, it is not a recognised diagnosis in either psychiatric classification.^{3,4} Yet it is used by the lay public, patients and healthcare professionals alike to refer to a medical diagnosis, a single symptom or a normal emotion. It is invariably unclear which meaning is intended by the speaker. This confusion contributes to massive over-prescription of an unfortunately named class of drugs;⁵ anecdotally, it is not uncommon even for senior psychiatrists to justify antidepressant treatment, having cast aside clear diagnostic criteria,^{3,4} with comments such as: ‘Well, there’s definitely a bit of depression there’ or ‘She says she feels depressed’.

In a similar vein, ‘paranoia’ and ‘paranoid’ are often used by clinicians in their lay meaning of ‘intense suspicion’,² when the true psychiatric definition is ‘delusional’;⁶ such ideation might involve purely grandiose or somatic themes. Despite this, one often sees ‘paranoid’ and ‘persecutory’ used synonymously. The subjective complaint of ‘paranoia’ is common in patients with neurotic presentations and personality disorders, and its inappropriate use in case notes without careful use of inverted commas, to signify a verbatim quote, risks inappropriate labelling of patients as psychotic and overtreatment with antipsychotics.

Next, the term ‘psychosis’ is increasingly used as a diagnosis – as if it were a singular disease for which specific treatments were indicated⁷ – rather than the syndrome that it is. It can occur in organic, substance-induced or affective disorders, yet I contend that ‘psychosis’ is often used, lazily, as a euphemism for schizophrenia, by psychiatrists either ignorant of established diagnostic criteria^{3,4} or wary of stigmatising their patients (as if one would happily tell guests at a dinner party that one was ‘psychotic’).

Most concerning, though, is the jargon that Timms includes in his own title: ‘mental health’.¹ The assumption that ‘mental health’ and the oxymoronic ‘mental health disorder’ are synonymous with psychiatry and its diseases is quite erroneous. Psychiatry, as practised by psychiatric nurses and psychiatrists, was once charged with the management of patients with psychiatric diseases. But our colleagues are now mental health nurses and our departments mental health services. Far from relating to recognised diseases, the doublespeak ‘mental health’ has become synonymous with a vague and unattainable concept of complete emotional well-being. Consequently, an increasing fraction of our population, even a majority according to some reports,⁸ young and old, are reported to have ‘mental health problems’. The jargon underlying this explosion has set us and our entire healthcare system up to fail, through unrealistic public expectations and ever unmet need.

Let us be psychiatrists and psychiatric nurses once more; let us work in psychiatric services. Let us diagnose schizophrenia and depressive episodes using recognised criteria and be judicious in our use of potentially hazardous and costly treatments; most of all, let us avoid terms steeped in ambiguity.

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Stigma remains pervasive in mental healthcare, despite efforts to challenge and quell it. Stigma begets more stigma, and a combination of discrimination, prejudice, misunderstanding and stereotyping can ensnare people with mental illnesses in a cycle of self-stigma.

Through a series of discursive essays derived from conversations with her partner, Jo McFarlane reflects on her decades-long experience of mental illness and the way in which she has been treated by clinicians and by society. She uses a ghetto as a harrowing metaphor for the isolation, vulnerability and feelings of entrapment which stigma has enforced upon her. As the metaphor suggests, her journey towards recovery and self-fulfilment is rife with challenges. However, patient-centred therapeutic relationships, the opportunity to volunteer, informal peer support, and the creation and

dissemination of art have all been instrumental in allowing her to achieve her full potential as an individual and as a member of society. She rightly throws shade on the patriarchal role psychiatry has historically had, in which her sexuality and social choices were pathologised rather than embraced, reminding us of the importance of a holistic and open-minded approach to care.

What I found most engaging about the book was the way in which creative endeavour was presented by the author not simply as catharsis but as a fulcrum for self-discovery, allowing her to shift her identity 'from patient to poet' and rise above the stigma which once shackled her. Furthermore, she uses her writing to give a voice to others, the oppressed 'ghettoised' masses, thus showing the role of art in activism and advocacy.

This book serves as a reminder of the importance of recognising and tackling stigma, particularly self-stigma, which I intend to continue to reflect upon as I embark on a career in psychiatry myself. It is an accessible, thought-provoking and stimulating read with occasional space for humour, and I believe it would be a worthwhile read not only for those working in the field of psychiatry, but also for those using mental health services.

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1.5.28 Antidepressants in paediatric depression: do not look back in anger but around in awareness

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2018-2

Abstract**Summary**

In this paper, we summarise and critique a network meta-analysis (NMA) of antidepressant efficacy and tolerability for paediatric depression and an accompanying editorial. Although we agree that many of the extant studies are flawed, this meta-analysis showed clear efficacy of fluoxetine in the NMA, and for sertraline and escitalopram in pairwise analyses. Consequently, these papers underestimate the benefits of antidepressants for paediatric depression, and provide support for current practice guideline, which recommends the use of an antidepressant if the patient does not respond to psychotherapy. In these circumstances, fluoxetine should be the first choice, with escitalopram and sertraline as alternatives.

Declaration of interest

D.A.B. receives royalties from Guilford Press, has or will receive royalties from the electronic self-rated version of the C-SSRS from eResearch Technology, Inc., is on the editorial board of UpToDate, and is a reviewer for Healthwise. R.D.G. serves as an expert witness for the US Department of Justice, Pfizer, Wyeth and GSK; and is the founder of Adaptive Testing Technologies. P.W. receives personal fees from Lundbeck and Takeda. B.D. reports a licensing agreement with Lundbeck for a psychosocial treatment manual for depression. No other disclosures were reported.

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- *Antidepressants in paediatric depression: do not look back in anger but around in awareness*

In this article, we review a network meta-analysis (NMA) that examines the relative efficacy and tolerability of antidepressants for paediatric depression, and the accompanying editorial that appeared in the *Lancet*. The meta-analysis provides useful information for researchers and practitioners, but undervalues the benefits of antidepressants and overweights the risks.¹ The accompanying editorial takes this bias as its point of departure, fuelled by righteous indignation about the deceptive reporting and publication practices of some industry-led studies.² While this anger is justified, we believe that it should not preclude the reporting of benefits from the use of antidepressants in depressed youth, when supported by data.

Cipriani and colleagues have contributed a carefully and transparently conducted NMA of the comparative efficacy and tolerability (defined as discontinuation of the drug) of antidepressants for paediatric major depression.¹ This meta-analysis examined 34 randomised clinical trials (RCTs) that encompassed 5260 participants and tested 14 different antidepressants. In the overall NMA, fluoxetine was the only agent found to be significantly more effective than placebo in reducing depressive symptoms ($d = 0.51$, 95% CI 0.99 to 0.03). Fluoxetine was no different from placebo with respect to tolerability and suicidal events, and was better tolerated than duloxetine or imipramine. Furthermore, imipramine, venlafaxine and duloxetine had more discontinuations than placebo. The quality of evidence was rated as ‘very low’ for most comparisons. The authors concluded that antidepressants do not appear to offer a clear advantage for children and adolescents, but if a pharmacological intervention is indicated, fluoxetine is ‘probably the best option’.

Pairwise meta-analyses found that three agents, fluoxetine, sertraline and escitalopram, showed superiority to placebo for both continuous and dichotomous outcomes. Venlafaxine was reported to have a higher incidence of suicidal events (OR = 0.13, 95% CI 0.00–0.55) than placebo and several other antidepressants, whereas none of the other agents studied had a higher rate of suicidal events than placebo.

The authors are to be commended for their careful attention to methodological quality, use of NMA and elegant presentation of results. We agree with the authors about the limitations imposed by low study quality, possible industry bias, incomplete assessment of suicidal events and overall small number of studies. This leads us to a different conclusion, which is that more studies that are conducted more rigorously are needed. Moreover, we found the interpretation of the findings to be inconsistent in three ways – with the data itself, across findings and compared with previous reports by some of the authors.

For example, the meta-analysis found that fluoxetine, compared with placebo, resulted in a medium effect size, yet because the confidence interval upper limit was close to zero (0.99 to 0.03), the authors raise the question of ‘whether this estimate is robust enough to inform clinical practice’. Many statisticians would agree that after passing the muster of NMA, this effect is robust enough. The authors do not offer a bar above which these data are expected to pass. Moreover, the authors support the use of evidence-based psychotherapy for the treatment of paediatric depression, although it has a much smaller effect on paediatric depression than does fluoxetine ($d = 0.29$).³

The authors raised appropriate suspicion about studies conducted by industry, yet, in the case of fluoxetine, they raise the reverse concern that most of the fluoxetine trials were done *without* industry sponsorship and were of smaller sample size, ‘which might result in an exaggerated treatment effect’. These concerns are not grounded in facts. First, the National Institute of Mental Health (NIMH)-sponsored Treatment of Adolescent Depression Study (TADS) was one of the largest placebo-controlled paediatric depression trials, involving 423 young people.⁴ Second, since both published

and unpublished studies with small samples were included, findings are just as likely to yield a Type II error as to result in a spurious positive finding. Third, other studies of paediatric and adult depression have found that the effect size is lower, and the placebo effect higher, when a greater number of sites is involved, as is more common in industry-sponsored studies.^{5–7} In fact, a paper co-authored by the lead author examining trends in clinical trials of antipsychotics observed that ‘effect sizes were reduced by industry sponsorship and increasing placebo response, not decreasing drug response’, and recommended that ‘drug development may benefit from *smaller samples but better-selected patients*’ (italics ours).⁸ We would argue that ‘smaller samples’ of ‘better-selected patients’ would be considered to be a positive design feature in antidepressant RCTs for paediatric depression as well. Finally, re-analyses of the fluoxetine trials for paediatric depression using patient-level data have found efficacy in the reduction of depression comparable to that reported in adults.⁹

The authors found that both sertraline and escitalopram had significant effects on the reduction in depressive symptoms on pairwise meta-analyses that apparently did not survive NMA. Given the reported high degree of homogeneity in these studies, and the fact that there were no indirect comparisons that would contribute extra studies, NMA may be inappropriately stringent. In the case of low heterogeneity, fixed effects meta-analysis, with narrow confidence intervals, may be more appropriate than the random effects used in NMA. Moreover, it may be justified to report also on the effects of *antidepressant drug classes* such as selective serotonin reuptake inhibitors (SSRIs), serotonin–noradrenaline reuptake inhibitors (SNRIs) and tricyclic antidepressants (TCAs). Inspection of the data suggests that SSRIs would show a more favourable effect on depressive symptoms and better tolerance compared with TCAs, which is a message found in previous meta-analyses, but worth repeating.¹⁰

The authors state that the risk–benefit profile is not favourable for antidepressants. Part of this argument is based on wide confidence intervals for efficacy. It seems inconsistent then to not put similar emphasis on the equally wide confidence intervals for discontinuation and suicidality, especially as the antidepressants with the best evidence for efficacy (i.e., fluoxetine, sertraline and escitalopram) are not significantly different from placebo for discontinuation or suicidality. With respect to suicidality, the rates of suicidal events ranged from 0 to 13% in those assigned to the drug, and 0 to 14% for those assigned to placebo. The authors report on a strong association between venlafaxine and suicidal events (OR = 0.13, 95% CI 0.00–0.55). While the rate of suicidal events in those assigned to venlafaxine (4%) was statistically higher than in those assigned to placebo (0%), the absence of events in the placebo group makes it difficult to obtain an accurate estimate of the odds of suicidal events associated with this agent.

The authors correctly point out limitations in the design and conduct of these clinical trials, but there are other limitations that greater access to data cannot remedy. First, the assessment of suicidal events in the majority of these studies was based on spontaneous report, rather than systematic assessment. One study that compared the rate of events by spontaneous reporting and systematic assessment found that spontaneous reporting of suicidal events underestimated the rate of events by a factor of 2.5.¹¹ Moreover, patients on medication, perhaps owing to side-effects, might be more likely to report suicidal events, thus biasing conclusions based on these methods. In one of the few placebo-controlled trials that utilised systematic assessment of suicidal events, no difference was found between duloxetine, fluoxetine and placebo in the frequency of suicidal events.¹² Second, there are inherent limitations in clinical trials, since those patients most likely to be treated with an antidepressant are least likely to be enrolled into an RCT. For example, a recent suicide attempt is an exclusion for almost all paediatric depression pharmacotherapy RCTs. In a study of the relationship between a suicide attempt and initiation of antidepressant treatment in one large healthcare system, a suicide attempt was a common precipitant for *starting* an antidepressant in adolescents and in adults.¹³ Moreover, in these youth, the rate of suicide attempts was highest *prior* to the initiation of treatment, suggesting that antidepressants are protective against suicidal behaviour, even in young people. Although causal inferences cannot be firmly drawn from observational studies, such studies have the advantage of larger size, representativeness, longer duration of treatment, and ability to link treatment to suicide, not just to suicidal events. While not incontrovertible, there are many observational studies showing strong inverse associations between prescription and sales rates of SSRIs and suicide, including suicide in adolescents.^{14–16} Conversely, after the Black Box Warning, there has been at least a temporary decline in antidepressant prescriptions in the United States, Canada and The Netherlands, accompanied by an uptick in adolescent suicides.^{17–18} If antidepressants were strongly associated with suicide, one would expect that a decline in antidepressant prescriptions would be accompanied by a corresponding decline in suicide, rather than the exact opposite.

This carefully conducted meta-analysis was accompanied by an editorial that was a polemic against the use of antidepressants, entitled ‘Antidepressants fail, but no cause for therapeutic gloom’.² The editorialist asserted that the extant

literature greatly exaggerates the benefits of antidepressants and downplays their risks, owing to the poor data quality and selective reporting of results. He recommended that clinicians reading the literature assume that the benefits of a drug are inflated, and that the occurrence of harmful events is more serious and frequent than reported. This editorial asserted that the reported association between fluoxetine treatment and improvement in symptoms and functional outcomes is not necessarily causative, and that fluoxetine is likely to be more dangerous, and less effective than presented in the extant literature. This editorial further opined that fluoxetine has never been compared with a supportive relationship, which the editorialist considered was likely to be more helpful and less harmful than antidepressant medication for depressed youth. The editorial concluded that industry-sponsored research should provide transparency and access to all data and procedures.

It is only with the last statement in this editorial that we can proffer agreement. We wholeheartedly endorse the need for data transparency in all clinical trials, including those conducted by industry, and acknowledge the damage to the credibility of all studies caused by failure to publish and disclose data. However, the largest single clinical trial of antidepressants in paediatric depression, TADS, was not sponsored by industry, but by NIMH. This study showed a higher rate of response and better functioning in those assigned to fluoxetine versus those assigned to placebo.^{4,19} While the editorialist raised the question of whether association implies causality, a blinded placebo-controlled trial has long been considered the gold standard for causal inferences. The editorialist also suggests that supportive therapy is likely to be more effective, and less harmful, than fluoxetine. However, the placebo condition in TADS involved supportive management, and resulted in a response rate of only 35% v. 61% for those treated with fluoxetine.⁴ Although there were more spontaneously reported suicidal events (which includes thoughts without acts) in those treated with fluoxetine than in those treated with placebo, the response rate after 12 weeks of treatment was much higher in those treated with fluoxetine, and absolute risk differences were several-fold higher for efficacy than for suicidal events.²⁰⁻²¹ Moreover, a comparison of another version of cognitive-behavioural therapy (CBT) with supportive treatment found that CBT was much more efficacious.²² Therefore, results of the TADS trial and other published data completely refute the editorialist's assertions that industry sponsorship of some studies automatically dilutes the efficacy reports of medication, including fluoxetine, that causality cannot be inferred from an RCT, and that supportive care would be superior to treatment with fluoxetine.

What is a clinician to make of this meta-analysis and editorial? We believe that the findings from the meta-analysis support current clinical guidelines. In the UK, National Institute for Health and Care Excellence (NICE) guidelines advise the first-line use of an evidence-based psychotherapy such as interpersonal therapy or CBT, and, if the patient does not respond, to then consider adding pharmacotherapy, namely, fluoxetine.²³ We continue to support this approach. Also, as per NICE guidelines, in cases of severe, chronic or treatment-resistant depression, there is evidence to support starting with a combination of psychotherapy and pharmacotherapy, which has been shown to be superior to medication monotherapy for treatment-resistant depression.²³⁻²⁵ Despite the 0% rate of suicidal events in the placebo cells for venlafaxine studies, we agree that caution is indicated in the use of this agent, insofar as SSRIs are just as effective for treatment-resistant depression as venlafaxine, but their use results in fewer side-effects, and lower levels of suicidal ideation and events.^{11,26} Moreover, these meta-analyses are consistent with the view that other antidepressants, such as sertraline and escitalopram, are reasonable and effective alternatives should patients have a history of not responding to an adequate trial of fluoxetine. The risk-benefit ratio for use of antidepressants in paediatric depression is relatively favourable, with about 11 times more young people responding to an antidepressant than developing suicidal events.⁵ Moreover, the shadow cast by the Black Box Warning should not discourage the clinician from using antidepressants for the treatment of anxiety and obsessive-compulsive disorders, as treatment of these conditions with SSRIs is more likely to result in a clinical response, and less likely to result in a suicidal event, compared with antidepressant treatment of paediatric depression.^{5,27}

Our job as responsible scientists and clinicians is to inform patients and families about the risks and benefits of each intervention, with appropriate confidence intervals and without bias, and to use this information to collaborate with families in making clinically appropriate treatment decisions. It is justifiable to be angry about scientific obfuscation and deception, but we should not paint all studies and findings with the same broad brush. Instead, let us consider the wise words of the blind, but insightful, author James Thurber, who advised us to 'not look back in anger, or forward in fear, but around in awareness'.²⁸

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1.5.29 Liaison psychiatry for older adults in the general hospital: service activity, development and outcomes

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Abstract**Aims and method**

This study used data collected to describe the activity, case-load characteristics and outcome measures for all patients seen during a 6-year period.

Results

The service reviewed 2153 patients over 6 years with referral rates and case-load characteristics comparable to those described in a previous study period. The team saw 82% of patients on the day they were referred. Data and outcome measures collected showed significant complexity in the cases seen and statistically significant improvement in Health of the Nation Outcome Scales (HoNOS) scores following service input.

Clinical implications

The outcome measures used were limited, but the study supports the need for specialist liaison psychiatry for older adults (LPOA) services in the general hospital. The Framework of Outcome Measures – Liaison Psychiatry has now been introduced, but it remains unclear how valid this is in LPOA. It is of note that cost-effectiveness secondary to service input and training activities are not adequately monitored.

Declaration of interest

None.

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Around two-thirds of National Health Service (NHS) in-patient beds are occupied by older people, with up to 60% having an existing mental disorder or developing one during their admission.¹ Medical in-patients are three to four times more likely to develop a mental illness than the healthy population, with high prevalence rates of depression in patients with diabetes and coronary heart disease.² High rates of dementia, delirium and depression have been reported in older in-patients.³ It is important to identify and treat these conditions, as mental illness has been shown to increase the risk of poor health outcomes, including loss of independence, reduced life expectancy and increased mortality.³⁻⁵

Early studies showed that around 30% of all liaison psychiatry referrals were for people over the age of 65.⁶ Despite an ageing population and strong arguments for specialist liaison old age psychiatry input in general hospitals, a report in 2003 showed that 73% of UK services were provided through a traditional sector-based model,⁷ and it is not clear to what extent this has changed. Recently, the rapid assessment and integrated discharge (RAID) liaison psychiatry service led to significant savings by reducing readmissions and length of stay.⁸ Notably, elderly people represented about a third of the sample but accounted for around 90% of savings through reduced bed use.

The aim of this study was to provide an in-depth analysis of a well-established liaison psychiatry for older adults (LPOA) service, regarding its activity, case-load characteristics and use of outcome measures.

Method

Setting and team development

King's College Hospital is a 950-bed London teaching hospital covering a large inner-city catchment area. The LPOA service was restructured in 2000, moving from an *ad hoc* off-site service to a dedicated specialist service with staff based in the hospital. Also, the old consultation model of service delivery was changed to a true liaison model in December 2000 as previously described,⁹ but has been focused on in-patients over the age of 65 years. No older adult specialist cover had been provided to the emergency department until early 2016, owing to the small team size and insufficient resources.

The staffing level of the service had been unchanged for around 10 years from 2000 to 2010, with limited (approximately two sessions) honorary consultant psychiatrist input, a full-time staff grade/associate specialist doctor, a full-time junior doctor, and no or very poor administrative support. Attempts to improve the staff skill mix of this strongly doctor-led service failed for a long time, owing to resource issues and cuts within the mental health trust. However, with the help of the acute trust providing funding for 18 months initially, the service employed a clinical nurse specialist (CNS) in late 2010. This post has continued and is now funded by the mental health trust. Funding was also secured for a half-time administrator in 2015 and, as the team has expanded, the CNS role has been extended and now also operates as the team manager.

Between October 2013 and September 2015, consultant cover for the service was provided by the substantive consultant from another older adult liaison service within the trust. Funding for a half-time substantive consultant psychiatrist was finally agreed and commenced in September 2015. Since then, and owing to increased demands on the service, there have been further developments to the team skill mix, including fixed-term funding (now made recurrent) for a band 6 psychiatric liaison nurse (PLN) to cover in-patients and Core-24 NHS England (NHSE) funding (<https://www.england.nhs.uk/mental-health/adults/crisis-and-acute-care/transformation-funding/>) for a CNS to provide specialist old age psychiatry input to the emergency department, and a part-time trainee psychologist has joined the team. The most recent developments are further NHSE Core-24 funding for a clinical psychologist and occupational therapist within the liaison psychiatry department; both posts will work across the general adult and older adult teams. The team has now become much more integrated with the general adult psychiatry team, with a single point of access and closer collaboration.

Service activity

The activity of the service has been monitored extensively since its inception in December 2000. This has included descriptive data about the source of and reason for referrals, characteristics of the case-load, outcome of the team's assessment, outcomes and follow-up arrangements. The rationale for this has been to gather information to support further service development and to identify any problems that needed addressing. The data collection has been anonymised throughout, with no patient identifiers recorded on the electronic database used for further analysis.

Sample and data collection

The study included all patients seen by the King's College Hospital LPOA service between January 2010 and December 2015.

A two-page form was filled in by the assessing clinician for each patient, containing demographics, reason for referral, response time, outcome of the psychiatric assessment, discharge destination and follow-up arrangements. Data about mental capacity assessment were also collected, and Mini-Mental State Examination (MMSE) scores¹⁰ were recorded where possible. The main performance and outcome data collected included response time (and whether target times were met) and Health of the Nation Outcome Scales for Elderly People (HoNOS 65+) © Royal College of Psychiatrists 1999.¹¹ The response time standards set for the service were assessment of all urgent referrals within 24 h, medium-urgency referrals within 3 days, and low-urgency referrals within 5 days. A second HoNOS 65+ rating was completed for patients under the care of the service for 2 weeks or longer. A record was also kept of new diagnoses of dementia

and antipsychotic medication reviews in patients with dementia. The information from each form was anonymised and transferred on to the electronic database by F.M.

Statistical analysis

Data were analysed using SPSS version 21.0. Descriptive statistics were used to analyse the main demographic characteristics of the case-load (age, gender, ethnicity), clinical characteristics, cognitive status (MMSE score) and outcome data of the patients in the sample. We also used paired *t*-tests to test the difference between paired HoNOS 65+ ratings.

Results

Case-load

The service reviewed 2153 patients during the studied period, amounting to approximately 360 patients seen on an annual basis. This did not include referred patients where the liaison service provided advice and information only, or where the referral was deemed more appropriate for another team.

The majority of patients were admitted from their homes ($n = 1940$; 90.1%), while only a minority were either admitted from care homes or transferred from another hospital. Apart from medical and surgical issues, 435 (20.2%) patients in this sample were admitted to hospital owing to falls, with 124 (28.5%) of these sustaining various fractures. Suicide attempts, overdose or other self-harm incidents were the reason for admission for 68 (3.1%) patients. The main characteristics of patients and referrals are outlined in *Table 1*. *Table 1* Main characteristics of the referral-

Age, mean years (s.d.) 78.6 (7.93); min 60, max 106
 Gender Female 1141 (53%) Male 1011 (47%)
 Ethnicity White European 1603 (74.5%) Caribbean 313 (14.5%) African 99 (4.6%) Asian 68 (3.2%) White other 46 (2.1%) Other 24 (1.1%)
 Referred by Geriatrics 598 (27.5%) Acute medicine 564 (26.2%) Acute medical unit 378 (17.6%) Orthopaedics 94 (4.4%) Other surgeons 152 (7.1%) Other 367 (17.0%)
 Referral urgency High 758 (35.2%) Medium 1292 (60.0%) Low 103 (4.8%)

Referral requests and assessment

The vast majority of referrals were for advice on issues affecting the patient's stay in the hospital, including mental health diagnosis (82.5%) and management (90.5%). Advice on mental capacity assessment was requested in 8.5% of the referrals, which is lower than when the service was first established and before the Mental Capacity Act 2005 was introduced.¹² Other requests were mainly related to patients' discharge arrangements and made a smaller contribution to the total number of referrals, e.g. advice on placement (1%) and mental health follow-up (5.1%).

The main presenting problems that triggered referral were low mood (65.8%), impaired cognition and confusion (36.2%), behavioural disturbance (21.7%), and abnormal beliefs and experiences (15.4%). The most specific referral questions asked were related to mental state (92.5%) and medication (52%), while other questions included issues with cognition (8.2%) and suicidality (11%).

The majority of patients were diagnosed with one or more psychiatric disorders. Only a small number of patients did not have any psychiatric diagnosis following the assessment (4.3%). The diagnoses are outlined in *Table 2*. *Table 2* Case-load

Diagnosis Main ($n = 2153$) Second ($n = 559$) Overall frequency of diagnosis ($n = 2016$)
 Delirium 473 (22.0%) 187 (33.5%) 660 (32.7%)
 Dementia 438 (20.3%) 113 (20.2%) 551 (27.3%)
 Adjustment disorder 483 (22.4%) 46 (8.2%) 529 (26.2%)
 Depression 307 (14.3%) 57 (10.2%) 364 (18.1%)
 Psychotic illness 125 (5.8%) 29 (5.2%) 154 (7.6%)
 Alcohol 135 (6.3%) 26 (4.7%) 61 (3.0%)
 Bipolar affective disorder 17 (0.8%) 8 (1.4%) 25 (1.2%)
 Other 183 (8.6%) 93 (16.6%) 276 (13.7%)
 No diagnosis 92 (4.3%) n/an/a

Interventions and outcomes

In most cases, the referring team received advice on the patient's ongoing management and medication (*Fig. 1a*). No further intervention was provided in 546 (25.4%) of cases, while others received some further interventions from the service. These included transfers to a mental health unit ($n = 98$, 4.6%); referral for community mental health team (CMHT) follow-up ($n = 249$, 11.6%); referral to the Mental Health for Older Adults home treatment team (HTT; $n = 45$, 2.1%); and referral for psychological intervention or assessment ($n = 21$, 1.0%). Mental capacity was assessed in a total of 12.2% of patients (as the main intervention in 7% and as an additional intervention in the remaining 5.2% of cases). *Fig. 1* The main interventions and discharge arrangements. (a) Main intervention. (b) Discharge arrangements.

Following discharge from hospital, most patients returned to their homes (62.3%) and were followed up by their general practitioner (GP; 48.7%) (*Fig. 1b*). Of the total number of patients, 112 (5.2%) were discharged into an EMI (elderly mentally infirm) care home.

Service activity and outcome measures

As shown in *Table 3*, the service was highly responsive, particularly for urgent referrals, for which almost all patients were seen on the same day and many within 4 h. The achievement was lower for medium-urgency referrals (95.2% seen within 3 days) and low-urgency referrals (93.2% seen within 5 days). *Table 3* Service responsiveness, contacts and HoNOS rating Referrals ($n = 2153$) Seen within 1 day Seen within 4 h High 754 (99.5%) 754 (99.5%) Medium 969 (75.1%) 493 (38.3%) Low 36 (35.0%) 19 (18.4%) All referrals 1759 (81.7%) 1097 (50.9%) Contacts All patients ($n = 2153$) Single assessment 1141 (53.0%) Mean time under care (days) 9.7 (s.d. 15.23) Average number of contacts 2.6 (s.d. 3.269) Mean time spent with patient 152.3 min. (s.d. 170.894) Follow-up patients ($n = 1012$) Mean time under care (days) 17.06 (s.d. 19.550) Mean number of contacts 4.4 (s.d. 4.070) Mean time spent with patient 228.84 min (s.d. 221.971) HoNOS 65+ rating Mean initial HoNOS 65+ rating ($N = 1081$) 12.53 (s.d. 4.125); min 1, max 32 Mean paired HoNOS 65+ ratings ($N = 230$) Initial 14.65 (s.d. 3.919) On discharge 11.80 (s.d. 4.599) Difference – paired t -test: 10.035 (d.f. 229); $P < 0.001$ Difference – 95% CI 2.296–3.418

Table 3 shows that for those patients who were seen on more than one occasion, the service had a substantial number of contacts, and significant time was spent on their mental healthcare during their stays in the hospital.

The HoNOS 65+ rating scale was introduced in January 2013 as one of the outcome measures for the service. Analysis of this data (*Table 3*) indicates a significant degree of complexity of the cases seen by the service and a statistically significant improvement in HoNOS scores following input from the service.

Good clinical practice

New diagnoses of dementia made by the service were included in data collection from January 2013, and a record of antipsychotic reviews in people with dementia started in May 2013. Between January 2013 and December 2015, 273 patients with no existing dementia diagnosis (21.6% of all referrals) were identified with probable dementia that needed further assessment, and 51 patients (4.0% of all referrals) were diagnosed with a new diagnosis of dementia by the liaison service. Of 50 patients with dementia who were on antipsychotic medication at the time of referral, only one patient (2%) did not have his medication reviewed by the service.

Discussion

The results of this study indicate that the LPOA service at King's College Hospital, London, has continued to play an important part in mental health provision to adults aged 65 and over admitted to general hospital beds since its initial description.⁹ The total numbers of patients seen per year, their demographic characteristics and case mix have all remained comparable to those described in 2000/2001. The service has also maintained a good responsiveness, particularly for urgent referrals which, although not described in this data set, the service has extended into the emergency department and clinical decisions unit during this study period.

There are two significant points that have changed in service activity since the last review. First, there has been a marked increase in the number of patients with delirium seen by the service; second, there has been a significant decrease in the number of referrals for assessment of mental capacity. The first point is likely to be explained by new developments within the general hospital and the close relationship of the liaison service with the King's delirium and dementia team that was established in January 2013. This may have led to better recognition of delirium and targeted involvement of liaison psychiatry in management of complex cases for which there is diagnostic uncertainty requiring expertise in recognition, or where pharmacological management is required owing to risks to patients and others. The second point is likely to reflect increased awareness and improved skills of medical and surgical teams in assessing mental capacity following the introduction of the Mental Capacity Act 2005 and the increased training that followed this legislation. Our service has retained an important role in providing a second opinion in complex capacity assessments.

The results presented suggest that the service has played a part in discharge facilitation, with the majority of patients returning home and being followed up by their GP. Relatively small numbers of patients required referral to the CMHT, and for those already under CMHT care there was good liaison between respective mental health services. Only a small percentage of patients required transfer to psychiatric units, but this may have also been influenced by the development of an older adults' HTT in the last 3 years of the study period.

The National Dementia Strategy has included good quality of care within general hospitals as one of its key objectives for patients with dementia.¹³ Around 27.3% of patients seen had a diagnosis of dementia during the study period. This is in line with previous estimates that, at any time, up to a quarter of older patients in general acute hospitals will have dementia.¹⁴ Fifty-one patients were diagnosed with a new diagnosis of definitive dementia from January 2013 and included in the total number of cases. A further 20% of patients seen during the 3-year study period were suspected to suffer from dementia, with a discharge recommendation for further assessment. These data, and the fact that all but one patient with dementia and on antipsychotic medication had this reviewed by the service, suggest that the service engaged in important local and national initiatives for dementia diagnosis and care.

Until the recent introduction of the Framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP), there had been no consensus on how to best capture the diverse activities, outcomes and performance of liaison psychiatry services.¹⁵ In addition, as was the case with this team, teams have often had small numbers of staff and limited administrative support, also limiting their capacity for routine outcome measure collection. Despite this, we have recognised the importance of monitoring activity in relation to further team development and during the study period have recorded referral response times and clinician-rated HoNOS 65+ outcome scores for all patients seen. Average HoNOS 65+ scores indicated that the patients seen had conditions of moderate severity and complexity, and a statistically significant improvement was seen in the patients for whom paired ratings were done. Although these are positive data, the extent to which the physical health domains and improvements contributed to positive outcomes is unclear, and this itself does not fully reflect all aspects of the service's activities and roles within the general hospital.

A recent review suggested that the FROM-LP is a very useful tool to measure service quality and clinical effectiveness, and represents a significant step towards developing nationally unified outcome measures.¹⁶ There is also an increasing expectation that outcome measures are available to secure funding and support liaison psychiatry service growth. In response to this, we have been collecting outcome measures as suggested by FROM-LP,¹⁷ as well as HoNOS 65+, since January 2016. However, from the outcome data collected so far, we have some concerns about the validity of the measures and also that they do not measure the aspects of LPOA services that have previously been shown to make them cost-effective. Economic analysis of the Birmingham RAID service suggested that elderly people in their sample accounted for around 90% of total savings with reduced bed usage. We therefore suggest that this is of particular importance for older adult liaison services, and that there is a strong economic case for targeting increased resources for this patient group. This would also support the case for developing specialist LPOA teams as a part of the national

strategy for improved liaison psychiatry services within the general hospital.

Strengths and limitations of the study

The strength of this study is that it provides a large data-set and reflects the everyday practice of a busy inner-city LPOA service. There is very little missing data, as collection was overseen and coordinated by a single practitioner who ensured that data were collected for all patients seen. As such, the study included a large number of patients, ensuring an adequate statistical power. It also gives a clear indication of the need for specific older adults' liaison teams, and indicates the scope for further development and analysis of outcome measures to support this and the cost-effectiveness of services.

This is a descriptive study and does not intend to compare the King's College liaison service for older people with other liaison service provision models for older adults. It is possible that an awareness of service monitoring by team members who were also responsible for data collection might have had an impact on the care provided, but arguably this is less likely as data collection is now a routine part of clinical practice within the team, and there is increasing emphasis on outcome measures and quality improvement activities. Another possible limitation is that the activities and outcomes of the team described in this paper may not be generalisable to other LPOA teams in the UK where the team structure or patient demographics differ.

Clinical implications

The results of this study support the need for specialist LPOA services for older people admitted to general hospitals. However, finding easily measurable outcomes of liaison psychiatry services remains a challenge if we are to find valid measures that also support the services in terms of identifying necessary developments and growth. The King's College Hospital LPOA team is now using the FROM-LP and will pilot the use of these outcome measures. However, we suggest that there are other aspects of service activity in older adult liaison that are not adequately monitored or audited using this framework. For this reason, we continue to use HoNOS 65+, as we feel that this provides a measure of complexity and also indicates improvement over time with paired scores. In terms of further development of outcome indicators for LPOA, we feel it is important to consider whether length of time from admission to referral to liaison affects overall length of stay, as this could help to provide information about cost-effectiveness of older adult liaison services. Similarly, we feel it will be important to measure the impact of training activities for general hospital staff in terms of raised awareness and timely referrals to the service.

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1.5.30 Unlocking an acute psychiatric ward: open doors, absent patients?

Damian Smith MacDara McCauley

date

2018-6

Contents

- *Unlocking an acute psychiatric ward: open doors, absent patients?*

In their recent paper, Beaglehole and colleagues¹ reported on the effects of unlocking an acute psychiatric ward. Despite a 58% increase in unauthorised absences and an 8% increase in violent incidents, they concluded that a less restrictive environment had some positive effects, most notably a reduction in the total hours of seclusion per month.

Our service has recently undertaken a similar transition from a locked acute ward opened (and locked) in the 1930s, to an unlocked newly built unit opened in 2016. When comparing the 6 months before and after this transition, we too found that the rate of unauthorised absences increased by 100% from a mean of 4 to 8 per month. Unlike Beaglehole, however, we observed a decrease in rates of violent incidents by 27.4% (from a mean of 31.7 to 23 per month), and an increase in the total hours of seclusion per month by 213.4% (from a mean of 28.21 to 88.42 hours per month). Of note, admission rates increased from a mean of 20 to 23 per month during the same time period.

Although a reduction in the rate of violent incidents (and, in the case of Beaglehole, reduced levels of seclusion) strengthens the case for provision of care in unlocked settings, should we be concerned about the increased rate of unauthorised absences found in both studies?

The largest available study on this topic² would suggest not. In their 15-year observational study involving 145,738 German in-patients, Huber *et al* concluded that locked doors do not prevent suicides, or indeed unauthorised absences.

Although a rare event, suicide is undoubtedly one of the most feared outcomes when any patient absconds. Preventing harm to self or others is often the main rationale for in-patient admission. It is also a ubiquitous criterion for involuntary admission. Consequently, preventing harm is one of the main motives for locking psychiatric units.

In our study, 86% of unauthorised absences over the 1-year study period were by involuntarily admitted patients. In opening our doors, are we doing these individuals a disservice by giving them the opportunity to leave hospital at a time when they are most unwell?

Previous studies have reported on the negative consequences of absconding for patients (interrupted treatment, suicide), staff (anxiety), family members (loss of trust in the service), and emergency services (expended resources).³ It could be argued that a reduction in the number of violent incidents (and, in Beaglehole's case, seclusion) is worth the risk of these adverse outcomes. In our view, however, a modern purpose-built environment coupled with increased staffing levels better explains these findings. Increased numbers of nursing staff result in improved relational security, an important element of therapeutic security provided by higher staff-to-patient ratios.⁴

Our study and that of Beaglehole and colleagues indicate that unlocking acute psychiatric wards leads to an upsurge in unauthorised absences. The majority of patients who absconded were admitted involuntarily. We suggest that acute mental health services give careful consideration to all the risks associated with unauthorised absences before opening their doors. This is of particular relevance given that rates of involuntary admission are on the rise.⁵

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1.5.31 Against the Stream: religion and mental health – the case for the inclusion of religion and spirituality into psychiatric care

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2018-6

Abstract

This paper argues for the inclusion of religion and spirituality in psychiatric care. After discussing the antagonism of psychiatrists and psychologists to religion, I present a critical overview of studies examining the relationships between spirituality, religion and diverse aspects of mental health: depression, suicide, anxiety, delinquency, drug abuse and schizophrenia. The need to assess the impact of religion in different faith groups is discussed. Measures of religious coping, both positive and negative, may provide a more accurate portrayal as to how individuals deploy religion in their lives than global measures such as belief and attendance. I highlight the fact that there is a dearth of research on ritual, prayer and other aspects of religious experience. While many studies demonstrate positive effects of religion on mental health, others find detrimental effects. Finally I examine the clinical implications of these findings.

Declaration of interest

None.

Contents

- *Against the Stream: religion and mental health – the case for the inclusion of religion and spirituality into psychiatric care*
 - *Recent findings*
 - *Criticisms*
 - *Clinical implications*
 - *Conclusion*

Psychiatry and religion have traditionally had a difficult relationship. The views of Freud and others such as Albert Ellis have negatively affected the attitudes of mental health professionals pertaining to the mental health effects of religion. Religious beliefs and practices are widely seen to be ‘primitive’, dependency forming, guilt inducing, non-empirical and necessarily bad for mental health. However, compared with psychologists and psychiatrists, the patients consulting them have been found to have higher levels of religiosity – there is a so called ‘religiosity gap’ between mental health professionals and those they treat.¹ For many people, religion is not only important in their lives but the central aspect of coping with life stresses. There is, moreover, evidence that psychiatrists tend to ignore religion; it is rarely part of standard psychiatric assessment and treatment. As Rosmarin *et al* state²: “[R]eligious beliefs are often ignored in the context of treatment as mental health professionals are often ill-trained in the assessment of these factors in clinical settings. This deficit creates a reticence to broach this topic in psychiatric research and practice, which in turn perpetuates assumptions throughout the field that these facets are tangential to human functioning and a side issue

in treatment. Protocols for assessment seem to ignore religious beliefs and there seem to be few interventions that take account of religious and spiritual beliefs.”

Here I argue against the assumption that religious beliefs are largely irrelevant to clinical psychiatric practice.

Recent findings

In the past 20 years, there has been escalating research focusing on the relationships between various dimensions of religiosity and mental health. To date, several thousand studies demonstrate positive associations between the two.³⁻⁴ Results indicate that those who are more religious generally fare better in terms of mental health.

The presence of religious faith is associated with greater hope, increased sense of meaning in life, higher self-esteem, optimism and life satisfaction. In terms of depression, Koenig (2012) reports that of 70 prospective cohort studies, 39 (56%) indicated that greater religion/spirituality (R/S) predicted lower levels of depression or faster remission of depression, seven (10%) predicted worse future depression and seven (10%) reported mixed results (both significant positive and negative associations depending on R/S characteristics).⁵ Higher religiosity has also been associated with lower rates of suicide,⁶ reduced prevalence of drug and alcohol misuse,⁷ and reduced delinquency.⁸ Findings in relation to anxiety are rather mixed. Although some studies demonstrate reduced anxiety rates, others indicate that anxiety levels are increased in the more religious.⁹ There are few studies relating schizophrenia to R/S. Recent studies from Switzerland suggest that religious individuals with psychotic illnesses frequently pray and read the Bible to facilitate coping with their voices, and that higher levels of religiosity may increase medication adherence.¹⁰ Little work has been conducted on explanatory models, treatment-seeking and outcomes in this condition.

Although the focus of the existing literature on religion and mental health predominantly relates to Christianity, there has been recent work on Islam,¹¹ Judaism¹² and Hinduism,¹³ similarly suggesting that those who are religious have better indices of mental health. Furthermore, these studies suggest that religious beliefs have different effects on mental health depending upon the faith group of subjects.

Global measures of religion such as belief may reflect dispositional religiousness rather than how people actually deploy religion during crises. As Pargament and colleagues¹⁴ (p. 521) state, ‘It is not enough to know that the individual prays, attends church, or watches religious television. Measures of religious coping should specify how the individual is making use of religion to understand and deal with stressors.’ There is evidence that some forms of religious coping are protective in the wake of adverse life events, while others may be maladaptive. This author contends that there are two sorts of coping: positive religious coping and negative religious coping.¹⁵ The former (e.g. benevolent religious appraisals, religious forgiveness) reflects a secure relationship with God and generally results in improved mental health. By contrast, the latter (e.g. reappraisals of God’s powers, feeling abandoned or punished by God) reflects a weak relationship with God and is associated with worse mental health indices. There is some recent discussion of the psychological implications of theodicy – the defence of God’s goodness and omnipotence in view of the existence of evil.¹⁶

There is a dearth of research examining the mental health effects of ritual, prayer and other aspects of religious experience. Although popularised in William James’ classic *The Varieties of Religious Experience*,¹⁷ religious experience has attracted less research than attendance, beliefs and coping, possibly because of its subjective nature and lack of clarity in definition. The focus has been on three main areas: mysticism, conversion and religious hallucinations. Religious conversion has generally been found to enhance mental health. There are phenomenological parallels between mystical and psychotic states (including visions, voices, loss of sense of self) although the outcomes are different. While mystical experiences typically affect mental health positively, psychosis is generally a negative experience.¹⁸ There has been some phenomenological research on hearing God’s voice among Pentecostal Christians in London. Among this group, hearing his voice is normative and many reported its utility in resolving distress.¹⁹ Finally, one study examined the differences between prophecy and loss of agency and thought insertion in schizophrenia. In contrast to schizophrenia, in prophetic experiences agency is preserved.²⁰

However, religion may also have a negative effect on health through inducing guilt and dependency, and in extreme cases may precipitate suicide (e.g. in extreme cultic groups).²¹ Of great contemporary interest, the wider social impact of mental health on radicalisation remains to be investigated. Bhui has provided initial data suggesting that among

Pakistani and Bangladeshi Muslims, those endorsing the most sympathy for violent protest and terrorism were more likely to report depression.²²

Criticisms

There have been a number of criticisms of the above findings.²³ First, there may be selection biases in recruiting subjects. Second, more work needs to be conducted on the non-religious and their mental health associations, including atheism and agnosticism.²⁴ Third, the vast majority of these studies have focused on religious attendance and beliefs among North American Christians, and findings cannot be generalised to other religious groups. Fourth, some people are spiritual – connected to a higher power from which they derive meaning – although not belonging to and participating in institutionalised religion. The similarities and differences between religion and spirituality warrant further research, as do the associations of spirituality with mental health. Finally, measurement scales need to be more culturally and theologically sensitive.²⁵

Clinical implications

Given the above findings, what are the clinical implications? It is clear that the assessment of religious belief should be included routinely in psychiatric assessment. It may be that the incorporation of religious activities such as prayer, Bible reading and ritual into cognitive-behavioural therapy (CBT) could enhance its effectiveness. Evidence suggests that Christian-based CBT is more effective among Christian patients with depression and anxiety than traditional non-religious CBT.²⁶ Future work in this area should concentrate on which therapies are efficacious, for which patients, and which therapists should be conducting them. Pargament provides a number of illustrative examples of how spirituality can be incorporated into psychotherapy.²⁷

Conclusion

There is now a voluminous literature examining the relationship between religion and mental health. On balance, it appears that being religious enhances mental health. Future work in this area needs to explore the clinical implications of these findings, and how working with patients' theological constructs such as guilt, sin and forgiveness helps to promote recovery. Most importantly, both clinical work and research need to be more sensitive to cultural and theological issues.²⁸ The Royal College of Psychiatrists²⁹ and the WPA³⁰ have published two Position Statements on spirituality, religion and clinical care.

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1.5.32 Prevalence of vitamin D deficiency in adult patients admitted to a psychiatric hospital

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2018-6

Abstract

Aims and method

Vitamin D deficiency is increasing in the general population, and is linked with physical and mental illness. However, evidence on its prevalence in people with mental illness is limited. This study investigated vitamin D deficiency in 104 adult patients admitted to a psychiatric hospital in the UK.

Results

Forty-nine per cent were vitamin D deficient (serum 25(OH)D <30 nmol/L), and a further 42.3% were vitamin D insufficient (<50 nmol/L). On admission, 8.7% of patients were vitamin D sufficient (>50 nmol/L). There were no statistically significant differences in mean serum vitamin D between different subgroups of mental illness.

Clinical implications

Vitamin D deficiency is highly prevalent among individuals with severe mental illness admitted to hospital. Assessment and treatment of vitamin D deficiency should be considered in in-patients to protect musculoskeletal health. Further epidemiological and intervention studies are needed to investigate the role of vitamin D in the pathophysiology of mental disorders.

Declaration of interest

None.

Contents

- *Prevalence of vitamin D deficiency in adult patients admitted to a psychiatric hospital*
 - *Method*
 - *Results*
 - *Discussion*

It has been known for many years that severe vitamin D deficiency increases the risk of metabolic bone disease, particularly rickets and osteomalacia, and that moderate vitamin D deficiency leads to an increased risk of osteoporosis and fractures.¹ More recently, observational studies have provided growing evidence of an association between vitamin D deficiency and an increased risk for many chronic diseases, including autoimmune diseases, some cancers, cardiovascular disease, infectious disease and type 2 diabetes.² The serum level of 25-hydroxyvitamin D (25(OH)D) is the most accurate reflection of an individual's vitamin D status. The National Osteoporosis Society's guidelines define serum

25(OH)D levels <30 nmol/L as deficient, 30–50 nmol/L as inadequate in some people, and >50 nmol/L as sufficient for almost the whole population.³ Vitamin D receptors are found in nearly all tissues of the body, including both neuronal and glial cells in the central nervous system and multiple areas of the human brain, including the prefrontal cortex, hippocampus, cingulate gyrus, thalamus, hypothalamus and substantia nigra, many of which have been implicated in the pathophysiology of mental illnesses such as depression and psychosis.⁴ At a molecular level, vitamin D is known to have numerous roles in nervous system health and disease. Animal models have increased our knowledge and understanding of the mechanisms by which vitamin D deficiency affects brain development and its subsequent influence on adult psychiatric and neurological disease. There is evidence that vitamin D has important roles in neurodevelopment, neuroprotection and neuroplasticity, not only by exerting its biological function directly, but also by influencing the expression of genes at a cellular level.⁵ Evidence on its prevalence in people with mental illness, in the UK, is limited. This study investigated the prevalence of vitamin D deficiency among adult patients being admitted to a psychiatric hospital in the UK, to ascertain how widespread and severe it is among our patients, and to further assess whether there are stronger associations with certain subgroups of illness such as depressive or psychotic disorders.

Method

This was a cross-sectional study, designed as a pilot, to estimate the prevalence of vitamin D deficiency in patients admitted to a psychiatric hospital, and to ascertain any associations between severity of vitamin D deficiency and severity and subclass of mental illness, in addition to environmental and social demographic factors.

Ethical approval was gained from the National Health Service (NHS) Health Research Authority via the Edgbaston Research Ethics Committee, reference 15/WM/0434. Management permission was sought and gained from the host research and development department at Leicestershire Partnership NHS Trust.

A total of 153 patients were admitted to the general adult wards of the unit, between 17 February 2016 and 23 April 2016, and were eligible for inclusion in the study. One hundred and thirty seven individuals had capacity to consent, of which 104 provided informed written consent. Vitamin D levels were requested alongside standard admission blood tests on serum samples collected by venepuncture. Plasma vitamin D levels of serum samples were analysed in the local pathology laboratory, using Siemens Centaur XP analysers with acridinium ester chemiluminescence technology.

Vitamin D deficiency was defined as a serum 25(OH)D level of below 30 nmol/L, insufficiency was defined as a serum 25(OH)D level of 30 nmol/L or above but less than 50 nmol/L, and vitamin D sufficiency was defined as a serum 25(OH)D level of 50 nmol/L or above.

Primary clinical diagnosis using ICD-10 criteria, ethnicity, gender, age and length of stay were subsequently obtained from participants' electronic in-patient medical records.

Data were initially input and analysed using Microsoft Excel, and further descriptive analysis was conducted on IBM SPSS version 20. The Mann–Whitney U test was used to compare means between different samples.

Results

A total of 104 participants were included in the study; 51% ($N = 53$) were male and 49% ($N = 51$) were female. As shown in *Table 1*, the mean age of the cohort was 40.6 years, and the median age was 39.5 with a range from 18 to 79. In terms of ethnicity, 76% ($N = 79$) of participants were White British, 11.5% ($N = 12$) were British Asian, 5.8% ($n = 6$) were Black British, 3.8% ($N = 4$) were of any other White background and 2.9% ($N = 3$) were of other Asian background. *Table 1* Demographic and clinical characteristics of the population sample

Demographic and clinical characteristics of population sample ($N = 104$)	Age, years	Mean	40.6	Median	39.5	Range	61	Minimum	18	Maximum	79	Gender	Frequency	%	Female	51	49	Male	53	51	Total	104	100	Ethnicity	Frequency	%						
White British	79	76	British Asian	12	11.5	Black British	6	5.8	Any other White Background	4	3.8	Other Asian Background	3	2.9	Total	104	100	Primary diagnosis	Frequency	%												
Depressive episode	29	27.9	Bipolar affective disorder	18	17.3	Schizophrenia	18	17.3	Personality disorder	14	13.5	Acute or unspecified psychotic disorder	7	6.7	Psychoactive substance-related disorders	7	6.7	Schizoaffective disorder	5	4.8	Anxiety disorder	3	2.9	Delusional disorder	2	1.9	Eating disorder	1	1	Total	104	100

In the sample studied, mean serum 25(OH)D was 31.9 nmol/L, and median serum 25(OH)D was 32.0 nmol/L, with a range from <15 nmol/L to 81 nmol/L.

There were no statistically significant differences noted in mean serum 25(OH)D associated with gender, age or primary diagnosis. As shown in *Table 2*, individuals with a primary diagnosis of schizophrenia were noted to have the lowest mean serum 25(OH)D of 29.5 nmol/L, while those with bipolar affective disorder had the highest mean serum 25(OH)D level of 33.8 nmol/L. Mean serum 25(OH)D was higher in participants of White British ethnicity compared with those of other ethnic backgrounds. *Table 2* Mean vitamin D in subgroups Serum vitamin D, nmol/L (N, s.d.)

Whole sample	Mean	31.9	104	13.5	Median	32	Minimum	15	Maximum	81
Gender	Female	32.15	114	14.1	Male	31.75	133	13.2	Primary diagnosis	
	Bipolar affective disorder	33.81	181	7.2	Personality disorder	33.51	141	15.8		
Depressive episode	31.42	99	9.4	Schizophrenia	29.51	181	10.3			
	Ethnicity	White British	33.27		91	13.7	British Asian	28.51	121	13.9
		Black British	28.86		14	Any other White background	23.54	62	Other Asian background	28

As shown in *Fig. 1*, 49% ($N = 51$) of participants were vitamin D deficient (serum 25(OH)D <30 nmol/L), and a further 42% ($N = 44$) were vitamin D insufficient (<50 nmol/L); 8.7% ($N = 9$) of participants were vitamin D sufficient (>50 nmol/L). *Fig. 1* Percentage of participants found to be vitamin D deficient, insufficient and sufficient ($n = 104$).

Although not statistically significant, mean length of stay in participants with vitamin D deficiency (<30 nmol/L) was 45.4 days, 8 days longer than those without deficiency ($P = 0.23$).

Discussion

To our knowledge, this is the first study to assess prevalence of vitamin D deficiency in patients admitted to a general adult psychiatry unit in the UK. We found a very high prevalence of vitamin D deficiency in patients with mental illness being admitted to psychiatric hospital, with a total of 49% being deficient and a further 42% being insufficient in vitamin D.

The reported prevalence in our study was greater than that found in psychiatric in-patient samples in Australia (58% less than 50 nmol/L),⁶ New Zealand (74% less than 50 nmol/L)⁷ and North America (52.3% less than 50 nmol/L),⁸ and in an out-patient sample in Northern Europe (56% less than 50 nmol/L).⁹

The prevalence of vitamin D deficiency in our study was higher, and the mean serum vitamin D considerably lower, than in the general population in the UK. Results from the National Diet and Nutrition Survey reported a mean serum 25(OH)D of 34.8 nmol/L and a 39.3% rate of deficiency (<25 nmol/L) in 19–64 year olds between the months of January and March, while individuals 65 years and older had a mean serum 25(OH)D of 40.5 nmol/L and a 29.3% rate of deficiency.¹⁰

In this study, although the differences were not statistically significant, of the four most common diagnostic groups, we found that participants in our sample with a primary diagnosis of schizophrenia had the lowest mean serum vitamin D of 29.5 nmol/L. This finding has been replicated in other studies. A trend towards lower vitamin D levels in individuals with schizophrenia has been reported in a study of psychiatric out-patients,¹¹ while a mini meta-analysis of seven studies found that individuals with schizophrenia had a medium effect size for lower vitamin D compared with healthy controls, and also a trend for lower vitamin D levels in comparison with other psychoses.¹²

The UK has an insufficient intensity of ultraviolet sunlight to enable cutaneous synthesis of vitamin D over the winter months, between October and April, thus resulting in the vitamin D status of the UK population peaking in September but then falling continually until the start of the following summer in May, when levels begin to rise again.¹³ Historically, vitamin D deficiency has been linked to metabolic bone disease, specifically serum concentrations of <20 nmol/L being associated with clinical osteomalacia in adults and rickets in children.¹⁴

It is unclear why the prevalence of vitamin D deficiency found in this study was higher compared with the general population. In addition to cutaneous synthesis during the summer months, vitamin D can be obtained from the diet, but only a few foods such as fatty fish are good sources of vitamin D.¹ Although institutionalisation in this case would not be a contributing factor, as the participants were newly admitted, it could be hypothesised that people with mental illness are less likely to be spending time outdoors in sunshine and thus produce less endogenous vitamin D over the summer months.

National Institute for Health and Care Excellence and Department of Health guidance identifies the need for vitamin D supplements to be taken by certain at-risk groups, namely all pregnant and breastfeeding women, particularly teenagers and young women; infants and children under 5 years old and people over 65 years old; people who have low or no exposure to the sun, i.e. housebound individuals; and people who have darker skin, for example, people of African, African–Caribbean and South Asian origin.

In a change to previous advice, Public Health England revised its guidelines in 2016, based on a report by the Scientific Advisory Committee on Nutrition. The report recognised the growing prevalence of vitamin D deficiency and is now recommending a reference nutrient intake for vitamin D of 10 g/day (400 IU/day) throughout the year, for everyone in the general UK population aged 4 years and above, to ensure that the majority of the UK population has enough vitamin D to protect musculoskeletal health year-round.¹⁵

Our study has some limitations in terms of its generalisability to the wider population. A total of 104 participants were included, representing a relatively small sample size. Of 153 potential participants, informed consent was obtained from 104 individuals, which could have affected results. As the study was cross-sectional in design, no firm conclusions can be made regarding vitamin D deficiency, mental illness and the direction of causality if present. Our study was also limited to participants being admitted to a single unit. Finally, the study was conducted during the winter months; thus, the reported prevalence of vitamin D deficiency would be affected by sun exposure if the study was conducted towards the end of summer.

Based on this study, in which almost half of the participants admitted to psychiatric hospital were found to be deficient in vitamin D, assessment and treatment of vitamin D deficiency by oral supplementation should be considered to protect musculoskeletal health, alongside other physical health interventions, in patients with mental illness admitted to psychiatric wards.

The NHS Five Year Forward View for mental health has recognised the importance of preventable physical health problems in people with severe mental illness,¹⁶ and thus musculoskeletal health should be optimised where possible.

At the current time, there is insufficient evidence to draw any firm conclusions regarding an association between vitamin D deficiency and non-musculoskeletal health outcomes, including mental illness. More research in the form of larger epidemiological and intervention studies are needed to investigate the association between vitamin D and mental health outcomes; indeed, randomised controlled trials are planned that will hopefully shed more light on this intriguing area in the future.

We would like to thank Dr David Clarke, Operational Lead (Research and Development), Leicestershire Partnership NHS Trust, for his invaluable support and guidance.

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1.5.33 Mentalising skills in generic mental healthcare settings: can we make our day-to-day interactions more therapeutic?

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Abstract

Aims and method

Caring for patients with personality disorder is one of the biggest challenges in psychiatric work. We investigated whether mentalisation-based treatment skills (MBT-S) teaching improves clinicians' understanding of mentalising and attitudes towards personality disorder. Self-report questionnaires (Knowledge and Application of MBT (KAMQ) and Attitudes to Personality Disorder (APDQ)) were completed at baseline and after a 2-day MBT-S workshop.

Results

Ninety-two healthcare professionals completed questionnaires before and after training. The mean within-participant increase in scores from baseline to end-of-programme was 11.6 points (95% CI 10.0–13.3) for the KAMQ and 4.0 points (1.8–6.2) for the APDQ.

Clinical implications

MBT-S is a short intervention that is effective in improving clinicians' knowledge of personality disorder and mentalisation. That attitudes to personality disorder improved overall is encouraging in relation to the possibility of deeper learning in staff and, ultimately, improved care for patients with personality disorder.

Declaration of interest

None.

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Personality disorder is of major clinical importance: a third of psychiatric out-patients and over half of in-patients are estimated to fulfil the criteria for personality disorder.¹ Borderline personality disorder (BPD) is the most prevalent personality disorder in the non-forensic setting^{2,3} and is associated with intensive use of psychiatric services and frequent admissions.^{4,5} Caring for patients with BPD can be experienced as emotionally challenging,^{6,7} and these patients are perceived by some clinicians to be manipulative, attention-seeking or threatening,⁸ making it hard to maintain a therapeutic stance towards them. In turn, patients may experience staff as prejudicial and unhelpful.¹ Negative staff attitudes towards personality disorder are associated with poorer therapeutic relationships, reduced standards of care and overall poorer outcomes.^{7,9}

Mentalisation-based treatment

A central component of BPD is that of a hypersensitive attachment system.¹⁰ At times of stress, patients will more readily seek proximity with a caregiver. Yet the behaviours that sometimes accompany this proximity-seeking, such as self-harm or suicidal acts, can seem irrational and frustrating to the caregiver, who might then lose their own ability to mentalise, for example, through the development of a judgemental attitude towards the patient or a belief that they are undeserving of care.

Mentalising in the context of generic mental health services

A mentalising stance involves having an inquisitive, empathic, open-minded and ‘not-knowing’ approach to mental states, and an ability to consider alternative perspectives. Mentalisation-based treatment (MBT) provides a framework to help healthcare staff understand their attitudes and feelings, and teaches ways to restore mentalising in both the professional and the patient. Bateman suggests that effective MBT skills can be gained through limited additional training and with moderate levels of supervision.¹¹

Teaching mentalising skills

There has been a recent governmental drive to improve systems for staff support and supervision in managing these patients, and to develop courses teaching staff to better address patients' needs.¹⁻⁷ In that spirit, a 2015 pilot study found that a brief (4 h) teaching intervention in MBT skills improved psychiatry core trainees' understanding of mentalising and their attitudes to personality disorder.¹³ To test whether this finding is replicated in a larger sample and whether it generalises to other professional groups, we conducted a before-and-after comparison of mental healthcare staff who underwent a 2-day course in MBT skills (MBT-S). To our knowledge, this is the first published quantitative evaluation of MBT-S. It addresses an important clinical question: alongside MBT constituting a specialist treatment, does a mentalising skills intervention provide an accessible theoretical framework for staff working in generic mental health settings?

Method

Participants

Participants in the MBT-S courses included doctors, nurses, psychologists and allied healthcare professionals working in various mental health services within NHS Lothian. Once a clinical team was identified by the course leaders as potentially able to benefit from the course, all staff members working in that service were invited to take part in the training. In some cases, individuals and teams self-selected to attend the training.

All participants attending the first day of training were eligible to be included in the study. Participants who only attended the second day were excluded.

Intervention

MBT-S is aimed at generic mental health practitioners and is taught in an accessible format to help staff in difficult day-to-day interactions, with the aim of fostering more effective therapeutic relationships with their patients. The teaching is based on a MBT skills package developed by the Anna Freud Centre¹⁴ in conjunction with MBT Scotland. It was adapted by two of the authors (J.P. and C.M.), and these adaptations were authorised by the Anna Freud Centre.

The MBT-S training was delivered on two single days separated by a few weeks to allow participants to practise their skills and complete allotted tasks. The format was a combination of didactic teaching, role-play and DVD clips. It included a theoretical framework that explains attachment theory and how personality disorder and mentalising difficulties develop, as well as specific MBT techniques designed to strengthen both the patient's and the professional's ability to mentalise in stressful situations. The training was delivered in the Psychotherapy department at the Royal Edinburgh Hospital by Anna Freud Centre-accredited trainers, including two of the authors (J.P. and C.M.).

Aims

This study aimed to answer the following questions. (a) Is a 2-day course in MBT-S effective in improving general mental health practitioners' understanding of mentalising? (b) What effect, if any, does it have on their attitudes to personality disorder? (c) How do different professional groups compare in terms of outcomes?

Outcomes

Anonymised self-report questionnaires were given to participants by the study authors immediately prior to commencing the programme and again directly after the programme ended. Data on the participants' professional groups were collected from five of the six training courses.

The main outcome measure was the Knowledge and Application of MBT Questionnaire (KAMQ; see Appendix 1) (A. Williams, C Cahill, J Patrick, personal communication, 2015). This 20-item questionnaire asks about knowledge of MBT (e.g. 'A key component of mentalising is thinking about people's attachment relationships') and how to apply MBT techniques, using a five-point Likert scale from 'strongly disagree' to 'strongly agree'. A higher score indicated better knowledge of mentalising concepts and MBT techniques, with a maximum total score of 100 points. Work is currently in progress describing the development of this questionnaire and evaluating its psychometric properties.¹⁵

The secondary measure was the Attitudes to Personality Disorder Questionnaire (APDQ; see Appendix 2), which measures clinicians' attitudes towards people with personality disorder. This questionnaire has 37 items that ask about the intensity of a person's feelings (e.g. 'I feel understanding towards people with personality disorder') using a six-point Likert scale, from 'never' to 'always'. A higher score indicated a more positive attitude, with a maximum score of 222 points. The APDQ has good internal consistency (Cronbach's alpha = 0.94) and test-retest reliability ($r = 0.71$).¹⁶

Statistical methods

Data were entered into MS Excel by three authors (H.J.W., G.C. and C.M.M.). They were analysed by author T.C.R. using R for Windows 3.2.3. Linear regression was used to compute within-person change in score from baseline to end-of-programme for the KAMQ and APDQ separately. We used unadjusted models to explore the changes in scores over time and then constructed models adjusting for job category (whether different groups had differences in scores at baseline, i.e. had different intercepts) and an interaction term between job category and time (whether different professional groups were affected more than others over time, i.e. had different slopes). Effect sizes (Cohen's D) were calculated in order to examine the magnitude of difference between pre- and post-scores.

Missing data

An intention-to-treat analysis was carried out. Missing items at baseline were assumed to be missing at random, and the mean score among all responders for that item was entered. For missing end-of-programme items, baseline values were carried forward.

Results

Six training courses, with a median 16 participants each (range 12–19), were carried out between June 2014 and March 2016. Across all six courses, a total of 92 participants attended the first day of training and so were eligible for the study. All 92 were enrolled and completed the baseline questionnaires. Two participants attended the second day of training only and were excluded from the study.

Across all baseline questionnaires, 77 individual items (1.46% of the total baseline data) were left blank and imputed (mean) values inserted.

Across all completed end-of-programme questionnaires, 139 individual items (2.65% of the total end-of-programme data) were left blank. Eight end-of-programme questionnaires were not completed as the participant did not attend; this accounted for 8.69% of the total end-of-programme data. All end-of-programme missing data were treated in the same way, with their baseline scores being carried forward.

A *post hoc* power calculation suggested that our sample size of 92 at conventional levels of statistical significance ($\alpha = 0.05$) would have 80% power to detect a small effect size (0.2).

Data on professional groups

Data on professional groups were not collected for the first of the courses (June 2014) but were collected for all subsequent courses. The 74 participants whose job title was known were categorised according to professional background. The biggest group was nursing, representing 46 (62%) participants. The second largest group was psychology with 12 participants (16%), and the third largest was medical, with eight participants (11%). Other professional backgrounds included occupational therapist ($N = 3$), art therapist ($N = 3$), social worker ($N = 1$) and recreation assistant ($N = 1$).

For the regression analyses using professional groupings, we compared participants with medical and psychology backgrounds with those with a nursing background, to allow large enough samples for the analyses. The justification for combining these two groups was that there are likely to be parallels in the experience and training of participants with a medical and psychological background in relation to personality disorders. The comparison with participants from a nursing background was thought to be of interest. We excluded the smaller groups.

Outcomes

Knowledge and Application of MBT Questionnaire

The mean KAMQ score at baseline was 74.7 points (s.d. = 7.6). There was a mean within-person increase of 11.6 points (95% CI 10.0–13.3) from baseline to end-of-programme. The effect size was 1.2, which was considered a large effect.

Attitudes to Personality Disorder Questionnaire

The mean APDQ score at baseline was 148.7 points (s.d. = 12.3). There was a mean within-person increase in APDQ scores from baseline to end-of-programme of 4.0 points (95% CI 1.8–6.2). The effect size was 0.2, which was considered a small effect. In 23 cases, there was no change in APDQ scores from baseline to end-of-programme; in 42 cases, the scores improved, and in 27 cases, APDQ scores worsened (*Fig. 1*). *Fig. 1* Jacobson plot of within-person change in KAMQ and APDQ scores. Markings above the oblique line indicate an increase in scores from baseline to end of programme.

Participants with a medical and psychological professional background had better baseline KAMQ scores when compared jointly with those with a nursing background, but their APDQ scores increased to a lesser degree after the teaching compared with nurses (see *Table 1*). *Table 1* Linear regression model including fixed effects for time and professional group (doctors and psychologists *v.* nurses) and an interaction term between job category and time
 KAMQAPDQD-difference in baseline scores: doctors and psychologists *v.* nurses
 Difference in score increase from baseline to end-of-programme: doctors and psychologists *v.* nurses
 Difference in baseline scores: doctors and psychologists *v.* nurses
 Difference in score increase from baseline to end-of-programme: doctors and psychologists *v.* nurses
 12.1 (CI 6.0 to 18.4)
 4.1 (CI 8.1 to 0.3)
 4.8 (CI 5.1 to 14.8)
 4.8 (CI 9.5 to 0.1)

Discussion

Interpretation of results

The main finding of our study is that MBT-S training improved mental healthcare professionals' KAMQ scores to a statistically significant degree and with a large effect size, suggesting that it is an effective way of teaching MBT concepts to staff working in generic mental health settings. Furthermore, this finding is in keeping with recent qualitative research that demonstrated that nursing staff who participated in an MBT-S course felt that it provided a 'straightforward but empowering skill set' in working with patients with personality disorder.¹⁷

Attitudes to personality disorder improved overall to a lesser, albeit still statistically significant, degree. By definition, attitudes are somewhat engrained in someone's personality and professional way of working, so they may, of course,

be hard to shift. It is interesting that in 27 cases, the APDQ scores worsened. Although we cannot rule out the possibility that the intervention might have resulted in a genuine worsening of a minority of participants' attitudes towards personality disorder, we think it is plausible that this reflects participants' increased awareness and acceptance (i.e. mentalisation) of negative feelings towards patients (c.f. limitations of the study, below). Alternatively, this may represent an artefact of test–retest reliability.¹⁶

We note the finding that doctors' and psychologists' APDQ scores improved less than those of nurses. Baseline APDQ scores were higher for doctors and psychologists, so it may be that we are seeing a 'ceiling effect' – there is less room to improve from a higher baseline. In the context of previous research,¹³ we think the salient point is that this intervention appeared to be effective for professional groups other than doctors in training.

Comparison to other literature

The only other study to date to evaluate staff knowledge and application of MBT following MBT skills training was a pilot study that also demonstrated an improvement in KAMQ scores with large effect.¹³

A number of studies have assessed the effect of training on staff attitudes to personality disorder. In a randomised controlled study, Clarke *et al*¹⁸ compared a psychoeducation programme with an intervention designed to help mental healthcare staff deal with the difficult feelings triggered by working with personality disorder patients (acceptance and commitment training). Participants had responded to an advertisement and volunteered for the free 2-day training. Both forms of training were found to significantly improve APDQ scores immediately post-training compared with baseline (based on their data, we have calculated Cohen's D to be 0.28 and 0.22 respectively), with no statistical difference between the two. The improvements were sustained at 6 months follow-up, although there was a high rate of drop-out resulting in a loss of statistical power.

A study assessing the effects of a 2-h personality disorder awareness workshop on prison staff ($N = 26$) found no significant difference in APDQ scores before and 2 months after the training.¹⁹

In a systematic review of interventions aimed at improving mental health nurses' skills, attitude and knowledge related to patients with BPD, Dickens *et al*²⁰ reviewed eight studies whose interventions ranged from a 90-min lecture to the complete 18-month intensive dialectical behaviour therapy training. None of these studies used the APDQ as an outcome measure. They found that changes in affective outcomes (including attitudes to personality disorder) were usually associated with small effect sizes, although changes in cognitive outcomes (including knowledge) were associated with larger effect sizes.

The outcomes of these studies indicate that these different forms of intervention have generally resulted in small improvements in participants' attitudes and emotional responses to personality disorder, but greater improvements in their knowledge relating to personality disorder. The ability to compare these outcomes with the present paper is limited owing to the use of different methodologies and the absence of studies that directly compare MBT-S with other interventions. Within this limitation, we note that the size of outcomes from the comparative literature mirror the results of the present intervention, MBT-S. This may confer preliminary support for the comparable efficacy of MBT-S.

Strengths and limitations of the study

To our knowledge, this is the largest quantitative study to evaluate the effects of MBT-S on clinicians. Strengths of the study include the low study drop-out rate (8.7%) and the intention-to-treat analysis.

One possible limitation is linked to the choice of questionnaire. The APDQ has no formal validity data, which limits the interpretation of our results. In addition, the APDQ relies on participants' reporting of feelings: the reporting of positive feelings is linked to a 'better' attitude, while the reporting of negative feelings is linked to a 'worse' attitude. Yet for clinicians, being aware of negative feelings towards patients is likely to be helpful, as it gives them a chance to consider and reflect on their responses, and makes them less likely to act on feelings in a counter-therapeutic way.²¹ A lower APDQ may not, therefore, indicate a less helpful clinician stance, and *vice versa*. Work is needed to establish benchmarks for the KAMQ – i.e. what constitutes a 'good' level of knowledge about mentalising.

That the training was delivered by two of the study's authors introduces the risk of bias. Data entry and analysis were performed by authors who had no role in the delivery or running of the courses, limiting this risk. Some individual participants and mental health teams self-selected to attend the training, which introduces a potential confounding factor. The internal validity would be improved by having a control group. This would pose some practical problems, not least the challenge of providing a convincing 2-day 'placebo' training. An alternative would be to have a practice-as-usual control group, who only complete the outcome measures.

There has so far been no longitudinal follow-up of the study's participants. Therefore, we cannot comment on whether the effects of training persist.

Research and clinical practice implications

Our study suggests that MBT skills teaching is a good way of improving staff knowledge about mentalising skills and is accessible to different professional groups. That attitudes to personality disorder improved overall is also encouraging in relation to the possibility of deeper learning in staff.

Our findings add weight to the need for a larger study of MBT-S that uses both staff and patient outcomes and incorporates a control group. We note the importance of follow-up beyond the intervention to investigate whether effects persist; accordingly, follow-up is planned. Future research should aim to establish the potential influence of teaching mentalising skills on 'real world' clinical work, such as better therapeutic relationships or reductions in self-harming behaviour. A recent case study assessing the utility of MBT-informed practice and reflection in the in-patient forensic mental health setting suggested that it may be helpful.²²

Drawing on guidelines on effective team approaches to working with people with personality disorder,²³ it would be prudent, in devising an intervention to train a clinical team in MBT skills, to ensure that good principles and structures are in place first. These include making time for formulation,²⁴ establishing a structured approach to clinical care (consistency, clarity of staff roles),²⁵ and ensuring that good systems of staff support, supervision and reflective practice are in place.²⁶

In summary, MBT-S is a short intervention that is effective in improving clinicians' knowledge of personality disorder and mentalisation. Recent UK health policies have urged mainstream mental health services to be more responsive to the needs of individuals with personality disorder.¹⁻⁷ Our findings suggest that MBT-S might be an effective way to respond to this need, and one that is accessible to a range of professional groups.

We thank Anthony Bateman, who kindly commented on the manuscript.

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Mentalising Skills Training Questionnaire

Thank you for your time. Please answer all of the questions.

Have you previously attended a course in Mentalising? YES/NO/Strongly Disagree/Disagree/Neutral/Agree/Strongly Agree

1. I believe mentalising is simple to put into practice
2. I think mentalising skills have a theoretical basis
3. I think mentalising skills help promote therapeutic communication with people who have problems like Borderline and Anti-Social Personality Disorder
4. I think providing mentalising skills requires a specialist psychotherapist
5. I believe treating people using psychological techniques is a poor use of resources
6. I think childhood experiences can have a profound impact on adult relationships
7. Mentalisation therapies do not allow patients to take medication
8. A person saying that a visit in the middle of the night from her partner was the only way she was reassured he loved her is an example of a teleological stance
9. Breaks in therapy (or from relationships with people) are not considered important by MBT
10. A key component of mentalising is thinking about people's attachment relationships
11. A therapist using mentalising skills will be expressionless
12. Using mentalising, you can ask questions to promote exploration
13. Mentalising avoids exploring the current therapeutic relationship with the person you are working with
14. In mentalising, professionals do not consider their own feelings
15. The professionals might use a 'stop and stand' technique if they get muddled in mentalising
16. As mentalising is straightforward, there is no need for supervision
17. Strong disagreements between professionals about a person's management may be an indication of non-mentalising
18. A partner being certain about what people are thinking, without checking, is an example of psychic equivalence
19. I feel confident in applying MBT skills into working practice
20. I understand when to apply/use MBT skills

Attitudes to Personality Disorder Questionnaire

For the purposes of this questionnaire we would like you to think about your feelings towards patients with personality disorder (PD) overall. We realise that you may have different mixtures of feelings about different personality disordered patients you have cared for in the past. For this questionnaire we would like to you try and average those out and tell us what your responses are in general towards patients with personality disorder as a whole.

For each response listed below please indicate the frequency of your feelings towards people with a personality disorder. Please circle your choice quickly, rather than spending a long time considering it. We want to know your honest, gut feelings. Never/Seldom/Occasionally/Often/Very often/Always

1 I like PD people
2 I feel frustrated with PD people
3 I feel drained by PD people
4 I respect PD people
5 I feel fondness and affection for PD people
6 I feel vulnerable in PD people company
7 I have a feeling of closeness with PD people
8 I feel manipulated or used by PD people
9 I feel uncomfortable or uneasy with PD people
10 I feel I am wasting my time with PD people
11 I am excited to work with PD people
12 I feel pessimistic about PD people
13 I feel resigned about PD people
14 I admire PD people
15 I feel helpless in relation to PD people
16 I feel frightened of PD people
17 I feel angry towards PD people
18 I feel provoked by PD people behaviour
19 I enjoy spending time with PD people
20 Interacting with PD people makes me shudder
21 PD people make me feel irritated
22 I feel warm and caring towards PD people
23 I feel protective towards PD people
24 I feel oppressed or dominated by PD people
25 I feel that PD people are alien, other, strange
26 I feel understanding towards PD people
27 I feel powerless in the presence of PD people
28 I feel happy and content in PD people company
29 I feel cautious and careful in the presence of PD people
30 I feel outmanoeuvred by PD people
31 Caring for PD people makes me feel satisfied and fulfilled
32 I feel exploited by PD people
33 I feel patient when caring for PD people
34 I feel able to help PD people
35 I feel interested in PD people
36 I feel unable to gain control of the situation with PD people
37 I feel intolerant. I have difficulty tolerating PD people behaviour

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1.5.34 What's the point of the *BJPsych Bulletin*?

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date

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Abstract

The incoming editor Dr Norman Poole sets out a vision for his tenure at the helm of the *BJPsych Bulletin*. There will be redoubled focus on training and educational articles and an engagement with the cultural and social ramifications of this most vital of specialisms.

Declaration of interest

Dr Poole is editor of the *BJPsych Bulletin*.

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I am honoured and not a little trepidatious taking over the reins (or reign) of the *BJPsych Bulletin* from departing editor Jonathan Pimm. Earlier in his career, Jonathan was a *bona fide* newspaperman and clearly relishes the business, since he is now moving on to *The Lancet* to take up the role of associate editor. During his editorship of this publication, Jonathan introduced open access in pursuit of equality, FirstView online for efficiency, and fewer briefer editions for expediency. He is a hard act to follow, so I won't even try. I would, however, like to thank him for his work on the *Bulletin* over his 5-year tenure and to wish him all the best in his future endeavours.

While preparing for the interview for this post, I discovered that the *Bulletin* aspires to be 'the foremost source of information about all aspects of mental healthcare'. A high bar indeed. In practice, its articles predominantly cover education, service provision, op-eds and profiles of renowned psychiatrists, both living and recently deceased, plus a smattering of book reviews and letters. While the *Bulletin* is seen as a place to publish original studies about service delivery, we are not here to publish research in the sciences basic to psychiatry. A glance at the most-read articles on the website suggests our readers value this focus, so I'm mindful that this should not be lost sight of in any future revisions. Still, it's the new guy's prerogative to tinker, and so I feel compelled to shape the *Bulletin* in my own image; but what sort of image is that?

While I ought to have been reading cardiology textbooks, I was in fact nose-deep in Edward O. Wilson's *Sociobiology*,¹ a fact that was to be reflected equally in my final exam scores and the ensuing purchase of Stephen Rose's edited volume *From Brains to Consciousness*?² I diverted myself from the former circumstance with Tim Crow's chapter claiming an intimate link between language development and schizophrenia, alongside Richard Bentall's, which questioned the validity of diagnosis. I found the stark divergence of explanatory theories and dispute about the very grounds of the debate invigorating after 5 years of didactic learning, so decided there and then to become a psychiatrist. Much as I admire my cardiology colleagues – and if I ever have heart trouble, I'd like to see one who doesn't doubt its existence – nothing else in medical school compared to the dizzying exciting uncertainty of the science(s) of human behaviour.

Of course, psychiatry also interacts with culture and values, more so than other medical specialities. I still firmly believe we are incredibly fortunate and privileged to work in such an intellectually stimulating and diverse, even at times fragmented, field. Yet, it appears to me that there is nowhere obvious other than the *Bulletin* for essays and articles that deal with psychiatry's myriad relationships. For instance, proposed changes to the Mental Health Act, the representation of psychiatry in the arts and media, philosophical and cultural critiques of psychiatric concepts, and so forth. The intention is not to criticise psychiatry but for the *Bulletin* to be a place for genuine reflection, which

occurs within the profession and specialist journals but is not always easily accessible or visible to trainees. I'd like to strengthen the *Bulletin's* coverage of psychiatry in all its breadth and glory.

Although the *Bulletin* should not concern itself with basic neuroscience, a core function is training and education. As Professor Wendy Burn has identified (<http://www.rcpsych.ac.uk/discoverpsychiatry/pastpresidentsblog/neuroscienceincurriculum.aspx>), learning about the neuroscience that underpins psychiatry is an area trainees find challenging. The Gatsby Foundation is currently partnering with the Royal College of Psychiatrists to review the training curriculum for neuroscience, and I hope to support this initiative by using the *Bulletin* as a forum for discussion and dissemination. I encourage authors to submit clinically relevant and readable reviews of neuroscience topics, such as Nour & Nour's recent paper on visual hallucinations.³

Finally, I believe that psychiatry trainees (and non-training grades) would benefit from a specific section similar to the *BMJ's* *Endgames* format exploring complex psychiatric presentations and management issues. I envisage that this section, to be co-written by consultants and trainees, will support the development of clinical reasoning,⁴ which is often hard to fathom for trainees in a busy clinic. In particular, the series should focus on differential diagnosis (identifying or excluding 'organic' aetiology; differentiating between superficially similar conditions such as adult attention-deficit hyperactivity disorder and borderline personality disorder). I encourage prospective authors to contact the *Bulletin* with proposals for more detailed advice on guidelines. Do please note that standards must accord with the International Committee of Medical Editors' Uniform Requirements for Manuscripts (<http://www.icmje.org/>) and co-production with patients is encouraged.

So, more op-ed pieces on the state of psychiatry and a focus on trainees' needs around neuroscience and clinical complexity. Is it achievable? Like all journals, whether the *Bulletin* sinks or swims depends on the articles submitted for consideration. I take this opportunity as your new editor to encourage readers to consider what you'd like the *Bulletin* to be and to get writing. It is, in fact, not my image that will shape the *Bulletin*, but yours.

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1.5.35 General practitioner referral of older patients to Improving Access to Psychological Therapies (IAPT): an exploratory qualitative study

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Abstract

Aims and method

To understand general practitioner (GP) reticence to refer older patients to a local Improving Access to Psychological Therapies (IAPT) service providing mostly cognitive-behavioural therapy (CBT)-based interventions. Semi-structured, hour-long interviews were conducted with eight GPs and then analysed by modified grounded theory and thematic analysis.

Results

GP views regarding the treatability of older adults with CBT influenced their willingness to refer to a CBT-based IAPT service. Perceptions of local IAPT assessment processes being distressing and onerous to older patients also motivated referral inaction. GPs expressed a preference to treat depressed older patients themselves (with medication and psychological approaches such as watchful waiting).

Clinical implications

Any strategy to increase referral rates of older adults to CBT-based IAPT services should address local GP concerns regarding assessment processes and the effectiveness of offered treatments.

Declaration of interest

None.

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The National Health Service (NHS) England ‘Improved Access to Psychological Therapies’ (IAPT) program was launched in 2009 to improve access to evidence-based talking therapies for people with common psychiatric conditions such as depression. It originally targeted working-age adults but was opened to older adults in 2010, with most interventions being based on cognitive-behavioural therapy (CBT).¹ Although IAPT is now a service for all ages, only 7% of people in treatment are over 65, despite constituting 20% of the population. This unequal distribution of

treatment worsens with age. In particular, there is a miniscule number of people over 90 years old enrolled in IAPT nationally, despite this being the fastest growing demographic group (see <https://www.england.nhs.uk/mental-health/adults/iapt/older-people/>).² Part of the problem is that people over the age of 65 are rarely referred for psychotherapies.³ It is important to understand referral obstacles to IAPT services, as these are now the main providers of talking therapies for adults of all ages.

Aim

The aim of this study was to understand why GPs did not routinely refer their older patients to a local IAPT provider. This was done by examining the referral decision from the perspective of referrers themselves.

Method

This was an exploratory, qualitative study. An interpretive approach in the grounded theory tradition was chosen for this research to understand the nuances of the referrer experience and to meanings attached to referral decisions.⁴ Semi-structured, hour-long interviews were conducted with eight GPs practicing in a home county of London. The majority of therapy offered by the local IAPT provider was CBT in nature. The interviewer (N.C.) was a local old-age psychiatrist, previously CBT trained, who was also a member of the Royal College of Psychiatrists Older Adult Faculty work stream aiming to improve access to psychological therapies for older people. An indicative topic guide was provided to all prospective participants in advance of scheduling an interview. As interviews progressed, there was less reliance on interviewer prompts as themes that arose inductively from the data were explored.

Several approaches were employed to mitigate the effects of N.C.'s existing beliefs and assumptions on the qualitative study, including supervision and reflexivity. The latter is an explicit self-awareness of how the interaction between researcher and participant can influence data collection, analysis and subsequent theory development.⁵⁻⁷ The evolution of deductive ideas from previous professional experience and the evolution of inductive theory, as it emerged from the data, were both made explicit. Memo writing was conducted and recorded to provide clear transparency in the analysis.⁶ Care was also taken to delineate worker and researcher roles, and interviews were carried out either out of hours or in non-clinical settings.

Participants

Purposive sampling of GPs from a variety of backgrounds was carried out to scrutinise deviant examples and increase the scope of subsequent findings.⁸ All eight GPs, who were initially contacted by email, agreed to participate. Half of the GPs were male and half were female. Age and seniority varied between a trainee and commissioner level.

Ethical considerations

This study was conducted as part of a supervised Master's thesis in Gerontology and was approved by the King's College London Research Ethics Committee prior to the recruitment and interviewing of participants.

Analysis

Verbatim transcriptions of audio-recorded interviews were made and uploaded to a qualitative software platform (MaxQDA) to assist coding and analysis. Interviews were coded line and by line and analysed using thematic analysis to explore referrer beliefs and their associated meanings, as well as other factors related to referral decisions.⁶ Emergent codes and thematic categories were constantly re-checked regarding their utility in understanding, developing and interpreting emerging themes in the data.⁹ Thematic saturation was observed by the penultimate interview. Several emergent thematic categories, which best captured reluctance to refer to IAPT, were chosen for further examination: (1)deeming older patients ineligible for CBT;(2)concern regarding appropriateness of IAPT assessment and treatment;(3)preferential usage of alternatives to IAPT referral.

These were chosen as the main focus of analysis because these ideas arose inductively from the data and were stable concepts across all transcripts.

Results

Theme 1: deeming older people ineligible for CBT

Participants conceptualised anxiety and depression in later life differently to that which occurs in younger adults. This in turn affected practitioner assessments of eligibility for referral, as older adult depression was felt less amenable to CBT for a variety of reasons. These reasons included the beliefs that older adult depression was an inevitable consequence of ageing, loneliness and age-expected losses: “‘Sometimes they have lost children. Work has disappeared. They can’t get out and do the things they want to do. Recognising the fact that they are old. And I think people grieve over this almost.’ (GP 4)‘You’re isolated; you’re not able to get out. You will get more anxious as you get older.’ (GP 1)”

One GP, who had a senior commissioning role, framed his decision not to refer older adults to IAPT using ‘maximising’ health-rationing principles, namely distributing health resources to achieve maximum benefit in a population:¹⁰ “‘I think it’s just an unconscious bias, not because I think it becomes less useful as you get older but it’s more useful if you are younger. Because I believe that bit about psychological maturity and I think if I took 100 65 year olds and 100 18 year olds, with say anxiety, I believe you would more likely to help more of the 18 year olds rather than the 65s. Because the 65s have probably reached psychological maturity and the 18 year olds haven’t. So whilst you might be able to help some of the 65 year olds, you’ve missed the opportunity of consolidating over a lifetime those patterns of behaviour.’ (GP 8)”

GP participants appeared to conflate normal ageing with the development of frailty, sensory or cognitive impairment and the loss of mental agility, which were viewed as obstacles to successful treatment with CBT. This could also explain why non-referral of older patients for CBT was magnified in the over-85 age group: “‘Maybe the older eighty plus person with chronic depression, a bit of dementia, that sort of thing ... it’s just their life. Is it part of their health, that sort of age? Are we ever likely to make a significant improvement with talking therapy?’ (GP 6)”

Theme 2: concern regarding appropriateness of IAPT assessment and treatment

Some GP participants in this study stated that they did not refer to IAPT due to their concerns that IAPT assessment processes were not suitable for older patients. In particular, telephone assessment and the use of repeated questionnaires were felt to be insensitive and inflexible when assessing older patients, particularly those with comorbid sensory or cognitive deficits. One participant described the abandonment of referral as a ‘rescue’ from the traumatising process of IAPT assessments: “‘I can think of one particular person with early memory loss, you may remember, who was absolutely traumatised by the process ... and I said this isn’t for you, let’s stop all of these appointments and phone calls and all of that ... and they’ve done well, having rescued them from the process they are doing absolutely fine.’ (GP 2)”

Other participant concerns regarding IAPT structural processes included inflexible CBT delivery, the poor availability of face-to-face counselling and the skills of IAPT workers in dealing with cognitive impairment or medical comorbidity. The exclusion of nursing home patients was also a particular concern: “‘If I suggested to the homes that these patients

be sent to IAPT, they are going to be asking how will we get them there? How will the cognitively, hearing and vision impaired cope? I think that's particularly true with psychologically multi-morbid patients for example: a patient with dementia and anxiety. I suspect you wouldn't refer to IAPT because they wouldn't be able to handle it.' (GP 8)"

A common concern among all GP participants was that IAPT interventions were too short term and superficial to change entrenched maladaptive behaviours in older patients: "I think again, most people probably feel as I do in that if you think psychological therapy is going to be helpful – a lot of these people have such strongly held, long term views – that a short course of CBT is not going to do it.' (GP 4)"

All GPs in this sample described feeling isolated from IAPT practitioners. This meant that any concerns regarding the effects of IAPT processes on older patients were never raised with IAPT providers. Additionally, GPs described not receiving any guidance regarding which older patients may benefit from CBT: "Obviously that big thing sitting there ... where the anxiety that comes in older age, I don't know if that's whom the IAPT service wants to see.' (GP 1)"

Theme 3: preferential use of alternatives to IAPT referral

When responding to the needs of depressed older adults, GP participants described a number of approaches that are preferentially used instead of referring to IAPT for CBT. These approaches included addressing physical issues and social needs, prescribing medication and GP-led psychological approaches. Prioritising physical issues was viewed as a pragmatic response to the competing demands present in a time-limited consultation with an older patient. It was hoped that by improving physical issues, mood would lift as a result: "You also get sidetracked by their UTIs [urinary tract infections] and their arthritis is really bad. I tend to focus on the physical problems as with a lot of the frail people, your assumption is that because they can't get out, they're not mobile, they don't feel well that they're feeling depressed. You therefore focus on those issues – you try to improve those things to improve mood.' (GP 5)"

Addressing social needs, like treating physical issues, was a highly regarded strategy when treating an older adult with depression. Senior GP participants, in particular, had strong convictions in this approach. This was linked to beliefs that older adult depression was often fuelled by social isolation and loneliness, and was therefore more responsive to social interventions rather than psychotherapies: "In terms of social interventions that may make a difference, if you were to ask me what differences I've made to people's lives, I can remember a very depressed Finnish lady and I knew close by there was another Finnish lady and I put them in touch, this probably made more difference to her and she didn't come and see me every week after that!' (GP 7)"

Prescribing antidepressants, in contrast to IAPT referral for CBT, was described by some GPs as a reflexive act. Perceived benefits of antidepressants over referral to IAPT included relief of associated insomnia and pain, and taking a tablet being 'less work' for patients. Participants also felt that prescribing an antidepressant was more acceptable to older patients and that it satisfied an expectation for a rapid medical response. Some participants also believed that medication was more appropriate than CBT referral when depression had a clear organic cause, had significant somatic symptoms or was associated with medical comorbidity. Concerns regarding side effects were notably absent in all participant accounts. This may relate to the practice of using lower dose antidepressants, described by one GP as 'gentle pick me ups': "Again it comes down to expectation, if they leave with a prescription in their hand, you've done something. Whereas, if I say to them I'll refer you to a counselling service, it'll take 6–8 weeks before you see somebody, then might have to wait for treatment and in 4 months time, you might be engaged with the service and you might start to feel better ... you're not giving them a quick fix.' (GP 5)"

In contrast to referral to IAPT, GPs reported that prescribing made them feel less impotent and helpless: "With a depressed elderly, you worry that they are going to wait so long [for CBT]. I must do something in the interim. Doctors hate that hopeless feeling. You know what you need to do, but you can't access that.' (GP 5)"

GPs described using their own psychological skills with older patients with depression rather than referring them to CBT. These approaches included supportive counselling, exploratory brief therapy and problem solving. Like prescribing medication, these strategies were deemed within the GP's control: "You learn the older you get that some people just want to acknowledge an issue and they have it within themselves, and having acknowledged and having told someone like their GP about it, that they're able then to go away ... and ... change their thinking about it.' (GP 2)"

Watchful waiting was frequently used as a tried-and-trusted approach to treating elderly people with depression in primary care. This intervention, centred on regular review but without active pharmacotherapy or psychotherapy, was felt by participants to be a tangible and containing approach compared with referral to IAPT for CBT: “I think it’s the personal support and contact, the commitment. Because quite often people who I think need a lot of support, I will book the next appointment whilst they are in the room and give them that piece of paper. So again, it’s that tangible thing. Even if I don’t think they need medication, I will say let’s find an appointment. And they will go out and come back.’ (GP 4)”

Some participants felt confident in delivering simpler CBT interventions themselves, such as behavioural activation, activity scheduling and challenging negative thinking. The willingness and desire to improve these skills, even within the constraints of brief consultations, was most clearly expressed by a GP registrar: “I think the more you learn about CBT, the more you can do very basic interventions yourself with some patients. We’ve been encouraged to do that and deliver very basic CBT ourselves. In the 10 minute consultation!’ (GP 5)”

Study limitations

The findings presented here must be interpreted in light of the study’s limitations. The IAPT service referred to in this study was reported by local GPs to only offer only CBT-based therapies. Participants had strong views regarding the use of CBT in older patients and this clearly influenced willingness to refer to their local service. The findings of this study cannot be generalised to the experiences of other GPs with other IAPT providers. Additionally, the sample comprised GP participants in only one semi-rural locality with little ethnic diversity. This meant that the experiences of more urban-based GPs working with multicultural populations were also absent. The scope of the project precluded a larger sample size, but data saturation was achieved by the seventh interview. Notwithstanding these caveats, this study does provide some insight into the reasons for underutilisation of IAPT services by older adults.

Discussion

The GP respondents in this study gave a wide range of clear reasons for their reluctance to refer their older patients to a local IAPT provider offering mostly CBT. These include the belief that older adult depression was an inevitable consequence of ageing and therefore more difficult to treat with CBT. This is consistent with previous research showing how depression in older adults can be viewed as a ‘justifiable’ consequence of ageing due to age-expected losses and social changes, and therefore less in need of treatment.¹¹⁻¹³ This view may in turn relate to historical comments by Freud, e.g. ‘above the age of 50 the elasticity of mental processes on which treatment depends is, as a rule lacking – old people are no longer educable’, still having an enduring effect on medical practitioners.³

In general, GP participants in this study viewed IAPT assessment processes as inflexible, insensitive and potentially traumatising for older adults. This is compatible with existing concerns that CBT can be too protocol driven, measurement focused and inflexible for older patients.¹⁴⁻¹⁵ There appeared to be some ‘frail-ist’ views where the older, more frail, depressed individuals in particular were deemed the least likely to benefit from or access CBT and therefore were ineligible for referral. The treatment preferences of GPs in this study are consistent with existing research showing that some GPs prefer simpler and more exploratory counselling rather than a manualised approach like CBT,¹⁶ and that they believe that pharmacotherapy offers quicker relief to people with depression compared with a talking therapy.¹⁷

The results of this study point to strategies that could achieve higher referral rates for older patients to IAPT services. Increased co-location of IAPT therapists into primary care would be a good starting point in promoting CBT as an effective treatment for older people, who often have higher rates of adherence and completion of therapy than younger patients.¹⁵⁻¹⁸ Some IAPT providers could aim to offer a greater range of other modalities of treatment to older patients and publicise these increased options to referring GPs. IAPT providers could also revise assessment processes, such as the use of simpler rating scales of improvement, to address concerns regarding onerous outcome measurement. The use of tele-health could also be trialled to improve access for those with mobility impairments and those living in residential homes.¹⁹ IAPT supervisors could also take on an active role in training carers in residential homes to deliver basic CBT techniques to depressed, older and frail adults who are currently disenfranchised by poor access to conventional face-to-face treatment.²⁰ It is hoped that this paper helps raise the profile of unequal access to psychological therapies

for older adults and that some of the suggested strategies derived from this study's findings can be trialled by some IAPT services to improve the situation.

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1.5.36 Community treatment orders in England: review of usage from national data

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date

2018-6

Abstract**Aims and method**

Community treatment orders (CTOs) have been in used in England and Wales since November 2008; however, their effectiveness has been debated widely, as has the question of which methodology is appropriate to investigate them. This paper uses national data to explore the use of CTOs in England.

Results

About 5500 patients are subject to CTOs at any one time. Each year, ~4500 patients are made subject to a CTO each year and ~2500 are fully discharged, usually by the responsible clinician; fewer than half of CTO patients are recalled, and two-thirds of recalls end in revocation. The low rate of CTO discharges by mental health tribunals (below 5%) suggests that they are not used inappropriately.

Clinical implications

The introduction of CTOs in England has coincided with a reduction in psychiatric service provision due to the economic downturn. Pressures on services might be even more severe if patients currently subject to CTOs instead needed to be detained as in-patients.

Declaration of interest

None.

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- *Community treatment orders in England: review of usage from national data*
 - *Background*
 - *Effectiveness of CTOs*
 - *Method*
 - *Results*
 - *Discussion*

Background

Community treatment orders (CTOs) were introduced into legislation for England and Wales by the Mental Health Act (MHA) 2007. They can be applied to a patient who is already subject to a section of the MHA which makes them liable to detention for treatment. The patient is discharged from the treatment section on to a CTO, which broadly means that they need to comply with a set of specified conditions that may include accepting prescribed treatment. The responsible clinician has the power to recall a patient to hospital. If the CTO is revoked, the treatment section is reinstated. CTOs are initially valid for 6 months but can be extended indefinitely. They are subject to scrutiny by independent first-tier mental tribunals (Mental Health), or MHTs, which can discharge the patient from the CTO if the grounds for its use, as laid out in the MHA, are deemed not to be met. Following the introduction of CTOs, uptake was initially higher than some had predicted, and over the past few years usage seems to be fairly stable.^{1–3} The attitude of many clinicians to CTOs has been favourable,⁴ but they have also been the subject of controversy.^{4,5} The power to coerce patients to accept treatment in the community clearly represents a conflict between the principles of respecting autonomy and of preventing harm to the patient and/or others, and thus between providing the ‘least restrictive’ treatment option balanced against ‘preventive’ principles.⁶ The difficulties in resolving this conflict satisfactorily have resulted in significant variations in the nature and implementation of these orders in different countries. Factors which could reduce the usage of CTOs may include a reluctance to use coercive measures, objections from patients’ advocates, concerns about liability, operational aspects and the lack of a strong evidence base.⁷

CTOs are typically indicated for psychiatric patients, usually with a diagnosis of psychosis, presenting with a ‘revolving door’ pattern of admissions secondary to poor treatment adherence and poor engagement with psychiatric services.⁸ Although a main aim of CTOs is to reduce readmissions by preventing relapse, another motivation might be to attempt to improve quality of life for patients and their careers. The responsible clinician devises a set of conditions appropriate to the individual patient in the CTO. The responsible clinician has the discretion to recall the patient, initially for a 72-h period, for further treatment if deemed necessary. During this recall period, a clinical decision has to be made as to whether the CTO should be revoked, which leads to the patient returning to being subject to the original hospital treatment section from which they were discharged on to the CTO. Alternatively, they may receive some brief intervention and be allowed to return to the community, or they may be informally admitted while continuing to be subject to the CTO. The responsible clinician has considerable discretion as to when to exercise the power of recall. Some clinicians may aim to recall patients promptly, with the aim of quickly re-establishing treatment and preventing further deterioration, possibly without needing to revoke the CTO. Others may prefer to wait longer, in the hope that things will improve without having to subject the patient to a measure which may seem overly coercive or even punitive. A recent follow-up study found that fewer than half the patients subject to CTOs are recalled, with about a fifth being recalled multiple times.⁹ In that study, half of these recalls were due to deterioration in clinical condition and about 70% of recalls resulted in revocation.

Effectiveness of CTOs

If CTOs were effective and were used effectively, they might lead to an overall reduction in requirement for in-patient treatment and a decline in the number of patients detained on treatment sections.¹⁰ Two older American randomised controlled studies (RCTs) of similar measures failed to find clinical benefits, but it has been argued that they had significant methodological drawbacks, for example, in that they excluded high-risk patients.^{11·12} Subsequent American studies have claimed to demonstrate benefits, especially when considered as part of a wider public health system involving the criminal justice system.⁷ Given the difference in psychiatric service provision, these studies may have limited applicability to the UK. The OCTET study, a RCT which was carried out soon after the introduction of CTOs, did not find clinical benefits.¹³ However, this study has been criticised as having significant methodological problems, such as again excluding high-risk patients and the fact that the CTOs were only used for a brief period of time.^{14·15} Small naturalistic UK clinical studies using before and after methodologies have reported positive outcomes.^{16–18} Swartz and Swanson (2015)¹⁵ suggested that RCTs may not be the best way to study these complex tools, and that larger, naturalistic studies may be more appropriate. A Care Quality Commission (CQC) 2009/10 report claimed that a third of CTO patients in England did not have a reported history of non-adherence or disengagement.¹⁹

Figures from the Mental Health Minimum Data Set show that the majority of people on CTOs are of working age, and more than twice as many are male than female; however, in the 65 and over age group, more women than men are on CTOs.²⁰ The descriptive data indicate that patients are typically male and around 40 years of age, with a long history of schizophrenia-like or serious affective illness, previous admissions, poor medication adherence, aftercare needs, the potential for violence and displaying psychotic symptoms, especially delusions, at the time of the CTO.⁶ CTO usage is more prevalent in urban areas.²¹

Method

We examined national data on aspects of CTO usage alongside that of other provisions of the MHA and information on psychiatric service provision. National data from the annual reports of Digital NHS (previously the Health and Social Care Information Centre) and Mental Health Reports of the CQC (the independent regulator of health and social care in England since 2009/10) were studied to look at the trends in implementation of CTOs. Thus, although CTOs are used in both England and Wales, the results we report are only for England.

Results

All the figures quoted in the results below and accompanying tables were extracted from the NHS Digital report: *In-Patients Formally Detained in Hospitals Under the Mental Health Act 1983, and Patients Subject to Supervised Community Treatment: 2015/16, Annual Figures*.²¹

As shown in *Table 1*, the annual rate of new CTOs is fairly stable at around 4500, with the number of patients subject to CTOs at any one time being around 5400. The annual number of discharges from CTOs has steadily increased over 5 years from 1712 (2011/12) to 2575 (2015/16), and each year somewhat fewer than half of all patients subject to a CTO are discharged. *Table 1* Annual numbers of patients in England who are subject to CTOs at any one time, along with the number of new CTOs initiated and numbers and percentages of patients discharged from CTOs

Year	2011/12	2012/13	2013/14	2014/15	2015/16
Number of patients subject to CTOs	4764	5218	5365	5461	5426
Number of new CTOs	4220	4647	4434	4564	4361
Number of CTO discharges	1712	1622	2302	4912	2575
Number of discharges as percentage of number of patients subject to CTO, %	35.9	41.4	44.1	64.5	64.7

As shown in *Table 2*, there are about 45 recalls per year for every 100 patients subject to a CTO (HSCIC 2015/16). Over the past 5 years, the average rate of revocation following such recalls is 65%, albeit with a fair degree of variation between years, with absolute numbers fluctuating between 1000 and 1500. *Table 3* shows that, including these revocations, around 9000 patients are detained under Section 3 each year. Given that about 4500 patients are discharged on a CTO annually, it seems that about half of patients detained under Section 3 will be discharged on a CTO. *Table 2* Annual number of recalls and numbers of recalls per 100 patients subject to a CTO

Year	2011/12	2012/13	2013/14	2014/15	2015/16
Number of recalls from CTO	2082	2227	2231	623	692
Recalls per 100 patients subject to CTO	20.8	22.3	22.3	6.2	6.9

100 CTO patients 4844434342 Number of revocations 14691509140114271557 Percentage of recalls resulting in revocation, %70.666.460.560.267.9¹ Table 3 Annual number of patients newly detained under Section 3 (S3) of the MHA, number of CTO revocations and the sum of these two numbers Year 2011/12 2012/13 2013/14 2014/15 Non-CTO Section 37701777674817690 Revocations from CTO 1469150914011427 Total 9170928588829117

Table 4 shows that each year patients make 3000–4000 applications to MHTs to be discharged from CTOs. Most applications proceed to a hearing, and the proportion of MHT hearings resulting in discharge was running at 4–5%, falling to 3.3% in 2015/16 (CQC 2012/13, CQC 2013/14, CQC 2014/15, CQC 2015/16). These rates are not dissimilar to the rates for discharge from hospital treatment sections (Section 3 and Section 37) of 4.4% in 2013/14, and less than that for all sections, which was 8.9% (CQC 2013/14). The application may not proceed to a hearing if it is withdrawn by the patient or if the responsible clinician themselves discharges the CTO. Of all patients subject to a CTO in a given year, the percentage discharged by a MHT is around 2.5–3.5%. The low rates could partly be explained by the higher proportions of automatic referrals made to the tribunal by hospital managers, as opposed to applications made by patients. Table 4 Annual numbers of applications to MHTs for discharge from CTO, numbers of hearings, and numbers and percentages of hearings resulting in discharge by the MHT Year 2011/12 2012/13 2013/14 2014/15 2015/16 Patients subject to a CTO 47645218536554615426 Applications to MHT 39014211443143494317 MHT hearings 32723169355036293942 MHT discharges 161132185165132 Percentage of hearings resulting in discharge, % 4.94.25.24.53.3 Percentage of all CTO patients discharged by MHT, % 3.42.53.43.02.4²

The past few years have seen a 17% reduction in the number of in-patient beds for people needing care for mental health problems: from 26 448 in 2008/09 to 21 949 in 2012/13.²² HSCIC data (2015) show that annual patient contact numbers have fallen significantly, while patient numbers are increasing.²³ The same report also shows that the greatest fall has been for assertive outreach services (more than 20%) and general psychiatric, substance misuse and forensic services (around 15% each). By contrast, contact with criminal justice liaison and diversion services saw the greatest increase in contacts (36.2%), while contact with psychiatric liaison increased by almost 28%.

Discussion

The rate of CTO use is about 10 per 100 000 of the population, which puts it in the low to moderate range by international comparison with similar provisions for compulsory treatment in the community. Australia and New Zealand and some parts of the USA have much higher rates, whereas rates are much lower in Canada and New York.²⁴

The pattern of usage of CTOs seems to be fairly stable in the context of ongoing reductions in psychiatric service provision. A CQC report claimed that the powers were being applied ‘preventatively beyond those for whom they were primarily designed’.¹⁹ However, we note that the rate of discharge by MHTs is low and possibly falling, indicating that these independent tribunals do not seem to regard CTOs as being used inappropriately.

The number of recalls is nearly half the total number of CTOs, and somewhat fewer than a third of CTOs are ended by revocation. Again, the fact that such a large proportion of patients subject to CTOs end up requiring readmission might be taken as an indicator that CTOs are largely being used appropriately, in an attempt to provide treatment in the community to patients who would otherwise remain in hospital. It is not possible to tell whether the number of revocations could be reduced if patients were recalled more promptly, at an earlier stage in their relapse, or whether

¹ (Note that some patients may be recalled more than once.) Also shown are the number of revocations and the percentage of recalls that result in revocation.

²

Also shown is the percentage of discharges by MHT of all patients subject to a CTO.

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the revocations represent a group of patients who are intrinsically difficult to maintain in the community. It would be helpful to investigate this aspect of clinical practice.

It is difficult to know the extent to which the use of CTOs has allowed psychiatric services to continue to function with reduced bed provision. Of course, many would argue that psychiatric services are in fact not functioning at an acceptable level, and the rise in contacts with the criminal justice system could be taken as evidence of this. The MHT will uphold a CTO only if it feels that the CTO is required for the patient to continue to accept treatment. Clinically, adherence to treatment is aimed at preventing relapse and hospital admission among ‘revolving door’ patients, and has wider significance for psychiatric in-patient service provision.

Overall, the success or failure of CTOs hinges on their appropriate application and implementation. There may well be large differences in practice between services and individuals; it would be helpful to explore these systematically and, if possible, relate them to outcome measures. Large numbers of patients are subjected to this provision, so it would seem sensible to take whatever steps possible to see that it is used effectively.

We thank Dr Jennifer Gant, Dr George Mikellides and Dr Peter MacRae.

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1.5.37 Ideology over evidence?

Sameer Jauhar Allan H. Young

date

2018-6

Contents

- *Ideology over evidence?*

In her narrative, Dr Moncrieff makes assertions about depressive illness, antidepressants, and psychotropic medications.¹ Her main points are that these medications are not clinically effective when using rating scales, and that the models proposed for antidepressant action are erroneous. We would suggest that the narrative reflects ideology, as opposed to evidence, and should be interpreted accordingly.

First, a 1969 narrative supplementary review is given as an example of the lack of efficacy of tricyclic and older antidepressants. A more recent (and comprehensive) review found significant benefits for monoamine oxidase inhibitors over placebo, which were surpassed by tricyclics.² The argument is then made that changes on the Hamilton Rating Scale for Depression (HRSD) are minimal, in comparison with placebo, and that differences are clinically insignificant when the Clinical Global Impression (CGI) scale is used, citing among other reviews the Kirsch meta-analysis (where the effect size was 0.313). A similar effect size was seen in a recent analysis of over 500 studies, which reported odds ratios of between 1.37 and 2.13 for response compared with placebo.⁴

In focusing the argument on change in total HRSD score, Dr Moncrieff appears unaware that the scale was never intended to measure change. A more robust way of analysing it was recently demonstrated, using the rating of subjective mood (item 1 on the HRSD), which would be akin to the CGI. This avoided the influence of antidepressant side-effects on the scale, and found clear benefits for paroxetine and citalopram over placebo.⁵

A study cited to indicate severity of depression did not predict outcome, evaluated the short-term efficacy of antidepressants and was not intended to test the hypothesis of severity, with the authors reporting significant benefits of fluoxetine over placebo in adults (improvement of approximately 35%).⁶ The 1964 Medical Research Council trial (which showed the efficacy of electroconvulsive therapy) is given as evidence of lack of effect of severity on response; however, the statement that antidepressants did not outperform placebo is not surprising, given that the dose of imipramine was

50 mg and that of phenelzine 15 mg. A more recent and influential publicly funded study (cited over 3000 times in Google Scholar) showed the effectiveness of imipramine (at a therapeutic dose of around 185 mg) in people with severe depression, in comparison with psychological therapies (cognitive-behavioural therapy and interpersonal therapy). These therapies showed little benefit over placebo in this group.⁷

The rest of the narrative dwells on ‘disease-centred’ models of psychiatric illness, as an alternative to the current ‘targeting a brain abnormality’ approach. We are unaware of modern psychiatry relying on the neurotransmitter models she discusses; the field has moved on significantly, and most neuroscientists would point to more nuanced models involving effects on neural networks and plasticity.⁸ The predominant references cited here are Dr Moncrieff’s own hypotheses.

In summary, we would suggest that Dr Moncrieff’s narrative is selective at best, and on cursory examination there is little effort to appraise the literature in a scientifically objective manner. One cannot help but assume that this opinion piece represents ideology over evidence, and therefore any interpretation should be cautious.

Declaration of Interests

Professor Young has the following disclosures: Employed by King’s College London; Honorary Consultant SLaM (NHS UK); paid lectures and advisory boards for the following companies with drugs used in affective and related disorders: AstraZeneca, Eli Lilly, Lundbeck, Sunovion, Servier, Livanova, Janssen; No share holdings in pharmaceutical companies; lead Investigator for Embolden Study (AZ), BCI Neuroplasticity study and Aripiprazole Mania Study; Investigator initiated studies from AZ, Eli Lilly, Lundbeck, Wyeth, Janssen. Grant funding (past and present): NIMH (USA); CIHR (Canada); NARSAD (USA); Stanley Medical Research Institute (USA); MRC (UK); Wellcome Trust (UK); Royal College of Physicians (Edin); BMA (UK); UBC-VGH Foundation (Canada); WEDC (Canada); CCS Depression Research Fund (Canada); MSFHR (Canada); NIHR (UK). Janssen (UK)

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1.5.38 Pathways to Recovery: development and evaluation of a cognitive-behavioural therapy in-patient treatment programme for adults with anorexia nervosa

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date

2018-6

Abstract

Aims and method

A cognitive-behavioural therapy in-patient treatment model for adults with severe anorexia nervosa was developed and evaluated, and outcomes were compared with the previous treatment model and other published outcomes from similar settings.

Results

This study showed the Pathways to Recovery outcomes were positive in terms of improvements in body mass index and psychopathology.

Clinical implications

Adults with anorexia nervosa can achieve good outcomes despite longer illness duration and comorbidities.

Declaration of interest

A.B., A.C. and L.H. work at The Retreat where the Pathways to Recovery were developed.

Contents

- *Pathways to Recovery: development and evaluation of a cognitive-behavioural therapy in-patient treatment programme for adults with anorexia nervosa*
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 - *Discussion*

There is very limited guidance available regarding effective, evidence-based, in-patient treatment for those people with severe anorexia nervosa who cannot be managed safely due to high medical and/or psychosocial risk and/or who have not responded to treatment in out-patient services.^{1,2} Treasure *et al*³ have recently proposed that severe and enduring anorexia nervosa (SE-AN) may be defined by an illness duration of seven or more years and that interventions should be matched to illness ‘stage’. This proposed ‘staging model’ helpfully emphasises the importance of early intervention for people with recent onset anorexia nervosa. However, the suggestion of shifting focus away from recovery towards

enhancing quality of life and harm minimisation for those with more enduring difficulties^{4,5} has the potential to fuel pessimism with regards to outcomes for this group of patients and the clinicians who work with them.

Aims

This article aims to describe the development of a new treatment programme called Pathways to Recovery: an innovative cognitive-behavioural therapy (CBT)-based approach for the in-patient treatment of people with eating disorders, including those with significant chronicity and comorbidity.

The following questions are addressed: •What is the outcome for patients treated by Pathways to Recovery?•How do the outcomes of patients treated by Pathways to Recovery compare with the outcomes of patients treated by the previous approach that used body mass index (BMI) guidelines (i.e. treatment as usual (TAU))?•How do the outcomes of patients treated by Pathways to Recovery compare with the outcomes in comparable in-patient settings?

Method

Development of the Pathways to Recovery model

The model was developed in a regional specialist eating disorder in-patient unit for women aged 18 and over with complex eating disorders and comorbidities including personality disorders, substance misuse and autistic spectrum disorders.

A CBT approach was adopted in response to evidence that CBT was the most effective treatment for bulimia nervosa⁶ and it had the potential to be effective trans-diagnostically with other types of eating disorders⁷ and a wide range of comorbidities. The collaborative CBT approach was not compatible with the pre-existing framework of using BMI to inform treatment and evaluate progress (i.e. the BMI guidelines).⁸ The Pathways to Recovery model was developed as a solution by a multidisciplinary group of clinicians with consultation with patients, their families/carers and the wider staff team. Pathways to Recovery incorporated key CBT principles and enabled the whole staff team to work collaboratively and coherently in an integrated and holistic way with each patient.

The Pathways to Recovery model was piloted and evaluated independently using qualitative methodology. Overall, Pathways to Recovery was found to be acceptable and a positive alternative to BMI guidelines.⁹

Pathways to Recovery broadly defines recovery as learning to live with eating-disordered thoughts without using eating-disordered behaviours. Emphasis is thus placed on behavioural change while developing a repertoire of CBT skills to manage difficult thoughts and feelings. The programme consists of seven parallel pathways: physical monitoring, psychological, physical activity, meaningful living, meaningful eating, self-catering and leave (*Fig. 1*). Progression up the pathways corresponds to the person's stage of recovery, moving from medical stabilisation through to gaining skills and concluding with the transferring skills stage. Progression is discussed collaboratively at weekly multidisciplinary team meetings and regular care programme approach reviews, which are run transparently with the patient present throughout the meeting. CBT principles, methods and techniques are central to each pathway; for example, the concepts of hierarchies, graded exposure, behavioural experiments, problem solving and goal setting are used. A guided discovery approach is encouraged for both staff and patients. In addition to the poster which delineates the pathways (*Fig. 1*), each patient receives a folder containing information about every step of each pathway. The information includes the aims of each pathway and defines what the person will be expected to work on at each stage. A complete set of supporting documentation is also provided, which includes: planning and evaluation forms for meals, self-catering, activity and leave. The emphasis is on learning from experiences, enabling the patient to take ownership of their recovery and to progress to higher levels of the pathways. As the person progresses, the level of independence increases and they receive less support from staff. This leads to increasing periods of home leave where the person can practice the skills they have learnt. The benefit of this is that patients and their families are able to gain confidence that they will be able to continue using their skills independently once they leave the programme. *Fig. 1*The Pathways to Recovery poster.

Participants and procedure

Clinical outcome data were reviewed from admission and discharge of 161 patients admitted consecutively from July 2008 (when routine data collection was initiated) until April 2015 (when the data were analysed). All patients provided written informed consent at the start of their admission for their data to be used anonymously for research and service evaluation purposes. This project did not require a research ethics committee review as it was a service evaluation project using outcome data routinely collected as a normal part of clinical practice on the unit.

Although data were collected for all patients admitted during this time frame, only data related to patients with a diagnosis of anorexia nervosa at admission were included ($n = 123$). Patients with additional comorbid diagnoses were included.

Further exclusion criteria were as follows: currently receiving treatment in the unit ($n = 13$), previous admission already included in the analysis ($n = 15$), present at the time the service model changed and thus received treatment under both models ($n = 11$) and did not have two or more sets of outcome data ($n = 10$). A total of 74 participants were therefore included. Of these participants, 25 were treated using the former BMI-guidelines approach (hereafter designated TAU) and 49 were treated using the Pathways to Recovery programme (designated Pathways to Recovery). Treatment completion was not routinely documented, so all patients were included in the data analysis providing they had at least one data set in addition to admission data.

Measures

The key areas targeted by in-patient admission were symptoms of eating disorder, general psychological distress and weight restoration. To evaluate change in these areas, the following outcome measures commonly used in eating disorder research were selected for their clinical utility:

Eating Disorder Examination – Questionnaire (EDE-Q): A self-report measure assessing eating disorder symptoms over the previous 28 days.¹⁰ This instrument has good reliability and validity.¹¹ High scores indicate greater eating disorder psychopathology.

Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM): A widely used, generic, 34-item self-report measure of psychological distress. This instrument has good reliability and validity.¹² High scores indicate greater psychological distress.

BMI: BMI (weight/height²) was recorded for each patient at admission and at discharge.

Statistical methods

Independent samples *t*-tests were used to compare the demographic and clinical variables between the two groups at admission. To evaluate the efficacy of Pathways to Recovery, comparisons between admission and discharge scores were assessed in the Pathways to Recovery group using paired sample *t*-tests. Cohen's *d* effect sizes are presented to enable comparisons across outcomes. To put any detected changes into a clinical context, outcomes were also compared to evidence-based guidelines and cut-off points. Comparisons between the TAU and Pathways to Recovery groups were assessed using a 2 (group: TAU and Pathways to Recovery) × 2 (time: admission and discharge) mixed design ANOVA, with repeated measures on the time factor. Data were explored to check assumptions of multivariate analysis. All statistics were carried out using SPSS version 22.0 for Windows. Missing data were dealt with using pairwise deletion.

Results

Sample characteristics

The demographic characteristics and clinical features of the two groups are shown in *Table 1*. There were no significant differences between the two groups in terms of these variables. The mean age of the overall sample was 27 years (range 18–57 years). Of the participants, 67% had previously been admitted for at least one specialist eating disorder in-patient treatment. The mean duration of anorexia nervosa was more than 9 years (range 0–31 years). More than half (51.9%) of the participants had an illness duration of 7 years or more, thus meeting the criterion proposed by Treasure *et al*³ for SE-AN. On admission the participants were significantly underweight: 86% had a BMI lower than 16 kg/m² and nearly one third (31%) had a BMI lower than 13 kg/m². More than half (54%) of the participants had at least one comorbid diagnosis including borderline personality disorder, post-traumatic stress disorder, obsessive compulsive disorder, generalised anxiety disorder, alcohol and substance misuse, autistic spectrum disorder, depression and gender dysphoria. *Table 1* Demographic and clinical features of the sample by group TAU (*n* = 25) Pathways to Recovery (*n* = 49) Test *P*-value Age at admission (years) 27.64 (8.12) 26.65 (9.27) *t* (72) = 0.45 *P* = 0.65 Ethnicity χ^2 (1) = 1.05 Fisher's *P* = 0.55 White (British) 25 (100%) 47 (96%) Black/African/Caribbean/Black British 0 (0%) 2 (4%) Age at onset of illness 16.07 (4.23) 17.44 (7.01) *t* (52) = 0.71 *P* = 0.48 Length of illness at admission (years) 11.97 (10.19) 8.05 (6.91) *t* (52) = 1.63 Levene's *P* = 0.11 Previous in-patient admissions 1.25 (0.97) 0.88 (0.95) *t* (59) = 1.42 *p* = 0.16¹

Question 1: What is the outcome for patients treated by Pathways to Recovery?

For participants who did not complete the programme, the last available set of outcome data was used as discharge data (*Table 2*). BMI data were available for all patients as this was recorded weekly. However, patients who dropped out within the first four weeks of their admission only completed one set of self-report questionnaires and were therefore excluded from the analysis. *Table 2* Clinical characteristics for Pathways to Recovery group Admission Discharge BMI 14.14 (1.65) *n* = 49 18.73 (2.3) *n* = 49 *P* < 0.001 CORE-OM 22.85 (8.22) *n* = 45 15.59 (8.30) *n* = 45 *P* < 0.001 EDE-Q 3.97 (1.59) *n* = 43 2.49 (1.42) *n* = 43 *P* < 0.001²

There was a significant response to Pathways to Recovery in terms of improvements in BMI, general psychological distress and symptoms of eating disorder. At the point of discharge, the mean BMI had significantly increased from 14.1 (s.d. 1.7) to 18.7 (s.d. 2.3; *t* (48) = 13.32; *P* < 0.001; *d* = 2.78) for patients in the Pathways to Recovery group. A significant proportion of the group achieved a BMI 18.5 kg/m² at discharge: 67% (33/49). The mean CORE-OM score decreased by 7.2 (*t* (44) = 4.50, *P* < 0.001, *d* = 0.88). On average, CORE-OM scores remained above the clinical cut-off point (10) at discharge; however, nearly one quarter of the patients (24.5%) were discharged with scores below the clinical cut-off point. The mean global EDE-Q score at discharge was also significantly lower compared to admission (*t* (42) = 5.04, *P* < 0.001, *d* = 0.93). The mean EDE-Q score had reduced to <1 s.d. above the community norm at discharge (mean = 1.55, s.d. = 1.21) 10 compared to 2 s.d. above the community norm at admission. Almost one quarter of the patients (24.5%) had a global EDE-Q score of within 1 s.d. of the community norm at discharge, representing minimal eating disorder psychopathology.¹³

¹ Data are shown as mean (s.d.) unless otherwise indicated. TAU, treatment as usual.

² Data are shown as mean (s.d.) unless otherwise indicated. BMI, body mass index; CORE-OM, Clinical Outcomes in Routine Evaluation Outcome Measure; EDE-Q, Eating Disorder Examination – Questionnaire.

Question 2: How do the outcomes of patients treated by Pathways to Recovery compare with the outcomes of patients treated by TAU?

There were no significant differences at admission between the two groups on any of the three measures used (Table 3). Table 3 Clinical characteristics at admission and discharge, by group TAU Pathways to Recovery BMI Admission 13.55 (1.89), $N = 25$ 14.14 (1.65), $N = 49$ Discharge 16.94 (2.32), $N = 25$ 18.73 (2.3), a, b $N = 49$ CORE-OM Admission 20.87 (7.59), $N = 21$ 22.85 (8.22), $N = 45$ Discharge 17.09 (9.78), $N = 21$ 15.59 (8.30), a $N = 45$ EDE-Q Admission 3.60 (1.68), $N = 203$ 97 (1.59), $N = 43$ Discharge 2.50 (1.85), $N = 202$ 49 (1.42), a $N = 43$ ^{3,4,5}

A mixed ANOVA revealed a significant main effect of time ($F(1, 72) = 221.67, P < 0.001$) and group ($F(1, 72) = 7.87, P = 0.01$) on BMI. Both of these main effects were qualified by a significant interaction ($F(1, 72) = 5.01, P = 0.03$), which indicated that the change in BMI as a result of time was different between the two groups (Fig. 2). Fig. 2 Effect of treatment on BMI.

The effect of treatment on BMI was thus greater in the Pathways to Recovery group than in the TAU group. To further explore this, simple-effect analyses were conducted. Independent t -tests revealed that although there was not a significant difference in BMI between the groups at admission ($t(72) = 1.37, P = 0.17$), the Pathways to Recovery group had a significantly greater mean BMI than the TAU group at discharge ($t(72) = 3.16, P = 0.002$).

A mixed ANOVA revealed a significant main effect of time ($F(1, 64) = 16.89, P < 0.001$) on CORE-OM. The main effect of group on CORE-OM was not significant ($F(1, 64) = 0.02, P = 0.89$), nor was there a significant interaction between time and group ($F(1, 64) = 1.68, P = 0.20$).

A mixed ANOVA revealed a significant main effect of time ($F(1, 61) = 25.67, P < 0.001$) on EDE-Q. The main effect of group on EDE-Q was not significant ($F(1, 61) = 0.28, P = 0.60$), nor was there a significant interaction between time and group ($F(1, 61) = 0.57, P = 0.46$).

The mean length of admission was 27.4 (s.d. = 14.55) weeks for TAU and 33.2 (s.d. = 17.47) weeks for Pathways to Recovery.

Question 3: How do the outcomes of patients treated by Pathways to Recovery compare with the outcomes in similar in-patient settings?

The outcomes for Pathways to Recovery were compared to those reported by Dalle Grave *et al*,¹³ who describe findings from a CBT in-patient service in Italy, and Goddard *et al*,¹⁴ who describe outcomes from 12 adult in-patient services in the UK (Table 4). Table 4 Pathways to Recovery outcomes compared to other in-patient settings Goddard *et al*¹⁴ Dalle Grave *et al*¹³ Pathways to Recovery Mean length of admission (weeks) 26.4 (17.9) Up to 20 weeks 33.2 (17.47) Discharge BMI (kg/m²) 17.3 (2.1) 18.9 (1.5) 18.7 (2.3) Those achieving BMI 18.5 (%) 22%^a 86.1%^b 67% (49%^a) Discharge EDE-Q 3.3 (1.6) 1.7 (1.0)^{b, c} 2.5 (1.4) Those achieving EDE-Q < 1 s.d. above community mean (i.e. 1.74) (%) Not known 51.4%^b 24.5%^{6,7,8,9}

³ Data are shown as mean (s.d.) unless otherwise indicated. TAU, treatment as usual; BMI, body mass index; CORE-OM, Clinical Outcomes in Routine Evaluation Outcome Measure; EDE-Q, Eating Disorder Examination – Questionnaire.

⁴ $P < 0.001$ v. admission.

⁵ $P < 0.01$ v. discharge TAU.

⁶ BMI, body mass index; EDE-Q, Eating Disorder Examination – Questionnaire.

⁷ Those achieving BMI > 19 (%).

⁸ Only those who completed treatment rather than intent-to-treat sample.

⁹

EDE interview version rather than self-report.

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Pathways to Recovery in comparison to Dalle Grave *et al*13

The mean discharge BMI in both settings was broadly similar. A greater proportion of the Italian patients left with a BMI in the healthy range (BMI 18.5–25 kg/m²) and met the criterion for minimal eating disorder psychopathology.

Pathways to Recovery in comparison to Goddard *et al*14

The Pathways to Recovery outcomes appear to be substantially better than the average outcomes reported by Goddard *et al*14 from 12 adult in-patient services in the UK: 49% of the Pathways to Recovery sample achieved a BMI greater than 19 kg/m² at discharge compared to only 22% of the Goddard *et al*14 sample. The EDE-Q on admission for both groups was similar, and both achieved a statistically significant decrease in scores. However, the improvement in the Pathways to Recovery sample appears to be more clinically significant, achieving values closer to the mean taken from the general female population.

Discussion

In addition to briefly describing the development of Pathways to Recovery, the aim of this paper was to evaluate the outcomes of this CBT-based approach for the in-patient treatment of people with severe and enduring anorexia nervosa. Although the programme is designed for people with any eating disorder diagnosis, the focus of this service evaluation was restricted to those with a diagnosis of anorexia nervosa. The people treated were complex, with almost one-third starting treatment with a BMI of less than 13 kg/m² and more than half having one or more comorbid diagnoses. More than half the participants met the criterion of illness duration proposed by SE-AN.³ It is worth noting that the term SE-AN implies both a severe level of symptoms, including serious medical comorbidities as well as a long duration of illness. Although people with shorter durations of illness may also experience physical comorbidities and other disabling features of anorexia nervosa, these symptoms become progressively more likely as time goes on.

The first key finding was that introducing Pathways to Recovery significantly enhanced weight restoration compared to TAU, with more than two-thirds of participants gaining enough weight to enter the World Health Organization's healthy BMI range. This is important since lower BMI at discharge has been found to be a predictor of relapse.¹⁵ Pathways to Recovery also led to significant improvements in general psychological distress and symptoms of eating disorder, with nearly one-quarter having minimal eating disorder psychopathology at discharge; however, these improvements were not significantly different from those achieved by TAU.

The outcomes for patients treated by Pathways to Recovery were broadly comparable to those produced by another CBT in-patient programme.¹³ The mean discharge BMI in both settings was similar. Although a greater proportion of the Italian participants left with a BMI in the healthy range (BMI 18.5–25 kg/m²) and met the criterion for minimal eating disorder psychopathology, this only represented the outcomes for those who had completed the programme; whereas the Pathways to Recovery data set includes those who did not complete the programme (except those who left within the first four weeks). Furthermore, the Dalle Grave *et al*13 sample included adolescents (29% were younger than 18), thus the mean age and median illness duration were less than the Pathways to Recovery sample. The Dalle Grave *et al*13 sample recorded depression (53.6%) and anxiety (20%) but did not report any other comorbidities. Depression and anxiety are recognised complications of starvation and may have been a feature of the anorexia nervosa rather than comorbidities *per se*. This could indicate a less complex cohort than the Pathways to Recovery sample. This indicates that Pathways to Recovery is effective for not only patients with SE-AN but also for those with other comorbidities. Such patients are often excluded from specialist eating disorder in-patient services due to the complexity of their presentations.

Another key finding was that Pathways to Recovery appears to produce better than average short-term outcomes for in-patients with anorexia nervosa when compared with similar adult in-patient settings in the UK.¹⁴ The length of illness in both groups was virtually identical and although the length of stay was longer for the Pathways to Recovery group, the outcomes demonstrated that instead of being treatment resistant, this group of patients can achieve positive outcomes in terms of weight restoration and improvements in psychopathology. This may be important for generating greater therapeutic optimism for clinicians working with patients on the more severe and enduring end of the spectrum,

and thus give hope to these patients and their families. Improvements in both of these outcome measures are likely to result in sustained recovery post-discharge.

Treasure *et al*³ have suggested changing the focus of those with SE-AN ‘to improving quality of life and minimising discomfort rather than achieving optimal weight’. This approach runs the risk of clinicians and patients assuming that weight restoration is not possible or even acceptable. Furthermore, chronic low weight has many long-term health risks affecting all organ systems,¹⁶ many of which can potentially reduce life expectancy.

However, Calugi *et al*¹⁷ caution: ‘there are strong reasons to indicate that pessimism regarding the recovery prospects of patients with SE-AN may not be entirely justified and consequently steering away from a recovery model may be premature at this stage’. They go on to describe the 1 year follow-up treatment outcomes of their intensive enhanced CBT programme that reveal no significant differences between SE-AN and non-SE-AN patients in terms of BMI and EDE (global and brief symptom inventory) scores at the 12 month follow-up. The mean length of illness for their SE-AN group was 12 years.

Our experience is that offering hope in the form of a recovery-based program to patients with eating disorders – irrespective of length of illness, severity or complexity – is positively received. The uptake following assessment is high, with some patients requesting to be referred nationally.

As a service evaluation, this study inevitably has a number of limitations. The programme was devised, used and evaluated at The Retreat which could introduce potential bias. In addition, two of the authors (L.H. and A.B.) currently work in the service. The outcomes could be positively affected by the fact that the team was actively involved in the development of the programme. On the other hand, the adoption of this new way of working represented a significant cultural shift for the team. Unsurprisingly, a number of changes to the supporting materials and the processes were required, particularly over the first year or so. Any changes were made in collaboration with the participants and team. It is worth noting that no additional resources were used and the staffing levels remained consistent before and throughout the development and implementation of Pathways to Recovery. The only cost incurred was the printing of the materials and the graphics for the poster and folders.

In terms of the comparison between Pathways to Recovery and TAU (i.e. the in-patient programme before introduction of the new model), the patients were not randomised to the different treatment groups and thus there may have been variations between the two groups that could explain the differences in outcomes, despite there being no significant differences in the key demographic and clinical characteristics measured.

If patients had more than one admission, only their first admission was included in the data set (15 sets of data from 14 patients were excluded in total). It could be argued that using their most recent admission would have been more representative for evaluating the effectiveness of the programme in treating people with severe and enduring eating disorders, assuming that difficulties may be even further entrenched by the time people have had more than one admission. However, it may be the case that those who have had a previous admission do better in a subsequent admission as they are able to build on their experiences.

Furthermore, 10 patients were excluded due to having only one set of data. These patients who dropped out in the very early stage of their admission may represent a subset of even more complex cases, making the final sample somewhat self-selecting.

Although patients were contacted at 3, 6 and 12 months post-discharge and asked to complete self-report outcome measures, the uptake was poor and has therefore not been reported in this paper. We are currently investigating alternative methods to collect follow-up data including the use of digital technology. One of the differences between Pathways to Recovery and TAU is the emphasis on transference of skills and the development of increasingly high levels of independence and self-efficacy, which would predict that longer term outcomes are likely to be encouraging.

Many thanks to The Naomi Unit patients, their family members and members of the Naomi team – present and past – without whom the development of Pathways to Recovery would not have been possible.

Andrea Brown is a consultant psychiatrist and psychotherapist at The Retreat, York. **Richard Jenkinson** is an assistant psychologist at the University of Sheffield. **Julia Coakes** is a consultant clinical psychologist and **Annette Cockfield** is an advanced dietetic practitioner at Insight Eating, Leeds. **Tish O’Brien**, now retired, was an occupational therapist and **Louise Hall** is a clinical psychologist at The Retreat, York. All authors work or have worked in the eating disorders service (The Naomi Unit) at The Retreat in York.

1.5.39 Rational antidepressant use

Daniel Dunleavy

date

2018-6

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- *Rational antidepressant use*

In her contribution to the ‘Against the Stream’ series, Dr Moncrieff¹ articulates the case for the drug-centred model of antidepressant action. She notes that antidepressants do not typically outperform placebo in well-designed studies (particularly in rare instances where an active placebo is used as a control²), have little clinical effect and can cause serious adverse effects. Having made the case that antidepressants are not ‘specific’ antidepressant agents, she makes some comments about their use in clinical practice. I would like to offer a few remarks about these issues, including some musings about what ‘rational antidepressant use’ might look like.

Modern psychiatric practice has seen the rise and fall of several promising antidepressant agents (the monoamine oxidase inhibitors, the tricyclic antidepressants and selective serotonin reuptake inhibitors (SSRIs)). Recent efforts include testing the possible antidepressant properties of ketamine. But are these efforts futile? Perhaps yes, perhaps no. A truly specific antidepressant drug (if one is ontologically possible) appears to be a pipedream, given current diagnostic limitations. Our categorisation of major depressive disorder is highly heterogeneous,³ creating a disjunctive category of cognitive, behavioural and biological symptoms that do not reliably cluster together. Even if any of our current drugs had specificity for ‘depression’, this would be extremely difficult to uncover in clinical practice or research settings. As a result, drug development will be prone to ideological, as opposed to scientific, revolutions.⁴

Should we therefore abandon antidepressants as a treatment modality? As long as we are honest with our patients about our current state of knowledge, I think not. Drug use has always been an integral part of human life,⁵ helping to alleviate life’s various physical, emotional and existential pains. Antidepressants are no different in this respect. While researchers continue the search for a discrete condition called ‘depression’, drugs such as the SSRIs can be exploited for particular patient complaints. Antidepressants can cause emotional blunting, sedation, activation and decreased libido, among other things. Some have a proclivity towards one effect more than others. These effects can be exploited to relieve particular problems (e.g. sedation to alleviate insomnia, or emotional numbing to transcend an episode of intense anxiety or distress), without pretence towards a yet-to-be discovered condition. A rational provider would match a drug’s effects to the patient’s complaints, irrespective of diagnosis (or drug class); and would remain vigilant to the development of any adverse effects or deterioration of condition, start at the lowest recommended dose, and withdraw the patient from the drug as soon as possible. Psychosocial interventions can remain an important part of treatment, in many cases being the first treatment of choice. Antidepressants, like all drugs, are neither angels nor demons. They should be used selectively and thoughtfully, when used at all.

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1.5.40 Author's reply

Joanna Moncrieff

date

2018-6

Contents

- *Author's reply*

In response to Dr Jauhar and Professor Young, I am used to being accused of using ideology, of being selective, of not being balanced or of being polemical. I take no personal offence, but it is important to point out that this is a useful tactic if you want to shut down debate. It harnesses the authority of science to present one view as neutral, objective and credible, and the other as self-interested and unreliable. In truth, we all bring assumptions and biases to our work. I am obviously unable to describe every study ever done on antidepressants in a short article, but I have written books and papers that address all the evidence I could find that supports the disease-centred model of drug action in relation to antidepressants and other psychiatric drugs.¹

Indeed, one of the most important points I am making in relation to drug action is that existing psychopharmacological research is based on unexamined assumptions about how drugs work. These consist of the idea that drugs target the neurological mechanisms underlying symptoms, whether the latest theory about mechanisms concerns abnormalities of neurotransmitters, neural networks or neuro-plasticity. This idea has allowed psychopharmacology research to ignore the alterations to normal functioning that psychiatric drugs produce, and that will affect mental states including mental disorders, regardless of the underlying mechanisms.

Jauhar and Young point out that the latest meta-analysis of antidepressant trials finds impressive odds ratios for effects of antidepressants, but it analyses categorical outcomes derived from continuous data, which has been shown to inflate drug–placebo differences.² Network analysis is also likely to exaggerate differences, since the degree of improvement in comparative trials is higher than in placebo-controlled trials.³ The continuous data, which showed a standardised mean difference (SMD) of 0.3, is in line with other meta-analyses in showing small and almost certainly clinically insignificant differences between antidepressants and placebo, equivalent to around two points difference on the Hamilton Rating Scale for Depression (HRSD).⁴⁻⁵

Jauhar and Young make a good point about the validity of the HRSD, but it is nevertheless used as the primary outcome of most trials. Analyses of the subjective mood item are thus more likely to be influenced by selective reporting of positive findings. However, they are wrong about the Medical Research Council trial, where the dose of imipramine was 200 mg and that of phenelzine was 60 mg. There is indeed evidence either way on the association between severity and antidepressant response, but even in studies with positive findings, effect sizes in those with severe depression are small and unlikely to be clinically significant, and the association may be accounted for by differing expectations in people with more or less severe symptoms.⁶

I agree with the gist of Dr Dunleavy's response. Recommending antidepressants because they produce emotion-blunting effects, or other useful mental alterations (sedation with tricyclics, for example), is a drug-centred model of prescribing. I don't have a problem with this as long as the patient is properly informed that placebo-controlled trials suggest little if any superiority of antidepressants, that they have full knowledge of all the potential adverse effects, and that they are quite clear that the idea that antidepressants correct an underlying chemical imbalance is not supported by evidence. Then they can make their own informed decision.

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1.5.41 The development of an outcome measure for liaison mental health services

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Abstract

Aims and method

To develop and pilot a clinician-rated outcome scale to evaluate symptomatic outcomes in liaison psychiatry services. Three hundred and sixty patient contacts with 207 separate individuals were rated using six subscales (mood, psychosis, cognition, substance misuse, mind–body problems and behavioural disturbance) plus two additional items (side-effects of medication and capacity to consent for medical treatment). Each item was rated on a five-point scale from 0 to 5 (nil, mild, moderate, severe and very severe).

Results

The liaison outcome measure was acceptable and easy to use. All subscales showed acceptable interrater reliability, with the exception of the mind–body subscale. Overall, the measure appears to show stability and sensitivity to change.

Clinical implications

The measure provides a useful and robust way to determine symptomatic change in a liaison mental health setting, although the mind–body subscale requires modification.

Declaration of interest

None.

Contents

- *The development of an outcome measure for liaison mental health services*
 - *Method*
 - * *Settings*
 - * *Acceptability and ease of use*
 - * *Interrater reliability*

- * *Sensitivity to change*
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- * *Statistical methods*
- *Results*
 - * *Scale acceptability*
 - * *Interrater reliability*
 - * *Sensitivity to change*
 - * *Comparability with the CORE-10*
 - * *CAM*
- *Discussion*

Routine outcome measurement is important in mental health settings and can facilitate improvements in quality and outcome.¹ At present, there is no recognised, specific, routine outcome measure for liaison psychiatry services. The Health of the Nation Outcome Scales (HoNOS) have been used routinely in general psychiatry settings for the past 20 years,² but attempts to adapt them for liaison settings have never been realised. Liaison mental health services operate in a variety of different settings and treat people with a wide range of complex and heterogeneous clinical problems, which makes the development of a single outcome tool challenging.³

The Faculty of Liaison Psychiatry of the Royal College of Psychiatrists has developed an outcome framework (FROM-LP),⁴ which includes measures of patient and referrer satisfaction, and a generic clinician-rated measure, the Clinical Global Impression Improvement Scale (CGI-I).⁵ This measure, however, is not specific for liaison settings and does not generate individual symptom ratings.

The aim of this project was to develop and pilot a liaison outcome instrument to be used for local service evaluation, to supplement the FROM-LP framework and to provide data on symptom outcomes. Our intention was to develop a brief, acceptable and easy to use measure that covered common liaison mental health problems, with good reliability, stability and sensitivity to change. This paper describes the development of the measure and preliminary results from its use in two local acute hospital services in Manchester.

Method

Items included in the measure were determined using a modified version of the mini-Delphi method.⁶ We ran three cycles of the mini-Delphi process using panels of clinicians (nurses and psychiatrists) working in different types of liaison mental health services in the North West of England, including acute hospital wards, emergency departments, out-patient and community liaison services, and liaison services for older adults. A pool of potential items (64 items) was initially generated, and a prototypic measure was produced which then underwent 6 months of field testing in a Manchester liaison mental health service. Following this, the measure underwent a series of modifications, including the exclusion and rewording of many items. A subsequent 12-month testing period generated further minor revisions.

The final measure was piloted in this study. It had 22 items consisting of six subscales (mood, psychosis, cognition, substance misuse, mind–body problems and behavioural disturbance) and two additional items (side-effects of medication and capacity to consent to medical treatment). Each item was rated on a five-point scale from 0 to 5 (nil, mild, moderate, severe and very severe). In response to feedback from clinicians, a contextual subscale was also added to represent items which may not necessarily change because of a liaison intervention but may influence or affect outcome (e.g. prior history of severe mental illness). These items are meant to be rated at baseline only (*Table 1*). *Table 1* Liaison outcome measure subscales and items
 Subscale
 Items
 Mood
 1. Low mood
 2. Suicidal ideation or self-harm
 3. Psychological adjustment to physical illness
 Psychosis
 4. Perceptual disturbances
 5. Abnormal thought content
 6. Abnormal mood (excluding depression)
 Cognition
 7. Problems with orientation
 8. Problems with concentration
 9. Problems with memory
 Substance misuse
 10. Alcohol-related problems
 11. Illicit drug-related problems
 12. Proprietary medication problems
 13. Acute alcohol or drug withdrawal
 Mind–body
 14. Disproportionate disability
 15. Excessive or major

worry about physical health¹⁶. Pain¹⁷. Disproportionate treatment-seeking behaviourDisturbed behaviour¹⁸. Agitation or aggressive behaviour¹⁹. Non-adherence to treatment²⁰. Consciousness and hypoactivityAdditional items²¹. Side-effects of psychotropic medication²². Problems with capacity to consent to medical or surgical treatmentContextual itemsPhysical illnessPhysical disabilityIntellectual difficultiesPsychosocial stressorsEnduring mental health problemsSocial functionActivities of daily living

Settings

Both services involved in the evaluation were based in Greater Manchester. The first was a consultant-led ward-based service for working adults, which operates on a 09.00 to 17.00 h basis from Monday to Friday, based in a hospital with 850 beds. The second was a consultant-led liaison service for older adults, which operates from 09.00 to 17.00 h, Monday to Friday, based in a hospital with 778 beds. The older adult liaison service sees patients on general hospital wards and has a broad reach within the community, including residential and nursing homes, intermediate care units, hospices, home visits and an out-patient clinic in a local mental health unit for older people.

Acceptability and ease of use

Acceptability was measured by asking clinicians who used the measure to record the time taken to complete the measure, and to rate on a seven-point Likert scale the ease or difficulty of completion (1 = very easy, 4 = neither easy nor difficult, 7 = very difficult). Feedback was obtained from nine clinicians, including one consultant liaison psychiatrist, one consultant liaison older adult psychiatrist, three higher trainees in psychiatry, one specialist liaison nurse, two core psychiatry trainees and one FY2 trainee.

Interrater reliability

Interrater reliability was assessed by independent paired raters. Paired ratings were obtained when a patient was assessed on the same day by different members of the same team, or when jointly assessed by a trainee and a senior colleague for the purposes of a workplace-based assessment. Ratings were made separately, without consultation between the raters. Agreement between raters was assessed using intraclass correlation coefficients (ICC).

Sensitivity to change

The sensitivity to change of an instrument is its ability to accurately detect changes if they occur. For the purposes of this evaluation, change was determined by the Clinical Global Outcome Scale-I,⁵ which is recommended by FROM-LP4 and was completed routinely as part of clinical care for patients who were reviewed on at least two occasions. The CGI-I is a seven-point scale (1 = very much improved, 2 = much improved, 3 = minimally improved, 4 = no change, 5 = minimally worse, 6 = much worse, 7 = very much worse).⁵ Patients were divided into three groups: improved (a score of 1 or 2 on the CGI-I), no change (a score of 3, 4 or 5 on the CGI-I) and deteriorated (a score of 6 or 7 on the CGI-I).

It was hypothesised that, if the liaison measure was sensitive to change, there would be a significant difference between the above three outcome groups, and the improved group would show significant improvement on pre and post ratings of the liaison measure, while the deteriorated group would show significant worsening on the liaison symptomatic scores, and the no-change group would show no difference on pre and post scores. The effect size⁷ ($M_2 - M_1/s.d._1$, where M_2 = mean at time 2, M_1 = mean at time 1, $s.d._1$ = s.d. at time 1) for each group was also calculated.

Comparability

It was beyond the scope of this service evaluation project to compare all of the subscales of the measure with appropriate recognised, validated instruments. However, it was possible to compare two of the subscales of the liaison instrument with recognised, validated measures that are used routinely in the Manchester liaison services. The CORE-108 is a brief outcome measure comprising ten items, which has been widely adopted in the evaluation of counselling and psychological therapies in the UK. The CORE-10 is recommended by FROM-LP for appropriate subgroups of patients. The Confusion Assessment Method (CAM)⁹ is a standardised evidence-based tool that enables clinicians to identify and recognise delirium quickly and accurately in both clinical and research settings.

It was hypothesised that the CORE-10 scores would correlate highly with the depression subscale of the liaison measure, but not with the other subscales. As the CAM scale produces a positive or negative outcome, patients who scored positively on the CAM were compared with those who had a negative score (i.e. no evidence of confusion). It was hypothesised that those who had a positive score on the CAM would score significantly higher on the cognitive subscale of the liaison measure than those who had a negative score (i.e. no delirium).

This project was checked using the Health Research Authority website to determine whether or not it would be classed as research, and discussed with the local Research and Development lead. There was collective consensus that it should be classed as a local service evaluation.

Statistical methods

Data were collated and stored, and descriptive statistics were completed using SPSS version 22. Further statistical analysis used the R statistical programming language (version 3.2.5) with the assistance of the ‘RKWard’ graphical user interface (<https://rkward.kde.org/>), as well as the ‘irr’ (<https://cran.r-project.org/web/packages/irr/irr.pdf>) and ‘psych’ (<https://cran.r-project.org/web/packages/psych/psych.pdf>). packages. Normally distributed data were compared using either independent or paired-sample *t*-tests (for before and after comparisons). Non-parametric tests were used for comparison of data that were not normally distributed.

Results

A total of 360 patient contacts with 207 separate individuals were rated using the liaison outcome measure. One person had two separate episodes of care under the liaison team, resulting in 208 individual episodes of care. One hundred and thirteen people had only one rating, 64 people had two ratings, 18 people had three ratings, eight people had four ratings, two people had five ratings, and one person each had six, seven and ten ratings, respectively.

There were 45 parallel assessments of the same individual at the same point in time. Of these, 41 were paired ratings and four involved three raters. There were 78 pre–post ratings which were of the same individual at different points in time. Of these, 47 were undertaken by the same rater and 31 by a different assessor. Demographic information was recorded for 198 individuals, of whom 104 (52.5%) were male. The mean age was 52.6 years (s.d. = 21.7 years).

Scale acceptability

The ease of use of the scale was rated for 228 (63.3%) contacts ($x = 2.1$; s.d. = 1.1). The time taken to complete the measure was recorded for 233 (64.7%) contacts ($x = 2$ min, 30 s; s.d. = 2 min, 8 s).

Interrater reliability

Table 2 shows the ICC for each item of the scale as rated by 45 rater pairs. Kappa () scores for 15 of the 22 items of the scale and five of the seven contextual factors demonstrated ‘good’ ($\kappa = 0.61–0.80$) or ‘very good’ interrater reliability ($\kappa = 0.81–1.00$), using agreement categories as described by Landis and Koch.¹⁰ Four items involving the mind–body subscale showed very low kappa scores (14, 15, 16 and 17). Table 2 Intra-class correlation coefficients (ICC) for items of the liaison outcome measure Measure item n ICC (95% CI) 1 Low mood 360.827 (0.687–0.908)*** 2 Suicidal ideation or self-harm 410.802 (0.658–0.889)*** 3 Problems with psychological adjustment to physical illness 340.656 (0.413–0.812)*** 4 Perceptual disturbances 400.929 (0.869–0.962)*** 5 Abnormal thought content 420.920 (0.856–0.956)*** 6 Abnormal mood (excluding depression) 380.828 (0.693–0.906)*** 7 Problems with orientation 410.861 (0.754–0.923)*** 8 Problems with concentration 330.816 (0.660–0.905)*** 9 Problems with memory 310.821 (0.662–0.910)*** 10 Alcohol-related problems 390.825 (0.691–0.904)*** 11 Illicit drug-related problems 320.921 (0.844–0.960)*** 12 Proprietary medication problems 370.947 (0.899–0.972)*** 13 Acute alcohol or drug withdrawal 400.954 (0.915–0.975)*** 14 Disproportionate disability 360.224 (0.109–0.511) 15 Excessive or major worry about physical health 380.0523 (0.362–0.268) 16 Pain 370.299 (0.023–0.565)* 17 Disproportionate treatment-seeking behaviour 370.211 (0.117–0.498) 18 Agitation or aggressive behaviour 420.776 (0.620–0.873)*** 19 Non-adherence to treatment 410.518 (0.253–0.710)** 20 Consciousness and hypoactivity 420.805 (0.665–0.890)*** 21 Side-effects of psychotropic medication 340.546 (0.259–0.744)** 22 Problems with capacity to give informed consent to treatment 310.593 (0.307–0.780)** 1–22 Scale total 450.799 (0.662–0.889)*** **Subscale scores** A Mood 450.768 (0.614–0.865)*** B Psychosis 450.924 (0.866–0.958)*** C Cognition 450.802 (0.667–0.886)*** D Substance misuse 450.930 (0.876–0.961)*** E Mind–body 450.253 (0.041–0.506) F Behaviour 450.748 (0.584–0.853)***¹²

The ICCs and their 95% confidence intervals for the contextual items were as follows: physical health problems ($n = 43$; ICC = 0.496; CI = 0.233–0.692**); physical disability ($n = 37$; ICC = 0.601; CI = 0.347–0.772***); intellectual difficulties ($n = 35$; ICC = 0.670; CI = 0.437–0.819**); psychosocial stressors ($n = 35$; ICC = 0.696; CI = 0.476–0.843***); enduring mental health problems ($n = 19$; ICC = 0.750; CI = 0.459–0.896***); social function ($n = 28$; ICC = 0.556; CI = 0.237–0.767**); and activities of daily living ($n = 28$; ICC = 0.727; CI = 0.491–0.864***).

With the exception of the mind–body subscale, all subscales of the measure showed ‘good’ or ‘very good’ interrater agreement (Table 2). Agreement for the total score was ‘good’ at 0.799. This increased to ‘very good’ with an ICC of 0.845 (CI = 0.734–0.911, $P < 0.001$) when the mind–body subscale was excluded from the total score.

Sensitivity to change

Seventy-eight patients had a baseline assessment and a final rating, at least 1 week apart. There was an overall improvement on the liaison outcome measure, with a baseline mean of 15.68 (s.d. 10.90) and a post-intervention mean of 8.41 (s.d. 7.66). This was statistically significant ($t = 5.28$, d.f. = 77, $P < 0.001$). Thirty-seven of these patients were classed as showing improvement on the CGI-I (a rating of much improved or very much improved), 35 patients were classed as showing no change (a rating of minimally improved, no change or minimally worse) and five patients were classed as showing a deterioration (much worse or very much worse). One rating for the CGI-I was not recorded, so this individual could not be classified. Table 3 shows the mean scores for each of the three outcome groups, at the baseline assessment and the final assessment. The change in outcome among the three groups was also significantly different (Kruskal–Wallis test, $P < 0.001$). Table 3 Baseline and post-intervention

¹ n : number of rater pairs.

²

* $P < 0.05$; ** $P < 0.001$; *** $P < 0.0001$.

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scores, change scores and effect sizes for patients in the Clinical Global Impression Improvement Scale (CGI-I) improved, no change and worse groups CGI-I outcome category Baseline Post-intervention Liaison change score *P*-value (pre–post) Effect size Means.d. Means.d. Means.d. Improved (*N* = 37) 20.00 12.04 4.54 5.16 17.61 11.65 <0.001 1.29 No change (*N* = 35) 12.77 8.08 11.91 8.03 0.68 7.86 0.47 7.08 Worse (*N* = 5) 4.80 5.36 12.80 8.38 8.75 5.73 0.02 71.64

Comparability with the CORE-10

Twenty-three patients completed the CORE-10. For these patients, there was a significant correlation between the mood subscale and the CORE-10 score ($r = 0.60$; 95% CI 0.31–1.00; $P = 0.001$) and the overall liaison measure ($r = 0.46$; 95% CI 0.13–1.00; $P = 0.013$). There was no significant correlation between the CORE-10 and any of the other subscales: psychosis ($r = 0.31$; 95% CI 0.04 to 1.00; $P = 0.072$); cognition ($r = 0.15$; 95% CI 0.48 to 1.00; $P = 0.705$); substance misuse ($r = 0.10$; 95% CI 0.26 to 1.00; $P = 0.322$); mind–body ($r = 0.24$; 95% CI 0.13 to 1.00; $P = 0.140$); and behaviour ($r = 0.06$; 95% CI 0.40 to 1.00; $P = 0.603$).

CAM

CAM scores were available for 41 patients; 11 of these were positive scores. Patients who scored positively on the CAM had a significantly higher score on the cognition subscale of the measure than those who did not (mean 7.18, s.d. 3.42 *v.* mean 0.47, s.d. 1.43; $P < 0.001$). They also had higher scores on the psychosis subscale (mean 7.37, s.d. 3.26 *v.* mean 1.50, s.d. 2.56; $P < 0.001$) and the behaviour subscale (mean 5.64, s.d. 1.51 *v.* mean 0.73, s.d. 1.68; $P < 0.001$), but not on the mood subscale (mean 1.91, s.d. 2.34 *v.* mean 2.1, s.d. 3.00; $P = 0.612$) or the substance misuse subscale (mean 3.09, s.d. 4.11 *v.* mean 1.43, s.d. 2.22; $P = 0.441$). Comparisons were made using the Mann–Whitney *U*-test for independent samples. Data for the mind–body subscale were not analysed owing to the poor interrater agreement for these items.

Discussion

This study represents a preliminary attempt to develop an outcome measure for local use in Greater Manchester liaison psychiatry services. The findings are encouraging, but cannot currently be generalised beyond the settings involved in the evaluation. Strengths of the measure include: extensive involvement of liaison clinicians in all stages of development, particularly item generation; field testing and refinement of the measure; positive feedback from clinicians regarding ease of use and acceptability; good interrater reliability for most items and subscales, with the exception of the mind–body subscale; preliminary evidence of the instrument’s stability and sensitivity to change, and reasonable comparability for two of the measure’s subscales with recognised instruments used routinely for sub-populations of patients seen by liaison services.

The measure shares some similarities with HoNOS, although many items are more specific to liaison settings (items 2, 12, 13, 14, 15, 16, 17, 21 and 22). Like HoNOS, however, the measure was designed to cover a broad clinical area, rather than a specific psychological dimension.

The measure appears to have face validity in that it covers areas relevant to liaison psychiatry, and all the items were generated by working clinicians in the field. On average, it takes approximately 2 min to complete, but clinicians who are familiar with the instrument can complete it in shorter periods of time.

The heterogeneity of the instrument makes it challenging to validate in a conventional way, as each of the six subscales would need comparison with a separate recognised instrument. We compared it with two measures that are used routinely in our services. There was a significant association between the CORE-10 (a measure of psychological symptoms) and the mood subscale of the liaison instrument, which provides some support for the utility of this subscale. The cognition subscale scores correlated well with positive CAM scores, as did the psychosis and behaviour subscales. These findings provide support for the clinical utility of the instrument, as one might expect that patients who are confused and suffering from delirium may also have symptoms related to behavioural disturbance and psychosis.

It was beyond the scope of this project to use any other recognised appropriate measures for comparison with the other subscales, as no other measures are used routinely in the clinical services involved in this evaluation.

The mind–body items showed disappointingly poor interrater reliability. In the development of the scale, clinicians felt it was important to include mind–body items, but judgements as to whether behaviour or treatment-seeking are ‘disproportionate’ are difficult to make in practice. These items have subsequently been revised and rewritten for further evaluation.

Our clinician panels recommended inclusion of contextual items in addition to the main measure, in order to assess the complexity of patients’ physical, mental and social status. We will report in detail on the utility of these additional baseline items in a subsequent report.

The measure was primarily tested on acute general hospital wards; we are currently exploring the potential utility of the measure in out-patient and emergency department settings with a view to field testing. In addition, most of the raters were doctors, as opposed to nurses. This reflected the staffing of the two services involved in the evaluation, and the requirement of psychiatric trainees to have training in audit and service evaluation. The measure has no items that require specific medical expertise; further evaluation of its use by nursing staff would be informative.

The main purpose of developing the measure was to be able to record symptomatic outcomes in our local services, which would be credible and informative. Despite the above caveats, we believe the measure is better than any other currently available instrument for recording overall outcomes in the liaison setting, and it has been adopted locally and incorporated into an electronic format for routine use, in addition to the FROM-LP framework.

The measure requires further development and field testing in different settings before it can be recommended for widespread use. With this in mind, we are now in the process of applying for funding and ethical approval for a more robust evaluation of the instrument.

Elsbeth Guthrie is a professor of psychological medicine at the University of Leeds. **Mathew Harrison** is a specialist registrar in general adult psychiatry and medical psychotherapy in the Leeds and York Partnership NHS Foundation Trust. **Richard Brown** is a senior lecturer in clinical psychology and honorary consultant clinical psychologist in the Division of Psychology and Mental Health, School of Health Sciences, University of Manchester, Manchester Academic Health Sciences Centre. **Rajdeep Sandhu** is a locum consultant in old age psychiatry in the Pennine Care NHS Foundation Trust. **Peter Trigwell** is a consultant in psychological medicine in the Leeds and York Partnership NHS Foundation Trust. **Seri Abraham** and **Shazada Nawaz** are specialist registrars in general adult psychiatry in the Lancashire Care NHS Foundation Trust. **Peter Kelsall** is a specialist registrar in general adult psychiatry in the Pennine Care NHS Foundation Trust. **Rachel Thomasson** is a consultant neuropsychiatrist in the Salford Royal NHS Foundation Trust.

1.5.42 Community treatment orders in England: review of usage from national data

Daniel M. Bennett Andrew C. Bailey Alasdair D. Forrest

date

2018-10

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- *Community treatment orders in England: review of usage from national data*

We read with interest the paper by Gupta *et al* on community treatment orders in England.¹ This and other reports on the use of compulsory mental health powers are particularly welcome now, as legislation is being reviewed.^{2–4} Scotland’s distinct but comparable law and practice may be more relevant than those of the other jurisdictions mentioned. We are pleased to provide data from Scotland to broaden the picture and consider unique Scottish community provisions for mentally disordered offenders.

Community-based detention was made possible in Scotland by the Mental Health (Care and Treatment) (Scotland) Act 2003, enacted in October 2005. It allows mental health officers (social workers) with two supporting medical reports to apply for a compulsory treatment order (CTO). The Mental Health Tribunal for Scotland can grant either a hospital-based or a community CTO. The criteria are that: the patient has a mental disorder; medical treatment is available which alleviates the effects of the disorder or prevents it from worsening; without the provision of medical treatment there would be a significant risk to the health, safety or welfare of the patient, or the safety of any other person; the patient's decision-making ability with respect to medical treatment for mental disorder is significantly impaired; and the making of the order is necessary. Only the Tribunal can vary the powers between hospital-based and community provisions. Unlike in England and Wales, a community-based CTO can therefore be sought without admitting the patient to hospital and, when they are returned to hospital, it is by varying the order not by revoking it.

Gupta *et al* note that new CTOs in England have been stable at around 4500 per year over the past 5 years.¹ This is in contrast to Scotland, where the use of CTOs (with community-only powers) has increased from 11.2 to 20.5 per 100 000 population between 2008 and 2017.⁵ The proportion of CTOs with community-only powers was 44.9% in January 2017.⁵ If the legislation was similar in England (taking CTOs as a proportion of the total long-term sections, i.e. new CTOs and Section 3s), this was only slightly lower at 37% in 2014/2015.¹

Uniquely in the UK, Scotland also has a provision whereby a community-only compulsion order can be made by a criminal court (which is distinct from the equivalent of a probation order). Compulsion orders with community-only powers operate similarly to their civil equivalent, with breaches addressed by the mental health rather than the criminal justice system. In the 10 years leading up to 2017, three orders with community-only powers were made (where the patient was unfit or lacking criminal responsibility), representing only 2% of compulsion orders made in those circumstances.⁵ Over the same time scale, 14 community-only compulsion orders were made as disposals, representing 2.6% of such disposals.⁵ The role of community detention as a criminal disposal is therefore much less prominent in Scotland than in civil mental health legislation.

We hope this Scottish context adds to the review provided by Gupta *et al*, and we agree, having considered these figures for community-based detention, that it seems 'sensible to take whatever steps possible to see that it is used effectively'. We respectfully suggest that adopting a broader range of data and jurisdictions for such a study would assist in that regard.

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1.5.43 Dear BJPsych Bulletin...

Norman Poole

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date

2018-10

Abstract

The editor thanks the outgoing Correspondence Editor Greg Shields and welcomes Dr William Badenhorst as his successor. He reflects upon his own inadequacy as a letter writer in the hope it encourages others to be better.

Declaration of interest

None.

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- *Dear BJPsych Bulletin...*

I must confess that I do not often write letters. As a child I had to be cajoled and then threatened into composing thank you letters at Christmas. I assumed (wrongly, it turned out) that a mumbled ‘Thanks’ was quite sufficient. If only I’d known Heidegger’s arguments for the supremacy of the spoken word at the age of eight, my life would have been easier in so many ways. I’m still no better at postcards, notes of condolence, or work emails, and even texts feel just a little too much effort. It should come as no surprise that as a medical student I did not attempt to submit letters to the *BMJ* to gain an ‘easy’ first publication. Nor do I Tweet.

All this avoidance of letter writing would not appear to be good preparation for a career in psychiatry, however, and I am always immensely impressed by those who do put pen to paper. Freud was of course a prodigious writer of letters;¹ these are worth a read for the light they shed on the man’s foibles as much as the development of his ideas. His letter to the concerned mother of a young gay man,² in which he assures her that homosexuality is ‘nothing to be ashamed of’ and its persecution ‘a great injustice’, exemplifies the qualities of a good letter: crafted, lucid and brief, with a hint of wit. Not everyone can aspire to such prose, but the correspondence section of a journal is often its most lively and combative. Recent notable examples within these pages include the exchange between Sameer Jauhar and Allan Young³ and Joanna Moncrief,⁴ following her typically provocative paper in our *Against the Stream* series. I was also struck by Martin Plöderl and Clemens Fartacek’s admirably brief account of complexity theory in risk assessment in April’s edition.⁵ A well-written rebuttal can influence minds as much as any original paper, and quicker too.

Notwithstanding some admiration for the scribblers’ art, you can imagine my state of mind when our correspondence editor Greg Shields handed in his notice just a few weeks into my editorship. (A temporal relationship need not imply causality!) Greg has worked on the section for 2 years, but a first consultant post means he will now be frantically trying to keep on top of his own correspondence. I’d like to take this opportunity to thank Greg for his sterling work over the past couple of years and wish him all the best in all future endeavours. And I’m able to say this sincerely because in between his tendering his notice and now, we have interviewed for a new correspondence editor and, from a selection of three excellent candidates, appointed William Badenhorst as Greg’s successor. William is certified in both general adult psychiatry and medical psychotherapy so is trained to efficiently process and analyse the many letters sent to the *BJPsych Bulletin*. He promises a fair but firm approach to the publication of eLetters online and in the correspondence section of the journal. Sadly, not every submission realises each of the qualities listed above, and some none at all. Don’t let this put you off writing your own letter to the editor, however. Re-read this editorial and remind yourself, ‘I could do better than that’, then get going. Just don’t expect a reply.

Dr Norman Poole is Editor of the *BJPsych Bulletin* and Consultant Neuropsychiatrist at St George’s Hospital, South West London and St George’s Mental Health NHS Trust, UK.

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1.5.44 An evaluation of sleep disturbance on in-patient psychiatric units in the UK

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date

2018-10

Abstract

Aims and method

Sleep disturbance is common on in-patient psychiatry wards. This study explored subjective and objective patterns of sleep disturbance and contributory environmental factors. Participants were recruited from mental health acute admission wards and had a range of subjective and objective assessments of sleep. Light intensity and noise levels were measured to characterise potential environmental causes for poor sleep.

Results

We recruited 20 patients; 15% were high risk for obstructive sleep apnoea. Nineteen participants reported poor sleep quality on the Pittsburgh Sleep Quality Index, and 90% had significant sleep fragmentation with objective measures. Inside light levels were low (day <200 lux and night <10 lux). Night sound levels were 40–90 db.

Clinical implications

Sleep disturbance was highly prevalent. Increased awareness of sleep disorders is needed. Modifiable environmental factors on the ward were implicated, therefore increased awareness and a change of approach to sleep disturbance in in-patient psychiatry is recommended.

Declaration of interest

None.

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- *An evaluation of sleep disturbance on in-patient psychiatric units in the UK*
 - *Sleep disturbance in psychiatric disease*
 - *Overnight monitoring on psychiatry wards*
 - *Method*
 - *Results*
 - * *Actigraphy*
 - * *Light and noise levels across the wards*

– Discussion

* Limitations of the study

Sleep disturbance in psychiatric disease

The normal timing and duration of sleep is vital for normal mental health.¹ Poor sleep is a core symptom of many psychiatric conditions. However, sleep disorders such as insomnia, obstructive sleep apnoea, REM sleep behaviour disorder and circadian rhythm disorder are also common and remain underdiagnosed.² The frequent comorbidity of disrupted sleep and psychiatric disorder,³ and the negative prognostic effect of disrupted sleep, including on suicide risk,^{4,5} all demonstrate the challenge and importance for mental health professionals of assessing and protecting sleep when patients require admission.

Admission to a psychiatric unit represents both a particular need and opportunity to identify and manage disturbed sleep, including sleep disorders. However, it has been noted that sleep enhancement does not appear to be a priority on acute admission wards. In many trusts, for instance, hourly overnight monitoring of patients remains routine and is paradoxically used because of the risk of harm to the patient.

Overnight monitoring on psychiatry wards

Concerns about the risk of suicide⁶ place a perceived burden on staff in in-patient units to regularly monitor patients overnight. This monitoring can in itself further disrupt sleep and may therefore affect recovery. The standards for the safe care of patients on psychiatric wards by the Royal College of Psychiatrists⁷ do not include or specify protected sleep time, and current National Institute of Health and Care Excellence recommended in-patient pathways⁸ in acute hospitals make no mention of sleep beyond a single survey question about night-time disruption by staff. The best way to monitor, measure and enhance sleep on in-patient wards is unclear. We aimed to objectively assess sleep and the ward environment, and attempted to characterise patterns and causes of sleep disturbance on in-patient psychiatric wards.

Method

Participants were sequentially recruited from four acute psychiatric wards, two male and two female, in two separate in-patient units within Newcastle, Tyne and Wear NHS Foundation Trust. Recruitment was opportunistic, with all patients meeting the inclusion criteria being considered for the study. Inclusion criteria required that participants were aged 18–70 years, able to provide written informed consent and were fluent in English. All participants had capacity to consent and written consent was obtained after a period of at least 24 hours to consider the details of the study. Patients were approached after 72 h on the ward and were included in the study if they were expected to be staying on the ward for at least a 1-week period.

Sleep quality was then assessed with the Pittsburgh Sleep Quality Index (PSQI)⁹ and the risk of sleep apnoea was assessed with the STOP-BANG questionnaire.¹⁰ Using the PSQI, participants were categorised as having normal sleep (score <5), some level of sleep disturbance (score 10) or severe sleep disturbance (score >10). The STOP-BANG questionnaire is a validated screening tool for sleep apnoea. Participants scoring 5 were considered high risk for obstructive sleep apnoea. If a participant was found to be high risk for obstructive sleep apnoea, this was communicated by letter to their general practitioner.

Objective sleep quality was assessed with a wrist accelerometer with a light monitor (GENEactiv original). Participants were asked to wear the watch continuously for a week. Participants who continuously wore the wrist accelerometer for five or more continuous days and nights were included in the study (20 out of 32). The algorithm for analysis has been published and used to assess sleep–wake disturbance in those with and without mental health problems.^{11,12} Total sleep time, daytime naps and sleep fragmentation were all measured. Twelve participants were excluded because of incomplete data: patients were discharged sooner than expected, and for two participants, wearing the watch itself caused agitation and was not tolerated.

Participant medical records were accessed for basic demographics, current and past psychiatric history and any reference to sleep difficulties.

Sound level and light level were identified as potential environmental factors that could affect sleep quality. Monitoring of sound level was carried out with a decibel-metre (Extech 407760). The night-time noise level between 21.00 and 09.00 was analysed over three consecutive nights on two separate wards. Data was measured continuously to allow both baseline average to be calculated and spikes of higher decibel levels to be seen. An unused bedroom was used to avoid disturbing patients with the monitoring equipment itself.

Daytime and night-time light levels were measured with a portable lux meter (MINOLTA chroma meter cs-100). For daytime measurements, the lux level within the bedrooms, communal areas and dining areas across all the wards was measured. Once selected, the same areas were used for repeated measurements. Measurements were averaged over two separate days to account for any differences in inside light level attributable to outside light level. Light measurements were also taken at night-time after 22.00. Night-time measurements focused entirely on the patient bedrooms and were taken on two separate occasions on each ward.

Ethical approval was granted for the study by the East of England – Cambridge East Research Ethics Committee (approval number IRAS 222122).

Results

Over the study period (April 2017–July 2017), there were 150 admissions to the four study wards. Of these, only 40 met the inclusion criteria, mostly because of lack of capacity to consent or short duration of stay. Thirty-two patients agreed to participate and completed both the PSQI and STOP-BANG questionnaire. Twenty participants then provided five or more continuous days of accelerometry recording, and this group were analysed in more detail and the results are presented below. The median age of participants was 49 years (range 30–70 years). Female participants outnumbered male participants by a factor of just over 2:1, (13 women and 7 men). Depression was the most common primary diagnosis, followed by bipolar affective disorder and schizophrenia. Only a single patient had a diagnosis of mania during the admission.

All participants completed the STOP-BANG questionnaire, and three (15%) scored 5 and were therefore at high risk for having obstructive sleep apnoea. All three were male, aged 48, 51 and 57 years, respectively, and all had objectively abnormal sleep as measured by accelerometry, with prolonged sleep period and fragmented night sleep.

Nineteen participants had a global PSQI score 5, representing poor sleep quality, and 12 scored >10 in the more severe range. The single patient with mania self-rated sleep as normal, with a PSQI score of 4, but had objectively abnormal sleep on actigraphy, with irregular, short sleep periods. The range of PSQI scores was between 4 and 18. Fourteen participants scored 10 (severe sleep disturbance). The separate domains of the PSQI were also assessed with previously published subscales looking at sleep efficiency, daily disturbances and perceived sleep quality to see if there was one domain more likely to cause sleep disturbance. 13 Patients all had multiple causes of sleep disturbance including, but not exclusive to, the ward environment. All participants were prescribed some form of psychotropic medication, with 18 participants receiving multiple medications and 8 participants prescribed zopiclone for sleep disturbance.

Actigraphy

Twenty out of 32 participants wore the accelerometers continuously for five or more days. Representative actograms from six participants are shown in *Fig. 1*. Variable patterns of sleep and physical activity were easily visualised over 5–7 days of accelerometry. Participants were categorised as long (average duration of >10 h sleep in a 24 h period), short (<6 h within a 24 h period) or normal sleepers, with regards to the total amount of sleep achieved in 24 h. Eighteen participants had fragmented sleep during their main sleep period, with frequent night waking. No patient had an average sleep period of less than 6 h when on the ward, although three self-rated their sleep as short. Three were (15%) long sleepers and seven (35%) had sleep duration between 6 and 10 h. *Fig. 1* Accelerometry data from six patients showing variable sleep–wake patterns. For all participants, wrist accelerometry data is shown plotted over sequential days from 12.00 to 12.00 over a 48 h period to show the overnight sleep period. Periods of sleep can clearly be seen, as well as sleep fragmentation and night-time awakenings. (a) Female, 70 years of age with a diagnosis of schizophrenia.

A pattern of prolonged sleep with occasional night-time awakenings is seen and daytime naps. (b) Female, 59 years of age with depression. There is reduced daytime activity with naps, and also a very fragmented and prolonged total sleep time. (c) Male, 44 years of age with schizophrenia. There is a shorter sleep time, higher levels of daytime activity and a less fragmented sleep period. (d) Male, 53 years of age with depression. There is a pattern of prolonged sleep, fragmented night-time sleep and prolonged daytime naps. (e) Male, 39 years of age with schizoaffective disorder. There is a more delayed sleep onset between 00.00 and 02.00, with a wake time at 12.00. (f) Male, 48 years of age with depression, alcohol dependence and post-traumatic stress disorder. A striking pattern of delayed sleep phase is seen, with the sleep period during the day and high levels of activity at night.

Actigraphy results showed marked sleep fragmentation and night-time awakenings. It was apparent that light levels were intermittently increased during the night within the patient rooms, consistent with a disturbed night and often coinciding with night-time observations. Many of the long sleepers had fragmented nights with frequent awakenings. Prolonged daytime naps were also seen.

Light and noise levels across the wards

The sound level data showed that the wards maintained an overnight decibel level within a range of 38–70 db, between 21.00 and 05.00, with occasional spikes that reached 90 db. There was variation across the wards and a gradual rise in noise level between 03.00 and 07.00 across the wards to 45 db as an average background. Some causes of the brief spikes in noise included equipment alarms and safety doors closing.

Light intensity was measured across the entire unit and the data is summarised in *Table 1*. Throughout the in-patient areas, there was a very low level of light intensity across all communal areas. None of the indoor areas had a light intensity similar to that outdoors, however the light levels within the bedroom were very low. *Table 1* Mean light levels in different locations

Location	Mean light levels (lux)
Ward A	11.15
Ward B	15.35
Ward C	15.00
Ward D	11.15
Bedroom – door closed	23671138
Bedroom – door open	22881044
Bedroom – light on	231464752
Communal area	37326164221
Dining room	745012058
Outside	11 528
Night-time (approximate time)	23.1522, 4022, 4023, 30
Bedroom – door closed	0000
Bedroom – door open	0.30, 10, 80
Bedroom – side light on	3.73, 654, 1 ¹

Discussion

Subjective assessment of sleep quality showed disturbed sleep for almost all participants (19 out of 20), with marked sleep disturbance reported by 60%. The PSQI was tolerated well and completed by all patients, suggesting a variety of factors affecting sleep quality. Objective measures of sleep also showed significant sleep disturbance, and in particular sleep fragmentation, when measured with accelerometry. One potential cause was the hourly nightly observations, as fragmentation appeared regular and consistent in many participants along with brief periods of increased light levels, and all participants were subject to these hourly checks. We accept that this is simply one potential cause of sleep disturbance, as that it was not possible to correlate actigraphy at all times with the light and noise measurements, given the prolonged period of actigraphy over a 4-month period. However, if patient sleep is being disturbed by these checks, the implication is that this process could be counterproductive, slowing recovery because of the effect of sleep disturbance on mental health. The importance of regular observations is acknowledged in those at high risk of harm (accounting for a number of patients on the study wards); however, the most recent review from the National Confidential Enquiry

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On each ward, measures were taken at approximately the same time on one cloudy day and one sunny day and the mean was calculated (May 2017). At night-time, measures were also taken on two separate days and a mean calculated.

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into Suicide⁶ emphasised the need for a personalised care plan and the avoidance of routine checklists. Reports from this group have suggested that routine observations are not helpful and yet they remain widespread across acute mental health trusts throughout the UK.

There are clearly a number of potential reasons for sleep disturbance within an in-patient psychiatric population, including the mental health symptoms themselves and the medication used to treat symptoms; however, primary sleep disorders such as obstructive sleep apnoea are common in those with severe and enduring mental health problems, and will affect sleep quality and contribute to nocturnal hypertension.¹⁴⁻¹⁵ Risk factors include male gender, body mass index and obesity and age >50 years. It is notable that 15% of patients were high risk for sleep apnoea based on sleep questionnaire screening and all were male. Any in-patient admission offers an opportunity for physical health assessment, with increasing recognition of the poor cardiometabolic health of many with psychiatric disease.¹⁶⁻¹⁷ Obstructive sleep apnoea may be ameliorated by rationalising medication that may contribute to obesity and snoring (e.g. benzodiazepines) and via the effective, evidenced-based therapy of continuous positive airways pressure.

The ward environment may also be a modifiable part of sleep disturbance. It seems likely that sound levels were a contributory factor to sleep fragmentation. The sound level for both wards exceeded the recommended night-time noise level for a hospital ward of 30 db.¹⁸ They remained between 40 db (equivalent to the sound in a library) and 70 db (equivalent to the noise produced by a vacuum cleaner) during the overnight period. The occasional spikes of a much louder noise, which reached up to 90 db (equivalent to the noise produced by a food blender or a lawn mower), are likely to disrupt sleep. There have been previous reports highlighting concerns about noise pollution affecting health in hospitals. This seems an important and potentially modifiable part of night-time sleep disruption.¹⁹

The light levels recorded at night with the bedroom door shut did not exceed 1 lux. This implies that the night-time light environment of patient bedrooms is conducive for sleep when the doors are not opened for observations. At night, with the side light, the light levels recorded were <10 lux in the bedrooms. Daytime light levels, however, were also low, never exceeding 200 lux across the unit and <50 lux in the bedrooms. The retinohypothalamic tract controls circadian rhythm and is dependent on light intensity for normal function.²⁰ Lack of exposure to adequate light intensities may contribute to the dysregulation of circadian rhythms, which is increasingly recognised in psychiatric disorders and may, in turn, contribute to the tendency toward daytime napping and irregular sleep patterns, and may affect the ability of the patient to engage with psychological or occupational therapies.²¹ These data suggest that the light environment of psychiatric wards should be improved and highlight the importance of time off of the ward in outside spaces with natural light.

Limitations of the study

It was not possible to time-lock sound measurement to accelerometry data, as two different methods of recording were used. For future studies, more detailed in-patient assessments, such as video polysomnography, could be used or time-locked continuous video monitoring; however, this detail of recording may in itself cause patient agitation if symptoms such as paranoia and delusional ideation are present. Accelerometry was reasonably well tolerated but still only worn continuously for 20 out of 32 participants. Therefore, non-invasive methods of recording sleep-wake patterns are needed for this population to avoid distress. There has been only a single, smaller study that compared nursing observations, patient sleep diaries and 3 days of wrist actigraphy in eight patients in their initial 3 days on a psychiatry ward. This showed that nursing staff tended to overestimate sleep and that patient sleep improved from the first to the third night.²² This was one reason that we assessed all patients at least 72 h after admission.

The sample size was relatively small, and the study was not powered to look for significant differences across, for example, different diseases or those on or off of different psychotropic medication. A lack of capacity to give informed consent and short stay duration was a reason for many on an acute ward being unable to participate in the study. Therefore future studies may need to recruit over a longer time period to increase the sample size. This remains the first UK study to date to study sleep within acute psychiatry wards.

In summary, the results of this small study demonstrate high levels of sleep disturbance on in-patient psychiatric wards and variable patterns of sleep-wake disturbance. Sleep disturbance affects mental health and so should be a factor when developing care pathways; however, to date, there has been very little qualitative or quantitative research in this area. Some level of sleep disturbance may relate to ward environment and some may relate to an undiagnosed primary sleep

disorder. Therefore, further studies that evaluate a sleep care plan as part of standard in-patient care are recommended.

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1.5.45 Alan Haworth, OBE (UK), GDCS (Zambia), FRCPsych.

Chris Haworth

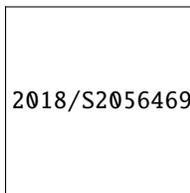
date

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- *Alan Haworth, OBE (UK), GDCS (Zambia), FRCPsych.*

Head, Psychiatry Service, University of Zambia, Zambia



Alan Haworth, who died on 17 December 2017 at the age of 89 was a pioneering psychiatrist who, over a long period from 1964 until he retired in 2013, established psychiatric services in Zambia. Shortly after his death, the Zambian Minister of Health issued a statement describing him as ‘the father of mental health among the medical fraternity of Zambia’. When he arrived in Zambia, first as a missionary doctor and shortly afterwards as a psychiatrist in the government medical service, the mental health services were extremely limited or, in most parts of the country, non-existent. Haworth took up government positions and had a pivotal role in setting up the mental health services of newly independent Zambia. Following this, he became Head of the Psychiatry Department at the University of Zambia. He set up the National AIDS Counselling Services Unit (at the National Mental Health Resource Centre (NMHRC)) and remained its head for 17 years. He was elected National President of the Zambian Red Cross.

Most importantly, as Chairman of the paramedical committee of the Medical Council of Zambia, he drafted a new Medical and Allied Professions Bill. This enabled the registration of paramedics after highly regulated training, and their substantial but controlled contribution to general healthcare in a country which, at the time, had only a fragmentary health service and hardly any higher educational facilities. Under Haworth’s leadership, Zambia established its own medical school. This enabled a build-up of resources for supplying suitable workers at all levels and the establishment of a healthcare system modelled on the Alma Ata declaration on primary healthcare.

His second achievement was the development of a system for the provision of countrywide mental healthcare, integrated into primary healthcare, and ensuring that the training of various types of specialised workers could take place in close liaison with generic health workers. In an article published in 1988, he described the first 25 years of his experience as a psychiatrist in Zambia.¹ This initially involved travelling around the country by air in an ageing Dakota for three weeks out of four, visiting medical facilities to establish mental health clinics. He developed a course for clinical officers in psychiatry who worked in communities around the country.

In 1972, he applied to the World Health Organization (WHO) for funding to enable him to visit universities in African countries. An invitation from the WHO to participate in a multicentre study of community response to alcohol-related

problems seemed to be mapping a future area of specialisation, but the advent of AIDS in Zambia forced a change and led to what he considered his third most important achievement in the field of health. He was asked to join an AIDS management group and became Director of the Zambian Ministry of Health AIDS Counselling Services Unit. Crash training programmes with some elements of counselling were developed and were adopted by many organisations within and outside Zambia, while Haworth himself became deeply involved in many HIV-related projects, the most important concerning couples' counselling, as well as the long-term monitoring and testing of discordant couples drawn from over 35 000 couples recruited. As a member of the board of an NGO he had set up, in response to the AIDS epidemic and as National President of the Zambia Red Cross Society, he was soon involved in the plight of children (on the streets, as victims of abuse and at risk of acquiring HIV). He took part in a series of studies and helped set up a 'one stop' specialist unit for victims of child sexual abuse at the teaching hospital. He was one of the five founder members of the Family Health Trust. He acted as Chair, ensuring that the organisation would meet the needs of orphans and vulnerable children and women, and that people living with HIV/AIDS were well looked after.

Alan had some special assignments requested of him, first in Zambia where he advised on the approach to the members of a religious cult who had engaged in bloody fighting against the new government. Then, in Congo, he was asked to advise on the possibility of accepting as refugees into Zambia 'boy soldiers' who, with a group of mercenaries, had rebelled against Mobutu. Since they were currently under siege by the Congolese National Army, Haworth found himself under fire, looking after wounded rebels. He reported how he found this less stressful than being caught up in subsequent diplomatic shenanigans. He remained in close contact with 'freedom fighters' from South Africa and Zimbabwe and did consultancies in Mozambique and Liberia on a WHO mission, where he was briefly hijacked by a group of warlord Charles Taylor's soldiers. Throughout his professional life, he seemed to be on the fringes of violence, having once been within seconds of being lynched himself. This experience gave him confidence to know when to intervene, and he certainly prevented at least one other lynching. Called to see a close friend with a serious gunshot wound to the head in a third assassination attempt, he met the former President of Zambia, Kenneth Kaunda, who showed him his own linear graze made by a bullet across his scalp incurred in the same episode.

Haworth received public honours both in the UK and in Zambia. In the UK, he was awarded the OBE for services to medicine. He was made a Grand Commander of Distinguished Service by the President of Zambia in recognition of his services to psychiatry.

Alan Haworth came from an extremely modest background. His parents had both left school at the age of 13, his father to work as a cotton spinner and his mother as a seamstress. Brought up on a council estate in Blackburn, he won a place at the local grammar school. Then, after National Service in the RAF, he studied medicine at Cambridge and the London Hospital. While still a medical student, he had offered to become a missionary and was sent to work in Northern Rhodesia (now Zambia).

Early in his career, while working on prison medical duties, he had several conversations with Zambia's future first president (Kenneth Kaunda), then under detention, and these had a significant influence on his future career.

He never married. However, in 1979, following the tragic death of his cook of 17 years, he took over the care of the widow and her seven children. They became his adopted family. Almost 40 years later, the grandchildren and great-grandchildren of this family claimed that even if he looked different, as far as they were concerned, he was their real grandparent.

Alan's activities began to be curtailed in 2013, owing to ill health, and he returned to Blackburn, where he had been brought up. He had a passion for classical music and spent many long hours in his final years attending the Leeds Piano Competition.

Alan will be remembered as he wished, as a loving grandfather and uncle by his English family, and as a kindly, caring and understanding doctor by his patients. His many former students think of him with affection and respect.

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1.5.46 Robert Spitzer's legacy: agreement is halfway to truth

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Abstract

Bob Spitzer died in December 2015 but is not likely to be forgotten quickly. His Herculean task in reforming psychiatric diagnosis, mainly by the development of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* in 1980, has been acknowledged by many, but it remains unfinished. To complete the process, we need more than good diagnostic reliability, we need better veracity.

Declaration of interest

None.

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- [Robert Spitzer's legacy: agreement is halfway to truth](#)

Most psychiatrists will have heard of Robert Spitzer, but outside the USA he is essentially known for his association with DSM-III, the defining third edition of the *Diagnostic and Statistical Manual of Mental Disorders*.¹ Even this association took some time to establish, and in my lectures I used to explain that the rather unusual name of Spitzer was only an acronym for 'Structured Psychiatric Interviews To Zealously Enhance Research', until people started to believe he was not a real person. Then I stopped.

Shortly after this, I was giving a lecture on the classification of personality disorder in the USA. It was a fairly light-hearted event, and I presented the talk as a debate between two protagonists, one supporting a categorical classification and the other a dimensional one. When I was criticising borderline personality disorder from the dimensional perspective, I joked, 'the classification of borderline personality disorder in DSM-III was only approved after a dead heat on the vote, so it was decided to include it by the casting vote of the chairman. Is this the way to organise a classification system?'

A voice growled from the audience: 'What's the matter with you? Don't you believe in democracy?' The voice came from Robert Spitzer. I have thought about this event continually since and concluded that the single word that summarises the work of Robert Spitzer is 'agreement'. This needs explanation.

Before 1980, international psychiatric classification was in a mess. There can be no other word for it. There were large national differences in the incidence of major mental disorders such as schizophrenia,² fractured understanding because of conflict between psychodynamic and organic schools, and a general cynical attitude towards diagnosis by clinicians, who essentially picked a treatment first and gave the nearest diagnosis afterwards.

Robert (Bob) Spitzer changed all this with his approach to DSM-III. He, and the American Psychiatric Association, recognised that, without substantial agreement in diagnostic assessment, psychiatry was going nowhere. Robert had developed a system using operational criteria to improve diagnosis in research, and now he was being asked to extend this to clinical practice. This was a much taller order than might be thought. Clinicians in busy practice do not take

kindly to research-based formats, and operational criteria had to be understood by everybody if they were going to be accepted.

Once a rough set of criteria had been developed, it was necessary to test them in practice. Nowadays, this would be carried out in the form of field trials; Bob did not have the time, or the resources, for these. So he organised a set of mass colloquia. All the experts in each given field were invited to meet with him at the New York Psychiatric Institute to sort out the new diagnostic prototypes. In this task, Bob became the Great Persuader. As was noted by David Shaffer, one of the experts brought in to examine diagnoses in child psychiatry, these occasions were fairly chaotic, but Bob was clearly in charge and was found everywhere arguing about detail; a key element of all these meetings was that they continued until agreement was reached on all essentials.³ Sometimes, fatigue became the defining factor in getting this agreement; it can be a most effective enabler.

Within days of each meeting, Bob had produced a summary of each meeting in which a new classification emerged with all the levels of agreement listed. A few people scratched their heads – ‘did I really agree to that’ – but they were persuaded by the stellar company of other experts that this was indeed the right way forward. So, when Bob sent in his list of revolutionary proposals to the American Psychiatric Association, he had all the authorities in each field signed up to the new system, and so it had to be accepted.

Views about the DSM-III since its publication in 1980 have oscillated widely. The system of operational criteria worked well for some diagnoses, but not for others such as personality disorder,^{4,5} and there is continued argument over the status of the portmanteau diagnosis of ‘major depressive disorder’, which covers too wide a range of pathology.⁶ Although Spitzer is credited with the removal of homosexuality from psychiatric diagnosis in the 1970’s, it still appeared in DSM-III. There has also been criticism of the expansion of diagnoses and suggestions, some warranted but others unfair, that some of the new diagnoses were engineered to suit the products of pharmaceutical companies.

With each successive version of DSM, the contribution of Bob Spitzer has receded and the volume of dissent has increased, perhaps illustrated most forcefully in the popular writings of Allen Frances.⁷ But Bob kept an eye on these DSM revisions and was far from happy with many of them, particularly when they deviated from his firm notions about agreement, which he was not slow to express.⁸

Of course, agreement is not everything, and the search for validity has to follow. Since DSM-III was published 38 years ago, we have made only the slightest furtive steps towards the aim of independently verified psychiatric diagnoses. Bob Spitzer showed the way, quite brilliantly, but he left us halfway down the track, and it is now up to others to finish the race.

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1.5.47 Maintenance doses for clozapine: past and present

Avneet Sharma

date

2018-10

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- *Maintenance doses for clozapine: past and present*

We recently completed a quality improvement project for patients on long-term clozapine treatment, with the main aim of assessing the side-effect burden with a view to optimising the treatment. We compared our current clinical practice with one described in a publication 20 years ago in the *BJPsych Bulletin* in 1998 on maintenance doses for clozapine.¹

Murphy *et al* presented findings on 44 patients who had been on clozapine for 6 months or more. Our patient number was 41, and the information was retrieved from electronic case records, although this did not make the job easier as the relevant information was scattered across time and in different sections of the record system.

The patient group in Murphy's study had a mean age of 38 years (21–62 years) with 35 males and nine females, the majority being Caucasian, with a mean duration of clozapine treatment of 38 months (7–69 months). The highest treatment dose prescribed ranged from 300 to 900 mg per day (mean 568 mg), with 50% patients on 500 mg per day or less; only one patient received the maximum dose of 900 mg. The current or maintenance doses of clozapine ranged from 150 to 750 mg per day (mean 460 mg), with eight patients on doses of 150 and 300 mg per day. This was within the British National Formulary (BNF) guidelines at the time (BNF: number 33, March 1997), which clearly differentiated between the higher doses (200–450 mg daily, maximum 900 mg) required initially to stabilise the mental state, and the lower doses (150–300 mg daily) required subsequently for maintenance treatment. The authors found that dosage reductions had been achieved in 29 cases, while there was no attempt to reduce the dose in the majority of the rest of the patients, owing to partial response or less-than-expected symptom control.

Our group included older patients with a mean age of 44 years (29–70 years), who were predominantly Caucasian, with 30 males and 11 females. The mean duration of treatment with clozapine was more than 10 years (range 1–30 years). The dose ranged from 200 to 900 mg per day, with a mean dose of 405 mg per day; 25 patients were on doses between 300 and 500 mg per day, which would have been deemed higher by the BNF guidelines of 1997.

We found that that 80% of patients reported significant side-effects including drooling, sedation/tiredness, gastrointestinal symptoms, weight gain, urinary incontinence, and constipation. Also, a significant proportion (50%) were on medication for side-effects, generally in combination. There were significant metabolic problems, with an average body mass index (BMI) of 29.40 and most of the patients (apart from five) having a BMI above 23; two cases were diagnosed with diabetes and on treatment.

We also found that there had been no reduction in clozapine doses in any of the cases over the past 7 years including more recent cases. Of course, one big difference is that there are no current BNF guidelines for maintenance doses for clozapine; BNF (September 2016–March 2017) mentions a usual dose range for clozapine of 200–450 mg per day that one needs to titrate to when starting clozapine.

The side-effect burden on its own should be enough to make clinicians keep dose review on the agenda on a regular basis. Owing to large variations in metabolism, it is hard to predict the optimum dose and plasma level in an individual patient; the manufacturers² advise that once maximum therapeutic benefit has been established, many patients can be maintained effectively on lower doses with careful downward titration. The past BNF guidelines regarding maintenance doses were thought to be not based on evidence,¹ but empirical; it may be time to revisit the past, as patients appeared to be getting a better deal.

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1.5.48 Michael Graham Gelder MA, DM Oxon, FRCP, FRCPsych (Hon), FMedSci, DPM

Philip J. Cowen

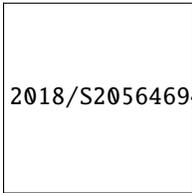
date

2018-10

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- *Michael Graham Gelder MA, DM Oxon, FRCP, FRCPsych (Hon), FMedSci, DPM*

Formerly Foundation Professor of Psychiatry, University of Oxford, UK



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As a young clinical researcher at the Institute of Psychiatry in London in the 1960s, Michael Gelder was only too aware of the need for better treatments of the ‘neuroses’. Management of these conditions was limited to dependence-producing anxiolytic medications and lengthy psychoanalytic psychotherapies, neither of which were particularly effective. Around this time, psychologists had begun to apply learning theory to clinical anxiety disorders, which were conceived as a manifestation of faulty learning or, more specifically, the failure to ‘extinguish’ anxiety that was contextually inappropriate. However, it was not until Gelder’s work that these ideas influenced mainstream psychiatry. Gelder, with his characteristic intellect and scientific rigour, developed effective clinical methods to lessen anxiety by ‘desensitisation’, in which gradual exposure to the feared stimulus was coupled with physical relaxation. This resulted in his seminal 1966 publication with Isaac Marks, which described the first controlled trial of this form of therapy in patients with severe agoraphobia.¹

A few years later, Gelder’s growing reputation as someone able to carry out original and clinically important research across disciplinary boundaries led him to be recruited to the Foundation Chair in Psychiatry at the University of Oxford. Arriving at the Warneford Hospital in 1969, Gelder’s task was to establish from scratch, and with limited resources, a world-class psychiatric research department, as well as organising and conducting undergraduate and postgraduate teaching and sharing in the clinical work of the hospital.

These goals were formidable, but Oxford had chosen well. Rather unusually for a brilliant researcher and clinician, Gelder also possessed remarkable organisational abilities and committee skills, which he used tirelessly and selflessly to build a thriving Department of Psychiatry, one recognised as a world-leading centre for the development and clinical application of psychological treatments.² Early work on agoraphobia used home-based methods to enhance the effectiveness of the behavioural therapy he had developed at the Institute of Psychiatry. Although this was a major advance, Gelder was quick to realise the limitations of a purely behavioural approach and encouraged exploration of the value of adding cognitive strategies, focusing on modifying thoughts, attention and memory. The Oxford Centre that he led was distinguished by an unusually close interplay among psychological theories, experimental studies and clinical innovation – a particularly productive approach. New and highly effective forms of cognitive-behavioural

therapy were developed for panic disorder, generalised anxiety disorder, social anxiety disorder, obsessive–compulsive disorder, hypochondriasis, post-traumatic stress disorder, chronic fatigue syndrome and bulimia nervosa. These cognitive–behavioural treatments have been widely adopted in clinical practice, are recommended by the National Institute for Health and Care Excellence and provide better long-term outcomes than alternative approaches such as antidepressant medication. They have benefited enormous numbers of people worldwide.

In addition to his personal interest in psychological treatments, together with David Grahame-Smith, Nuffield Professor of Clinical Pharmacology, Gelder developed a research unit for the equally new field of psychopharmacology. At the time, this was an almost unique example of cross-departmental collaboration in the Oxford Medical School. The unit's work on the mechanisms by which treatments such as electroconvulsive therapy, anxiolytics and antidepressants actually work has fundamentally shaped our understanding of the biology underlying psychiatric disorders.

Michael Gelder was born in 1929 in Ilkley, the only child of Philip Gelder, a wool merchant, and Alice Gelder, the daughter of a general practitioner. The family soon moved to Bradford, where Gelder attended the local grammar school. Gelder had a longstanding desire to study medicine, but his parents discouraged this ambition, arguing that he should join his father in the family business. However, Gelder persisted, taking science A-levels at evening classes and then winning a scholarship to Queen's College, Oxford, where he took first class honours in physiology. A further scholarship to University College Hospital allowed him to complete his medical training, which was followed by National Service as a Medical Officer at the British Army of the Rhine Headquarters from 1956 to 1958. Through his medical training and early clinical work, Gelder became intrigued by the pervasive role of psychological factors in medical practice. This led him to embark on his training in psychiatry at the Maudsley Hospital, during which he won the prestigious Gaskell Gold Medal of the Royal College of Psychiatrists. Strongly encouraged by Professor Aubrey Lewis, he then worked as a Medical Research Council Research Fellow at the Institute of Psychiatry.

Gelder led the Oxford Department of Psychiatry until his retirement in 1996. He was notable for 'leading from the front', attending all departmental academic meetings, as well as carrying a significant clinical and teaching load. His unparalleled lucidity of thought and encyclopaedic knowledge made him an inspirational teacher; this was captured particularly in the Oxford Textbook of Psychiatry, which he co-authored with Dennis Gath and Richard Mayou. Translated into six languages, this became the standard textbook for psychiatric trainees. One of his most important priorities was to foster the talented young clinicians and scientists who joined his department. Many went on to be leaders in the psychiatric and research communities.

Although Gelder served on major research committees of the Medical Research Council and Wellcome Trust, he had no interest in the personal accumulation of power, and was self-deprecating and modest. Invariably dressed in a grey suit and tie – even when walking his Alsatian dogs – he had a formality of manner, which, coupled with his intense drive for clinical and scientific excellence and his formidable intellect, could make him a somewhat forbidding figure. However, patients spoke of his approachability and kindness, while trainees would comment on how his acute clinical perception and genuine concern for them helped them cope with and learn from the most difficult of situations.

This side of Gelder's nature was, of course, well-known to his family. His daughter Fiona remarked that, as a father, 'he was kind, fair and unfailingly supportive of us all – in school life, marriage and work decisions'. She is a general practitioner, Colin is a chest physician and Nicola runs her own business. Gelder met his wife, Mandy, when he was a medical student at University College Hospital and she was a nurse. Gelder regarded persuading her to marry him as his greatest achievement, and he was devoted to her throughout their nearly 64 years of marriage, showering her with flowers on anniversaries and Valentine's Days.

In retirement, Gelder was able to find more time to indulge his love of travel. He had a wide circle of fond and loyal friends who would have been astonished to learn of the trepidation he had sometimes engendered in junior colleagues. When he gained an Italian son-in-law, he joined Italian classes and at the wedding gave a speech in both English and fluent Italian. Until arthritis supervened, he continued to play real tennis at Merton College, where he was a Fellow. He was an affectionate and attentive grandfather to his eight grandchildren, one of whom, to his delight, recently qualified in medicine.

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1.5.49 Individuals seeking gender reassignment: marked increase in demand for services

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Abstract

Aims and method

To describe the pattern of referrals and characteristics of people aged over 18 seeking gender reassignment in Oxfordshire over a 6-year period (2011–2016).

Results

A total of 153 individuals attended for assessment (of 162 referred); 97 (63.4%) were natal males and 56 (36.6%) were natal females. Mean age at referral was markedly different between the two groups, with females being younger. The number of referral significantly increased over the time period, by an average of 18% per year (95% CI 1.08–1.30). Eighty-seven patients sought transition from male to female, and 46 from female to male, while a smaller group ($n = 13$) had non-binary presentations. Twelve patients (7.8%) had autism spectrum disorder.

Clinical implications

There are various possible reasons for the increased demand for services for people with gender dysphoria, which we discuss here. When planning services in the UK, both the increase in overall referral rates and the apparent earlier age at referral should be taken into account.

Declaration of interest

None.

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- * *Educational level*
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 - * *Consideration of reasons for changes in referral patterns*

Gender dysphoria is the personal experience of dissonance between assigned and desired gender. It has always been considered to be a rare disorder, but in recent years there has been an extraordinary increase in the number of referrals to both adult and child and adolescent gender clinics, with services becoming overwhelmed.^{1–3} Five years ago, our group published a service evaluation of referrals to the adult (age 18 onwards) Oxford Gender Clinic between 2004 and 2009.⁴ In this 5-year period, there were 56 referrals. We found levels of psychiatric morbidity to be lower than described in other samples, and there were significantly more individuals seeking male-to-female transition (70%) than female-to-male transition (30%). The natal females (those assigned female at birth) were significantly younger than their natal male counterparts at referral. However, since 2011, there has been an increase in referrals to gender clinics, in particular to child and adolescent services,^{2,3} which has been noted in systematic reviews of prevalence as well as being the subject of considerable discussion in the media.^{5,6} We wanted to determine whether a similar pattern was occurring in services designed to cater for individuals aged 18 and over.

All individuals who request treatment for gender dysphoria in Oxfordshire are referred to a single clinician (C.B.) for psychiatric assessment and subsequent referral to a specialist centre. We aimed to review case notes for all referrals from 2011 until 2016 and to answer the following questions. (1) Have referral patterns changed over time? (2) If so, what are the main demographic and clinical characteristics? We also discuss possible reasons for any changes in referral patterns.

Method

Individuals referred to C.B. between January 2011 and December 2016 were identified from a referral database kept by the Gender Clinic based in the Emergency Department Psychiatric Service at the John Radcliffe Hospital in Oxford. C.B. and J.F. reviewed case notes, and data were extracted and entered into a spreadsheet. All patients who had attended an appointment had had a full psychiatric assessment, as well as a review of any available medical records, such as the general practitioner (GP) summary. All patients were asked at assessment about current or past hormone therapy (prescribed or non-prescribed).

Patients were excluded if they were seen for follow-up only (i.e. they had been referred prior to the start of data collection) or if they had been referred after having previously transitioned. Two patients were also excluded owing to rare conditions: as this was a service evaluation, specific consent was not required, and the small sample size and unusual nature of the conditions meant that there would be concerns about the individuals being potentially identifiable. Data on age at referral were analysed with independent sample *t*-tests using IBM SPSS Statistics version 24.0, and the relationship between year of referral and numbers of referrals was examined using a negative binomial regression model in Stata, version 12 (StataCorp).

Results

Demographic characteristics

From a total of 164 referrals received, 153 individuals attended for assessment. The majority of patients were referred for initial assessment, and the 'did not attend' rate was low at 5.6%.

The numbers of referrals, in 6-monthly intervals, between 2011 and 2016 are shown in *Fig. 1*. *Fig. 1* Referrals for gender dysphoria from 2011 to 2016.

Analysis of the numbers of referrals over time from 2011 to 2016, with data in 6-monthly intervals, was performed using a negative binomial regression model. This showed that the relationship between the numbers of referrals and year was significant at $P < 0.001$. The incidence rate ratio was 1.18 (95% CI 1.08–1.30), meaning that, on average, each year saw an average increase in the number of referrals of 18%. When the analysis was repeated separately by natal sex, the number of referrals of both natal males and females increased significantly over time, but there was no significant difference between the natal sexes in the relationship between number of referrals and time.

The increase appeared most marked in the second half of the time period: the number of referrals nearly doubled over the 6 years, with 59 referrals from 2011 to 2013 and 103 from 2014 to 2016. Furthermore, mean ages were significantly lower in the latter 3 years compared with the first 3 years (a mean of 5.7 years younger, $t(112) = 2.4$, $P = 0.018$) (*Fig. 2*). *Fig. 2* Mean age at referral.

Gender characteristics

Of the 153 individuals who attended for assessment, markedly more were natal males (97, 63.4%) compared with the 56 (36.6%) who were natal females (*Fig. 3*). The natal females were significantly younger than their male counterparts at referral: there was a mean difference of 10.5 years ($t(160) = 5.5$, $P < 0.001$), with a mean age of 34.4 years for males and 24.3 years for females. This is consistent with the findings of our previous study; see *Table 1* in Saunders and Bass (2011). There was no significant difference in the overall age of the sample compared with the previous study ($t(209) = 0.98$, $P = 0.33$). *Fig. 3* Diagnoses. *Table 1* Mean ages of all patients referred 2011–2013 and 2014–2016

Referral period	n	Mean ages	d.s.e.m.
2011–2013	59	34.37	1.49
2014–2016	103	28.70	1.34

Eighty-seven individuals (56.9%) were seeking to transition from male to female, and 46 (30.1%) from female to male, while 13 (8.5%) had non-binary gender identities. All but one of these 13 individuals were seen from 2014 to 2016. Overall, 146 patients (95.4% of those attending the clinic) were assessed as having gender dysphoria.

The remainder ($n = 7$, 4.6%) had a number of problems or reasons for referral that were not assessed as gender dysphoria (including body dysmorphic disorder, homosexual identity, discomfort with certain aspects of gender identity but not to the extent of gender dysphoria, fetishistic transvestism, and ideas about gender related to psychotic beliefs).

Hormone therapy

Twenty individuals (13.1%) reported taking hormone replacement therapy at the time of assessment, with an additional five who had had hormones at some time in the past, plus two who had been prescribed finasteride for male pattern baldness. Of the 25, six were taking or had taken male hormones (such as testosterone), and 19 were taking or had taken female hormones (such as oestrogens).

Educational level

Notably, perhaps partly because of the geographical location of the study, a high proportion of our sample (39.2%) had either been educated at BA degree level or higher (34, 22.2%, including those currently undertaking postgraduate study) or were current undergraduate university students (26, 17.0%).

Comorbidities

Of those who attended for assessment, 60 (39.2%) had a current psychiatric comorbidity, and 81 (52.9%) had a past history of mental illness. Twelve (7.8%) had a diagnosis of autism spectrum disorder (ASD). Depression was the most common mental disorder overall; 26 (17.0) had a current episode of depression and 59 (38.6) had had at least one previous episode. Seven patients (4.6%) also reported a current or past history of self-harm. Other comorbidities are reported in *Table 2*.

Comorbidity	Current, n (%)	Past, n (%)
Any	60 (39.2)	81 (52.9)
Depression	26 (17.0)	59 (38.6)
Bipolar affective disorder	3 (2.0)	0 (0.0)
Substance misuse – alcohol	2 (1.3)	8 (5.2)
Substance misuse – drug	1 (0.65)	8 (5.2)
Psychotic illness	2 (1.3)	4 (2.6)
Post-traumatic stress disorder	1 (0.65)	2 (1.3)
Generalised anxiety	6 (3.9)	7 (4.6)
Social phobia	9 (5.9)	4 (2.6)
Panic disorder	3 (2.0)	3 (2.0)
Obsessive–compulsive disorder	4 (2.6)	0 (0.0)
Other anxiety disorders	1 (0.65)	1 (0.65)
Dissociative episodes	0 (0.0)	1 (0.65)
Eating disorder	0 (0.0)	4 (2.6)
Body dysmorphic disorder	4 (2.6)	0 (0.0)
Autism spectrum disorder	12 (7.8)	0 (0.0)
Attention deficit hyperactivity disorder	5 (3.3)	1 (0.65)
Personality disorder	2 (1.3)	4 (2.6)
Chronic somatoform disorder	1 (0.65)	0 (0.0)
Learning disability	2 (1.3)	0 (0.0)

Outcomes

The majority of patients ($n = 135$, 88.2%) were referred on to a specialist referral centre for further assessment.

Of those not referred, 11 (7.2%) had gender dysphoria but were not ready to pursue transition or onwards referral was considered inappropriate. For example, some did not wish to disclose their transgender identity to their spouses, or felt that transition would be unacceptable to their social networks given their cultural backgrounds. Of the remaining seven patients described above who were not thought to be transgender, six (3.9%) were not referred but were offered alternative treatment or discharged, and one (0.65%) was nevertheless referred on to a specialist gender clinic for a second opinion.

Discussion

Summary of findings

In a study of 162 patients referred to the Oxford Gender Clinic between 2011 and 2016, we report a significant increase in the number of referrals over the 6-year period, despite no changes in local policy or funding of the clinic. In particular, there is no designated endocrine clinic for patients to access in Oxford. The increase was marked in the past 3 years, with 103 referrals from 2014 to 2016 compared with 59 from 2011 to 2013. Similar findings have been reported in child and adolescent services.² Our experience is also consistent with recent findings from a paediatric endocrinology service:³ of 38 patients seen over a 13-year period, 74% of referrals to the clinic occurred during the past 3 years. In our detailed case note review of the 153 patients who attended for assessment, we also found a high rate of psychiatric comorbidity (in particular, depression and ASD), consistent with existing literature.

Strengths and limitations

The strengths of our study were that there is a single point of access in Oxfordshire for onward referral to specialist gender clinics, so our case note review was able to capture all patients referred within a certain time period in this geographical area. We were also able to compare the results with those of our previous study in 2004–2009.

Limitations of our study were that the clinic's assessment does not include a structured diagnostic interview, and although previous medical records were available in some cases, this was variable. Patients who had recently moved to the area, for example, might have had incomplete information in their local records, which might have particularly affected the large student population. Some information, such as on the number of patients taking hormones, was largely gathered through self-report, which may lead to underestimation.

Consideration of reasons for changes in referral patterns

Examination of our referrals in more detail revealed that the patterns of referrals changed during the 6-year period, with mean age at referral decreasing. The prevalence of non-binary gender presentations also increased during the 6-year period, echoing the phenomenon discussed by Richards *et al.*⁷ This may reflect a change in how people's gender identities are developing, possibly because of the increased availability of information about non-binary genders from social media, the internet and peers. An alternative explanation might be that patients identified in this way previously, but perceived that if they disclosed this at assessment they might be denied treatment. It is conceivable that with greater awareness and less social stigma, these individuals may be developing more confidence about explaining their complex gender identities to professionals. The provision of comprehensive and accessible information to patients about options for gender identity and expression and possible medical interventions is crucial.⁸

We found similar rates of comorbid psychiatric disorders to those reported by others,⁹ with depression being the most common comorbidity. Like de Vries *et al.*,¹⁰ we found anecdotally that after patients had declared their gender dysphoria to others, or 'come out', their mood often improved and self-harming behaviour reduced in frequency or ceased. Also, as in previously published literature,¹¹ we found high rates of patients referred with a diagnosis of comorbid ASD (in our sample, about 8% of those attending for assessment). Although the assessment in the clinic does not include a structured diagnostic interview or a formal autism assessment, and hence our case note review only included previously established autism diagnoses, even this potential underestimate was still notably higher than the prevalence in the general population (estimated at 62 per 10 000 in a worldwide review¹²). This echoes the findings of de Vries *et al.*,¹⁰ who systematically assessed children and adolescents referred to a gender identity clinic and found an incidence of ASD of 7.8%. They commented on the diversity of their findings, with both males and females having increased rates of ASD, and the variety of gender identity disorder diagnoses found in those individuals in their study with ASD. They speculated that in some individuals with ASD, feelings of gender dysphoria might be related to an experience of being 'different' generally and having difficulty with identity development, or to more rigid and concrete ideas about gender norms.

An unexpected finding was that only 20 (13.1%) of patients were taking hormone treatment at the time of assessment, which is below the figure of 23% reported by Mepham *et al.*¹³ Our study methods did not allow us to explain this discrepancy, although, like Mepham *et al.*, proportionately more of our patients were transwomen taking oestrogens. Our findings do raise the possibility of underreporting, as hormone use was assessed through self-report, but this cannot be confirmed without more invasive methods such as blood tests, which were beyond the scope of our study. Another possibility would be that our sample truly had a lower rate of taking hormones, perhaps owing to an increased awareness of the medical risks of non-prescribed hormone treatment.

How can these recent marked increases in referral rates be explained? Our study does not provide any clues as to aetiology, but there are many possible explanations. An increase in referral rates can be due to an increase in the prevalence of the condition in the population, or to a change in help-seeking behaviour. Although our study does not provide evidence to differentiate between the two explanations, there have certainly been some recent cultural shifts which could influence the likelihood of patients with gender dysphoria seeking treatment. First, the public profile of transgender issues has been raised of late, with a recent increase in high-profile media figures such as Caitlyn Jenner and Chaz Bono coming out as transgender, and the broadcasting of a variety of documentaries about transgender people, including transgender children.¹⁴ The internet also provides much greater access to information about gender issues, so

that individuals can research their condition and treatment options, and connect with others for support and advocacy. Many people, for example, document the story of their transition on YouTube to provide others with encouragement and advice from their personal experience. Lesbian, gay, bisexual and transgender (LGBT) support groups may also be more accessible because of the internet, and these also provide a source of peer support and information. Second, there have been campaigns to promote transgender people's rights and reduce discrimination in the UK and elsewhere, although significant stigma and discrimination do remain.¹⁵ All of this may have helped individuals with gender dysphoria to overcome barriers to seeking treatment, and potentially to presenting to healthcare professionals at an earlier age. Third, when patients present in primary care, or other contexts such as secondary mental healthcare, GPs and other health professionals have acquired a greater awareness of gender dysphoria and may be more likely to refer people for assessment.

However, decreased stigma and increasing access to information may not wholly account for changes in referral patterns, and additional factors may be needed to explain this. Advances in understanding the cause of gender dysphoria could help account for changes in prevalence; however, neurological studies investigating the possibility of structural or functional changes in the brains of those with gender dysphoria have as yet been inconsistent or inconclusive,¹⁶ and it is difficult to see how they could account for rapid changes of the nature seen in this and similar studies.

The implications of our findings support those of other recent studies, and together suggest that commissioners and others need to take into account the accelerating trend in referrals when planning services. People with gender dysphoria are distressed by long waiting lists and perceived health inequalities.¹⁷ In order to cope with increased demand, services need to provide multidisciplinary and interdisciplinary teams and networks that work and collaborate in the provision of services for people with gender dysphoria, as recommended in the Royal College of Psychiatrists' guidelines.¹⁸ Given the recommendations in ICD-11¹⁹ that gender dysphoria be removed from the mental health section and renamed gender incongruence, a further question arises as to which medical discipline is most appropriate to provide these services.

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1.5.50 What leads to innovation in mental healthcare? Reflections on clinical expertise in a bureaucratic age

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Abstract

This paper considers a witness seminar in which healthcare professionals discussed working on an acute admissions ward run along therapeutic community lines from the 1960s to the 1980s. Participants remarked that older styles of working are ‘unimaginable’ today. This paper discusses why. Literature from the humanities and social sciences suggest healthcare is reactive, reflecting wider cultural changes, including a preference for a more bureaucratic, standardised, explicit style of reasoning and a high valuation of personal autonomy. Such a reflection prompts questions about the nature of professional expertise, the role of evidence and the importance of the humanities and social sciences.

Declaration of interest

None.

Contents

- *What leads to innovation in mental healthcare? Reflections on clinical expertise in a bureaucratic age*
 - *Professional autonomy as a source of authority*
 - *Healthcare and its cultural surround*
 - *Clinical memory as a source of knowledge*
 - *Understanding the Phoenix from the perspective of the present*
 - *Conclusion*

Professional autonomy as a source of authority

It is tempting to think of clinical expertise as autonomous. Indeed, it appears to be an essential part of the role of mental healthcare clinicians that they do not merely reflect or reproduce everyday ideas and assumptions about mental disorders and their treatment, but bring something distinctive to the table. This distinctive contribution is the result of intensive training, painstaking clinical experience and robust scientific research. Understood in this way, collective professional sovereignty seems to be a critical ingredient in differentiating experts from the lay public. It is on the basis of this differentiation that expert opinion may be seen as deserving more weight than the views of a non-specialist. This might suggest that a contrast between expert knowledge and lay knowledge is both necessary and desirable. Educating patients, their family and friends, and the wider public typically means challenging lay assumptions and replacing them with clinically authorised knowledge. This has been the way that campaigns against stigma have been conceived.¹ Similarly, ‘psychoeducation’, which is deemed to be a possibly beneficial adjunct to care for people receiving treatment for mental disorders, is designed by clinicians and intended for the patients, and not the other way round.

There a number of reasons that disciplinary autonomy might be a useful and attractive notion. Autonomy contributes to authority in a setting where authority is both justified and necessary. However, these considerations might encourage a lack of attention to the real status of mental healthcare expertise. This autonomy may not be quite as it appears. I do not want to suggest here that the collective professional sovereignty of mental healthcare clinicians is entirely false, illusory or illegitimate. Instead, I want to make a more cautious argument that, in practice, professional expertise is deeply reactive. Rather than being the sole active agent, mental healthcare professionals as a group are acted upon by wider social and cultural forces. Factors external to professional bodies can shape expertise and practice in ways that are critical and yet difficult to detect.

The views of the general public about, say, what might count as a pathological personal trait and how this might be differentiated from what might better be thought of as eccentric, shape clinical judgement. In practice, any other relationship would be rather odd: mental healthcare professionals are in a position to develop common-sense thinking about distress and madness, but if it were to diverge too far from public opinion, it would be likely to lose its claim

to authority. A concrete example might be homosexuality. In the 1960s and 1970s, this was first modified and then dropped as a diagnostic category, not because of research findings, but because of wider shifts in public opinion.^{2,3} This is instructive. However much it is predicated on science, the authority of mental healthcare practitioners also rests on popular consent. A widespread loss of confidence in mental healthcare would mean an existential challenge for the discipline as a whole. This complex and two-way relationship between expert knowledge and common sense is not unique to mental healthcare. In a major study of scientific and folk thinking about biology, Atran found continuity between ‘ordinary thinking’ categories describing vegetation and those of the biological sciences, such that each can learn from the other.⁴

Healthcare and its cultural surround

An important point for this discussion is that the external factors that shape clinical work are not always as simple as popular views about sexuality, or the acceptability of unusual character traits. More subtle influences are at work. Basic clinical categories and practices that clinicians might typically think of as arising out of autonomous clinical expertise seem to resonate with widely discussed social and cultural processes. These processes are moral as much as scientific, dealing with values, commitments and orientations. We might wonder whether the cart is pulling the horse or, indeed, which is which.

Take, for example, the notions of risk, accountability, responsibility and anxiety. All figure large in clinical practice. Drawing on the work of Beck, Giddens argues that accountability is linked to risk and anxiety, forming part of what he calls the ‘contours of high modernity’ in which personhood is being ‘reshaped’.^{5,6} It appears that this high modernity shapes medicine as much as medicine shapes high modernity. Giddens notes how individuals increasingly see life as containing risks, and that dealing with risk and controlling the future is one of the ‘core aspects of modernity’. Critically, according to him, dealing with risk is now an individual challenge. The modern individual seeks to personally equip himself or herself by means of gaining knowledge to enable autonomous decision-making. These ideas seem to be reflected in the way that patient-centred care or patient empowerment is conceptualised. We might conclude that the personalisation of care and the goal of patient empowerment are part of modernity rather than arising out of autonomous clinical reason.

In a similar way, for many commentators, what knowledge is and what might count as good reasons for a decision are changing. For example, it is increasingly the case that a good decision is one that might be defended in an impersonal way. In *Trust in Numbers*, Porter makes a distinction between what he calls ‘disciplinary objectivity’ and ‘mechanical objectivity’.⁷ The former arises out of a consensus of experts. As it consists of expert judgement, it demands trust. By contrast, mechanical objectivity is derived from the use of quantified data and the following of rules. This appears impartial, rigorous and unbiased.

Porter suggests that much of the appeal of quantitative, mechanical objectivity is ‘mythical’ and confused. It is nonetheless very attractive. Part of the reason for this is that it appears impersonal, in that data and algorithms replace personal judgement. According to Porter, underlying mechanical objectivity is an ethic that ‘rules should rule’, rather than people ruling. He puts it like this: ‘Scientific objectivity thus provides an answer to a moral demand for impartiality and fairness. Quantification is a way of making decisions without seeming to decide’⁷ (p. 8). These epistemic preferences shape our sense of what expertise consists of. Expertise is taken to be a capacity for explicit and auditable decision-making. Good decisions are impartial and fair, which is signalled by the erasure of the decision maker.

These trends are widely recognised. A great deal of professional work today is being reconfigured. Whether it is education, banking, the military or international development, expertise is becoming formalised and ‘managerialised’, reinterpreted as a sequence of explicit decisions, capable of being scrutinised externally, and underwritten by the mechanical objectivity of evidence and policy. Graeber talks of the ‘era of total bureaucratization’ in which standardised forms of knowledge are reductive and yet dominant, unsatisfactory and yet overpowering.⁸ The effects of this are ubiquitous, but particularly found in medicine. Porter⁷ comments that: “In public even more than in private affairs, expertise has more and more become inseparable from objectivity. Indeed, to recur to the previous example, it is in part because the relation of physician to patient is no longer a private one – due to the threat that it might be opened up in a courtroom – that instruments have become central to almost every aspect of medical practice (p. 7).”

Harrison argues that the rise of evidence-based medicine and the introduction of market mechanisms in the National Health Service has led to a change in the way that clinical knowledge and expertise are conceived of, a transition away

from instinct or personal judgement, and towards propositional knowledge and instrumental rationality.⁹

Clinical memory as a source of knowledge

One way of thinking through these issues is to attend to the experiences of staff whose careers span different working styles. The Phoenix Unit was an acute admissions ward run according to the therapeutic community concept at the Littlemore Hospital in Oxford. It was set up by Bertram Mandelbrote in 1959 and closed in 1996. The ethos of the Phoenix was to explore the behaviours and feelings of residents through community life and, in particular, in group settings. Daily community groups formed the centre of care and were supplemented by working groups, occupational therapy, crisis groups and relatives' groups. Over time, the ward became well known and attracted considerable interest.

A reunion of Phoenix Unit staff members took place on 19 October 2016 in the Barns Conference Centre, part of the Planned Environment Therapy Trust (PETT), near Cheltenham in Gloucestershire. There were 23 participants, including psychiatrists, nurses, a psychologist, a social worker, an occupational therapist and an art therapist. The reunion consisted of six recorded sessions. After a 30-min introductory session, the group split in two, with each subgroup talking for about 80 min. There followed three sessions involving all participants, totalling almost 2.5 h. So, the total record is a little short of 6 h discussion. All the recordings were transcribed, and both the recordings and the transcriptions are archived by the PETT. There was a lot of mutual recognition among the participants. Many were happy to be reunited with former colleagues. Some participants were longstanding friends, others less known. Participants were mostly confident about speaking in a large group. In fact, participating in group discussion might be understood as a facet of clinical skill. No formal methodology was adopted to analyse the material. As might be appropriate, given the themes of the paper, the author relies on his own judgement about the discussions, rather than seeking authority through algorithm or quantification.

Staff remember the Phoenix as 'very 60s' and 'very permissive'. A culture of openness extended to patients, ex-patients, families and staff. 'We were all part of it', said one. The atmosphere on the ward was described as 'apparent chaos' or 'chaos', and by one person as 'the maddest place I've ever seen'. Hierarchies were flattened, professional roles blurred, and staff understood themselves to work 'alongside' patients as equals. Interaction was relaxed and informal. Patients were encouraged to express themselves. One participant said people 'came to be mad'. Another remarked that staff 'allowed behaviour'. Expertise was not located solely with the professionals. Patients helped other patients, and staff learned from patients. It was said that 'Everyone was a therapist, including the patients'.

The unit gave staff huge amounts of freedom. Discretion and professional judgement were favoured over routines and standardised rationales. Care seemed to rest on spontaneous creative decisions. A spate of broken windows led to patients being paid to break windows. As one participant put it: 'there was no plan ... no structured response' to events. There was a stress on 'carrying the culture' but less emphasis on note-taking. Written documentation was minimal. It is telling that key therapeutic events took a form that, to the bureaucratised imagination, sounds like an oxymoron: 'agendaless' meetings.

Diagnosis and targeted medications seem to have played a small part. The flexible, non-medicalised culture of the unit was described as helping staff to understand patients as people, rather than carriers of impersonal disorders. It helped one participant to see 'the person behind the patient', and another to see that 'we're all human beings'. In addition, a less medical approach to distress reduced the superordination of doctors and meant all the staff members had a part to play. The opinions of cleaners, for example, were frequently sought. However, patients had to commit to the process. Group attendance was compulsory, and patients who didn't engage might be considered for discharge. And when drugs were prescribed, even if it was to 'contain' excessive mania or anxiety, rather than to treat a disorder, they were in what one psychiatrist dubbed the 'monster doses' typical of the period.

Understanding the Phoenix from the perspective of the present

The witness seminars are remarkable because they show how profoundly and how rapidly care has changed. My suggestion is that this change reflects wider cultural processes. It isn't that accurate forms of measurement showed that the unit was less effective, or less safe or more expensive than contemporary arrangements (although it may have been some or all of those things). Rather, the cultural surround changed such that less patterned practice seems less professional. In Porter's terms, improvised, intuitive exchanges between staff and patients are not constitutive of mechanical authority.

Several participants remarked that problems with the production of paperwork are why such a unit could not be imagined today. People on the Phoenix 'were bad at taking notes', which made it 'the opposite of what is going on now'. It is hard to see how the kinds of activities described by the participants could be recorded in an economical and standardised way. Unpatterned, improvised and complex activity is difficult to document. In highly bureaucratised times, care that can't be documented is not professional. Personal judgement and the 'culture' of the institution are weak justifications for treatment.

Moreover, care was more organised around personal development than patient empowerment. As a permissive setting in which individual preference trumped rules, the unit might be seen as the vanguard of individualism. Yet care in the Phoenix was modelled around goals that reflected a more social and less individualistic conception of personhood and human flourishing. The reunion suggests something further: that seeing people as social beings might be difficult to square with bureaucratic culture. This social dimension of mental health might fall somewhere beyond what we might expect an accountable bureaucracy to successfully address. To use Giddens's phrase, the Phoenix shared few of the contours of high modernity.

The influence of all of this on staff members appears mixed. Routinisation can protect staff members from the pressures of deliberation and personal responsibility. Rule-following requires less of a staff member than thinking problems through afresh. In Porter's terms, impersonal 'mechanical objectivity' erases the individual clinician. By contrast, spontaneity is hard work. As a result, staff seem to have found it extremely taxing to work at the Phoenix, but also enormously educative and influential. More was expected of them, and more was gained by them. Staff could flourish, but they could also burn out. Working at the Phoenix led to self-exploration that was at once therapeutic and intensely stressful. The impression created by the seminar participants is that standardisation and mechanical objectivity protect clinicians. It appears that this comes at a cost: clinicians who are shielded by rules have reduced opportunities for learning.

Conclusion

The recollections of the Phoenix staff resemble in striking ways widespread changes in professional culture discussed in the humanities and social science literature. A trend towards more bureaucratic working practices, and for expertise to consist of a capacity to adopt a standardised, explicit style of reasoning, are widely observed in the literature and were widely remarked upon by the Phoenix staff. This suggests that innovations in clinical practice are, to a degree at least, determined by cultural factors external to the mental healthcare professions. This is not to claim that the only source of innovation is the cultural surround. However, clinical practice, styles of service delivery and planning, and even notions of professional expertise and patient health are being reconfigured in ways that appear to be part of a wider transformation of professional lives. Whether we like it or not, we live in bureaucratic times. Bureaucratic values increasingly enter professional domains, blurring distinctions between formerly separate bodies of expertise. Clinical sensibilities about risk, for example, resemble those of a policy maker or bureaucrat.¹⁰ It is telling that good mental health is increasingly framed in terms of personal autonomy and social and economic independence. There is nothing specifically clinical about these categories. Instead, they are rather open and flexible notions, which may be transferred across professional frontiers. They seem to naturally belong to Giddens's high modernity.

This might seem an unappealing state of affairs. As I tried to suggest in the first part of the paper, one reason for unease might be that admissions of cultural influence can be seen to undermine clinical authority. I suggest that this need not be the case. Further, I argue that such influence is anyway inevitable. The relatively unstructured and hard-to-document working practices in the Phoenix unit would be unthinkable today not for reasons of evidence of effectiveness, safety

or value for money. Instead, they look unprofessional. They would be difficult to audit. We might imagine they would stick out in documentation presented to the Care Quality Commission, or to the local clinical commissioning group.

This has a number of implications, not least regarding how to understand innovation in medical practice. If a cultural impetus as identified by Porter, for ‘rules to rule’ and not people to rule, leads to shifts in clinical practice such as those described by the Phoenix staff members, what are we to make of other accounts of innovation, such as those that refer to accumulating evidence? If the old style of working is just out of epistemic fashion, where does that leave the rise of evidence-based medicine? Perhaps Grimley Evans is right when he comments, acerbically, that part of the appeal of evidence-based medicine is that it offers ‘total managerial control’ of healthcare.¹¹

These reflections also prompt questions regarding the status of ‘expertise by experience’. We might suspect that the kind of expertise that patients have by virtue of first-person experiences of health and healthcare more closely resembles the expertise of the Phoenix Ward staff than that of contemporary clinicians. Do current epistemic sensibilities prejudice us against expertise by experience? Do we undervalue expertise by experience because of quite recent changes in how we understand the nature of expertise itself?

These questions are of significant clinical weight. Yet they are more the province of the humanities and social science disciplines, not least anthropology and philosophy, than the disciplines that make up mainstream mental healthcare research. Mental healthcare is increasingly the subject of investigation by disciplines whose starting assumptions and methods are not those of medicine. This appears to be an opportunity, not a threat. If the reunion attendees tell us anything, it is of the potential value of the contribution of the humanities and social sciences to the investigation of biomedicine.

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1.5.51 Mental health problems, benefits and tackling discrimination

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Abstract

Poverty is strongly associated with mental illness. Access to state benefits can be a lifeline for people with mental health problems in times of hardship and can assist them on their journey of recovery. However, benefit application processes can discriminate against those with mental illness and can result in individuals unjustly missing out on support. Clinical evidence from mental health professionals can ameliorate these challenges and ensure that people get access to financial help.

Declaration of interest

Dr Billy Boland is on the advisory board of the Money and Mental Health Policy Institute.

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The relationship between money and mental illness

There is a clear link between financial hardship and mental disorder.¹⁻³ In 2009 the global financial crisis was estimated to be responsible for an additional 4884 suicides worldwide.⁴ In Britain, people with severe mental illness are three times more likely to be in debt than the general population.⁵ The aim of this article is to help clinicians understand Employment Support Allowance (ESA) and Personal Independence Payments (PIP) (*Box 1*), two key state benefits in England and Wales, as well as provide further advice on writing supporting clinical evidence for applications. *Box 1* 'We can provide the best treatment in the world for our patients but if they can't afford accommodation, heating or food this will be ineffective. It's essential that clinicians know how to support their patients in applying for the benefits they are entitled to.' Professor Wendy Burn, President, Royal College of Psychiatrists (personal communication, 2017)

The modern, post-war British welfare state was founded to eradicate what *The Beveridge Report* of 1942 identified as the five 'giant evils' in society: squalor, ignorance, want, idleness and disease.⁶ In 2011 the World Health Organization reported mental illnesses to be the leading cause of worldwide disability,⁷ with global costs estimated to exceed \$6 trillion by 2030.⁸ It is therefore no surprise that people with severe mental illnesses are the largest group (49%) claiming working age sickness benefits in the UK.⁹

Disadvantage and discrimination

However, in England and Wales the benefits system often does not work, especially for people with mental disorders, leaving some claimants ‘fearful, demoralised, and further away from achieving their work-related goals’.¹⁰ In 2013 the Court of Appeal upheld a ruling that people with mental disorders, along with those with intellectual disabilities and autism, are specifically disadvantaged by the ESA application process.¹¹ Many benefits assessors do not have prior training or experience in mental health.¹² Award decisions are often inaccurate; 67% of ESA and 68% of PIP decisions are later overturned by appeal tribunals.¹³ ¹⁴ In January 2018, the Government announced a review of 1.6 million PIP claims following a High Court ruling in December 2017 that described recent changes to the mobility component as ‘blatantly discriminatory’ against people with mental health problems.¹⁵

The reliance on self-reported information in claims is a major obstacle, particularly for those with impaired insight.¹⁶ Submission deadlines are short and those who miss them (perhaps because they do not check their post or were in hospital) may be penalised for the very problems that led them to apply for benefits in the first place. Disturbingly, there is evidence that the assessment for ESA, known as the Work Capability Assessment (WCA; see below), is linked with harm as it is independently associated with an increase in suicides, self-reported mental health problems and prescribing of antidepressants.¹⁷ Clinical and academic experts have long argued that clinicians should have a good understanding of benefits to better care for patients.¹⁸ People using community mental health services frequently under-claim and, for these people, benefits advice can result in additional payment.¹⁹

ESA and PIP claims

ESA and PIP claims share much in common; both require assessment by an independent provider of the functional impact of a claimant’s condition based on a completed medical questionnaire, supporting clinical evidence and, potentially, face-to-face assessment. Nevertheless, there are notable differences: ESA provides a basic day-to-day income for a claimant unable to work full time due to illness, whereas PIP provides a supplement for the increased costs of living with disability. Claimants may receive either benefit, or both, if eligible.

ESA

ESA is awarded instead of Jobseeker’s Allowance when a claimant is determined by the Department for Work and Pensions’ (DWP) WCA to have limited capability for work due to illness or disability. ‘Limited’ does not imply *no* capability and claimants are assessed in terms of whether they can sustain full-time work (16 h per week or more).

ESA applications, once separate, are now being integrated into Universal Credit claims as the programme rolls out nationwide. As the assessment process remains the same, this article will use the term ESA to refer to either route of application.

To establish limited capability for work, a claimant initially needs only to provide a medical certificate from their doctor. At this point, their claim is processed and provisional payment is issued (if applicable). The claimant is then placed in the ‘assessment phase’, which lasts for 13 weeks, or until the DWP completes the WCA, whichever is longer. If this phase lasts longer than 13 weeks, successful claims will have any additional payment due as a result of passing the assessment backdated to the 13th week.

Following the WCA there are three possible outcomes: (1)The claimant is found to be fit for work and is redirected to claim Jobseeker’s Allowance (or their Universal Credit claim is adjusted accordingly).(2, 3)The claimant is found to have limited capability for work and is awarded ESA. Within this cohort are two subdivisions: •The ‘limited capability for work group’, typically shortened to the ‘work group’. In this group, a claimant can be mandated to attend work-focused interviews at their local Jobcentre (or by phone if necessary) and perform ‘work-related activity’, for example skills or CV training. Failure to participate can result in financial sanctions, although a claimant in the work group cannot be asked to apply for or take paid employment. •The claimant is found to have ‘limited capability for work-related activity’. In this case, they are placed in the ‘support group’ (technically the ‘limited capability for work-related activity group’), which has no attached requirements. Claimants may still choose to do part-time or voluntary work, or other forms of work-related activity if they wish.

PIP

PIP has replaced the Disability Living Allowance for new claims for 16–64 year olds. Both are based on the presumption that functional impairments incur additional living costs. Unlike ESA, PIP is not means tested and eligibility is unaffected by savings, income, household or work status. Award duration varies from 1 to 10 years (an ‘ongoing award’) and successful claimants may still appeal the award length.²⁰

The PIP assessment separates functional difficulties into two components: daily living and mobility. Support for either or both components may be awarded, with payments at a standard (requiring 8 points) or enhanced rate (12 points).

The assessment process

For both ESA and PIP assessments, points are scored for key functional tasks known as ‘descriptors’, according to the claimant’s assessed level of difficulty. For PIP there are ten daily living descriptors (such as preparing food, dressing and budgeting) and two for mobility. ESA assessments are split between ten descriptors for physical disabilities and seven for mental, cognitive and intellectual function (see *Box 2*). Scoring 15 points or more anywhere in the ESA assessment qualifies a claimant for the work group. There are also specific descriptors that, if awarded, will further qualify a claimant for the support group. *Box 2* ESA and PIP assessment criteria

ESA descriptors concerning mental, cognitive and intellectual impairment:

- learning tasks
- awareness of everyday hazards
- initiating and completing personal action
- coping with change
- getting about
- coping with social engagement
- appropriateness of behaviour with other people
- conveying food or drink to the mouth/chewing or swallowing food or drink (if due to severe disorder of mood or behaviour)

Adapted from *A Guide to Employment and Support Allowance – The Work Capability Assessment*.²¹

PIP criteria:

- Daily living activities: Activity 1 – preparing food
- Activity 2 – taking nutrition
- Activity 3 – managing therapy or monitoring a health condition
- Activity 4 – washing and bathing
- Activity 5 – managing toilet needs or incontinence
- Activity 6 – dressing and undressing
- Activity 7 – communicating verbally
- Activity 8 – reading and understanding signs, symbols and words
- Activity 9 – engaging with other people face to face
- Activity 10 – making budgeting decisions
- Mobility activities: Activity 11 – planning and following journeys
- Activity 12 – moving around

Taken from *PIP Assessment Guide Part Two: The Assessment Criteria*.²²

ESA contains ‘substantial risk’ rules that may allow claimants with insufficient scores (including zero) to qualify for either the work or support group if ‘there would be a substantial risk to the mental or physical health of any person if the claimant were found not to have limited capability for work/work-related activity.’²³ As well as obvious risks, such as self-harm or hospital admission, substantial risks may also include that of causing increased distress (e.g. if forced to travel by public transport) or the possibility that medication will need to be changed as a direct consequence.²³ Reportedly up to 23% of ESA claims are awarded by this route.²⁴

There is some degree of overlap in the descriptors for ESA and PIP, as well as notable differences; the activities relevant to mental, cognitive and intellectual functioning can be found in *Box 2*. For further information on specific criteria and how they are judged, please see the Royal College of Psychiatrist’s guidance to clinicians on the ESA WCA²⁵ (see *Box 3* for a summary). Similar College guidance on the PIP assessment is in development. *Box 3* Advice on writing supporting clinical evidence

The general structure for supporting letters advised by the Royal College of Psychiatrists²⁵ is as follows:

- (1) Basic clinical details: diagnosis, medication, side effects, length of service contact, current contact, variability of condition (e.g. diurnally, between episodes and during the most severe peaks of illness), impact of stress and overall symptoms.
- (2) How this affects level of functioning in regards to the specific descriptors. If unaware whether a specific criteria applies, a clinician can still state they believe it is likely it does on the balance of probabilities.

Information about difficulties a claimant may have travelling to an assessment centre or completing paperwork should be clearly stated.

In addition to ensuring accurate award decisions, supporting clinical evidence can also provide assistance and safeguards throughout the application process itself. Given the disadvantages claimants with mental health problems face,¹¹ there are numerous areas where problems can arise.

Completing the questionnaire and initial review

Once a valid claim for ESA or PIP has been made, the case is referred to an independent medical assessment provider. The claimant is sent a Limited Capability for Work questionnaire (ESA50/UC50) or How Your Disability Affects You form (PIP2), covering their condition and its impact, and it is to be completed by them, or on their behalf. This is submitted along with any supporting clinical evidence. Once received, the assessor – who may be an occupational therapist, nurse, physiotherapist, paramedic or doctor – conducts an ‘initial review’ of the file. They may request a face-to-face interview or decide there is sufficient evidence to make an immediate determination. Supporting clinical evidence can therefore make the process far more straightforward for the claimant.

Notably, supporting clinical evidence is not mandatory at any stage of the process. An independent review of the WCA for the Government concluded: ‘it is essential that all relevant medical and allied evidence about the claimant is available to the DWP Decision Maker at the earliest possible stage in the assessment process.’²⁶ Following a more recent independent review of the PIP assessment,²⁷ the Government accepted the DWP should make clear that the responsibility to provide further evidence ‘lies primarily with the claimant and they should not assume the Department will contact health care professionals.’ The same problems exist with ESA applications.¹¹

Questionnaire problems

Claimants can face numerous difficulties when completing the initial questionnaire. In 2013 the High Court¹¹ identified 11 reasons why people with mental health problems may struggle with self-reporting at this stage, including: failure due to lack of insight, inability due to difficulties with social interaction or confusion and unwillingness because of shame or fear of discrimination. Failure to return the questionnaire may result in termination of the benefit. There are some safeguards against this for ESA, as the WCA Handbook²⁸ states: “‘Where a claimant has a mental function problem an assessment will be carried out even if the [medical questionnaire] is not returned.’”

However for PIP claims, failure to return the questionnaire can be more problematic. Regarding customers with additional support needs, the PIP assessment guide²² states: “‘1.12.2 Some may have an Appointee ... or support from a family member, carer, Community Psychiatric Nurse or other person who will usually ensure that the claimant is supported throughout the process. In those circumstances, the claimant would not be classified as requiring additional support from the DWP. These people already have support.’”

This assumption effectively means less protection for PIP than ESA applicants and makes early termination of claims more likely. In this event, supporting clinicians can write to the DWP to provide evidence as to how the claimant’s condition has adversely affected their ability to fulfil their requirements, ask for good cause to be accepted and for the claim reinstated.

Arranging the assessment

A determination is not usually made on initial review of paper evidence. The assessor may attempt to contact professionals named in the questionnaire for additional information or, more commonly, refer the claimant for a face-to-face assessment (as with 72% of ESA assessments in 2013).²⁹ If a claimant cannot reasonably be expected to travel to an assessment centre they can request a home visit, but this will almost certainly require specific supporting clinical evidence.

Assessment problems

If a face-to-face assessment for ESA or PIP is missed, the case file is returned to the DWP to decide whether to accept good cause or to terminate the claim. Both ESA and PIP legislation require that the decision maker consider the claimant's state of health and the nature of their disability in making this determination.³⁰³¹ As such, these decisions can be challenged using clinical evidence to justify why the claimant was unable to attend.

Assessment providers will typically refuse to conduct a home visit if there is a history of violence or aggression, which may lead to an impasse if the claimant cannot attend the assessment centre. In such cases, it is advisable to write directly to the assessment providers, explaining why the individual cannot travel and offering to provide further evidence. This may allow a paper-only assessment to be conducted.

The face-to face assessment

The face-to-face assessment can be extremely stressful for claimants, although they can be accompanied by a person of their choice who may also provide evidence. The assessor should have read all available information beforehand, although further clinical evidence can be provided on the day. The claimant's overall presentation at the interview can form a large part of the assessment, which may be problematic for those who lack insight, have a fluctuating condition, under-report or have become adept at masking their difficulties. This further highlights the importance of supporting clinical evidence to provide the full context.

Following the assessment, the health professional completes a report including recommendations to the DWP, who make the final decision.

Challenging decisions

The two initial stages of challenging an outcome are mandatory reconsideration and formal appeal. To challenge a decision, claimants must first request a mandatory reconsideration by the DWP, the legal term being 'any grounds revision'. Mandatory Reconsideration requests must be submitted within 1 month of the original decision, however this can be extended by up to 13 months if there is good cause.³² This 1-month rule applies not only to final award decisions but to any decisions made by the DWP, which carry right of appeal. For example, claimants could challenge the termination of their claim for failing to attend a face-to-face interview. In the real world, such situations are likely and mental health services may only discover essential information long after the designated 1-month limit. In these cases, clinical evidence should support both the original challenge and also why a late application for revision should be accepted. Even if application for a late revision is denied, a recent Upper Tribunal case³³ ruled that a claimant still has a statutory right of appeal if a late request is not considered.

If the Mandatory Reconsideration outcome is unfavourable, the claimant can then submit (within a month) an appeal to the independent Courts and Tribunals Service. Further clinical evidence can be provided. It is important to ensure claimants are aware that reconsideration or appeal of one aspect of a decision could lead to a potentially disadvantageous revision of the whole decision. For example, challenging a decision about PIP mobility could theoretically lead to an existing daily living award being revoked. Appeals can be withdrawn at any point prior to the hearing.

Supporting clinical evidence

Reports can be sent directly to the assessment centre or, preferably, given to the patient to submit with their completed questionnaire. Additional evidence can be provided at any point, however early submission ensures its use throughout all subsequent stages and may allow for a quicker decision. Most supporting evidence will be requested to establish whether a claimant meets the qualifying descriptors (*Box 2*), however it might also be necessary to provide evidence in response to, or in anticipation of, specific problems outlined above. For example, if a patient reports their ESA has stopped, it may be due to insufficient points scored during their WCA or because they failed to attend it at all. The clinical evidence should address the issue in question.

It is important that supporting letters are objective, link functional problems to health issues, expand on common clinical concepts (e.g. negative symptoms of schizophrenia) and state obvious clinical inferences explicitly (e.g. negative symptoms persist even during periods of remission). It should be remembered that DWP decision makers are not medical professionals and they may have a limited understanding of terminology or mental health problems.

Care plans can be valuable evidence if they demonstrate that a claimant cannot manage relevant domains of functioning, such as their own self-care. However, there is a danger of care plans inadvertently giving a positively skewed impression of functioning if they are too simplistic. One example is preparing meals: PIP defines a 'simple meal' as 'a cooked one-course meal for one using fresh ingredients'. Therefore, a care plan that refers to independent cooking but does not clarify that this extends only to the use of a microwave could adversely affect the outcome.

The DWP's overall definition of capability is more narrow than it might first appear and requires some measure of consistency; the claimant must be able to perform the given tasks reliably (defined as 'safely, repeatedly, to an acceptable standard and as often as is reasonable to require'²⁸) on a majority of days. In addition, judgments about qualifying for a particular descriptor need not be unequivocal and may be accepted on a balance of probabilities.

Finally, when providing clinical evidence, it is always worth bearing in mind that you must demonstrate not only whether a claimant is affected by their condition, but also whether they are affected in the specific legal ways that qualify them for the benefit. The best evidence will therefore directly address the descriptors and, as such, a working knowledge of the criteria is vital in ensuring that claimants have the best possible support throughout the process.²⁵

Conclusions

With some basic knowledge, mental health professionals can play a key role in redressing the discrimination against people with mental health problems and ensuring accurate award decisions by providing relevant, well-written clinical evidence for benefits assessors. Clinicians should be vigilant in demonstrating individuals' needs eloquently, accurately and in a timely way. Through an appreciation of the additional stresses on patients applying for benefits, mental health services can provide better support and signpost appropriately to agencies such as Citizens Advice. Welfare expertise is outside the experience of many mental health clinicians, but a patient's access to (eligible) benefits is an important part of recovery. Clinicians should work towards forging closer links with the benefits system and supporting services such as benefits and welfare advice to enable better outcomes for patients. Professionals need to understand the subtleties and potential for discrimination in the system to best support people.

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Julia Samuel, grief psychotherapist and Founder Patron of Child Bereavement UK, presents a moving and thoughtful collection of therapeutic encounters. Each brief narrative traces a careful line between study and story, reminiscent of *The Examined Life* by Stephen Grosz. The style of the case story captures the uniqueness of grief and the therapeutic process, reminding us that these are not illustrations of pathology.

Samuel's studies, written in spacious and measured prose, are fearless in their approach. She includes those bereaved by miscarriage, trauma and suicide, and explores the many ways people try to cope. She gently reveals the complex emotional experiences and interpersonal difficulties that emerge, yet her own human response is never far from the text.

The case stories are divided according to the relationship to the deceased, and each section is followed by Samuel's own reflections and references to existing research. The author is keen to present positive accounts of healing and recovery, together with practical advice for the bereaved. This may explain why abnormal grief does not feature among the selected cases.

Samuel's person-centred psychotherapeutic approach is apparent throughout. This alliance carries through to her reflections and may explain why she often does not grapple with conceptual questions or distinctions. Indeed, Samuel avoids an explicit espousal of any particular model of grief. While classical theorists such as Bowlby and Kübler-Ross are summarily acknowledged, Samuel maintains her person-centred focus, helping to construct narratives with her clients. She reveals the tensions that arise and hints at the inner workings of grief while resisting any theoretical speculation. At times, Samuel uses a more integrated therapeutic approach, allowing for a broader understanding of her clients' difficulties according to different modalities. She identifies unhelpful defence mechanisms and cognitive distortions: where grief is bound up in strong cultural identity, Samuel makes reference to Jungian archetypes; to help a client struggling to achieve emotional stability, she works with a transitional object.

The significance of grief may be immediately recognisable to the psychotherapist, whether in the form of bereavement or as part of uncomplicated psychosocial development; however, hidden among Samuel's optimistic reflections are many reminders of why grief matters to the psychiatrist. Historically, grief has represented a line in the sand, demarcating normal experience from psychopathology. However, the removal of the 'bereavement exclusion criteria' from DSM-5 appears to challenge this, reintroducing grief as a viable precipitant in some disorders. Additionally, failure to recognise features of normal or unresolved grief can lead to misdiagnosis. Even in cases of uncomplicated grief, hallucinatory phenomena remind us that the boundary between normal experience and mental illness may not be a fixed one. Though choosing to err on the side of hope and resolution, Samuel's tenderly written accounts give voice to the weight of these experiences. Unresolved grief nonetheless continues to raise many questions and, as noted in the DSM-5, remains a recommendation for further study.

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1.5.52 The transition from child and adolescent to adult mental health services with a focus on diagnosis progression

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Abstract

Aims and method

This article examines mental health disorders as individuals transition from adolescence to adulthood. Data were collected from clinical records of patients who had transitioned from child and adolescent mental health services to adult mental health services in a region in South Wales. Demographics and clinical diagnoses under both services were recorded. Patterns between adolescent and adult disorders as well as comorbidities were investigated using Pearson's χ^2 -test and Fisher's exact test.

Results

Of the 98 patients that transitioned from one service to the other, 74 had changes to their diagnoses. There were 164 total changes to diagnoses, with patients no longer meeting diagnostic criteria for 64 disorders and 100 new disorders being diagnosed. Comorbidity increased in adulthood.

Clinical implications

Diagnoses can evolve, particularly during adolescence and early adulthood. Therefore regular re-assessment is paramount for successful treatment.

Declaration of interest

None.

Contents

- *The transition from child and adolescent to adult mental health services with a focus on diagnosis progression*
 - *Patterns of diagnostic transition*
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The majority of mental health disorders are identified during adolescence and early adulthood.¹ By the age of 21, more than half of the population have experienced at least one mental health disorder.^{2,3} Adolescent mental health disorders also place individuals at an increased risk of further difficulties as adults.^{4,5} However, this effect has been found to be limited when adolescent episodes are brief, emphasising the need for prompt and effective treatment.⁶ Despite many studies having identified adolescence as a risk period for the onset of mental health disorders, the course these disorders take is not yet fully understood. To date, it is unclear why some individuals develop a recurrent pattern of mental illness, whereas mental illness is confined to the adolescent period for others.

Patterns of diagnostic transition

As people with mental health disorders transition from adolescence to adulthood, their disorders can follow different trajectories. In some cases, they can be predecessors of a different disorder in adulthood, displaying a heterotypic pattern.^{4,5,7,8} In other cases, they may remain diagnostically stable and follow a homotypic pattern.^{1,4} It is possible for both a heterotypic and homotypic pattern of transition to be displayed along with the development of comorbid disorders, especially as these are more likely to develop during the adolescent and young-adulthood phase of development.^{9,10}

Study aims

Using a clinical sample, this study aims to examine mental disorders as people transition from adolescence to adulthood in a population in South Wales, UK. Patterns between adolescent and adult mental health disorders as well as comorbidities were investigated.

Method

Data were collected in July 2013. Clinical records were examined retrospectively for all patients referred to adult mental health services (AMHS) within Cwm Taf University Health Board over a 5-year period.

Inclusion criteria

Included participants were aged 15–22 at the time of referral and had a documented history of involvement with child and adolescent mental health services (CAMHS) in the 2-year period prior to referral to adult services.

Exclusion criteria

People were excluded from the study for the following reasons: •lack of sufficient engagement with CAMHS or AMHS to allow a full assessment;•AMHS involvement of less than a year;•lack of documented diagnosis from CAMHS or AMHS;•CAMHS service provided by another health board.

Data collection

Electronic AMHS notes were analysed. CAMHS paper documentation were accessed if required. The data collected included: •date of referral to AMHS;•age at time of referral;•geographical area;•documented diagnosis in discharge paperwork from CAMHS;•documented diagnosis in AMHS clinical notes or correspondence.

Diagnoses were recorded as per clinical coding, based on the ICD-10 (1992). In a small number of participants ($n = 17$), no formal ICD-10 diagnosis was made by CAMHS clinicians. Instead, formulation was used to describe the participant's presentation at the time. The term emotional difficulties was used to capture these cases.

Some disorders were grouped into categories. Hyperkinetic disorder, conduct disorder and oppositional defiant disorder (ODD) were classified together as externalising disorders. Generalised anxiety disorder, obsessive–compulsive disorder (OCD) and phobic disorders were classified together as anxiety disorders. Different forms of substance misuse were categorised as mental and behavioural disorders due to psychoactive substance use. These disorders were grouped in this way because of their level of comorbidity within the category. No diagnosis of conduct disorder or ODD presented without comorbid hyperkinetic disorder. Phobic disorder and OCD did not present as single anxiety disorders. Those participants who misused substances, misused at least two. Therefore, we could not make conclusions regarding an individual diagnosis transition for those individual disorders. Listing all the individual disorders led to a multitude of combinations within the categories and a pragmatic decision was made to group the disorders.

Ethical approval

Support for this research was obtained from the Research and Development Department within Cwm Taf University Health Board, which is responsible for both the AMHS and CAMHS clinical records. The need for ethical approval was discussed extensively but deemed unnecessary for the following reasons: we were trust employees and collected data on site, originally as part of an audit; the method of data collection allowed identifiable information to be anonymised at the point of collection; and the data used in this study were limited to demographic and diagnosis details.

Statistical analysis

Pearson's χ^2 -test and Fisher's exact test were used for the comparison of frequencies between two discrete variables. All of the reported P -values are two tailed. Statistical significance was set at 0.05 and analyses were conducted using the SPSS version 21 statistical software for windows. Standardised residuals (S_i) were calculated where a significant result was found.

Results

A total of 207 people aged 15–22 were referred to AMHS in the study period. *Figure 1* illustrates how the final sample of 98 participants was created. Of the 98 participants, 60 were male (61.2%). The mean age was 18.1 (s.d. 1.46), with an age range of 16–23. There were three sources of referrals to AMHS: 60 participants (61%) were referred by their general practitioner, 37 (38%) by CAMHS and 1 (1%) by the AMHS Crisis Resolution Team. There were 42 participants (43%) who had been referred within 1–12 months of 1 July 2012; 19 (19%) were referred within 13–24 months; and 19 (19%) were referred within 25–36 months, 9 (9%) within 37–48 months and 9 (9%) within 49–60 months. Fig. 1Flow chart illustrating the selection process for participation in the study.

The CAMHS disorders were categorised into 13 diagnostic categories. A total of 65 participants (66%) had a singular diagnosis, 29 (30%) had two diagnoses and 4 (4%) had three diagnoses. This led to 135 individual diagnoses. The most common diagnostic category in CAMHS was the externalising disorders. The AMHS disorders were also categorised into 13 diagnostic categories, 10 of which were present in the CAMHS sample. A total of 46 participants (47%) had a singular diagnosis, 37 (38%) had two diagnoses, 14 (14%) had three and 1 (1%) had four diagnoses. This led to 166 individual diagnoses. Externalising disorders remained the most prevalent diagnosis. Frequencies of individual diagnostic categories are detailed in *Table 1*. Table 1Frequencies of individual diagnostic categoriesClinical code of

disorders (ICD-10 codes) CAMHS frequency (%) AMHS frequency (%) Bipolar affective disorder (F31) 2 (1) 5 (3) Depression (F32) 19 (14) 30 (18) Elective mutism (F94) 1 (1) 0 (0) Dissocial personality disorder (F60.2) 0 (0) 8 (5) Anorexia nervosa (F50) 5 (4) 0 (0) Emotional difficulties 17 (13) 0 (0) Emotionally unstable personality disorder (F60.3) 0 (0) 12 (7) Externalising disorder (F90–91) 57 (42) 38 (23) Learning disability (F81.9) 1 (1) 1 (1) Neurotic disorder (F40–42) 14 (10) 23 (14) Mental and behavioural disorder due to psychoactive substance use (F10–19) 5 (4) 25 (15) Mental disorder due to brain damage or dysfunction (F06) 0 (0) 1 (1) Pervasive developmental disorder (F84) 8 (6) 7 (4) Schizophrenia (F20) 4 (3) 6 (4) Acute and transient psychotic disorders (F23) 1 (1) 9 (7) Tic disorder (F95) 1 (1) 1 (1)

When the diagnoses of participants in CAMHS were compared with the diagnoses in AMHS, 164 changes (mean 1.65, s.d. 1.15) were found. Of the disorders diagnosed by CAMHS, 64 were no longer present after participants transferred to AMHS, and 100 new disorders were diagnosed in AMHS. Of the 98 participants, 23 (23%) had no changes to their diagnosis.

Disorders diagnosed in CAMHS were examined retrospectively, observing how these cases developed diagnostically under AMHS. Heterotypic continuity was observed to be significant in three disorder categories. These categories were CAMHS externalising disorders to dissocial personality disorders (DPP) ($P = 0.01$), CAMHS eating disorders to emotionally unstable personality disorders (EUPD) ($P = 0.01$) and CAMHS emotional difficulties to EUPD ($P = 0.01$). Homotypic continuity was evident for externalising disorders ($\chi^2 = 37.5$, $P < 0.001$), neurotic disorders ($\chi^2 = 6.04$, $P = 0.01$), bipolar affective disorder ($P < 0.001$), pervasive developmental disorder ($P < 0.001$), mental and behavioural disorder due to psychoactive substance use ($P = 0.01$) and Tourette's syndrome ($P = 0.01$). Several disorders displayed an inverse relationship and, if present in CAMHS, the presence of other disorders in AMHS decreased. This was the case for the following diagnoses: CAMHS neurotic disorder and AMHS externalising disorder ($\chi^2 = 5.47$, $P = 0.02$), CAMHS externalising disorders with both AMHS neurotic disorders ($\chi^2 = 5.02$, $P = 0.03$) and EUPD ($\chi^2 = 8.07$, $P < 0.001$), and CAMHS depression and AMHS externalising disorder ($\chi^2 = 6.08$, $P = 0.02$).

There were two new cases of schizophrenia in the AMHS sample. The participants had diagnoses of emotional difficulties and externalising disorder while under CAMHS. Of the three new cases of bipolar affective disorder, one participant had a diagnosis of externalising disorder and two had a diagnosis of depression while under CAMHS.

Discussion

In our sample, the majority of participants experienced a change in diagnosis between adolescence and adulthood. The aim of this study was to explore the patterns of this change. A total of 59% of participants recovered from their CAMHS diagnosis, indicating effective treatment or evolving symptoms. After transitioning to AMHS, 75% of all participants had been diagnosed with a new diagnosis. This highlights that comorbidity and complexity is still developing.

Cwm Taf University Health Board has an agreed transition policy between CAMHS and AMHS. Since 2011, patients are referred from CAMHS when they are 17.5 years old. A period of transition is then expected, with joint clinical reviews, until the patient reaches the age of 18. Prior policies recommended the transfer to adult services at age 16 or when formal education ended. Previous research has indicated that only 49% of CAMHS patients that have reached the age of service transition successfully engage with AMHS.¹¹ If these individuals had a history of severe mental illness, prescriptions or previous admissions they were more likely to transition. Our study includes people who have been assessed and diagnosed by both CAMHS and AMHS. In this context, it is therefore difficult to establish if the sample is representative as comparable research has mostly been done on a population level. This may explain why several disorders displayed an inverse relationship although research indicates a comorbid relationship.^{8, 10, 12} In our sample, externalising disorders were more prevalent than depression. This is a possible explanation for the higher proportion of male participants in our sample.¹³ This is important as females are at a higher risk for adolescent mental illness continuing into adulthood⁶ and are more likely to develop comorbid mental disorders than males.¹⁴

Homotypic continuity into adulthood was statistically present for several disorders, including externalising disorders. This was an expected finding as attention-deficit hyperactivity disorder has an accepted degree of diagnostic stability, continuing into adulthood with population rates ranging from 1.2 to 7.3%.¹⁵ Neurotic disorders also continued into adulthood. This supports research showing adolescent depression and neurotic disorders displaying a modest continuity into adulthood, in a relapsing and remitting pattern.^{4, 16} This pattern may have influenced why neurotic disorders, but not depression, showed homotypic continuity in this cross-sectional study. Homotypic continuity was also evident for bipolar disorder. Despite this being a small sample, the finding is in keeping with research showing bipolar disorder

to be relatively stable diagnostically.¹⁷ Homotypic continuity was also present for pervasive developmental disorder. This is to be expected as it is considered a lifelong diagnosis.

All CAMHS participants with anorexia nervosa had recovered, and 60% developed EUPD. The DSM defines borderline personality disorder (BPD) instead of EUPD. As EUPD and BPD are comparable, research into both disorders may provide insights into their relationship with eating disorders. Eating disorders have been reported in histories of people with BPD at a rate of 54%, a percentage comparable with our findings.¹⁸ Difficulty in mood regulation, less distress tolerance and a history of childhood emotional abuse are shared findings for these disorders.^{19–22} Identifying such shared characteristics may be the key to developing an understanding of which individual's disorders progress and which resolve.

Within the EUPD population in AMHS, six participants (50%) had a history of emotional difficulties in their childhoods. In the ICD-10, diagnostic categories separate children and adults at times. It could therefore be argued that homotypic continuity be considered despite a change in diagnosis. However, we would argue the existence of these age-related restrictions highlights that symptoms are different at different developmental stages. It is important to note that no diagnostic criteria for child- or adult-specific disorders are the same, minus the age restriction. For this reason, CAMHS emotional difficulties progressing to AMHS EUPD was considered a heterotypic transition. Similarly, externalising disorders transitioning to DPD was considered a heterotypic transition. This is despite the frequency of this particular diagnostic transition.²³ Research has shown that particular traits make the transition to DPD more frequent.²⁴ These traits include persistent conduct problems and engaging in more victim-orientated and violent offences. In our sample, 15% of CAMHS externalising disorders progressed to DPD. All of these participants were initially diagnosed with conduct disorder. As antisocial behaviour peaks in adolescence, this could be considered the ideal time to target intervention, especially as research indicates poor outcomes when antisocial behaviour is related to conduct disorder and substance misuse.²⁵

Two cases of adolescent depression developed into bipolar disorder. Bipolar disorder is commonly diagnosed within the first 5 years after the first depressive episode.^{26–27} This time frame highlights diagnostic progression during the transition to adulthood. Prodromal syndromes, preceding schizophrenia, are also often associated with this epoch. These non-specific changes to a person's mental state are often assumed to be normal behaviour or mental disorders, such as depression or anxiety.²⁸ It is debatable as to whether these adolescent diagnoses should be seen as displaying heterotypic change or are better characterised as prodromal syndromes. Although prodromal symptoms may be present in the childhoods of people with schizophrenia, diagnosable mental health difficulties may also be present. It is hoped that further research in this area will benefit from the DSM-5 (2013) inclusion of attenuated psychosis syndrome.

This study has highlighted patterns of disorder transition as individuals move from adolescence to adulthood. A developmental perspective of mental illness would postulate that these disorders develop from common vulnerabilities, displaying different symptoms at different developmental stages.^{1–4} Research has also indicated diagnostic transition peaks in adolescence and early adulthood.^{4–9–10} Future research, focusing on adolescence and young adulthood as the formative years for mental health, could facilitate an early identification of individuals at risk and the development of targeted interventions.

Owing to this study's sample size, there is a limit on how generalisable the results are to other mental health teams. This study also contained young people, on average aged 18, and over half had transitioned within 2 years. Follow-up until the mid-twenties may have better captured the diagnostic change during the at-risk period of early adulthood.^{6–29} It is assumed that the standard of practice would have been similar among the CAMHS professionals as they worked for the same organisation and used the same diagnostic criteria, and the same is assumed for the AMHS professionals. However, bias may have been introduced into this study during the transition from CAMHS and AMHS. CAMHS services were developed using the Common Assessment Framework or the Choice and Partnership Approach, with a focus on formulation. Care and Treatment Plans, with a diagnostic focus, were more common in AMHS. In Wales, both teams are now required to produce a Care and Treatment Plan in keeping with Part 2 of the Mental Health Measure.³⁰ This was made law in 2012 and one of the key aims is that it would improve consistency. As this study captures a predominately earlier cohort, it would be interesting to see if legislation has had its desired effect and if bias in diagnosis is now less of a concern. In our opinion, further research would benefit from a larger sample size, longer follow-up and structured interviews by blinded researchers.

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1.5.53 Evaluating the effects of a peer-led suturing and wound management workshop for doctors working in a psychiatric hospital

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Abstract

Background

Psychiatric in-patients are often transferred to an emergency department for care of minor wounds, incurring significant distress to the patient and cost to the service.

Aims

To improve superficial wound management in psychiatric in-patients and reduce transfers to the emergency department.

Method

Thirty-four trainees attended two peer-led suturing and wound management teaching sessions, and a suturing kit box was compiled and stored at the Royal Edinburgh Hospital. Teaching was evaluated using Kirkpatrick's model, and patient transfer numbers were acquired by reviewing in-patient Datix reports and emergency department case notes for 6 months before and after teaching.

Results

The proportion of patients transferred to the emergency department decreased significantly from 90% 6 months before the workshop to 30% 6 months after ($P < 0.05$). Trainees engaged positively and there was a significant increase in self-confidence rating following the workshop ($P < 0.05$). The estimated cost saving per transfer was £183.76.

Conclusion

The combination of a peer-led workshop and on-site suturing kit box was effective in reducing transfers to the emergency department and provided a substantial cost saving.

Declaration of interest

None.

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Junior doctors working within in-patient mental health settings are often required to assess self-harm injuries and wounds sustained from unintentional accidents. Such superficial wounds are encountered frequently by trainees in surgery and emergency medicine, but less commonly by junior trainees in psychiatry. National clinical guidelines advise that all clinical staff involved in the treatment of self-harm should have appropriate training in the treatment and management of superficial uncomplicated injuries.¹ However, we noted that there was no provision in our department for this kind of tailored teaching. In our methods, we describe a retrospective audit which revealed 18 episodes in 6 months where a patient was transferred to the emergency department for simple wound management. As a result, it was hypothesised that significant savings could be made by training junior doctors in psychiatry in the recognition of wounds that could be treated without transfer to the emergency department. Furthermore, this could reduce the stress and perceived stigma that patients experience when attending the emergency department for self-inflicted wounds. We

identified two key interventions that could be made: first, compiling a suturing kit box to be kept available on site; and, second, providing a suturing and wound management workshop for trainees. In this paper, we describe the process of designing a workshop, compiling a kit box and evaluating the effect of this teaching programme using Kirkpatrick's Hierarchy of Learning.²

Methods

Wound management workshop design

A 1-h workshop was designed by two psychiatry trainees, a surgical trainee and a consultant in emergency medicine. This was offered to all trainees working in adult, intellectual disabilities, adolescent and elderly care psychiatry at the Royal Edinburgh Hospital (REH). It was advertised by email at the time of trainee induction, and an emphasis was placed on making the workshop accessible to all (it was run in two separate time-slots in an afternoon session reserved for trainee teaching). Our learning objectives were to: manage common wounds, safely use local anaesthetic, select an appropriate treatment for a wound, demonstrate correct handling of suture and instruments, and perform interrupted sutures. An example lesson plan is outlined in *Table 1*. *Table 1* The structure of our workshop, showing topics covered and the time taken

Topic	Time allocated (min)
Introduction and learning objectives	2
Common types of wound	10
Principles of wound management	5
Safe use of local anaesthetic	2
Choice of closure technique – dressing, steri-strip, glue and suture	5
Post-closure care	2
Demonstration – local anaesthetic and interrupted suturing	20
Practice	20
Discuss four images	5
Summary	2

Suturing kit box design

We compiled a list of equipment required for closing wounds with either sutures or steri-strips. The equipment was stored in a portable plastic box and kept on site at REH. In order to keep track of stock, all items were photographed and displayed along with their order codes on the lid of the box (*Fig. 1*). We purposefully included only the equipment required for simple suturing. This included 3-0 or 4-0 non-absorbable suture, a basic instrument pack, a sterile dressing pack, lidocaine without adrenaline, and needles for drawing up and injecting. In choosing this limited range we hoped that trainees would not treat wounds beyond their level of competence. *Fig. 1* Suturing kit box.

Evaluation of teaching

To assess engagement in teaching (Kirkpatrick level 1), attendees completed an online questionnaire with Likert-rated statements. This was emailed to attendees 1 week following the workshop, and a certificate of attendance was provided on completion of the questionnaire. These statements were: 'I enjoyed the wound management workshop', 'The content was relevant to me as a trainee' and 'I feel confident to suture wounds independently'.

To assess knowledge and confidence acquisition (Kirkpatrick level 2), attendees completed a questionnaire prior to and following the workshop. In this questionnaire, they viewed two images of deep wounds (e.g. wrist laceration with tendon visible and deep laceration through muscle) and two images of superficial wounds (i.e. only through skin with subcutaneous fat showing). Trainees were blinded to whether a wound was deemed superficial or deep – they had to assess it by appearance alone with no other history provided. They were asked to view the images and respond on a Likert scale to the statement 'I could manage this wound without referral to the emergency department'. An example of the wound images used is shown in Supplementary Appendix 1, available at <https://doi.org/10.1192/bjb.2018.41>.

Collecting transfer data

In order to assess whether trainees displayed a behavioural change (Kirkpatrick level 3), we collected Datix (an on-line incident reporting system) reports from all in-patient psychiatric wards at REH. These are completed by nursing staff whenever there is a self-harm or wound incident. Datix reports were in an electronic SBAR (situation, background, assessment and recommendation) format which allowed free-text search. Incidents which mentioned 'laceration', 'wound', 'doctor' and 'suture' were identified and the individual entries reviewed. This allowed us to ascertain how many patients were treated on site with first aid or simple wound management (steri-strips, sutures and dressings).

To assess the effect on service delivery (Kirkpatrick level 4), we identified the number of patients transferred for superficial wound management to the Royal Infirmary of Edinburgh (RIE) emergency department over a 6 month period before and after the workshop. These data were collected retrospectively from August 2016 to August 2017. All patients transferred from REH to RIE were identified using the 'Trak' electronic healthcare record system, and the case notes for each patient were reviewed. In each case the documented presenting complaint was noted, along with any treatment provided. This allowed us to identify a subset of patients with superficial wounds which could have been managed without specialist input. Inclusion criteria were: (a) wounds documented as subcutaneous or superficial; (b) wounds closed by either a junior trainee or emergency nurse practitioner; (c) wounds which needed no treatment. Episodes where the wound was significant enough to be referred to a senior emergency department clinician or specialty doctor were excluded.

Calculating cost savings

We itemised the steps involved in patient transfer and requested a breakdown of cost from our hospital finance department. This included an estimate of the time an emergency department clinician spent assessing and treating the patient. The cost of treating a patient on site was estimated by summing the cost of raw materials required to close a wound (i.e. suture, local anaesthetic and dressings) and 30 min of clinician time. The cost of running the workshop in terms of materials, room booking and clinician time were also outlined.

Results

Evaluation of teaching

A total of 34 trainees attended two workshops in February ($N = 14$) and August 2017 ($N = 20$). Attendees were foundation year 2 ($N = 17$), general practice ($N = 12$) or core psychiatry ($N = 5$) trainees.

Level 1 – Engagement in teaching

Of the 34 trainees, 24 rated the statements in *Fig. 2* – 91% of responses were 'agree' or 'strongly agree'. *Fig. 2* Agreement of trainees attending the workshop to the statements illustrated.

Level 2 – Knowledge acquisition

Self-confidence rating was completed by 32 of the 34 attendees (94%) prior to the workshop and by 26 of the 34 attendees (76%) following the workshop. *Figure 3* shows the Likert responses for wounds that could be managed by a novice trainee and those that should be referred. Responses of 'agree' and 'disagree' pre and post workshop were analysed with a chi-squared test in a 2×2 contingency table. *Fig. 3* Self-confidence rating of trainees before and after the workshop for (a) superficial wounds and (b) deep wounds which should be referred.

For simple superficial wounds, there was a significant increase ($P = 0.001$) in post-workshop confidence, with a reduction in 'disagree' responses and an increase in 'agree' responses (to the statement 'I could manage this wound without referral to the emergency department').

For complex deep wounds (which should be referred), there was an unexpected, significant increase in confidence. Following the workshop, several attendees changed their response, with 23% stating that they would be confident to manage these wounds without referral to the emergency department.

Levels 3 and 4 – Assessing behavioural change and effects on service

Combining data collected from emergency department referrals and review of Datix reports of in-patient self-harm, *Fig. 4* outlines locations of treatment before and after the teaching workshop. Chi-squared analysis showed a significant difference between patients treated on site and those transferred to the emergency department ($P = 0.0001$). *Fig. 4* Data from Datix incident reports and emergency department case notes showing the number of wounds treated on site compared with those transferred in the 6 months before the workshop and 6 months after.

Calculating cost savings

Table 2 compares the itemised cost of transfer to the emergency department with treatment on site. *Table 2* Itemised costs involved in transferring a patient to the emergency department compared with the cost of raw materials required to treat on site and the cost of the teaching intervention

Transfer to the emergency department	Treatment on site	Teaching intervention
Item	Cost	Item
Patient transport return trip	£28	Suture instrument pack
1 h room booking	£1.90	1 h room booking
Nurse escort (minimum estimate of 4 h)	£823	0 non-absorbable suture
£91.20	Attendance at emergency department (including triage, review by doctor and treatment materials)	£901
× 10 mL vial lidocaine with syringe and needle	£0.35	Artificial skin pad x 12 (£16 each)
£17.60	Suture instrument pack x 12 (£1.90 each)	£22.80
Total	£200	Clinician time (estimated 30 min)
		£13.05
		Suture x 20
		£17.60
		Total
		£16.24
		Total
		£339.60

Discussion

To the best of our knowledge, this is the first study aiming to reduce the number of psychiatric in-patients transferred to the emergency department for treatment of minor wounds. Specifically, we were interested to know whether simple superficial wounds could be treated on site, negating the need for transfer and reducing the psychological distress to the patient.³ Several studies have described the effects and cost to the emergency department of self-harm in general, but these primarily involve self-presentation rather than transfer from an in-patient setting.⁴⁻⁷ One study did describe psychiatric in-patient self-harm episodes and reported that 8% of these resulted in emergency department attendance, although the nature of treatment in the emergency department was not outlined.⁷

One possible reason for transferring such superficial wounds to the emergency department could be that our junior trainees lacked confidence and skills in managing simple wounds. This may be representative of national challenges in the UK: a recent national survey of undergraduate medical students suggested that most leave medical school lacking in confidence in basic suturing skills and knowledge of which suturing technique to deploy.⁸ This is despite 'skin suturing' and 'wound care and basic wound dressing' being stipulated as expected outcomes for medical undergraduates by the end of their medical training within the UK.⁹ While junior doctors working in psychiatry may be expected to be less knowledgeable in wound management compared with those in surgical or emergency specialties, the Royal College of Psychiatrists expects core psychiatry trainees to be able to 'Know the principles underlying management and prevention of ... self harm'.¹⁰

Therefore, the first challenge of this study was to engage junior doctors working in psychiatry and empower them to manage simple wounds without transfer to the emergency department. We accomplished this by adopting a peer-led, multi-specialty approach. The workshop described above (*Table 1*) was facilitated by junior psychiatry trainees who had invited attendees via email. It was then taught by a surgical trainee who demonstrated practical suturing skills and an emergency medicine consultant who outlined general wound management principles. With this combined range of expertise, we found that most participants engaged positively (91%), agreeing that they enjoyed the workshop, felt more confident and that the teaching was relevant to their skill level (level 1 outcome, *Fig. 2*). Having input from a senior emergency department clinician was a crucial factor in this, as trainees often enquired as to what complexity of

wound they should treat and what should be referred. This does raise the question of what level of wound management should be expected of a junior doctor in psychiatry. With reference to National Institute for Health and Care Excellence guidance for self-harm,¹ we suggest that skin lacerations greater than 5 cm in length which are deep enough to reveal underlying structures (not just subcutaneous fat) should always be discussed with the emergency department. We believe it is reasonable to expect a junior doctor working in psychiatry to manage a wound which is superficial and less than 5 cm in length, given the correct training. This was one of the key learning objectives in the workshop and was the rationale behind our evaluation of confidence change (level 2 outcome).

Assessing the competency of trainees in differentiating deep from superficial wounds was beyond the scope of this workshop. Equally, formally assessing the acquisition of technical suturing skills was not required, as this is an expected outcome of undergraduate medical education.⁹ Instead, in our level 2 outcome, we sought to measure the change in self-confidence rating following the workshop (*Fig. 3*). Confidence ratings are commonly used when evaluating surgical skill workshops. There is no relationship between confidence and competence prior to surgical skill teaching, but confidence does increase when a competency is gained.¹¹ Since all attendees at our workshop had been taught suturing as undergraduates, we sought to enhance their confidence by focusing on re-teaching wound management and refreshing technical skills, rather than formally assessing technical competence. Trainees responded to an online questionnaire presenting them with a series of wound images. They were asked to rate the statement 'I could manage this wound without referral to the emergency department' on a five-point Likert scale. Prior to teaching, only 42% of trainees agreed with this statement, suggesting that they would be confident to treat the wound with their current skill set. Following teaching, this confidence was increased, with 71% of trainees agreeing with the statement. This increase was only true for wounds which were visibly superficial. When rating images of deep wounds (including those with visible tendon damage), there was an unexpected significant increase in trainee confidence (*Fig. 3*). Responses stating they would manage the wound without referral rose from 1.6 to 22.9%, suggesting that there is potential for trainees to treat wounds beyond their level of competence. Encouragingly, during the study period, there were no reported complications from the increased number of patients having their wounds managed at our psychiatric hospital, and no reports of inappropriate suturing attempts. We suggest that the change in confidence may reflect the challenge novice trainees encountered in determining the depth of deep wounds based only on a two-dimensional photograph.

As an objective measure of knowledge application (level 3), we collected Datix reports of in-patient self-harm episodes. Unfortunately, this is a free-text system based around an SBAR template; as a result, some incidents mentioned a laceration but did not outline how it was treated. In the remaining entries (where a treatment was recorded), we found a statistically significant increase in the number of wounds treated on site following our workshop. There was a corresponding decrease in the number of transfers to the emergency department in those same 6 months, as outlined in our level 4 outcome (*Fig. 4*).

The cost saving per patient is outlined in *Table 2*. This shows that a single transfer to the emergency department can cost a minimum of £200. To the best of our knowledge, no other study has investigated the costs of in-patient transfer to the emergency department for superficial wound management. One study estimated the cumulative cost from admission to discharge of a patient with self-harm presenting at the emergency department to be £425.24 per patient.¹² Another more recent study suggested the mean immediate cost to the hospital for each episode of self-harm to be £809.4. The latter estimate includes an average of £254 for psychosocial assessment. It also includes the costs of in-patient admission and medical treatment that would be required for certain types of self-harm, such as poisoning, trauma (e.g. fall from height, asphyxiation, jumping in front of a moving object) and drowning. These studies discuss self-harm which results in a superficial wound; however, the cost of treating this is not expanded on as a subcategory of self-harm. In our paper, we identify a very specific subset of self-harm patients that could benefit from on-site treatment. Such self-injury represents only 22% of emergency department presentations,⁴ and so it is likely that our estimated costs are considerably lower because they represent only the treatment of simple, superficial wounds.

There is a substantial difference in cost between treating the patient on site and transferring to the emergency department. *Table 2* outlines the costs of treating on site, of treatment at the emergency department and of running the teaching workshop. A single, hour-long teaching workshop for 12 trainees cost an estimated £339.60. This included an hour of clinician time (two middle-grade trainees and a consultant), although in reality clinicians volunteered to teach in their spare time. Equally, we included an estimate of room booking cost, although this was provided to us free of charge as a departmental seminar room. Considering a single transfer costs £200 and treatment on site costs £16.24, it becomes cost-effective to run the workshop when the outcome is two or more patients being treated on site (this represents a potential £183.76 saving every time a patient is treated on site instead of being transferred to the

emergency department).

This study was limited by being a small, single-centre study across two cohorts of junior doctors working in psychiatry. Data were collected retrospectively, and wounds documented in the emergency department notes were observer dependent. Equally, follow-up was limited to 6 months after teaching. A larger-scale study could more fully assess the effects of peer-led teaching interventions and could account for seasonal variation in patient transfer numbers. Additionally, future qualitative work should focus on the perspectives of patients and staff following such training.

This teaching evaluation showed that a peer-led workshop improves trainee self-confidence in managing superficial wounds. We have shown there was a significant reduction in transfers and considerable cost saving from two key interventions: providing training on wound management and making resources available on site. Combining these interventions had an effect on service delivery, and as a result more patients were treated without transfer to the emergency department. We hope that our findings illustrate a small but important improvement in the care we give to our patients, which could easily be replicated in other centres.

We would like to thank Andy Johnston from eHealth analysis and our self-harm nurse Merrick Pope for their contributions to data acquisition in this study.

T. A. Buick is a Core Surgical Trainee at NHS Lothian, UK; **D. Hamilton** and **G. Weatherdon** are Core Psychiatry Trainees at the Royal Edinburgh Hospital, UK; **C. I. O'Shea** is a Clinical Teaching Fellow at NHS Lothian, UK; and **G. McAlpine** is an Emergency Medicine Consultant at the Royal Infirmary Edinburgh, UK.

Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2018.41>.

[click here to view supplementary material](#)

We used the Health Research Authority ethics decision tool to confirm that this study did not require ethical approval.

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1.5.54 Rethinking engagement

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Abstract

People affected by health conditions bring insights and wisdom to transform healthcare – ‘jewels from the caves of suffering’. Yet traditional patient and public engagement relies on (child–parent) feedback or (adolescent–parent) ‘representative’ approaches that fail to value this expertise and buffers patients’ influence. This editorial outlines the emergence of ‘patient leadership’ and work in the Sussex Musculoskeletal Partnership, its patient director (the first such role in the National Health Service)

and a group of patient/carer partners, who are becoming equal partners in decision-making helping to reframe problems, generate insight, shift dynamics and change practice within improvement and governance work.

Declaration of interest

David Gilbert is Director of *InHealth Associates Ltd*, a small consultancy organisation that supports patient and public engagement.

Contents

- *Rethinking engagement*
 - *Valuing what patients can bring – patients as partners*
 - *Changing how engagement is done*
 - *Supporting people’s capabilities – the emergence of Patient Leaders*
 - *New opportunities – the patient director and patient partners*

“‘Some important principles are becoming well established: these are the antiseptic power of transparency, a commitment to both personal and shared responsibility and a renewed engagement with patients and the public.’ Rethinking Regulation. (p. 21)¹” Calls for patient engagement in mental healthcare seem ubiquitous. There appears to be a consensus that people who use services must now work alongside staff to identify solutions to current healthcare challenges. However, if we are serious about this renewed engagement, we need to think carefully. The task is fourfold. First, we need to learn to value what patients can bring, which I call ‘seeing patients as partners’. Second, we need to change how engagement is done, by rethinking the engagement process. Third, we need to support people’s capabilities to better work together. This includes developing the right skills. Finally, we must develop new opportunities for patients to influence decision-making by creating new roles.

Valuing what patients can bring – patients as partners

People who have been affected by life-changing illness, injury or disability can help. We bring jewels of wisdom and insight from the caves of suffering² – we know intimately what it is like to feel vulnerable and powerless, the effect of pain and suffering on lives, the primacy of healing relationships in care and what good and poor services look like. This combination of vision, humanity and integrity are essential components of high-quality leadership.

About 20 years ago, I was sitting on a psychiatric ward with nothing to do – the lunch had been awful, the occupational therapist had been sacked (so no activities that afternoon) and the ward seemed full of screaming folk. A doctor strolled onto our bay and gave a perfunctory nod before gingerly pulling on the curtain rail beside my bed. Even in my disturbed state, I could see his behaviour was odder than mine. I asked him what he was doing. ‘Just checking to see if you could do anything stupid’, he replied, before walking back down the corridor. I was left contemplating the sudden and unintended addition to my range of ‘treatment’ options.

Fast forward 10 years: I was Head of Patients and the Public at the Commission for Health Improvement, the health inspectorate at the time (predecessor of the Healthcare Commission and Care Quality Commission). I was reading the National Patient Safety Agency standards on mental healthcare (though I don’t recall which one, exactly). One of them was to decrease in-patient psychiatric suicides to zero by... removing all non-collapsible curtain rails. I remembered that doctor who had checked my curtain rail. At about that time, three fellow in-patient friends of mine died. One had choked to death on her food while unsupervised, after she had left the psychiatric unit and gone to a nursing home (she had earlier been paralysed from the neck down through a failed suicide attempt). One had gone to his caravan and hanged himself. And one had drowned himself in the local reservoir.

All those deaths had occurred away from the in-patient environment, so the unit would have passed its inspection by having removed ligature points. It might also have been congratulated on its risk policies. This was ‘hitting the target and missing the point’. The unit had responded to the caravan and reservoir deaths by locking the doors at 20.00 h. This deprived me of my one visitor, a local chaplain who I could only get to see at 21.00 h. Nights became a pressure cooker of aggravated emotions – the consequence of this lack of trust and forced containment felt unsafe. I wonder whether dialogue between us in-patients and staff about what makes for a safe environment might have saved my friends.

Later, as part of a Collaboration for Leadership in Applied Health Research and Care Fellowship (North-West London), I undertook qualitative research that revealed seven benefits of high-quality patient engagement in improvement work (<https://futurepatientblog.com/2015/03/22/seven-things-that-patients-bring-the-benefits-of-patients-as-partners-for-change/>).³ I found several distinct benefits. Having patients as partners in the room will reframe the problems to be tackled. Focusing on what matters to patients leads to pathway redesign with better awareness of access issues, information and explanations needed at each stage, more humanity and better customer care. Patient engagement also promotes the finding of potential solutions to problems. Patients have the passion, insight, imagination and freedom from institutionally limited thinking to ask ‘What if...?’ They also widen the array of options for improvement and change.

This process necessarily leads to changed relationships. With patients in the room, others are given permission to explore. Dynamics change, trusted relationships develop, people work together and move beyond us–them conversations to dialogue. Shared decision-making emerges. There are also individual benefits. Patients feel more confident, develop new skills and build on those skills buried during times of illness – and come to feel better. Staff gain too. Morale is lifted as conversations become about what can be done, they can feel that we are truly all in this together. This sort of work rehumanises healthcare. It should be noted that this approach may also help staff who suffer emotional distress. In mental health (and perhaps beyond) there has never been a better time for people with health problems to work with staff (clinicians and support staff alike) to change and improve approaches to well-being and to explore our common humanity, rethink professional role boundaries (the ‘them and us’ mentality) and approaches to safety and risk.

The result is better quality decisions. If people know why decisions have been made and been part of that process, this generates trust, confidence and it becomes easier to build consensus. This has deep implications for transparency, governance and accountability. I have seen and heard about dozens of changes in policy and practice as a result of patients being partners in improvement work: making guidelines more flexible, better ways to tackle access and equalities, tackling attitudes and behaviours, different ways of meeting unmet need, the list is endless. There are even benefits beyond the project. When people see the advantages of patients as partners for improvement and change in one area, they will help spread it to others. It is a virtuous cycle with implications for scaling up improvement processes, spreading good practice and sustainability.

Changing how engagement is done

The traditional approaches to involving or engaging patients do not work, and so we fail to value the jewels offered or to change the ‘currency’ of healthcare toward what matters. Patient and public engagement, as traditionally conceived, buffers power by distancing patients from decision-making. Thus, it maintains the status quo by preserving the institutional authority of professional system leaders. Ironically, when engagement is seen to fail, as it often does, this can be attributed to the lack of value that patients bring rather than to faulty mechanisms. The engagement industry focuses largely on inputs, activities and processes (the methods of gathering data, how to capture views, etc.) over impact and outcomes.

The approaches and methods used rely on two main styles. The first is that of feedback: patients are invited to fill in questionnaires, attend focus groups or tell their stories (if they are lucky) at board meetings or the like. The focus is what happened to them in the past, mostly about their experience of services (rather than living with a condition, or about their lives beyond the institutional scope of interest), and the meaning of their data is left to professionals to assess through their own lenses based on their own assumptions and often narrow institutionalised thinking (often what is seen as feasible rather than necessary). Patients are not permitted to eyeball the data or bring their own interpretations to it, let alone be partners in decisions about what to do. This feedback approach mirrors traditional medical paternalistic models – you tell us the symptoms and we will provide the diagnosis and treatment. It is stuck in child–parent mode.

The second style is scrutiny. Whenever there is a governance committee, an advisory group or the like, the call goes

out for a lay representative. I know a patient and public involvement lead who likened her role to that of ‘lay rep pimp’. Without clarity of role, support or training, a representative is expected to bring the patient perspective to the decision-making table. I was once asked ‘so David, what do patients think?’. What, all of them? I thought. In search of credibility and leaning on what we know, we tell our stories, and half the people in the room applaud this ‘telling truth to power’ and the other half fall asleep (‘another patient with an axe to grind’ or ‘personal agenda’ they mutter later in the corridors). If we wise up and come to the table next time wearing a suit and tie, brandishing data, those that were awake last time fall asleep and accuse us of ‘going native’. I have written about this representative trap in more detail elsewhere.⁴

The consequence of failed representational mechanisms is that committees lapse into a default ‘us and them’ mode. Frustrated, marginalised and unprepared representatives start finger-wagging or fall silent. This is adolescent–parent style engagement. If we are serious about partnership, then we need to overhaul the engagement industry.

Supporting people’s capabilities – the emergence of Patient Leaders

The past few years have seen the rise of new forms of engagement such as online dialogue, experience-based co-design, health champions, peer support and the like. Mark Doughty and I founded the Centre for Patient Leadership to support patients (those with life-changing illness injury or disability, and/or with long-term conditions) to be influential change agents. CPL trained over 1000 patients to develop the capabilities to work with professionals as equal partners. Further information on patient leadership is available online (<http://www.inhealthassociates.co.uk/patient-leadership-articles-and-reports/>).

Patient Leaders are those who have been affected by life-changing illness, injury or disability and want to work with others in partnership to influence change. This can, of course, include carers. They can have many roles. Some are entrepreneurs like Michael Seres, a patient who had undergone a bowel transplant and then invented a Bluetooth sensor-enabled colostomy bag that does not overflow. He has also led the way on remote-access technology to allow people to communicate with their clinicians, and is Chief Executive of his own company, Health 11. Others are campaigners or activists, online dialogue specialists, improvement advisors or help organisations as governors or are part of inspection processes. They work at local, regional and national levels. (I am writing a book entitled ‘*The Jewel Merchants*’, which will be published in 2019, that is based on the stories of 15 such people, including Alison Cameron, Ceinwen Giles, Dominic Makuvachuma-Walker, Patrick Ojeer and Sibylle Erdmann).

There needs to be wider investment in skills development; indeed, one might question why tens of millions of pounds is spent investing in the capabilities of managerial and clinical leadership, and none on this emerging army of people who could – and I think will – regenerate healthcare. There is still a widespread assumption that system leaders are professionals, but for Patient Leaders to achieve their full potential, they also need the learning and development that enables them to be true leaders.

Finally, there has to be an equal emphasis on creating the right opportunities, for example, in governance, research and audit, service improvement and training and education. This could be at a local or national level, but needs to be where professionals are willing and able to work as partners too. Opportunities must also be created at a senior level. In much the same way that it is not considered appropriate that a service purporting to deliver ‘women-centred care’ is led entirely by men, in a few years’ time it will seem odd that we have ever had a patient-centred National Health Service (NHS) run entirely by clinical and managerial leaders. The Sussex Musculoskeletal (MSK) Partnership (Central Sussex) receives referrals from general practitioners of people who have joint, muscle or bone problems. The service stretches from Brighton and Hove, through mid-Sussex and Horsham to Crawley. Clinicians screen referrals, and many are offered an appointment at our specialist clinics, with advanced MSK practitioners or physiotherapists (often working alongside consultants and others, such as psychologists). The Partnership is a lead accountable provider. It comprises the Sussex NHS Community Trust, Sussex Partnership Trust, HERE (a social enterprise) and The Horder Centre (a charity). In Autumn of 2015, three clinical commissioning groups pooled a total of £50 m per year for 5 years to us, so we could run a better system for people who use services. We want to get it right first time, so that people do not have to go here, there and everywhere for different diagnostic and treatment interventions. And we, like the NHS rhetoric always says, want patients to be at the heart of what we do.

New opportunities – the patient director and patient partners

The Sussex MSK Partnership (Central) made a brave decision to appoint the first patient director – someone who has had experience of a life-changing illness, injury or disability (in my case, mental health problems) and can harness these experiences at senior decision-making levels. This role ensures that patient leadership is embedded at a senior level, within an executive team that includes a clinical director and managing director. This models shared decision-making at corporate level. The patient director's role is to help the Partnership focus on what matters. This includes embedding patient-centred cultures, systems and processes such that they become 'hardwired' and making sure we learn from, and act on what patients' think about services. The patient director will also support patients to enable them to be influential and valued partners in decision-making.

Being a patient director has enabled me to experiment with a different approach to engagement. For example, we have eight patient and carer partners. They bring professional and personal wisdom alongside their experiences of using our services. Patient and carer partners are not representatives or there to provide feedback, but are 'critical friends' who check assumptions, ask questions, provide insights into reframing issues or identifying problems, change dynamics and model collaborative leadership.

My role is to broker opportunities in improvement or governance and support them to ensure they have the capacity and capability to be effective. Patient and carer partners augment other involvement and feedback work. This work has been developed during a period of intense operational pressures. During the past 3 years, the Partnership has transformed the way MSK services are delivered (through a lead accountable provider model – see box) and patient partners have been alongside as we have done so. We wanted them to be partners in every MDT that oversees quality in each of our musculoskeletal pathways (orthopaedics, rheumatology, pain management and physiotherapy).

The first step was for the patient director to identify opportunities for meaningful engagement and ensure their presence in improvement and redesign work. Then, to be clear that they were more than storytellers or to feed back on their experiences (we had other data for that), they stayed in the room, proving themselves well able to reframe problems, generate new solutions, model collaborative leadership and shift dynamics. Patient partners have been involved in seven major improvement programmes: pain services redesign, fibromyalgia pathways, development of patient reported outcome measures, plans for shared decision-making, administrative systems, support for receptionists and call handlers and integration of physical and mental health provisions.

An early experience helped us to demonstrate benefits. We were discussing how to communicate with patients about booking appointments. We were receiving lots of calls to cancel or change inconvenient appointments that we had booked for people. A woman who had been through our service, told us that our team phoned at inconvenient times to book appointments. She suggested that, instead, we send opt-in appointment letters and put her in the driving seat. Let her phone back when she had her diary in front of her and she could plan out her week. We experimented with the idea and it was successful, with patients and call handlers alike delighted with how it worked. If this approach were rolled out, we would save an estimated 3500 cancelled appointments per year.

Slowly, they have become trusted equals. It has not been easy and is dependent on clarity of role, shared understanding of purpose, demonstrating benefits and the perennial time, money, space, trust... all things the NHS has precious little of. We are ready for the next step – for partners to move from an improvement role into a more steady-state governance role. However, given inevitable resource constraints, we realise that we cannot support two patient partners in each of our eight MDTs. So patient partners have come up with a different approach: the idea of a pilot special MDT. This might model the sort of reflective dialogue they want to demonstrate and focus on issues of quality and patient experience. We would evaluate the work and see whether it could be a model for other pathways. Members of the hip and knee pathway MDT seem keen on the idea, and next month we will be talking to them about how it could work.

We will also discuss whether and how we can ensure that patients are a part of regular MDTs. Several other clinical leads are watching this experiment with interest, and it could pave the way for a different model of reflective governance across the Partnership. It has taken 3 years for this work to take off – the role of patient director is still novel, and this particular model of patient partnership is an experiment. It has taken months of building relationships, doing the ground work and making the case for a different model of engagement.

In the current frenzy surrounding NHS policy and practice, it is worthwhile remembering that long-term improvements take time, space and trust. There are no quick fixes. Our work in Sussex demonstrates one novel approach to the chal-

lenges of rethinking engagement. It is predicated on the four steps necessary to renew engagement – to value what people bring, establish different mechanisms for dialogue, to develop people’s capabilities and provide new opportunities for the new breed of patient (or carer) leaders. Looking back, I now wonder what might have happened if a patient director had been around when I was on the psychiatric unit. Might my three friends still be alive?

David Gilbert is Director of *InHealth Associates* and Patient Director at *Sussex Musculoskeletal Partnership* (Central Sussex), UK.

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1.5.55 Adult safeguarding under the Care Act 2014

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date

2019-2

Abstract

Summary

Safeguarding adults is everybody’s business, and it is now standard practice for clinicians to undertake safeguarding training as part of their mandatory training in the UK. Nevertheless, safeguarding work is complex and can involve significant dilemmas for professionals. The Care Act 2014 has introduced a number of differences in the way safeguarding is approached, emphasising the overall well-being and choice of the patient rather than merely focusing on their safety. This paper sets out to illustrate evolving safeguarding demand and practice, and aid clinicians in protecting people at risk by describing how they can approach challenging presentations.

Declaration of interest

None.

Contents

- *Adult safeguarding under the Care Act 2014*
 - *Background*
 - *Definitions*
 - *Safeguarding activity*
 - *Guiding principles*
 - *Responsibilities*

- *Safeguarding dilemmas*
- *Conclusion: implications for patients and carers*

Background

Safeguarding adults in England and Wales is set out in the Care Act 2014.¹ The new law came in to being in April 2015 and superseded earlier documents that sought to protect vulnerable adults,² or ‘adults at risk of harm’,³ from abuse. The Care Act itself brought together a wide range of social care concerns and activities, including personalisation, social care assessment and Mental Health Act 117 aftercare, as well as safeguarding, in a single statute.⁴ This aimed to create ‘a legal framework so key organizations and individuals with responsibilities for adult safeguarding can agree on how they must work together and what roles they must play to keep adults at risk safe’.⁵

In Scotland, the Support and Protection Act 2007 ‘seeks to protect and benefit adults at risk of being harmed’. The Act ‘requires councils and a range of public bodies to work together to support and protect adults who are unable to safeguard themselves, their property and their rights’.⁶ In Northern Ireland, *Adult Safeguarding Prevention and Protection in Partnership* was published in July 2015.⁷ It makes it clear that ‘safeguarding is everyone’s business and that as good citizens we should all strive to prevent harm to adults from abuse, exploitation or neglect’.

Definitions

The term ‘vulnerable adult’ was a term used in *No Secrets* to describe those adults who may need to be subject to safeguarding.² However, in 2011, the Law commission recommended that this concept should no longer be used, as the label of vulnerability was not appropriate and could be ‘stigmatising, dated, negative and disempowering’.³ The Care Act uses the term ‘adult at risk’ and also, at times, ‘adult with care and support needs’.

Most doctors will be used to definitions of abuse from statutory training in child protection and adult safeguarding, which is now a mandatory training requirement. Full details of forms of abuse under the Care Act are included in the Care Act statutory guidance.⁸ It should be noted that services now have responsibilities to ensure that carers are also considered within the safeguarding context. Care Act statutory guidance note 14.45 recognises the circumstances in which a carer could be involved in a situation that may require a safeguarding response and provide information on how to manage these.

A ‘concern’ is used technically in the Act as the point at which the statutory authority is notified by someone that an adult at risk of harm is suspected to be the subject of abuse.

‘Enquiries’ are the investigations that the statutory authority makes in order to determine whether abuse has taken place, and whether the individual would benefit from safeguarding.

Safeguarding activity

Statistics gathered in the first 6 months following the implementation of the Care Act suggest that the number of adult safeguarding cases doubled during this period.⁹ During the year following implementation of the Act, the Local Government Association undertook a series of six Care Act stocktakes to help them to understand the implications of the Act for local authorities. These stocktakes suggested that the rise in safeguarding referrals has continued, with 73% of councils involved in stocktake 6 reporting an increase in the levels of activity, and 34% stating that they had increased greatly.¹⁰ By contrast, figures gathered by NHS Digital in their *Safeguarding Adults: Annual Report* for 2015–2016¹¹ indicate that 102 970 Section 42 *enquiries* were reported for the period 2015–2016, compared with 103 445 *referrals* during the period 2014–2015. It is difficult to directly compare statistics across these two reports in light of changes in terms of reference used within the safeguarding proceedings and therefore the reports. However, it should be noted that a total of 184 860 safeguarding concerns and 8365 ‘other enquiries’ were reported for the 2015–2016 period, suggesting that the rate of overall referral was greater than the recorded number of enquiries given above. When these are considered alongside the ‘referral’ rates from the previous year, it appears that the level of safeguarding concerns

being raised has indeed increased. Statistics for 2016–2017 support this trend, showing 109 145 individuals under a safeguarding enquiry starting during the period measured, an increase of 6% from the previous year.¹²

Guiding principles

As with all aspects of the Care Act, the concept of well-being underpins safeguarding practice, with ‘protection from abuse and neglect’ cited as one of the key elements of promoting individual well-being.⁸ Within this, the Care Act guidance also outlines six fundamental principles for safeguarding (*Box 1*). *Box 1* Six Principles of Safeguarding

Empowerment People being supported and encouraged to make their own decisions and informed consent
Prevention It is better to take action before harm occurs
Proportionality The least intrusive response appropriate to the risk presented
Protection Support and representation for those in greatest need
Partnership Local solutions through services working with their communities; communities have a part to play in preventing, detecting and reporting neglect and abuse
Accountability Accountability and transparency in safeguarding practice

In line with these principles, the Care Act focuses on early identification and prevention of potential abuse and neglect, rather than specifying thresholds for intervention. Any actions proposed should take into account the needs, goals and wishes of the patient, ensuring that their consent is gained before any action is taken. To support this aim, Making Safeguarding Personal (MSP), a sector-led safeguarding initiative, has also been introduced to help develop a more outcome-focused response.¹³

The MSP ‘temperature check’ in 2016¹⁴ recorded a number of positive outcomes in places where MSP was being implemented. Patients reported feeling more in control, with professional meetings declining but smaller patient meetings becoming more common. Overall, the results suggested that while MSP takes no longer than traditional approaches to implement, there is evidence to suggest that it leads to better outcomes and savings in time and resources.

Responsibilities

“*Effective safeguarding cannot be achieved without a large number of organizations and individuals working closely together, and there being an explicit recognition that safeguarding is everyone’s concern.*”¹⁵

The local authority is required under Section 42 of the Care Act to take a leading role in coordinating safeguarding enquiries, and may do this either through making enquiries themselves or by ensuring that others do so. Guidance for carrying out Section 42 enquiries is set out in paragraphs 14.63–14.67 of the Care Act Statutory Guidance.⁸ Section 43 of the Care Act also requires local authorities to establish a Safeguarding Adults Board for its area, with the objective of helping and protecting adults that meet safeguarding eligibility criteria, through coordinating and ensuring the effectiveness of each of its members. A useful diagram showing the simplified responsibilities of key parties can be found in the *Safeguarding Adults* paper produced by the Care Quality Commission (CQC), the Association of Directors of Adult Social Services, NHS England, the Local Government Association and the Association of Chief Police Officers.¹⁶

Alongside local authorities and other partner agencies, individual clinicians should seek to work with individuals at an early stage to promote well-being and independence, with the aim of preventing abuse and neglect from occurring.¹⁵ Further to this, the focus should be upon identifying abuse or neglect early and raising a safeguarding concern. Care Act guidance states: ‘*No professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. If a professional has concerns about the adult’s welfare and believes they are suffering or likely to suffer abuse or neglect, then they should share the information with the local authority and, or, the police if they believe or suspect that a crime has been committed.*’⁸ The safeguarding process can be time consuming, and it is important that clinicians continue to offer appropriate care and treatment to the patient. Where appropriate, clinicians should also attend safeguarding meetings in order to provide a more cohesive and robust plan of support.

Although not all concerns will be escalated to become Section 42 enquiries, this will be decided by the relevant safeguarding team, who will have overall responsibility for the decision on whether an enquiry is required. The team will consider the criteria as outlined in S.42(1) Care Act (*Box 2*). They will also consider issues such as mental capacity¹⁷ and consent, which will be explored in more detail in the case examples below. *Box 2* Care Act Safeguarding eligibility criteria (1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether

or not ordinarily resident there);(2)has needs for care and support (whether or not the authority is meeting any of those needs);(3)is experiencing, or is at risk of, abuse or neglect; and(4)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Where clinicians have concerns that important factors are not being acknowledged, these can be raised with the enquiry officer and through initial strategy discussions and case conferences, which will be held during the safeguarding enquiry process. All individuals involved in the process will be included in determining whether allegations of abuse are substantiated and in developing an appropriate plan with the patient. Whereas under previous guidance, the emphasis was often on taking professionally proscribed measures to ensure patient safety, statutory Care Act guidance states that ‘professionals and staff should not be advocating “safety” measures that do not take account of individual well-being, as defined in Section 1 of the Care Act’.⁸ As in the assessment of social care needs, practitioners should approach safeguarding concerns in an inclusive, outcomes-focused, person-centred manner, and the emphasis should be on ‘sensible risk appraisal, not risk avoidance’.¹⁸ It should be made clear to the individual that they will be included at all stages of the enquiry and that factors such as their wishes, preferences, history and lifestyle will be taken into account throughout the process. Outcomes should be primarily patient determined. While there may be occasions when views of those involved in the process differ, decisions are made in a multidisciplinary manner with the patient’s wishes at the forefront, with overall responsibility for reaching consensus falling to the safeguarding manager.

Safeguarding dilemmas

The case studies below highlight some of the factors and considerations which may be pertinent to safeguarding processes.

Case Example 1: Cheryl – Consent, Coercion and Domestic Violence “Cheryl is a 30-year-old woman with a diagnosis of severe anxiety and depression. She is living with her partner, Julian, and two children, both of whom are under a Child Protection Plan. There have been a number of concerns raised over recent months about Julian, who will often present as verbally aggressive towards professionals. Julian will also ensure that he is present at all of Cheryl’s appointments. Cheryl comes to her out-patient appointment with a black eye which Julian states is due to walking into a door frame. Her psychiatrist manages to speak to Cheryl alone and Cheryl tells her that in fact Julian has hit her the evening before. Cheryl asks her psychiatrist not to tell anyone and says that she does not want police involved or for any action to be taken. Cheryl’s psychiatrist feels that Cheryl has capacity to make this decision, but is concerned about the risks to Cheryl and her children. Cheryl’s psychiatrist raises a Safeguarding Adults concern and also contacts Children’s services to ensure they are aware of the incident.”

Unlike previous guidance, which emphasised the duty to report and act on all allegations of abuse, the Care Act emphasises empowerment and the patient’s right to choice and control over how and with whom information is shared. In this instance, Cheryl is refusing consent to contact police or for a safeguarding investigation to take place. Since Cheryl has capacity to refuse to report abuse to police or for a safeguarding enquiry to be undertaken, a risk assessment will need to be made in regards to whether others are at risk (public interest), a serious crime is taking place (public interest) or Cheryl’s life is in danger (vital interest). In line with principles of protection and proportionality, if there is an identified risk in either of these areas, the investigating team may decide to overrule their consent and continue with the safeguarding investigation, involving only professionals and not friends or family members.

In light of Julian’s behaviour, consideration should also be given to whether Cheryl’s decision is being made under the influence of coercion and control, in which case Cheryl’s consent may be overridden and a safeguarding investigation commenced. This new offence of ‘coercive and controlling behaviour in intimate and familial relationships’ was introduced into the Serious Crime Act 2015 as a way of providing better protection to victims experiencing continuous abuse.⁸ In cases such as these, the individual may present as having capacity in relation to a decision but in fact be unable to make this decision owing to coercion or control. In these cases, the individual will not fall under the auspice of the Mental Capacity Act. This kind of enquiry is often complex and will require a range of professionals to work with the person to identify appropriate safeguarding options. In serious cases, the situation may ultimately require application to the inherent jurisdiction of the High Court,¹⁵ who may legally be able to act against the wishes of the individual to safeguard them from further harm. Similarly, police now have the ability to use a Domestic Violence Protection Order under Sections 24–33 of the Crime and Security Act 2010 to remove an alleged perpetrator from the family home for a period of up to 28 days with or without consent from the person alleged to be experiencing abuse.¹⁹

Should it be decided that safeguarding needs to proceed, with or without Cheryl's consent and involvement, there is a need to undertake 'safe enquiry', ensuring that any investigation does not increase risk to Cheryl. The Local Government Association guide to adult safeguarding and domestic abuse²⁰ provides a useful and comprehensive guide to dealing with these situations within the safeguarding context.

Finally, if Cheryl refuses consent and none of the above risk factors are present, this decision should be respected and Cheryl should be supported in considering other avenues outside the safeguarding agenda. Information may still need to be shared with children's services if there is a perceived risk to the children, which will need to be addressed under child safeguarding procedures.

Case Example 2: Layla – Unintentional Abuse, Carer Safeguarding and Mental Capacity "Layla is a 77-year-old woman with physical mobility difficulties and early symptoms of Alzheimer's disease. She is currently in a relationship with Giles, a 78-year-old man who also has physical mobility issues. Layla and Giles both attend Layla's Care Programme Approach meeting, during which Layla's psychiatrist notices that Layla's hair and clothes are unclean and she has lost weight. He asks Layla about this, who replies that Giles does not help her with her personal hygiene or give her food regularly. Giles explains that he is doing his best but is struggling to care for Layla at the moment owing to his physical health, and that he did not want to contact anyone for help as Layla does not want carers involved. He also discloses that he has found caring for Layla more difficult recently, as on a number of occasions she has lashed out at him and caused him minor injuries. Layla's psychiatrist is concerned that Layla is being neglected and raises a safeguarding concern."

This case study, while on the face of it simple, in fact outlines complex issues around unintentional abuse, carer safeguarding and mental capacity.

In this case study, a safeguarding alert has been raised owing to what appears to be unintentional neglect of Layla, which has arisen because Giles is struggling to care for her. Unintentional abuse is a recognised issue under the Care Act, and guidance is clear that the unintentional nature of this does not change the fact that it is a form of abuse or make the need for action any less important.

In this case example, professionals will need to consider Layla's capacity in relation to a range of safeguarding-related decisions, for example, whether she has capacity to decide whether to allow carers into the home, and whether she can consent to information being shared as part of a safeguarding enquiry.¹⁵ The Care Act works together with the Mental Capacity Act 2005, and if Layla is found to lack capacity, an Independent Mental Capacity Advocate (IMCA) must be made available to her. Unlike most best-interests decision situations, an IMCA may be required even if there is an appropriate friend or family member who could support Layla.

If Layla is found to have capacity in these areas but also appears to have substantial difficulty in engaging with safeguarding processes, it may be appropriate for a Care Act Advocate to be involved. This is a new role under the Care Act which is used where a person with capacity demonstrates substantial difficulty in being involved in decision-making and does not have an appropriate friend or family member to support them. Where there is no appropriate individual, the local authority must provide an independent advocate.²¹

Also pertinent in this case is that one of the major changes to safeguarding processes introduced by the Care Act is the need to provide safeguarding responses for carers who may be experiencing abuse due to their caring role. Since it has been identified that Giles is experiencing physical abuse from Layla in the course of his caring role, this avenue will need to be considered as a framework for providing him with appropriate support. Although the primary focus is likely to remain on safeguarding Layla, consideration will also need to be given to providing a more appropriate package for Giles as carer to help prevent further abuse to both parties.⁸ In this instance, there is no indication that Giles lacks capacity; however, it should be remembered that where an alleged perpetrator lacks mental capacity, they are entitled to support from an IMCA throughout the safeguarding proceedings.⁸

Case Study 3: Alexis – Organisational Abuse "Alexis is a 42-year-old Black British man living in a residential placement owing to his moderate learning disability and physical mobility issues. Alexis attends a routine out-patient appointment, during which he discloses that one of the staff members at the placement has left him sitting in the bath for an extended period of time on a number of occasions. Alexis also shares some racially derogatory names which he says the staff member has been calling him when he asks for help. Alexis's psychiatrist decides to raise a safeguarding concern."

This case example allows us to consider issues round organisational abuse, including neglect and poor practice within an institution or specific care setting, and action which will need to be taken in these instances, as set out in the Care Act statutory guidance.⁸

In situations such as this, the safeguarding investigation will need to include Alexis's residential placement. The placement should be made aware that, as instructed by Care Act guidance, where a complaint or allegation has been made against a member of staff, they 'should be made aware of their rights under employment legislation and any internal disciplinary procedures'.⁸

The local authority does not have the right to direct Alexis' care home as to what actions to take against their staff; however, they should report concerns to the CQC and continue to monitor the situation. Since this is a care setting, the local authority must also advise other placing authorities of the concerns so that appropriate measures can be taken to safeguard all other residents as well as Alexis. Since Section 44 of the Mental Capacity Act makes wilful neglect or mistreatment of an adult who lacks capacity a criminal offence, should Alexis be deemed to lack capacity, police involvement may be required in the safeguarding process.¹⁵

Conclusion: implications for patients and carers

The introduction of the Care Act 2014 has had a number of implications for patients and carers requiring support under the safeguarding framework. One of the positive developments in regards to individual empowerment is that the Act places a greater emphasis on individual self-determination and desired outcomes. Patients now have a more robust framework protecting their rights to make decisions about their lives, with new advocacy requirements ensuring that their voices are heard. Prevention principles have removed some of the previous thresholds which would have prevented those in the early stages of abuse or neglect from being overlooked, and require services to be more proactive in preventing the escalation of abuse.

However, it could be argued that the Care Act's emphasis on patient outcomes and goals could come at the price of leaving some individuals unsafeguarded who would previously have been supported under a less flexible framework. Services may need to develop new ways of responding to these concerns, ensuring that front-line staff across the multidisciplinary team work together to ensure that needs are met and risks are mitigated as far as possible. There are also questions over where this leaves family members, friends and other members of social networks who will continue to worry about the well-being of the vulnerable person. There is scope under Care Act legislation for support to be offered to carers under the safeguarding framework, and it may be that support can be offered to carers in this situation. For example a carer's assessment may be considered to discuss the effects of the caring role, including worry caused by these concerns.

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1.5.56 The effect of a youth mental health service model on access to secondary mental healthcare for young people aged 14–25 years

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Abstract

Aims and method

The Norfolk Youth Service was created in 2012 in response to calls to redesign mental health services to better meet the needs of young people. The new service model transcends traditional boundaries by creating a single, ‘youth friendly’ service for young people aged 14–25 years. The aim of this study was to investigate the effect of the transition to this new model on patterns of referral, acceptance and service use. We analysed routinely collected data on young people aged 14–25 years referred for secondary mental healthcare in Norfolk before and after implementation of the youth mental health service. The number of referrals, their age and gender, proportion of referrals accepted and average number of service contacts per referral by age pre- and post-implementation were compared.

Results

Referrals increased by 68% following implementation of the new service model, but the proportion of referrals accepted fell by 27 percentage points. Before implementation of the youth service, there was a clear discrepancy between the peak age of referral and the age of those seen by services. Following implementation, service contacts were more equitable across ages, with no marked discontinuity at age 18 years.

Clinical implications

Our findings suggest that the transformation of services may have succeeded in reducing the ‘cliff edge’ in access to mental health services at the transition to adulthood. However, the sharp rise in referrals and reduction in the proportion of referrals accepted highlights the importance of considering possible unintended consequences of new service models.

Declaration of interests

None.

Contents

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Adolescence is a high-risk period for the emergence of mental health problems¹ but mental health service provision for this age group is often inadequate.^{2–4} Traditional mental health service models bisect the adolescent period, with young people under 18 (or in some cases 16) years seen by child and adolescent mental health services (CAMHS) and those aged 18 years and over by adult mental health services (AMHS). Consequently, there is often a gap in service provision for young people transitioning to adulthood, meaning that young people are unable to access timely and developmentally appropriate support.^{5–6} In response to these problems, a number of innovative services have emerged that traverse the traditional CAMHS–AMHS divide in an effort to meet the specific needs of young people and reduce the need for disruptive transitions between services.⁶

Norfolk and Suffolk National Health Service Foundation Trust (NSFT) established the Norfolk Youth Service as a pilot in 2012. The pilot service provided mental healthcare for young people aged 14–25 years with severe and complex non-psychotic mental health problems. Following the success of the pilot, the service was expanded to provide staged intervention for all young people aged 14–25 years living in Norfolk and Waveney, replacing the existing traditional CAMHS–AMHS service model. In 2015, Norfolk and Waveney was home to 271 698 children and young people aged under 25 years.⁷ The county is predominantly rural and 86% of residents identify as White British; it has higher rates of looked after children, children in need because of abuse, neglect or family dysfunction, and pupils with behavioural, emotional and social support needs than the average for England.⁷

The new service model was intended to be youth-oriented, non-stigmatising and recovery-focused to maximise access and engagement. The new service kept the same referral criteria, continuing to accept referrals for young people with mental health problems requiring specialist or secondary care interventions. However, young people no longer had to be referred from a CAMHS service into an AMHS service when they reached 18 years old, increasing the continuity of care. The national and local context for this service transformation, and the design of the new service have been described in detail elsewhere.⁸

The empirical evidence of the effect of redesigning mental health services to bridge the CAMHS–AMHS age range on young people's access to mental health services is limited. The aim of this study was to investigate the effect of implementing a youth mental health service model for young people aged 14–25 years, based on patterns of referral, acceptance and service use. The study involved retrospective analysis of service data collected before and after the implementation of the Norfolk Youth Service.

Method

Design

The study used a historical control design. The investigation focused on two 12-month periods, one before and one after the implementation of a specialist youth mental health service for young people aged 14–25 years in Norfolk, UK. The first time period, September 2010 to August 2011, fell immediately before the development of the youth mental health service pilot. The second time period, April 2014 to March 2015, was the second year of operation of the substantive Norfolk Youth Service, chosen to coincide with the completion of the transition to the new service model and embedding of new clinical teams. The service models in operation during these two time periods are outlined in simplified form in

Fig. 1. Pre-existing data on young people referred to secondary mental health services in Norfolk during these two time periods was obtained and analysed. Fig. 1 Service models in operation before and after creation of the Norfolk Youth Service as part of Norfolk and Suffolk National Health Service Foundation Trust's redesign of services for children, families and young people. AMHS, Adult Mental Health Services; CAMHS, Child and Adolescent Mental Health Services.

Data collection

Data on all referrals to NSFT are routinely collected and processed by the Trust's Informatics Department for the purpose of business delivery and development. To meet the aims of our study, the research team requested data held by the Informatics Department on all referrals to secondary mental health services in Norfolk of young people aged 14–25 years during the above 12-month periods. All data was anonymised before being transferred to the research team; the researchers accessed no personally identifiable data. The study was approved by NSFT as a service evaluation and did not require ethical approval.

The data requested included the demographic characteristics of those referred, the outcome of the referral (i.e. whether the young person was accepted into mental health services) and the number of recorded service contacts (i.e. the number of appointments, including both face-to-face and telephone appointments), which served as an indicator of service use.

Analysis plan

The number of referrals received, proportion of referrals accepted, and the age and gender of those referred and accepted were examined for each of the two time periods under consideration. The average number of service contacts per referral by age was also calculated for each time period. These descriptive statistics were used to make comparisons across the two time periods studied, with the aid of tables and figures. The use of inferential statistics to make comparisons between the two time periods was not considered appropriate given that the dataset included all recorded referrals made during the pre-specified time periods of interest, not a sample of such referrals.

Results

Referral and acceptance rates

During a 12-month period before the implementation of the youth service model, from 1 September 2010 to 31 August 2011 inclusive, NSFT received 7476 referrals for young people aged 14–25 years living in Norfolk. Of these referrals, 27.7% were for young people under 18 years of age. Across services, 90.8% of referrals received were accepted. The acceptance rate was higher for AMHS than for CAMHS (95.5 v. 78.5%). During a 12-month period post-implementation of the new service model, from 1 April 2014 to 31 March 2015 inclusive, NSFT received 12 559 referrals for individuals aged 14–25 years living in Norfolk. Of these referrals, 45.8% were for young people under 18 years of age. During this period, the Norfolk Youth Service accepted 68.2% of referrals received. The acceptance rate for adults referred to the service was higher than for young people aged under 18 years (75.8 v. 59.2%). The referral and acceptance data for both time periods are summarised in *Table 1*.

	14–17 years	18–25 years	Total
Pre-implementation	2070	5406	7476
Post-implementation	2070	5406	7476
Referred	2070	5406	7476
Accepted	1624	5162	6786
Percentage accepted	78.5	95.5	90.8

¹

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Pre-implementation refers to the 12-month period from 1 September 2010 to 31 August 2011. Post-implementation refers to the 12-month period from 1 April 2014 to 31 March 2015 inclusive.

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The majority of those referred during both time periods were female (58.8% pre-implementation and 59.5% post-implementation). For both pre- and post-implementation of the youth service model, the gender disparity in the referrals received was most marked among younger referrals under 18 years of age, with a more even gender split in referrals of those aged over 18 years.

Service contacts

During the 12-month period before the implementation of the new service model, the total number of contacts with young people aged 14–25 years in Norfolk was 56 759. The average number of contacts per referral was markedly higher for young people aged 15–17 years than for young people aged 18–20 years, with a clear disparity between the rate of contacts per referral for those younger than 18 years and those aged 18 years or over. On average, a young person referred at 17 years of age went on to have 11.3 service contacts, whereas a young person referred at 18 years of age went on to have just 5.3 service contacts.

In the 12-month period following implementation of the youth service model, the total number of service contacts with young people aged 14–25 years in Norfolk was 79 659. Although overall the average number of contacts per referral was lower than before implementation of the new model, the average number of contacts received was more equitable across age groups. On average, a young person referred at 17 years of age went on to have eight service contacts, whereas a young person referred at 18 years of age went on to have an average of seven service contacts. The average number of contacts with services during the periods before and after implementation of youth service model by age of referral are presented in *Fig. 2*. *Fig. 2* Average number of service contacts per referral for young people aged 14–25 years pre-implementation (Time 1) and post-implementation (Time 2) of the youth mental health service model.

Discussion

The purpose of this study was to explore whether a change in service structure from a traditional CAMHS–AMHS model with transition at 18 years of age to a youth mental health service model for young people aged 14–25 years was associated with altered patterns of referral, acceptance or service-use.

A number of interesting changes post-implementation were identified. The number of referrals to mental health services for young people aged 14–25 years living in Norfolk increased by 68% following implementation of the new service model: from 7476 before the implementation of the youth service to 12 559 after its implementation. The number of referrals increased most for young people aged 14–17 years: there was a 2.8-fold increase in the number of individuals aged 14–17 years referred but only a 1.3-fold increase in referrals for individuals aged 18–25 years.

The reason for this increase in referrals is unclear. One possibility is that the increase reflects increased local awareness of the support available for young people with mental health problems as a result of the publicity surrounding the new service model. New referral routes (including the option for young people to self-refer) may also have led to an increased volume of direct referrals to secondary mental health services. Previously, these young people might have been referred to primary care or third-sector agencies in the first instance, with only more severe or complex cases being referred on to secondary care. It is also possible that the increase in referrals reflects a wider increase in demand for mental health support for young people, not directly associated with the change in service model. There is some evidence that rates of internalising problems in children and young people have been increasing in recent years,⁹ and a substantial rise in the demand for children and young people's mental health service has been reported nationally.¹⁰

Both before and after the implementation of the youth service model, more females were referred than males, with the gender disparity being more marked among younger referrals. The reluctance of young men to seek care for mental health problems is well documented.^{11–12} The small number of males referred relative to females, both before and after the implementation of the new service model, suggests there is more work to do to encourage young men to access

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support. NSFT have recently launched a Men's Wellbeing Project that aims to encourage men and boys to talk more openly about their mental health and increase access to mental health services.¹³

Although the raw number of referrals accepted by the service increased substantially following implementation of the youth service model, the proportion of referrals accepted fell: from 91% pre-implementation of the model to 68% post-implementation. This decrease might be at least partially explained by the increased number of referrals coming into conflict with limited service capacity. As previously reported,⁸ a consequence of improving access to services when resources remain limited has been increased wait-lists and sometimes overwhelming case-loads. Although acceptance criteria were unchanged following implementation of the new service model, it is possible that pressures on service capacity might have led to an upward shift in the threshold for secondary care. However, it is also possible that the fall in the proportion of referrals accepted can be explained by an increase in the number of inappropriate referrals due to the introduction of new referral routes. These referrals are then signposted on to more suitable agencies. The service is in the process of investigating this with a view to developing strategies to further improve access for young people across all agencies, to reduce the number of referrals ending up in the wrong place and subsequently being passed around services.

The number of recorded service contacts was used as a proxy for service use. The overall average number of contacts per referral for those aged 14–25 years decreased following the introduction of the youth service model. Although the service offered by Norfolk Youth Service is not time-limited, there is an emphasis on offering appropriately staged intervention and not retaining individuals within the service for longer than needed.⁸ The reduction in overall average service contacts for young people in this age group might, therefore, reflect this change in service philosophy, toward encouraging flexible re-referral if needed.

Before implementation of the Norfolk Youth Service, young people aged 18 years or over were referred to services in high numbers but received substantially fewer contacts with services relative to those aged under 18 years. This 'cliff edge' in mental health service use at the transition to adulthood has also been reported in the USA,¹⁴ suggesting this problem is not specific to the local context. Following the implementation of the youth service model, the average number of contacts per referral was more equitable across ages, with the cliff edge in service contacts no longer evident. Pre-implementation, the average number of contacts per referral at 18 years of age was less than half that at 17 years of age. Post-implementation, the average number of contacts per referral was just one fewer for 18-year-olds than for 17-year-olds.

It is possible that the new service model simply moved the transition down from 18 years to 14 years. Data for 13-year-olds demonstrated that this was not the case: 574 referrals for 13-year-olds were accepted by the service and they received 5103 contacts. This gave them an average of 8.9 contacts per referral, which is broadly similar to 14-year-olds. This does not support the idea that the previous disparity in contacts per referral has been moved to a transition at 14 years instead of 18 years.

Overall, this study suggests that implementation of the youth service model might have been successful in reducing the disparity between demand for, and access to, service during young adulthood.

Limitations

As the study had a historical control design, it is not possible to know whether the changes in referral, acceptance and service-use patterns observed following implementation of the youth service model were the result of the change in service model. It remains possible that the changes observed resulted from wider factors influencing demand for and/or engagement with mental health services. Further, because the data used were routinely collected service data, it is possible that there were variations in the quality of data collection over time that may have affected the study's findings.

Although moving from separate CAMHS and AMHS to an integrated service for 14- to 25-year-olds removes the service boundary at age 17/18 years, it also creates new boundaries at age 13/14 years and 25/26 years. Arguably, these new service boundaries fit more closely with developmental transitions and coincide less closely with peaks in the incidence of mental health problems. Nonetheless, it will be important for future research to investigate the effect of these new service boundaries on those who fall outside the 14–25 year age range.

We would like to acknowledge the valuable input of Valerie Gage, Kevin Brown (NSFT Informatics Department) and Dr Dickon Bevington.

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1.5.57 Liaison psychiatry services in Wales

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Abstract

Aims and method

Recent funding from Welsh Government for mental health has helped to develop liaison psychiatry services in Wales. Systematic data collection was undertaken to map the liaison psychiatry services in Wales in collaboration with the Royal College of Psychiatrists in Wales and Public Health Wales 1000 Lives Improvement. A questionnaire was designed and circulated to all the health boards in Wales to gather information to map liaison psychiatry services in Wales. Up-to-date information was confirmed in January 2018, via email.

Results

Over the past 2 years, liaison psychiatry services have been set up in six out of seven health boards in Wales. Staffing levels have increased and the remit of services has broadened.

Clinical implications

Mapping has highlighted that liaison psychiatry services in Wales continue to evolve. It will be important to continue to monitor these developments and their effects. Comparison with services in England will provide a useful comparison of service provision. A particular challenge will be to establish and monitor liaison psychiatry standards in Wales.

Declaration of interest

None.

Contents

- *Liaison psychiatry services in Wales*
 - *Method*
 - *Results*
 - * *Service expansion*
 - * *Staffing*
 - *Discussion*

In 2008, Wales had 2.6 full-time equivalent consultants in liaison psychiatry.¹ Overall, where provided, liaison psychiatry services were not meeting the standards specified in the guidance ‘*Developing Models for Liaison Psychiatry Services*’.² Furthermore, three Welsh National Health Service (NHS) trusts did not provide a liaison psychiatry service.¹ In 2009, 29 NHS organisations merged to form seven integrated health boards, providing all healthcare in Wales.³ Unlike England, there are no separate mental health trusts. Therefore mental health services are part of unified health boards that comprise both mental health and general hospitals. Every health board caters for a number of large and some smaller community hospitals within the geographical area covered by the respective health board.

A policy paper for England, ‘*Achieving Better Access to Mental Health Services by 2020*’,⁴ outlines the need to provide liaison psychiatry cover for all ages in the accident and emergency (A&E) department. In 2012, the Welsh Government published ‘*Together for Mental Health*’, its 10-year strategy to improve mental health services.⁵ Within this document there was an acknowledgement that ‘Improved liaison psychiatry services can ensure that mental health care needs are met for those people on general wards and reduce length of stay’ (p. 65).⁵ The strategy required that all district general hospitals in Wales should have a liaison psychiatry team in place by March 2017.

In response to a request from NHS England, the national surveys of Liaison Psychiatry in England (LPSE) in collaboration with the Liaison Faculty of the Royal College of Psychiatrists charted the extent and growth of liaison psychiatry in England.⁶

In 2015 the Welsh Government allocated more than £8 m of recurrent revenue investment to establish enhanced dementia, liaison psychiatry, psychological therapy and women and perinatal services. Additional funding was also made available to implement the legislative requirements of the Mental Capacity Act 2005.

Method

A collaboration between Public Health Wales 1000 Lives Improvement service, the Welsh Government, the NHS Delivery Unit and the Royal College of Psychiatrists in Wales systematically mapped liaison psychiatry services in Wales. This multi-agency quality improvement project did not require approval from an ethics committee.

A structured questionnaire was designed to gather information on the level of service provision, the make-up of teams by discipline, the type of service provided, the clinical areas and hospitals covered, the hours of working and any plans for further service development. The first draft of the questionnaire was piloted to test for suitability and for ease of data collection. Suggested changes were made to improve the quality of data collection, using Microsoft Excel. A lead clinician or manager (link person) with a remit for liaison psychiatry service was identified within each health board in Wales. The final questionnaire was disseminated electronically by the Public Health Wales 1000 Lives Improvement service to the link person in each health board. The data was collected and analysed with Microsoft Excel.

The collected information was presented in a meeting organised by the Public Health Wales 1000 Lives Improvement service attended by representatives from the liaison psychiatry services in Wales. In January 2018 the level of services across Wales were reconfirmed via email by each health board. This provided an opportunity to confirm or reconcile the information collected in the initial distribution of the questionnaire. The information collected in this mapping exercise is set out below.

Results

The six health boards in Wales with general hospitals responded to the questionnaire. The seventh health board, Powys Teaching Health Board, does not have an acute hospital and therefore did not respond. The liaison psychiatry services for working-age adults and older age adults were the main focus of this mapping exercise. The information gathered is summarised in *Table 1*. *Table 1* Remit of liaison psychiatry services in Wales Health board (geographical areas covered) Notes on service structure and remit Abertawe Bro Morgannwg (Swansea, Neath Port Talbot) Services split geographically. One area has a combined service, the other has services split by age and combined with other teams. Aneurin Bevan (Gwent, Monmouthshire) Services split by age, adult combined with crisis resolution home treatment team. Betsi Cadwaladr (North Wales) Single all-age service, meeting Core 24 criteria. Cardiff & Vale (Cardiff and Vale of Glamorgan) Services split by age, Poisons Unit linked with the adult service. Cwm Taf (Merthyr Tydfil, Rhondda Cynon Taf) Single all-age service. Hywel Dda (West Wales) Older adult service in place. Adult being set-up. *Table 2* Staffing establishment comparison by health board between 2007 and 2018

Health board	Total in Wales 2007	Total in Wales 2018
Abertawe Bro Morgannwg	1745	1577
Aneurin Bevan	1975	1487
Betsi Cadwaladr	1067	1011
Cardiff & Vale	4334	424
Cwm Taf	Hywel Dda	65
Hywel Dda	65	65
Average daily available beds, 2016–2017	1781	1745
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Service expansion

There has been a significant increase in the availability of psychiatric liaison services in Wales in the past 10 years. Six Welsh health boards now provide a liaison psychiatry service for older adults, and all but one provide a working-age adult service. All services now operate in A&E departments.

Table 1 shows the variation in the structure and remit of psychiatric liaison services across Wales. Some health boards have combined services covering working-age adults and older adults whereas others were split by age. One health board provides distinct geographical services. Two health boards have combined the crisis resolution home treatment team with the adult liaison psychiatry team. *Table 2* identifies the total number of general hospital beds in each health board and the number of major general hospitals that make up each health board.

Betsi Cadwalder University Health Board provides a 24 hour liaison psychiatry service. This service meets the requirements of the Mental Health Partnerships' Core 24 model and is accredited by the Psychiatric Liaison Accreditation Network (PLAN)⁷ service. Other services provide a broadly '9 to 5' service, although in many cases, this includes weekends and some services provide extended 12 or 14 hour cover of A&E departments. Two health boards, Cardiff & Vale University Health Board (C&V UHB) and Abertawe Bro Morgannwg University Health Board, provide liaison psychiatry out-patient clinics. The liaison psychiatry service in Betsi Cadwalder University Health Board provides follow-up out-patient review appointments.

Dedicated intellectual disability liaison services (also known as learning disability in UK health services), substance misuse liaison services and child and adolescent liaison services were not the main focus of this survey. Some information was included in some of the responses. Two health boards have substance misuse liaison services as a stand-alone service.

Staffing

Table 2 summarises the staffing levels for the liaison services by discipline, together with total staffing levels in Wales in 2007.¹ The table also identifies variation in the staffing levels between health boards; however, direct comparison is not possible given the different structures and remits of services. At this stage service provision cannot be explained by level of need or referral numbers in each health board as this information is only collected on a local level. To present the mapping more clearly and allow easier comparison, the data is set out by health board rather than by individual liaison teams or hospitals covered by the teams. In the two health boards where age-specific liaison teams operate, we have included the breakdown of these teams.

We identified that in the past 2 years there has been a considerable overall increase in the level of staffing within liaison psychiatry services in Wales. No health board has a liaison service comprising only nursing staff, whereas in 2007, this was the case in three out of eight liaison psychiatry services. Dementia support workers have been included in two old-age liaison psychiatry services. Five health boards include the provision of occupational therapy services. One old-age service includes support from a pharmacist. C&V UHB previously established a nurse-led substance misuse liaison service consisting of three nurses. The health board also has a dedicated service for people presenting to the A&E department with alcohol-related issues, which was developed with separate public health funding. Betsi Cadwalder University Health Board provides two nurses dedicated to an alcohol misuse service within its liaison psychiatry service.

Discussion

This is the first survey of liaison psychiatry services in Wales since additional funding was provided by the Welsh Government in 2015. At a national level, medical staffing has trebled and nurse staffing has doubled since 2007. This mapping process identified the progress in establishing multi-disciplinary services with an increase in the number of nurses, dedicated psychology support, the inclusion of occupational therapists and dementia support workers with additional consultant posts. This mapping exercise was undertaken using the available resources, with no additional funding for this work. We achieved this through multi-agency collaborative work between the Public Health Wales 1000 Lives Improvement service, NHS Wales Delivery Unit and the Royal College of Psychiatrists in Wales.

Historically some health boards had no specific liaison psychiatry teams and relied on community mental health teams and duty psychiatrist cover. In some areas a collaborative 'goodwill' arrangement existed between consultant colleagues to provide cover for the mental health needs of patients in acute hospitals where no specific cover for liaison psychiatry teams was in place. For these health boards, the new funding from the Welsh Government for liaison psychiatry has been of particular significance. In certain instances, the duty system and crisis teams continue to provide cover to A&E departments out of hours. In addition to government-funded developments, locally funded initiatives have also enhanced these services. This survey did not collect detailed information on these local arrangements or the division of government funding for setting up these services, which is a potential limitation.

The health boards in Wales had autonomously established services according to local needs and requirements. Wales is diverse in its geography and demography, with a mix of rural and urban centres, and the size of geographical areas covered by the individual health board varies. These factors could have influenced the manner in which liaison psychiatry teams have been established by health boards.

The previous survey undertaken in 2008 reported that, in total, there were only two relatively well-established services in Wales: Cardiff and Swansea.¹ In North Wales, a service delivered by a less than full-time consultant with some nursing support existed. Before funding from the Welsh Government becoming available, Cardiff and Swansea had set up old-age liaison psychiatry services. Aneurin Bevan University Health Board piloted the old-age Rapid Assessment, Interface and Discharge⁹ model in the Royal Gwent Hospital and this is now also the model used by the old-age liaison service in C&V UHB.

A liaison psychiatry team should include a consultant psychiatrist, mental health nurses and a psychologist as a core part of this team. Recommended minimum staffing numbers vary with the size of the hospital and type of service.² Published models of liaison psychiatry are named Core, Core 24, Enhanced 24 and Comprehensive. For example, the minimum numbers for a Core liaison psychiatry service covering around 500 beds are two whole-time equivalent consultant psychiatrists and eight whole-time equivalent nurses, in addition to other staff.

The PLAN⁷ has provided quality standards for liaison psychiatry services. Since LPSE-1 was undertaken, there have been two further surveys of liaison psychiatry in England, with response rates of 100% and 97%, respectively. The LPSE has charted the growth of liaison psychiatry in England against the government commitment to establish liaison psychiatry in every acute hospital with an A&E department in England by 2021, with half of these meeting the Core 24 specifications. A fourth survey, LPSE-4, is planned for 2018.

The challenge within Wales will be to evaluate the effect of the newly established liaison psychiatry services. Information currently available suggests that different health boards have invested in developing services in line with their local vision and perceived requirements. Within the relatively small sample of Welsh health boards, there is diversity in the type of liaison psychiatry services provided.

We recommend that information for the next logical phase should be obtained on referral rates to these services. Furthermore, it would be prudent to set standards for liaison psychiatry services in Wales. These standards could be similar to the standards that have evolved in England or bespoke liaison psychiatry standards could be developed for Wales. Hence, further work might also involve assessment of adherence to the agreed standards.

There is an opportunity to learn from the experiences in England. An important lesson from the experience of the LPSE process in England is the need to repeat the mapping exercise over a period of time to assess progress. Moreover, comparison with services in England may emphasise the need for future funding to develop liaison psychiatry services in Wales.

There is an opportunity to gather further data on referrals, standards, patient experience, outcome measures and the evolution of services. There is also an opportunity for health boards to learn from services with a well-established substance misuse liaison service and intellectual disability liaison service.

Liaison psychiatry for children and adolescents in Wales, as in England, is less well developed. Furthermore, investment in a liaison psychiatry service for the specialist Velindre Cancer Centre will need to be considered, as will the arrangements in Powys Teaching Health Board, which does not have any acute general hospitals.

It is anticipated that the development in Welsh liaison psychiatry services will attract trainees to liaison psychiatry for foundation, core and higher training. Previously there were only two services in Wales that provided higher training leading to endorsement in liaison psychiatry.

In conclusion, liaison psychiatry services in Wales are developing and evolving. It would be prudent to monitor this evolution with a view to setting standards, surveying adherence to the standards and monitoring the referrals for an outcome-oriented evaluation of these services. Already, in collaboration with Public Health Wales and the NHS Delivery Unit, plans are in place for developing the governance to address the recommendations discussed in this paper.

We are grateful to all the liaison psychiatry teams in the health boards who contributed to information for this paper.

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1.5.58 Night-time confinement is an unacceptable hospital practice

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Abstract

Night-time confinement, currently imposed as a blanket restriction on all patients on wards in UK high secure hospitals, constitutes an arbitrary restriction of liberty, not being based on any therapeutic purpose for those so restricted, nor serving a need for the protection of others. Its imposition constitutes a form of 'degrading' treatment as well as an unjustified restriction of 'residual' liberty. Persons who are vulnerable, especially those who are involuntarily detained as in this case, are particularly at risk of suffering human rights abuses. A compelling case can be made, based on ethics, law and accepted practice standards, for ruling out night-time confinement as an acceptable measure.

Declaration of interest

None.

Contents

- *Night-time confinement is an unacceptable hospital practice*
 - *Degrading treatment*
 - *Deprivation of ‘residual liberty’*
 - *Mental Health Act Code of Practice 2015*
 - *Conclusion*

Night-time confinement (NTC), currently imposed as a blanket restriction on all patients on wards in UK high secure hospitals (see Silva & Shepherd and Thomson this issue), represents an arbitrary restriction of liberty, not being based on any therapeutic purpose for those so restricted, nor serving a need for the protection of others. Its imposition, I propose, constitutes a form of ‘degrading’ treatment as well as an unjustified restriction of ‘residual’ liberty. This is especially troubling when occurring in a hospital, not a prison. Treating patients with respect for their dignity is a fundamental principle of medical care. Persons who are vulnerable, especially those who are detained as in this case, are particularly at risk of suffering human rights abuses.

While there is a duty on those working in the healthcare system to optimise the use of resources, there are ‘red lines’ limiting what actions can be justified. Locking all patients in their rooms from 9:15 pm to 7:15 am in order to save money on nursing costs crosses such a ‘red line’.

Treating patients in this manner cannot be seen as therapeutic or as facilitating recovery; if anything, the reverse. It has been argued that NTC is welcomed by some patients because they feel safer at night. My reaction to this is one of disappointment that wards cannot be made safe using other means. For example, NTC confinement of an individual patient assessed as presenting a risk to others can be acceptable. Further, if patients feel safer when locked in their rooms, they could be offered this option on a consenting, voluntary basis. A valid consent would make the action not a restriction of the person’s liberty.

Degrading treatment

A good case can be made that NTC constitutes a form of ‘degrading treatment’.

A definition of ‘degrading treatment’ can be difficult to establish. Before considering legal aspects, it is helpful to examine, as Waldron¹ suggests, the ordinary meaning of ‘degrading’. The word ‘degrading’ in everyday language connotes treatment of a person that significantly diminishes their normally accepted rank or status. In this sense, NTC can be seen as degrading the status of ‘patient’ when set against all other patients (as opposed, say, to prisoners). A further ethical argument is that in NTC patients are being instrumentalised, used as ‘means to an end’, the ‘end’ being the saving of money (albeit with the claimed aim of enhancing therapeutic possibilities during the day).

Article 3 of the European Convention on Human Rights (ECHR)² says that ‘no one should be subjected to torture or to inhuman or degrading treatment or punishment’. While the European court concedes there is a threshold of severity to be met, the fact that a person is held in control by state agents, for example in detention, will influence that decision. As a rule, the threshold depends on a number of factors – including the vulnerability of the person, as well as the duty of care owed by the authorities towards persons held in their care.

The approach of the European court has been to assign the terms ‘inhuman’ or ‘degrading’ to an accumulation of particular kinds of practice in particular settings.¹ The meaning of the terms is then read back from the list of particular practices ruled prohibited and identified descriptively. Until a case of NTC, or one relevantly similar to it, is considered, it is not clear whether the European court would regard NTC as constituting ‘degrading’ treatment.

The Equality and Human Rights Commission (EHRC)³ states that ‘degrading treatment’ means treatment that is extremely humiliating and undignified. Whether treatment reaches a level for such an ascription depends on a number of factors. These include the duration of the treatment, its physical or mental effects, and the vulnerability and health of the victim. In NTC the duration is long-term, perhaps lasting years, and a health problem is the reason for the person being in a hospital. Presumably, the hospital is intended to offer a therapeutic environment for persons with a mental disorder, one that, for example, enhances a sense of agency or self-worth. It is hard to see how NTC encourages, rather than impedes, such progress.

The recognised defence of ‘medical necessity’⁴ for what may on the surface appear to be degrading treatment, it can be argued, cannot be applicable in NTC: there simply is no medical purpose.

It is commonly stated that the right not to be treated in a degrading way is ‘absolute’. The EHRC notes that ‘it must never be limited or restricted ... For example, a public authority can never use lack of resources as a defence against an accusation that it has treated someone in an inhuman or degrading way.’³

Waldron poses the question whether treatment can be ‘degrading’ even if the person subject to it is unconscious of it.¹ He proposes that we may judge the treatment as objectively degrading even if the victim accedes to it. A decision in the High Court⁵ supports this contention: “Treatment is capable of being ‘degrading’ within the meaning of article 3, whether or not there is awareness on the part of the victim. However unconscious or unaware of ill-treatment a particular patient may be, treatment which has the effect on those who witness it of degrading the individual may come within article 3 [ECHR]. It is enough if judged by the standard of right-thinking bystanders it would be viewed as humiliating or debasing the victim, showing a lack of respect for, or diminishing, his or her human dignity.”

This view comports well with the results of a survey of patients and staff concerning their ‘agreement’ or ‘disagreement’ with NTC.⁶ This showed that while the majority of the small number of patients (comprising fewer than 50% of eligible participants) were not in disagreement with NTC, 100% of staff were.

Deprivation of ‘residual liberty’

Thus far, English law has not recognised the concept of ‘residual liberty’. However, the European court following the case of *Munjaz v UK*⁷ now does. While the residual liberty of *Munjaz* was ruled not to have been infringed, the validity of the concept was confirmed by the Court – there can be a further deprivation of one’s liberty under Article 5 of the ECHR, even if already detained. The Court held that whether there was a further deprivation of liberty of someone already detained depended on their concrete situation, for example, the type of measure used, and its duration, effects and manner of implementation. In fact, the Court stated, the criteria for a further deprivation ‘must apply with greater force’ when the person is already detained.

The grounds given for the Court’s negative decision in *Munjaz* offer reasons why NTC, by contrast, might well be considered as a deprivation of residual liberty. The court recognised that Mr *Munjaz* was secluded when already in a high secure hospital where he was already subjected to greater restrictions on his liberty than a normal mental health patient. However, reasons for a rejection of his claim were: his seclusion was ‘to contain severely disturbed behaviour likely to harm others’; the length of the seclusion was ‘foremost a matter of clinical judgment’; and great store was placed on ‘the manner of implementing the seclusion policy’ – the hospital’s approach was ‘to allow secluded patients the most liberal regime that was compatible with their presentation’, and seclusion was being ‘flexibly applied’. Behind each reason lay a critical assumption: that the deprivation of liberty served the fundamental purpose of protecting other patients from the harm that might have been caused specifically by Mr *Munjaz*. The problem with NTC is that its purpose is not therapeutic, nor an individually planned response to the risk of harm to others by the person deprived of their liberty. Furthermore, NTC is clearly not ‘the most liberal regime compatible’ with the person’s presentation, nor is its consistent application for 10 h each night ‘flexible’.

The case for a violation of the patient’s ECHR Article 8 right to a ‘private life’ was also considered. Mr *Munjaz* argued that the hospital’s seclusion policy was not in accordance with the law as it lacked the necessary foreseeability and procedural safeguards. The European court affirmed the presumption that those deprived of their liberty will continue to enjoy all of the other fundamental rights and freedoms guaranteed by the Convention. It stated: ‘the importance of the notion of personal autonomy to Article 8 and the need for a practical and effective interpretation of private life demands that when a person’s personal autonomy is already restricted, greater scrutiny be given to measures which

remove the little personal autonomy that is left ... [Mr Munjaz's periods of] seclusion must be regarded as additional interferences with the private life of the applicant, which were distinct from the inevitable interference with his private life that arose from his detention in high security conditions'.

NTC offers little evidence of the kind of additional 'greater scrutiny' demanded by the court. Furthermore, the court stated that any potential breach of Article 8 must be in accordance with the law requiring the impugned measure both to have some basis in domestic law and to be compatible with the rule of law consistent with the object and purpose of Article 8. 'The law must thus be adequately accessible and foreseeable, that is, formulated with sufficient precision to enable the individual – if need be with appropriate advice – to regulate his conduct'. In NTC, on the other hand, the patient's conduct is irrelevant to the deprivation of liberty and thus represents 'arbitrary interference'.

I suggest that NTC would be very unlikely to meet criteria for a lawful restriction of persons' residual liberty or interference with their private life.

Mental Health Act Code of Practice 2015

NTC is furthermore inconsistent with 'guiding principles' expressed in Chapter 1 of the Mental Health Act Code of Practice (MHA CoP) 20158 – 'the least restrictive option and maximising independence'; 'respect and dignity'; 'purpose and effectiveness ... clear therapeutic aims, promote recovery ...'.

The MHA CoP (26.7) states that restrictive interventions, when required, 'should be planned, evidence based, lawful, in the patient's interests, proportionate and dignified'.

And later: "26.20 ... service providers should avoid blanket restrictions that apply to all patients; interventions should always be individualised, and subject to discussion and review by the whole clinical team. The individual's consent to the intervention should always be sought where the individual has capacity to consent or refuse the intervention, even if a refusal may be overridden ..."

Under the section entitled 'Respecting human rights': "26.45 Any use of restrictive interventions must be compliant with the Human Rights Act 1998 (HRA), which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR).26.47 No restrictive intervention should be used unless it is medically necessary to do so in all the circumstances of the case. Action that is not medically necessary may well breach a patient's rights under article 3, which prohibits inhuman or degrading treatment.26.48 Article 8 of the ECHR protects the right to respect for private and family life. A restrictive intervention that does not meet the minimum level of severity for article 3 may nevertheless breach a patient's article 8 rights if it has a sufficiently adverse effect on the patient's private life, including their moral and physical integrity."

These statements are clearly relevant to the earlier discussion.

I note 26.105 '... Seclusion does not include locking people in their rooms at night in accordance with the High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013'. Locking patients in their rooms at night is not seclusion; seclusion is justified by clinical considerations of the risk of harm to the patient or to others. Locking all patients on a ward in their rooms at night as a money-saving measure involves no therapeutic purpose.

Conclusion

A case, based on ethics, law and accepted practice standards, for ruling out NTC as an acceptable measure is compelling. It should cease as soon as possible.

I thank to fellow members of the Special Committee on Human Rights of the Royal College of Psychiatrists for their helpful comments on the manuscript.

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1.5.59 The assertive approach to clozapine: nasogastric administration

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Abstract

Aims and method

An ‘assertive approach’ to clozapine, where nasogastric administration is approved, is assessed through a case-load analysis to provide the first systematic description of its use and outcomes worldwide.

Results

Five of the most extremely ill patients with treatment-resistant schizophrenia were established and/or maintained on clozapine, resulting in improvements to their mental state; incidents were reduced, segregation was terminated and progression to less restrictive environments was achieved.

Clinical implications

Despite being underutilised and rarely enforced, in extreme circumstances, an assertive approach to clozapine can be justified. Nasogastric clozapine can be safely delivered and the approach itself, rather than actual nasogastric administration, may be enough to help establish and maintain patients with treatment-resistant schizophrenia on the most effective treatment.

Declaration of interest

E.S. has received speaker fees from Jansen Pharmaceuticals and Novartis.

Contents

- *The assertive approach to clozapine: nasogastric administration*
 - *Methods*
 - *Results*

– Discussion

* Conclusion

The efficacy of clozapine in treatment-resistant schizophrenia is well established.¹ Compared with alternative antipsychotics, clozapine provides superior symptom control, longer duration of treatment, shorter lengths of stay and reduces violence.² Although enforced antipsychotic treatment is generally widespread, clozapine is both underutilised³ and rarely enforced, with only a handful of case reports worldwide reporting the use of nasogastric^{4–6} and intramuscular^{7–9} clozapine.

With injectable clozapine unavailable in the UK until very recently, when presented with a crisis,¹⁰ nasogastric clozapine was successfully used for the first time at Ashworth high-security hospital in 2010 and has been used subsequently to help establish and maintain treatment with clozapine. We now present the first systematic description of the ‘assertive approach’ to clozapine via nasogastric clozapine, which commences not on the first administration of nasogastric clozapine, but on its approval for use; this in itself is often enough.

Methods

A retrospective case-load analysis of E.S.’s patients was conducted on an intent-to-treat basis, defined by the presence of a Second Opinion Appointed Doctor (SOAD) request for the authorisation of nasogastric clozapine, from the first case in 2010 through to 2016. This provided a minimum 12-month follow-up period. Clinical records were reviewed to identify patient demographics and clinical details including medication compliance and response to treatment, which was determined by Clinical Global Impression (CGI) scores¹¹ combined with segregation use and incident frequency for 12 months before and after SOAD approval for nasogastric clozapine.

The method used to deliver nasogastric clozapine is outlined within *Box 1*. **Box 1** How to deliver nasogastric clozapine. Clozapine preparation Although several brands of clozapine are available and unlicensed ‘special’ oral suspensions can be prepared (including crushed tablets), we advocate the use of Denzapine as this is currently the only licensed oral suspension in the UK. If an alternate clozapine provider is currently in operation, then registration of the hospital and prescribing psychiatrist with a second supplier are necessary before transferring the patient’s registration. This risks using two clozapine monitoring systems in one hospital, with possible confusion regarding dispensing medication and liaising with different clozapine-monitoring services as well as the potential of having to switch providers once the patient is established on tablet medication. **Restraint** A thorough risk assessment is required to ensure adequate numbers of trained, competent and resilient staff are present and it is essential they are well supported by the leadership team; consultant presence was initially provided, being replaced by more junior medical staff when confidence grew. At least one member of Resus Council (UK) ‘Immediate Life Support’ trained member of staff must be present. Throughout every intervention, patients should be repeatedly given the option of taking oral clozapine. Mechanical restraint was considered as an option but, even with our most difficult patients, was neither planned nor used. Manual restraint was sufficient with between two and six members of staff; in the most extreme cases one member of staff was allocated to each limb, with two controlling the head. Patients were usually seated upright on the edge of their bed, with their neck in line with their back. Precautions may be required to mitigate risks of spitting and biting, including lightweight disposable face visors and gloves. **Nasogastric tube placement** Appropriate training for both medical and nursing staff can be arranged with a general hospital clinical skills team. Fine bore feeding tubes should be used. The first-line, gold-standard method of confirming placement in the stomach is by demonstrating a gastric pH of 5.5.¹⁴ Acid-inhibiting medication reduces the sensitivity but does not alter the specificity or render the method unsafe¹⁴; actions to reduce this risk should be considered. Radiological confirmation is not required.¹⁴ Once placement is confirmed, nursing staff can administer the clozapine, which varies in volume (50 mg/ml) throughout titration. Unless safe to leave *in situ*, the nasogastric tube should be removed immediately after clozapine administration. **Legal authority** In England and Wales, incapacitous or non-consenting patients detained under the Mental Health Act 1983 may be administered drug treatments for mental disorders for longer than 3 months only if a Second Opinion Appointed Doctor (SOAD) approves the treatment, including the route of administration. Personal communication from the principal SOAD has indicated that the oral and nasogastric routes are equivalent: both are enteral. **Ethical dilemmas** Explored by Silva *et al*¹⁰, there are ethical dilemmas with administering nasogastric clozapine. These involve balancing the risks and benefits of an unacceptable status quo against the uncertainties of the possible risks and benefits of intervention, alongside contain-

ing and resolving the emotions of the team when using a novel, restrictive and coercive treatment on a vulnerable and incapacitous patient.

Results

E.S. had cared for five patients, whose demographics can be seen in *Table 1*, where a SOAD approved the administration of clozapine via a nasogastric tube. All were diagnosed with treatment-resistant schizophrenia (ICD-10 code F2012), all were confined in their rooms because of risk to others (long-term segregation¹³) and all were considered to be among the most extremely ill patients encountered within this particular population (CGI score of 7 for severity of illness). *Table 1* Patient demographics Patient Age at first episode of psychosis Age at admission to high-security services Age at SOAD approval of nasogastric clozapine Duration of illness at SOAD approval of nasogastric clozapine Length of stay in high-security services at SOAD approval of nasogastric clozapine Primary diagnosis Admission source Mental Health Act section on admission 11943432498 days F20.3 Medium-security hospital 322127432216 years F20.0 Prison 47/493213335142 years F20.0 Prison 47/494193945265 years F20.0 Medium-security hospital 37/415152533188 years F20.3 Medium-security hospital³

For all patients, their families, advocates and/or legal team were consulted. None objected.

At the time the assertive approach to clozapine was initiated (i.e. SOAD approval for its use was gained), two patients had not started clozapine and three patients had started clozapine but were not reliably compliant (median duration of 31 days); ultimately, only three patients received nasogastric clozapine and other than the use of restraint, no adverse incidents occurred.

Patient 1 commenced clozapine after SOAD approval and received four doses of nasogastric clozapine on non-consecutive occasions over a period of 3 weeks, before being established on oral clozapine. Patient 2 only commenced oral clozapine after SOAD approval for nasogastric clozapine, but nasogastric administration itself was never required. Patient 3 commenced oral clozapine after persuasion, but threatened to stop and SOAD approval was enough to maintain compliance without nasogastric administration being necessary. Patient 4 took oral clozapine for 1 month but then repeatedly threatened to refuse. SOAD approval was sought and nasogastric clozapine was administered once, which was enough to maintain compliance thereafter. Patient 5 maintained erratic compliance with oral clozapine and despite taking it for 617 days, was approved for nasogastric clozapine because of life-threatening clozapine withdrawal catatonia that had previously been unresponsive to benzodiazepines or electroconvulsive therapy (ECT). In the 12 months after SOAD approval for nasogastric clozapine, he received it four times on non-consecutive occasions over the first 6 months.

All five patients were considered to have shown a global improvement on CGI scores after the initiation of an assertive approach to clozapine, with the drug efficacy index showing that, for the majority of patients, clozapine had resulted in a 'vast' or 'decided' improvement in their condition (*Table 2*). Across all five patients, incidents reduced from an average of 72 over the 12 months before SOAD approval to 29 in the 12 months after SOAD approval. No patients were unchanged or worse, and only patient 5 remained in segregation beyond 12 months (terminated on the 476th day). Therefore, despite a significant reduction in incidents (*Fig. 1*), they were registered as having only minimally improved according to their CGI score. *Fig. 1* Incident frequency in the 12 months pre- and post-SOAD approval for an assertive approach to clozapine. SOAD, Second Opinion Appointed Doctor. a. Incident data for patient 1 was unavailable beyond 3 months before SOAD approval as they had not been admitted. *Table 2* Patient outcomes, including Clinical Global Impression scores, time in segregation and referral/transfer status Patient Clinical Global Impression scores (>12 months post-SOAD) Days in segregation (total pre-SOAD) Days in segregation (12 months pre-SOAD) Days in segregation (12 months post-SOAD) Transfer out of high-security services high dependency unit Referral out of high-security services Transfer out of high-security services Severity of illness Global improvement Efficacy in-

¹ Age and duration of illness is presented in years. Primary diagnosis is given by ICD-10 code (see ICD-10 for full definitions). SOAD, Second Opinion Appointed Doctor.

dex172069898133NoYesYes27102104628094YesYesYes37206373798aYesNoNo472062094365287NoYesYes573092492365365NoYes

Our most recent data (with a minimum follow-up of 2 years after SOAD approval for nasogastric clozapine) demonstrates that none of the five patients required clozapine re-titration, and that all are now compliant with clozapine (although patient 5 did require a nasogastric tube to be passed on one occasion before accepting clozapine orally nearly 2 years (626 days) after it was last administered nasogastrically).

Discussion

The majority of patients are transferred to high-security hospitals in the UK because the severity of their psychotically driven violence is considered to be uncontrollable elsewhere, and a large proportion of the patient population already complies with clozapine without using what we can only describe as a highly assertive approach.¹⁵ This is reserved for those with the most severe and debilitating conditions. They have often been detained for decades, with some spending years in segregation despite persistent attempts at engagement in psychological work and/or numerous trials of both evidence-based and/or other none or weakly evidence-based treatments (including failed attempts on clozapine secondary to poor compliance), commonly including treatment with high-dose and/or multiple antipsychotics, which are both unlikely to work and hazardous to the individual.¹⁶⁻¹⁷

Although all health professionals prefer to initiate treatments with patients who fully understand and actively consent and cooperate, in these rare cases, the status quo is clearly unacceptable and the ethical argument for this very assertive approach to clozapine, once conceived of, is not hard to make to establish and maintain patients on clozapine.¹⁰

However, a survey of psychiatrists working in psychiatric intensive care units in the UK found that even restraint to take bloods for clozapine was very rarely reported and attitudes towards it were variable, with a significant minority describing it as never appropriate.¹⁸ The same author's description of an approach to enforcing clozapine, including taking bloods in restraint,¹⁹ resulted in critical responses: one expressing dismay that the article was published at all,²⁰ and the other setting out why it would not work.²¹

Our results demonstrate that simply accepting refusal of clozapine from a patient with treatment-resistant schizophrenia can deprive them of the benefits that this significantly superior (compared with all other antipsychotics²²) and recommended treatment of choice provides, and how an assertive approach to clozapine, rather than actual nasogastric administration, can help initiate and maintain treatment leading to improvements in mental state, reductions in incidents, terminations of seclusion and transfers to less restrictive environments.

These results were not unexpected, given the unique properties of clozapine on treatment-resistant schizophrenia and violence.² Neither was the sometimes significant period of decompression before segregation was stopped, as despite some patients having a rapid improvement and almost immediate cessation of incidents of aggression or violence, they had significant histories of being involved in dramatic and disabling assaults against staff and therefore extreme caution was exercised.

What was clinically unexpected, given the individual patient histories, was the surprising level of cooperation. There were fewer restraints and enforced nasogastric clozapine administrations than had been expected, and one patient who had repeatedly refused oral clozapine for years cooperated without nasogastric administration at all, although this was also a finding when intramuscular clozapine was enforced in the Netherlands.²³

It is possible that teams redoubled their efforts, that patients were aware of the possibility of restraint and were coerced by the prospect alone or that patients regained a level of insight, or even a combination of the three; it is difficult to tell.

2

Fourteen additional episodes of seclusion totalling 80 days.

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As Silva *et al*¹⁰ discuss, teams that embark on this approach are faced with very difficult decision-making, such as how long to persist with one attempt at passing a nasogastric tube? When is a patient's distress at the procedure too great? And how many times should clozapine be administered via a nasogastric tube before accepting that oral compliance will not be maintained? These questions are not easy to answer, and the judgements can only be made by individual teams and will vary on their own capacity to maintain treatment and a relationship with a patient in very difficult circumstances.

For some patients their previous refusals will be based on psychotic motivations and it is hoped that these patients may quite rapidly respond. Others may have a combination of psychotic, personal and possibly comorbid motivations that may not be remedied by either clozapine or this assertive approach. For these patients, we would not advocate the regular use of nasogastric administration of clozapine as a long-term solution. We know, particularly when huge effort and resources are expended on initiatives, that there can be a tendency to get stuck in a persisting course of action or to fail to consider alternative approaches²⁴ (although in this case many of these are less likely to work²²), and teams must be careful not to fall into this trap.

One good alternative, with local guidelines emerging,²⁵ is the option of trying to establish patients on clozapine by an assertive approach with intramuscular injections. Having recently become available again, intramuscular clozapine may be preferred to nasogastric clozapine, given the less intrusive and unpleasant method of administration. However, unlike nasogastric clozapine, intramuscular clozapine is limited by the deliverable dose and therefore duration of treatment, with large volumes required (25 mg/ml) as the titration increases toward the average UK dosage of around 450 mg/day.²⁶ Intramuscular clozapine also remains an unlicensed product, with an increased likelihood of prone restraint and a theoretical risk of accidental intravenous administration. Therefore, although intramuscular clozapine provides an additional treatment option, nasogastric clozapine can continue to have an important role to prevent re-titration and administer clozapine when the maximum deliverable dose of intramuscular clozapine is insufficient.

Another alternative, where an assertive approach to clozapine fails or for the significant number of patients who do not respond to clozapine monotherapy or clozapine augmentation strategies, is the more restrictive treatment of ECT, which may well be the most appropriate next step.²⁷ However, for the cohort we describe, this intervention is particularly difficult to deliver and maintain the safety of both staff and patients.

Ethically, what remains is a real argument about the wrongs of a failure to treat the most severely ill patients with treatment-resistant schizophrenia against the perceived wrongs of nasogastric clozapine. Clearly, this approach can never be a panacea: clozapine can often not be used (because of adverse effects) and nearly 50% of patients fail to achieve a satisfactory therapeutic response.²⁸ However, for those who have suffered with the most debilitating conditions imaginable, clozapine can result in dramatic and seemingly unexpected improvements in mental state and function. Accepting a patient's refusal of treatment and failing to offer them that chance of improvement via an assertive approach to clozapine through nasogastric administration seems, in our opinion, cruel and unnecessary.

Conclusion

Our case series shows that nasogastric clozapine can be safely delivered and that the approach itself, rather than actual nasogastric administration, may be enough to establish and maintain treatment with clozapine.

An assertive approach to clozapine can therefore play an important role in managing patients with treatment-resistant schizophrenia. It can be justified to help reduce patients' extreme suffering and distress as a result of their psychosis, can be expanded in a variety of psychiatric in-patient settings and can help reduce the usually disappointing outcomes seen with other drugs or drug combinations.

This is the first systematic description of the assertive approach to clozapine and helps counter likely objections regarding the efficacy and risk of administering nasogastric clozapine that might otherwise prevent or delay patients with treatment-resistant schizophrenia receiving the recommended treatment of choice.

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1.5.60 Barriers to using clozapine in treatment-resistant schizophrenia: systematic review

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Abstract

Aims and method

To systematically review the literature on barriers to the use of clozapine and identify any interventions for optimizing clozapine use in treatment-resistant schizophrenia. Journal databases were searched from 1972 to March 2018. The following search terms were used: treatment-resistant schizophrenia, clozapine, barriers, use, prescription rates, implementation, clozaril and prescribing practices. Following a review of the literature, 15 papers were included in the review.

Results

The major barriers that were identified included mandatory blood testing, fear of serious side-effects and lack of adherence by the patients, difficulty in identifying suitable patients, service fragmentation, and inadequate training in or exposure to using clozapine.

Clinical implications

In view of consistent evidence across the studies on inadequate knowledge and skills as a significant barrier, we suggest that a certification requiring competence in initiating and managing side-effects of clozapine becomes a mandatory requirement in training programmes.

Declarations of interest

None.

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Clozapine use in schizophrenia

Clozapine is the only medication licensed for treatment-resistant schizophrenia (TRS), which affects about one-third of those suffering from the disorder. Recently, there has been increased interest in redefining the role of clozapine in the treatment of schizophrenia in view of the evidence of superior efficacy and safety, despite serious side-effects.¹ Meta-analyses have demonstrated that clozapine is significantly better at treating symptoms than first-generation antipsychotics and some (but not all) second-generation antipsychotics.² This superior efficacy was also supported by two large, independently funded studies.^{3,4} Clozapine also appears to have broader effects, with evidence for efficacy in suicidality, aggression and substance misuse.¹ In the USA, clozapine is approved by the Food and Drug Administration for the management of suicidality in people with schizophrenia or schizoaffective disorder. In addition, clozapine has been shown to have anti-aggressive properties⁵ and may also be effective in diminishing substance misuse.^{6,7} Tiihonen *et al*⁷ found, using a large database, that people regularly taking clozapine had the lowest risk of premature mortality compared with both those on other antipsychotics and those not taking regular medication, despite the fact that the drug is associated with a number of serious adverse side-effects.⁷

Potential barriers and delays in clozapine use

Despite the evidence of superior efficacy and recommendations by different treatment guidelines, the drug is grossly underutilised.⁸ Studies based on prescription patterns in routine practice almost universally show lower prescriptions of clozapine in individuals with Schizophrenia, even after taking into account potential barriers such as inadequate service provision.⁹ There is also substantial evidence that the use of clozapine is delayed for several years, which may result in less than optimal efficacy for the drug. A study by Howes *et al*¹⁰ showed that the mean theoretical delay from meeting the National Institute for Health and Care Excellence (NICE) criteria for TRS and starting clozapine was about 4 years. In New Zealand the theoretical delay was almost 10 years.¹¹ In the USA, only six states reported that more than 10% of Medicaid-eligible patients with schizophrenia had received a prescription of clozapine.¹²

The reasons for such suboptimal use of clozapine remain obscure, and may include several factors related to patients, carers and clinicians. These may include the perception of the drug as a dangerous medicine¹ or difficulties associated with initiating and maintaining the treatment. The life-threatening side-effects of clozapine and mandatory requirement for white blood cell (WBC) counts may partly account for the less than optimal use of the drug in clinical practice. Experience in using clozapine may be an important factor. A study by Nielsen *et al*¹³ of the attitudes and knowledge of 137 psychiatrists in Denmark, including 100 consultant psychiatrists, revealed that some had never prescribed clozapine despite having worked for over 5 years. The barriers to effective use of clozapine have not been reviewed systematically.

We therefore aimed to review the literature on barriers to the effective use of clozapine in clinical practice for TRS. We also wanted to identify any interventions that could potentially improve the use of clozapine. This systematic review aimed to answer the following questions. •What barriers or factors have been identified that prevent the optimal use of clozapine in TRS, based on the current literature?•What strategies have been explored to promote the effective use of clozapine in TRS?•What is the methodological quality of the evidence that is available exploring the barriers to optimal use of clozapine?

Method

We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement guidelines.¹⁴ A protocol defining the key methodological parameters was developed prior to the literature search and was registered at the International Prospective Register of Systematic Reviews (PROSPERO).¹⁵

Search strategy

Electronic databases (PsycINFO, Medline, PubMed, AMED, CINHALL and EMBASE) from 1972 onwards were searched, followed by a search of the reference lists of the full texts of the retrieved articles for further relevant articles. The following search terms were used: treatment-resistant schizophrenia, clozapine, barriers, use, prescription rates, implementation, clozaril and prescribing practices. These keywords were searched for in the title, keywords, or abstract. Truncations and related terms were used as appropriate based on individual database procedures. The search was last updated in March 2018.

All study types (intervention, observational and descriptive) were included in the review if the following inclusion criteria were met. •Adult populations with a diagnosis of TRS for whatever indication. Clozapine has been used for other diagnoses; however, we limited our present review to TRS. •Included primary research information on the outcome variables, i.e. barriers or factors associated with low use or implementation strategies. •Published between 1972 and 2018.

Studies that examined the pattern of use of clozapine, the rate of prescriptions, or its efficacy and effectiveness were excluded, unless these provided data on the barriers or factors associated with low or high use of clozapine.

There is no agreed definition of the 'optimal use' of clozapine. However, a number of studies^{9-11,16} indicate that the optimal use is determined on the basis of time since the start of the first antipsychotics (considering that clozapine is used after failure to respond to two antipsychotics) and the prevalence of clozapine prescription relative to total antipsychotic prescriptions (based on fact that about 30% of those suffering from schizophrenia develop TRS). These provide useful guidance but do not take into practical factors such as patient willingness to start clozapine or non-availability, or the cost of clozapine in low- and middle-income country settings. We used these parameters as a broad guideline for our review, but we will also report clozapine use and how it is defined as adequate or optimal by different studies.

Data extraction

The screening for searches examining the relevant abstracts, examination of full-text articles and data extraction were done by two reviewers independently, as outlined in the protocol.¹⁵ Any disagreements were resolved by consensus and, where appropriate, by consultation with the third reviewer. A data extraction sheet was developed based on the pre-specified outcomes and relevant data were extracted on to this sheet. We planned a meta-analysis of primary and secondary outcomes, but it was not possible to statistically summarise the data owing to the heterogeneity of studies, lack of adequate data and low quality of studies. We instead provide a descriptive summary of main findings.

Results

The electronic searches returned 253 relevant abstracts and titles; no further articles were identified from the other sources. We screened the titles and abstracts, and excluded any studies that were not directly relevant to the objectives of the review. After screening these titles and abstracts and removal of duplicates, we further examined 47 full-text papers. Finally, we included 15 papers in the review. The details of the search yield and reasons for excluding full-text articles are provided in *Fig. 1*. *Fig. 1* Summary of the abstracts reviewed to identify papers relevant for the review.

Characteristics of included studies

The studies were conducted in a number of different populations, settings and periods, and also used diverse methodologies. Owing to the diverse methodologies and number of variables examined across studies, it was inappropriate to pool the data to produce a statistical summary. We therefore describe the main findings and produce a narrative summary of results.

Fifteen studies met the inclusion criteria. Twelve of these studies focused on barriers or factors associated with clozapine use. These comprised surveys ($n = 5$), case note reviews ($n = 4$), and semi/structured interviews and consultations with stakeholders ($n = 3$). The majority of these studies ($n = 8$) involved eliciting views from clinicians, particularly consultant psychiatrists. Three studies described interventions or quality improvement initiatives to facilitate the use of clozapine. These are described separately.

In survey-based studies, response rates varied from 8.8 to 76%. The mean response rate from the papers which had figures available ($n = 5$) was 52.3%. The total number of males from the studies providing this information ($n = 6$) was 608, and the number of females was 402. The populations in these studies comprised 902 psychiatrists, 68 trainees, 49 pharmacy staff and 15 nursing staff or staff in mental health leadership positions. One database study reviewed the Medicaid patients on antipsychotic medication using records of 629 800 patients in the analysis.

In the three intervention studies, 158 participants were involved. One study did not provide details of sample size.

The characteristics of included studies are shown in *Table 1*. Table 1 Characteristic of included studies Author/year Population Method/design Sample characteristics and response rates (ReR) 1. Gees *et al* (2013) All staff at South London and Maudsley NHS Foundation Trust Survey $n = 144$

Trainee doctors 42% $n = 60$

Consultants 14% $n = 20$

Pharmacy staff 16% $n = 232$. Cirulli (2005) 24 Consultant psychiatrists working in child and adolescent mental health services in-patient unit Survey $n = 83$

ReR 59 (71%) 3. Najim *et al* (2013) 20 Out-patients on clozapine in UK community population Retrospective case note review $n = 42$

ReR 100%

4. Swinton & Ahmed (1999) 19 In-patients in high-secure hospital – patients, consultants, nurses Case note review and survey of patients and staff $n = 95$

ReR 72 (76%) 5. Grover *et al* (2015) 21 Patients initiated on clozapine in North India tertiary hospital (Jan 2006–June 2014) Retrospective record review $n = 200$ patients 6. Tungaraza & Farooq (2015) 22 Psychiatrists Survey $n = 2771$

ReR 243 (8.8%) 7. Apiquian *et al* (2004) 23 Psychiatrists Survey $n = 200$

ReR - 148 (74%) 8. Goren *et al* (2016) 26 Key informants (Psychiatrists, clinical pharmacists, advanced practice nurses) involved in the clozapine process at US Department of Veteran Affairs with high and low utilization of clozapine Semi structured telephone interviews $n = 70$ participants

Psychiatrist 31.4%

Pharmacy staff 37.1%

Mental health leadership 15.7%

Advanced practice nurse 5.7%

Other 10% 9. Kelly *et al* (2015) 18 Psychiatry residents, fellows, and psychiatrists in the state of Maryland Survey with each question rated using Likert scale: 1 = strongly disagree, 5 = strongly agree $n = 860$

ReR 277 (32%) 10. Stroup *et al* (2014) 25 Patients with schizophrenia spectrum disorder, using Medicaid data from 2001 to 2005, who used clozapine or standard antipsychotic medication in one or more treatment episodes Comparison between standard antipsychotic and clozapine use, using statistical analysis $n =$ Patients on clozapine ($n = 15\ 524$)

Patients on other antipsychotics ($n = 614\ 285$) 11. Nielson *et al* (2009) 13 Psychiatrists from six counties in Denmark; three highest and three lowest prescription rates of clozapine Structured interview $n = 100$

72 Consultant psychiatrists

20 psychiatrists

8 trainee psychiatrists¹². Kelly *et al* (2018)²⁷Clinicians and researchers identified by the National Association of State Mental Health Program DirectorsExpert opinion, literature review and focus group¹¹ Psychiatrists and researchers; however, no specific details givenIntervention studies¹³. Carruthers *et al* (2016)²⁸Academics and clinicians in clozapine prescribing and patients with treatment-resistant schizophrenia in receipt of Medicaid in New YorkEducational initiative utilizing web-based modules to educate consumers and carers as well as clinicians regarding clozapine useNo sample details provided¹⁴. Nielson *et al* (2012)¹³Psychiatric out-patients on treatment with clozapine in DenmarkPoint-of-care (POC) testing using capillary sampling v. venous sampling⁸⁵ participants¹⁵. Bogers *et al* (2015)²⁹Patients established on clozapineRandomised cross-over trial design for POC testing using capillary sampling v. venous sampling⁷³ patients were included in this study; three dropped out before completion

Barriers to the use of clozapine in TRS

It was possible to classify the barriers in three groups with some overlap: •barriers related to patients and the drug;•clinician-related barriers;•health system-related factors.

Patient- and drug-related barriers

Five studies commented on patient-related factors affecting the use of clozapine in TRS. The complete refusal of blood tests was considered a major barrier, with patients delaying the initiating of clozapine (56%, $n = 72$).¹⁷ This was replicated by Kelly *et al*,¹⁸ who surveyed psychiatrists in Maryland, USA, and found that the main barrier, ranked highest on the Likert scale (1–5), was patient non-adherence with blood work (3.7 ± 1.1) and the burden of blood work on the patient (3.6 ± 1.2).¹⁸ In a survey of patients, Swinton and Ahmed (1999)¹⁹ reported that almost two-thirds of participants did not want the burden of regular blood tests. This was replicated in a survey of staff, with 65% ($n = 83$) reporting that patients did not want the burden of regular blood tests and that frequent blood tests were considered a major barrier to initiating clozapine.¹⁷

Concerns about tolerating clozapine were considered to be fairly or very frequently related to delays in clozapine use by 46% ($n = 59$) of clinical staff.¹⁷ Complications related to clozapine, such as constipation, hypersalivation, myocarditis and neutropenia, can inhibit clozapine use; a survey of clinical staff found that 37% ($n = 76$) felt that these potential medical complications frequently restricted the use of clozapine.¹⁷

Najim *et al*²⁰ reviewed 42 case notes of patients on clozapine and found that there were significant delays in commencing clozapine in patients aged over 30.²⁰ This was replicated by Grover *et al*,²¹ who carried out a case note review on 200 in-patients from a tertiary care centre in North India. A greater delay in initiating clozapine was noted in the older age group (over 20) compared with those under 20 (mean 0.91 v. 2.05; s.d. 1.05 v. 1.86).²¹ In addition, they found a significant delay in patients prescribed polypharmacy compared with non-polypharmacy (mean 2.58 v. 1.68; s.d. 2.06 v. 1.67), and delays were also associated with being in an urban locality (mean 2.11 v. 1.37; s.d. 1.98 v. 1.11).²¹

Clinician-related factors

Inadequate knowledge of or experience in clozapine use. Fifty-two per cent ($n = 75$) of staff surveyed in South London Maudsley NHS Foundation Trust¹⁷ reported not being familiar with initiation of clozapine. In another large survey, 74% ($n = 136$ total 184) of psychiatrists working in the UK also highlighted a lack of knowledge or experience amongst consultants, leading to delays.²² A significant number of consultants (42%; $n = 96$) had fewer than five patients on clozapine, despite half of these consultants working in trusts with a dedicated clozapine service and having been in-post for 7 years.²² This was replicated by Nielson *et al* (2009), who found that 48% of psychiatrists surveyed had treatment responsibility for fewer than five patients treated with clozapine.¹³ In Mexico, Apiquian *et al*²³ reported that fewer than half of the 200 surveyed psychiatrists in Mexico knew the recommended average dose of clozapine.²³

The fear of side-effects or lack of knowledge in dealing with these were considered to be serious hurdles in initiating clozapine. Sixty per cent ($n = 70$) of practitioners surveyed in South London and Maudsley NHS Foundation Trust

raised concerns about tolerability and side-effects that delayed the initiation of clozapine.¹⁷ Nielson *et al*¹³ reported that in terms of side-effects and knowledge, only 33% ($n = 33$) knew that the risk of agranulocytosis was highest in the first 6 months and 23% ($n = 23$) overestimated this risk of agranulocytosis.¹³

The majority of the clinicians in a survey (78%; $n = 105$) said they would support clozapine initiation after a trial of two antipsychotics.¹⁷ However, Nielson *et al* (2009) found that only 44.9% ($n = 44$) would go to clozapine after two antipsychotics,¹³ and about a third 30.6% ($n = 30$)¹³ of clinicians in one survey and 14% ($n = 19$) in another would wait until three adequate trials of antipsychotics prior to initiating clozapine, while 18.4% ($n = 19$)¹³ would wait until more than three failed adequate trials of antipsychotics. In another survey, 28% ($n = 51$, total 184) of consultants said they would trial at least another antipsychotic before going to clozapine after a failed trial of two antipsychotics,²² and 40.5% ($n = 92$) preferred to use several other antipsychotics before clozapine.¹⁹ Nielson *et al*¹³ found that 64.7% of psychiatrists surveyed ($n = 64$) would rather combine two antipsychotics than prescribe clozapine, and 15.2% ($n = 15$) would augment with a mood stabiliser before using clozapine in a non-schizoaffective state.¹³

Difficulty in identifying suitable patients and unclear diagnosis were highlighted by 12% of consultant psychiatrists ($n = 22$) in a survey conducted by Tunganaza & Farooq.²² Although consultants felt they had good exposure to clozapine as trainees, 36.2% ($n = 83$) felt it was not easy to identify suitable patients for clozapine.²²

Need for intense monitoring

Forty-two per cent ($n = 77$) of psychiatrists in a UK-wide survey felt it was complex and cumbersome to initiate and manage clozapine, which led to delays in starting the drug.²² In a survey of consultants based in child and adolescent psychiatry, 29% ($n = 17$) reported that they did not prescribe clozapine owing to the need for intense monitoring.²⁴ Tunganaza & Farooq²² found that 74% ($n = 136$) of clinicians felt there were delays owing to refusal of patients to have blood tests.²²

Serious side-effects

In a survey of consultant psychiatrists, 105 out of 231 respondents (45.5%) acknowledged that their patients experienced untoward side-effects while on clozapine, which was considered to be major factor in delaying clozapine use.²²

Staff in child and adolescent services highlighted unfamiliarity with clozapine (41%; $n = 4$) and side-effects (41%; $n = 4$)²⁴ as major factors in delaying clozapine initiation. Swinton & Ahmed¹⁹ reported that 22% ($n = 7$) of the clinical staff in their study believed that the risks associated with clozapine outweighed the benefits of starting clozapine.¹⁹

Perception that patients may not adhere to treatment

Clinical staff surveyed at a high-secure hospital reported likely poor adherence by the patients as a reason for not prescribing clozapine in 53% of cases ($n = 17$).¹⁹ Other clinical staff reported that patients were likely to refuse blood tests 43% ($n = 13$).¹⁹ Tungaraza & Farooq²² reported that 54% ($n = 99$) of practicing psychiatrists felt that likely poor adherence to the drug was a reason for delays.²²

Health system-related barriers

Studies based on clinician surveys identified the following health system-related barriers. (a) Difficulties in obtaining baseline bloods and the time taken to register patients for blood monitoring were considered as major factors in initiating clozapine by 22% ($n = 26$) clinicians.^{17(b)} Staff resources, including inadequate staff to monitor clozapine initiation, were a major factor for 22% ($n = 26$) of clinicians in delaying clozapine initiation.^{17(c)} The need for admission as required by some health providers to initiate clozapine and a shortage of beds were highlighted by 20% ($n = 23$) of clinical staff.¹⁷ In another survey, 32% ($n = 40$) of clinical staff felt that a lack of resources in the home treatment team led to frequent delays in commencing clozapine.^{17(d)} Service fragmentation owing to separate teams providing community and in-patient services and a lack of community support were cited as major barriers ($n = 39$) by clinicians in one study.²² A survey of staff at Ashworth high-secure hospital also revealed that clinicians felt that a lack of resources was responsible for delays or non-prescription of clozapine in 16% ($n = 5$) of cases.¹⁹

Stroup *et al*²⁵ conducted a retrospective study using Medicaid claims data from 45 states in the USA. It was found that among 629 809 unique antipsychotic treatment episodes, 79 934 showed service use patterns consistent with treatment resistance. Clozapine accounted for 2.5% of starts of antipsychotic medication among patients in the overall sample, and 5.5% of starts among patients with treatment resistance. Clozapine initiation was significantly associated with male sex, younger age, White ethnicity, more frequent out-patient service use for schizophrenia, and greater prior-year hospital use for mental health.²⁵ Patients residing in counties with historically high clozapine usage were almost twice as likely to start clozapine as patients residing in historically low-use counties (adjusted odds ratio (AOR) 2.03; CI 1.75–2.30).²⁵ A high concentration of psychiatrists (>15 per 100 000 residents) was also associated with a greater likelihood of clozapine initiation (AOR 1.17; CI 1.03–1.33).²⁵ However, there were no significant effects of population density or measures of poverty or income on clozapine initiation.

Goren *et al*²⁶ carried out 70 semi-structured interviews with stakeholders such as psychiatrists, mental health nurses, and pharmacy and laboratory staff at five sites with high clozapine use and five low-utilization sites. Low utilization of clozapine was associated with a lack of champions to support the clozapine process. Some of the barriers highlighted included the complex and time-consuming paperwork.²⁶ Lack of transport, particularly for rural patients, inability by disorganised patients to navigate public transport, paranoia around travelling by public transport and the cost of transportation²⁶ were reported as major barriers. Patients living far away from clinics were not considered suitable for clozapine owing to their inability to attend for regular blood tests.²⁶

Kelly *et al*¹⁸ elicited the views of psychiatrists using an anonymous survey questionnaire. The questionnaire consisted of 56 questions to be scored on a five-point Likert scale (1 = strongly disagree, 5 = strongly agree) regarding the barriers related to clozapine, and the physician's interest and willingness to use point-of-care (POC) devices. The survey was sent to 860 psychiatrists, of whom 277 (32%) responded. Among the 28 listed barriers (clinical, nonclinical, and side-effects) to more frequent use of clozapine, the two highest ranking barriers were: (a) the likely non-adherence of patients to blood work (score 3.7 ± 1.1) and (b) the burden of ongoing blood monitoring for the patient (score 3.6 ± 1.2). Among nine potential solutions for increasing the use of clozapine, the use of POC devices was the highest ranked. The physicians agreed that a POC device would improve care and that it would increase their clozapine use with a mean score of 3.9 ± 1.0 .¹⁸

The National Association of State Mental Health Program Directors (NASMHPD) in the USA formed a working group to identify barriers to clozapine underutilization and interventions to overcome these at a national level.²⁷ The initial work group included 11 clinicians and researchers and consulted a wide range of stakeholders and existing literature on the subject. They identified 14 major barriers, which included all the factors mentioned above, as well as benign ethnic neutropenia (BEN), which occurs among people of African or Middle Eastern ancestry. The lack of a definition for BEN in product labelling and clear guidance on monitoring requirements may be responsible for the low use of

clozapine in this population. A lack of standardised materials for shared decision-making, complex protocols for treatment monitoring and management of side-effects, formulary issues and costs of ancillary services such as transportation and service coordination were also identified as barriers (*Box 1*).²⁷ *Box 1* Barriers to clozapine use and strategies to overcome these

Barriers to clozapine use

- Patient/drug-related barriers
 - Refusal of blood tests^{17–19}
 - Tolerating clozapine and side-effects¹⁷
 - Age > 20^{19,20}
 - Patients prescribed polypharmacy²¹
 - Benign ethnic neutropenia²⁷
- Clinician-related barriers
 - Inadequate knowledge of or experience in clozapine use^{17,22–24}
 - Fear of side-effects for patient/lack of knowledge about clozapine side-effects^{13,17,19,22,24}
 - Lack of adherence to guidance^{13,17,22}
 - Difficulty identifying suitable patients and unclear diagnoses²²
 - Need for intense monitoring^{22,24}
 - Perception that patients may not comply with treatment^{19,22}
- Health system-related barriers
 - Not enough resources, including not enough staff resources to monitor clozapine initiation¹⁷
 - Shortage of beds¹⁷
 - Service fragmentation²¹
 - Lack of champions to support the clozapine process²⁶
 - Complex and time-consuming paperwork²⁶
 - Lack of standardised shared decision-making²⁷
 - Complex protocols for treatment monitoring²⁷
 - Formulary issues and costs of ancillary services such as transport and service coordination²⁷

Strategies to overcome barriers to clozapine use

- Use of POC devices²⁹
- Support for prescribers and decision-aid tool for consumers grounded in principles of shared decision-making²⁷
- Internet-based educational programmes to provide information for consumers, family members and clinicians²⁷

Interventions to overcome the barriers

Three studies described interventions that could help to overcome the barriers identified above. These included a training initiative²⁸ and two studies describing the use of POC devices.^{28,29} As these studies employed different methodologies and interventions, the results are briefly summarised here.

Bogers *et al*²⁹ compared a POC device using capillary blood sampling with a finger prick that provided WBC counts with conventional venous sampling. An open-label randomised cross-over trial design was used to compare the two procedures. The main outcome measure was the subjective experience of various aspects of blood sampling, as measured by a visual analogue scale (VAS). A consistent pattern in favour of capillary blood sampling was found (total perceived burden blood sampling: capillary 5.79 *v.* venous 13.4 ($P < 0.001$)). Both patients and practitioners showed preferences for the capillary blood sampling.²⁹

Similarly, Nielsen *et al*³⁰ evaluated a POC using a randomised cross-over trial design. Patients were randomised to one of two blood monitoring sequences. The first group underwent venous sampling followed by capillary sampling in a twice-repeated procedure (venous–capillary–venous–capillary); in the other, the sequence was reversed (capillary–venous–capillary–venous). Eighty-five patients were included in the study using a VAS; patients indicated that they found capillary blood monitoring less painful than venous sampling (VAS ratings: 0.55 *cm* 25–75th percentiles: 0.1–1.4 *cm* *v.* 1.75 *cm* 25–75th percentiles: 0.7–2.6, $P < 0.001$). They also felt less inconvenienced by the POC method than by traditional blood sampling.³⁰

Carruthers *et al*²⁸ described an educational intervention to promote the evidence-based use of clozapine in New York,²⁸ consisting of support for the prescriber and a decision aid tool for consumers grounded in the principle of shared decision-making. A manual for clinicians was developed and academics presented a series of state-wide grand rounds presentations to provide information on clozapine prescribing. Internet-based educational programmes and a telephone consultation service by experts to support the prescribers were also provided. A key component of the programme was testimonials from patients, who described personal benefits alongside the challenges.²⁸ The programme was evaluated using Medicaid data on the pattern of new antipsychotic start-ups. The number of new starts amongst all antipsychotic trials increased from 1.5% in 2009 to 2.1% 2013.²⁸ The greatest change was seen in state-operated facilities, where the rate of clozapine new starts per quarter increased compared with all new antipsychotic starts. The change in the rate of clozapine new starts in these facilities was three times higher than in other settings (3.77% *v.* 1.13%).²⁸

Quality assessment of included studies

The published protocol outlined separate quality assessments for qualitative and quantitative studies, using appropriate checklists for different study designs.¹⁵ However, after examining the included studies, it was felt that only two trials²⁹⁻³⁰ could be assessed for quality using the risk of bias tool, as per protocol. These randomised cross-over trials compared capillary blood sampling using a POC device with traditional venous blood sampling. Patients were randomised to two sequences, starting with either capillary or venous blood sampling, followed by a repeated sequence. Neither of these trials provided details of how participants were randomly allocated to the two sequences, and the outcome assessments did not appear to have been done by blind assessors. Both studies had high risk of bias.

Other studies did not use appropriate study designs, which could be evaluated using the checklists we proposed in the protocol for observational studies. These studies were mostly surveys and provided little information on how the samples were selected and the validity or reliability of the questionnaires/instruments used, or any information on non-responders. All these studies were considered to be of low quality.

Discussion

This was the first systematic review aiming to examine the barriers to effective use of clozapine. The following major barriers or factors related were identified: the mandatory blood testing requirement; fear of serious side-effects, lack of familiarity in use of clozapine; lack of clarity in diagnosis and difficulty in identifying suitable patients; service fragmentation; and lack of adequate training in or exposure to using clozapine. Only one educational intervention was available that showed some effect on clozapine prescription rate. POC testing using capillary blood was more acceptable to patients than traditional blood sampling, being less painful and less time consuming, but no studies tested whether it increased the uptake of clozapine.

A conservative estimate suggests that TRS adds more than \$34 billion in annual direct medical costs in the USA.³¹ In the UK, NICE has included the extent and the degree of clozapine use in the quality criteria for commissioners when commissioning services for mental health.³² However, initiatives to overcome this major service need are rare.

Almost all studies highlighted routine blood monitoring as the top-ranking barrier to initiating and maintaining clozapine treatment. Two randomised cross-over trials showed that blood testing using a simple finger prick that was undertaken as part of routine assessment by psychiatric staff, either in the patient's home or at a psychiatric out-patient clinic, was feasible and convenient for patients. However, none of these trials looked at the effect of POC testing on prescription rates. The POC devices will also need to comply with regulatory requirements for monitoring blood counts.

It appears that there is a common perception amongst clinicians that clozapine is a dangerous drug, and that patients will not adhere to it or would not like to consider it as a treatment option. The findings in this review suggest that these negative beliefs about clozapine result from a lack of experience and knowledge, owing to the current limited use of clozapine. A self-perpetuating cycle can ensue, as practitioners do not see the benefits of clozapine, and thus do not develop confidence in its use.¹ This is consistent with the study by Stroup *et al* which showed that higher clozapine initiation was significantly associated with patients residing in areas associated with historically high clozapine usage and higher concentrations of psychiatrists (>15 per 100 000 population).²⁵

The NASMHPD published 36 recommendations on its website for expanding the use of clozapine.³³ One important recommendation included improving residency trainee standards. Considering the disease burden resulting from TRS and the central role of clozapine in its treatment, we suggest that training in the use of clozapine becomes a mandatory requirement for all psychiatry residence and continuing professional development programmes. A certification requiring competence in initiating, maintaining and managing side-effects of clozapine is required, based on clinical experience, similar to the certification that is now required for electroconvulsive therapy.

The use of clozapine is alarmingly low in many developing countries. In Pakistan, for example, about 1300 patients were receiving clozapine as recorded in the Clozaril Patient Monitoring System. Although generic clozapine has become available recently, numbers are still very low, considering that the country has a population of about 200 million (R. U. Rahman, personal communication, 2016; data available from the authors on request). To put this prescription rate into perspective, The Netherlands, with a population of about 17 million, has over 12000 patients on clozapine, which

is 0.07% of the population (<https://www.gip databank.nl/>). This means that, at current rates of use, there is a more than 100-fold difference between the two countries. This situation requires a public health intervention to improve access to clozapine in certain countries.

The major limitation of the review was the low quality of the included studies. Studies were based on surveys, which are prone to a number of biases, including selection bias of respondents, and lacked control groups. The low numbers of studies from a few countries also limit the generalisation of results. None of the studies defined the optimal use of clozapine. The lack of patient perspectives is striking, considering that a number of studies suggested patient-related factors as major barriers.

Despite these limitations, this systematic review indicates that there is broad agreement on the major barriers that hinder the effective use of clozapine. There is certainly a need to improve the methodological quality of studies and the way these are reported, but the present study identifies gaps in clinical practice and health services that can be addressed in intervention studies. Use of POC devices, educational interventions targeting clinicians and shared decision-making involving patients need to be evaluated using controlled study designs. Future research should be guided by the implementation science methods and behaviour change principles that have successfully been used in implementing and evaluating evidence-based interventions in medicine.

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1.5.61 Christopher (Chris) Freeman FRCPsych FRCP (Ed)

James Hendry Tom Brown Derek Chiswick

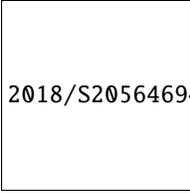
date

2018-8

Contents

- *Christopher (Chris) Freeman FRCPsych FRCP (Ed)*

Formerly Consultant Psychotherapist and Consultant Psychiatrist, Royal Edinburgh Hospital, and Honorary Professor, Queen Margaret University, Edinburgh



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Christopher (Chris) Paul Lindsay Freeman, who recently died at the age of 70, had an unusually bright and enquiring mind and loved challenging existing orthodoxies. In 1978, while still a junior academic, he carried out a double-blind trial of the effectiveness of electroconvulsive therapy (ECT) — then, as now, a controversial intervention. The trial, which found ‘real’ ECT to be superior to ‘sham’ ECT, was published in *The Lancet*, a remarkable achievement for such a young researcher. Subsequently, he published a number of other key research papers, almost 150 publications in total. He also contributed substantially to the teaching of a generation of psychiatrists, personally writing chapters on neuroses, personality disorder and ECT for the *Companion to Psychiatric Studies*. In addition, he was co-editor of the 7th and 8th editions of this textbook, required reading for those studying for the MRCPsych qualification.

Despite his academic productivity, Chris was more interested in developing and improving services than in pursuing an academic career. His considerable energies went especially into his areas of expertise: psychotherapy as it relates to eating disorders, post-traumatic stress disorder and ECT. It is an indication of his breadth of knowledge that he chose to focus on opposite ends of the psychiatric treatment spectrum. Although his influence on psychological therapies in the treatment of eating disorders and trauma-related morbidity was broad, the most tangible evidence of his efforts was the establishment of the Cullen Centre at the Royal Edinburgh Hospital, the Anorexia Nervosa Intensive Treatment Team and the Regional Unit at St John’s Hospital that provide, respectively, out-patient, community-based and in-patient treatment for people with eating disorders.

When he recognised the increasing number of referrals his service was receiving for the assessment and treatment of traumatic stress disorders, Chris took practical steps to meet the changing needs. He ensured that specialist services for people suffering from these disorders were available by establishing the Rivers Centre, together with Claire Fyvie. This centre was named after W. H. R. Rivers, the psychiatrist who worked at Craiglockhart Hospital during the First World War, and among whose patients were the poets Siegfried Sassoon and Wilfred Owen. Chris also undertook much related medico-legal work that ensured the condition was better understood by the courts and, where appropriate, that sufferers were compensated. He broadened his influence in this field by establishing the Scottish Trauma Advisory Group with direct links to the Scottish Government. He also served as President of the UK Psychological Trauma Society.

Chris had a strong interest in maintaining high standards in the quality of psychiatric care. In Scotland, he established the ECT Accreditation Service and later chaired a similar body for the Royal College of Psychiatrists. He also chaired the Ethics Committee of the College and most recently was its Clinical Lead for Quality Improvement.

After a childhood in York, Chris studied medicine at Edinburgh University Medical School, from where he graduated in 1971. He trained in psychiatry at the Royal Edinburgh Hospital, obtaining the Membership of the Royal College of Psychiatrists in 1976. Three years later, he was awarded the Gaskell Gold Medal. He was appointed Senior Lecturer at Edinburgh University Medical School and Honorary Consultant Psychiatrist at the Royal Edinburgh Hospital in 1980, but in 1984 surprised many with a move to a National Health Service Consultant post in Psychotherapy. Exploring new territory in psychotherapy, he changed the focus of the department from traditional psychoanalytically based psychotherapy to cognitive-behavioural therapy (CBT). He was able, with colleagues, to develop a training course in CBT for doctors, psychologists, nurses and other professionals. This grew to become the South of Scotland CBT course. The emphasis in therapy was on a positive collaboration with the patient, with the aim of developing the patient’s motivation to change.

Chris’s personality was characterised by his infectious enthusiasm, coupled with an eager willingness to take on new challenges. On occasion, his reluctance to turn down opportunities resulted in serious overload and a need to ‘wing it’. When his ‘just in time’ approach became ‘just too late’, colleagues could be left spinning or catching falling plates. This sometimes led them to feel frustrated with him, but there was never any lasting animosity.

Although he placed great importance on getting personally involved with patients, carers and colleagues, he was never happier than when working with his hands in his garden or workshop. He was fascinated by new technology and its

accompanying gadgets, but also spent a great deal of time and effort gathering an extensive collection of old children's toys.

At an extremely well-attended memorial service for Chris held at the University of Edinburgh, Playfair Library, on 13 October 2017, colleagues from many different disciplines paid tribute to his massive contributions to the field. Chris was devoted to his family. At the service, his wife and two sons described his role as a family man whose happiest times in his later years were spent playing with his grandchildren. A quotation from John Buchan on the cover of the order of service eloquently summed up his life.

'His presence warmed and lit up so big a region of life that in thinking of him one is overwhelmed by the multitude of things that he made better by simply existing among them.'

Born on 21 April 1947, Chris Freeman died of cancer of the prostate at home in East Lothian on 20 August 2017. He is survived by his wife Katherine, his sons Paul and Robin, and his grandchildren.

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1.5.62 Mental health crisis resolution teams and crisis care systems in England: a national survey

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date

2018-8

Abstract**Aims and method**

A national survey investigated the implementation of mental health crisis resolution teams (CRTs) in England. CRTs were mapped and team managers completed an online survey.

Results

Ninety-five per cent of mapped CRTs ($n = 233$) completed the survey. Few CRTs adhered fully to national policy guidelines. CRT implementation and local acute care system contexts varied substantially. Access to CRTs for working-age adults appears to have improved, compared with a similar survey in 2012, despite no evidence of higher staffing levels. Specialist CRTs for children and for older adults with dementia have been implemented in some areas but are uncommon.

Clinical implications

A national mandate and policy guidelines have been insufficient to implement CRTs fully as planned. Programmes to support adherence to the CRT model and CRT service improvement are required. Clearer policy guidance is needed on requirements for crisis care for young people and older adults.

Declaration of interest

None.

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Crisis resolution teams (CRTs) are multidisciplinary, specialist mental health services that offer brief intensive home treatment to people experiencing a mental health crisis, with the aim of averting hospital admission wherever possible.¹ CRTs for working-age adults have been implemented nationally in England since the National Health Service (NHS) Plan of 2000,² and elsewhere in Europe and Australasia.³ The English national mandate for CRTs was accompanied by policy implementation guidance⁴; the CRT model it specified has been endorsed in numerous subsequent policy guidelines.⁵ Trials suggest that CRTs can reduce in-patient admissions and increase patients' satisfaction with acute care.⁶⁻⁷ However, when scaled up to national level, the implementation of CRTs has been highly variable,⁸⁻¹⁰ and their effects on admission rates have been disappointing.¹¹ In England, improving access to and quality of mental health crisis care across the age range has been identified as a priority by expert bodies and policy makers.¹²⁻¹⁵ To inform

future mental health workforce planning, in 2016 Health Education England commissioned a team from University College London to conduct a national survey of CRTs.

Method

Aims

The nationwide implementation of CRTs for working age adults in England mandated by the NHS Plan² represents an unusually prescriptive attempt to implement a new mental health service model on a national scale. In this paper, we aimed to investigate the consequences of this national implementation, through addressing two main research questions. First, to what extent do CRTs adhere to the implementation guidance for CRTs⁴ that accompanied the national mandate? Second, how has the implementation of CRTs changed, compared with results from a similar CRT survey⁹ conducted in 2012? Secondary aims were to map the provision of CRTs in England for working-age adults, children, and older adults and people with dementia; to explore variation in the local acute care system contexts in which CRTs operate; and to describe the staffing and access arrangements of CRTs.

Setting

We sought to map and include all CRTs in England. CRTs were defined as mental health services that exclusively provided brief, intensive home treatment for people in mental health crisis with the aim of averting hospital admission. Services that provided longer-term intensive home treatment (e.g. assertive community treatment teams) or intensive home treatment as part of a broader community service (e.g. within the context of a community mental health team) were excluded.

Participants

Team managers of each identified CRT were invited to participate in the survey. Where the manager was unavailable, an alternative senior CRT staff respondent was sought.

Measures

The study team developed a 91-item questionnaire, informed by the measure used in a previous CRT survey.⁹ This included a mixture of quantitative questions and questions requiring brief free-text responses. Questions covered: current CRT staffing and caseload size; referral and access arrangements, including opening hours, eligibility criteria, referral routes and response time; working arrangements with other acute services; the role of the CRT in decision-making regarding hospital admission ('gatekeeping'); staff training; and team philosophy of care.

Procedures

CRTs were mapped by multiple means, including registers of adult and older adult CRTs from two research studies and a national quality improvement network, and through the websites of all mental health NHS trusts in England. CRT managers were asked to identify other CRTs in their area (including teams for young people or older adults) when contacted about the survey, in order to identify any CRTs previously missed.

The survey met Health Research Authority criteria for a service evaluation¹⁶ and was approved as such by the North London Research Consortium. Local processes for approving the service evaluation were followed by the study team wherever required.

Details of mapped CRTs were entered into Opinio,¹⁷ UCL's secure online survey system. Team managers were then automatically invited to complete the survey by email, through Opinio, and were also contacted by researchers, sent an

information sheet about the study and given the opportunity to ask any questions. Following three, weekly automatic Opinio email reminders, researchers contacted remaining non-responders by phone. The option of completing the questionnaire as a telephone interview was offered. Respondents consented to take part by completing the survey: those who completed the survey online entered their own data directly into Opinio; researchers entered the data into Opinio for phone respondents.

The survey took place from September to November 2016. At the beginning of December 2016, the online survey was closed and the data were downloaded from Opinio into SPSS for Windows for data analysis. Data files were stored on the secure, password-protected UCL IT system.

Analysis

Data were analysed in SPSS and descriptive statistics were presented separately for adult, older adult/dementia, and children and young people's CRT teams. Survey questions which directly mapped on to national policy implementation guidance for adult CRTs⁴ were identified, and the proportion of adult CRTs meeting each policy recommendation was reported. For variables where comparable data were available from both our survey and the 2012 national CRT survey,⁹ differences in responses between the two time points were explored using bivariate statistics.

Results

Overall, 198 adult CRTs, 15 CRTs for children and young people, and 31 CRTs for older adults and/or people with dementia were mapped. (One adult CRT originally mapped in error was excluded.) Survey responses were obtained from 190 adult teams, 13 children and young people's teams, and 30 older adult teams: an overall response rate of 95%. Two administrative health regions (NHS trusts) had no adult CRT services: in these regions, crisis response was organised within broader community mental health teams.

Adult CRTs' adherence to policy recommendations

Table 1 summarises how far adult CRTs were adhering to the recommendations of the influential Mental Health Policy Implementation Guide⁴ which accompanied the national mandate for adult CRTs in England. Only one team was fully adherent in all respects; recommendations for having a multidisciplinary staff team and for accepting referrals directly from general practitioners (GPs) and patients were most frequently unmet. Regarding staffing levels, 76% of teams met the minimum recommended staffing level of 14 full time equivalent staff for a caseload of 30 patients, based on their current caseload on the day of the survey. However, this figure dropped to 55% of teams, based on their reported highest typical caseload. *Table 1* Adult CRTs' adherence to national policy implementation guidance regarding access and staffing

Department of Health 2001 policy implementation guidance requirement for CRTs	Proportion of CRTs for working age adults implementing this guidance	n/N (%)
The CRT can provide home treatment 24 h a day, 7 days a week	[Coded as: the CRT can provide home visits to patients on its caseload at any time of the day or night]	132/190 (70%)
The CRT has easy referral processes including accepting direct referral from GPs and patients/families		78/185 (42%)
The CRT will work with adults aged 16–65 years		42/190 (22%)
The CRT should act as gatekeeper to in-patient services	[Coded as: does the CRT always assess voluntary patients in person before hospital admission?]	92/185 (50%)
Adherence to all the above access requirements		33/185 (18%)
The CRT includes a psychiatrist	[Coded as: the CRT includes a consultant or staff grade psychiatrist]	173/185 (94%)
The CRT team should be multidisciplinary	[Coded as: the CRT includes psychiatrist, nursing, social work, psychologist and occupational therapist staff and support workers]	27/185 (15%)
The CRT should include at least 14 full time equivalent staff for a team caseload of up to 30 patients	[Coded based on current caseload from survey responses]	137/180 (76%)
Adherence to all the above staffing requirements		17/180 (9%)
Adherence to all staffing and access requirements		1/180 (1%)

Changes to CRT implementation 2012–2016

Table 2 summarises recent changes in adult CRT implementation, based on a comparison of results from this survey with those from a previous national survey conducted in 2012.⁹ Overall, adult CRTs appear to be more accessible in 2016: compared with 2012, significantly more CRTs accept self-referrals, provide a 24 h service, and work with people with personality disorders and with older adults. An exception to this trend is that fewer CRTs in 2016 accepted young people aged 16–17 years. More CRTs in 2016 were able to access non-hospital crisis beds, compared with 2012, and more teams in 2016 fulfilled a full ‘gatekeeping’ function and assessed all patients before voluntary hospital admission. Changes in CRTs’ staff mix were less marked, although social workers were less well represented and psychologists were better represented in CRTs in 2016 than in 2012. The proportion of teams meeting recommended minimum staffing levels fell from 87 to 76%. Table 2

Service domain	2012 CRT survey	2016 CRT survey	Characteristic	n/N (%)	Significant differences
Eligibility (diagnosis)	The CRT will accept people with dementia	39/192 (20%)	32/190 (17%)	n/s	
Eligibility (age)	The CRT will accept people with personality disorder	151/192 (79%)	187/190 (98%)	$\chi^2 = 36.6, P < 0.001$	
Access (hours of service)	The CRT will accept people age 16+	99/192 (52%)	60/190 (32%)	$\chi^2 = 15.7, P < 0.001$	
Access (referrals)	There is no upper age limit to the CRT service	110/191 (58%)	137/190 (72%)	$\chi^2 = 8.8, P = 0.003$	
Access (gatekeeping)	The CRT provides a 24 h telephone response	138/171 (81%)	176/190 (93%)	$\chi^2 = 11.3, P = 0.001$	
Access (referrals)	The CRT accepts referrals from GPs	147/190 (77%)	148/184 (80%)	n/s	
Access (gatekeeping)	The CRT accepts self-referrals from known patients	106/191 (55%)	127/184 (69%)	$\chi^2 = 7.4, P = 0.007$	
Access (gatekeeping)	The CRT accepts self-referrals from new patients	40/191 (20.9%)	79/184 (43%)	$\chi^2 = 20.9, P < 0.001$	
Access (gatekeeping)	The CRT assesses all patients in person before voluntary hospital admission	62/187 (33%)	92/185 (50%)	$\chi^2 = 10.5, P = 0.001$	
Staff mix	The CRT includes consultant psychiatrists	148/171 (87%)	163/185 (88%)	n/s	
Staff mix	The CRT includes nurses	171/171 (100%)	182/185 (98%)	n/s	
Staff mix	The CRT includes social workers	122/171 (71%)	105/185 (57%)	$\chi^2 = 8.2, P = 0.004$	
Staff mix	The CRT includes occupational therapists	72/171 (42%)	88/185 (48%)	n/s	
Staff mix	The CRT includes psychologists	50/171 (29%)	73/185 (39%)	$\chi^2 = 4.1, P = 0.04$	
Staffing level	The CRT has at least 14 full time equivalent staff for a caseload of 30 patients (based on current caseload)	116/134 (87%)	137/180 (76%)	$\chi^2 = 5.4, P = 0.02$	
Crisis alternatives	The CRT has access to a crisis house	65/184 (35%)	85/185 (46%)	$\chi^2 = 4.3, P = 0.04$	
Crisis alternatives	The CRT has access to an acute day hospital	41/184 (22%)	40/185 (22%)	n/s	

CRTs within the acute care system

Table 3 shows the different acute care contexts within which CRTs operate. While all NHS trusts include acute in-patient wards, there was wide variation in the availability of other crisis services within local acute care systems. About half of adult CRTs were supported by a separate, staffed crisis phone line, and had access to residential, non-hospital crisis beds. About one-fifth of adult CRTs could access places for patients at an acute day hospital. Three innovations in acute care systems are highlighted by the survey. First, there is a split between crisis assessment and crisis home treatment functions: nearly one-third of adult CRTs are now supported by a separate triage/crisis assessment service. Second, 15% of adult CRTs are supported by non-residential crisis drop-in services, which typically function at evenings and on weekends, and can signpost elsewhere or refer individuals to CRTs. Third, specialist CRTs for young people and older adults, which were not nationally mandated, have been developed: these typically have less access than adult CRTs to other supportive crisis services. Table 3

Variation in the acute care systems within which CRTs operate	Acute care system characteristic	CRTs operating within this type of acute care system	n/N (%)
Adult CRTs	Children and young people’s CRTs	Older adult/ dementia CRTs	
A separate, 24 h crisis line is provided			106/184 (58%)
A separate crisis assessment/triage service is provided			59/184 (32%)
The CRT has access to residential crisis beds (non-hospital)			85/185 (46%)
The CRT can access an acute day hospital			40/185 (22%)
A separate sanctuary/crisis drop-in service is provided			28/185 (15%)

Staffing and access: adult CRTs

Full descriptive results from the survey are provided in the supplementary data (File DS1) available at <https://doi.org/10.1192/bjb.2018.19>. Adult CRTs exhibited wide variation in staffing and access arrangements. While most teams included nurses (98%), psychiatrists (94%) and support workers (88%), whether teams included social workers (57%), occupational therapists (48%) or psychologists (39%) was much more variable. Current team caseloads varied from 5 to 144 patients; current staffing varied from 3 to 69 full time equivalent staff. A typical adult CRT, based on median scores, comprised 21 full time staff for a caseload of 29 patients.

Eligibility criteria for adult CRTs also varied. Most teams (72%) accepted patients over the age of 18 with no upper age limit, but only a third of teams (32%) would support young people aged 16–17. This was in the context of 13% of adult CRTs reporting that there was a local children and young people's CRT which operated 24 h a day, and 6% of adult CRTs with a local older adults' CRT operating 24 h a day. Half of adult CRTs (50%) reported that they would accept patients with comorbid learning difficulties, and only a minority (17%) supported people with dementia. Referrals from GPs were accepted by 80% of teams; self-referrals were accepted by two-thirds of teams (69%) if the patient was already known to services, but by fewer than half (43%) if the person was not previously known.

Most teams (93%) provided a 24 h telephone response, but just over two-thirds (69%) operated a full 24 h service, including capacity to make home visits. Half of adult CRTs (50%) reported that they always assessed patients in person before hospital admission was arranged, but only 19% of teams reported always attending Mental Health Act assessments, which precede compulsory hospital admissions. Eighty-six per cent of adult CRTs set a target response time for starting an assessment, having accepted a referral for a patient in crisis, but these targets varied from 1 h to 1 week. In 45% of teams, this target response time was 4 h or less.

Staffing and access: children and young people's and older adult CRTs

While nurses were represented in all teams, only a minority of children and young people's CRTs (46%) and older adult CRTs (38%) included medical staffing. Occupational therapists were included in a majority of older adult teams (55%), and social workers in a majority of children and young people's teams (61%). For children and young people's teams, current caseload size ranged from 3 to 49 patients, and 59% of teams met a minimum staffing level benchmark of 14 full time equivalent staff for a caseload of 30 patients. For older adults, current caseloads ranged from 8 to 226 patients; 59% of these teams also met the minimum staffing level.

All but two of the children and young people's CRTs accepted all ages up to 18 years the other two had lower limits of 11 and 12 years, respectively. Of the 30 older adult teams included in the survey, 11 were exclusively for people with dementia, while the other 19 also accepted older adults with mental illness. Compared with adult CRTs, fewer CRTs for older adults (30%) and for children and young people (46%) offered a full 24 h service, including capacity to provide home visits. While most teams would accept direct referrals from GPs (69% of children and young people's teams; 76% of older adult teams), fewer than half would accept any referrals directly from patients or their families (46% for people already known to services in children and young people's CRTs; 45% in older adult CRTs). Target response times for starting an assessment following a new referral were very varied, as in adult CRTs: the response time target was 4 h or less for 64% of children and young people's teams which set a target, and for 33% of older adult teams. Only about a third of older adult and children and young people's teams (31% for each) reported always assessing patients in person before hospital admission.

Philosophy of care and staff training

Forty-four per cent of adult CRTs and 52% of older adult CRTs reported having any philosophy of care or theoretical model which underpinned their service, with the recovery model being by far the most common response in each case. Only three of 13 children and young people's CRTs reported any underpinning philosophy or model – either a 'psychosocial' model or a dialectical behaviour therapy approach. Fewer than half of CRTs for adults (41%), older adults (28%), or children and young people (31%) reported providing any CRT-specific training for the whole staff team.

Discussion

The survey findings show that current implementation of the CRT model is highly variable. Almost no adult CRTs adhere fully to the model recommended in policy guidance. This is consistent with the findings from previous surveys.⁸⁻⁹ Adult CRTs appear to have become more accessible since 2012. The finding that fewer adult CRTs met recommended staffing levels in 2016 compared with 2012 should be treated with caution: it may be an artefact of a better response rate to the relevant questions in the 2016 survey, and may also reflect the proliferation of separate crisis assessment services, which, where present, reduce the workload for CRTs in responding to new referrals.

While adult CRTs remain almost universal in England, CRTs for children and for older adults are comparatively rare. The teams which do exist may serve larger geographical areas than adult CRTs, but in most areas of England, neither children nor adults with dementia can access crisis support from a specialist CRT team. Children's and older adult CRTs are typically less well staffed and less likely to be organised to provide easy-access, 24 h intensive home treatment, compared to adult CRTs.

Strengths and limitations

The very high response rate provides confidence that this survey is representative of CRTs in England. As a self-report questionnaire, it is vulnerable to social desirability bias and to the possibility that respondents do not all interpret questions in the same way. It provides only a cross-sectional snapshot of CRT implementation at one moment in late 2016, although the comparison with results from a similar survey in 2012 allow some assessment of changes over time. Our survey did not ask about the types of intervention provided by CRTs.

Implications for research

Four priorities for future research can be identified from this service evaluation. First, there is a need to evaluate mental health crisis care systems, not just individual service models. *Table 3* showed that CRTs are operating in extremely variable acute service contexts; these contexts – both the configuration of crisis services and the continuity of care among them – are likely to influence outcomes for CRT patients and the overall effectiveness and costs of acute care. The separation of crisis assessment and home treatment teams in many areas represents a major change in acute care in England, which appears to have occurred in response to perceived local need rather than policy guidance or supporting research evidence. We lack evidence about optimal acute service system models. Second, a systematic review¹⁸ has highlighted the lack of high-quality evidence regarding older adult CRTs, and evidence is equally lacking for effective models of crisis care for younger people. It is unclear whether an adult CRT model is also appropriate for these client groups, or how the model should differ: specification and evaluation of CRT service models for children and older adults is required. Third, our survey suggests that CRTs may be improving access to care without increased staffing resources. This may be occurring in the context of increased demand for CRT services and reduced budgets.¹⁹ The effects of absorbing these pressures on the quality of care delivered to CRT patients are unknown. The need to understand the relationships between CRT resources, service organisation and access, and the quality of care provided to patients is therefore of high importance. A recently developed fidelity measure for CRTs²⁰ offers a means to assess the organisation and delivery of care in CRT services rigorously and reliably, which could help to address this need. Fourth, the lack of adherence to best practice recommendations in adult CRTs indicates a need to develop resources to

support CRTs in achieving high model fidelity and service quality. A current nationally funded study²¹ is evaluating a service improvement programme for CRTs in a cluster randomised trial, which, if effective, should help to address this need.

Implications for practice

A generalisable implication of this service evaluation is that a policy mandate and guidelines are insufficient to achieve complete and consistent implementation of a desired service model. Active monitoring and support has been shown to be essential for the successful implementation of complex interventions in mental health in international contexts.²² Clear specification of desired service standards for CRTs, with audit and service improvement support to identify and address difficulties with implementation, is required for CRTs at local and national levels. For example, there is a huge difference for someone in a mental health crisis between waiting an hour for CRT support and waiting a week – yet this is the range of local response time targets reported by CRTs. This survey provides benchmarking data, which can inform the setting of feasible national standards for CRTs and assessment of future changes in CRT implementation. The apparent recent improvements in the accessibility of CRTs suggested by our survey may indicate that recent national policy campaigns in England to achieve better access to mental health crisis care¹⁵⁻²³ have had some positive effect. Notwithstanding the need for more research evidence about effective service models, the current ‘postcode lottery’ found by our survey regarding the availability of specialist crisis services for children and older adults indicates a need for action from policy makers and service planners to ensure appropriate services are provided in all areas for these vulnerable groups at times of crisis.

Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2018.19>.

[click here to view supplementary material](#)

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I am a big fan of short books and, at around 100 pages, this is a remarkably short book. The authors outline the debate between autonomy and paternalism, and also aim to demonstrate where philosophy can be useful to psychiatry and medicine. The book succeeds in both areas, although in places it could have benefited from further elaboration and exposition.

Part 1 summarises the arguments for personal autonomy, defined as ‘acting on one’s own reasons, not on those of other people’. The authors outline why this is valued as a good in its own right, only to be interfered in with significant moral justification. Paternalism is shown generally to act to undermine individual autonomy (although it can be justified e.g. for public health). Medicine is defined ‘not as a science but an interpretive practice relying on clinical reasoning’.

The patient–doctor consultation is rightly situated as the ‘central act of medicine’. The way people make decisions is considered: not as isolated units but in dialogue with their significant others.

The best section is on Miranda Fricker’s concept of epistemic injustice. Fricker has highlighted two types of injustice: testimonial and hermeneutical. Testimonial injustice refers to a speaker being awarded less credibility owing to prejudice on the listener’s part, e.g. a woman speaking in a male-dominated boardroom. Psychiatric patients are particularly susceptible to this *credibility deficit*. The authors cite Elyn Saks’s account of attending the accident and emergency department with a brain haemorrhage. When doctors heard of her history of schizophrenia, they stopped diagnostic investigations and sent her home. Hermeneutic injustice occurs when an individual/group does not have access to, or is not represented within, the shared generation of meaning. Here the injustice is often to the subject who questions the credibility of their own testimony. An example is a depressed new mother trying to make sense of her feelings without any knowledge of postnatal depression.

Part 2 addresses specific problems: mental health legislation, do-not-resuscitate orders, and assisted dying. These are condensed and well-written, but there is nothing new for anyone working clinically in these specialties.

Overall, this is a clear and concise introductory work useful for anyone interested in this area.

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1.5.63 The over-35s: early intervention in psychosis services entering uncharted territory

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Abstract

¹

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Aims and method

Following the introduction of new standards for early intervention in psychosis (EIP) in England, EIP services are accepting referrals for people aged 35–65. The Cambridgeshire and Peterborough EIP service (CAMEO) aimed to explore the immediate implications for the service, especially with regards to referral numbers and sources. Data were collected from April 2016 to June 2017.

Results

Referrals for over-35s represented 25.7% of all new referrals. Fifty per cent of referrals for over-35s were accepted onto caseload (40.2% for under-35s). The over-35s were more likely to be referred from acute and secondary mental health services ($P < 0.01$) and had longer durations of untreated psychosis than the under-35s ($P = 0.02$).

Clinical implications

CAMEO has received a significantly higher number of referrals as a result of age inclusivity, with an increased proportion of patients suffering from severe, acute psychotic presentations and existing mental health difficulties. This has implications for service planning.

Declaration of interest

None.

Contents

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In April 2016, a new Access and Waiting Time Standard for early intervention in psychosis (EIP) services in England¹ came in to force. At least half of all referrals to EIP services should have access to and commence a National Institute for Health and Care Excellence (NICE)-concordant package of care for psychosis within 2 weeks of referral. Although EIP services had promoted easy access and prompt responses to new referrals since their inception, the new policy offered detail on how to achieve and report the Standard. In addition, the policy, in accordance with NICE recommendations,² provided information about the need to expand current care provision in order to treat those individuals that might be at risk of developing psychosis, and to ensure prompt access and treatment for people with a first-episode psychosis regardless of their age. The effect of age inclusivity on the *modus operandi* of previously youth-oriented services was unknown. In fact, those EIP services that adhered to the new policy in full entered an uncharted territory that, inevitably,

would require cultural and structural changes. However, the magnitude of these changes was unclear and not fully informed by previous evidence. For instance, the paucity of studies on the administrative incidence of first-episode psychosis in people aged over 35 assessed in early intervention settings^{3–5} complicated new workload calculations and commissioning decisions.

The CAMEO EIP service in the Cambridgeshire and Peterborough NHS Foundation Trust (<http://www.cameo.nhs.uk>) decided to conduct a service evaluation to determine the initial effects of this policy change and assess how well it was achieving its intended aims with this population. In the first instance, CAMEO managers and clinicians were particularly keen to explore the immediate implications for the clinical service, especially with regards to referral numbers and sources for individuals aged over 35 with a suspected first-episode psychosis. This would help generate meaningful information that could drive local decision-making.

Method

Setting and data collection

CAMEO is an EIP service that offers management for people aged 14–65 years suffering from first-episode psychosis across Cambridgeshire and Peterborough, UK. CAMEO serves a very diverse population of around 870 000, from the international scientific community in Cambridge city and multicultural population of Peterborough to a large rural base in the Fens.⁶ Referrals of suspected psychosis are accepted from multiple sources, including general practitioners, other mental health services, the third sector, school and college counsellors, relatives and self-referrals.^{7,8} CAMEO started accepting referrals of people aged over 35 from 1 April 2016.

Data on referral numbers and sources for people aged over 35 were collected over 15 months, from 1 April 2016 to 30 June 2017. Additional personal information was de-identified and did not contain sensitive details. It included data available from the Cambridgeshire and Peterborough NHS Foundation Trust electronic clinical records, such as demographic information (age, gender, ethnicity and marital status) for all referrals, and duration of untreated psychosis (DUP) and working diagnosis (usually based on the clinical judgement of two senior clinicians, including a senior consultant psychiatrist, and discussions at multidisciplinary team meetings) for those referrals accepted onto the CAMEO case-load. For comparative purposes, we also collected some information for under-35s referred to our service during the same period. This included referral numbers and sources, age, gender and DUP for those accepted to case-load.

Data analysis and publication followed the guidelines established by the *Anonymisation Standard for Publishing Health and Social Care Data*.⁹ Raw data were not shared with any third party.

Statistical analysis

All analyses were performed using version 20 of SPSS (SPSS, Inc., Chicago, Illinois). Comparisons were made using the χ^2 test for categorical variables and *t*-test or Mann–Whitney U-test for continuous variables. A *P*-value of less than 0.05 represented a significant difference.

Results

Referral numbers and characteristics

One hundred and sixty-two referrals for individuals over 35 were received during the 15-month evaluation period; 458 referrals were recorded for people under 35. Thus, referrals for over 35s represented 25.7% of all referrals.

50% of referrals for patients over 35 were accepted onto the CAMEO case-load ($n = 81$). Based on the population aged 35–65 in Cambridgeshire and Peterborough,¹⁰ this represented an administrative incidence of approximately 25 per 100 k per year for this group. Notably, a lower proportion of the total number of referrals for individuals aged under 35 were accepted onto case-load (40.2%) (*Fig. 1*). *Fig. 1* Flow chart for referrals received by CAMEO from April 2016 to June 2017.

Of the referrals for over-35s, 21.7% ($n = 35$) were not assessed and 28.3% ($n = 46$) were assessed but not accepted onto case-load. Reasons for those over 35 referred but not assessed or taken onto CAMEO were: (a) absence of psychotic symptoms and/or diagnosis of non-psychotic disorder, usually anxiety disorders, after assessment ($n = 55$); (b) evidence of a first-episode psychosis in the past ($n = 12$); and (c) psychotic symptoms in the context of neurodegenerative disorders, i.e. dementia ($n = 3$). The rest were not taken onto case-load for a variety of reasons, such as change of residence to outside CAMEO's catchment area, disengagement during the assessment period or cancellation of referral.

The mean age for all referrals for this group was 47.66 (s.d. = 8.44, range = 36–66.5 years). Fifty-one per cent of referrals for over-35s were female *v.* 38% for under-35s ($\chi^2(4) = 420.55, P < 0.01$). Forty-four (54.3%) out of the 81 referrals for over-35s finally accepted onto case-load were women.

Approximately one-third of over-35s referred to CAMEO were married or cohabiting, 16.3% were divorced or separated, and 34.7% were single (15.6% not known/recorded). The majority (60.5%) considered themselves White British (the remainder were White other (11.1%), Asian British (1.2%), Asian other (6.8%), African–Caribbean British (1.2%), African–Caribbean other (2.5%), other (3.1%) and not known/recorded (13.6%)).

Referral sources

A higher proportion of referrals for over-35s were received from acute (acute psychiatric wards and crisis resolution home treatment teams) and secondary (community mental health teams) mental health services in comparison with under-35s, who were referred from primary care more often. Differences in referral sources between the two groups were statistically significant ($\chi^2(5) = 27.84, P < 0.01$). Also, self-referrals from over-35s were less common (2 *v.* 39 individuals) (Fig. 2). Notably, 45.9% of all over-35s referred to our service had a confirmed previous history of mental health problems. Fig. 2 Percentage of referrals for over- and under-35s by referral source.

Duration of untreated psychosis

DUP for over-35s accepted onto case-load ranged from 2 days to 20 years (median 2.6 months, mean = 1.88 years; s.d. = 4.32; $n = 68$, 13 not known). Five patients had a DUP of more than 10 years, and another six of more than 3.5 years. Under-35s had a mean DUP of 8.5 months (s.d. = 1.76 years, median = 1 month, range 1 day to 12 years; $n = 157$, 27 not known). The difference in DUP between under- and over-35s was statistically significant ($u = 3129.5, P = 0.02$).

DUP was longer than 3 years for 13.5% of patients over 35 accepted onto case-load ($n = 11$), compared with 3.8% for patients aged under 35 ($n = 7$).

Working diagnosis

Working diagnoses for the over-35s accepted onto case-load were as follows: unspecified nonorganic psychosis (22.2%, $n = 18$), psychotic depression (16.0%, $n = 13$), delusional disorder (14.8%, $n = 12$), bipolar disorder (12.3%, $n = 10$), schizophrenia (11.1%, $n = 9$) and acute and transient psychotic disorder (8.6%, $n = 7$), with a further 6.2% ($n = 5$) having other diagnoses, including schizoaffective disorder and drug-induced psychosis, and 8.6% ($n = 7$) not known/recorded. Differences in diagnoses by gender were statistically significant ($\chi^2(7) = 14.30, P = 0.05$); women were more likely to suffer from affective psychoses, such as psychotic depression.

Discussion

Our findings contribute to a sparse research landscape looking into the administrative incidence of first-episode psychosis in people aged over 35 assessed in EIP settings. What little is so far known has been gathered from services already offering a broader EIP service in predominantly urban areas prior to 2016.³⁻⁵ By collecting data after the introduction of the new Access and Waiting Time Standard,¹ we were able to evaluate the effects of these changes in existing EIP services, such as CAMEO, and anticipate further challenges and opportunities.

Following the changes to our service, almost 26% of new referrals were for patients over 35 years old. This confirms previous evaluations in early-adopter services, which suggested that patients over the age of 35 would make up a significant proportion of referrals, ranging from 25 to 33%.³⁻⁵ A higher proportion of patients over the age of 35 were referred from secondary and acute care in comparison with those aged under 35; the over-35s were more likely to have existing mental health issues.

Since referral processes may differ across EIP services, data from early-adopter services are difficult to compare with ours; however, they also suggested relatively few referrals from primary care for this older group. This might reflect lack of awareness in the wider health system, but, for some patients, it may well be related to psychosis developing as a secondary feature of depression and other conditions for which they had already received some support.¹¹ Interestingly, 50% of referrals for over-35s were taken on by our early intervention service, whereas only 40.2% of referrals for under-35s were accepted to case-load. This would also support the idea of those aged over 35 suffering from a longer history and higher burden of mental health issues.

Previous studies suggested a different distribution of diagnoses for older *v.* younger patients, with an increased proportion of primarily affective psychoses in over-35s.³⁻⁴ Our results reaffirm these findings, with 16% of over-35s suffering from psychotic depression. The proportion of our patients aged over 35 with non-affective psychosis, approximately 55–60%, is similar to that found by previous evaluations and lower than would be expected in younger patients, where non-affective psychosis is usually reported in approximately 75% of cases.⁴ This is consistent with the natural course of mood disorders, such as resistant depression, which becomes progressively more prevalent in older patients, some of whom may have suffered hypomanic episodes for which they did not seek treatment. Non-affective psychotic disorders are less likely to present for the first time over the age of 35.¹¹ Also, the higher representation of females in our over-35s sample and those of other studies may reflect a bimodal pattern of psychotic disorders in women, with an first peak at around the same age as in men (18–25 years) and a further peak, usually of an affective nature, in the 40s.¹² A willingness to treat these older female patients would support age inclusivity across EIP services.

Selvendra *et al*¹³ showed that older patients referred to their mental health service in Italy had been unwell for significantly longer than younger patients. Our results, from an EIP context, also found a statistically significant difference in DUP between over- and under-35s. This indicates the need to continue to enhance outreach approaches to detect emerging psychotic symptoms earlier,⁸ or to consider different approaches for a group of patients whose illness may have become more chronic by the time they are assessed by EIP services.

Although only three referrals were not taken on by CAMEO owing to comorbid dementia in our evaluation, other studies have shown a steady increase in transition to organic pathology in older patients. In fact, neurodegenerative diagnoses creep into the fold as the upper age limit increases above 35.¹⁴ Accordingly, follow-up studies of over-35s treated in EIP services under the new Standard¹ will be required in order to evaluate this potential clinical issue and the subsequent effects on services that are not designed to treat such conditions.

In summary, our evaluation has begun to unfold the practical challenges that the implementation of the new Access and Waiting Time Standard¹ brings to established EIP services with regards to age inclusivity. The CAMEO service received a significantly higher number of referrals as a result of this, with an increased proportion of patients suffering from severe, acute psychotic presentations and with existing mental health issues for which they had already received treatment. These patients were more likely to be referred from secondary mental health services after an acute crisis, and to have longer DUP and psychotic symptoms in the context of other conditions, such as mood disorders.

The main limitation of this evaluation pertains to the collection of data from electronic records routinely employed in clinical practice; some clinical information was missing and working diagnoses were not confirmed with structured diagnostic questionnaires. However, data on referral numbers and sources, which represented the main purpose of this work, were complete and will aid future analyses on clinical and functional outcomes after completion of the early

intervention care pathway. This should help to determine whether EIP services, as currently implemented, achieve the required standards with a group of patients whose characteristics clearly differ from those traditionally treated in what used to be exclusively youth-oriented clinical services.

We thank all members of CAMEO services for their help and support with this evaluation.

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1.5.64 Emanuel (Gus) Moran FRCP FRCPsych, DPM

Gerald Russell

date

2018-8

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- *Emanuel (Gus) Moran FRCP FRCPsych, DPM*

Formerly Consultant Psychiatrist, Claybury Hospital, Woodford Bridge, and Chase Farm Hospital, Enfield, UK

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Emanuel Moran, known to many of his Maudsley colleagues (though not to family and friends) as Gus, died on 18 August 2017, aged 89. He had become the UK's foremost authority on the psychiatric and social aspects of pathological gambling. His interest had developed during his time as a psychiatric registrar at the Maudsley. He had seen patients who had attempted suicide when they were in difficulties resulting from their gambling dependence. Over the next few years, he accumulated a series of 50 such patients and published his findings in 1970 in the *British Journal of Psychiatry*.¹ He proposed a definition of pathological gambling and put forward a tentative typology. He concluded that gambling was due to a complex interaction between personal factors and social pressures. Among the latter, he noted that the gambling urge would be triggered by new opportunities, such as the opening of a licensed betting office near the person's home or place of work.

It is striking that among the 50 subjects there were no women, a finding probably due to the limited opportunities at that time for women to indulge in serious gambling. They seldom frequented betting shops or casinos and confined themselves to bingo halls, playing that sedate game in the company of friendly neighbours. It was only in the late 1980s that fruit machines were introduced into bingo halls and there was a rapid increase in more active gambling among women. Even more pernicious was the advent of online gambling, attracting young women in particular.

A similar increase in pathological gambling occurred when regulations on gambling were relaxed. Warning signals were sounded following the 1960 Betting and Gambling Act, which had resulted in increased gambling facilities. In more recent years, Emanuel campaigned tirelessly against any further relaxation of restrictions on gambling. He was the first chairman of the Society for the Study of Gambling and insisted that no funding was received by the Society from the gambling trade. Subsequently, he founded the National Council on Gambling.

The Gambling Act, which was passed in 2005 and became effective in 2007, had as one of its stated objectives the protection of children and other vulnerable persons from being harmed or exploited by gambling. This laudable aim has been somewhat undermined by the acceptance of an elastic definition of 'responsible gambling'. From 1974 to 2010, Emanuel was the specialist adviser on gambling to the Royal College of Psychiatrists. Under his guidance, the College submitted crucial advice on restricting the more harmful 'remote gambling' (including mobile phones and the internet). He recognised that the regulation of online companies was only possible when these were based in Britain, but, in fact, most internet companies promoting gambling are now based abroad. Towards the end of his life, Emanuel felt that his efforts to reduce the dangers of gambling had been of no avail, a source of considerable distress to him. Yet his efforts had been determined and valiant.

Emanuel was born in Charlottenberg, Berlin, in 1928. His parents originally came from Kiev. His father, a Baptist minister, moved to Berlin to run a Christian mission. Emanuel was evacuated to England on his 10th birthday, where he was quite alone and knew no English, yet he pursued his schooling with ease. His parents and two younger siblings joined him in London a few months later. His further education took him to Fitzwilliam College, Cambridge, and Guy's Hospital to study medicine. After a period in neurology at the Whittington Hospital, he trained in psychiatry at the Maudsley Hospital under the influence of the formidable Professor Aubrey Lewis. From 1966 to 1980, he was a psychiatrist for Gamblers Anonymous. Through his work, gambling came to be recognised as an addictive disorder. His definition of gambling disorder was adopted by the World Health Organization. Throughout the 1970s, he worked closely with the Home Office. He advised Parliament through the Royal Commission chaired by Lord Rothschild, opposing the deregulation of gambling laws.

Emanuel was an extremely kind and considerate colleague. As a junior consultant, I had admitted a not-so-young lady who became depressed when her engagement to marry was broken. She disappeared from the ward and, justifiably, I feared the worst. The Thames River Police asked me to identify the body. Witnessing my dismay, Emanuel offered to accompany me to the mortuary, an offer I gladly accepted.

In 1965, he was appointed Consultant Psychiatrist to Claybury Hospital, Woodford Bridge, and Chase Farm Hospital, Enfield, where he worked for almost 30 years. He was clinically responsible for one of the busiest general adult sectors in north London, a role which consumed a great deal of his time and energy

In the early 1970s Emanuel began to suffer from severe ill-health, and in 1974 his wife was told that he had only weeks to live because of a bladder cancer. He survived for another 40 years, for which he felt indebted to two urosurgeons, but his illness greatly affected his subsequent quality of life. He took delight in his family. Jane was his wife for 51 years. His elder son, Paul, became a psychiatrist, and his younger son David was active in education. He leaves five grandchildren.

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1.5.65 Profile: David O'Flynn

Julia Bland

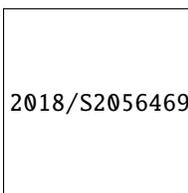
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- *Profile: David O'Flynn*

Julia Bland meets Dr David O'Flynn, the insider of 'outsider' art, Chair of The Adamson Collection Trust and Consultant Rehabilitation Psychiatrist in Lambeth.



Dr O'Flynn contains within himself some of the contradictions of 'outsider' art. On first meeting, I unthinkingly proffered my right hand to shake his right hand, and then kicked myself as he offered his left hand: he has a right-sided hemiplegia. I don't think he was remotely bothered by the momentary awkwardness. From the beginning he exudes a joyous, almost boyish, enthusiasm; both for the works of The Adamson Collection and for his work on the Tony Hillis Unit, a 15-bed locked ward in Lambeth Hospital for men with chronic psychosis, behavioural problems and addictions. His sparky nature seems paradoxically linked to a very unfunny situation. Living with a terminal illness for much of his 30s, he has developed a sense of proportion about what really matters: 'I shouldn't really be here it's all extra'.

He enthuses about his work with intractable, sometimes violent, patients with psychosis, many of which have substance misuse problems in the mix. The atmosphere on the ward is calm and the patients are friendly, albeit with intense psychopharmacological treatment. They have an inside gym, an outside area and art sessions on the ward. 'It's really a therapeutic community, exactly what I always wanted.' The mean length of stay is 15 months. He remembers learning a slow, thoughtful approach to crisis on the ward from a consultant when he was a trainee. There had been a fight between five patients and 'he taught me to go slowly, considering each patient, one by one.'

How did Dr O'Flynn get involved with The Adamson Collection?

He continued working in the emerging field of rehabilitation psychiatry, in spite of his poor health, and went to a psychiatric conference in Delphi where – by chance – he met a trustee of The Adamson Collection. O'Flynn was subsequently co-opted onto the committee that was planning Edward Adamson's legacy. Through this work, he became a personal friend of Adamson's surviving partner, John Timlin.

What is The Adamson Collection?1

Edward Adamson (1911–1996) was an artist who was employed at Netherne Hospital to run an art facility for the patients from 1946 until his retirement in 1981. Before he started, some psychiatrists had set up the art studio as a kind of experimental laboratory, for example to compare a patient's work pre- and post-lobotomy.

Adamson had a very different approach. He created a calm place, with classical music in the background, where patients could produce whatever they liked and there was no interpretation. He believed that making illustrations of any kind had a healing effect. As Anthony Stephens the Jungian analyst wrote: 'Adamson enabled them to formulate the meaning of their predicament; and by mobilising the creative resources latent within their own personalities, he assisted them to heal themselves.'

He even managed to arrange separate spaces for patients who couldn't tolerate the studio with other people. He also enacted respect for each patient by providing a chair, an easel and a small table for paints and brushes so that each person

had a distinct individual space within the room. This was in contrast to the uniformity of the institutional regime: beds lined up in a ward with no privacy.

Adamson was a trained artist and not a therapist; although he was influenced by Jungian ideas, regularly visiting the Jungian art therapy community Withymead in Oxfordshire. He had been a conscientious objector during the war and trained as a chiropodist. He established the British Association of Art Therapists in 1964, as well as the first art therapy training programme in 1969.

Particularly remarkable artists in The Adamson Collection (see below) include J. J. Beegan, who poignantly drew on lavatory paper with burnt matchsticks, and Mary Bishop, who expressed her utter despair and frustration with psychiatrists in paintings such as *Cri du Couer* and *Sadist in a White Coat*. Other notable workers in Adamson's studio include William Kurelek, a Canadian of Ukrainian origin who went on to be a successful, recognised artist later in his life. Rosanda Polonska spent 35 years in Netherne, producing drawings, poetry and sculpture, including the *Stations of the Cross* which were put up in the Netherne Hospital chapel. In 1982 she left hospital to live with her sister in Paris. Gwyneth Rowlands was completely original, making painted sculptures out of flints and pebbles she found. Some of these are permanently on display in Lambeth Hospital. Other Rowlands flints, pottery and other sculptural works are kept in The Adamson Collection Trust at the Bethlem Royal Hospital, and another 6 are in the Reading Room of the Wellcome Collection. Fig. 1 *Key Centres* by Martin Birch, date currently unknown. Pencil on paper. Courtesy of the Adamson Collection/Wellcome Library.

The thousands of works produced at Netherne underwent complicated selection processes. Adamson himself organised a group exhibition as early as 1947; and in 1956, 500 works were chosen by Adamson for the gallery he had established at Netherne. After he retired this became a physiotherapy room.

In 1981 Adamson and Rudolph Freudenberg selected several thousand works for storage and display at the entomologist Miriam Rothschild's Ashton Wold estate in Northamptonshire. When they later returned to Netherne, the rest of the works had disappeared.

In 1997 the whole collection was moved to Lambeth Hospital, which didn't have an adequate storage facility, and pieces were stored on open shelves and even in a disused shower cubicle! Fig. 2 *Graffiti on Lavatory Paper 2: 3 Lions* (detail) by J. J. Beegan, c. 1946. Match char on Izal medicated toilet paper. Courtesy of the Adamson Collection/Wellcome Library.

Finally, the works on paper were accepted into the Wellcome Library in 2013, where they are now stored and curated.

In what ways does David O'Flynn think art therapies help? Is it an expression of distress and frustration without violence, respect for the production process or do the boundaries of the therapeutic group make it a safe place? Is it a validation of experience? Is it that the act of concentrating on producing an external concrete object, e.g. a painting, relieves the mind of tormenting internal preoccupations, allows distancing and an objectification of thoughts and feelings and thus provides a positive relief? Could engagement with the medium in a quiet place, with a soothing but non-judgemental parental presence, perhaps allow some reworking or reawakening of childhood playfulness?

In 1996 the Hayward Gallery exhibited 'psychotic art' from the German Prinzhorn Collection; the art consisted of poignant pieces by long-term institutionalised patients.² Like The Adamson Collection, there are recurrent themes of fear, disintegration, fragmentation, feeling observed (multiple eyes), loss of control/being controlled (e.g. rays, pursuing objects, etc.), magical creatures and variable and multiple perspectives. The artworks feel like attempts at mastery of internal chaos. Fig. 3 *The Sadist in the White Coat* by Mary Bishop, date currently unknown, probably late 1950s. Poster paint on paper. Courtesy of the Adamson Collection/Wellcome Library.

The past decade has brought a newer phenomenon of 'community arts': public arts associated with well-being that include drama as well as painting. This phenomenon seems to be targeted at a different patient group, i.e. people that are managing in the community, rather than the long-stay asylum population that Adamson was catering for.

David O'Flynn seems like an ideal fit for The Adamson Collection: interested in art, he used to escape the claustrophobic suburb as a child to look at pictures. When he was at school at Westminster, he often dropped into the Institute of Contemporary Arts, where he spotted his first punk. He lives with his husband in a not-yet-gentrified part of West London in a house full of reggae. He describes the area as 'a real mix ... there are old ladies who still go to the shops in slippers and a dressing gown ...'

He was brought up in respectable Blackheath, the son of a dedicated surgeon at Guy's Hospital. His brother is also a psychiatrist and is married with children. The young David was sent to Dulwich Preparatory School and then went on to Westminster from 1974–1978, an institution he appreciates for giving him 'confidence without arrogance'. And for a final irony, long before he was aware of Adamson, he had a Jungian analysis with someone who was also an art therapist. Fig. 4 and 5 *Self-portrait: Skull Head* by Gwyneth Rowlands, date currently unknown. Vault and underside. Indian ink, watercolour and varnish on flint. Courtesy of the Adamson Collection Trust.

Abandoned Goods is a film that has been made about The Adamson Collection. It powerfully illustrates how the meaning of the works is radically altered by their location. Probably the most extreme example of this is how the work of J. J. Beegan, on lavatory paper, came to be the centre of an exhibition in Paris while on loan from the Wellcome Collection.

Within the film there is a marvellous vignette of a conversation between two (male) psychiatrists. First psychiatrist: 'We haven't got a clue why they get ill, why they get better or what causes them to relapse.' Second psychiatrist: 'So we don't know anything about ourselves?' First psychiatrist: 'Yes that's probably true.'

I think that the works of The Adamson Collection challenge us as contemporary psychiatrists. When Adamson was working at Netherne, many patients were there for 30 years or more. They were subjected to physical restraint, overcrowding and neglect in many cases. Adamson's work was about respecting the individual as the author of the meaning of their experience.

Modern psychiatrists try to respect each individual but we have created the organisation of mental healthcare in such a fragmented fashion: the patient moves from team to team and sees different mental health professionals each time. We risk losing sight of the importance of the long-term, one-to-one relationship where patients feel respected rather than pushed from pillar to post.

Interestingly Dr O'Flynn's approach in the Tony Hillis Unit does allow time for each patient to be treated as an individual. So who better to be Chair of The Adamson Collection?

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<http://www.adamsoncollectiontrust.org/resources/>.

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1.5.66 Peter Sykes MB, ChB, FRCPsych, DPM

Emma Savin

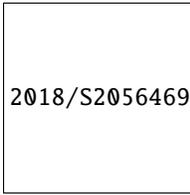
date

2018-8

Contents

- *Peter Sykes MB, ChB, FRCPsych, DPM*

Formerly Consultant Psychiatrist, Greaves Hall Hospital, Banks, Southport, UK.



Peter Sykes, who died aged 86 in March 2017, was a pioneer in the field of the psychiatry of learning disorders. After postgraduate training, he held consultant posts in the north of England and in Scotland. He then spent 2 years in Canada from 1969 to 1971, where he was appointed Director of Mental Health Services for the Province of New Brunswick. He carried out a complete reorganisation of the mental health and mental subnormality services. The new service was based on community involvement and divisional responsibility. Throughout his working life, he championed a person-orientated approach to the care of patients with severe mental health problems and learning difficulties, moving away from the ‘asylum’ principle of care towards a more integrated, community-based approach that still recognised the important role of residential units.

On returning to England, he took up a post in Peterborough and Cambridge, where he again set up services in a general hospital unit rather than the then traditional model based on subnormality hospitals. On appointment to the Greaves Hall Hospital, Southport, in 1973, he provided a model for community-based services that was influential both locally and nationally. He was widely involved in the planning and design of new hospitals in the north of England and Scotland, always working in close association with the charity MIND.

Throughout his career, he carried out a considerable amount of forensic work. He also lectured widely, having, at various times, honorary lecturer appointments at the Universities of Liverpool and Aberdeen.

At the end of his clinical training in the Medical School of the University of Sheffield, he was the prize medallist in both clinical medicine and surgery. After psychiatric training, he was appointed to his first consultant post at the age of 29, being at that time the youngest doctor in England to be appointed as a consultant.

Peter saw medicine as an art rather than a science and had an open mind about new approaches to psychiatric care. Colleagues would often refer their complex patients to him, and he would use new techniques such as hypnotism to bring about dramatic improvements.

Always a practical man, as well as a plain-speaking Yorkshireman, Peter loved to find out how things worked and would spend hours tinkering with his old Morris Minor. His approach to these endeavours is best summed up by his motto ‘when all else fails, read the instructions’. As an example of his practical skill, while working in Scotland he devised a means of stopping bulls from falling over (a catastrophic event) and shared his technique with the local farmers.

He leaves his wife Jean, four daughters, seven grandchildren and five great-grandchildren.

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According to Dr Lee personality disorder is ‘not your fault’ and is a treatable ‘disorder’ for individuals that are both able and willing to become involved with available therapeutic programmes. This book immediately highlights the importance of responsibility, not only on the part of clinical staff, but also for the person engaging with services, and as someone who has lived with the diagnosis of borderline personality disorder for many years, I was pleased to find that a key theme was one of empowerment.

The format and content allows a wide reach in terms of audience, being accessible to both clinicians and those with lived experience, their families and others with whom they may come into contact. The author utilises well the fictional character Nina to portray real-life examples, while not apportioning blame, nor attributing her difficulties to one particular aspect of her life. Although the focus is mainly on borderline personality disorder, the use of case examples in a chapter dedicated to other personality disorders gives an excellent insight into how these may present. Indeed, within this, is also the notion of the enduring and pervasive nature of personality disorder, how it affects lives, and the ability to question whether a label is indeed always helpful or necessary.

Lee uses the term ‘personality configurations’ to describe individual differences and how carers may adapt to a role which enables the individual. The label of personality disorder is often perceived as stigmatising and, therefore, reframing how this is presented to others can be significant in accepting both the diagnosis and how to manage it. Overall, he attempts to reduce stigma and the feeling of being stigmatised, while retaining an honest approach to how negative perceptions can influence relationships of all levels. This notion of relationships is also addressed, being key to personality disorder and to therapeutic alliance.

The information on the differences between borderline personality disorder and other psychiatric diagnoses may help to dispel some myths. For example, Lee suggests that clinical depression and depressive symptoms of borderline personality disorder are not the same. Although this comes across as a medicalised view, it fits well with my personal experience where unnecessary pharmacological treatment pathways were the only option given, rather than an effective therapeutic management of negative emotion.

The chapter on treatments provides a comprehensive overview of evidence-based therapies for borderline personality disorder and indirectly highlights the paucity of evidence-based options for other personality disorder classifications. From the range of treatment options available, albeit limited, the information given is easy to digest, providing key concepts and a tabulated summary of areas such as goals and the all-important patient-therapist relationship.

At one point Lee outlines the role of choice in finding a treatment programme and therapist. In an ideal world, the choice of therapist can be an essential aspect of engagement in services but in reality this is not always the case – this is perhaps an area towards which health care services can move their focus.

I would have welcomed discussion around the role of gender in personality disorder, in relation to both diagnosis and treatment outcomes, as well as a more explicit and detailed examination around the role of emotion (and how this underlies relationships and day-to-day or even minute-to-minute interactions). Although this idea is present in the examples used, further elaboration may be helpful.

For me, the book summarises a positive approach to understanding and helping individuals with personality disorder without leaving the reader feeling helpless; this is achieved not by changing who we are but, as the author suggests, by building on the positive qualities we already have. I liked the idea that the final chapters provide an ending, not just for Nina but for the reader.

Taking a collaborative approach to treatment goals and enabling individuals to have a sense of agency in their passage to self-discovery is an essential aspect of the book – and a way of working that I found to be imperative to discovering a way through what for me was a confusing, frustrating and distressing journey.

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1.5.67 The clinical utility of the IRAC component of the Framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP)

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date

2018-8

Abstract

Aims and method

The clinical utility of the multidimensional Framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP) has not previously been examined. We sought to establish whether referral accuracy and ability to achieve the reason(s) for referral to our liaison service improved after incorporating the Identify and Rate the Aim of the Contact (IRAC) scale of this tool into our referral process. We carried out a retrospective analysis of electronic case notes of all appropriate referrals to the team before and after this adaption.

Results

Accuracy of referrals to our team improved from 73.8 to 93.7% following intervention. Referral requests that were fully achieved improved from 57.4 to 77.8%, and referral requests that were not achieved decreased from 26.2 to 6.4%.

Clinical implications

The IRAC component of the FROM-LP measures what it was developed for, and thus has clinical utility supporting its widespread adoption across liaison services in the National Health Service.

Declaration of interest

None.

Contents

- *The clinical utility of the IRAC component of the Framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP)*
 - *Development of the FROM-LP*
 - *Implementation of the FROM-LP*
 - *Method*
 - * *Data collection*
 - * *Statistical analysis*
 - *Results*
 - *Discussion*

* *Conclusion*

The value and cost-effectiveness of an adequately funded and organised mental health liaison team (MHLT) have been demonstrated and promoted in national policy documents and economic analyses over the past 5 years.¹⁻⁴ Although the economic benefits of a MHLT have been established, there is a lack of evidence relating to clinical (and other) outcomes.⁵ Measurement of clinical outcomes is essential for clinical teams to evaluate their work and enable ongoing service development. A Centre for Mental Health (CMH) report highlighted the challenges associated with measurement of outcome across MHLTs, which are operating in a number of different settings and carrying out a wide range of clinical activities in support of patients with many different types of clinical problems.⁵ A systematic review on the effectiveness of liaison psychiatry found that many studies had disparate results and were methodologically flawed.⁶ The CMH report proposed the use of a framework for measurements based on a logic model approach which took into account structure (inputs), process (activities) and outcomes (outputs) and suggested using a combination from each, 'the so-called Scorecard approach'.⁵

Development of the FROM-LP

In response to these recommendations, in 2015 the Faculty of Liaison Psychiatry of the Royal College of Psychiatrists produced the Framework for Routine Outcome Measurements in Liaison Psychiatry (FROM-LP).⁷ The authors, after further describing its development, proposed that it was adopted across all MHLT's in the National Health service (NHS).⁸ Their aim was to enable consistency of data collection and effective reporting of outcomes such that patients, referrers, the NHS Trust providing the service and commissioners could all understand and have confidence in the beneficial effects of their MHLT. The authors acknowledged that rolling out this tool quickly across MHLT's nationwide meant that it was potentially an imperfect tool; however, they recognised that it could be refined over time.⁷

Implementation of the FROM-LP

Until recently, our MHLT had been measuring a number of outcomes; however, these were not based on national guidelines and therefore could not be directly compared with other MHLTs across the NHS. In addition, our in-patient team were assessing patients and finding that the reason for referral documented on the e-referral form was not always accurate. In April 2017, we adapted our routine data collection to include the FROM-LP outcome measurements. As shown in *Table 1*, there are three broad outcome categories. For the purposes of this evaluation, we focused on the *Process* section, which includes the 'Identify and Rate the Aim of the Contact' (IRAC) scale, comprising ten aims of contact (*Table 1*). We replaced the four referral options on the e-referral form with the ten IRAC categories (*Table 2*) and then evaluated whether this: (a) improved the *accuracy* of reason for referral to our service (b) in turn, improved our *ability* to fully achieve those reasons for referral, i.e. with this analysis could we determine the construct validity and thus the clinical utility of this component of the FROM-LP? *Table 1* Framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP) content. Adapted from Trigwell & Kustow.⁷ FROM-LP summary table Measurement Case type 1: single contact Case type 2: series of contacts Process 1. Response time

2. IRAC 1. Response time

2. IRAC Outcomes (clinician-rated) 3. CGI-I3. CGI-I (at beginning and end of series of contacts) Outcomes (patient-rated) 4. CORE-10 (at beginning and end of series of contacts) Patient satisfaction 4. Patient satisfaction scale

5. Friends and family test 5. Patient satisfaction scale

6. Friends and family test Referrer satisfaction 6. Referrer satisfaction scale (as a regular survey if frequent referrers) 7.

Referrer satisfaction scale (as a regular survey if frequent referrers)¹ *Table 2* Adaption of the e-referral form incorporating the ten IRAC categories Reason for referral categories of original e-referral form IRAC (Identify and

1

CGI, Clinical Global Impression – Improvement scale; CORE-10, Clinical Outcomes in Routine Evaluation (10-item version); IRAC, Identify and Rate the Aim of the Contact.

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Rate the Aim of the Contact) categories incorporated into adapted e-referral form Was it achieved? 1. Diagnosis 1. Assessment & diagnosis

2. Medication management

3. Assessment & management of risk Fully achieved

22. Management of disturbed behaviour 4. Management of disturbed behaviour

5. Providing guidance and advice

6. Signposting & referring on Partially achieved

13. Medication advice 7. Assessment of mental capacity

8. Mental Health Act

9. Brief psychological intervention Not achieved

04. Capacity assessment 10. Treatments (other)

It would also provide more detailed data about the type of activities our team were routinely carrying out.

Method

Our MHLT is adult ageless and is based in a large 800-bed teaching hospital in Bristol. It is composed of doctors, nurses and social workers, and is split into an emergency department team and an in-patient team. This paper focuses on the in-patient, which received an average of 106 referrals per month during the period October 2016 to September 2017, often involving a series of patient contacts. The referrer has to complete an e-referral form which consists of a drop-down menu and free-text boxes. Once the referral form has been accepted and opened by administrative staff, it is then triaged by the shift coordinator. The clinical information provided by the referrer enables the shift coordinator to determine the urgency of the referral, and can also help facilitate decisions such as which member of staff might be most appropriate to see the patient.

The e-referral form includes a 'reason for referral' section, which has a drop-down menu from which the referrer can select more than one option. *Table 2* shows the original e-referral form, which had four categories (left column), and the e-referral form adapted for our team by the Trust IT department, which has ten categories based on the IRAC scale. All the other information on the e-referral form remained unchanged.

Following the launch of the modified e-referral form, when a clinical member of our team closed a case, they were asked to record the reason for referral (categories 1–10, *Table 2*) and whether the reason for referral was fully achieved (2), partially achieved (1) or not achieved (0) in accordance with FROM-LP guidance. As the in-patient team did not collect these data prior to modification of the e-referral, our researcher (S.C.) rated whether the team had met the reason(s) for referral before and after the intervention so that a more direct comparison could be made.

Data collection

Our researcher (S.C.) retrospectively reviewed the electronic healthcare records of patients referred to the in-patient team before and after the intervention. The initial group consisted of all appropriate referrals to our team from 3 to 16 Oct and 24 Oct to 6 Nov 2016. The comparison group consisted of all appropriate referrals to our service from 24 Apr to 7 May and 15 May to 28 May (2017). The electronic records were scrutinised for each patient referred to determine whether the reason for referral on the e-referral form was accurate (i.e. by probing the content of the assessments). If the reason for referral stated on the e-referral form was established as accurate, the researcher then further reviewed the electronic records to determine whether the in-patient MHLT had fully achieved, partially achieved or not achieved the reason(s) for referral. If the reason for referral on the e-referral form was not accurate, it was recorded as 'did not achieve the reason(s) for referral' (because it would not have been possible to meet the reason for referral if we had been given inaccurate referral information from the outset).

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Statistical analysis

The following outcomes before and after modification of the e-referral form were compared using Fisher's exact test: (a) accuracy of the reason for referral (b) referral outcome – did the in-patient MHLT fully achieve, partially achieve or not achieve the referral request?

The effect estimates are reported as odds ratios with 95% confidence intervals, and all the *P*-values reported are two-tailed.

Results

A total of 124 cases were analysed; 61 were referred prior to the modification of the e-referral form and 63 were referred after. Comparison of the accuracy of the reason for referral before and after modification of the e-referral form (Table 3) demonstrated a statistically significant difference. Referrals were assessed as accurate in 73.8% of cases when using the previous referral system, compared with 93.7% when using the new referral system ($P = 0.0030$). Table 3 Referral accuracy

	Before ($n = 61$)	After ($n = 63$)	Odds ratio (95% CI)	<i>P</i> -value
Yes, n (%)	45 (73.8)	59 (93.7)	5.24 (1.53–22.76)	0.0030
No, n (%)	16 (26.2)	4 (6.4)		

Comparison of whether the reason(s) for referral were met before and after modification of the e-referral (Table 4) also demonstrated a statistically significant difference. The referral request was assessed as fully achieved for 57.4% of referrals when using the previous referral system, and for 77.8% of referrals when using the new referral system ($P = 0.0210$). There were no significant differences identified between the two referral systems when the referral request was assessed as partially achieved (16.4 v. 15.9%, $P = 1.0000$). The percentage of referral requests assessed as not achieved decreased significantly when using the new system, from 26.2 to 6.4% ($P = 0.0030$). Table 4 Referral outcomes

	Before ($n = 61$)	After ($n = 63$)	OR (95% CI)	<i>P</i> -value
Fully achieved, n (%)	35 (57.4)	49 (77.8)	2.60 (1.11–6.16)	0.0210
Partially achieved, n (%)	10 (16.4)	10 (15.9)	0.96 (0.33–2.82)	1.0000
Not achieved, n (%)	16 (26.2)	4 (6.4)	0.19 (0.04–0.65)	0.0030

Discussion

The adapted e-referral form went live in March 2017. A retrospective analysis of the electronic healthcare records demonstrated that, following this intervention the reason, for referral was five times more likely to be accurate and the team was 2.6 times more likely to fully achieve the reasons for referral. The results suggest that improving the accuracy of the referrals improved the team's ability to achieve the reasons for referral.

Following the intervention, 6.4% of the referrals (compared with 26.2% before the intervention) were inaccurate. Periodic review of inaccurate referrals may help to determine why they were inaccurate. One possible explanation might be that the referrals to our team are generally made by the most junior doctor on the team, and the reason for referral may not have been made clear to them by the senior doctor asking for the referral. Another possibility is that none of the ten referral options adequately covered the reason for referral.

Following our intervention, the referral request was achieved (fully or partially) in 93.7% of referrals. In liaison work, it is not unexpected to partially achieve a referral request. Many patients might only be seen briefly prior to discharge from hospital, requiring handover to community teams or health professionals to complete the work. Despite this, further in-depth exploration as to the reasons would be useful.

An accurate referral to the MHLT is important because it enhances triage, so that patients can be prioritised accordingly and assigned to an appropriate member of staff (i.e. doctor or nurse, consultant or trainee doctor). It also potentially enables a more focused assessment based on the referrer's expectation; this could improve time efficiency, which in itself is important for a variety of reasons, such as when the patient is very unwell, or to facilitate financial savings and flow through the acute hospital. In addition, by outlining very specifically the referral categories to the referrers, it highlights exactly what type of work the MHLT can do and encourages referrers to consider the objectives of their referral, which in turn improves general efficiency.

We are aware that our evaluation, by embedding the IRAC scale into the referral form and asking the referrer to select the aim of contact, is in contrast to many other MHLT around the country, who tend to complete both the aim of the

contact and achievement of the contact themselves. However, there were several reasons behind this process variance: (a) it was in alignment with the way many other specialties designed and operated their e-referral pathways in our trust, and so was not too dissimilar when making a referral to, e.g. respiratory or cardiology; (b) based on our experience, we felt that referrers often have a reasonably good idea of what they want assistance with in managing their patient, and it is then for us to be able to achieve that as providers of the service; and (c) it made data collection and measuring a much more reliable, more consistent and simpler process.

A number of limitations with this evaluation are worth commenting on. The number of patients involved in the retrospective analysis was small, and the confidence intervals were relatively wide as a consequence. A single researcher examined the electronic healthcare records for each referral, determining the accuracy of a referral based on the available clinical information and whether the reason for referral had been fully achieved, partially achieved or not achieved. This introduces the possibility of observer bias. If the researcher found the reason for referral to be inaccurate, then it was recorded as 'not meeting the reason for referral'; this may have introduced exclusion bias.

In this evaluation, we did not measure or comment on referrer satisfaction, but we can predict that if there was an improvement in the team's ability to fully meet the reasons for referral, there would also be an associated improvement in referrer satisfaction. Using all the FROM-LP outcome measurements, our MHLT will be able to capture this information in the future. Our MHLT now routinely measures the IRACs for all referrals made to our service. Our results show that the main reasons for referral were: (a) assessment & diagnosis (37.5%) (b) medication management (11.8%) (c) assessment and management of risk (12.5%) (d) providing guidance and advice (16.5%).

This type of information can be used (alongside the structure and outcomes measurements in FROM-LP) to gain a clearer understanding of the work that the in-patient team are routinely carrying out, as described in the paper by Guthrie *et al.*⁹ This can then guide service development; for example, do our staff have all the necessary skills to manage the referrals, or do they require training in specific areas?

In the future, our team plan to incorporate the structure, process and outcomes data into a mental health dashboard on the Trust IT system, which will provide live up-to-date performance data, allowing our MHLT to anticipate trends quickly and respond in a timely fashion. This information will also be made available to our various 'customers' (commissioners, patients, carers, and referring staff).

Conclusion

Since the launch of FROM-LP, there has been encouraging feedback based on opinion and observation, and numerous MHLT's have already implemented it.⁸ However, the developers acknowledged that rolling out this tool quickly across MHLTs nationwide meant that it was potentially imperfect.⁷ Tadros's commentary¹⁰ further encouraged MHLTs to develop a positive approach integrating the collection of outcome measures into everyday clinical practice, and found the FROM-LP a very useful tool to measure service quality and clinical effectiveness. To date, however, there has not been an actual appraisal of the tool or any part of it.

Through our evaluation of the IRAC scale of the FROM-LP, we have demonstrated an improvement in the accuracy of the referrals to our service. In turn, this has helped our team's ability to achieve the referral request and we have therefore been able to establish the instrument's construct validity. We conclude that the IRAC composition of FROM-LP does indeed measure what it was intended for, and we thus have demonstrated the clinical utility of the IRAC scale, which hopefully has reinforced its recommended incorporation into MHLTs across the NHS.

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Still Down by Dean F. MacKinnon, a US-based psychiatrist, is a patient-centred guide written primarily for patients – and their families – seeking effective management for treatment-resistant depression.

The book begins with a revision of the symptoms of major depressive disorder and a summary of how treatment has developed to include a wide range of antidepressant medications that allow patients to be trialled on alternative

treatments when any one agent is unsuccessful. The author explains treatment-resistant depression – where patients fail to respond to antidepressant therapy – using nine case studies that suggest reasons for treatment failures, starting with relatively straightforward cases and ending with more complex scenarios. Scenarios include patients who have been inadequately treated or misdiagnosed as well as patients who are ‘treatment resistant.’ Strategies, both biological and psychological, based on the author’s own clinical experiences are suggested as ways to overcome antidepressant failure. These are summarised in a table towards the end of the publication.

MacKinnon presents cases concisely, in an engaging and conversational style. Each presentation ends with a summary of the key (general) clinical points and case notes which highlight diagnostic features specific to the patient’s individual presentation.

The main strength of this work is its clarity of information. Easy-to-read prose, bullet-points and tables help break up the text in ways that aid comprehension. Explanation of medical jargon where used and the relative absence of jargon ensures suitability to the target audience. Limitations include its focus on treatments approved by the U.S. Food and Drug Administration, which may be less relevant in countries other than the USA. Furthermore, the book does not include novel evidence on pharmacological or psychological treatments. Irrespective of this, it remains a valuable commodity for healthcare professionals, offering a general revision of the topic and inspiring an individualised approach to managing patients.

In summary, this is a well-written and helpful resource for patients and relatives seeking to gain a better understanding of depression and its management.

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1.5.68 Doctors, suicide and mental illness

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2018-8

Abstract

This article focuses on doctors and suicide. It provides real examples to illustrate why doctors die by their own hand. These reasons are replicated in the general population, but also include a host of additional risk factors related to being a doctor. In each case, information about the doctor is in the public domain or, as in one case, consent from the next of kin has been obtained for a detail not in the public domain. The author is a doctors’ doctor, heading up a confidential health service for doctors with mental illness or addiction, the National Health Service Practitioner Health Programme. Mortality data from the programme (January 2008–January 2017) will also be included. For the sake of confidentiality, data is collated and details regarding age and gender have been approximated.

Declaration of interest

None.

Contents

- *Doctors, suicide and mental illness*
 - *Doctors and suicide*
 - *Suicide and mental illness*
 - *Deaths of doctors attending the National Health Service Practitioner Health Programme*
 - *Doctors, suicide and barriers to care*
 - *Doctors, suicide and complaints*
 - *Prevention*
 - *Conclusion*

In most healthcare systems (whether privately or publicly funded), and across all ages, genders, specialties and seniority, doctors have higher rates of depression and anxiety compared with the general population and other professional groups.¹ This is counterintuitive given that doctors have a host of apparently protective attributes, including career and financial security, high status and a generally rewarding job. However, doctors are as exposed as anyone else to risks associated with genetic predisposition, early traumatic life events, later bereavements, illnesses or relationship breakdowns. Doctors also have additional risk factors. They are chosen for personality traits that predict good doctoring – perfectionism, obsessiveness and even elements of martyrdom – traits that can act against them. From an early age they are driven, competitive, compulsive, individualistic and ambitious – features that can go into overdrive when stressed. As doctors work harder, they blame themselves for not being able to deliver the care required by their patients, and feel guilty for events beyond their control. Consequently, doctors can suffer from a triad of guilt, low self-esteem and a persistent sense of failure.² To survive a lifetime in medicine, doctors also have to develop psychological defences that include depersonalisation and dissociation. This can make it harder to create attachments to others or to recognise when the emotional burden of their work becomes too much, and thus contributes to the spiralling of discontent and increased risk of suicide.

Doctors and suicide

In the UK, around one in five adults has considered suicide and one in 15 have attempted it. Very few attempts result in death, estimated to be about 1 in 10 000 per annum.³ The suicide rate for doctors have been variably estimated at between two and five times the rate of the general population.^{4,5} In a systematic review, Lindeman *et al.* estimated physicians' relative suicide risk at 1.1–3.4 for men and 2.5–5.7 for women compared with those for the general population, and at 1.5–3.8 for men and 3.7–4.5 for women compared with those for other professionals.⁶ Anaesthetists, general practitioners and psychiatrists appear to be associated with higher risk. In an Australian survey, approximately a quarter of doctors reported having had thoughts of suicide prior to the past 12 months (24.8%), and 10.4% reported having had thoughts of suicide in the previous 12 months. Thoughts of suicide are significantly higher in doctors compared with the general population and other professionals (24.8 v. 13.3 v. 12.8%).⁷ In a 2008 study, members of the American College of Surgeons were sent an anonymous survey with questions on suicidal ideation and use of mental health services, and questionnaires for depression, burnout and quality of life.⁸ Of 7905 participating surgeons (a response rate of 31.7%), 501 (6.3%) reported suicidal ideation during the previous 12 months (more common in older surgeons). These levels of suicidal thoughts were between 1.5 and 3.0 times more common among surgeons than the general population. Importantly, only 26.0% of the surgeons with suicidal thoughts had sought help, whereas 60.1% (301) were reluctant to seek help because of concern that it could affect their medical license. This study shows the high rate of mental health distress accompanied by low use of treatment services.

Suicide and mental illness

Major risk factors for completed suicide across all populations are depression and substance misuse, both of which are also common in doctors who take their own life. For example, Dr Louise Tebboth, a gifted south London general practitioner, was only 40 years old when she killed herself. Her husband Gary Marson, in his book *Carry on Breathing*,⁹ describes in poignant detail the first year of his bereavement, starting on Friday 23 January 2015 when he found her hanging from the bannisters in their home. She fought a long battle against bipolar disorder. She had survived a near fatal overdose in her late 20s but decades later, despite the intervention of psychiatric services and daily monitoring by her husband, and an intensive regime of activity to keep her occupied and safe, she killed herself.

Deaths of doctors attending the National Health Service Practitioner Health Programme

As well as being a local general practitioner colleague, Louise was a patient of the National Health Service Practitioner Health Programme (PHP) when she died. Of the approximately 3500 doctors who have presented between 2008 and 2017, 80% have done so with mental health problems (mainly depression, anxiety and symptoms indistinguishable from post-traumatic stress disorder). Another 15% have predominantly suffered from alcohol or drug misuse (mostly alcohol dependence) or a mix thereof; the service also has a number of doctors with personality disorder, bipolar disorder, physical health problems affecting their mental health and a small number with undiagnosed schizophrenia or psychosis. During this period, 21 patients of the service have died; approximately 6 times as many men died as women. The average age at death was 44 years, ranging from under 30 to over 65 years old, and from early on in training to senior consultants near retirement. General practitioners accounted for 7 out of 21 (33%) of the deaths; the remainder were drawn from different medical, surgical, anaesthetic and emergency specialties in almost equal numbers. Six doctors died from suicide. A further ten died from accidents where the cause of death was not given as suicide, but which could be considered to be part of a suicidal act or from fatal overdoses of drugs/alcohol (not classified as suicide). Five were from either natural causes or the doctor died overseas and we have been unable to find the cause of death.

Doctors, suicide and barriers to care

It is not just mental illness that predisposes doctors to killing themselves. Suicide is also linked to how doctors are treated, how they treat themselves, unique issues related to their job and a system where doctors with mental illness are handled through an adversarial rather than treatment system. This equates to personal, professional and institutional stigma, which doctors face when trying to access care and also once in treatment. Stigma is one of the most important barriers for doctors trying to be treated, illustrated by the next doctor. Daksha Emson was a young psychiatrist. On 9 October 2000, when her first child, Freya, was 3 months old, she stabbed her baby, poured accelerant on them both and set it alight. Both died. Daksha had written in her diary, just before her death, about her feelings of hopelessness. What follows is an abridged extract from that diary entry:

'Feel useless as a mother as a wife as a woman.

See no hope for the future.

sleep unrefreshing food forced down because my baby needs nourishment. Focusing on my precious baby Freya – she means everything to me, I desperately want to be a good mother to her but I'm starting to feel I'm failing her in a big way, that everyone can see I'm a useless mother that I'm no good.

... hits me in early hours of morning – thoughts churn round and round.

Finding it difficult to hang on to reality - am I bad and wicked? I don't deserve good things, is there really hope for the future?'

Extract from the last diary entry of Dr Daksha Emson, published in *Report of an Independent Inquiry into the Care and Treatment of Daksha Emson and her Daughter Freya*.¹⁰

The subsequent inquiry identified stigma as a major factor in her and her daughter's deaths. Daksha, like many doctors, felt that she had failed by becoming mentally unwell. The study by Henderson *et al.*¹¹ of doctors out of work with

mental illness found that most felt guilty, shamed and fearful. Doctors feel a dreadful sense of personal failure and inadequacy if they struggle to keep working and despair can be sudden and overwhelming. The researchers describe an overwhelming stigmatisation that mentally ill doctors were exposed to by friends, family and peers, which left them isolated and sad. Some sick doctors deliberately concealed their problems, and this resonates with doctors attending PHP who will pretend to go to work each day rather than admit to their families that they are unwell. In the Henderson *et al.* study, doctors described a lack of support from colleagues and feared a negative response when returning to work. Self-stigmatisation was central to the participants' accounts and several doctors appeared to have internalised the negative views of others. Stigma was also a key feature of a survey conducted by Cohen *et al.* of almost 2000 doctors.¹² Cohen *et al.*'s view is that fewer professions stigmatise mental health disorders more prominently than medicine, a conclusion supported by the finding that 41% of doctors with mental illness said that they would not disclose it. Garelick *et al.*,¹³ reporting on the service for doctors with mental health problems, also cites stigma as a major barrier to receiving appropriate care.

Daksha was concerned about the stigma of her mental illness and its effect on her career progression; she mentioned this fear to her best friend several times. Even if, as with Daksha, doctors present for help, it is difficult for caregivers to see beyond the professional to the patient and treat the sick doctor as the frightened, vulnerable individual they are. Doctors tend to treat sick doctors differently from other patients. They engage in medical talk, discuss academic papers or the latest research and go way beyond what the sick doctor really wants or needs. The PHP discourages shared decision-making until the sick health professional begins to improve. Daksha's untimely death led to funding for PHP, with which thousands of doctors with mental illness have been helped.

Doctors, suicide and complaints

Dr Wendy Potts was a 46-year-old mother of two and a general practitioner in Derbyshire. She also suffered from bipolar disorder. Dr Potts wrote about her experience with depression on an online blog. In it, she wrote openly on how fluctuations in her mood affected her and her life in general. It is reported that a patient complained after reading her blog, questioning whether she should be able to practise as a general practitioner. She was suspended by her practice and National Health Service (NHS) England, and referred to the General Medical Council (GMC). In November 2015, Dr Potts hung herself. Dr Potts' case incorporates both stigma and mental illness, but also the additional burden that weighs heavily on doctors and adds to their risk – complaints and disciplinary processes. Bourne *et al.*¹⁴ conducted a study of doctors comparing the mental health (using standardized tools) of those who had and had not received a complaint. A total of 10 930 out of 95 636 (11.4%) responded, and 7926 (8.3%) completed the full survey and were included in the complete analysis. Of those who completed the survey, 16.9% of doctors with current or recent complaints reported moderate/severe depression (relative risk 1.77; 95% CI 1.48–2.13) compared with doctors with no complaints (9.5%). A total of 15% reported moderate/severe anxiety (relative risk 2.08; 95% CI 1.61–2.68) compared with doctors with no complaints (7.3%). The authors found that distress increased with complaint severity, with highest levels after a GMC referral (26.3% depression, 22.3% anxiety). Doctors with current or recent complaints were 2.08 (95% CI 1.61–2.68) times more likely to report thoughts of self-harm or suicidal ideation. This analysis illustrates how damaging complaints and regulatory processes are to doctors' health and job performance. Similar findings of the negative effect of disciplinary processes on the mental health of doctors were found in a study from the Netherlands.¹⁵ Analyses of the deaths of doctors at PHP show a significant correlation between mortality and involvement of the regulator. Among PHP patients who have not died, the GMC is involved in around 10% of cases, compared with 11 out of 21 (52%) of patients who have died and 9 out of 16 (56%) patients who died from accidents, suicide or overdoses (Table 1). Table 1 Analysis of patients seen at the National Health Service Practitioner Health Programme who have died, and their involvement with General Medical Council (GMC) procedures

Cause of death	Number of patients	GMC involvement
All deaths	21	11
Overdose drugs/alcohol or accidents	10	9
Suicide	6	6

In response to concerns about high numbers of deaths among doctors, the GMC commissioned an independent study examining 28 deaths of doctors due to suicide (or suspected suicide) where the doctor was also involved in fitness-to-practise processes between 2005 and 2013.¹⁶ The case reviews of doctors during this period showed that many of the doctors who died by suicide suffered from a recognised mental health disorder or had drug and/or alcohol addictions. Other factors that often followed from those conditions may have also contributed to their deaths. These include marriage breakdown, financial hardship and in some cases, police involvement, as well as the stress of being investigated by the GMC. Of course, correlation between death and regulatory involvement does not equate to causation, as the GMC

review found. The interaction between complaints and mental illness is complex, with many possible issues to take into account (*Table 2*). *Table 2* Relationship between regulatory processes and mental illness in doctors Relationship between suicide in doctors and complaints/regulatory or disciplinary processes •A complaint may lead to a doctor becoming depressed or worsen a pre-existing mental illness. •Mental illness can lead to cognitive impairment, which can lead to a boundary transgression or inappropriate behaviour such as bullying or acting inappropriately with a patient or work colleague. •Mental illness might lead to out-of-character criminal behaviour (such as shoplifting), which itself can lead to worsening of the mental illness. •Mental illness might involve criminal activity; for example, drug use. •Drug use can lead doctors transgressing good medical practice, such as stealing drugs, self-prescribing or prescribing in a patient's name for the doctor's own use. •Mental illness in itself might be considered counter to fitness-to-practise; for example, bipolar disorder, schizophrenia, personality disorder or schizoaffective disorder. •The very act of trying to kill oneself might lead to criminal or professional sanctions where the means of the suicide attempt involves obtaining drugs illegally or via self-prescription.

At Dr Potts' inquest, the coroner commented that the system had lost sight of the fact that there was a human being behind the complaint and investigation.¹⁷ It is indeed common to underestimate the effect that complaints can have on doctors, and to lose site of the severe pain this causes to the doctor and how a complaint can threaten a doctor's sense of self. A complaint challenges a doctor's values. It is a catastrophic personal event, described by one doctor at PHP as akin to a diagnosis of cancer. The overwhelming feeling (once the anger and shock has subsided) is that of shame: shame of disclosure, of appearing in front of the regulator, of having to face the gauntlet of the press and the shame brought on their families, friends and colleagues. All too often, their shame becomes exaggerated and they begin to feel responsible for the entire profession's values and future.

Prevention

Preventing a very rare event (completed suicide) and identifying those who will go on to complete a suicide act from those who express suicidal thoughts is extremely difficult, if not impossible. A systematic review of risk assessment for suicide by Large *et al.*¹⁸ concluded that the overwhelming majority of people who might be viewed as high risk for suicide will not kill themselves, and about half of all suicides will occur among people viewed as low risk. Carter *et al.*¹⁹ found similar results in their systematic review of instruments aimed at predicting high risk of suicide and concluded that no high-risk instrument was clinically useful. This is what we have found among our doctors at PHP. PHP risk-assesses all patients at first assessment and reviews thereafter as required. Patients are risk-assessed depending on the perceived risk to self, service/institution or their own patients. This assessment forms part of the weekly multidisciplinary team meeting. Only 3 of the 21 doctors who died were assessed as being high risk (red) (recent/current suicidal ideation, past attempt to take one's own life, drug misuse, alcohol dependence or depression are all risk factors), and most (16 out of 21) were considered by the service as low (green) risk. Two doctors who killed themselves were rated red (the highest risk), and the other doctor died from an overdose of drugs.

Conclusion

It is important to remember that the vast majority of doctors do not kill themselves. Most doctors thrive in their working environment. However, each death is a tragedy which sends repercussions through the system and poses the risk of creating contagion. Going forward, we have to halt the decline in morale among doctors. This will mean addressing many systemic issues that are creating unhappiness: tackling the culture of naming, blaming and shaming and the constant denigration of NHS staff by the press; allowing doctors to maintain a sensible work-life balance and not ignoring the basic needs of staff who give their all to their patients. We must restore doctors' collective self-esteem by treating them as intelligent adults and not naughty schoolchildren, and by creating a culture in which their skills can flourish. We need to ensure doctors have access to early intervention and confidential support services.²⁰ Finally, we have to ensure that all NHS staff receive the same compassion that they, rightly, are expected to give to their patients.

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1.5.69 Against the Stream: lowering the age of sexual consent

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Abstract

Lowering the legal age of sexual consent would decriminalise a large number of ‘underage’ young people engaging in sexual intercourse. The arguments against such a change in the law are summarised and shown to lack validity.

Declaration of interest

None.

Contents

- *Against the Stream: lowering the age of sexual consent*
 - *The present legal situation*
 - *The arguments against*
 - *The arguments in favour*

The proposal that the age of consent should be lowered is not just ‘against the stream’. It is regarded by many as a preposterous idea. When, in 2013, the then President of the Faculty of Public Health, Professor John Ashton, made the proposal that the age of consent should be reduced from 16 years to 15 or even 14 years, it was immediately rejected by both government and opposition spokesmen.¹ Indeed, David Cameron, when Prime Minister referred to the proposal as ‘offensive’.

The present legal situation

It is the case that there are many cogent arguments against such a move. It will be claimed here that none of these is valid. Further, it will be proposed not only that there would be specific advantages to changing the law in this way, but that the principles on which this proposal is based have implications for other ways in which the rights of young people are inappropriately curtailed.

The existing laws in all the jurisdictions of the UK state² that the age of consent for any form of sexual activity is 16 years for both men and women. The age of consent is the same regardless of the gender or sexual orientation of a person and whether the sexual activity is between people of the same or different gender.

It is an offence for anyone to have any sexual activity with a person under the age of 16. However, Home Office guidance is clear that there is no intention to prosecute teenagers under the age of 16 where both mutually agree and where they are of a similar age.³ Further, it is an offence for a person aged 18 or over to have any sexual activity with a person under the age of 18 if the older person holds a position of trust (for example, a teacher or social worker) as such sexual activity is an abuse of the position of trust.

There is wide variation between countries in the age of sexual consent. In Europe, all countries have minimum age limits for sexual relations. Nowhere is this age set lower than 14 years.⁴ In Europe, consensual relations with 14-year-olds are legal in half of the jurisdictions, and with 15-year-olds in three-quarters.⁵ This places the UK among the quarter with the most restrictive legislation. There is no evidence that the legal minimum age of sexual consent in a country is in any way correlated with the sexual behaviour of young people.

Various principles have been adduced which should govern the legal position of minors.⁶ Although it is often implied that children should not be regarded as such, Waites⁶ (p. 218) suggests that children are indeed citizens who, like adult citizens, have a right to protection as well as a right to freedom of activity. He argues that sexual behaviour below the age of 14 should be criminal, and that there is a role for legal prohibitions for the collective good which goes beyond preventing harm in individual cases (pp. 220–241).

The arguments against

The following arguments have been used against the proposal to lower the age of sexual consent. These are followed by counter-arguments. (a) A change in the law would result in more younger children becoming inappropriately engaged in sexual activity. There is a lack of evidence this is the case and, indeed, much evidence suggesting that the existing law has no effect on the sexual behaviour of young people. Information collected between 2010 and 2012 suggests that 31% of British males and 29% of British females had full sexual intercourse before the age of 16 years. Fifty years previously, this had been the case for 15% of males and 4% of females.⁷ There had been no change in the law in relation to heterosexual intercourse in the interim. A study of the reasons for sexual abstinence in American school students revealed that the law was not cited as a reason for abstaining from sexual activity.⁸(b) The existing law gives young people, especially girls, who do not want to engage in sexual activity a powerful reason for refusing to consent. Although this reason is often cited, there is not even anecdotal evidence to suggest it is valid. It is indeed difficult to imagine a girl saying to her boyfriend that she does not wish to have sex with him because it is against the law. She might not wish to have sex with him, but she wouldn't want him to laugh at her either.(c) Focus group discussions with 11–16 year-olds reveal that they are generally opposed to a change in the law on this matter.⁹ This is indeed the case, but, as indicated above, there is a marked disparity between the behaviour of young people and their views on the existing law.(d) Young people aged 14 years are not physically mature enough to engage in full sexual activity. The median age of menarche in English and Welsh girls born between 1982 and 1986 was 12 years and 11 months.¹⁰ Thus, the great majority of girls of 14 years are indeed sufficiently physically mature to engage in full sexual activity.(e) Young people aged 14 years are not cognitively mature enough to evaluate the risks of engaging in sexual activity. There is ample evidence that 14-year-olds are as capable of analysing the risks and benefits of different interventions in complex medical situations as are 21-year-olds.¹¹(f) Young people aged 14 years are not emotionally mature enough to engage in full sexual activity. Steinberg¹² – while accepting that mid-teenagers have sufficient cognitive maturity – suggests there is evidence that this is not the case when they are emotionally aroused or exposed to peer pressure. In particular, he cites his own work¹³ pointing to age differences in sensation-seeking and impulsivity. These studies of young people aged from 10 to 11 years up to 30 years show reduction of impulsivity with increasing age under experimental conditions. The problem with his argument is that the greatest reduction in impulsivity occurs between adults aged 22–25 and those aged 26–30 years. Is it really suggested that sexual consent should be invalid up to the age of 26 years?(g) Neuroscientific evidence suggests that the adolescent brain undergoes significant changes throughout the teens and beyond. For example, Casey *et al*¹⁴ report that 'recent human imaging and animal studies provide a biological basis [...] suggesting differential development of subcortical limbic systems relative to top-down control systems during adolescence relative to childhood and adulthood'. This is taken to mean that those in their teens are not physiologically competent to make important decisions relating to risk-taking. It is surely unwise to rely on such indirect evidence when much more directly relevant studies suggest that it is the inexperience of the young rather than biological limitations that lead to their greater vulnerability in risky situations. For example, McCart *et al*,¹⁵ studying traffic accidents among young people, found that 'of the studies that attempted to quantify the relative importance of

age and experience factors, most found a more powerful effect from length of licensure’.

The arguments in favour

Having effectively countered the arguments against lowering the age of sexual consent, it only remains for me to point briefly to the obvious advantages of such a change in the law. (a) Lowering the age of sexual consent would result in the decriminalisation of just under one-third of the adolescent population. Most such law-breakers are not currently prosecuted, but it cannot be right that their freely given sexual consent is deemed illegal. (b) The numbers of young people whose sexual activity results in sexually transmitted infections is substantial.¹⁶ The number of pregnancies in 15–17-year-olds, although it is reducing, remains substantial.¹⁷ Further, the sexual experience of many young people, particularly girls, is distressing, and a substantial number of girls regret their first full sexual experience.¹⁸ Lowering the age of sexual consent would make it distinctly easier for appropriate sex education to be provided to children and young people to enable them to make wiser decisions. It would also make it easier to provide sexual health services to people of this age without the fear of conniving in illegal activity.

Note that it is not proposed here that there should be any changes in the position of those adults who abuse their positions of trust to have sex with people younger than themselves. Further, it is firmly accepted there should be a minimum age limit for sexual consent, a view that has been contested. It is important that it remains recognised that children under the age of 14 years have neither the cognitive nor the emotional maturity to make decisions about their own sexual behaviour.

It will not have escaped the notice of the attentive reader that the principles and evidence adduced here are also relevant to a number of other situations in which the current legal position of minors is highly questionable. For example, at the present time, the age of criminal responsibility in England and Wales is 10 years, while in Scotland it is currently 8 years, with 12 years as the age of criminal prosecution. The age of criminal responsibility should surely be raised to 14 years. The voting age in England and Wales is currently 18 years, while in Scotland it is 16 years. The voting age should surely be reduced to 16 years in England and Wales, with an expectation of a further reduction in due course.

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1.5.70 Ethnic variation in personality disorder: evaluation of 6 years of hospital admissions

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Abstract

Aims and method

There is limited evidence on ethnic differences in personality disorder prevalence rates. We compared rates of people with personality disorder admitted to hospital in East London from 2007 to 2013.

Results

Of all people admitted to hospital, 9.7% had a personality disorder diagnosis. The admission rate for personality disorder has increased each year. Compared with White subjects, personality disorder was significantly less prevalent among Black and other minority ethnic (BME) groups. Personality disorder was diagnosed in 20% of forensic, 11% of general adult, 8% of adolescent and 2% of old-age in-patients.

Clinical implications

The increasing number of personality disorder diagnoses year on year indicates the increasing impact of personality disorder on in-patient services. It is important to identify and appropriately manage patients with a personality disorder diagnosis due to the significant strain they place on resources. The reasons for fewer admissions of BME patients may reflect alternative service use, a truly lower prevalence rate or under-detection.

Declaration of interest

None.

Contents

- *Ethnic variation in personality disorder: evaluation of 6 years of hospital admissions*
 - *Prevalance of personality disorder*
 - *Review of literature*
 - *Local context*
 - *Objectives*
 - *Method*
 - *Results*
 - *Discussion*
 - * *Limitations*
 - * *Recommendations*

Personality disorders are characterised by enduring maladaptive patterns of behaviour, cognition and inner experience, exhibited across many domains and deviating markedly from those accepted by the individual's culture.¹ Comorbidity of personality disorder with other mental disorders is common, and the presence of personality disorder often has a negative effect on treatment outcome. Personality disorder is associated with premature mortality and suicide² and people with the disorder often use services heavily,³ leading to calls for improved identification in clinical practice.⁴

Prevalance of personality disorder

The prevalence of personality disorder increases with levels of care. In the community, estimates range from 4.4% in the UK,⁵ 6.1% in a World Health Organization (WHO) study across 13 countries,⁶ to 8.6% in Bangalore.⁷ Prevalence of personality disorder is 24% in the UK at the primary care level.⁸ At the secondary care level, psychiatric out-patient prevalence rates varied between 40 and 92% in Europe, 45–51% in the USA and 60% in Pakistan.⁹

Personality disorder is under-diagnosed in routine practice compared with when structured instruments are used.¹⁰ A USA study showed 31% of psychiatric in-patients met criteria for personality disorder, but only 12.8% of them had a chart diagnosis of personality disorder.¹¹ In the UK, there is a reported prevalence rate of 7% of admissions in general adult psychiatry wards based on routine case note diagnosis.¹²

Review of literature

We searched the PubMed, PscyInfo and EMBase databases using the search strategy ‘personality’ AND ‘disorder’ AND ‘prevalence and ethni*’. We found 10 relevant results and hand-searched references of these papers for additional relevant studies. A meta-analysis (which identified 391 relevant publications and finally included 14) showed significant differences in prevalence between different ethnic groups, raising the question of whether there is a neglect of diagnosis in some ethnic groups or whether these are genuinely differing rates. However, the study does highlight the paucity of research into the prevalence rates of personality disorder among different ethnic minorities.¹³ A study based on a national household survey suggests that the prevalence of personality disorder is at least similar in minority populations to the native population within the UK.¹⁴

Local context

London is one of the most ethnically diverse cities in the world, and East London is the most ethnically diverse part of London with 73% of the population being non-native in origin. East London contains 8 out of the top 15 constituencies in the UK with the highest diversity index scores,¹⁵ making it a useful area for investigating whether there is an ethnic variation in prevalence of illness. Within the data gathering period, East London National Health Service Foundation Trust provided services to three boroughs – Tower Hamlets, Newham and City and Hackney – comprising a population of 815 000.¹⁶ This audit and service evaluation was undertaken in partnership with the Trust as a quality improvement initiative.

Objectives

The objectives of this audit were: 1.to describe the ethnic variation of psychiatric in-patients with a personality disorder diagnosis in East London;2.to contrast services such as old age, adolescent, forensic and general adult services.

Method

Anonymised data from routine service contact were collected from the Trust’s electronic patient record system on all admissions between April 2007 and April 2013. Ethnicity categories from the 2001 UK census were used. These data were then compared to census data of local demographics from the census data of 2011. Individual identifiers were not examined because routine clinical data were used in aggregate. As this was a service audit to inform our quality improvement initiatives, ethical approvals were deemed to not be necessary.

Results

Out of a total of 19 102 in-patient admissions in 6 years across three boroughs in all services, 1853 of them had or were eventually given a diagnosis of a personality disorder, which gives us a mean prevalence estimate of 9.7%. Of these in-patients, 56% were female and 44% male. This mean prevalence varied from 3% in Indian and Pakistani populations, to 17% in the native White British population (Table 1). There is a statistically significant lower prevalence of personality disorder in all ethnicities compared with the White British population, except in those of mixed race heritage where the sample size is too small. There was little variation in personality disorder diagnosis rates between Black and other minority ethnic (BME) groups where there was a sufficiently large sample size. Table 1 Mean period prevalence of personality disorder diagnoses in in-patients in the years 2007–2013

Ethnicity	Prevalence of personality disorder	Odds ratio (95% CI)
White British	17%	1.0
Irish	7%	0.3635 (0.25–0.52)
Black African	4%	0.19 (0.105–0.24)
Black Caribbean	4%	0.22 (0.17–0.28)
Chinese	4%	0.17 (0.06–0.56)
Indian	3%	0.17 (0.11–0.25)
Bangladeshi	4%	0.22 (0.17–0.28)
Pakistani	3%	0.28 (0.19–0.419)
White/Asian mix	20%	1.192 (0.68–2.11)
White/Black African mix	1%	0.0638 (0.009–0.46)
White/Black Caribbean mix	16%	0.8904 (0.62–1.28)
Other mix	14%	0.799 (0.54–1.18)
Other Asian	11%	0.6 (0.46–0.9)
Other Black	7%	0.38 (0.29–0.49)
Other White	8%	0.408 (0.34–0.88)
Other ethnicity	7%	0.36 (0.28–0.47)

Table 2 shows the breakdown of the prevalence of personality disorder diagnosis in the different directorates of the Trust. The prevalence was 20% in forensic, 11% in general adult, 8% in adolescent services and 2% in old-age in-patients. Table 3 compares admission rates to the local population levels of each ethnicity. Table 2 Prevalence of personality disorder diagnosis in adult, child and adolescent, old-age and forensic services

Directorate	Prevalence of patients
Adults	11%
Child and adolescent	8%
Forensic	20%
Old-age service	2%

Table 3 Comparison of admission rates to local population levels

Ethnicity	White British	White Irish	White other	Mixed White and Black Caribbean	Mixed White and Black African	Mixed White and Asian	Other mixed	Indian	Pakistani	Bangladeshi	Chinese	Other Asian	Black African	Black Caribbean	Other Black	Other ethnic	Not stated	Total	General population																										
Number of in-patients	224	029	1256	3107	895	1183	077	408	778	1215	157	095	534	679	1250	6015	7473	266775	38939	61420	96029	690815	734																						
Percentage of in-patients	27.46%	1.54%	13.23%	1.45%	0.95%	1.08%	1.49%	7.00%	4.25%	15.33%	1.93%	4.00%	9.24%	4.86%	2.57%	3.64%	Number of patients with personality disorder	1090	3314	9361	1530	2317	6936	3897	3645	9391	853	Prevalence of personality disorder	17%	7%	8%	16%	1%	20%	14%	3%	3%	4%	4%	11%	4%	4%	7%	7%	7%

The number of people admitted to hospital with a diagnosis of personality disorder has increased year on year, nearly doubling at the end of the 6 year period (Fig. 1). Fig. 1 Number of yearly admissions of people with personality disorder.

Discussion

Our analysis of in-patients in East London demonstrated a 9.7% prevalence rate of personality disorder, which is in line with previous studies of in-patients in the UK.¹²

Although our results indicate little variation in personality disorder rates between different BME groups, they consistently show lower rates compared to the White British population. Lower rates of referrals for BME groups to the local personality disorder service have also been found.¹⁷ Our findings raise key questions in light of international and national data pointing to the contrary (e.g. the WHO study across 13 countries that found that personality disorder is no less prevalent outside ‘westernised’ countries⁶ and the UK survey¹⁴). However, the lower incidence of personality disorder presentations in psychiatric emergencies in ethnic minorities has been noted before.¹⁸

Possible reasons for our findings may include that BME community structures contain the mild to moderate presentations of the disorder, meaning that only those people with extreme cases present to mental health services. BME communities also have difficulties in accessing healthcare, more complex pathways to specialist treatment¹⁹ and lower rates of accessing healthcare than the majority of the population.²⁰

There is some evidence that there are ethnic variations in the presentation of the disorder,^{21,22} that specific symptoms can be shaped by culture²³ and that individuals of differing ethnicity may present with different patterns of personality disorder pathology.^{24,25} In the key population group in East London, there is insufficient consistent evaluation into

prevalence, recognition and service access for people with personality disorder from Asian populations²⁶ and studies showing low rates of personality disorder in Asian-origin samples may be a result of a lack of understanding of what constitutes personality and personality disorder in Asian culture.²⁷ Differences in the presentation of symptoms of personality disorder in different cultures would not adequately be screened for by the tools currently in use. The preceding factors raise the possibility of misdiagnosis and suboptimal treatment.²⁸ In addition, ‘reverse racism’ may be occurring, with psychiatrists reluctant to make a diagnosis of personality disorder because it may be perceived as racist.

The annually increasing number of personality disorder diagnoses may reflect an increased willingness to diagnose this condition due to the increase in evidence-based treatment and the publication of National Institute for Health and Care Excellence guidelines on personality disorders in 2009. However, it is interesting to note that the proportion of patients admitted under sections of the Mental Health Act (2007) (MHA) has been steadily increasing since at least 2009 (<http://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-report#old-reports>), and there could possibly be a correlate, especially after the changes introduced to the act in 2007.²⁹ Our analysis did not pick out whether the people diagnosed with personality disorder were informal or under a section of the MHA.

The prevalence of 8% of adolescent in-patients with a diagnosis of a personality disorder is remarkable, as ICD-10 (1992) discourages the diagnosis in under 18s.³⁰ This suggests that clinicians may find the diagnosis of heuristic value. There has been considerable evidence that the diagnostic criteria for borderline personality disorder (and other personality disorders) are as valid, reliable and stable before age 18 as after age 18.³¹

The prevalence of personality disorder among older people in the community has been estimated to be about 10%.³² Among older in-patients, personality disorder has been seen in 6% of those with organic mental disorders and 24% of those with major depressive disorder.³³ Our finding of a 2% prevalence suggests that personality disorder may be under-diagnosed significantly in routine practice in old-age patients.

Limitations

Data were collected from one Trust in the UK. However, it is the most ethnically diverse one (Census 2011)¹⁶, and there is no reason to expect differences in routine diagnostic practice in other Mental Health Trusts in the UK. We do not anticipate problems relating to quality and validity of the personality disorder data compared with other diagnostic groups because all diagnoses are made on the basis of routine clinical care provided by the Trust.

Recommendations

The significant and rising proportion of in-patients diagnosed with personality disorder, combined with cost and pressures on in-patient beds, indicates that variations in recognition, access and management of these patients needs to be understood to ensure accurate identification and an improvement in present services.

Research targeting reasons for the lower diagnostic rates of personality disorder in BME groups could include whether there are cultural norms shared between BME communities that limit seeking help from mental health services for symptoms of personality disorder, whether there are variations in pathways to care, or whether there are variations in the attitudes of clinicians in diagnosing personality disorder in different ethnic groups.

The high proportion of adolescent in-patients diagnosed with personality disorder highlights the importance of a good transition from Child and Adolescent Mental Health Services to adult services, especially given difficulties these patients have with attachment. The ongoing presence of personality disorder in old-age services indicates the need for expertise in detecting and managing this diagnosis in these services, as these patients may represent the most difficult of personality disorder presentations in terms of not having ‘burnt out’ as is often expected.

There is a role for well-designed databases that lend themselves to ongoing analyses of routinely collected clinical data reflecting real service activity. All our results and inferences were obtained from such data, which provides us a low-cost opportunity for comparison over time and in different regions.³⁴ These data inform our quality improvement actions to improve clinical skills in assessment and management of personality disorder, and to better understand the needs of adolescents and elderly people with personality disorder.

We thank the staff at the Information Department of the East London National Health Service Foundation Trust for their excellent help in routine data retrieval. A poster presentation of preliminary results was presented at the 3rd World Congress of Cultural Psychiatry in London on 9–11 Mar 2012.

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1.5.71 Revisiting neuropsychiatry as a psychiatric discipline

Jack C. Lennon

date

2018-8

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- *Revisiting neuropsychiatry as a psychiatric discipline*

There has been a long-standing debate around the merging of disciplines, owing not to a lack of necessity in multidisciplinary approaches, but the increase in specialisation and fear of each field losing its perceived uniqueness. Fitzgerald¹ made this clear in his remarks regarding how neuropsychiatry can possess that which is both neurology and psychiatry. In a strong refutation, Datta² stated with vigour that while psychiatry could be improved with greater knowledge of behavioural neurology and neurosciences, it is unique in its approach. This rebuttal seems to have touched on a view of the psyche that may be one specific to psychiatry and psychology, but it cannot escape the organ from which these cognitions spontaneously arise.

It is clear that behavioural neuroscience is the foundation of psychiatry, an unassailable statement with which Datta² agreed. Fitzgerald's editorial,¹ however, does not necessarily minimise or underappreciate the importance of psychiatry in managing presentations such as suicidality from psychosocial perspectives, which a neurologist, for example, would not have the training to assess and treat. Instead, this editorial seems to serve an explicit purpose – to identify how specialisation in these specific circumstances may actually harm the field of psychiatry. It can be seen in the present day that psychiatry is stigmatised as much as the disorders it treats – it has been viewed as an intentional deviation from neurology, which is well known to treat organic disorders of the brain. A lack of merger, then, serves to ostracise psychiatry insofar that it becomes less about the brain. To state that discussions about psychotherapy and other psychological interventions are not rooted in neuroscience would be demonstrably fallacious. Even cognitive-behavioural therapy, one of the most studied psychotherapeutic interventions, was developed by a neurologist and recognises that the brain undergoes significant changes due to cognitions, ultimately leading to maladaptive behaviours beyond conscious awareness or personal agency.³ One cannot speak of psychiatric disorders without recognising and appreciating the organ responsible for behaviour and cognition.

The formulation of diagnoses and treatments for psychiatric conditions certainly differs from that of ‘neurological’ conditions such as mild traumatic brain injury, stroke and epilepsy. However, significant evidence suggests that psychiatric research is on the brink of discovering quantitative measures of its disorders, including but not limited to neuroimaging techniques,^{4,5} neuropsychological evaluations,⁶⁻⁸ and psychological tests such as those related to implicit associations.^{9,10} If one is to believe that psychiatry will remain entirely distinct from neurology and that the field need not merge with the professionals who also treat the central nervous system manifestations of brain dysfunction, regardless of aetiology, then psychiatry is destined to lose its footing when technology catches up to the incessantly changing brain that falls prey to inter- and intrapersonal events.

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The Mental Capacity Act (MCA) has now been in operation for 10 years, and MCA case law has proliferated over this time. Books on this subject still remain vital to continue to embed this statute in practice. This book is a reprint of the original publication in 2013. It is aimed at psychiatrists and other mental health professionals and aims to provide ‘user-friendly’ guidance for medico-legal dilemmas that require an understanding of the MCA (and where it juxtaposes with the MHA statute). It is a readable book of only six chapters and 128 pages, which should appeal to busy professionals.

All chapters contain salient advice. Probably the most apposite chapter is that on best interests, especially with important case law having emerged in this area in recent years since the book was published (and given a prescient statement regarding best interests assessments and the need to fully involve the person and people who know them well that psychiatrists ‘have not been accustomed to this type of thinking’, which this chapter readily addresses). The section on the role of the Court of Protection is enlightening. Useful advice around the practical challenges of applying the MCA in the clinical setting is elucidated in the final chapter analysing clinical ambiguities in the assessment of capacity.

The book could have been improved for the reader by having easy to read learning points at the end of each chapter, and by having an annexe with the relevant MCA sections cited in full. Also, because case law does evolve, having a section recommending various legal resources would be helpful to enable professionals to readily keep up to date, e.g. online legal search engines and access to free monthly legal newsletters. A table comparing enduring power of attorney and both types of lasting power of attorney would also be useful.

It is unclear as to why the book has been reprinted without being updated with the advances in MCA case law since 2013. Some of these advances have been seminal in nature, especially in the areas of consent to treatment, best interests, end-of-life care and Do Not Attempt Cardiopulmonary Resuscitation orders, and, importantly Deprivation of Liberty Safeguards (DoLS), namely the ‘acid test’ that emerged from the Supreme Court after a ‘DoLS-athon’ in the lower courts. However, it still covers many areas of the MCA well enough for clinical practice, and is indeed ‘user-friendly’. It is a shame it wasn’t updated, as it would undoubtedly then be an extremely useful book to have for clinical practice.

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1.5.72 Accurate recording of personality disorder in clinical practice

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2018-8

Abstract

Disturbances of personality are recorded very poorly in official statistics, but there are signs that this is changing. For many years, personality disorder has been either regarded as a secondary diagnosis that can be forgotten in the presence of another mental disorder, or avoided as the diagnosis gives the impression of untreatability or stigma. What is now abundantly clear is that under-diagnosis of personality disorder represents a disservice to patients and practitioners. It prevents a proper understanding of the longitudinal course of psychiatric disorder and an appreciation of some of the positive aspects of abnormal personality that can be used in treatment. We must no longer bury personality disorder, ostrich-like, in the diagnostic sand. It is there for the asking and needs to be embraced honestly and without fear if we are to improve the management of psychiatric patients.

Declaration of interest

None.

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- *Accurate recording of personality disorder in clinical practice*

The paper by Hossain *et al* in this issue is noteworthy for two reasons: it records ethnic variation in a sensitive subject and provides a rare longitudinal record of personality disorder diagnosis. This type of research, based in clinical practice, should help to destigmatise the diagnosis of personality disorder, which for many years has been under-recorded in formal statistics. There is something bizarre in the contradiction between the research data, showing prevalence figures of up to 40% in psychiatric in-patients^{2,3} (and much higher for those in tertiary services)⁴ and the official national diagnostic figures, which rarely exceed 8%.⁵ This difference can only be explained by either (a) failure of detection; (b) diagnostic avoidance for a number of reasons; or (c) observance of a separate axis for personality disorder, one of the advantages of the DSM system that has now been lost.⁶ I would like to think that the fourth option, a complete rejection of the diagnosis of personality disorder, is not currently embraced.

It is likely that all three may be relevant in under-diagnosis and readers might ask themselves how they normally avoid this diagnosis in practice. One of the reasons may be the perceived lack of utility of the diagnosis. Does it help clinical practice? Many feel it does not as it is felt to confer an unfair label of untreatability; but this is mistaken. Three-quarters of those with personality disorder admitted to UK psychiatric hospitals are given the diagnosis of emotionally unstable (borderline) personality disorder,⁵ and this has the best evidence base for treatment.⁷ Lack of treatment options may be a reason for the low diagnosis rates of other personality disorders – anankastic personality disorder only accounts for 0.18% of all diagnoses in the group⁵ – but this does not mean diagnoses of personality disorders other than borderline are of no therapeutic value.⁸

Personality dysfunction may also be an advantage in aiding the effectiveness of certain forms of treatment^{9,10} and such findings, if confirmed in other settings, would help greatly in destigmatising the disorder. Hossain *et al* also report a high rate of diagnosis in adolescence. The new ICD-11 diagnostic classification of personality disorder, to be introduced later in 2018, includes the diagnostic option of ‘personality disorder in development’,¹¹ and this will allow clinicians to make this diagnosis in younger people. This does not mean that a diagnosis made at this time becomes an indelible stain on a person’s mental health; it merely states that, at that particular time, the individual concerned has

significant personality dysfunction and this should be acknowledged instead of reducing every form of pathology to symptoms or behaviour.

The low rate of diagnosis in Black and minority ethnic populations¹ can probably be explained by what could be called 'compensatory stigma'. Of the three prevalence studies of personality disorder in ethnic minorities, two have shown reduced prevalence compared with White comparators^{1,2} but the other, assessed as part of a national survey, showed an increase.¹³ My view is that the national survey is nearer to the truth. There is a concern that a psychiatric diagnosis of personality disorder in certain ethnic minority groups might be construed as racist and so is avoided. I have certainly behaved like this in my own diagnostic practice in the past.

The increased prevalence of personality disorder over time shown by Hossain *et al*¹ should not be regarded as necessarily a true reflection of increase; rather it shows that clinicians may be less wary about making the diagnosis that they previously did. This may well be good for practice, as assessment of personality as well as mental health status makes for better understanding and broader predictive value. The ICD-11 classification may increase prevalence rates of personality disorder³ as it allows for the diagnosis to be made for the first time both earlier and later in life.¹¹

Further studies along the same lines as Hossain *et al*¹ should also examine the proportion of people admitted with personality disorder under the Mental Health Act. Those with personality disorder are sectioned less often after formal assessment than those with other diagnoses, but at 41% the proportion is still substantial¹⁴ and may be increasing. This certainly appears to be the case in those with personality dysfunction and intellectual disability¹⁵ and is a matter of some concern, as in this population the diagnosis of personality disorder is more contentious. It should also help to have a simpler diagnostic system that clarifies the difference between severe and milder forms of personality disorder; the severe level is actually rare.

Peter Tyrer is Emeritus Professor of Psychiatry at the Centre for Psychiatry, Imperial College, London. He was the Chair of the World Health Organization ICD-11 Revision Group for Personality Disorders between 2010 and 2017.

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1.5.73 Size and clustering of ethnic groups and rates of psychiatric admission in England

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Abstract

Aims and method

To compare rates of admission for different types of severe mental illness between ethnic groups, and to test the hypothesis that larger and more clustered ethnic groups will have lower admission rates. This was a descriptive study of routinely collected data from the National Health Service in England.

Results

There was an eightfold difference in admission rates between ethnic groups for schizophreniform and mania admissions, and a fivefold variation in depression admissions. On average, Black and minority ethnic (BME) groups had higher rates of admission for schizophreniform and mania admissions but not for depression. This increased rate was greatest in the teenage years and early adulthood. Larger ethnic group size was associated with lower admission rates. However, greater clustering was associated with higher admission rates.

Clinical implications

Our findings support the hypothesis that larger ethnic groups have lower rates of admission. This was a between-group comparison rather than within each group. Our findings do not support the hypothesis that more clustered groups have lower rates of admission. In fact, they suggest the opposite: groups with low clustering had lower admission rates. The BME population in the UK is increasing in size and becoming less clustered. Our results suggest that both of these factors should ameliorate the overrepresentation of BME groups among psychiatric in-patients. However, this overrepresentation continues, and our results suggest a possible explanation, namely, changes in the delivery of mental health services, particularly the marked reduction in admissions for depression.

Declaration of interest

None.

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It has been known for some time that Black and minority ethnic (BME) groups are overrepresented among psychiatric in-patients in the National Health Service (NHS).¹ The Count Me In census confirmed that this overrepresentation persists and may be becoming more pronounced.² The census also consistently demonstrated significant variation between BME groups, with most having higher rates of admission but some having lower rates compared with the national average. These differences in admission rates are likely to be explained by three main factors: differences in the incidence and rates of mental disorder; service-related factors, such as pathways into in-patient care; and changes in the size and distribution of the ethnic minority groups in the UK.^{1,3-5}

Background

One of the earliest demonstrations of the ethnic density hypothesis was the study of psychiatric admission rates in Chicago by Faris and Dunham.⁶ Several subsequent studies have supported this idea of a ‘protective’ ethnic density effect, whereby individuals living in areas with a greater proportion of people of the same ethnicity have better health.⁷⁻¹⁰ However, not all studies have consistently found results that support the ethnic density hypothesis.¹¹ A study at a wider regional scale in England failed to show any effect within individual ethnic groups, although there was some evidence to support differences between ethnic groups.¹²

In response, Halpern argued that within-group ethnic density operates at a local level, for example, by reducing levels of ethnic discrimination and increasing levels of social support, and may not be detected when the scale of investigation is at a regional or national level.¹³ Halpern made two predictions about between-group effects that might be evident at a larger scale: (a) smaller ethnic groups will tend to have higher psychiatric admission rates than larger groups, and (b) groups that have a stronger tendency to cluster together will tend to have lower admission rates. We aimed to empirically test these two predictions at a national level in England by linking NHS mental health admission rate data from 2005/06 to UK census ethnic group population estimates, and examining national level mental health admission rates for each BME group according to the population size of each group and the degree of clustering of each group across England.

Method

Rates of admission were calculated for the 16 ethnic groups as used in the UK census, while controlling for age and symptom type.

Population

The population size of each ethnic group was obtained from the ‘Understanding Population Trends and Processes’ section of the Ethnic Group Population Projection (ETHPOP) database. This is a web resource maintained by the University of Leeds, which provides projections of each ethnic group at various levels, including the national level.¹⁴

The index of dissimilarity was used as a measure of clustering for each ethnic group.¹⁵ This ranges from 0 (indicating full integration) to 100 (indicating full segregation). An index of less than 40 indicates low levels of segregation, while one of 40 or more indicates moderate to high levels of segregation.¹⁶ Data were obtained from the Centre on Dynamics of Ethnicity website.¹⁷

Number of admissions and symptom type

Routine clinical data were used. The numbers of in-patient episodes in the NHS (finished consultant episodes) in 2005/06 were obtained for three broad diagnostic groups: schizophreniform (schizophrenia and related disorders), mania (manic episodes) and depression (unipolar and bipolar depressive episodes).

Age at admission

Five age bands were created: 10–19, 20–29, 30–39, 40–49 and 50–59 years. The age range was restricted to 10–59 years for two reasons. First, there are far fewer admissions for these diagnostic groups prior to the teenage years. Second, beyond 60 years of age, the population size of several ethnic groups is so small, even at the national level, that there are too few admissions for the calculation of meaningful rates to be possible.

Rates

Rates of admission were calculated per 100 000 population for each ethnic group. Age standardisation was used to compare the 16 groups by assuming each group had the same population as the European standard.

Relative rates

The average rate of admission for BME groups was compared with the White British group to calculate relative rates for each of the 10-year age bands.

Outlier

One group (other Black) had rates that were consistently outside the spread of the other groups. Subsequent years of the Count Me In census showed that this was the one group that decreased in size as self-recording of ethnicity improved instead of staff recording of ethnicity. An adjustment was made by distributing the excess admissions among four other groups (Black Caribbean, Black African, mixed White and Black Caribbean, and mixed White and Black African).

Results

Rates of admissions

The average (s.d., range) age standardised rates of admission per 100 000 were 139.3 (89.9, 46.7–335.0) for schizophreniform disorders, 30.0 (16.3, 6.6–53.5) for mania and 66.9 (23.9, 21.9–106.6) for depression. There was an eightfold difference in rates of schizophreniform and mania admissions, and a fivefold difference in the rate of depression admissions, between ethnic groups. The rate of admission in the White British group was within the range for all three types of admission, albeit at the lower end of the range for schizophreniform (59.3) and mania admissions (14.3), and the middle of the range for depression (63.7).

Relative rate of admission

In each of the 10 year age bands, the average relative rate of admission for BME groups was higher than that of the White British group for schizophreniform and mania admissions, but not for depression. These differences were most pronounced in younger age bands and tended to decrease with age. The relative rate of admission for mania dropped the most, from 3.5 (1.6–5.4) to 1.7 (1.2–2.3). The relative rate of admission for schizophreniform disorders dropped from 2.9 (2.0–4.0) to 2.3 (1.6–3.1). In depression, the relative rate was 1.5 (0.9–2.2) in those aged 10–19 years and 1.1 (0.8–1.3) in those aged 50–59 years (*Fig. 1*). *Fig. 1* Average relative rates (with confidence intervals) of admissions for BME groups compared with the White British group. Data are shown separately for schizophreniform (red), mania (blue) and depression (black) admissions. Data are for England 2005/6.

Association of rate of admission with group size and clustering

The mean (s.d.) index of dissimilarity score for the 16 ethnic groups (including White British) was 46% (13) with a range of 27–67%. The average population size for those aged 10–59 years was 2116 k with a range of 65 k to 28 170 k. There was a moderate positive rank correlation between the index of dissimilarity score and rates of admission for schizophreniform disorders, and a weak correlation with rates of admission for mania, and no correlation with rates of admission for depression. By contrast, there was a weak or moderate negative rank correlation between the size of each of the 16 ethnic groups and the corresponding age-standardised rate of each category of admission (*Table 1*). *Table 1* Spearman's correlation between age-standardised rates of admission and ethnic group population size and the index of dissimilarity score for each group

Category	ρ	P	N
Schizophreniform	+0.50	0.04	16
Mania	+0.20	0.46	16
Depression	+0.04	0.88	16

Population aged 10–59

Category	ρ	P	N
Schizophreniform	0.39	0.14	16
Mania	0.47	0.06	16
Depression	0.21	0.44	16

Ethnic groups with populations aged between 10 and 59 years that were larger than half a million had relatively low rates of admission. Smaller ethnic groups with low levels of clustering (<40% index of dissimilarity) also tended to have lower rates of admission. Smaller ethnic groups with high levels of clustering (>40% index of dissimilarity) had higher rates of admission.

This pattern was most evident in schizophreniform admissions, where rates were on average three times higher in small clustered groups than the rates in groups with a larger population size. The rates of admission for mania were twice as high in smaller ethnic groups with high levels of clustering when compared with rates of admission for mania in ethnic groups with a larger population. The increase was least evident in depression admissions, where rates were about 40% higher in small clustered groups than the rates in groups with a larger population size (*Table 2*). *Table 2* The rate of admission in 16 ethnic groups including White British for schizophreniform, mania and depression admissions, according to large or small group population size and high or low group clustering.

Category	Population > 500 000	Population < 500 000
Schizophreniform	71.673	10206.4
Mania	17.919	341.3
Depression	56.950	880.0

1

The data are for 16 ethnic groups in England.

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Discussion

In line with previous studies, our results demonstrate an increased rate of admission in the majority of BME groups. There was significant variation in admission rates between ethnic groups, and there appeared to be an interaction with age. According to our results, the greatest increase in admission rates was in teenagers and young adults. By contrast, the AESOP study indicated that the incidence of psychosis remains raised in ethnic minority groups throughout the age range of our study.¹⁸ This may indicate a reduced risk of (re)admission with increasing age in BME groups relative to the White British population.

Our findings provide support for the hypothesis that larger ethnic groups have lower rates of admission. This is a between-group effect rather than a within-group effect. In this study, located in England, which has a population aged 10–59 years of 40 million, ethnic groups with populations over half a million had lower rates of admission. Our findings do not support the hypothesis the more clustered groups have lower rates of admission. In fact, they suggest the opposite: groups with low clustering had lower admission rates. Again, it is important to emphasise that this study only looked at between-group effects and did not investigate within-group effects.

The BME population in the UK is increasing in size and becoming less clustered.¹⁶ Our results suggest that both of these factors should ameliorate the overrepresentation of BME groups among psychiatric in-patients. However, the Count Me In census indicated that this overrepresentation continues. The answer may lie in changes in the delivery to mental health services. We have previously shown that although rates of admission have fallen across England, one of the largest reductions has been in admissions for depression, whereas admissions for schizophrenia and mania have shown only a modest, if any, reduction.¹⁹

In this work, we have shown that the increased rate of admission for BME groups was confined to schizophreniform disorders and mania, but was not found in depression. Therefore, all other things being equal, reducing the rate of admissions for depression alone will have the unintended consequence of increasing the overrepresentation of BME groups in the psychiatric in-patient population. The same applies to interventions that are more effective in reducing admissions in adults over 35 years of age than in younger adults, such as crisis resolution home-based treatment (<http://www.ethpop.org>).

Limitations

Gender-specific data were not available; hence, standardisation by gender was not possible. The diagnostic information was from routine clinical practice. For the majority of patients, ethnicity was self-determined, but for a minority of patients the ethnicity category would have been picked by staff.

It is impossible to avoid the ecological fallacy when analysing population level data. This ecological study was undertaken at a national level and, therefore, the results may be affected by the ecological fallacy (i.e. associative results observed at this national level are not necessarily replicated at the individual or smaller geographical levels.²⁰ However, the finding of an association between ethnic groups and higher rates of detention is fully consistent with a number of studies that have found higher rates of psychosis and admission among individuals from BME groups.

Local area of residence is likely to reflect aspects of group membership dynamics, such as local ethnic density, dissimilarity and sense of membership. These are likely to be more fluid than individual-level variables. We argue that ethnicity may operate at various levels, including those of the individual, local area, region, and nation, and perhaps even beyond national boundaries; however, our national-level data did not allow us to investigate these nuances.

This study included information on the number of admissions in England for each ethnic group. It did not have access to any individual-level data or local area data. A further study is required with a more detailed data-set, including detention outcomes recorded at individual, local area, regional and national levels, and corresponding explanatory variables as in our previous study.²¹ Dual diagnoses, specific substance use and multiple admissions should all be considered in future studies.

Clinical implications

If these associations are replicated, then this study has several implications. The first is that as ethnic groups increase in size and become more evenly spread, relative rates of admission will fall.

Second, any change in the pattern of admission, according to broad diagnostic group, symptom type or age, is likely to affect the ethnic make-up of the psychiatric in-patient population. For example, home-based treatment as an alternative to admission has been shown to be more effective for depression and for adults over the age of 35. An indirect consequence of this could be an exacerbation of the overrepresentation of BME groups among the remaining in-patient population.

Future research in this area will model the effects that population change and changes in psychiatric practice since 2005/6 have had on the psychiatric in-patient population over the subsequent decade.

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1.5.74 Donald Eccleston, FRCPsych, PhD, DSc

Ian McKeith

date

2018-12

Contents

- *Donald Eccleston, FRCPsych, PhD, DSc*

Formerly Professor of Psychiatry, Newcastle upon Tyne Medical School, UK

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Donald (Don) Eccleston, who died recently at the age of 86 years, was one of the first to elaborate a hypothesis of depression which argued for the role of monoamines, particularly 5-hydroxytryptamine (5-HT), in the regulation of mood. He went on to translate his experimental observations into treatment for patients with refractory depressive disorders, devising the ‘Newcastle cocktail’ (phenelzine, L-tryptophan and lithium). This was a pharmacological strategy offering a window of opportunity through which cognitive-behavioural therapy (CBT) and intensive nursing care could be directed to reduce the secondary handicaps of chronic depression.

In 1962, he took up a post at the Medical Research Council (MRC) Brain Metabolism Unit at the University of Edinburgh, joining a highly innovative group of psycho-pharmacologists including George Ashcroft. Between them, over the next decade, they elaborated the role of amines, in particular 5-HT, in the regulation of mood. In the absence of today’s sophisticated imaging and analytical techniques, these must have been difficult experiments to conduct; his

first published paper describes measuring changes in 5-HT metabolites in volunteers who were being investigated for neurological disorders by air encephalography, a procedure in which most of the cerebrospinal fluid was drained from around the brain by means of a lumbar puncture and replaced with air.

In 1966, he spent an enjoyable year at the National Institutes of Health in Bethesda, Maryland, USA, where he worked with Julius Axelrod – one of the three winners who shared the 1970 Nobel Prize in Physiology or Medicine for their discovery of the actions of neurotransmitters in regulating the metabolism of the nervous system. He then returned to Edinburgh to be appointed Deputy Director of the MRC unit, where he continued to elaborate the monoamine hypothesis of depression by demonstrating that drugs which influence mood in humans may alter the turnover of 5-HT, and levels of 5-HT, in the brains of animals.

On appointment to the Chair of Psychiatry in Newcastle upon Tyne in 1977, he set up his own research unit at 1–4 Claremont Terrace and established the Regional Affective Disorders Unit, the longest-standing in-patient unit for the treatment of depression in the UK. The Newcastle Chronic Depression Study, published in 1987, described new therapeutic approaches to treatment-resistant chronic depression, including the use of CBT, which was just emerging from US research as having antidepressant potential. The Chronic Depression Study demonstrated a now well-accepted principle in the treatment of chronic depression, namely that intensive drug treatment may be a necessary preliminary that enables effective rehabilitation of the secondary handicaps. Donald promoted development of psychotherapeutic treatments, particularly CBT, and innovative nursing practices for his patients, and became increasingly interested in predictors of refractory depression and its prophylaxis.

While he was Head of the Academic Department of Psychiatry in Newcastle, lecturer and fellowship posts in his department were always in demand; it was a happy place to work, with many appointees going on to professorial appointments in psychiatry, psychology, nursing and neuroscience, both within and beyond Newcastle. He also trained a generation of research-supportive National Health Service (NHS) clinicians who, through him, had been exposed to evidence-based medicine just as the term began to be coined. Early on, he realised the limitations of an academic ivory tower. As the management of the NHS started to change, he recognised the mutual benefits of close partnerships between academia and care providers.

Born in Preston, Lancashire, Don was encouraged by his local general practitioner to consider a career in medicine, even if only to get enough money to support his preferred option of working on the land! He attended Preston Boys' Grammar School. After leaving school, Don studied medicine in Aberdeen, balancing bookwork with what became lifelong interests: fishing, tennis and squash. In 1958, he married Maureen (Mo) Ellison and they settled in Aberdeen where he had commenced psychiatric training.

He was an early advocate of work–life balance, and this at a time when medical prowess was generally measured by how much time one spent at work. In addition to his family life, home and animals, Don made sure that he found plenty of time for his friends, his love of food and wine, fishing, squash, gardening and his art collection. His welcoming family home, West Luddick House, with its walled garden and greenhouses, was populated not only by Don and his family, but by generations of cats, dogs and hens. The monthly entry in his diary for 'the Melrose Clinic' was a euphemism for a day's fishing in the Scottish Borders and wasn't the most closely guarded secret from those around him.

After retirement in 1995, at the age of 64, Donald continued to see patients and remained involved in University life, but had more time to busy himself with his cottage deep in the Borders where he spent happy days foresting and looking after the land. He benefited from modern surgical advances, with a total of five joint replacements that kept him mobile. He died suddenly at home on 18 March 2018.

Don is survived by his wife Mo, three children and five grandchildren.

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1.5.75 The outcomes of home treatment for schizophrenia

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date

2018-12

Abstract

Aims and method

We examined whether intensive home treatment (IHTT) was beneficial for acute schizophrenia, using the Clinical Global Impression (CGI) scale as a measure of severity and change, between 2011–2015. Demographic and clinical details were collected.

Results

309 cases were referred to IHTT, comprising 245 separate individuals. This represented all severe acute psychotic episodes in Edinburgh during the study period. Three quarters of individuals had an improvement in CGI following IHTT and were safely managed at home. Thirty-nine per cent of all people received three or more regular medications. Comorbid drug and alcohol misuse was also frequently seen.

Clinical implications

IHTT can be beneficial to those suffering an acute episode of psychosis and has been shown to improve overall clinical outcome based on the CGI. Medication polypharmacy, as well as drug and alcohol use, are commonly seen in this population.

Declaration of interest

M.T. worked in IHTT at the time of the study, and has received fees and/or hospitality from Janssen, Lundbeck and Otsuka in the past 3 years.

Contents

- *The outcomes of home treatment for schizophrenia*
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 - *Aims*
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- * *CGI*
- * *Medication*
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- *Discussion*
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Background

Crisis resolution and home treatment (CRHT) teams have been recommended in mental health for many years,¹ with intensive 24 h home treatment being seen as an alternative to hospital admission. A randomised control trial reported by Johnson *et al*¹ showed a reduction in the number of hospital admissions as well as a decrease in the cost to the service² with CRHT. There have been positive experiences for patients or consumers of CRHT,³ although reports have also highlighted some dissatisfaction, namely that too many staff members are involved and the contacts are short-lived.⁴

The Edinburgh CRHT is called the Intensive Home Treatment Team (IHTT)³ and has two main points of entry into treatment – referral from the community (either from primary or secondary care) and from in-patient units to facilitate early discharge from hospital (but no self-referral). Edinburgh has well developed community mental health teams but no specific first episode or early intervention programme for adult psychosis; therefore, as far as is known, all acutely relapsing patients with schizophrenia and psychosis are referred to the IHTT.

Coping with schizophrenia and related psychoses remains a challenge, and globally⁵ schizophrenia contributes 7.4% of all lost years of life to all disabilities. Relapse of schizophrenia, sadly, is common, with only about 20% of patients having only one episode of psychosis.^{6,7} Predictors of relapse include medication non-adherence and comorbid substance misuse,^{6,7} and relapse is considered a time of increased risk of suicide in schizophrenia.⁸

Aims

Although there have been reports of patient satisfaction with CRHTs, very few studies have examined how a CRHT affects patients' clinical outcomes. In this observational study, we examine whether intensive home treatment was of benefit to people experiencing a relapse of schizophrenia in terms of routine clinical outcome measures, and identify the demographic and clinical characteristics of those who have responded (or not) to this intervention.

Method

Data were collected retrospectively from medical records of patients assessed and cared for by the IHTT between 2011 and 2015. Those with an ICD-10 code diagnosis of schizophrenia (F20) and related disorders (F22 – delusional disorder, F23 – acute transient psychosis, F25 – schizoaffective disorder, F28 – other psychotic disorder not due to substance or known physiological condition, and F29 – unspecified psychosis not due to a substance or known physiological condition) were included. The validity of the diagnosis was established by consultant psychiatrist review. Using unique identifying codes, the electronic records of these patients were retrieved and reviewed using *a priori* criteria. Ethical approval for the study was provided by the University of Edinburgh, UK.

IHTT records the severity of the presenting mental disorder using the Clinical Global Impression Scale⁹ (CGI) at the time of referral to IHTT. The CGI objectively assesses the global severity of illness and change in clinical condition over time.⁹ CGI-S is rated on the following seven-point scale: 1, normal/not at all ill; 2, borderline mentally ill; 3, mildly ill; 4, moderately ill; 5, markedly ill; 6, severely ill; 7, among the most extremely ill patients. CGI-I is similarly rated on a seven-point scale: 'compared with the patient's condition at admission, this patient's condition is' 1, very much

improved: 2, much improved; 3, minimally improved; 4, no change; 5, minimally worse; 6, much worse; 7, very much worse. IHTT clinicians noted the improvement or lack thereof in the presenting condition via the CGI-Improvement (CGI-I) score at the point of discharge from IHTT. This was routinely rated for every patient during his or her care with the team by an adequately trained clinician, although the pattern of staff shift working meant that the CGI and CGI-I for an individual patient were not always rated by the same clinician.

Other data collected for each patient included demographic details and relevant clinical details (see Supplementary Appendix 1 available at <https://doi.org/10.1192/bjb.2018.56> for full list), as well as data about each patient's regular medication(s) (see Supplementary Appendix 2 for a list of categories).

Statistical analysis

Unpaired *t*-tests were used (with the assumption of normality in CGI distribution being satisfied) to test whether there was a statistically significant change in CGI for patients who were discharged to the community, compared with those who required hospital admission, as well as to determine whether there was a statistically significant reduction in CGI for all referrals treated by IHTT.

Pearson's ²-test was used to test the hypothesis that people who were not prescribed medication or were non-adherent with their medication were more likely to be admitted to hospital than patients who were taking prescribed medication.

Mixed model regression analysis was used to control for any confounders that could be significantly associated with CGI difference. Variables included as potential confounders were age, gender, treatment duration, number of psychotropic medications prescribed, and drug and alcohol status. Pearson's correlation was also conducted to see whether there was a correlation between CGI and age or gender.

Results

Demographics of patient population

Over the 5-year period, there were 309 referrals to IHTT that met the inclusion criteria, comprising 245 separate individuals with the majority (82%) being new to IHTT and mental health services. Thirty-six individuals were referred more than once, with 16 people being referred to IHTT at least three times. One person was referred on five separate occasions, and another individual was referred seven different times. The patients referred had a mean age of 41 years, and 162 (52%) were men (*Table 1*). *Table 1* Demographics of individual referrals *N* = 309 Age, mean (range), S.D. 40.4 (18–66), 12.0 Male gender, *n* (%) 158 (51) Number of psychotropic medications prescribed, mean (range), S.D. 1.6 (0–4), 1.0 Treatment duration in days, mean (range), S.D. 22.3 (1–167), 23.2 Drug use: *n* (%) 23 (7.4) Alcohol use: *n* (%) 46 (14.9) Both drug and alcohol use: *n* (%) 26 (8.4)

Referrals and outcomes

The majority of the 309 referrals to IHTT over the 5-year period (56%, *n* = 173) were from the community. The remaining 44% of referrals were from in-patient units, in order to facilitate early discharge from hospital.

In terms of outcomes at discharge from IHTT, a total of 221 referrals (76%) were discharged to the community, and 70 referrals (24%) required transfer into hospital owing to their risk status or severity of illness. Twenty-seven per cent of repeat referrals were discharged to hospital, compared with 23% of 'one-off' referrals (*P*-value = 0.6).

There were five deaths (2%) within the 5-year period, including one suicide, from the total group of 255 people. None of those who died were under the care of IHTT at the time of death. Two of the deceased had a history of extensive alcohol and drug misuse. All five of those who died had a history of repeated hospital admissions. The suicide occurred in December 2013, after an urgent referral to hospital, but the person was not deemed unwell enough for admission at that time.

Fifty-two per cent (14 referrals) of the 27 referrals who were on no regular medications, or who were non-adherent with their medications, went on to require hospital admission, in comparison with 20% of patients who were taking at least one medication, and 24% of all referrals.

Eighteen referral outcomes were missing from records throughout the 5-year period.

CGI

The mean value of CGI of all patients at admission to IHTT was 4.1. The mean value of CGI of all patients at discharge was 3.05, an improvement of 1.05 (Table 2), which was a significant change ($P < 0.05$). Patients who were later admitted to hospital from IHTT had a higher mean value of CGI at 4.2 on admission to IHTT compared with the mean value of CGI of all patients. The mean value of CGI on discharge to hospital in this population was 4.6, i.e. they were more unwell, according to CGI. Table 2 Severity of illness and any subsequent improvement or not with IHTT, as measured by CGI

Year	2011	2012	2013	2014	2015	Total
Average CGI at referral – all patients	3.84	24.34	04.14	1.1		
Average CGI on discharge – all patients	3.33	02.93	32.83	1		
Average CGI at referral, those later discharged to the community	3.84	24.23	94.14	0		
Average CGI on discharge to the community	3.02	92.52	72.22	6		
Average CGI at referral, later transferred to hospital	3.84	34.64	34.14	2		
Average CGI on transfer to hospital	3.53	254.25	05.04	6		

Patients whose clinical outcome was discharge back to their usual carers had a mean value of CGI of 4.04 on admission to IHTT and a mean value of CGI on discharge from IHTT of 2.57. This was a decrease of mean CGI (i.e. improvement in health) of 1.47.

The difference in average CGI between the mean discharge CGI of all referrals and the mean discharge value of patients admitted to hospital was non-significant (1.55, $P < 0.15$). The difference in average CGI, on discharge, between referrals admitted to hospital and referrals discharged to the community was 2.03, a statistically significant change ($P < 0.05$).

The average CGI of all repeat referrals at the beginning of treatment with IHTT was 3.94, 0.11 lower than the average CGI of all referrals. The CGI on discharge for repeat referrals was 3.22, an average decrease in CGI of 0.72. These differences were not significant.

Age, gender, number of medications prescribed and drug/alcohol status were found not to be significant confounders in the regression analysis (see Supplementary Appendix 3). Only treatment duration was found to be a significant confounder, with patients having a longer treatment duration demonstrating a greater difference in CGI.

Medication

Table 3 illustrates the different medications and number of patients taking them: 2.8% of patients were on no medications, 31% were prescribed one medication, 27% were prescribed two medications, 18% were prescribed three medications and 21% were prescribed four or more medications. The mean number of any medications, including non-psychotropic medications, taken by an average patient across the 5 years was 2.1. A total of 27 referrals (9%) refused medication, did not require medication or were judged as non-adherent. Table 3 Medications prescribed

Year	2011	2012	2013	2014	2015	Total
FGA	243	232	352	614	9	1518
SGA	151	84	55	85	71	93
Benzodiazepines or other hypnotic	81	02	63	92	71	110
Antidepressants	64	131	22	15	6	221
Mood stabilisers/anticonvulsants	42	56	21	9		125
Other medications	68	102	03	07	4	184
No medication	2	12	38			52
No information	7	21	37	20		85
Mean number of medications	2.01	1.61	1.92	2.22	0.2	1.1 ¹

Pearson's χ^2 -test showed that patients who were taking no medications, or were non-concordant with their medication, were more likely to be admitted to hospital from IHTT compared with patients who were taking at least one medication ($\chi^2 = 43.3$)

¹ FGA, first-generation antipsychotic; SGA, second generation antipsychotic.

Drug and alcohol use

In total, 122 (39.5%) referrals were misusing either alcohol or drugs (*Table 4*) as rated by the IHTT clinician. The drug use was varied and often involved poly-substance misuse. Cannabis had the highest frequency of use, followed by amphetamines. *Table 4* Comorbid drug and alcohol misuse

Year	2011 (n = 42)	2012 (n = 33)	2013 (n = 60)	2014 (n = 80)	2015 (n = 94)	Total (n = 309)
Drugs	7 (17%)	8 (24%)	19 (32%)	27 (34%)	22 (23%)	83 (27%)
Excess alcohol	18 (19%)	9 (27%)	19 (32%)	24 (30%)	13 (14%)	73 (24%) ²

Discussion

Crisis resolution and home treatment teams, such as IHTT, are designed to manage acute mental health problems in the individual's home environment, minimising the risk of hospital admission while promoting autonomy and self-efficacy. It is incumbent on health services to demonstrate the effectiveness of their interventions, and IHTT from inception chose the CGI as an observer-rated measure of illness severity and subsequent improvement (or deterioration).

Our results show that 76% of people were discharged back to their usual care after IHTT involvement following an acute episode of psychotic illness, supporting the conclusion that IHTT can help people manage an acute psychotic episode, and avoid hospital admission. This belies a negative therapeutic outlook for schizophrenia, with the majority of people with schizophrenia in crisis or relapse avoiding the need for hospital care.

The total CGI score diminished by 1.05 for the whole sample, and a one-point shift in CGI is usually regarded as a clinically significant change.⁹ Since CGI has been shown¹⁰ to be an effective method of mapping illness severity, with reliability equivalent to that of more complex scales such as Positive and Negative Symptom Scale (PANSS), we can conclude from our results that the Edinburgh IHTT service, on average, can help reduce the severity of schizophrenia and related disorders. The CGI score of those people discharged home from IHTT improved by 2.03 compared with those being transferred to hospital from IHTT, implying an association between hospital admission and a worsening CGI score, and adding to the face validity of this measure. A study from Taiwan¹¹ also showed that patients with schizophrenia treated with community home care case management had a significant reduction in the frequency of hospital admission, and a systematic review¹² from 2017 showed that home-based intervention improves patients' quality of life and autonomy.

Twenty-four per cent of patients were admitted to hospital from IHTT, and the average CGI score at entry to IHTT of those who were eventually admitted to hospital was 0.16 higher than those who were eventually discharged home. This implies that those with a more severe psychotic relapse were more likely to require hospital admission, although non-illness-related factors such as accommodation were not taken into account in this study.

Of note, the gender ratio of the patient population in our study was almost 1:1, whereas usually one would expect a ratio of 1.4:1 in a population of patients with a diagnosis of schizophrenia.⁵ This may have been due to our inclusion criteria being not just schizophrenia but also its related disorders. Additionally, amongst the five deaths in our patient population over the 5-year period there was only one suicide, which is theoretically lower than expected for this city-wide population.⁸ Beyond this, however, we have no reason to regard our study population as unrepresentative, given the lack of local alternative acute care pathways.

2

Number and percentages of referrals with a history of use of illegal drugs or legal highs declared within records, and number of referrals with significant alcohol-related history, e.g. consistently over weekly recommended allowance, often by a considerable margin.

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The mean number of medications a patient was taking was 2.1, with 21% of patients prescribed four or more medications. This replicates work elsewhere in the UK,¹³ indicating that polypharmacy in this complex disorder is often the ‘real world’ norm, despite a paucity of supportive evidence on added efficacy.¹⁴⁻¹⁵ Polypharmacy is also generally associated with an increased burden of adverse side-effects.¹⁶ Our results show that people who were taking no medication, or were non-adherent with their medications, were more likely to be admitted to hospital than those taking medication. Interestingly, patients taking four or more medications demonstrated the most improvement, as measured by CGI-I.

Our results showed that 9% of the patient population in this study were taking no medication or were non-adherent with medication according to recorded clinician ratings, although medication non-adherence rates in wider community samples are closer to 50%.¹⁷ This discrepancy may have been due to many factors, including simple forgetfulness, a reluctance of the patient to acknowledge non-adherence, and a failure to enquire about it in a consistent manner.

Drug and alcohol misuse are common in people with schizophrenia,¹⁸ and our results show a higher proportion of people with schizophrenia misusing drugs than alcohol (*Table 4*), suggesting a correlation between drug use, rather than alcohol misuse, and schizophrenia. Menezes *et al*¹⁹ analysed drug and alcohol problems among 171 individuals with severe mental illness in South London, finding that 36% had a 1-year prevalence rate for any substance problem, compared with alcohol at 32% and drugs at 16%, contrary to our findings. This comorbidity has been shown previously to contribute to the premature mortality of those with schizophrenia.²⁰

Limitations

There were various limitations to this study. First, the patient population was from one IHTT only; therefore, the results may not be applicable to all IHTTs or CRHTs. Furthermore, this was an observational study, so comparative conclusions should not be made. Although CGI has been shown to be a good measure of observer rated clinical outcomes,¹⁰ it remains open to potential bias. Finally, data collection errors may possibly have occurred without our knowledge.

Summary

Intensive multi-disciplinary home treatment (here via IHTT) can be an effective intervention for most people suffering an acute episode of psychotic illness, with the majority being successfully managed at home and not requiring hospital admission. The minority that do go on to need hospital admission tend to have higher initial severity of illness, as measured by CGI, as well as being on no medication or being non-adherent with medication according to their treating clinicians.

Polypharmacy appears to be standard medical practice for people with schizophrenia, despite a lack of supportive evidence of added efficacy. Drug and alcohol misuse are common in people with psychotic illness, with higher rates than in the general population, arguably contributing to the significant morbidity and mortality seen with this condition.¹⁹

We thank Dr Kader, Julie, Trish and all other IHTT staff, as well as Nicoletta Adamo.

Hannah Chu Han Huang is a core trainee at the South London and Maudsley Trust, UK; **Mark Taylor** is an honorary senior lecturer at the University of Edinburgh, UK, University of Queensland, and an associate professor and consultant psychiatrist at Metro South Health, Brisbane, Australia; **Alasdair Carmichael** was a medical student at the University of Edinburgh, UK.

Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2018.56>.

[click here to view supplementary material](#)

1.5.76 Author reply

Philip Graham

date

2018-12

Contents

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Lachlan Campbell has a point. My own view is that children under the age of 14 are unlikely to have sufficient emotional maturity or knowledge to make an informed decision as to whether to engage in sexual intercourse.

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John Eagles's first novel is a rollicking tale of a young psychiatrist in the early 1980s, on the threshold of his career. Unfortunately, this promising career is nearly terminated as a consequence of various antics – alleged and otherwise – and the book culminates in a visit to the General Medical Council after the protagonist, Dr Douglas Barker, is accused of sexual misconduct with a patient.

This book was easy to read and something of a page-turner, but ultimately the characters were rather difficult to like. Douglas, who is clearly meant to be a nice chap, has a hint of arrogance that detracts from any potential sympathy for his plight. His approach to women centres on their appearance and he has no compunction in forming quick and easy relationships. There are allusions to his lost girlfriend, Spider, possibly in an attempt to account for his behaviour, but this is never really developed in a credible way. Most of the women in the book are minimally developed as characters, either presented as sexually attractive, needy, unpleasant or a combination of these. Pauline, a nurse who supports Douglas at his hearing, may be an exception. However, at the end of the book, Douglas rather disappointingly refers to her as sexy and it also becomes evident that she lied for him; suggesting that she may not be an exception after all.

Douglas's best friend, Chris, is another male psychiatric trainee from the west of Scotland, with a rather stereotypical accent and drinking habit. Both his educational supervisors are men and both of them are rather unlikely characters, particularly Dr Burlington, who speaks in a strange psychopathological manner, involving bizarre words that often start with consecutive letters of the alphabet. Dr Burlington is actually unbelievably nasty, but there is no hint as to why this is, which might have created some more tension. There are two female trainees in the story: Douglas has a fling with one before casting her off to Chris, the other achieves a liaison with the much older, married psychotherapy consultant. It would have been good to have incorporated an intriguing female character with a storyline beyond providing interest to the male characters of the book.

There is potential historical interest to current trainees, who may like to read about training practices and services nearly 40 years ago. Some things don't change and the patients' presentations and many treatments remain similar; but it is a very different job now.

However, my main difficulty with this book was the denouement (spoiler alert). Douglas was technically innocent because he had slept with the patient in question before she was a patient, and he had forgotten due to his previously unmentioned facial agnosia. But any opportunity for exploration of such an unusual ethical dilemma was then subsumed in a drunken train journey, in my view a great loss.

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We are called, as citizens and as professionals, to sit down and examine the facts. We must somehow assimilate the bewildering array of information, as it hurtles towards us, through our screens and across our airwaves, to get to the truth of the matter.

In our clinical lives, this becomes a responsibility and the challenge here is considerable. The public perception of mental illness, its fixation with ‘madness,’ is fertile ground for the development of half-truths, fallacies, myths and speculations. Publicly and privately propagated, we amass a compendium of ‘alternative facts,’ harmful to our patients as well as to our professions.

Psychologists Arkowitz and Lilienfeld are having none of it. They have subjected our day-to-day assumptions to a rigorous interrogation, pitching them against the most current evidence, to separate fact from fiction. Their book is presented neatly into sections by diagnostic category, each comprising a collection of bite-size chapters, asking questions such as: *What is a psychopath? How violent are people with mental illness? Can herbs ease anxiety and depression? Is divorce bad for children?* The questions they select feel current, the sort frequently encountered in the public domain, making the book highly suitable for a general readership. It is also probably quite helpful for mental health professionals, who may read the pages with the occasional blush, when they find a long-held position ruthlessly upended.

At times the book feels a little political, particularly in its service to psychological therapies; there is a sense that the authors feel a duty to redress the pharmaceutical dominance in mental health treatments. Though perhaps a worthy pursuit, this sits a little uneasily as a potential source of bias in a book that sets itself up on a truth-seeking mission.

Nevertheless, the book is a steadying force in a world where we now take a rather relaxed attitude to accuracy. Where the truth is often obscured by a more marketable headline, it is important as professionals that we anchor ourselves as far as we can in the facts. Arkowitz and Lilienfeld are to be thanked for doing a lot of the hard work for us.

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1.5.77 Patients with depression who self-refer for transcranial magnetic stimulation treatment: exploratory qualitative study

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Abstract

Aims and method

As part of a larger clinical trial concerning the use of transcranial magnetic stimulation (TMS) for treatment-resistant depression, the current study aimed to examine referral emails to describe the clinical characteristics of people who self-refer and explore the reasons for self-referral for TMS treatment. We used content analysis to explore these characteristics and thematic analysis to explore the reasons for self-referral.

Results

Of the 98 referrals, 57 (58%) were for women. Depressive disorder was the most commonly cited diagnosis, followed by bipolar affective disorder. Six themes emerged from the thematic analysis: treatment resistance, side-effects of other treatments, desperation for relief, proactively seeking information, long-term illness and illness getting worse.

Clinical implications

TMS has recently been recommended in the UK for routine use in clinical practice. Therefore, the number of people who self-refer for TMS treatment is likely to increase as its availability increases.

Declaration of interest

None.

Contents

- *Patients with depression who self-refer for transcranial magnetic stimulation treatment: exploratory qualitative study*
 - *Depression*
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 - *The TMS trial*
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 - * *Proactively seeking information about treatment for depression*
- *Discussion*
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Depression

Approximately one-half of patients with depression do not achieve an adequate response to antidepressants.¹ A review found that approximately one-third of patients with depression showed no response while some achieved only a partial response to treatment, as operationalised by a reduction in depressive symptoms.²

Brain stimulation technique

Electroconvulsive therapy (ECT) is a well-established neuromodulation technique used to treat depression,^{3,4} but it is associated with side-effects such as memory deficits⁵ and risks associated with general anaesthesia. This has provided the impetus to develop other brain stimulation techniques, such as transcranial magnetic stimulation (TMS). TMS is a non-invasive brain stimulation technique that induces changes in cortical excitability using high-intensity magnetic pulses delivered through the scalp.^{6,7} It has been used to treat various neuropsychiatric conditions including depression. In the UK, repetitive TMS (rTMS) for depression has been recently recommended for use in routine clinical practice.⁸ In comparison with ECT, TMS treatment confers certain advantages, in terms of tolerability and ease of administration.⁹

The TMS trial

The current study was conducted as part of a clinical trial (TDep TMS trial, Clinicaltrials.gov: NCT02016456), which sought to examine the effectiveness of repetitive high-frequency TMS versus intermittent theta burst TMS in reducing the symptoms of treatment-resistant depression. The trial was conducted under the auspices of the Nottingham Neuro-modulation Unit. The lead trial investigator (S.L.) received emails from patients enquiring about the trial or requesting TMS treatment. Such enquiries were considered important given the generally poor rates of treatment-seeking and self-referral by people with depression.¹⁰

The current study

The self-referral emails offered a novel opportunity to explore why people with depression self-referred for TMS. The current study aimed to explore the referral emails and describe the clinical characteristics of people who self-refer and the reasons for self-referral for TMS treatment.

Method

Design

This qualitative study used self-referral email correspondence to explore the characteristics of patients self-referring and the reasons for self-referral for TMS treatment. Emails had been sent by the self-referrer, their relative or their doctor, and requested TMS treatment for medical conditions (most often depression).

Approvals

This study is part of a clinical trial which has both research ethics and Research and Development approval. Approval to review the content of the referral emails was granted by the Research and Innovation Department of the Nottinghamshire Healthcare National Health Service (NHS) Foundation Trust.

Participants

The participants were people with a health condition, most commonly depression, seeking treatment or further information on TMS. The emails were often sent by the potential participant themselves; however, a few were sent by doctors or family members. These were also regarded as self-referrals because it was clear that they were written on the instruction of, or in collaboration with, the patient. All 98 self-referral emails received between the start of the trial in May 2014 and October 2015 were analysed.

Analysis

Referral emails were redacted to obscure all identifiable patient information. They were analysed using content and thematic analysis. Details about participant characteristics were briefly stated in the emails or in some instances inferred from details such as name, and so content analysis was used to extract and analyse these data. Thematic analysis was used to explore reasons for self-referral, as this approach enables the researcher to explore themes both inductively from the data and deductively based on theory and research.¹¹ Analysis followed Braun and Clarke's six phases of thematic analysis.¹¹ Emails were read and re-read (by M.B.) and, after familiarisation with the data, codes were generated by coding interesting and shared features in a systematic way across all the emails. Codes were sorted into potential themes and the coded extracts were collated into these themes. Analysis proceeded iteratively and was refined in collaboration with another qualitative researcher (C.B.). Themes were defined and coded, following accepted guidelines.¹² Interrater reliability of coding was also assessed; 89% interrater reliability was achieved (scores >70% are considered acceptable).¹²

Results

Participant characteristics

Of the 98 referral emails analysed, in 90 (91.8%), it was clear whether the potential participant or someone else had written the email. Of these, the majority (78.9%, $n = 71$) were written by an individual who was applying to take part in the TMS treatment, with the others written by doctors (11.1%, $n = 10$) or family members on behalf of the individual (10.0%, $n = 9$). Gender was explicitly stated, or could be inferred from the name, for 83 referrals (84.7%). Of these, there were 48 women (57.8%) and 35 (42.2%) men. Age was provided for 31 referrals (31.6%). The mean age was 44 years (range early 20s to mid-70s). The length of illness was given for 33 referrals (33.7%). Where stated, the mean length of illness was 17 years (range 4 months to more than 40 years). The primary diagnosis was specified for 63 referrals (64.3%). Depression was the most commonly cited diagnosis (88.9%, $n = 56$), followed by bipolar affective disorder (6.3%, $n = 4$) and schizophrenia (4.8%, $n = 3$). Twenty referrals (20.4%) mentioned comorbidities, the most common being anxiety (50.0%, $n = 10$).

Reasons for self-referral

Thematic analysis of the data revealed six themes that explained the reasons for self-referral for TMS treatment. The self-referral emails varied widely in the depth of detail provided, and themes were expressed in very diverse ways. Given that there were 98 emails, the prevalence of themes was reported (*Table 1*). This is important since a powerful and memorably described theme might assume disproportionate importance. *Table 1* List of themes

Theme	Number of participants identifying with theme	Percentage
1. Current treatment not working	39	39.8%
2. Proactively seeking information about treatment for depression	29	29.6%
3. Suffering from chronic or long-term depression	25	25.5%
4. Desperate for relief from depression	13	13.3%
5. Motivated to seek alternative treatment owing to side-effects of current or previous treatment	12	12.2%
6. Getting worse in spite of current treatment regime	6	6.1%

Current treatment not working

This theme was coded in 40% of the emails. The most commonly cited reason for self-referral for the TMS trial was lack of, or only limited response to, treatment despite undergoing various treatment modalities. For example, one email described constant relapsing even after many different treatments. “I have tried various medications, CBT and Mindfulness but I relapse again and again (W7, Female).”

Another email described how treatment, including ECT, had never worked, even partially or for a short period of time. “I have tried at least 20 different types of anti-depressant tablets ... none of which have worked. I have also had [sic] 2 courses of ECT and several years of CBT (both group and individual) all with no effect (M15, Male).”

This theme reflects the definition of treatment resistance used in the wider study, namely the ‘failure to improve or only partially improve after trying two or more antidepressants or two or more psychotherapies/ECT’. Indeed one writer explicitly stated that her mother’s depression was treatment resistant. “... has suffered with what is proving to be treatment resistant depression for over 12 months (W61, Female).”

Suffering from chronic or long-term depression

Another important motivator for self-referral was experiencing chronic or long-term depression, with this theme coded in a quarter of the emails. For example, one writer stated that he had suffered with depression for more than 20 years. “I have been suffering with depression for over 20 years (M30, Male).”

‘Desperate’ for relief from depression

For some participants, their self-referral was prompted by their desperation for relief from depression (13%). One writer powerfully described how he was not even really ‘living’ and was desperate for this to happen. “I am desperate of finding a way to start living and enjoining [sic] life again (M3, Male).”

Another writer described their increasing state of despair. “As I feel that age and time are against me, and I feel that I am slipping further and further down the well of total despair (M15, Male).”

These calls for help are all the more powerful given that they were sent to a clinician with whom the patient had no therapeutic relationship. Such desperation is clear in the following plea. “Sir, I have no idea where to turn next, please offer me some help and hope before my marriage is stretched beyond it’s [sic] tolerance – before it is too late (M7, Male).”

For some, this desperation was caused by depression affecting their ability to function normally. This impaired functionality often affected the participant’s ability to work. It also manifested in other ways such as problems with social functioning and lack of motivation. One email described how the writer had previously had a good career, but depression had significantly affected this and resulted in him losing his job. “Although I had a good professional career, 2 postgraduate degrees, my personal, social and working life is seriously limited by depression (I lost my job as well) (M3, Male).”

Another email described how his social life had been affected so badly that he had cut himself off from those around him. “Have not been able to work since and have now become a recluse cutting myself off from family and friends (M20, Male).”

Another writer talked about how upsetting they found their lack of functionality. “I am finding it very tedious and upsetting that I am unable to do the things I would [want] to do and need to do at times (W46, Female).”

Motivated to seek alternative treatment by side-effects of current or previous treatment

Self-referral was sometimes prompted by a desire to seek an alternative treatment to avoid side-effects. TMS is a treatment with few side-effects; these include headache, nausea, tiredness, syncope and, very rarely, epileptic seizures. As such it was attractive to people who had previously experienced negative side-effects with other treatments. Participants were clearly aware of this and referred in their emails to the intolerable side-effects they had previously experienced. “I was on medication for several years but after coming off I have found it impossible to get back to a medication without intolerable side effects (W1, Female).”

Some participants had received ECT treatment and also had problems with the severe side-effects associated with it. TMS is recognised as having fewer severe side-effects, which is probably why the opportunity to receive TMS was being explored. For example, one email described a patient who had previously tried ECT but could not tolerate it so was looking for a similar treatment but with less severe side-effects. “I attempted ECT with her which she could not tolerate (W11, Female).”

Getting worse in spite of current treatment regime

A small number of people requesting TMS mentioned that their symptoms were worsening despite treatment and that this is what prompted their request to participate in the trial (6%). While this theme appeared in only six emails, it powerfully describes the effect of progressive deterioration on people’s lives, as in the account below of a patient’s relative. “She is now living a twilight existence and progressively deteriorating (W61, Female).”

Proactively seeking information about treatment for depression

An interesting inductive theme that emerged from the data was that for some individuals, the self-referral was motivated by a desire to try newer, unconventional, treatments for their illness (29.6%). Proactive searching of the internet or health-related articles in papers and magazines for novel treatments was how these individuals had found out about the TMS trial.

Many of the patients had significant knowledge about TMS, having previously researched TMS treatment. This theme illustrates how patients with depression wish to be actively involved in exploring treatment choices which are not offered by their general practitioner or psychiatrist. For example, one patient described how they had been researching TMS compared to other treatments they had been offered and had found that it could be better. "I have read and looked at articles regarding TMS and they look promising to cure depression with much better success rate than medications alone or medication and counselling (W7, Female)."

Another patient had been offered ECT but, having researched TMS, decided that TMS was superior to ECT. "I have researched ECT and found that TMS seems to [be] much superior but still evolving as a treatment for depression (M20, Male)."

Discussion

Depression is one of the most commonly cited causes of morbidity worldwide,¹³ with a lifetime prevalence of approximately 8–12%.^{14,15} Depression can result in suicide,¹⁶ which accounts for 1.4% of all deaths worldwide.¹⁷ To our knowledge, this is the first study to describe the characteristics of people with depression self-referring and the reasons for self-referral for TMS treatment, albeit in the context of a trial.

Content analysis of the emails revealed that self-referrers were a heterogeneous group. There was a broad age range, indicating that TMS has a broad appeal across all age groups. Participants had generally experienced their illness for several years. However, the average illness length may be confounded if those who included their length of illness were those who had experienced it for longer. For example, participants may have included their long length of illness to emphasise its severity, perhaps in the belief that it would increase their chance of being accepted onto the trial.

More women than men self-referred for TMS treatment. This is in line with research that has shown that women are more likely than men to seek help for mental disorders,^{18,19} and that depression is more prevalent in women than men.²⁰

Thematic analysis of the emails revealed a number of factors prompting self-referral. The themes offer some important insights into what motivates people with depression to enquire about TMS treatment. The most common theme that emerged was 'current treatment not working'. Other related themes included 'motivated to seek alternative treatment owing to side-effects of current or previous treatment', 'suffering from chronic or long-term depression' and 'getting worse in spite of current treatment regime'. The side-effects of treatments with antidepressants have been well documented^{21,22} and so this was not an unexpected theme. The chronicity and possible long-term nature of depression are also well documented²³ and perhaps unsurprisingly this was mentioned in one-quarter of self-referrals. Self-referrers also reported that their symptoms were 'getting worse in spite of a current treatment regime'. Although this theme was the least common, revealed in only six emails, it was powerfully described and resonates with the literature on why people seek help,²⁴ and so should not be ignored.

A related and powerful theme was 'desperate for relief from depression'. Participants movingly described their desperation for relief from depression. The lack of treatment options, and not just symptom severity, may contribute to feelings of desperation.²⁵ Evidence of such themes need not exclude participants from trials; as Swift²⁶ commented, desperation affects voluntariness rather than capacity to enter into a trial, and this is related to whether acceptable alternative treatments are available. Moreover, Dunn and colleagues argued that including desperate patients in clinical trials is ethical.²⁵

The themes described above go some way towards explaining why, despite their depression, participants were actively seeking information about treatment. The unexpected and inductive theme 'proactively seeking information about treatment for depression' revealed how participants had found information about the TMS trial while researching alternative

treatments.

To date, no published studies have examined why patients with depression self-refer for TMS. However, gaining access to additional services, such as otherwise unavailable interventions, has been identified as a key facilitator for recruiting people with depression into clinical trials.²⁷ Although TMS was not discussed, the authors noted a preference for interventions that did not involve medication.²⁷ This has important implications for recruitment and resonates with Locock and Smith's study, which found personal benefit to be a primary motivation for volunteering in a research study, more so than altruistic considerations.²⁸ Their study explored the reasons people volunteered to participate in clinical trials across different (mainly physical) conditions, and found that such personal benefits included access to new treatment, access to better information and receiving care from expert specialised teams.²⁸

Limitations

The main limitation of this study was the availability of data. Analyses were constrained by the information available in the initial referral email. Emails tend to be short and contain only information the writer wishes to share. Accordingly, there was no opportunity to clarify information with the participants, and relevant information may have been omitted in the referral email. For example, there were missing data for some of the participant characteristics. Furthermore, the prospective provision of TMS was linked to a clinical trial where participants received an intervention 4 days a week for 4 weeks. Potential self-referrers may have been restricted by this costly and time-consuming commitment, especially for those who lived further afield. However, while these constraints may have had an influence on who ultimately participated in the trial, the email writers were enquiring about, rather than enrolling in, the study. Therefore, the participant demographics may still be credible. Future research should include interviews with participants to explore their reasons for referral to TMS, to see whether similar reasons are identified which support our findings. There was also no opportunity for participants to provide feedback on the findings. It would also be informative to explore whether participants' reasons for referral were related to their response to TMS. However, given that TMS is a relatively new technique and is not yet widely used in the NHS, we are not aware of any previous research on the characteristics of those who request the treatment or their reasons for referral to it, particularly in the UK.

Summary

In conclusion, the 98 people who self-referred for TMS were a heterogeneous group, although the majority were female (57.8%). Thematic analysis of the self-referral emails revealed that participants were motivated by a desire for an effective alternative treatment for their treatment-resistant depression. These findings have implications for how participants for future TMS trials could be targeted; they also suggest an increased demand for TMS as it becomes more widely known. Given the updated guidance recommending rTMS for depression in routine clinical practice in the UK⁸, it is likely that more treatment centres will be developed to facilitate this.²⁹ Prior to this, rTMS was only administered in research settings as National Institute for Health and Care Excellence guidelines stated that although TMS was judged to be safe, there was uncertainty about the clinical efficacy.^{6:30}

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1.5.78 Getting a balance between generalisation and specialisation in mental health services: a defence of general services

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Abstract

Mental health services in the UK National Health Service have evolved to include primary-care generalist, secondary-care generalist and secondary-care specialist services. We argue that there continues to be an important role for the secondary-care generalists as they minimise interfaces, can live with diagnostic uncertainty and support continuity of care. The lack of commissioning and clinical boundaries in secondary-care generalist services can undermine their feasibility, leading to difficulties recruiting and retaining staff. There is a risk of a polo-mint service, where the specialist services on the edge are well resourced, but the secondary-care generalist services taking the greatest burden struggle to recruit and retain clinicians. We need to establish equity in resources and expectations between generalist and specialist mental health services.

Declaration of interest

None.

Contents

- *Getting a balance between generalisation and specialisation in mental health services: a defence of general services*
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 - * *Abolish secondary-care generalist teams and have specialist-only teams*
 - * *Minimise the use of local specialist teams and return to generalist mental health teams*
 - * *Have realistic and equitable estimates for all teams in terms of clinician case-load and team case-load*

– *Some suggestions*

We all like to feel special. The word ‘generalist’ seems to imply the opposite – ‘Jack of all trades, master of none’. Being a specialist suggests one is at the top of the knowledge tree, whereas the generalist might feel that the term implies that there is someone out there with greater expertise.

And yet ... the crowning glory of the British National Health Service (NHS) is the general practitioner (GP). All western countries have specialists, but the central role of the GP in British medicine is a distinctive characteristic of the NHS. There is a high degree of trust between the GP and patient,¹ created by continuity of care, good therapeutic relationships and a holistic view of the whole patient. The role of the GP creates a degree of efficiency, as those referred to the specialists are screened by doctors who know the patient and ration precious health resources according to need. This may be an idealised picture, but there is still a strong coherent relationship between the GP and patient in the UK. Leinster² argued that medical schools need to concentrate on producing doctors who are good generalists who can orchestrate good care by specialists.

Within UK secondary-care mental health services, there are disparities between general services and specialist services. The latter include specialist services defined by diagnosis or treatment: rehabilitation, early intervention in psychosis, eating disorder, forensic and personality disorder teams. Within secondary-care mental health general services, there can be specialised services according to the environment (in-patient wards), crisis teams and community mental health teams.

As a result, it can be argued that a three-tier service structure has developed, in terms of medical treatment of mental illness in the NHS (*Table 1*). Some areas straddle the secondary-care generalist and specialist categories, such as forensic teams who are accessed through secondary-care generalists but also through the criminal justice system. We will refer to ‘secondary-care generalist psychiatrists’ as generalists for brevity in this article. *Table 1* The three-tier service structure for medical treatment of mental illness in the National Health Service

Medical expertise	Characteristics	Example environments	Patients treated
Primary-care generalists	GPs with broad medical knowledge, open access to the public	General practice	Mild to moderate depression and anxiety
Secondary-care generalist psychiatrists	Psychiatrists working across an age group, usual access by referral from a GP	Psychiatric wards, community mental health teams, crisis teams, liaison teams	Severe mental illness
Secondary-care specialist psychiatrists	Psychiatrists working in narrow diagnostic fields, usual access through secondary-care generalist psychiatrists	Early intervention teams, personality disorder teams, eating disorder teams, rehabilitation/recovery teams	As defined by the team diagnoses ¹

Strengths and weaknesses of generalists and specialists in secondary-care psychiatry

Specialists concentrate on a specific diagnosis or treatment of mental illness. In doing so, they develop greater expertise in interventions, which may improve clinical outcomes. There is clear coherent communication to the team and regarding what they are trying to achieve. Often, workload is more precisely commissioned and framed by inclusion criteria and case-load limits. Evidence suggests experts may be better at detecting clinical errors in their field.³

Generalist psychiatrists take responsibility for patients across a broad group of diagnoses and often across different environments. Their strength is in their versatility, working across situations, with diagnostic uncertainty and with patients who have more than one diagnosis. As such, they may provide more holistic care, and interfaces between services are less likely to hinder care or waste time. Continuity of care and therapeutic relationships may be easier to establish.

¹

GP, general practitioner.

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The weaknesses of specialisation include interfaces between teams, which are often inefficient. Working with one group of patients can get boring for staff and they can miss the variety that comes with being a generalist. There is evidence that specialists 'pull' cases toward their specialism and are less flexible in their thinking. Their specialism can lead to a bias in their clinical reasoning.⁴

The weaknesses of generalists mirror the strengths of the specialist in that, because they are doing a variety of interventions less often, they can have less expertise, and this can compromise outcomes. Paediatric heart surgery is an example of specialist teams having better outcomes than general heart surgeons in the cardiac care of children. Generalists may neglect certain diagnoses that are difficult to treat and provide a service skewed toward their own interests.

A defence of generalist services

The issue of diagnostic uncertainty and avoiding difficult patients

A difficulty in mental health is that diagnostic boundaries are not so sharp that competent colleagues may disagree. For example, there can be differences in defining psychosis from non-psychosis, leading to disagreements as to individual suitability for the early intervention teams. The distinction between bipolar type II disorder and emotionally unstable personality disorder is grey, so that many patients meet diagnostic criteria for both. Dual diagnoses are common, for example, between depression and personality disorder, and psychosis and substance misuse. It is human nature that if a particular patient is challenging to treat, we see aspects of their presentation that exclude them from our responsibility and make them suitable for another team.

The pain of interfaces

The resulting disagreements between multiple teams are distressing for patients, inefficient and cause resentment between staff, in that referrers have to convince the specialist team that a patient is appropriate. The fewer interfaces the better, and if different staff members know each other and have a relationship, these problems are easier. For a successful service, therapeutic relationships between staff are as important as the therapeutic relationships between patients and clinicians.

The inequitable distortion of resource allocation

Specialist services often have more tightly defined boundaries than general services and are often commissioned with a defined capacity. For example, specialist teams may have a cap on individual clinician case-loads (e.g. 12–15 in early intervention services) whereas generic community mental health teams (CMHTs) often do not, and case-loads can increase to over 40, with no managerial definition of a reasonable case-load despite the same team taking and assessing most referrals from primary care. The lack of a 'lid' on capacity in generalist CMHTs can lead to staff burnout, difficulties in retention and unsafe services.

The risk of the polo-mint service

Commissioners can prioritise specialist teams over generic teams and skew the service. When the more specialist teams have a protected case-load size and patient number, they can effectively become a local tertiary service. Staff can observe that clinicians have the time and resource in the specialist teams to deliver better quality care that they do not have in generic teams on the wards and in the CMHTs, and apply for specialist posts. This can result in a polo-mint service: posts are filled in specialist teams, which do not take on the immediate burden of new assessments, admissions and the ongoing care of the majority of the patients. Generic teams can be staffed with less-experienced staff and temporary staff. This is inequitable and breeds resentment. There is good evidence that staff burnout increases levels of sickness absence and staff turnover.⁵

The needs for specialist teams change over time

In the 1980s the day hospital specialist was popular as the asylums were closing. There are very few day hospitals now. The HIV psychiatrist emerged in the 1990s, but thankfully was soon not needed because of the rise of better treatments for HIV. Specialists in assertive outreach were appointed in the 1990s and 2000s but are now disappearing. In the past decade, addiction specialist posts have been eroded, but liaison psychiatry is experiencing a renaissance with medically unexplained symptoms a rediscovered clinical challenge and patients with dementia in general hospitals also a priority to manage.

So what? The world changes, patients' needs change and specialisms come and go. That may be a good thing, but it emphasises the need for psychiatrists and mental health clinicians to protect their core generic skills and adapt them to fluid challenges. Being a specialist and protecting your speciality may stifle innovation and generalists have the overview to spot new needs requiring innovation.

How do we get the balance right?

We offer some scenarios to consider.

Abolish secondary-care generalist teams and have specialist-only teams

This would be an answer, and has parallels in acute medicine where the role of the general physician has diminished and cardiologists, renal physicians, gastroenterologists and other subspecialists have emerged. This may have led to better treatments and outcomes. However, the care of elderly patients with multiple morbidities has fragmented, and the experience of going to hospital has become socially quite unpleasant because of this fragmentation. Patients often do not have a named consultant or a named nurse.

Both politicians and leaders in the Royal College of Physicians have called for a greater emphasis on generalism.⁶ The former editor of the *BMJ* has stated that doctors and patients are heading in opposite directions, 'patients have multiple conditions whilst doctors are specialising not just in organ systems but parts of organs'.⁷ In the USA, the Council on Graduate Medical Education recommended an increase in the percentage of generalists among practicing physicians to increase from 32 to 40% in 2010 – not only is this target predicted to be unmet, but the percentage of generalists is likely to fall to 25%.⁸

The biggest difficulty for psychiatry is that the lack of clear delineation between diagnoses and patients could be passed between disagreeing teams. However, it is an option that needs consideration.

Minimise the use of local specialist teams and return to generalist mental health teams

This does seem somewhat backward, but may be a less-fashionable description of integrated services. After all, general adult psychiatry is a speciality in its own right, so why can't one team treat all diagnoses? Generic psychiatric skills require a holistic biopsychosocial approach and the incorporation of a full multidisciplinary team. The secondary-care generalist psychiatrist does not become deskilled when they are on call as they are used to diagnostic uncertainty and a broad view of aetiology and treatment.

Many specialist teams were introduced because of charismatic proponents claiming better outcomes but without evidence for effectiveness, and subsequent research failed to demonstrate efficacy. Just as assertive outreach teams have waned in the UK because of a lack of evidence of better outcomes, with patients returning to generalist teams, others may go the same way.⁹ Some staff might take on a specialist interest within a generalist team, although it is hard to meet and learn with specialist peers if they are separated between teams.

Have realistic and equitable estimates for all teams in terms of clinician case-load and team case-load

There needs to be equity in the commissioning of secondary-care mental health generalist and specialist services. Specialist teams often have tightly defined commissioning criteria whereas the criteria for generic CMHTs are not defined. The case-load size for different teams may not need to be equal, but they do need to be justified. Although generic teams exist, it is likely they will be the default service for complex patients with diagnostic uncertainty, and boundaries are harder to define than for specialist teams.

Generic CMHTs have tried to control their workload by defining inclusion and exclusion criteria and treatment pathways. However, commissioning needs to allow for the uncertainty of the interface between primary and secondary care. Patients and GPs get frustrated when criteria are so inflexibly followed that patients who are presenting in an unusual or atypical manner are refused care, or have to get worse before they are offered help. Some patients who are ill and at risk do not follow the pathway or treatments recommended. Mental health services are unique in being asked to be assertive in caring for reluctant patients and forcing care in certain circumstances.

Some suggestions

We believe that generic general adult psychiatric services are likely to be required because specialist-only services will not have the flexibility to roll with diagnostic uncertainty and changes in patient needs. In the past 30 years, new treatments have emerged for emotionally unstable personality disorder, which was once a diagnosis of exclusion and adult attention-deficit hyperactivity disorder, which was completely ignored (and still is in some places). Patients with high-functioning autism still tend to be pushed away, but treatments may emerge. Generalists are flexible and can think on their feet.

Somehow, we need to make working in a generalist CMHT attractive again. This may be through better management of expectations and case-load, career opportunities, pay or quality of life. We cannot lose good staff to specialist teams and leave more junior staff doing demanding generalist jobs.

Currently, the most pressing need is for equity between generic and specialist teams in terms of defined case-load. Staff/patient ratios are a cause of burnout, which increases staff turnover.⁵ Staff in generic CMHTs must have boundaries put on their patient case-load in the same way that specialist teams define their capacity. This does not have to be equal – it may be 35 cases compared with 15 for teams with more intensive input. There have been attempts to develop tools to promote equity between teams in Australia.¹⁰ Government policy and commissioners cannot continue to be inequitable in their expectations of generic and specialist teams, and as long as CMHTs are treated as inexhaustible, they will not retain the skilled clinicians they need.

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1.5.79 Conversion therapy and the LGBT community: the role of the College now?

Annie Bartlett

date

2018-12

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- *Conversion therapy and the LGBT community: the role of the College now?*

The history of the relationship between the LGBT (lesbian, gay, bisexual and transgender) community and psychiatry has not been a happy one, reflecting but also at times reinforcing hostile social attitudes. More recently, both psychiatry and psychological therapies have been at pains to distance themselves from previous discriminatory practice and align themselves with more contemporary understandings of diverse sexual identities and behaviour. The College and other bodies such as the UK Council for Psychotherapy have developed clear statements on sexual orientation and the issue of conversion therapy in particular, pointing out that it does not work, can create distress and should not be undertaken.¹

This position on conversion therapy is echoed in the raft of 75 measures announced recently by Women and Equalities Minister Penny Mordant, based on the results of the largest survey of LGBT people ever undertaken. The measures are designed to create a more inclusive society in which, among other things, individuals of any sexual persuasion may feel able to hold hands in public without fear of ridicule or attack (Hansard HC Deb, 3 July 2018, cWS). That a Conservative government has launched such an initiative seems remarkable to those of us able to remember Section 28, brought in by the Thatcher government 30 years ago (Local Government Act 1988).

However, we should be mindful as a profession that some practitioners may not be so sympathetic to this direction of travel. Not so long ago, a significant proportion of psychiatrists and therapists, 4%, were still prepared to treat individuals for their gay and lesbian identities.² It is not clear how much this has changed, if at all, on the ground. Equally, it is still very easy to locate reparative therapy options on the internet, a common port of call for those wanting some help negotiating same sex sexual preferences. A quick search picks up, among others, Nicolosi's website, which continues to say 'If gay doesn't define you you don't have to be gay,' accompanied by claims of treatment efficacy, in line with the views he so publicly expressed until his death in 2017 (<https://www.josephnicolosi.com>). He recommended reparative therapy, saying that it worked and should be offered as a psychological therapy. The number of individuals currently involved with reparative therapy is unclear and seems likely to be difficult to establish, as recent medical and political pronouncements may well drive it underground.

The College has an international reach. Many countries are still much more punitive to LGBT individuals than the UK; some have the death penalty on their statute books. Major world religions are internally divided on LGBT issues and can legitimise not only adverse social attitudes but also attempts at religious rather than medical cures. It remains to be seen how energetic the College feels it should be in sharing its liberal understanding of sexual preference. Its position on change-oriented treatments of any kind has international applicability. There may well be many individuals overseas who would thank psychiatry for taking part in this ongoing debate.

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1.5.80 Review and update of the Health of the Nation Outcome Scales for Elderly People (HoNOS65+)

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Abstract**Aims and method**

The Health of the Nation Outcome Scales for Elderly People (HoNOS65+) has been used widely for 20 years, but has not been updated to reflect contemporary clinical practice. The Royal College of Psychiatrists convened an advisory board, with expertise from the UK, Australia and New Zealand, to propose amendments. The aim was to improve rater experience when using the HoNOS65+ glossary by removing ambiguity and inconsistency, rather than a more radical revision.

Results

Views and experience from the countries involved were used to produce a series of amendments intended to improve intra- and interrater reliability and improve validity. This update will be called HoNOS Older Adults to reflect the changing nature of the population and services provided to meet their needs. These improvements are reported verbatim, together with the original HoNOS65+ to aid comparison.

Clinical implications

Formal examination of the psychometric properties of the revised measure is needed. However, clinician training will remain crucial.

Declaration of interest

None.

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The Health of the Nation Outcome Scales (HoNOS) was originally developed for use with working-age adults.¹ Subsequent testing found that, in general, the scales also performed well with older people, but that some adaptations (especially relating to ratings of physical health and cognitive impairment) would be beneficial.² This resulted in the development of the HoNOS65+,³ which was validated against other established mental health measures used with older people and shown to have good interrater reliability.³ As well as this standardised version, a further version was developed with a tabulated glossary.⁴

Like the HoNOS, the HoNOS65+ was intended to: •be short and simple for routine use and acceptable to a range of mental health professionals;•have adequate coverage of clinical and social functions;•be sensitive to change over time;•have demonstrable and acceptable reliability;•have known relationships with more established scales.⁵

Since its development over 20 years ago, the HoNOS65+ has been translated into several other languages, including Spanish, Dutch, French, Greek and Italian, and is now routinely used in clinical practice and research around the world.⁶ Australia and New Zealand have mandated use of the original format of the HoNOS65+ scales for routine monitoring and outcome measurement across their mental health services,^{7,8} while across England both the original version and the more recently developed tabulated version are used to provide these nationally required data.^{3,4,9}

Experience of staff training and the evaluation of aggregated data-sets over this period, together with considerable advances in mental healthcare for older people, led to a recognition that the HoNOS 65+ required review and updating. As copyright holder for the HoNOS family of measures, the Royal College of Psychiatrists (RCPsych) elected to undertake a limited review that aimed to use expert opinion to improve the utility of the HoNOS65+ in contemporary older people's mental health services (rather than a full redevelopment and revalidation), while remaining true to its original aims and maintaining comparability with existing data-sets. This paper outlines the scope and process of the review, the issues identified and a revised set of scales (subsequently renamed HoNOS Older Adults).

Method

In recognition of their nationally mandated use of HoNOS65+⁷⁻⁹ and to ensure that each country's interests were considered, an advisory board (chaired by the RCPsych's National HoNOS Advisor) was convened with representatives from England, Australia and New Zealand. Each government nominated individuals with extensive experience in any of the following: HoNOS65+ staff training; using HoNOS65+ in practice; using aggregated HoNOS65+ data; or service-, professional- or governmental-level oversight. In addition to their own views, board members canvassed widely for clinicians' opinions regarding which aspects of the HoNOS65+ required refinement.

To ensure consistency with the concurrent HoNOS review, the same criteria were used to judge suggestions.¹⁰ These criteria were that for a change to be supported, it needed to result in a tangible improvement (e.g. simplification/clarification/removal of anachronisms) and: •maintain the original instrument's integrity as far as possible;•maximise comparability with existing individual and aggregated data;•support the use of HoNOS Older Adults as a summary of clinical assessment(s);•adhere to the HoNOS65+ 'core rules' i.e. each item is a behaviourally anchored five-point scale items are sequentially rated (1–12) all available information is used to make a rating information already rated in an earlier item is disregarded the most severe problem/worst manifestation from the preceding 2 weeks is rated problems are rated according to the degree of distress caused and/or its effects on behaviour problems are rated by a mental health professional trained in clinical assessment problems are rated regardless of cause.

In addition to these original HoNOS terms of reference, the board was keen to take this opportunity to consider whether there were opportunities to optimise alignment between the newly updated adult and older people's versions. The rationale for this was threefold. First, some of the HoNOS updates had come from the original HoNOS65+.¹⁰ Second, anecdotal reports suggested that some electronic patient record systems were unable to differentiate between the two versions and/or make both glossaries available to clinicians. Third, since the development of the HoNOS65+, the somewhat arbitrary age cut-off of 65 has become less justified given the increasing variation in functional impairment with age across different populations.¹¹

Using the collated feedback and the ensuing board discussions, a summary paper was produced by a board member with extensive experience in old age psychiatry. This highlighted some scales where alignment might be considered a viable option and those where alignment was unlikely owing to the nature of presenting needs in this population. This dictated the sequence of the board's teleconferences and its approach to each scale.

For the scales where alignment was considered to be potentially feasible and likely to improve utility, two questions were asked: first, does it resolve the concerns or problems with the scale reported by old age clinicians in the field; and, second, is the new HoNOS (2018) wording appropriate for older people's mental healthcare? Two positive responses resulted in the revised HoNOS scale being adopted for older people. A negative response led to an iterative process to produce a revised wording that was appropriate for the older people's version of the tool. During this process, consideration was given to whether these proposed changes could also be applied to the draft HoNOS (2018). Where

appropriate, to improve both, the draft HoNOS (2018) was aligned with the HoNOS older adult. Where this was not possible, the scale was grouped with items where full alignment had been deemed unfeasible.

For this second group of scales, the board considered both the new HoNOS and the original HoNOS65+ wording in the context of the collated feedback in order to produce a revised HoNOS65+ scale glossary.

Results

Upon completion of their discussions, the board was able to fully align seven of the 12 scales, with the remaining five having a high degree of similarity but also retaining some key differences. The revised tool (ultimately renamed HoNOS Older Adults) can be seen in Supplementary Table 1, available at <https://doi.org/10.1192/bjb.2018.68>. Each item's original wording is also included (in greyed-out boxes) to aid comparison.

Discussion

This publication follows the review of the original (working age) HoNOS.10 However, in reality, each review was informed by the other prior to each version of the tool being finalised. As a result, issues specific to older people will be discussed in full below, whereas those common to both tools (and hence previously discussed) will be summarised here purely for completeness. Readers are therefore advised to refer to James *et al* (2018) to gain an understanding of these common issues.

Overarching rating guidelines

After reviewing the HoNOS65+ introductory guidance, the board agreed that the issues were identical to those identified with respect to the HoNOS, i.e. that brevity had been prioritised at the expense of clarity. The board also agreed that the newly amended HoNOS guidance was entirely appropriate given that the two tools were intended to function in the same way. Consequently, the same guidance was used, as it: •clarified the severity threshold between subclinical (0–1) and clinical (2–4) ratings;•made an overt statement regarding the need for cultural competence on the part of assessors;•acknowledged the limitations of continuing to use the term ‘patient’.

Scale 1: overactive or aggressive or disruptive or agitated behaviour

There was agreement that the issues with this scale were similar, regardless of age, i.e. that: •raters should be encouraged to consider all four concepts in the title (rather than just focusing on aggression);•the issue of culturally sanctioned aggression was now satisfactorily addressed in the preceding, over-arching guidance.

However, some of the original HoNOS65+ examples were felt to be of continued value; hence, those pertaining to the following behaviours were retained: •restlessness/wandering•uncooperativeness/resistiveness and the need for persuasion•sexual disinhibition and deliberate incontinence.

There was some discussion about whether to contextualise inappropriate behaviours (i.e. in public *v.* in private); however, in keeping with the underpinning principles of the scales, it was agreed to simply focus on the behaviour itself. As a result, the two new versions of this scale are broadly similar, but not identical.

Scale 2: non-accidental self-injury

There was agreement that the issues with this scale were the same regardless of age, i.e. that the new scale should:

- consider risks, thoughts and behaviours
- rely on the over-arching guidance to ensure culturally competent ratings of some forms of ritualistic self-harm.

As a result, the newly revised HoNOS 2018 version of this scale was adopted without amendment.

Scale 3: problem drinking or drug-taking

There was agreement that the issues with this scale were the same regardless of age, i.e. that the new scale should:

- include descriptors of craving, dependency and behaviour that align with contemporary ratings of severity¹² and which accommodate rating individuals undergoing short-term, enforced abstinence;
- omit the subjective concept of 'social norms';
- exclude tobacco use unless it has led to problems over and above the detrimental effects traditionally associated with a person's physical health.

As a result, the newly revised HoNOS 2018 version of this scale was adopted without amendment.

Scale 4: cognitive problems

After an iterative process of revisions to both the original HoNOS 65+ and the draft HoNOS 2018 versions of this scale, a shared version of the scale was produced. The main issues addressed were therefore:

- the unhelpfully narrow focus on dementia
- the large step between the original ratings of 2 and 3.

A final review, however, identified the need to retain one example from a rating of 4 on the original HoNOS 65+, i.e. 'consistently unable to recognise or name close friends/family'. As a result, the two versions of this scale are almost, but not absolutely, identical.

Scale 5: physical illness or disability problems

The new HoNOS 2018 version of this scale was not suitable for older people, and alignment was not deemed viable owing to the effects of age-associated complexities including spectacles and hearing aids, as well as the differing clinical significance of minor falls for the two age groups. Hence, while some text is shared between the new versions of this scale, many of the original HoNOS65+ examples were retained to reduce ambiguity. The two new versions of this scale are therefore notably different.

Scale 6: problems associated with hallucinations and delusions

There was agreement that the issues with this scale were the same regardless of age. As a result, the newly revised HoNOS 2018 version of this scale (i.e. limited to minor linguistic changes) was adopted without amendment.

Scale 7: problems with depressed mood

There was agreement that the issues with this scale were the same regardless of age, i.e. that: •descriptors should be aligned with the scale's title to remove the current HoNOS65+ contradictions (helpfully, focusing on mood and excluding the wider symptoms of depression also avoided any need to accommodate the differing presentations of depression between the two age groups);•ratings should include a more balanced description of cognitive, affective and behavioural aspects of low mood (e.g. loss of interest, guilt and low self-esteem) to avoid unduly focusing on feelings of guilt.

As a result, the newly revised HoNOS 2018 version of this scale was adopted without amendment.

Scale 8: other mental and behavioural problems

There was agreement that the issues with this scale were the same regardless of age, i.e. the need to: •recognise the dominance of anxiety ratings in this scale, although the creation of a separate scale was deemed to be outside the scope of this work;•recognise the possibility that rating the most severe problem can lead to a failure to capture less severe issues, while electing to retain this approach;•add 'elated mood' to the list of options and re-code the options to accommodate this;•provide additional explanations of each option to improve consistency of ratings.

As a result, the newly revised HoNOS 2018 version of this scale was adopted without amendment.

Scale 9: problems with relationships

There was agreement that the issues with this scale were the same regardless of age. As a result, the newly revised HoNOS 2018 version of this scale (limited to minor linguistic changes) was adopted without amendment.

Scale 10: problems with activities of daily living

As with Scale 4, after an iterative process of revisions to both the original HoNOS 65+ and the draft revisions to the HoNOS 2018 version of this scale, a shared version of the scale was produced. The main issue addressed was therefore: •clarifying how to 'manage' the effects of any existing support the person is receiving.

A final review, however, identified the need to retain two examples from the original HoNOS 65+. 'Occasional urinary incontinence or continent only if toileted' was therefore included as an example for a rating of 3, while 'full supervision required with dressing and eating; frequent incontinence' was included to help illustrate a rating of 4. As a result, the two versions of this scale are almost, but not absolutely, identical.

Scale 11: problems with housing and living conditions

The new HoNOS 2018 version of this scale was found to be unsuitable for older people, and complete alignment was not deemed viable owing to the need to maintain references to the risks posed to older people by their environment. Removing this feature from the HoNOS65+ was judged to represent a major (and unhelpful) change. Therefore, much of the revised HoNOS 2018 version was adopted, i.e.: •clarification that the scale is intended to rate how well the person's current environment matches their needs/abilities, not their abilities *per se*;•clarification that when rating patients temporarily admitted to hospital their 'usual' place of residence should be considered;•updates to some of the terminology used.

However, in addition: •the original HoNOS65+ references to risk were maintained (and, for consistency, introduced to a rating of 1).•the original HoNOS65+ concept of patient satisfaction was removed owing to potential contradictions between suitability of and satisfaction with housing and living conditions.

As a result, the two new versions of this scale are similar, but not identical.

Scale 12: problems with occupation and activities

There was agreement that the issues with this scale were the same regardless of age, i.e. that there was a need to:

- clarify that the scale is intended to rate how well the person's current environment optimises opportunities to meet their needs or develop their abilities, not their abilities *per se*;
- clarify that when rating patients temporarily admitted to hospital their 'usual' place of residence should be considered.
- update some of the terminology used.

As a result, the newly revised HoNOS 2018 version of this scale was adopted without amendment.

Other issues

The advisory board was aware that since the publication of the HoNOS65+ there have been shifts in the well-being of older people, with frailty and disability tending to occur later in life.¹¹ With this has also come a shift in the focus of some services for this population. As a result, the existing title, with its focus on the over-65s, was felt to be unhelpful and slightly anachronistic. Increasing the age limit (e.g. to HoNOS 70+) may be more reflective of the group of individuals for whom the tool would be most appropriate in some countries, but still somewhat arbitrary. As a result, it was agreed to rename the scales HoNOS Older Adults, as this would allow clinicians and services to exercise their judgement about when it was appropriate to use each new version of the tool. This could allow the measures to be aligned with variations in the cut-off age for service organisations and practice in different countries and over time. While this variability may have some effect on the comparability of data internationally, it could significantly simplify utilisation of the measures in individual countries.

As with the review of HoNOS, 10 additional areas for development were identified that had merit, but these would have constituted substantial changes and required the development of a completely new instrument. These of course remain an option for future development, pending sector agreement, as well as government interest and funding.

Summary

The anticipated benefits of these changes should ideally be subject to empirical testing through assessment of interrater reliability and revalidation of the measure in the field. This type of study requires funding and preferably involvement from countries that have heavily invested in the HoNOS65+ to date. This issue is being actively pursued by members of the advisory board

It is also acknowledged that the different jurisdictions involved in the review (and others that have also invested in the use of HoNOS65+) may encounter a range of differing implementation issues. Training programmes in particular are likely to be affected, and while the proposed changes are intended to improve the ease and accuracy of using the scales, it must be stressed that these do not obviate the continued need for training in the use of the scales.

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Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2018.68>.

[click here to view supplementary material](#)

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1.5.81 Awareness and documentation of the teratogenic effects of valproate among women of child-bearing potential

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Abstract

Aims and method

We aimed to evaluate clinical note documentation of valproate prescribing and establish the level of knowledge among women of child-bearing potential regarding valproate-associated adverse effects, including teratogenesis, in a regional Irish mental health service.

Results

Of the 42 women prescribed sodium valproate, 21.4% ($n = 9$) had some documentation in relation to associated risks and 33.3% ($n = 14$) described an awareness of these risks from consultation with their treating mental health team. On clinical interview, 9.5% ($n = 4$) of individuals with clear documentation of the risks of teratogenesis described no such awareness. Augmentation with lithium was associated with greater awareness of the teratogenic risks of valproate ($P = 0.011$).

Clinical implications

A clear description of the teratogenic risks of valproate and potential management strategies, including advice regarding contraception and supplementation with folic acid, should be clearly documented and provided repeatedly and in context to all women of child-bearing age who are prescribed valproate.

Declaration of interest

None.

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Valproate is a broad-spectrum anticonvulsant with well-established efficacy for the management of partial and generalised seizures,¹ acute (hypo)mania and prophylaxis of (hypo)manic episodes both as a monotherapy or in combination with other psychotropic agents.² In addition, valproate can be utilised for the prophylaxis of depressive episodes in bipolar disorder,² although this reported therapeutic effect is of lesser magnitude.³

Risk of teratogenesis

However, valproate use in women of child-bearing potential is associated with a wide range of neurodevelopmental deficits,⁴ with an approximate risk of teratogenesis of 7%⁵ and 70% of teratogenesis malformations consisting of neural tube defects (NTDs),⁶ which is a 20-fold increase compared with the general population.⁷ NTDs occur when the embryonic neural tube fails to completely close during development, and include spina bifida and anencephaly.⁸ In addition to NTDs, valproate use in pregnancy is also associated with an increased incidence of cleft lip and palate, cardiovascular abnormalities, genitourinary defects, endocrine disorders, cognitive impairment, developmental delay and autism spectrum disorders in the foetus.⁹ A 'foetal valproate syndrome' has also been described and includes a constellation of physical traits consistently observed in foetuses exposed *in utero* to valproate such as a flat nasal bridge, epicanthal folds, small upper lids and a downward-turned mouth.^{10,11} Potential contributory factors to the teratogenicity of valproate have been reported and include the number of co-administered medications, higher dosages of valproate, differences in maternal and/or foetal metabolism, gestational age of the foetus at exposure to valproate and hereditary susceptibility.^{12,13}

The teratogenic risk associated with valproate has resulted in significant caution with its use, with the summary of product characteristics for sodium valproate and the related compound semi-sodium valproate and the National Institute of Health and Care Excellence (NICE) guidelines of 2014 stating that valproate should not be initiated in women of child-bearing potential without specialist advice or unless other treatments are not tolerated or are ineffective (<https://www.gov.uk/government/publications/toolkit-on-the-risks-of-valproate-medicines-in-female-patients>).

Awareness of teratogenic risk

Given the risks associated with valproate use during pregnancy, awareness of these risks and a consideration of what precautions are required in relation to the use of valproate in women of child-bearing potential is important. However, previous research has demonstrated low rates of documentation in clinical notes of advice from mental health staff regarding both the teratogenic risks of valproate and the importance of both contraception and folic acid use.¹⁴⁻¹⁷

Aims

Consequently, in this study we wanted to establish if women of child-bearing potential attending a mental health service in Ireland were prescribed valproate and ascertain the indications for this treatment. In addition, we wanted to assess the rate of documentation of advice relating to the teratogenic risks of valproate and importance of the use of contraception and folic acid. We wanted to establish the awareness of women of child-bearing potential who are prescribed valproate regarding the teratogenic risks of this agent, and the potential benefits of contraception and folic acid. We also wanted to enquire establish how those with such awareness attained this information.

Method

Participants

This study was undertaken in an Irish mental health service region with an approximate population of 250 000 people. All female adult patients attending this mental health service in January 2016 were screened ($n = 1620$) to ascertain if they were being treated with valproate. Community mental health team staff members, including consultant psychiatrists, non-consultant psychiatry hospital doctors, community mental health nurses, allied health professionals and administrators, were contacted to ascertain potential participants. Inclusion criteria included women aged 18-49 years who had been in receipt of care from the mental health service for >1 year and had been treated with valproate.

Exclusion criteria included individuals <18 years of age, the presence of an intellectual disability (IQ<70), a diagnosis of dementia and the presence of acute psychosis. None of the 42 individuals identified as receiving treatment with valproate fulfilled these exclusion criteria. Clinical diagnoses were attained utilising ICD-10 diagnostic criteria after consultation with the relevant treating consultant psychiatrist and a full clinical chart review.¹⁸

Ethical approval was attained from the Galway University Hospitals Research Ethics Committee (C.A. 841) and the study was conducted in accordance with the Helsinki declaration on research ethics. Written informed consent was attained from each participant for clinical note review, clinician contact and semi-structured interview. On completion of the semi-structured interview, psychotherapeutic support was offered to each participant.

Chart review

A retrospective chart review was undertaken of the lifetime clinical notes of included individuals. Clinical notes were examined in depth (by D.M., A.M. and S.F.) and included all handwritten, typed and electronically generated entries pertaining to in-patient admissions to one of three acute psychiatric in-patient units; attendance at the different day hospitals, day centres and out-patient clinics in the region;

Correspondence

and from general practitioners and specialists

(including neurologists) and all prescription records.

Demographic data collected included gender, age and socioeconomic, employment, marital and domiciliary status. Clinical data included diagnosis, prescription of valproate, time duration and dose of valproate prescribed and prescription of any concomitant psychotropic medication (mood stabilisers, anticonvulsants, antidepressants, antipsychotics, anxiolytics, hypnotics and anticholinergic agents). We also ascertained if children were conceived to patients when prescribed valproate, and if any foetal abnormalities were recorded. Data pertaining to the documentation of the risk of teratogenicity or congenital malformations secondary to valproate, and precautions including adequate contraception and use of folic acid were recorded.

Semi-structured interview

All 42 identified participants participated in a semi-structured interview. Information gathered included awareness of the teratogenic risk of valproate; how, when and by whom participants were first informed of this risk (if informed); advice regarding use of contraception; wishes regarding pregnancy before or during treatment with valproate; undertaking a pregnancy test before commencement of valproate and advice regarding, or prescription of folic acid. We also enquired if participants became pregnant or conceived when treated with valproate and ascertained what advice regarding treatment with valproate was attained from their treating clinician during their pregnancy (see Appendix 1, *Semi-Structured Interview Topic Guidelines*).

Data analyses

Statistical analyses were performed with SPSS 22.0 for Windows (SPSS Inc., New York, USA). We utilised the Student's *t*-test for parametric data and the χ^2 -test for non-parametric categorical data, where appropriate. Linear regression was conducted to ascertain the effect of age, dose of valproate and duration of treatment in relation to clinical documentation or awareness of the teratogenic risks of valproate.

Results

Demographic and clinical data

Demographic and clinical data are described in *Table 1*. Of note, the most common diagnosis was bipolar disorder (33.3%, $n = 14$) and the most common comorbid psychotropic medications prescribed were antipsychotic agents (71%). In addition, 16.7% of individuals ($n = 7$) were treated with valproate for prophylaxis of epilepsy due to treatment with high dosages of clozapine. *Table 1* Demographic and clinical characteristics

Variable	(%)	or mean (s.d.)
Employment status		
In third-level education	3 (7.1)	
Employed	10 (23.8)	
Unemployed	26 (69.0)	
Relationship status		
Single	27 (64.3)	
In a relationship	4 (9.5)	
Married	10 (23.8)	
Divorced/separated	1 (2.4)	
Living arrangement		
Alone	2 (4.8)	
With parents or siblings	12 (28.6)	
With partner or spouse	14 (33.3)	
In supported accommodation	14 (33.3)	
Socioeconomic class		
I or II	10 (23.8)	
III	0 (0.0)	
IV	30 (71.4)	
V	2 (4.8)	
Mental disorder (ICD-10)		
Bipolar disorder	14 (33.3)	
Recurrent depressive disorder	12 (28.6)	
Schizophrenia	7 (16.7)	
Schizoaffective disorder	6 (14.3)	
Emotionally unstable personality disorder	3 (7.1)	
Other psychotropic agents		
Antipsychotics	30 (71.4)	
Antidepressants	20 (47.6)	
Lithium	6 (14.3)	
Anti-epileptics	5 (11.9)	
Benzodiazepines	8 (19.0)	
Hypnotics	5 (11.9)	
Anticholinergics	3 (7.1)	
Age at interview	41.5 (6.7)	[24–49]
Sodium valproate dose, mg/day	923 (434)	[300–2000]
Duration of treatment, years	7.59 (3.92)	[1–14] ^{1,2,3}

Clinical documentation

Documentation of risks associated with valproate in pregnancy were present in 21.4% ($n = 9$) of the clinical files and included advice on contraception (16.7%, $n = 7$), the specific teratogenic risks of valproate (9.5%, $n = 4$) and use of folic acid (2.4%, $n = 1$). No individuals had a documented pregnancy test before initiation of valproate.

A range of sociodemographic factors, including maternal age at interview ($B = 0.101$, $P = 0.54$), or clinical variables, including dose of valproate ($B = 0.205$, $P = 0.21$) and treatment duration ($B = 0.127$, $P = 0.45$), were not associated with clinical documentation of the teratogenic risks of valproate. All nine individuals with a comorbid diagnosis of epilepsy had no clinical documentation of the risks of valproate, although this was not statistically significant when compared with those treated with valproate for a mental health disorder ($P = 0.17$, Fisher's exact test). Valproate augmentation with psychotropic medication was present in 95.2% ($n = 40$) of individuals. Three of the six individuals treated with lithium had written documentation of the risks of valproate.

¹ In this study, undertaking a university course.

² Socioeconomic class was scored based on NRS grading: I = upper-middle class/higher managerial, administrative or professional; II = intermediate managerial, administrative or professional; III = supervisory or junior managerial or skilled manual workers; IV = semi-skilled or unskilled manual workers, V = unemployed, on social welfare, minimum-wage workers.

³

Used as a prophylactic treatment for seizure control due to treatment of schizophrenia with clozapine.

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Structured interview

On interview, 33.3% ($n = 14$) of participants demonstrated some awareness of the risk of valproate, with 19.0% ($n = 8$) aware of specific teratogenic risks, requirement for contraceptive use and need for a pregnancy test before valproate initiation, and 16.7% ($n = 8$) aware of the need for folic acid use when taking valproate. All but one of these participants stated that they had acquired this information from their treating consultant psychiatrist. Nine (64.3%) individuals who stated that they were informed of the risks of valproate as acquired from their treating clinician had no documented information detailing this advice/information in their clinical files. Overall, 18 (42.9%) individuals had either documented data in their clinical notes or stated that their mental health team had advised them on at least some of the risks of valproate for women of child-bearing potential. Four individuals (9.5%) had documented advice in their clinical notes but had no awareness of same (on clinical interview).

Regression analysis showed that younger age ($B = 0.315$, $P = 0.042$) was associated with a greater awareness of the teratogenic risks of valproate. Additionally, individuals augmented with lithium were more likely to be aware of the teratogenic risks of valproate (83 v. 25%, $P = 0.011$).

Pregnancies on valproate

Four participants had pregnancies (all uncomplicated) when treated with valproate. Three continued on the same treatment and dosage, with documentation that they should continue because of the risk of relapse of their seizure disorder. There was no documentation in these clinical files in relation to the risks of valproate in pregnancy or advice regarding contraception or folic acid use. The fourth participant had a diagnosis of bipolar disorder and had documentation to discontinue valproate (at 4 weeks' gestation), but there was no documented advice to commence folic acid. On structured interviews, in addition to the individual who discontinued valproate treatment, two of the other three participants stated that their consultant psychiatrist advised them to commence folic acid, but there was no documentation in the clinical files in relation to this.

Discussion

This is the first study to date, to our knowledge, to review both clinical documentation and undertake semi-structured interviews with women of child-bearing potential who were prescribed valproate. Either clear documentation of the risks of valproate or an awareness of these risks after discussion with their treating clinical team was present for 43% of individuals.

Our findings of poor clinical documentation of specific risks of valproate are consistent with previous research, with rates of 16–29% noted for documentation of risks of teratogenesis or the provision of advice in relation to contraception for women of child-bearing potential who are prescribed valproate.¹⁴⁻¹⁶ Similarly, documented advice in clinical notes relating to the use of folic acid has previously also been noted to be particularly low (4%).¹⁶ Our findings in relation to patient awareness of teratogenic risks of valproate are also consistent with previous studies (17–28%);¹²⁻¹⁷ however, awareness of the need for contraceptive use was lower in our patient cohort compared with a number of previous studies (55–67%).¹⁵⁻¹⁷

It is probable that the majority of patients examined in this study were provided with verbal advice regarding the risks of valproate. Two-thirds of patients who said they had been advised of the risks of valproate had no clinical documentation relating to this advice. Some participants, despite clinical documentation stating they had been informed of the risks of valproate, stated at the time of interview that they had no awareness of such a discussion (which may potentially be related to recall bias). This highlights the need for information (including in a written format) relating to the teratogenic risks of valproate to be provided repeatedly and in context to patients to ensure awareness of these risks. This may be particularly important for this cohort of patients who are being treated for bipolar disorder or schizoaffective disorder, where impulsive behaviour including risky sexual behaviour may occur during a (hypo)manic episode.¹⁴ The lack of documentation in mental health clinical notes of advice to individuals treated for epilepsy with valproate may be secondary to the fact that mental health staff had not initiated this treatment, with evidence suggesting that clinicians are less likely to inform patients of medications adverse events if they have not initiated the particular medication

themselves.¹⁷ However, three individuals diagnosed with epilepsy described being advised of the risks of valproate by their mental health team, and it is probable that some participants additionally attained advice from other clinicians (i.e. neurologists, general practitioner) relating to the teratogenic risks of valproate. The provision of written information, and advice on appropriate resources that gives accurate advice in relation to the risks and benefits of valproate and precautions required with its use is suggested. Information recently produced by the National Clinical Programme for Medicine Management is one potential option in this regard.¹⁹

This study highlights the low rates of documentation of contraceptive use or advice regarding folic acid. Consultations with mental health staff (preconception consultations) in relation to the risks and benefits of continuation or discontinuation of medications, including for women diagnosed with bipolar disorder, have previously been demonstrated to influence both choices regarding conception and treatment.²⁰ This study suggests that such consultations, focusing on issues of conception and pharmacotherapeutic treatment, should be considered for all women of child-bearing potential (even if not in a significant relationship) who are prescribed valproate. NICE guidelines²¹ state that valproate should not be offered to women of child-bearing potential for either the management of acute mood episodes or the long-term management of bipolar disorder, and if already prescribed, should gradually be discontinued because of the teratogenic risks of valproate. Additionally, folic acid should always be prescribed to women of child-bearing potential who are prescribed valproate,²² with levels to be undertaken both before commencement of valproate and on a 6-monthly basis.

Limitations

This study includes a number of limitations, including that females of child-bearing age who were under 18 years old were not included. Findings were attained from one region in Ireland and may not be representative of other regions or other jurisdictions; however, many of the findings are consistent with those noted in other jurisdictions and thus may indeed be generalisable. Clinical notes from other practitioners, including neurologists and general practitioners (excluding correspondence from them as detailed in the mental health clinical notes), were not examined or available. Finally, the semi-structured interviews conducted were retrospective in nature, and thus potentially liable to recall bias. Recall bias may partly explain the discrepancy we found, where documentation detailing the teratogenic risk of valproate was noted but not recollected by participants. It is probable that other non-mental health service clinicians may have disseminated information relating to the risks of valproate; however, this was not evident on clinical interview and this study principally investigated documentation in mental health clinical records.

Semi-Structured Interview Topic Guidelines

1. Are you aware of any risks associated with the use of sodium valproate? Please list these risks. Please identify how you became aware of these risks.
 2. Are you specifically aware of any problems this medication has in relation to pregnancy and foetal development? What have you been told? Who told you? When were you told?
 3. Was your wish or likelihood of becoming pregnant ascertained before commencing therapy?
 4. Was contraceptive advice offered?
 5. Was use of contraception confirmed before commencing treatment?
 6. Was a pregnancy test done before commencing sodium valproate?
 7. Were you advised regarding the use of folic acid supplementation?

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1.5.82 The forgotten foundations: in core mental health services, no one can hear you scream

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date

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Abstract

The Five Year Forward View for Mental Health (FYFVMH) was a welcome development in the emerging 'Parity of Esteem' agenda, but focused mainly on a select few specialist services; much more limited attention was given to 'core' general adult and older age mental health services, such as community mental health teams, crisis teams and in-patient units. This relative policy vacuum, when combined with prolonged financial pressures and limited informatics, has left core services vulnerable and struggling to meet growing demands, with little sense of hope, in contrast to some of the newer, 'shiny' specialist services growing around them. Policy makers need to recognise the growing crisis and take action, ensuring that any sequel to the FYFVMH redresses this imbalance by clearly prioritising core services as the vital foundations of the larger whole-system. The potential benefits are huge and wide-ranging, but the harms of a second missed opportunity are perhaps even greater.

Declaration of interest

A.M. works in a National Health Service general adult community mental health team and is an elected member of the Royal College of Psychiatrists General Adult Faculty Executive Committee.

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- *The forgotten foundations: in core mental health services, no one can hear you scream*
 - *Front-line messages*
 - *What to do?*

The Five Year Forward View for Mental Health (FYFVMH)¹ is now halfway through its lifespan, with policy makers assessing its early effects and pondering the sequel. Perhaps the biggest effect was simply having a specific mental health version of a Five Year Forward View. The 'Parity of Esteem' (for Mental Health) agenda is still relatively young, with considerable gaps between rhetoric and action, but the existence of a mental health version helped keep early momentum going. This must now accelerate, but with new priorities much more explicitly focused on 'core' general adult and older age mental health services, especially community mental health teams (CMHTs), crisis teams and acute in-patient units. Historically, these central foundations of the wider system have been vulnerable to ongoing, quiet erosion by chronic underfunding and systemic structural disadvantages (e.g. block contracts). The FYFVMH, despite enabling progress in some areas of its specific focus, was a painfully missed opportunity to take a more whole-service approach; this must not be repeated. There were some core service aspirations in the FYFVMH, such as enhanced 24/7 crisis teams, elimination of acute out-of-area placements and development of community pathways, but these were weakened by a lack of clear targets and/or specific ring-fenced funding. Despite early winners in the first FYFVMH, there are still some long-neglected losers. Future service planning urgently needs to redress this imbalance; systems are only as strong as their weakest parts, especially if they are core foundational components.

Quantitative analysis is dogged by informatics challenges. Despite a plethora of information sources, each has its limitations and none tell the whole story on their own. The National Health Service (NHS) England FYFVMH Dashboard² is good in principle, but is inevitably focused on select areas of current policy, with minimal content on core services.

Other sources include NHS Mental Health Benchmarking Data, 'Fingertips' Public Mental Health Data³ and a raft of *ad hoc* reports such as the Commission on Acute Adult Psychiatric Care,⁴ the Carter Report on Mental Health Services⁵ and Care Quality Commission reports.⁶ A 2017 Royal College of Psychiatrists survey of front-line clinicians, regarding perceived progress on the Acute Adult Psychiatric Care Commission recommendations, highlights deep and widespread concerns (personal communication). Combining all these, along with front-line experience, is not an easy task for dedicated researchers and policy leaders, and is almost impossible for busy clinicians. When attempted, an information bias emerges toward those areas that already have a national focus, making it all the harder for those services outside the current policy spotlight to make a coherent case for inclusion. Key information on core services can be hard to extract and harder still to interpret, giving a rather foggy, delayed view of a complex, changing landscape, leaving them vulnerable to institutional neglect, and easy prey for under-the-radar cost-savings.

Figures for total spending on mental health services vary depending on source and definition, inevitably leading to confusion, claim and counterclaim; although clearly of some importance, what matters more to core services is the detail. Nevertheless, analysis by the Royal College of Psychiatrists⁷ suggests that, despite claims that spending 'is higher than ever', total income (in today's prices) received by English mental health trusts in 2016–2017 was 1% less than in 2011–2012 (Scotland, Wales and Northern Ireland were 6, 0.3 and 1.3% less, respectively). An analysis by the British Medical Association⁸ concluded that despite geographical variations, there appears to be no obvious uplift in spending in recent years, noting concerns that government commitments to increased funding are not reaching front-line services, and a significant number of English Clinical Commissioning Groups are not meeting the Mental Health Investment Standard set out by NHS England. With the size of the overall cake barely changing, but several new and specialist ('non-core') services significantly expanding with 'new' investment, it seems likely that actual funding available to core services has decreased. Regarding the detail, what numerical and narrative features can be discerned within the core landscape, e.g. from NHS Benchmarking and the various other reports?

Between 2012 and 2017 there was a 17% reduction in adult acute beds, a 36% reduction in older adult beds and a 10% decline in acute adult admission rates.⁹ Average length of stay decreased slightly in adults and increased slightly in older adults. Adult bed occupancy (excluding leave) rose from 91 to 95% and involuntary admissions rose from 25 to 35%. In 2016–2017, delayed transfers of care increased to 5.4% of occupied bed days, up from 3.7% the year before. An analysis by the British Medical Association found that during 2016–2017, there were 5876 acute adult out-of-area placements for mental health treatment, a rise of 39% on 2014–2015.¹⁰ In May 2018, around 600 acute adult out-of-area placements, costing £9 million per month, were needed each month (in England) because of local bed unavailability.¹¹

FYFVMH did include crisis teams aspirations: by 2020–2021, NHS England 'should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to acute inpatient admission'.¹ The latest monitoring (2016–2017) shows that only 23% of crisis resolution team services were able to meet selected core functions.¹²

The NHS nursing workforce has grown between 2010 and 2017, but the number of mental health nurses has declined by 12%,¹³ mostly within acute in-patient care as bed numbers have reduced, whereas the number of (mental health) community nurses has increased slightly. In generic CMHTs, overall staffing levels per population, perhaps surprisingly, seem to have been relatively stable in 2014–2017, although with some changes to the skill-mix. Before this, however, were at least 6 years of austerity, during which an unknown quantity of 'easy, low-hanging fruit' workforce cost-savings were likely made. Community case-load figures per population have declined slightly in the past 2 years: by 10% in older age CMHTs and 5% in working age CMHTs. Current data shows that for every 100 patients in community teams, there are only two qualified community psychiatric nurses. Generic CMHT referrals peaked in 2015–2016, but waiting times vary considerably and seem to be growing. More data (due October 2018) is needed to clarify trends, but the general sense is of CMHTs struggling to hold back the rising tide of demand in all its forms.

There are further complexities: many assertive outreach teams were reabsorbed into generic CMHTs (only 25% of trusts still reported assertive outreach teams/data in 2017), increasing CMHT clinical case-load intensity; how many of the staff also transferred is simply unclear. Vacancy rates are not benchmarked at all, whereas generic CMHT 'cost improvement savings achieved' are, remaining steady at 2–6% for most trusts. These were likely achieved, at least in part, by holding vacancies, which the King's Fund reports as currently about 10% across all mental health services;¹³ it also notes, 'trusts must deliver annual cost-savings, and a key area for achieving this is workforce management'. Generic CMHTs, without any national policy priorities, no targets to measure and no 'safer staffing' safeguards, will

remain highly vulnerable targets for ongoing cost-savings.

Looking ahead, the latest Health Education England mental health workforce planning for FYFVMH14 estimates that an additional 20 900 posts will be needed nationally (across all professions: qualified, support and admin, including 700 medical staff). However, the only core service mentioned is crisis teams (with no increase in medical staff); there is no mention at all of in-patient or CMHT services.

Capacity, however, is a complex concept, depending not just on workforce, but on a multitude of inter-related factors, including demand, productivity and influences from other systems. The raw numbers rarely tell the whole story; narrative is needed, and the clear message from the range of commentators is of ever-increasing pressures within core services that were already operating on, or at the margins of, full capacity. The Care Quality Commission notes ‘an unprecedented set of challenges – high demand, workforce shortages, unsuitable buildings and poor clinical information systems’.⁶ Other sources include 2017 NHS Mental Health Benchmarking, available via www.nhsbenchmarking.nhs.uk, which reports, rather ominously, that: “‘In recent years, concerns have been raised that the levels of community care have not risen as quickly as may be required to match the reduction in acute inpatient beds, and that provision may still not be at the levels needed... whilst safe staffing level requirements have benefitted the inpatient environment, unfortunately they have not helped staffing in the community whose responsibilities have increased in terms of caseloads and having to care for more unwell patients in community.’”

With that background, caveats and all, what would front-line clinicians in core adult mental health services like the policy makers to hear, and do?

Front-line messages

One answer comes forcefully from a 2017 Royal College of Psychiatrists survey of front-line clinicians, regarding perceived progress on the Acute Adult Psychiatric Care Commission recommendations (personal communication). It describes an ‘overwhelming consensus that the provision and quality of care is declining’, highlighting deep and widespread concerns over core services, including in-patient care, crisis teams and particularly CMHTs. There is a clearly perceived chronic and growing lack of service capacity, when matched to increasing demands (clinical, operational and regulatory).

The issues are familiar by now: raised clinical thresholds to enter services, and increasing severity and complexity within them; growing waiting times for CMHT care coordination; bed shortages and increasing use of the Mental Health Act 1983 (possibly linked to health inequalities for Black and ethnic minority groups¹⁵); increased acute out-of-area placements (<https://www.bma.org.uk/news/2016/october/plan-to-reduce-discharge-distances>); an increasingly stressed workforce and flagging morale.¹⁶ System changes compound the pressures, such as shrinking social care services and expanding roles like safeguarding. Attempted mitigation measures usually have a modest effect at best, whereas their unintended consequences can sometimes make things worse. Creative service redesigns have mostly confirmed that whatever the model, capacity (and probably continuity¹⁷) trumps configuration. Quality and productivity improvement activities, although clearly valuable, usually produce more gradual, longer-term gains, but too slowly to turn the current tide.

The FYFVMH simply did not take a whole-systems view of mental health services. Instead, it focused heavily on specialist areas such as liaison psychiatry, perinatal mental health, early intervention in psychosis services, child and adolescent mental health services, forensics and primary care psychological therapy. To their credit, these typically generated significant political attention through a clear and up-to-date evidence base (especially health economics research) or public attention via the media. In contrast, core severe mental health services seemed less newsworthy, less politically appealing and had a more limited, historical evidence research base (itself symbolic and symptomatic of long-term relative neglect). Yet it is precisely these core services where the vast majority of care for severe mental illness is delivered, forming the backbone and foundation of the whole service; if they are struggling, and overwhelming evidence and opinion suggests that they are, then the whole system will inevitably struggle too because sufficient capacity is needed in every part of the system.

Currently, the FYFVMH’s blind-spot over core services risks a lack of Parity of Esteem within mental health going undetected under the policy radar. Furthermore, early progress in many of the more specialist areas may become undermined because core and specialist services are inevitably linked and interdependent. Child and adolescent mental

health services patients grow up, with many still needing care; acute hospital liaison patients may be followed up in CMHTs; early intervention in psychosis often becomes ongoing intervention within a generic CMHT; perinatal care does not stay perinatal forever and acute mental health in-patient units and forensic services transfer patients both ways. Each recipient of specialist services should later be able to swiftly access quality care within a core generalist service, when needed, as should those who are referred straight from primary care, yet this is becoming more and more challenging, given the growing core pressures.

Finally, it is worth reflecting on why the core services, particularly CMHTs, currently feel so neglected. Historically (1990s), they were once the new expanding services, following the shift from asylums to community care, and they were considered progressive and attractive to work in. Around 2000, new investment was linked to new services (National Service Framework¹⁸ teams: crisis teams, assertive outreach and early intervention in psychosis), making these now the exciting teams to work in, with attention, enthusiasm and talent shifting away from the core CMHTs and in-patient wards.

Following the onset of austerity after 2008, alarm bells soon rang for the already drifting core, with senior clinicians noting that ‘demographic trends ensure that demand will rise and harsh economic realities dictate that resources will in real terms shrink’.¹⁹ Cost improvement plans inevitably followed, and rationalisation took place, with many assertive outreach teams merging back with CMHTs.²⁰ The search got underway for any new service configurations that might be inherently more efficient; they were not especially (as noted before²¹), at least not in the prevailing climate.

Finally came the paradoxical pairing of ongoing austerity and an emerging Parity of Esteem agenda, both within a confusing commissioning environment, hampered by immature information systems. Priority areas grew, with commissioners and senior managers more focused on newer, ‘shiny’ services, whereas the older core, typified by CMHTs and in-patient units, were quietly considered ‘fair game’ for ongoing cost-savings (typically 3–6% each year), systematically slicing them to part fund the newer services. This gradual shift of resources away from core areas went largely unreported, hidden by limited informatics, minimal relevant national core targets, a chronic accommodation to the growing clinical risks and a lack of media appeal. Much like their patients, most core services, and CMHTs especially, have quietly remained out of sight and out of mind, a no-show in the FYFVMH calls for evidence, and therefore not making the policy cut. Front-line core staff were optimistically exhorted, ‘We’ve always made annual cost-savings before, so we know we can do it again’. But as with most simplistic rules of thumb, it only works for so long, and up to a point. Like anorexia, there comes a time when further safe reduction is simply not possible. For many core services, that point was probably reached some time ago.

What to do?

Policy makers now need to publicly recognise the burgeoning crisis in core services. Any FYFVMH sequel must refocus policy more explicitly on CMHTs, crisis teams and in-patient care, rescuing, resuscitating and relaunching them all, along with improved information systems to support and monitor their regeneration.

There are glimmers of hope: the National Collaborating Centre for Mental Health ‘Mental Health Care Pathway: Community Mental Health Services’ project,²² nearing completion, arose from an FYFVMH recommendation to ‘establish comprehensive pathways and quality standards for the rest of the mental health system’. But it came with worrying limitations: they were last in line for development, waiting times were to be informed by clinical evidence (not targets), and they can be implemented as funding becomes available. Urgently addressing this wooliness would be a welcome start.

The potential benefits of reinvestment (and the risks of not reinvesting) are not limited to the core services, but extend to the whole wider system, even beyond mental health into general society.²³

For too long now core services have been allowed to struggle along in a relative policy, priority and informatics vacuum, through which only muffled cries have so far travelled. Please, finally and quickly, will someone see the signs, hear their voice and begin to restore the foundations?

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This book is the fruition of an idea by the author that has germinated since the 1970s. It was largely inspired by his concern with unfair discrimination against people with mental illness. From its evocative title to its thought-provoking review of 200 years of mental health legislation (both in the UK and globally), this is a book that should appeal to a wide audience. It has been deliberately written to include patients and family ('experts by experience') as part of a multidisciplinary audience. The fluent and conversational writing style, the purposeful use of 'typical' case histories, the text being well signposted with subheadings, and references being readily accessible at the end of each chapter certainly help in this respect.

There are two main themes – the use of coercion in mental health practice and an equally interesting bold and well-thought-out exposition of a proposed new mental health legislation termed a 'Fusion law'. This law is non-discriminatory and generic for all specialties, with no need for specific mental health law, the framework being based on decision-making capability and a modified best interests approach to involuntary admissions and treatment decisions.

The book has five parts and comprises 13 chapters. Part I considers problems associated with involuntary detention, which the author believes actually contributes towards discrimination against people with mental illness. Part II offers an exciting solution to involuntary detention and treatment and proposes in-depth new legislation. This part has a more theoretical or academic feel, but this is where the author elucidates and validates his proposed reforms. A visual flowchart of these reforms may have been helpful to help understand these better. The author does acknowledge that there would need to be some initial interim measures in the forensic setting were these reforms enacted. Part III analyses coercion and treatment pressures in everyday clinical practice and provides ideas to try and reduce recourse to coercive measures in both detaining and treating people. This part would be particularly useful for junior doctors of all specialties. Parts IV and V are about translating the theoretical basis of new reforms into the reality of clinical practice across all physical and mental health settings.

Given that mental health law has not fundamentally changed for around 200 years (essentially still being based on the two criteria of having a mental disorder and posing a risk of harm, but *not* including any form of capacity criteria) it would surely be an epoch-making quantum leap in mental health legislation to enact this Fusion law. However, the author opines that 'change is now essential' and is optimistic that such legislation favouring patient empowerment will continue to emerge globally, citing a version of Fusion law and its principles having been passed in the Northern Ireland Mental Capacity Bill 2016. This was an invigorating read, challenging the long-held orthodoxy of mental health law. It is a text that will surely resonate with all clinicians involved in the application of the Mental Health Act.

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1.5.83 Author reply

Philip Graham

date

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- *Author reply*

I quite understand Jennifer Smith's concern. It seems, on the face of it, silly to suggest that the age of consent be reduced when the great majority of people, including me, think it is unwise for adolescents to engage in full sexual intercourse at least until their late teens. But, once one has considered how the existing law is flouted, it no longer seems at all silly. The idea that changing the law will encourage 50-year-old men to seduce 14-year-olds rather than 16-year-olds seems highly improbable. The reality is that the best safeguards against premature sexual activity are those that emphasise much better sex education for children and young people who would thus be empowered to say 'no'. And lowering the age of sexual consent would allow parents and teachers to engage in imparting meaningful information earlier than is currently the case.

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1.5.84 Against the Stream: lowering the age of sexual consent

Jennifer Smith

date

2018-12

Contents

- *Against the Stream: lowering the age of sexual consent*

I read with unease the Special Article by Philip Graham in the August 2018 edition of the *BJPsych Bulletin*. His counter arguments seem insufficient. He argues that existing law has had no effect on young people's sexual behaviour over the previous 50 years, but doesn't take into account changing social, cultural and religious attitudes over that period. He references a survey of American school students who failed to cite the law as a reason for abstinence. However, conservative beliefs and promotion of abstinence before marriage are likely to be much more significant factors in the USA than in the UK. With respect to arguments about physical and physiological maturity, these seem largely irrelevant either way as these attributes bear no firm relationship to cognitive maturity.

Regarding cognitive and emotional maturity, while those aged 14 to 16 may be able to recognise the risks of sexual activity, as he points out himself, their ability to evaluate the risks can be compromised by other factors.¹ Life experience and perspective are also imperative when making potentially life-changing decisions; an extra two years in adolescence

is a significant amount of time. Graham's assertion that the law is unlikely to be used as a reason to refuse consent seems speculative, and even if only a small proportion feel empowered that is surely important.

In my opinion, the most worrying aspect of lowering the age of consent is the legalisation of adults of any age having sexual relationships with children under 16. Consider a 50 year old with a 14 year old; it is obvious that the power dynamic is unhealthy even if the person isn't in a trusted position. Worse still is the risk of greater difficulties in prosecuting cases of vulnerable children involved in prostitution, sex abuse rings or forced marriage.

We also have to consider children below 14. It is currently an offence for a person (A) aged 18 or over to intentionally engage in sexual touching of a child under 16. Where the child is aged 13 to 15, the prosecution must prove that A did not reasonably believe that he was 16 or over (Sexual Offences Act 2003). If the age of consent was 14, presumably prosecutors would have to prove that A did not reasonably believe that the child was 14 or over. Logically, that would likely lead to claims that people thought children under 14 were at or above the age of consent.

To address Graham's arguments in favour of lowering the age of consent, he himself points out that where both parties are below the age of consent there is little likelihood of prosecution. There is also no current reason that 14- to 16-year-olds cannot access sexual health services, as is made clear by the National Health Service (<https://www.nhs.uk/live-well/sexual-health/>). Similarly, sex education is already compulsory from the age of 11 (<https://www.gov.uk/national-curriculum/other-compulsory-subjects>).

In conclusion, I see no compelling argument to lower the age of consent; we should instead be taking inspiration from other countries like France that are strengthening their existing inadequate laws.

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1.5.85 Street triage services in England: service models, national provision and the opinions of police

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Abstract

Aims and method

Street triage services are increasingly common and part of standard responses to mental health crises in the community, but little is understood about them. We conducted a national survey of mental health trusts to gather detailed information regarding street triage services alongside a survey of Thames Valley police officers to ascertain their views and experiences.

Results

Triage services are available in most areas of the country and are growing in scope. There is wide variation in levels of funding and modes of operation, including hours covered. Police officers from our survey overwhelmingly support such services and would like to see them expanded.

Clinical implications

Mental health crises now form a core part of policing and there are compelling reasons for the support of specialist services. Recent changes to the law have heightened this need, with a requirement for specialist input before a Section 136 is enacted. Those who have experienced triage services report it as less stigmatising and traumatic than a traditional approach, but there remains little evidence on which to base decisions.

Declaration of interest

None.

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 - * *The views and experiences of police officers regarding street triage services*
 - *Discussion*
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Law enforcement officers routinely come into contact with members of the public who have mental health problems. In the UK, estimates of police incidents linked to mental health crises have increased over recent years.¹ Within England and Wales, Section 136 of the Mental Health Act 2007 allows police officers to detain people who are experiencing a mental health crisis and who are considered to pose a risk to themselves or others.² Although this measure may be unavoidable, it is often distressing, expensive and labour-intensive.³ In addition, police officers often feel that they lack the training to appropriately support those in mental health crisis.⁴

In response to the increasing use of Section 136, the Department of Health funded several regional pilots of street triage for mental healthcare in 2013.⁵ Triage models typically involve mental health professionals working in partnership with police officers, providing expertise through a telephone service or an in-person mobile unit.

More services have now been commissioned at a local and regional level by mental health trusts and police forces. The provision of triage services nationally, however, remains unknown and there is a lack of information regarding the operational models used. There is also no systematic information regarding police officer opinions of such services.

Recent changes to the Policing and Crime Act 2017 made it a legal requirement to consult, where practical, with a mental health professional before instigating a Section 136.⁶ Street triage schemes, whose primary function is to introduce mental health expertise during police incidents, may be ideally placed to do this. As mental health police partnerships become more vital at the point of crisis, information on service models will enable better planning of services to meet the requirements of the legal changes.

Our study aimed to determine the prevalence of mental health street triage services in England and to characterise their operational models. We asked whether services were predominantly mobile- or control room-based, how they were staffed, which vehicles and locations were used, the hours of operation and the reasons cited for use.

Our second aim was to systematically collect the views and experiences of police officers who have used services. We identified how regularly officers had contact with individuals experiencing mental health crises, whether they frequently used Section 136 and their confidence levels when dealing with mental health crises. We also asked whether police officers were aware of local street triage services, their preferences regarding their model and whether they found them beneficial.

Method

Survey design and samples

We conducted two surveys. Data were collected between June and October of 2017, using an online survey tool (www.surveymonkey.com). The first was a cross-sectional survey of all 55 National Health Service (NHS) mental health trusts in England.

The second was a survey of operational police officers in the Thames Valley police force. Thames Valley Police provide police services for 2.1 million people residing in Berkshire, Buckinghamshire and Oxfordshire. Street triage services have been available in the region since 2013 because of collaboration between Thames Valley Police and Oxford Health NHS Foundation Trust. The street triage service provides telephone support and a co-response mobile unit (where a police officer and mental health worker respond to incidents in a police vehicle) between the hours of 18.00 h and 04.00 h.

Both surveys met Health Research Authority criteria for a service evaluation and were approved by Oxford Health NHS Foundation Trust.

Procedure

For the NHS trust survey, letters were sent to every trust's Chief Executive. Non-responders were followed up twice when necessary, at 4 and 8 weeks. For the police survey, surveys were emailed to all response police constables and police sergeants employed by Thames Valley Police in September 2017, with responses collected until October 2017. A single reminder was sent out to all officers 2 weeks after the initial request.

Survey questionnaire

The surveys were constructed to address the primary and secondary aims of the project. The surveys took up to 30 min for participants to complete, and were conducted solely online. We collected demographic information and length of service for all respondents. The survey questionnaires are available from the corresponding authors upon request.

Results

Identifying and characterising NHS street triage services

Prevalence of street triage services

A total of 40 out of 55 (73%) mental health trusts in England responded to our survey. Of the 40 respondents, 28 (70%) offered street triage services. Of those that had services, the mean length of provision was 2.9 years, with wide variability from 6 months to 5 years of operation. Most areas reported that services had been available for 2–4 years.

Of those that did not provide a service, two (17%) had definite plans for introduction. Seven trusts reported having more than one street triage service, crossing different jurisdictions (police and/or social services) in their geographical area, giving a total of 41 street triage services represented in the survey.

Models of street triage

Eight out of 41 (20%) of the services described a telephone support only street triage service, 19 (46%) reported a mobile unit and 12 (29%) reported they had both means of response (*Fig. 1*). Two respondents (5%) did not specify. *Fig. 1* Reported frequencies of models of triage.

Staffing

A total of 28 out of 36 respondents (78%) reported their service was staffed by police officers and mental health staff, and eight out of 36 (22%) reported it was staffed by mental health staff only (a model in which mental health staff provide telephone support or attend police incidents after a referral from the police at the incident).

Services were overwhelmingly led by health staff (27 out of 41; 82.5%), although several services had police officers as lead (five out of 41; 12.5%) or a combined leadership model (six out of 41; 12.5%). One of the services (5%) did not have a designated lead. Two respondents (5%) did not specify. On average, there were 2.05 whole-time equivalent staff on duty per shift.

Vehicle and location

Of the 31 reported mobile services, ten (32%) used marked and 11 (36%) used unmarked police vehicles. Four (13%) used personal vehicles or ambulances and six (19%) respondents reported that they used a combination.

A total of 38 services reported on their main location for street triage services, with 28 (74%) services located at police stations and ten (26%) located at mental health sites.

Hours and days of operation

There was a wide range of reported hours and days of operation. Only three of the 28 trusts (11%) offered 24/7 availability, with the majority (79%) typically only providing night shifts (usually between late afternoon or early evening and a few hours past midnight).

Methods of contact

Street triage teams were contacted in a variety of ways, including 999 emergency operators (10%) and from the police control room (18%). The most common method, however, was a combination of means (72%), including 999 calls, control room, individual police officers and other emergency services.

Reasons cited for service use

Service providers gave a number of reasons for street triage call-outs: 98% (39 out of 41) reported that call-outs had been made for cases of self-harm and there were also high figures for other reasons, as shown in *Table 1*.

Reasons cited	Percent of respondents
Deliberate self-harm	98%
Previous mental health history	80%
Substance misuse	20%
Psychosis	50%
No alternative support available	10%
Support Section 136 decision-making	8% ¹

The views and experiences of police officers regarding street triage services

Demographic information

The police survey was sent out to 579 officers, of whom 264 responded, for a response rate of 45.6%. *Table 2* presents service and demographic results of respondents.

Characteristic	n	%
Gender		
Male	161	61
Female	94	36
Other	00	00
Prefer not to say	73	28
Did not specify gender	20	8
Rank		
Police Constable	74	28
Sergeant	47	18
Inspector	15	6
Police Community Support Officer	27	10
Other	52	20
Did not answer question	10	4
Department		
Response team	13	5
Investigation team	12	5
Neighbourhood policing teams	12	5
Did not specify department	10	4
Length of service		
Served <5 years	10	4
Served 6–10 years	69	26
Served 11–20 years	75	29
Served >20 years	18	7
Did not specify length of service	10	4

1

Percentages do not add up to 100% because of multiple responses per question.

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Mental health training

A total of 207 out of 256 (81%) of respondents reported they had received formal mental health training in the past 3 years, often in more than one form. Eight respondents did not respond. This training was generally mandated (181 out of 221 respondents; 82%).

Contact with mental health crises

A total of 87% (222 out of 255) of respondents reported regular (approximately every shift) face-to-face contact with the public, with 79% (202 out of 255) reporting weekly or more frequent contact with people in mental health crises; within this subset, 115 (45%) reported daily or more frequent contact (*Fig. 2*). Respondents reported that on average, four out of their past ten incidents involved mental health crises. *Fig. 2* Frequency of contact with members of the public with mental health problems.

Officers' confidence regarding mental health incidence varied: 71% (178 out of 252) reported they were at least fairly confident, whereas 10% (25 out of 252) described themselves as unconfident.

Awareness and use of street triage

Levels of awareness of the service were high at 97% (249 out of 256): 92% of respondents who answered this question had used street triage (234 out of 257) and 92% of these respondents described the triage service as helpful. Sixty per cent (145 out of 245) had used both mobile units and telephone support.

Respondents were further asked for their experiences of and preferences for the two systems. There was a clear preference for response in person, with 47% (68 out of 145) reporting this as being more helpful and only one respondent feeding back that telephone support was better. The remainder (52%; 76 out of 145) reported that both were equally helpful. A total of 98% of respondents (240 out of 245) overall felt that the service has been beneficial in the Thames Valley area and 71% (173 out of 245 respondents) felt that it should be available 24 hours a day.

Use of Section 136 and interactions with street triage

More than half of respondents had used Section 136 of the Mental Health Act 2007 (58%; 146 out of 251) and only 52% of those using the powers (76 out of 146) had involved the street triage service in the process. The most common reason cited was the unavailability of the street triage service because of hours of operation or other demands on it (83%; 58 out of 70).

Officers' free-text responses and feedback

Sixty respondents made comments in the free-text section, with 58 (98%) commenting that the service was highly beneficial. Officers noted that the service was 'long overdue' and 'one of the best decisions made by Thames Valley Police and NHS in recent years'. One officer directly commented on its necessity: '[Mental health] is a specialist area and police officers are not mental health specialists'. Additional reported benefits included saving police time and reducing stigma.

Many stated that they wished that the service was available 24/7 or at least extended hours. One officer wrote 'the only downside is that it is not already a 24-h service'. Additional comments referenced the lack of availability of child mental health workers and social workers, as '[police officers] seem to come across a lot of younger people with mental health issues too'.

Discussion

These surveys are the first attempt to characterise street triage services nationally since the launch of the pilot projects in 2013, and to get a detailed snapshot of police attitudes toward them. It is clear that street triage services, although still a relatively new model of care, are now widespread across England. They have continued to expand in spread and scope since their introduction, understandably given the increasing contact between police officers and those with mental illness. This is also reflected in the changes to the Policing and Crime Act, which will necessitate better police–mental health interagency collaboration;⁶ street triage is best prepared to fill this gap in service.

Our National NHS survey highlights significant variations in street triage models. Hours of operation vary, although usually with an emphasis on evenings, night-times and weekends, with little or no cover during the daytime. Levels of investment vary substantially and are reflected in staffing numbers and types of model; a mobile in-person response is inevitably initially costlier than telephone support. However, the former service is more valued by officers and may be more effective at freeing up police time and allowing for appropriate interventions, and as a result may be more cost-effective. We simply do not know. Future research must concentrate on what the effective elements of street triage are that improve patient experience, reduce ‘wasted’ police time and improve outcome in terms of health use, functioning and criminal justice interactions.

Most services are located on police premises, but are led by NHS staff. This may be appropriate in the short-term, but there needs to be consideration of whether a merger of personnel would be more effective. There is similar lack of clarity in many funding models, with the key question being ‘who should pay for these services?’. We did not specifically explore this in our study, but opinions seem to differ between the three main agencies concerned (the police, health and social care). A hybrid funding model involving the interested parties would likely be most appropriate but this requires negotiation and thought; in these austere times this will not be easy. Future work to determine how to best navigate such financial and institutional barriers to interagency cooperation between the police and health sector is needed.

Police officers from our survey are overwhelmingly supportive of street triage. There was a clear preference for services to exist and to be provided in-person. There was strong support for 24/7 services. There was a high frequency of responding to mental health incidents described by participants, supporting the view that mental health work is now ‘core police business’.⁷ This underpins the need for triage services, heightened by recent changes to legislation that require officers to seek qualified mental health advice before using Section 136, rather than seeking guidance retrospectively.⁶ As mental health crises occur at any time of the day, it was not surprising that the majority of officers in our survey believed that street triage should be available 24/7. Longer hours of operation, more integration and a higher profile may help to improve the training and confidence of officers.⁸ We do not know whether face-to-face triage is more effective than telephone triage. Only one previous study has compared these models.⁹ Their analysis suggested that a face-to-face model can reduce the overall use of Section 136 and increase the proportion resulting in hospital admission, while the telephone-only service did not.

Limitations

Both surveys may include some selection bias, in common with any survey of this type. However, the respondents in our police survey were fairly large in number, there was a reasonable response rate and they appear representative. Our national NHS survey achieved an excellent response rate of 73%, unusually high for such a survey and likely to be protective against selection bias.

Implications

In conclusion, street triage services are widespread across England and increasingly seen as a permanent part of our response to mental health crises. Despite this, models vary significantly and there is little or no evidence on which to base good practice or commissioning decisions. Outcome data is almost non-existent. Our surveys show a clear appetite for services to exist and to be strengthened. Recent changes to the Police and Crime Act will almost certainly stimulate this, with officers being required to seek advice in real time. Public concerns regarding civil liberties and the unacceptable cases of people being stranded in police cells while arrangements are made also make the case that mental health expertise during these crises is vital.

However, the increase in use of street triage will require greater resources and further investment. Questions should be asked as to how services can be organised most effectively and efficiently and how they can most benefit those experiencing mental health crises. Evidence is urgently needed regarding the effects of street triage services and, crucially, what elements of the service are effective in reducing risk and improving outcome. Future studies could also investigate mental health staff or patients' perceptions regarding the quality of triage care.

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1.5.86 Even more against the stream

Lachlan Campbell

date

2018-12

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- *Even more against the stream*

We all know the law is an ass, but when it comes to defining an age of consent it is more like a badly assembled chimera. You can become criminally responsible at the age of 8 or 10, liable to criminal prosecution from the age of 12, legitimately have sex at the age of 14 while on holiday in Germany, join the Army at 16 and perhaps later die for your country, vote and purchase alcohol or cigarettes at the age of 18, but not hire a car until the age of 25. What an Alice in Wonderland world we live in! Logic would suggest a similar age for all of these activities, perhaps with some allowance for variation justifiable by the extent of risk involved.

The appropriate legal age of sexual consent is not immediately obvious. However, as sexual intercourse with a child under the age of 13 amounts to statutory rape, this might provide a logical starting point. Incidentally, when I last checked, the lowest age of sexual consent in a European country was actually 12 (in Vatican City, somewhat ironically).

Of course, in reality, the limited availability of parliamentary time will make a logical alignment of the various ages for consent a complete non-starter. So perhaps a better question is 'Why have an age of consent at all?' This allegedly offers protection but in reality mainly just criminalises a substantial proportion of the juvenile population and potentially even criminalises an underage victim of a sexual assault. Surely criminal responsibility should only rest with the perpetrator? In this scenario, a perpetrator would commit a crime if, and only if, a sexual act occurred in the absence of consent,

and not simply by reason of some arbitrary age. Can we not trust our children to reach their own decisions and just make consent, or rather lack of consent, the sole reason for engaging criminal law?

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1.5.87 Men in eating disorder units: a service evaluation survey regarding mixed gender accommodation rules in an eating disorder setting

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2018-12

Abstract**Aims and method**

This service evaluation was conducted to find out: (1) if mixed gender accommodation in eating disorder units is perceived to be helpful or unhelpful for recovery, and (2) if men were being discriminated against by the implementation of the 2010 Department of Health (DoH) guidelines on the elimination of mixed gender wards. All 32 in-patient units accredited on the Quality Network for Eating Disorders were contacted via a survey.

Results

We received 38 responses from professionals from 26 units and 53 responses from patients (46 female, 7 male) from 7 units. Four units had closed admissions to male patients due to DoH guidelines.

Clinical implications

We found that it is possible to provide admission for men with eating disorders, while respecting the single gender accommodation rules, and that doing so is likely to be helpful for both genders and prevents discrimination against men.

Declaration of interest

None.

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- *Men in eating disorder units: a service evaluation survey regarding mixed gender accommodation rules in an eating disorder setting*
 - *Method*
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 - * *Patients*
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In 2010, the Department of Health (DoH) set guidelines for all hospitals to eliminate mixed gender wards to preserve privacy and dignity for patients.¹ In specialist eating disorder services, all-male wards do not exist due to the low prevalence of the disorder in males compared with females. This leads to the paradoxical situation where men have difficulty accessing an eating disorder bed under these DoH guidelines. Some hospital trusts have modified their accommodation or procedures in light of Care Quality Commission (CQC) guidelines set by the DoH to accommodate men; however some have had to close admissions for male patients as the trusts believed they would be fined for breaching single gender accommodation rules.

Anecdotally, there has been positive feedback from having men in eating disorder wards: they provide a less competitive atmosphere, a different perspective in group treatments and reduce the institutional nature of the environment. A survey performed by Mezey *et al*² in a medium secure forensic setting found similar results, where most female patients preferred to be among male patients. A small qualitative study interviewed male in-patients with eating disorders and one participant said that eating disorder is ‘gender-excluding as a disorder’ and ‘reasons why you get there are probably slightly different but in the end all roads lead to Rome’,³ suggesting that the same treatment applies to both genders. There has yet to be any evaluation of patient perceptions on mixed versus single gender environments in an eating disorder setting. We therefore collaborated with National Health Service England to conduct a service evaluation survey, gathering information from patients and professionals.

Method

All 32 in-patient units accredited on the Quality Network for Eating Disorders (QED) in the UK were contacted via email, using an electronic survey (Supplementary Appendix 1 available at <https://doi.org/10.1192/bjb.2018.51>). The individuals contacted were those registered on the QED network and included consultant psychiatrists, psychologists, senior nurses and occupational therapists. The survey for the professionals asked for feedback on three themes: (1) if they were a single or mixed gender unit and how they arranged the ward to accommodate both genders; (2) if the trust, commissioners or the CQC had ever commented on or stopped admission of male patients; (3) if the professional had any views on recovery of patients in same or mixed gender environments.

The third point was conducted by asking positively and negatively framed questions with a five-point Likert scale and mean scores were then calculated. The points ranged from 1 for strongly disagree to 5 for strongly agree. A ‘free comment’ box was placed at the end for added opinions.

In-patients were asked to provide feedback on their experience of single or mixed gender environments and similar scores were then calculated (Supplementary Appendix 2). Male patients had extra questions to complete. Data were

collected between October 2016 and August 2017.

Results

Professionals

A total of 38 eating disorder professionals registered on the QED network responded from 26 different units across the UK. Six of these units did not admit men: three of these units had stopped admitting men after a CQC inspection and one had been advised similarly by Health Improvement Scotland. *Figures 1 and 2* show the responses to questions on perceptions of mixed gender wards. In general, professionals thought that mixed gender units carried more benefit than harm to patients. There was a general agreement that eating disorder units should be mixed gender wards (mean score 4.37 out of 5) and that it was easy to ensure safety and dignity in mixed gender wards (4.11). Most did not think that mixed gender wards discriminated against women (1.63), nor did they think that having one male patient was detrimental to that man's care (1.71). There were mixed responses about whether it has been difficult to find a bed for male patients since the single gender rule was introduced (3.24). *Table 1* highlights some comments that were provided in the free-text box. *Fig. 1* Survey for professionals: positively framed questions. *Fig. 2* Survey for professionals: negatively framed questions. *Table 1* Comments by professionals in the free-text box

Themes
Response from professionals
Is mixed gender accommodation helpful in eating disorder units?
On the whole we have found having a male on the unit quite refreshing and beneficial to both client sexes... We have only had a small number of males admitted to the unit but on the whole our experience so far is positive.'

'Mixed sex units for ED are a necessity. Both sexes benefit from having the other gender on the ward. ED units attempt to support individuals in recognising what is "normal" this includes being in an environment with members of the opposite sex.'

'We tailor our groups to accommodate the needs of all patients, and dynamics that arise around gender, as with any other issue, would be explored through the group process and in community group settings where appropriate.'
Are men being discriminated against due to single gender accommodation guidelines?
The concern seems disproportionate and the impression is that the response from CQC varies dependent upon the individual assessor on the day.'

'I believe it could be quite tricky to manage the issue of having different corridors for male and females especially if you are not a purpose built unit. The feedback from males during their stay is they prefer to be included in the group as it often makes them feel awkward and isolated from peers.'

'There needs to be some work done to alleviate blanket rules around single sex wards. Some elements ought to be ward or unit specific.'

Patients

A total of 53 patients (46 female, 7 male) from 7 eating disorder units responded to the survey. Three of these surveys were partially incomplete; however the scores and comments that were provided have been included in the results. A total of 49 participants (92%) had experienced admission on a mixed gender unit and 29 (56%) had experienced both single and mixed gender environments. *Table 2* shows the distribution of services from which the patients responded, although many had experience of admission at a variety of other centres. *Table 2* Sources of responses
Eating disorder unit
Number of responses
Vincent Square Eating Disorder Service, London 23
The Haldon Eating Disorder Service, Exeter 15
The Priory Hospital, Chelmsford 9
Specialist Treatment for Eating Problems (STEPS), Bristol 3
Kimmeridge Court, Dorset Healthcare Services, Dorset 1
The Retreat, York 1
West Park Hospital, Northern Centre for Eating Disorders, Durham 1
Total 53

Figures 3 and 4 shows the attitudes from patients towards mixed gender accommodation. Most patients agreed that men were being disadvantaged (75.5%). Nearly the entire patient group (98%) answered positively or neutrally to whether having a mixed gender accommodation was helpful for their recovery. A total of 45 participants (85%) gave a similar (positive or neutral) response to 'I've learnt helpful things about myself by having male patients'. There were minimal safety issues noted, most participants (75.5%) disagreed to being 'intimidated by male patients on the ward'. *Fig. 3* Patients' responses scoring above 3 (neutral). *Fig. 4* Patients' responses scoring below 3 (neutral).

Figure 5 shows the responses from the seven male patients. Of these, six agreed to the statement 'I don't mind if I'm the only male patient on an eating disorder ward' and five agreed to 'As a man I feel accepted on a mixed gender ward'. Six men said that they would not want to be treated on an all-male ward if it were far from home. Fig. 5 Perceptions from male patients.

Of the 41 patients who wrote in the optional free-text box (see Table 3), 36 (88.8%) were in favour of having a mixed gender unit. Many voiced that having a 'mixed unit is reflective of the outside world' and that mixed wards were 'healthy for dynamics' and 'reduces competitiveness'. A male patient thought it was 'crucial' to his recovery that he was on a mixed gender ward and believes his presence 'was a benefit to others on the ward'. Only three participants (8%) had negative feelings towards this (one male, two female); however both female patients with this opinion had not experienced a mixed gender eating disorder ward. The male patient voiced strong concerns about feeling 'isolated and slightly intimidated' as the only man because 'many groups were geared towards females'. Table 3 Comments by patients in the free-text box Themes Response from patients In favour of having mixed gender wards 'Mixed unit is reflective of the outside world.'

'Having a male upon the ward allowed me to see from a different perspective during therapy groups which helped me to understand the illness from this kind of viewpoint and hence supported my treatment.'

'All female wards can be stifling and very competitive.'

'I feel sure that had I been forced to be on an all-male ward that I would have found it much harder. I also believe that my presence as a man was a benefit to the others on the ward.'

'I think it's not a problem having male patients on the ward too. It's not fair to restrict their treatment options.' In favour of having single gender wards 'I see that there will be fewer wards for men which is unfair but also there is a percentage of women with eating disorders who have PTSD or have suffered from sexual abuse that need to be taken into account.'

'Many groups were very geared toward females and I have often felt isolated and slightly intimidated in both units. I have often felt that my recovery, or lack thereof, has been in part not helped by being the only male in treatment at in-patient units, although I would still rather be the only male than have no treatment or community based treatment only which for me is ineffective.'

Discussion

The results show that the majority of both patients and staff believe mixed gender units work just as well as, if not better than, single gender units for patient recovery in both genders. Some of the original thoughts behind segregating the genders, such as having to dress differently or having separate lounges, were not deemed very important by the patients. Unfortunately we confirmed that a handful of units have closed to male admissions due to interpretation of DoH regulations. Drawing parallels from the study by Mezey *et al*,² it may be that due to the long-stay nature of the ward and treatment duration, having a sense of normality and the reduction in competitiveness by having a mixed gender unit helps to provide a more therapeutic setting. This survey suggests that both professionals and patients believe that eating disorder wards should be open to males, and that patients will have a better recovery journey as a result of the mixed gender environment. We hope that research will now follow to better understand the risks and values of a mixed gender treatment environment.

Recommendations

With the support of QED, clarity was sought about how the DoH single gender guidelines apply to settings such as eating disorder services. The following guidance has been approved by the CQC as entirely consistent with the DoH single gender accommodation guidance and should make possible male admissions to every in-patient eating disorder service: •A risk assessment has been carried out to ensure that the male patient does not pose a specific risk to female patients. •There is an agreement in place with National Health Service England commissioners on the admission of male patients and the admission is consistent with this agreement. •Appropriate arrangements have been put in place to ensure that female patients do not feel unsafe or compromised in terms of privacy. •Male patients are accommodated in single bedrooms with en-suite bathroom and toilet facilities, if possible. •If this is not possible, male patients occupy a single room with use of male-only bathroom and toilet facilities. •Patients do not have to walk through a sleeping area or a bathroom occupied by another gender. A sleeping area is a bedroom or a bay of beds. Men can walk through a corridor, off of which there are doors to female bedrooms and bathrooms, to access a male bathroom. •A women-only day room is available.

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Supplementary material

For supplementary material accompanying this paper visit <http://dx.doi.org/10.1192/bjb.2018.51>.

[click here to view supplementary material](#)

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1.5.88 Dhirendra Nath Nandi, FRCP (Edin.) FRCPsych

Parthasarathi Nandi

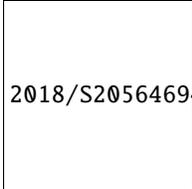
date

2018-12

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- *Dhirendra Nath Nandi, FRCP (Edin.) FRCPsych*

Formerly Psychologist, Psychoanalyst and Psychiatrist



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Dhirendra Nath Nandi, who passed away quietly aged 98 on 26 March 2017, was Head of the Department of Psychological Medicine at the University of Kolkata and a prominent leader of Indian psychiatry. Assisted by a team of several postgraduate students, he carried out significant epidemiological research in different tribal groups in villages of West Bengal. His research findings, which included important longitudinal data, were published not in just Indian but several British and US journals. One important finding related to a dramatic fall in hysterical and anxiety disorders with an equal rise in affective illnesses.¹ His papers were used as standard texts in several educational programmes.

Professor Nandi had a strong interest in raising public awareness of mental health problems. He organised several public awareness programmes on his own and with the Indian Red Cross Society in different parts of Kolkata and other districts of West Bengal. He was frequently invited to be a speaker on various television shows and radio programmes to talk about mental health. In 1990 he wrote a book in Bengali on psychiatry, *MonerBikar o Pratikar*, which was very popular with the general public, and postgraduate students in psychology and psychiatry. In the later years of his life, he founded the Girindra Sekhar Institute of Psychological Education and Research, where he started a counselling course affiliated with a recognised university of West Bengal for graduates in basic and social sciences. He also established a popular quarterly journal in Bengali, *Moner Katha*, as well as running an out-patient clinic for the poor and underprivileged mentally ill, which retains its reputation to this day.

Born on 13 August 1918, in a remote village of a district of West Bengal to a poor family and losing his mother in his early childhood, Dr Nandi showed early promise in his studies. He struggled considerably in early life but showed indomitable energy in the pursuit of knowledge in medicine and psychology. After graduation from Carmichael Medical School, then the R. G. Kar Medical College and Hospital, Kolkata, in 1945, he obtained an MSc in psychology in 1950, and a PhD in psychology in 1958 from the University of Calcutta. He trained in clinical psychiatry and psychoanalysis with Professor Girindra Sekhar Bose, the eminent psychiatrist and founder of psychoanalysis and psychiatry in India, and with Professor N. N. Dey, his own maternal uncle and first editor of the *Indian Journal of Psychiatry*. He began his career in 1948 as a teacher, examiner and researcher in physiology at NRS Medical College and Hospital, Kolkata, where he worked for nearly 10 years.

Marrying in 1949 into a business family, he went abroad in 1960, leaving his wife and three children in Kolkata with his in-laws. He obtained his Scottish Diploma in Psychological Medicine in 1961 and became a Member of Royal College of Physicians (Edinburgh) with a special paper in psychiatry in 1963. In those days, there was no postgraduate training in psychiatry available in India. Returning to Kolkata he was appointed Associate Professor of Psychiatry at R. G. Kar Medical College and Hospital, Kolkata. In 1970 he became Head of the Department of Psychological Medicine at the University of Calcutta. He retired in 1979 as Professor of Psychiatry from R. G. Kar Medical College and Hospital, Kolkata. During his professional life he held a number of important positions in Indian psychiatry, including being President of the Indian Psycho-analytical Society for more than 20 years, and President of the Indian Psychiatric Society and Indian Association of Social Psychiatry. His contributions to the advancement of the fields of psychiatry and psychoanalysis were recognised by numerous awards and prizes.

Professor Nandi had an active interest in cooking, fishing and hunting, and travelled widely with his family and friends. It is noteworthy that his two sons are consultant psychiatrists, his daughter and younger daughter in-law are psychoanalysts, one grandson is undertaking a post-graduate degree in psychiatry, a second grandson is a graduate in medicine, and a third is a final-year medical student.

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1.5.89 The Risk Reference Panel: a thematic analysis of a multidisciplinary forum for complex cases

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date

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Abstract

Aims and method

To describe the functions of the Aneurin Bevan University Health Board Risk Reference Panel and characterise the typical referrals presented and outcomes from the panel. A structured thematic analysis was performed on verbatim transcripts of 48 panel sessions.

Results

The 79 codes identified were grouped into 16 subthemes. Four principal themes were identified: two characterising cases brought to the panel (childhood risk factors and current presenting difficulties) and two describing advice given (risk management and wider organisational issues). Quotations are given to illustrate cases presented and advice given by the panel.

Clinical implications

The panel provides a valuable source of special expertise in the management of complex and exceptional cases where risk of harm is significant and clinical teams have ongoing concerns. This paper describes a model of peer-working to support staff and may further reduce the risk of harm associated with mental illness.

Declaration of interest

None.

Contents

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Background

The assessment and management of the risk that a patient poses to themselves and others is a core duty for psychiatric services. There are several ways in which this is achieved, depending on the complexity of the case, the configuration of local services and resources available. In many cases, issues around risk are managed effectively by individual practitioners or teams on a day-to-day basis, using evidence-based guidance from national bodies such as the Royal College of Psychiatrists¹ or the Department of Health,² as well as locally agreed policies and procedures and clinical supervision. However, in some circumstances the risks posed may be exceptional or unclear, and individuals can engage in high levels of self-harm or antisocial behaviour. This can be analysed retrospectively by complex case reviews to reduce risk of recurrence,³ but prospective prevention or minimisation of harm is clearly preferable.

The Risk Reference Panel

Multidisciplinary working is a key strategy for particularly risky cases, which can take various forms. From 2008 the Aneurin Bevan University Health Board Risk Reference Panel was developed by Dr Alan Wright, Forensic Psychologist, and author I.E., Forensic Psychiatric Nurse, as a local response to the public and professional anxiety surrounding exceptionally risky cases. The panel is intended to provide a pool of multidisciplinary expertise with representation from social work, nursing, forensics, intellectual disability and general adult psychiatry. To date, the panel has not included patient representation, but this could be considered in future. This paper offers an analysis of a way of addressing risk and management of complex cases by describing the types of cases that have been presented and the outcomes of panel meetings. A retrospective thematic analysis of the meetings was conducted.

Method

Thematic analysis

Our aim was to describe the typical cases presented to the panel, the discussions that took place and the advice given. To best produce this narrative from the data available, we felt a qualitative approach was appropriate. We required a method of qualitatively analysing transcribed data, such as the meeting transcripts that formed our data-set, and decided on thematic analysis. This provided a framework with which to identify and organise the discrete ideas within the transcripts, outlining patterns in the data but also indicating their relative frequency within the meetings as a whole.

Although qualitative research uses many specific, prescribed techniques to evaluate non-empirical data, there has historically been some discrepancy as to what strictly constitutes thematic analysis and its methodology. For our purposes, we have followed the model proposed by Braun and Clarke,⁴ which describes six discrete stages of thematic analysis.

The stages of the above method as applied to our analysis are described in the Appendix.

Discrete ideas (referred to in the process as ‘codes’) and broader groupings of these ideas into key patterns (‘subthemes’) were identified. The subthemes can then be grouped together to identify the main themes within the data.

Data collection

The Risk Reference Panel meetings are attended by a secretary who records what is said by typing verbatim as far as is possible; there is no audio recording of the meetings. These transcripts are then used to produce letters to the referring team, outlining what was discussed and the recommendations of the panel.

A pilot analysis was conducted whereby authors A.T. and G.J. independently applied the method described below to a sample of original transcripts for 8 of the 48 cases that had been presented to the Risk Reference Panel between May 2010 and April 2016. Ethical approval was not required as our study is a retrospective service evaluation where no change to the service was implemented and no service users were interviewed. All reported data are anonymised. Anonymised samples of the transcribed data, as well as examples of the codes generated from them and how they were recorded, are given in *Boxes 1* and *2*. Box 1 Sample transcription and coding process '... [I] can count on one hand how often [she's been] seen, very difficult to engage¹⁹, [she] abuses drink and drugs³⁶, chaotic lifestyle, she has several relationships with different men³⁵... [The house] is a very dangerous place to visit.'¹⁹ Lack of engagement/difficult to engage

³⁵ Vulnerable adult

³⁶ Substance misuse issues '... in the first instance, refer to [Learning Disability Consultant]⁷⁰ as it was recognised that [he] needs to be embedded in LD services, [but] it was suggested that LD services will not accept responsibility for his care ... [they] should be contacted regarding the interface between the relevant services⁷⁸.'⁷⁰ Refer to specialist

⁷⁸ Funding/responsibility issues '... it sounds like it's taking quite a toll on [his] CPN, what support is there for her⁷⁶? In these cases rotation of staff⁷⁷ can be helpful in preventing burnout and getting a fresh perspective on things.'⁷⁶ Extra support for staff involved

⁷⁷ Suggest rotation of staff Box 2 Box 2 Sample of code database Code G.J. frequency A.T. frequency Total frequency Theme Subtheme History of being in care 21311 Aggressive as a child 12312 History of sexual abuse 561113 History of neglect and witness of violence and physical abuse 951413

The pilot analysis generated an initial list of codes that were used as the basis for coding the rest of the transcripts, as well as demonstrating an acceptable consensus on what constituted individual codes. The remaining 40 transcripts were then coded, 20 each by authors A.T. and G.J., and the frequency of codes were recorded. The resultant database allowed the rest of the thematic analysis to be completed. A thematic map provided a diagrammatic representation of the various themes, subthemes and relationships between them (*Fig. 1*). Fig. 1 Thematic map of Risk Reference Panel meeting transcripts. CJS, criminal justice system.

A feedback form allowed participants to indicate, via a Likert scale, the degree to which they agreed with a number of statements (outlined under 'Feedback' within Results) and to provide free-text feedback.

Results

Using this method, 16 subthemes were identified to group similar codes. The subthemes were further grouped into four principal themes: childhood risk factors, current presenting difficulties, assessment and management of risk to self or others and team or wider organisational issues. The first two themes encapsulate information presented to the panel during presentations by referrers; the latter describe recommendations made or issues identified by the panel.

The subthemes are organised by frequency of codes, referred to hereafter as occurrences, with absolute frequencies (i.e. the number of times a code occurred in the whole of the transcribed data, given as *n*) and the proportion of occurrences within that theme (given as a percentage). Percentages are rounded to the nearest 0.5%. There were a total of 522 occurrences of codes throughout the 48 transcripts analysed.

Childhood risk factors

The first theme contains codes pertaining to the history of the case, outlining risk factors pertinent to the current problem. There were four individual codes that accounted for 31 of the 522 occurrences (i.e. 6% of all occurrences). These were primarily adverse experiences that the person had endured in childhood, but also included childhood traits that are associated with subsequent antisocial behaviour.

The most common childhood adverse experience was being a victim of physical abuse ($n = 14$, 45% within theme) or sexual abuse ($n = 11$, 35%), followed by having been in care ($n = 3$, 10%). A history of aggressive behaviour as a child was also identified in a number of individuals ($n = 3$, 10%).

Current presenting difficulties

This theme accounted for the greatest proportion of individual codes, with 245 occurrences (47%). Five subthemes were identified within current presenting difficulties, namely nature of offences, problematic behaviour, factors affecting current presentation, police/criminal justice system involvement and established diagnoses.

The nature of offences subtheme explored the various types of offences committed, if applicable (only some of the cases presented had criminal convictions, hence their low frequencies). The offences captured in the transcripts included arson ($n = 3$, 1%), non-assaultive sexual offences ($n = 3$, 1% within theme), threats to kill ($n = 1$, 0.5%) and sexual assault (1, 0.5%).

The most common problematic behaviour was suicide attempts/self-harm ($n = 32$, 13%), which was often seen to be chaotic and instrumental. However, there were several cases where severe self-harm without suicidal behaviour was the primary problem. The next most frequent was a lack of engagement with services ($n = 19$, 8%). The remaining codes within the problematic behaviour subtheme were sexually inappropriate behaviour ($n = 7$, 3%), antisocial behaviour ($n = 7$, 3%), disruptive behaviour ($n = 6$, 2.5%), harassment of care-giving staff ($n = 6$, 2.5%), multiple contacts by phone ($n = 6$, 2.5%), absconding risk ($n = 6$, 2.5%), complaints to health board/Welsh Assembly Members/counsellors ($n = 5$, 2%), false allegations ($n = 4$, 1.5%) and litigation ($n = 1$, 0.5%). Although the most prevalent individual code was risk of self-harm or suicide, the combined frequency of codes relating to risk to others was around 1.5-times as high.

Another subtheme was factors affecting current presentation, which captured issues in the person's life at present that were affecting their level of risk. Substance misuse was the most prominent among these ($n = 27$, 11%). Other codes within this subtheme were chronic pain/illness/physical issues ($n = 7$, 3%), social isolation ($n = 7$, 3%), multiple admissions to psychiatric hospital ($n = 7$, 3%), homelessness/moving area frequently ($n = 6$, 2.5%), family history of mental health issues ($n = 5$, 2%), admissions under the Mental Health Act ($n = 5$, 2%) and lack of insight ($n = 5$, 2%).

Less commonly, people had problems with anger ($n = 3$, 1%), bereavement ($n = 3$, 1%), sexuality ($n = 3$, 1%) and personality traits without a diagnosis of personality disorder ($n = 2$, 1%). There was police involvement in nine cases (3.5%) and the person was subject to the criminal justice system in 15 cases (6%).

Most of the cases presented to the panel had an established diagnosis, although within the 60 code occurrences in this theme, 'conflicting/unclear diagnosis' occurred 13 times (21.5%). These subthemes grouped the diagnoses by psychopathology.

'Developmental disorders' were the most common presentation and included autism spectrum disorder ($n = 8$, 13%), intellectual disability ($n = 5$, 8%), attachment disorder ($n = 5$, 8%), 'Special needs' ($n = 3$, 5%) and attention-deficit hyperactivity disorder ($n = 3$, 5%). Emotionally unstable personality disorder (EUPD) was the only specified personality disorder diagnosis ($n = 9$, 15%) and the most common individual pathology. This was followed by psychotic illnesses, with 'treatment-resistant psychosis' accounting for seven cases (11.5%). Schizophrenia was only given as a named diagnosis in one case (1.5%). Lastly, affective/anxiety disorders included depression ($n = 3$, 5%), eating disorders ($n = 2$, 3%) and post-traumatic stress disorder ($n = 1$, 1.5%).

Risk assessment and management

There were 31 occurrences of codes (6%) related to an assessment of the level of risk posed to others by the individual. Three of these (9.5% within theme) were an observation that there was a poor understanding of the risks posed and that specific further information was required.

Much more of the output from panel meetings was regarding the management of specific risks to the person or others, with 95 code occurrences. Within this theme, four subthemes were identified: need for further assessments, specialist care plans, capacity/placement factors and responsibility of other services.

Most commonly, the panel advised that specific assessments would be beneficial to manage risk. In disorders that modulated risk, such as autism spectrum disorder, the panel would often suggest 'expert/specialist opinion required' ($n = 17$, 18%). If the risk was more general, then suggestions of which avenues to pursue included a need for HCR-20 (Historical Clinical Risk Management-20; an established actuarial tool for assessment of violence risk) ($n = 3$, 3%); legal advice ($n = 4$, 4%) and a need for more background information ($n = 11$, 12%) or updated formal risk assessment ($n = 8$, 8%).

Issues regarding the assessment of capacity, or the established lack of capacity, were also commonly cited. There were 14 occurrences (15%) of recommendations that a Mental Health Act assessment had not been considered and could be of use in containing the risks posed. Further to this, there were 13 recommendations (13.5%) that the acute problems should be managed as an in-patient.

Several of the cases indicated longer-term in-patient or other compulsory interventions were necessary, such as the need for low secure placement ($n = 5$, 5%) and management under guardianship ($n = 2$, 2%) or Protection Of Vulnerable Adults scheme ($n = 2$, 2%).

Team issues within the context of risk management were need to improve engagement ($n = 1$, 1%), need to take positive risks ($n = 1$, 1%) and need for child protection training for team members ($n = 1$, 1%).

In eight cases (8%) the panel identified that responsibility for the patient's actions did not lie with health services as they were independent of mental health issues. These were divided into a recommendation that their behaviour be dealt with under the criminal justice system ($n = 4$, 4%), or an acknowledgement that although there is no criminal element to pursue in some cases, all appropriate actions to reduce risk have been considered and there is no more that the team can realistically do ($n = 4$, 4%).

Occasionally, the panel recommended specific management plans to manage particular disorders. Most frequently this was stated as a need for a specialist care plan ($n = 24$, 77%), incorporating advice from specialist assessments. The need for structure in the patient's life was identified ($n = 3$, 10%), as was the need for family work/family meeting ($n = 1$, 3%). More specifically, clozapine for treatment-resistant psychosis ($n = 2$, 6%) and dialectic behaviour therapy for EUPD ($n = 3$, 10%) were suggested.

Team/wider organisational issues

The final theme generated by the analysis contained 29 occurrences (0.5%) between five codes, and was subdivided into team working issues ($n = 8$, 27.5%), funding issues ($n = 7$, 24%), need for special staff/staff rotation ($n = 6$, 20.5%), need extra support for the staff involved ($n = 5$, 17%) and trust management issues/needs escalation ($n = 3$, 10%).

Team working issues captured differences within the team that may have hindered progress in the management of particular behaviours. For example, the panel acknowledged that because of splitting in the context of EUPD, it was necessary to establish a clear and consistent boundary narrative. However, outright disagreement within teams, over significant issues such as primary diagnosis and level of risk posed, was identified as an issue.

Funding issues identified that responsibility for funding was not always clear and had delayed the provision of appropriate placement. This was particularly relevant where the person had moved frequently between areas or was of no fixed abode.

The panel stressed that the staff who were dealing with particularly demanding individuals needed extra support themselves, which can often be neglected, and suggested rotation of staff to prevent burnout. In a small number of cases

it was identified that the particular service or treatment indicated for a person's condition, such as dialectic behaviour therapy, was not available, and it was suggested that this was escalated on a trust level on the basis that this would reduce risk of harm.

Feedback

Feedback was overwhelmingly positive, with 20 out of 22 respondents (91%) indicating agreement or strong agreement with the following statements: 'New ideas were generated in the session', 'The case feels safer as a result', 'I learned a great deal during the session', 'The questions I brought were answered' and 'I would recommend the process to a colleague.'

Discussion

The Royal College of Psychiatrists has highlighted a need for improved, tiered risk assessment and interventions on both a local and national level.⁵ A qualitative analysis of the content of Risk Reference Panel meetings has illustrated how it provides a potential model for services to address this need. The panel is an innovative service model that was set up to provide a further level of support for teams who had been looking for support in managing very complex individuals with high-risk behaviour and has provided new direction and specialist advice in the management of these cases.

Most cases described physical or sexual abuse, with many experiencing multiple adverse childhood events (ACEs). These findings support the existing body of work on the relationship between multiple ACEs and subsequent morbidity and risk behaviours, such as that by Bellis *et al*,⁶ which showed that individuals with four or more ACEs were several times more likely to smoke, drink heavily, have low mental well-being and chronic health conditions. This also correlates with well-documented risk factors for self-harm,⁷ suicide⁸ and interpersonal violence.⁹ These data have more general implications on history-taking in risk assessment, with the inclusion of this background information crucial to the working of the panel. The potential for referrers to exaggerate the risk, both consciously and unconsciously, to encourage acceptance by the panel should be acknowledged.

Although a person's risk of harm cannot be entirely removed,⁵ particularly in such complex cases, a thorough understanding of risks posed and their severity is crucial. The panel often identified areas where risk was not fully understood and suggested specific assessments or specialist opinion that would be beneficial. Having said this, the responsibility for risky behaviour, particularly in a capacitous patient, does not lie entirely with mental health teams and it is prudent to identify when all reasonable steps have been taken, or if involvement of the criminal justice system is more appropriate. Taking the case to such a panel allows an independent debate and makes this decision more defensible.

For patients who remain in the community, it is particularly difficult for teams to provide care and ameliorate risk if engagement is poor. Surprisingly, the meetings often highlighted that capacity assessments and use of the Mental Health Act beyond admission for brief assessment had not been considered. This may reflect a lack of appropriate placements available to community teams, particularly long-term in-patient services when patients cannot be managed in the community.

This model provides a valuable multidisciplinary source of special expertise in the management of complex and exceptional cases, where risk of harm is significant and clinical teams have ongoing concerns. The format may not be appropriate for every service and there is also a place for improved training in formulation and management of patients with complex personality difficulties, but model could certainly be reproduced in other areas where clinical teams feel it would have a beneficial role, particularly to inform Care Programme Approach unmet needs, training needs within the staff workforce and service development needs.

Lastly, it is pertinent to consider alternatives to such a panel. As the heaviest burden appears to be personality pathology, these would primarily consist of improving training in managing patients with personality disorders. In some cases, it may be that this is the better and more economical option, although it has been acknowledged that the panel approach uses relatively few resources in terms of clinician sessions while providing an additional tier of support for community teams to reduce the risk of harm associated with mental illness.

Limitations

This study is only able to describe the function and output of the panel in question, rather than give a rigorous analysis of this model in comparison with other models, and there were no available data on matched people who were not referred. We were also unable to comment on the make-up and training of the teams referring into the panel; it is possible that the referrals represent professional anxiety that stems from sources other than the patient in question, such as gaps in senior management or reluctance to engage with complex individuals with personality pathology, although the panel meetings analysed cover a period of 6 years where it is likely that there would be some fluctuation in team make-up.

All referrals to the panel are made via a written referral letter, which details the history of the case, the assessments that have previously been conducted, a risk assessment and concerns that the referrers wish to address. As the panel will already be familiar with this information, some of it may not have been verbalised at the meetings and thus not captured by the transcription. However, it was noted that there was a verbal presentation of each case and that the relevant history was given.

We would like to thank Dr Alan Wright, Forensic Psychologist with the Gwent Forensic Psychiatry Service, without whose work the Risk Reference Panel would not have come to exist, for information on the formation and workings of the Panel. We would also like to acknowledge the contribution of Jen Strange, Team Secretary, toward setting up and maintaining the Risk Reference Panel.

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1.Familiarisation with the data-set: All transcripts were read and re-read by authors A.T. and G.J., considering the application of the coding process to the data and noting initial observations.*2.Generating initial codes:* Each transcript was read line by line and discrete ideas within the data were identified and systematically coded. Eight cases were coded by both A.T. and G.J. and the remainder were divided in half between these two authors. Each occurrence of a code was recorded as a simple tally. For example, the history of the patient in question would be given and each feature would be assigned a different code, such as ‘history of being in care’, ‘history of sexual abuse’, ‘diagnosis of schizophrenia’ or ‘poor engagement with the CMHT.’ Individual risks identified and management suggestions offered by the panel would all produce individual codes.*3.Searching for themes:* Codes were reviewed and collated into potential themes. It was decided whether each code represented, for example, a demographic feature, a specific risk to his or her self or others, or a suggestion for managing a particular risk. All data relevant to each theme were identified, as some ideas could be given two distinct codes or fit into two or more themes.*4.Reviewing themes:* Consideration was given to whether the identified themes adequately captured and collated the data in relation to both the individual coded transcripts (i.e. the narration of each Risk Reference Panel meeting) and the entire data-set (i.e. the overarching patterns of input and output for the Risk Reference Panel meetings as a whole). A ‘thematic map’ was generated.*5.Defining and naming themes:* After satisfactory completion of stage four, each theme was analysed to refine its specific categorisation and the overall ‘story’ that the analysis has produced. Clear names and definitions were produced for each theme.*6.Producing the report:* Writing the present report provided the final opportunity for analysis of the insights gained from the process. The analysis was used to address the initial research questions.

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1.5.90 Follow-up study of 6.5 years of admissions to a UK female medium secure forensic psychiatry unit

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Abstract

Aims and method

We aimed to examine clinical and risk outcomes at follow-up, and reoffending and readmission rates, for a sample of 50 admissions to a female medium secure unit (MSU). Demographic, clinical risk assessment (HCR-20 and HoNOS-Secure) and quality of life data were collected using validated measures for all admissions to a female MSU ward in London, UK, between April 2008 and November 2014.

Results

All clinical and risk assessment scale scores had improved at follow-up. Quality of life compared favourably to community samples and was good for physical, social and environmental factors and acceptable for psychological health. Twenty-six per cent had at least one readmission, while 17.5% reoffended in the period studied. A longer duration of admission and use of restrictions on discharge was associated with reduced reoffending, but not readmission.

Clinical implications

Admission is associated with improvement on clinical risk assessment at follow-up. Longer hospital admissions and use of restrictions on discharge may be necessary to prevent reoffending in this group.

Declaration of interest

None.

Contents

- *Follow-up study of 6.5 years of admissions to a UK female medium secure forensic psychiatry unit*
 - *Methods*
 - * *Sample and study setting*
 - * *Data collection*
 - * *Statistical analysis*
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 - *Discussion*

Forensic psychiatry services are low-volume, high-cost services which seek to balance clinical treatment for public protection with caring for vulnerable patient groups.¹ In the UK, forensic psychiatric in-patient care is organised into three levels: high, medium and low secure facilities.² Patients are admitted to a specified level of security based on forensic history, level of risk to self or others, and diagnosis of a mental disorder. On discharge from in-patient services, many patients are subject to conditions under a Community Treatment Order (CTO), or 'restrictions' under Section 41 of the Mental Health (MHA) 1983, as amended in 2007 (for England and Wales), known as 'conditional discharge'. After discharge, such patients may leave hospital, but if they breach conditions or restrictions, they may be recalled to hospital. Examples of conditions and restrictions include being resident at a specified address, medication adherence, or cooperating with supervision by mental health services. Prevention of reoffending after discharge and reduction in readmission rates are key roles of forensic services. It is therefore essential that services be aware of factors involved in reoffending and readmission.

In the past decade, there has been a six-fold increase in the number of women admitted to medium secure forensic psychiatry services (MSUs³). Approximately 12–15% of medium secure beds in the UK are occupied by women.^{2:4:5} Despite this, there remains a paucity of demographic and clinical data on female MSU patients, particularly in relation to progress after discharge. Using a longitudinal cohort design, we assessed clinical risk assessment follow-up data and quality of life, using validated measures, in a female MSU sample. We also sought to identify clinical and demographic factors associated with reoffending and readmission rates following hospital discharge.

Methods

Sample and study setting

This study comprised all patients admitted to Spring Ward, the female ward of River House MSU in South London and Maudsley Foundation (SLaM) Trust, between April 2008 and November 2014 (6.58 years). Spring Ward contains 16% of the beds within the unit. The service covers a population of 1 090 544 people in London, approximately 50% of whom are female. Spring Ward opened in April 2008 and employs a multidisciplinary biopsychosocial approach to support women in their pathway of recovery and reintegration into the community. Ethical approval for this project was sought and obtained from the SLaM Trust Research and Ethics Committee.

Data collection

We examined the electronic clinical records of all patients. Demographic, clinical and risk assessment data are collected routinely at admission and throughout the course of admission. Standard risk assessment during MSU admission in the UK includes the Historical Clinical Risk Management-20 (HCR-20), Health of the Nation Outcome Scale (HoNOS), and Health of the Nation Outcome Scales for Users of Secure and Forensic Services (HoNOS-Secure⁷). The predictive validity for violence of the HCR-20 has been established in female patients in medium secure settings,⁸ and HoNOS has previously been used to identify clinical improvements following admission to female MSUs.⁹ All patients were assessed using these scales at the time of their admission, or shortly after. All patients were reassessed using the HCR-20, HoNOS and HoNOS-Secure scales between April and October 2015. Readmission and reoffending rates following initial discharge were collated, based on SLaM data. Quality of life was measured using the World Health Organization Quality of Life Scale, brief version (WHOQOL-BREF¹⁰), which has been validated in large international samples, including those with mental illness.¹¹ One assessment was obtained for each patient, close to or soon after discharge.

Statistical analysis

Comparisons between the groups were conducted using χ^2 -tests for categorical variables and t -tests for continuous variables. All statistical tests were two-sided, and the level for statistical significance was 0.05. All analyses were conducted in SPSS version 22.0.

Results

Within the study period, 50 female patients were admitted to Spring Ward. The mean age was 37.5 years (s.d. 11.17). The sample comprised 20 (40%) White, 26 (52%) Black and four (8%) individuals of 'other' ethnicity. The most common primary diagnoses were schizophrenia spectrum disorders ($n = 38$; 78% of sample) (International Classification of Diseases (ICD-10) category F20–29) and personality disorders (category F60–F69) ($n = 36$ patients, 18%). Nine patients (18%) with a schizophrenia spectrum disorder had a secondary diagnosis of a personality disorder. A diagnosis of a schizophrenia spectrum disorder was associated with non-White ethnicity ($\chi^2 = 8.059$, d.f. = 1, $P = 0.005$), while a diagnosis of personality disorder was associated with White ethnicity ($\chi^2 = 4.678$, d.f. = 1, $P = 0.031$).

A history of physical or sexual abuse or neglect was present in 26 (52%), and 22 (44%) had a history of self-harm. Twenty-three patients (46%) had a history of alcohol and/or drug misuse, with those of White ethnicity having increased alcohol misuse compared to those of non-White ethnicity (alcohol: $\chi^2 = 6.63$, d.f. = 2, $P = 0.036$; drugs: $\chi^2 = 7.49$, d.f. = 2, $P = 0.024$). Eighteen patients (36%) had no index offence, 17 (34%) had a violent index offence (actual or grievous bodily harm, manslaughter or murder), eight (16%) had committed arson and seven (14%) had a non-violent index offence.

The median length of hospital admission was 503 days (1.39 years). As of November 2014, 46 of the 50 patients were discharged at least once following admission; four were still in hospital following their first admission. Thirteen patients (26%) were readmitted once or more during the study period. The median follow-up period was 1390 days (3.8 years) for the 46 patients who were discharged. Of this group, five (10.8%) were discharged to prison; 32 (69.5%) were subject to a CTO, probation, or section MHA restriction order; and nine (19.5%) were not subject to conditions or restrictions.

Table 1 shows outcome data on the HCR-20, HoNOS and HoNOS-Secure scales. There were significant improvements on each of these scales at follow-up. Quality of life outcomes on WHOQOL-BREF were 'good' (60–69) for physical (mean 66.2), social (mean 64.3) and environmental domains (mean 67), which compared favourably with international samples of individuals with mental illness.¹¹ The mean score for psychological health (mean 58.9) was 'acceptable' (50–59), which was comparable to that of patients with psychotic disorders in international samples.¹¹ Table 1 HCR-20, HoNOS and HoNOS-Secure scales: mean differences between initial assessment and follow-up assessment. Initial assessment mean score Follow-up assessment mean score Mean differences. d.95% CI d.f. Sig. (2-tailed) HCR clinical items 6.323.342.973.441.78–4.155.10634<0.001 HCR risk items 5.914.131.773.080.73–2.823.462350.001 HoNOS scale 15.077.717.3516.302.07–12.642.818380.008 HoNOS-Secure scale 15.154.3010.8420.874.07–17.613.244380.002

Of 41 discharges to a hospital or community setting, data on reoffending were available for 40. In this group, seven patients (17.5%) reoffended (four with violent offences). Those who reoffended had a significantly shorter hospital stay (mean days 231.7, s.d. 226) compared with those who did not reoffend (mean days 631.7, s.d. = 326; $t = 3.701$, d.f. = 12.66, $P = 0.005$). The length of stay of those who were readmitted did not significantly differ compared with those who were not readmitted ($t = 0.215$, d.f. = 27.05, $P = 0.831$). Likewise, use of conditions, restrictions or probation was not associated with readmission ($\chi^2 = 4.66$, d.f. = 2, $P = 0.097$), but was associated with reduced reoffending ($\chi^2 = 43.14$, d.f. = 6, $P < 0.001$). Alcohol or drug use was not found to be associated with readmission ($\chi^2 = 0.02$, d.f. = 1, $P = 0.887$), but was associated with increased reoffending ($\chi^2 = 4.49$, d.f. = 1, $P = 0.034$).

Discussion

We report clinical characteristics and follow-up outcomes on 50 female MSU patients, a group that has been underrepresented by research to date. Studies of this group have focused primarily on readmission and reoffending only, and there have been few new published data in the past decade. Our study provides an update in this important area of forensic psychiatry, including clinical outcome measures. This is also the first study in this group to include self-reported quality of life data.

A key finding of our study was that women discharged from hospital maintained their improvement for the follow-up period and reported good outcomes. Reduction in clinical and risk items on HCR-20 suggests both clinical improvement for patients and reduction in risk of future violent offending in the community. Overall quality of life measures (WHOQOL-BREF) were grossly comparable to a population of individuals with mental health problems.¹¹ Quality of life is an important outcome for patients and their family following discharge. Lower scores on physical and psychological domains were a concern, although this is perhaps to be expected given the complexity of our population.

As with previous studies, we found that a longer hospital stay was associated with a lower rate of reoffending. While forensic services have been criticised for longer periods of stay in hospital,¹² it has also been argued that this is necessary for patient recovery and public protection.¹³ Our findings provide support for this hypothesis, and are in keeping with results from a previous large-scale study showing that a longer in-patient stay was protective against reoffending following discharge.⁴ The use of restrictions in forensic services is also controversial, but has also been shown to be associated with reduced reoffending following discharge.⁴ This was also the case in our sample. These results suggest that longer stays in hospital and judicious use of restrictions on discharge are necessary to prevent reoffending in this patient group.

In our sample, alcohol and drug use were also associated with increased reoffending. The largest study of reoffending following discharge from MSU settings did not identify this association, demonstrating only an association between alcohol use and arson.⁴ However, this association may also be due to distinct clinical characteristics of our sample and warrants further exploration.

Our sample's demographic characteristics were similar to those of previous studies which have examined female MSU patients.^{4,5,9,14} There were high rates of abuse and neglect, alcohol and substance misuse and self-harm, emphasising that this is a vulnerable group, and supporting the view that there is a need for specialised MSU services for women.^{2,9} There were higher rates of psychotic disorders than in previous samples, and lower rates of personality disorders.⁴ This may be due to a tendency in some settings to diagnose personality disorder, rather than psychosis, on the basis of the presence of self-harm, impulsive behaviour and substance misuse, an issue that has been identified as a concern in clinical guidelines.¹⁵ Our exclusively urban sample may also contribute to the discrepancy.

There was a high representation of ethnic minorities within our female forensic service. Black women admitted to MSUs have previously been shown to be more likely to have diagnoses of psychotic disorder or drug misuse, and to be less likely to be diagnosed with depression, alcohol misuse and borderline personality disorder than White women.¹⁴ In the current study, ethnicity was also associated with different clinical profiles in our patient group. Owing to our small sample size, we limited our categorisation of ethnicity to White and non-White. In keeping with previous research, non-White ethnicity was associated with increased rates of schizophrenia spectrum disorders, while White ethnicity was associated with increased rates of personality disorder.¹⁴ This tentatively supports the hypothesis that there is a deficit in adequately providing appropriate non-forensic services to non-White women with psychotic disorders, leading to escalation to offending and admission to forensic services. Also in keeping with previous studies,¹⁴ White ethnicity was associated with increased alcohol misuse. However, in contrast to previous findings, White ethnicity in our sample was also associated with increased drug misuse. This suggests a potential shift in clinical characteristics of White female patients being admitted to medium secure settings. Inferences are limited, however, by our small sample size and exclusively urban population.

The study was limited mainly by a relatively small sample size, although this needs to be considered in relation to the relatively small female MSU population, and the lack of relevant data on this group. The study benefited from robust data collection – very few data were missing – and from the use of standardised and objective measures of outcomes.

In conclusion, admission to female MSU is associated with improvement on clinical risk assessment outcomes at follow-up. Longer hospital admissions and the use of restrictions on discharge may be necessary to prevent reoffending

in this group. Further research on the role of ethnicity in this group is warranted.

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1.5.91 Against the stream: drugs policy needs to be turned on its head

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Abstract

Humans have always used mind-altering drugs. However, in 1961 the United Nations approved the Single Convention, under which the production, sale or possession of a number of drugs, including heroin, cocaine, ecstasy and cannabis, became illegal. The prohibitionist regime was then introduced by most countries around the world and has substantially remained in place ever since. Some countries, particularly those in Latin America, have never criminalised the use of cannabis. A small number of countries have introduced more liberal policies. This article examines the evidence of the consequences of policy liberalisation and argues that there is now a clear case for every country to examine its drug policies and to introduce evidence-based policies with a public health focus.

Declaration of interest

None.

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- *Against the stream: drugs policy needs to be turned on its head*

Human beings have taken mind altering drugs since the Stone Age, but the current global ‘war on drugs’ dates only from 1961. At that time, the addictive qualities of drugs like heroin and cocaine led the United Nations Member States

to conclude that drastic action had to be taken as they were ‘concerned with the health and welfare of mankind’¹ – the objective of the United Nations Single Convention on Narcotic Drugs. The assumption at the time was that a drug-free world could be created if those who produce, sell, possess or use certain addictive drugs were severely punished. Currently, in the UK, those arrested for possession of a controlled drug (e.g. heroin, cocaine, ecstasy or cannabis) can have a maximum prison sentence of 7 years under the UK Misuse of Drugs Act 1971. Producers and suppliers can be put behind bars for a maximum of 14 years.

A policy objective to advance the health and welfare of mankind is fine if the policy makers know the consequences of their proposed policies. In fact, instead of advancing the health and welfare of mankind, the drug laws that followed the United Nations Convention have led to untold violence and corruption in the producer countries, drug-related deaths, the accumulation of wealth worth billions of dollars by terrorists and violent criminals, the non-availability of essential pain-relieving medicines in many developing countries and the emergence of an extremely dangerous online market for synthetic psychoactive drugs. Of course, none of these consequences was predicted in 1961. It is not that the policy makers at that time were bad, they were simply ignorant of the consequences of their policies.

For political reasons, two of the most dangerous drugs widely used across the globe – alcohol and tobacco – were excluded from the Convention. Although rated as less dangerous than heroin and cocaine on a carefully devised scale of harm, both these drugs have been rated well above cannabis and ecstasy in their potential danger to the individual.² A Royal College of Psychiatrists Working Party report³ concluded that, ‘In the long run, society will only be at ease with its drug control policies if they are based on a rational assessment of the risks associated with the different psychoactive substances and an objective appraisal of the consequences of previous policy changes, rather than on moral postures, the mistaken assumptions of the past and the accidents of history’ (p. 259).

This suggests we need an entirely new approach to controlled drugs. The starting point must be a clear definition of the objectives of drug policy. The All Parliamentary Group for Drug Policy Reform⁴ proposed the following objectives to the United Nations: (a) to ensure the adequate availability of essential controlled medicines to those who need them (relevant to the many developing nations who have minimal or no access to morphine);(b)in production and supply countries, to prioritise education, community development, infrastructure development and employment in vulnerable communities;(c)in user countries, to minimise addiction and the harms associated with drug use.

In 1961 there was widespread consensus that a criminalising approach to the sale and use of heroin, cocaine and cannabis was appropriate, but this is no longer the case today. Now, even the Global Commission on Drugs Policy reports that the prohibitionist approach has failed.⁵ Arguments for and against drug prohibition in relation to heroin and cocaine may be more finely balanced, but there has been a major swing both among scientists and politicians toward the view that the illegal status of less harmful drugs, especially cannabis, does more harm than good.

Considerable concern has been raised concerning the decriminalisation of cannabis as a result of studies showing links between ‘skunk’ (high-potency cannabis) and the onset of psychosis. An influential study has shown that people who use skunk daily are five times more likely to develop psychosis than those who do not.⁶ However, the same study showed that, when the effects of low-potency cannabis were examined, hash users did ‘not have any increase in risk of psychotic disorders compared with non-users, irrespective of their frequency of use’. Further, although it is now widely accepted that there is a causal relationship between regular high-potency cannabis users and psychosis, the possible importance of the effect of confounding factors makes the significance of even this finding for drugs policy unclear. It has been estimated, for example, that 98% of regular cannabis users will not develop a psychotic disorder.⁷ Further, decriminalisation would allow much more effective control, especially of high-potency cannabis, than is the case at the present time.

The uncertainty regarding the effects of decriminalisation can only be resolved by examining the effect of decriminalising legislation where it is occurring elsewhere in the world. There are now a number of studies examining the effects of drug law liberalisation, especially, but not only, in relation to cannabis. A recent review suggested that liberalisation of cannabis laws is associated with a slight increase in use of cannabis among the young.⁸ A cross-national study of 38 countries confirmed this finding, noting that the increase was only detectable after 5 years and then mainly in girls.⁹ Further, although adolescent use remains criminalised in US states where marijuana use has been legalised for adults, decriminalisation has led to decreases in possession and felony arrests among adolescents as well as reduction of associated juvenile-justice involvement.¹⁰ It has also been shown in a 20-country comparison that cannabis law liberalisation leads to increased help-seeking behaviour for people with drug problems, an encouraging finding suggesting that if some of the savings made as a result of the discontinuation of prohibition policies were put into increasing and

improving drug services, any negative effects might be significantly reduced.¹¹

It has recently been suggested that positive experience from cannabis law liberalisation might lead to some countries looking more critically at their laws relating to other potentially more dangerous drugs.¹² There is already some evidence to suggest this might have beneficial effects. In 2001, Portugal changed its approach to the possession of all drugs. The drugs remained illegal, so the policy did not resolve the problem of illegal drug dealers enriching themselves by selling contaminated drugs. However, children and young people who go through a drug-taking phase do not end up with a criminal record and can much more easily give up the habit and progress with their education and employment – the best protections from addiction.

This policy is not ‘soft’ on drug users. If a police officer finds a young person with drugs, they will be taken to the police station and required to hand over the drugs, they are then referred to a Commission for the Dissuasion of Drug Addiction or tribunal including a legal, health and a social work professional. The tribunal will determine whether the drug possessor is addicted to drugs. If so, they will be referred for treatment. The treatment becomes the basis of a contractual agreement between the drug user and the tribunal. If the drug user breaks the contract, they could receive an administrative penalty, although this rarely happens. Importantly this has no implications for their future employment. A casual user is sent on their way by the tribunal and strongly told not to continue using the drug. Portugal invested heavily in prevention, treatment, harm reduction and social integration services. The combination of decriminalisation with improved health and social care services probably account for the good results.

Importantly the policy has been extensively evaluated.¹³ Portugal now has levels of drug use well below the national European average. The numbers sent to the criminal courts in Portugal fell from more than 14 000 to 5000–6000 a year after the policy was introduced. The proportion of offenders for drug-related offences fell from 44 to 21% between 1999 and 2012. The numbers of addicted children and young people has decreased. All the same, critical analysis of studies of those who claim that the Portuguese drug policy has been a resounding success or, in contrast, a disastrous failure suggest that the evidence does not support either extreme view.¹⁴

Switzerland has shown how to replace drug dealers with heroin treatment services. The services largely cater for poly drug users. The service has three parts: the drug consumption room (DCR), the heroin clinic and the methadone clinic. The service providers have an agreement with the police that anyone approaching the DCR will not be arrested for drug possession. The DCR is a vital part of the service. A doctor spends time there each week, treating ulcers and other health problems, and a social worker is available to help with housing, financial and other social issues. Addicted clients who come in off the street with their illegal drugs are welcomed and cared for. Over about 3 weeks these two professionals encourage the street drug users to come along to the clinic and have clean heroin in exchange for agreeing to a demanding contract. These chaotic individuals are required to hand over their benefits in the early stages, to make sure their rent and bills are paid. They are given back the money they need for food or other essentials, but not enough for them to buy drugs.

The constraints are worth it in return for the clean heroin as well as the psychological and social care. The Swiss heroin treatment programme has been rigorously evaluated.¹⁵ The results are impressive. Until they arrived at the clinic these individuals were committing an average of 80 crimes a month to feed their addiction. After 18 months in treatment, one third are entirely drug-free and leading normal lives; a further third are leading their lives within the law, but still taking some heroin or methadone. The last third need more time to achieve their objectives. The savings to the tax payer and the benefits to the community from reduced crime levels are huge. The estimate is that for every franc spent on this service, two francs are saved for the taxpayer. The cost of the service per person is 15 000 euros. Not cheap but well worth it.

In the meantime, in England, the Durham Police are beginning to use the Swiss route for users of all narcotic drugs and even for low-level drug dealers and traffickers.¹⁶ Their Check Point programme recognises that many who are arrested for theft motivated by drugs and other less serious crimes have underlying mental health and social problems. The programme offers drug-related offenders and others a 4-month contract. This requires them to engage with treatment and not to reoffend. If they succeed on their contract then no further criminal justice action is taken. If successful in rehabilitating drug users and cutting reoffending, this will surely be an important policy across the country. The government will be funding 10 pilots of Checkpoint and 25 police forces are wanting to apply to be involved.

To conclude, an independent review of UK drug policies is urgently needed. Each drug needs to be individually considered. Regulation of heroin, for example, needs to be very different from the regulation of cannabis or ecstasy.

The objectives must be to reduce addiction and limit as far as possible the harms associated with drug use. Drug policy reform would also dramatically reduce the ill-gotten gains from the drugs trade of terrorists and violent criminals.

In fact, we need to turn, not just policy about cannabis, but our whole drugs policy in its head. Opponents of the legalisation of cannabis, who suggest that this might well represent a slippery slope leading to the legalisation of other, currently proscribed drugs are right. But that is exactly what needs to happen.

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1.5.92 Making up symptoms: psychic indeterminacy and the construction of psychotic phenomena

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Abstract**Summary**

Psychotic phenomena include a far wider range of experiences than is captured by the brief descriptions offered in contemporary diagnostic guides. Given the richness of historical clinical phenomenology, what can account for the recent ascendancy of relatively impoverished descriptions of psychosis? One possible explanation is provided by Hacking's notion of dynamic nominalism, where human categories change over time in tandem with those who they classify. But although dynamic nominalism makes sense of changes in behaviour, it fails to account for change at the level of subjective experience. In this paper, psychotic symptoms are addressed in the light of the indeterminacy of subjective mental content. A naïve-introspectionist approach to mental symptoms assumes that, notwithstanding practical difficulties, such symptoms are reliably describable in principle. Contemporary philosophy of mind challenges this assumption. Lighting upon a verbal description for ineffable phenomena changes their nature, resolving them into new forms.

Declaration of interest

None.

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Introduction: historical moving targets

The DSM-5 provides brief descriptions of the central positive psychotic symptoms of delusions, hallucinations and disorganised thought. In this schema, delusions are defined as ‘false beliefs’ and hallucinations are defined as ‘perception-like experiences’. It is to this framework that patients’ experiences are matched to make a psychiatric diagnosis. The dissemination of such definitions and criteria has pervaded society’s understanding of what psychosis is like. Their influence can now also be seen in the push for the re-description of psychosis in terms not of symptoms, but as ‘unusual beliefs’ or ‘hearing voices’.¹ However, it is not always clear that delusions are best characterised as beliefs,^{2,3} and auditory hallucinations can include experiences that do not resemble ‘hearing’ and do not involve voices.⁴

Historically, delusions, to examine just one of these symptoms, were not necessarily defined as beliefs. Tracing the conceptual history of this particular symptom, German Berrios⁵ has argued for the falsity of what he calls the ‘received view’ that delusions are beliefs, and detailed its emergence. Berrios suggests that historical intellectual processes shape delusions, although it is not clear whether he intends to suggest that this shaping affects only the received clinical view or also the symptom itself. Berrios argues that the received view was in place by the end of the 19th century. However, a more complex picture of delusions can be seen in the work of two prominent psychopathologists of the early 20th century.

In his original description of the features of the group of schizophrenias, Eugen Bleuler’s⁶ overview of delusions includes no explicit requirement that they be beliefs. At many points he seems to be describing a wider variety of mental states. Patients with delusions are described as being unconcerned with evidence or reasons for their ideas, “‘It is just so”, and with this he appears to be quite satisfied’ (p. 118). Additionally, delusions are described – unlike a dogmatically held belief – as sitting comfortably alongside other inconsistent ideas: ‘Unconnected or even mutually contradictory ideas can be maintained simultaneously or appear one after the other within a short interval of time’ (p. 125). Bleuler includes false statements that might not be held with any conviction: ‘A catatonic’s bed is a polar bear. “I lay on it and it seemed like a bed, but it was nevertheless a polar bear”’ (p. 126). Additionally, Bleuler explicitly extends his description of delusions into cases of non-belief-like states: ‘The delusions can appear in the form of “hunches,” “intuitions,” etc., which can persist permanently in their indefinite forms’ (p. 135).

Karl Jaspers, in his seminal description of the phenomenon of delusions,⁷ does not speak of them in terms of belief, but rather builds a complex picture through case examples and phenomenological descriptions. For Jaspers, contrary to modern psychological theorists,^{8,9} delusions proper (what Jaspers terms ‘primary delusions’) are not belief-like inferences that have been made from an anomalous perceptual input, but form part of the direct experience itself. Jaspers emphasises the immediacy of a delusional interpretation. A delusional patient sees their delusion in their experience of the world in the same way as ‘If I see a knife, I see a tool for cutting’² (p. 99). The word ‘belief’ does not appear in this part of his discussion.

Compare these rich and heterogeneous descriptions with the formal definition of delusions provided in the DSM-5:¹⁰ ‘Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence. Their content may include

a variety of themes (e.g., persecutory, referential, somatic, religious, grandiose)' (p. 87). This historical transmutation of psychotic symptomatology is a curious phenomenon. I suggest that it represents something potentially significant, occurring not only in the literature but also in the patients. Paraphrasing the philosopher of science Ian Hacking (who referred to 'making up people' 11), I call this 'making up symptoms'.

Dynamic nominalism

Historical variation in psychiatric presentations has been understood in terms of bidirectional feedback loops between the patient and world that shape the patient's expression of symptoms.¹²⁻¹³ Consider the phenomenon Hacking terms 'dynamic nominalism', the process he posits whereby people come to fit the categories they are assigned. A classification or description of people is created on the basis of some observed regularity or classificatory principle (autistic, anorexic, gay). Observations about this classification are then made by academics, journalists, medics and so forth. Because the individuals classified are people, and not rocks or trees, they can become aware of the classification, and of various facts, fashions and stereotypes associated with it. Such knowledge is apt to change people as they behave increasingly in line with the way that they have come to see themselves described. Hacking has suggested that entire disorders ('transient psychiatric illnesses') can be brought into existence by interactive processes he calls 'looping effects'.¹²⁻¹⁴ Plainly there are hard limits on the influence of looping effects (people cannot, for example, become taller just because they have been classified as belonging to a group that is stereotypically tall), but the more plasticity there is associated with important elements of a classification, the more we might expect looping effects to exert their influence.

Thus, as clinical phenomenologists produce ever more succinct descriptions of psychotic experiences, people may have come to experience themselves as actually having these simpler symptoms. This, in turn, would have changed the psychiatric classification of psychosis, confirming ever more specific and limited definitions of the phenomena at hand. This story is powerful, but – at least in Hacking's telling – it leaves an explanatory gap in between the world and the patient's symptoms. Dynamic nominalism can readily account for changes in historical behaviour (the culturally determined manifestations of psychiatric distress) because we can readily intuit the ways that behaviour can be influenced by expectations. But there is more to psychosis than behaviour. Mental symptoms feel a particular way, and it is intuitive to suppose that the way they feel is a 'bottom-up' result of internal illness processes. We need more detail about how personal mental experiences could be subject to the same sorts of external influence.

We cannot account for symptom variability without appeal to an important but unacknowledged feature of the mental experience: its ethereal nature. Unlike livers and larynxes, subjective conscious experiences can never be directly observed by another person. Moreover, despite our casual intuitive sense that we have direct access to our subjective experience, it can be uncannily difficult to pin that experience down, even for ourselves. Consciousness is messy, inchoate and often ineffable. It may even be that its contents are indeterminate, and even indeterminable.

Psychic indeterminacy

The indeterminacy of mental content has been perhaps most thoroughly explored by the philosopher Eric Schwitzgebel.¹⁵ Schwitzgebel articulates scepticism about the possibility of accurate introspection on one's perceptual experiences. We might think that we know what our perceptual experiences are like in some detailed and accurate way. At first blush, what could be more immediately knowable? But subjectivity is often transient and difficult to pin down. We are not always clear whether an impression (the impression, for example, that one is looking at a scene that contains spatial depth) arises from something that is more directly perceptual or more inferential in character. For Schwitzgebel, questions like 'Do you always have a constant tactile experience of your feet in your shoes?' and 'What do you see when your eyes are closed?' are not as readily answerable as they might appear.

Schwitzgebel provides an example of a historical change that he takes to reflect this indeterminate nature of subjectivity.¹⁴ Multiple researchers examining reports of dreams in the early 20th century found that a minority of respondents' dreams (9–41%) involved the experience of colour. Since the 1960s, however, that figure changed and research participants reported that the majority of their dreams (74–100%) included the experience of colour. Schwitzgebel takes this to suggest that 'I don't know, and you probably don't know, whether we dream in color or not' (p. 3), and suggests that the dramatic change in people's assumptions about their dreams reflects the emergence of widespread access to colour

television and films. Dreamers changed their assumptions about the nature of visual experiences and translated this into a judgement about the quality of their dreams.

Schwitzgebel's pessimism about the reliability of introspection has obvious implications for the assessment of psychiatric phenomena. If he is right about the unreliability of naïve introspection, then the assessment of experiences like hallucinations and delusions is open to variability and influence. To ask whether someone is hearing voices or whether they believe in a given proposition is doubly problematic. Such queries presuppose that there is a fact of the matter, and create unwarranted certainty as respondents confabulate an account of their subjective impressions.

Something like this indeterminacy of the subjective has already been posited in the realm of psychiatric symptoms. Citing Dennett's¹⁶ scepticism about the possibility of relying on inner experience, Stephens and Graham¹⁷ note that not all auditory visual hallucinations are voice-like, and suggest that individuals who come to hold certain ideas may sometimes engage in a sort of *ad hoc* confabulation about their origin. The result of such confabulation might be a conclusion that an idea came to be held because a voice was heard⁸ (pp. 26–31). The psychoanalyst Roy Schafer¹⁸ has also explored the indeterminacy of psychiatrically relevant symptoms, pointing out that inquiring about certain vague experiences (e.g. the location of a felt mental presence) can alter the nature of the experience itself⁹ (p. 123).

Does this not lead us to phenomenological nihilism? If our mental life is indeterminate, is there any value in asking people about their inner lives? What about asking people whether they are in pain? (I am grateful to an anonymous reviewer for raising this question.) I think we can fruitfully distinguish more or less fine-grained aspects of experience, with greater difficulty attendant on making determinations about more detailed phenomenology. It is relatively straightforward to say, 'I'm in pain', but far more complex to make detailed descriptions of the nature and quality of that pain. Physicians also ask questions like 'is the pain sharp or dull?' or 'is it a shooting pain?'. Some people, lacking a clear idea about how to answer, could have their experience of the pain changed by the question. Equally, it may be possible to establish the presence of a hallucinatory experience, but harder to describe its form without contamination by interrogation.

If subjective experiences are indeterminate in this important way, then there are grounds to worry about the emphasis on specific symptoms in contemporary psychiatry and clinical psychology. Over the latter half of the 20th century, psychiatry saw a push toward more precise measurement of psychiatric phenomena. A loss of confidence in diagnostic categories shifted attention to the observation and measurement of specific symptomatic experiences.

Paradoxically, however, this focus on symptoms (and especially the use of familiar terminology like hearing voices or unusual beliefs as opposed to the vaguer and more clinical hallucinations or delusions) may be taking us further from the individual experience of people in profound states of disturbance. When we ask people whether their experience is like hearing voices, they may be inclined – when confronted with the immense difficulty of describing what it is really like – to accede that it is.

Take a question like 'Do you ever seem to hear noises or voices when there is no one about, and nothing else to explain it?' from Wing *et al*'s Present State Examination.¹⁹ A person answers yes. In response to the follow-up question ('Do you ever seem to hear your name being called?'), they also say yes. It is possible that this individual does not, in fact, have those experiences (they do not actually hear noises or voices, they experience something else that feels impossible to describe in other terms), and that they do not actually hear their name being called. Perhaps they just have some sense that there are voices or noises in the vicinity that are having some kind of a perceptual effect on them. Perhaps there is a sense in which they are feeling called, but they never actually have the perceptual experience of a voice calling their name.

I have administered this kind of a questionnaire to people, and it is true that they can prompt the interviewee to provide reflections on how, no their experience is not 'quite' like that being described in the question. Interesting discussions about personal phenomenology can ensue. However, people also have difficulties articulating their experience. People have more or less ability to communicate, and more or less interest in getting the nature of their experience precisely articulated ('I don't really hear the voices but, ah, close enough!').

Making up their minds

The myth of measurable and determinate psychotic symptoms neglects entire aspects of people's experiences and recent research has revealed that some people with psychiatric illness can come to feel alienated by the discipline's failure to encompass the variety of phenomenology.⁴ 19 Jones and Shattell²⁰ describe the experiences of people who have had psychotic experiences that 'simply did not map onto available terms and constructs' (p. 769). These authors find participants afraid of describing their experiences to doctors in case they were dismissed, and others who had been told there was 'no such thing' as non-auditory voices: 'It was not that the textbooks were wrong ... her experiences were' 19 (p. 769). Too tight a focus on preordained symptom categories (the core positive symptoms of the DSM-5) omits those experiences that do not readily fit them. Psychiatric symptom erasure is a systematic failure to take seriously an individual's own account of what is happening to them.

But perhaps more fundamentally, the process of making up symptoms unwittingly shapes people to clinician expectations. Anyone is potentially vulnerable to introspective error and this vulnerability is compounded by the frightening, unusual and private nature of a psychotic symptom. The clinicians who assess such experiences ask specific questions and have diagnostic expectations, thereby providing a particular framework for their patients to fit into. It is a mistake to minimise the potential power of such shaping.

In his discussion of multiple personality disorder,¹² Hacking outlines the moral hazard involved in the inadvertent creation of psychiatric subjectivity by reference to a Marxist concept. To create and impose new ways of being psychiatrically disturbed, he says, is to subject people to a form of false consciousness. If my argument here is correct, we cannot successfully demarcate false from true consciousness. If there is no plain fact of the matter about the nature and contents of mental states to begin with, there is no 'pure' unobserved form of consciousness to compare against a putatively 'false' form. Nonetheless, I submit that Hacking is on to something significant. When psychiatrists come into contact with disturbances of consciousness, they cannot hope to only observe them. The mind is not infinitely malleable (it would salve much therapeutic angst if it were), but encounters with others – especially powerful professional others – can be expected to influence the form that peoples' thoughts can take.

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1.5.93 Depression, memory and electroconvulsive therapy

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Abstract

Current neuroscience suggests that although short-term memory difficulties frequently occur immediately after electroconvulsive therapy (ECT), longer-term problems are less common. However, gaps in our knowledge remain regarding longer-term cognitive problems after ECT, including memory function. Some of these relate to the complexities surrounding cognitive testing and interpretation of test results. An important question in clinical decision-making is why, despite current evidence suggesting long-term memory problems are less frequent, some patients still report subjective memory difficulties. To further advance clinical practice and the neuroscience surrounding post-ECT cognitive function, assessment of cognitive function, possibly including neuropsychological testing, should potentially become more routine as part of clinical practice.

Declaration of interest

None

Contents

- *Depression, memory and electroconvulsive therapy*
 - *Memory complaints post-ECT*
 - *Assessing cognition post-ECT*
 - *Remaining questions*

Measuring treatment response after depression is often not entirely straightforward in clinical practice. What matters to clinicians might not always perfectly align with what is important to their patients. For example, the DSM-5 lists a combination of physical, cognitive, affective and behavioural diagnostic criteria representing major depressive disorder (MDD).¹ For patients with MDD, subjectively, fatigue is sometimes the most disconcerting symptom, whereas for others it might be impaired concentration or the persistent feelings of sadness and hopelessness, resulting in a range of subtly different presentations. Similarly, a wide range of effective treatments for MDD are now available, depending on patients' clinical presentation. Treatments range from pharmacological approaches, talking therapies and physical exercise, to electroconvulsive therapy (ECT) or a combination of these, among others. Treatment approaches all have different levels of efficacy, potential side-effects, and accordingly their acceptability to patients with MDD varies.

A recent retrospective study found that patients were generally satisfied with ECT as a safe and effective treatment for depression.² Nevertheless, one of the suggested adverse side-effects of ECT concerns possible memory problems. Whether ECT can have a deleterious effect on memory presents an important question for both the clinician and patient when discussing treatment options. An appraisal of the current neuroscience knowledge on memory and ECT can provide some guidance to further inform clinical decision-making, including addressing patients' concerns regarding treatment choice. Lezak *et al*, reviewing neuropsychology and other neuroscience findings concerning ECT and memory, conclude that memory difficulties immediately post-ECT can be present in some patients, but that it is less common beyond this period, even in patients who have had longer-term treatment.³ Similarly, Kirov *et al* conclude that long-term memory effects are rare and that ECT appears to be safe as regards adverse neuropsychological outcomes.⁴ Furthermore, a recently published, large cohort study found that the risk of developing dementia in patients previously treated with ECT was not significant.⁵ These findings might reassure clinicians, but what about patients' views? Understanding patients' preferences and concerns as regards treatment choice is an important aspect of clinical decision-making and ultimately for determining overall treatment response.

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Memory complaints post-ECT

Vann Jones and McCollum⁶ report the findings from their systematic review of ECT and subjective memory complaints. Although there were methodological limitations to some of the included studies, which made definitive conclusions difficult, their review does suggest that generally subjective memory ratings improve over time, and that ultrabrief-pulse ECT potentially has less side-effects. Interestingly, another study not included in their review reported that although cognitive function appears to be largely unchanged in many (but not all) areas of neuropsychological functioning, improved depression long-term post-ECT appears to be associated with improvement in some cognitive functions.⁷ Vann Jones and McCollum's review raises some interesting questions for clinical practice and neuroscience. In particular, if the above (and other) findings from the research literature is correct in concluding that ECT is safe as regards memory functions, why is it that a number of patients consistently continue to report longer-term subjective memory difficulties after ECT?

Addressing the above question is potentially of considerable relevance not only to patients, but also clinicians. For example, from a policy and practice perspective there is an acknowledgement of the importance of considering cognition as part of ECT service delivery. The Royal College of Psychiatrists Statement on Electroconvulsive Therapy advises that cognitive functioning should be assessed before ECT and monitored after every three or four ECTs, and also after the final ECT.⁸ Furthermore, the Statement indicates that in addition to orientation being assessed after each ECT, retrograde amnesia, new learning and subjective memory complaints should be tested more than 24 h post-ECT. However, exactly how to perform testing of these functions is not specified. Interestingly, looking at some current National Health Service ECT policies fails to identify a consistent and clearly defined approach to assessing cognition in ECT services. To summarise, although the relevance of assessing cognition after ECT is clearly acknowledged, how to do this remains less clear. At present, there is not a straightforward answer doctors can give to patients receiving ECT, if they ask exactly how their memory functions will be monitored.

Assessing cognition post-ECT

Assessment of cognition can be performed at different levels, providing objective or subjective data. Patients can be asked about their own views on their cognitive functioning, which provide subjective data. Objective testing can be performed at the bedside, or can constitute formal neuropsychological testing. In the latter case, the patient's results are compared against standardised norms as well as their own predicted premorbid level of functioning. Patient effort is also measured to identify any underperformance that might influence the interpretation of test results. Cognitive domains assessed generally include information processing, language functions, new learning and retention, construction, visual-spatial abilities and executive control functions, among several others. Kolar suggests that neuropsychological testing should be an integral part of ECT service provision.⁹ In ECT services, testing will most likely focus on cognitive domains such as new learning and retention, as well as information processing. Although the assessment of cognitive functions appears straightforward enough, interpretation of the results is not. This may be one of the reasons why wider implementation of cognitive assessment post-ECT has not occurred.

Returning to the relevance of diagnostic criteria as outlined at the beginning of this editorial provides a good example of some of the complexities surrounding post-ECT cognitive assessment. Cognitive symptoms of MDD, such as poor concentration, can be affected by some of the other features of the disorder. For example, insomnia can adversely affect concentration, which will have a negative downstream effect on memory (new learning and retention). The same applies to fatigue. In terms of the statistical interpretation of neuropsychological test results, one example would be that consideration should be given to the possibility that when compared with standardised norms, depressed patients may already (before ECT) be underperforming, or even be near floor level (a score that is too low to reliably identify any further decline in performance). This is one of the reasons why the individual patient's neuropsychological profile ideally should be interpreted against their own predicted premorbid level of cognitive function by using, for example, demographic data or formal tests of premorbid intellectual function. Other issues related to interpretation of test results concerns for example determining what constitutes a reliable clinical change during serial testing, or identifying what represents an impairment versus a below average performance of a given cognitive function in a test protocol.

There are also non-cognitive factors to consider when interpreting data. Particularly relevant to Vann Jones and McCollum's study would be the effect of patients' self-awareness (or 'insight') on their subjective judgements of memory function. Problems in this area can influence how patients rate their memory performance and result in very different

scores from actual objective test performance. For example, a small study looking at repeated neuropsychological testing about 3 weeks after ECT found objective as well as subjective memory difficulties to be present, but the authors cautioned that subjective post-ECT reports of memory problems may be influenced also by problems of awareness, questioning their reliability.¹⁰ Perhaps if routine standard cognitive assessment were available in ECT services, patients could be reassured that in addition to their own 'report back' opportunities to identify their concerns about memory problems with their doctor, their cognitive functions (including memory) would be closely monitored for objective change.

Remaining questions

Although current research appears to indicate that ECT in most patients does not appear to have lasting adverse effects on memory, we can, of course, not be entirely sure that this is always the case for all patients. For example, prospective studies that look at ECT effects on cognition, where baseline neuropsychological testing including consideration of premorbid intellectual ability is included and compared with a control group, could help to further advance our understanding of the cognitive neuroscience surrounding this topic. However, of particular relevance to Vann Jones and McCollum's interesting review, to help address patients' concerns expressed through their subjective reports of ongoing memory difficulties, the following could possibly be helpful to think about. Future research in the area may wish to consider more closely which specific non-cognitive factors, including self-awareness, might account for a discrepancy between actual and reported cognitive impairment. For example, a recent study of patients with acquired brain injury found that most of the variance between actual and perceived cognitive impairment was explained by affective factors such as anxiety or low mood.¹¹ Conversely, it may be helpful to also look more closely at which specific symptom(s) of MDD improve post-ECT. As an example, one interesting hypothesis to test would be to determine how much of improvement in depression can be accounted for (or not) by a specific improvement in patients' ability to think or concentrate post-ECT.

As regards clinical practice, one of the possible implications from Vann Jones and McCollum's study is that there may be a need to consider if it is necessary to determine recommended standards of cognitive testing or clearer guidance on testing for UK ECT services. It may, of course transpire, that routine standardised cognitive testing of all patients receiving ECT would possibly be unhelpful or even harmful, raising anxiety-provoking questions in patients' minds that were not there before. However, if standardised testing were deemed necessary to implement, close consideration might need to be given to factors such as which cognitive functions are most relevant to test in the ECT situation, the length of such assessments and, closely related to the latter, what type of assessment (bedside, formal neuropsychological testing or a hybrid approach), among other questions. To conclude, several recent papers illustrate the essence of some of these questions. Although the Montreal Cognitive Assessment¹² is considered to be useful in monitoring cognitive function after ECT,¹³ on the other hand, cognitive assessment after ECT is also presently thought to not be comprehensive enough, especially if limited to bedside testing only.⁹ As with many of the questions surrounding the clinical practice and neuroscience of ECT, this is not an easy one to provide a definitive answer to.

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1.5.94 A new inner-city specialist programme reduces readmission rates in frequently admitted patients with bipolar disorder

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Abstract**Aims and method**

The OPTIMA mood disorders service is a newly established specialist programme for people with bipolar disorder requiring frequent admissions. This audit compared data on hospital admissions and home treatment team (HTT) spells in patients before entry to and after discharge from the core programme. We included patients admitted between April 2015 and March 2017 who were subsequently discharged. Basic demographic data and numbers of admissions and HTT spells three years before and after discharge were collected and analysed.

Results

Thirty patients who completed the programme were included in the analyses. The median monthly rate of hospital admissions after OPTIMA was significantly reduced compared with the rate prior to the programme. HTT utilisation was numerically reduced, but this difference was not statistically significant.

Clinical implications

These results highlight the effectiveness and importance of individually tailored, specialist care for patients with bipolar disorder following discharge from hospital.

Declaration of interest

None.

Contents

- *A new inner-city specialist programme reduces readmission rates in frequently admitted patients with bipolar disorder*
 - *Method*
 - *Results*
 - *Discussion*

The period immediately following hospital admission for mania or bipolar depression is an important opportunity to optimise treatment and to prevent episode recurrence and readmission.¹ Studies show that this period is one of high risk of readmission and episode recurrence.²⁻⁴ It is also a period of high suicide risk.⁵ The OPTIMA mood disorders service was established in 2015 in the South London and Maudsley (SLaM) NHS Foundation Trust.⁶ OPTIMA's core programme aims to consolidate recovery for people with bipolar disorder who have recently required a hospital admission or home treatment team (HTT) care for an episode of mania or depression. Importantly, the core programme focuses particularly on those who have required frequent hospital admissions. In a preparatory audit of admissions for bipolar disorder in the Trust, over a three-year period, there were approximately 500 admissions per year for bipolar disorder. Two-thirds of these were readmissions, emphasising the need for better preventive strategies. Approximately 150 people were admitted more than once a year: this group accounted for a quarter of the total number of admissions for patients in this diagnostic group.

The OPTIMA core programme offers an individually tailored treatment, comprising ongoing psychiatric assessment and review, the prescribing of psychotropic medication, specialist nursing, occupational therapy and individual psychoeducation.

This preliminary audit assessed the effect of this programme on readmission rates by comparing median admission rates before and after engagement with OPTIMA. A similar comparison was made with rates of HTT episodes.

Method

Approval for this audit was obtained from the SLAM Mood, Anxiety and Personality Clinical Academic Group Governance Committee. The audit focused on patients who had been admitted to the OPTIMA core programme between April 2015 and March 2017.

The core programme began with an assessment appointment with a consultant psychiatrist or senior trainee, and a key worker (a senior nurse or an occupational therapist). When the patient entered the programme, they were offered a period of engagement in which goals were agreed. Psychiatric review and medication changes were made to address ongoing affective episodes or subsyndromal symptoms. 'Key working' was offered: this was an individually tailored psychoeducation programme which aimed to reinforce prevention strategies. It included sensitive work, such as the identification of past episode triggers and early warning signs of mania and depression. Self-management skills, early intervention strategies and crisis planning were taught to prevent full episode recurrence.⁷

The programme also offered specialist nursing interventions and occupational therapy. Appointments were offered at times and at a frequency convenient to the patient to encourage attendance. Initially, it was planned that the core programme should last 12 weeks, followed by less frequent contacts prior to discharge to the patient's community team. However, in practice, a more flexible approach was used, and the duration of the core programme was adapted in each case to allow for individual variation in the time needed to engage patients and to address ongoing affective symptoms.

Basic demographic data were collected. The number of hospital admissions and HTT episodes in the three-year period before entering OPTIMA were extracted from electronic health records. Similarly, the number of hospital admissions and the number of HTT episodes in the (shorter) period following discharge were determined. Monthly rates of admission and HTT episodes in the 36 months before OPTIMA were calculated. For the period following discharge from OPTIMA, rates of admission and HTT contacts were calculated by dividing the number of admissions/HTT contacts by the number of months since discharge from the programme. Descriptive statistical analyses were used to characterise the audit sample. A Wilcoxon signed-rank test (Shapiro–Wilk, $P = 0.001$) was used to conduct comparisons of pre- and post-OPTIMA admission and HTT rates.

Results

At the time of this audit, 30 people had engaged with and had been discharged from the OPTIMA core programme; a further 22 patients remained in the programme. Of the group of 30 discharged patients, 20 were female and 10 were male. The median age was 40.5 years, with an interquartile range (IQR) of 25.

The median number of months since discharge from OPTIMA was 9.5 (IQR 8). Eighteen people did not complete the whole programme for the following reasons: recurrence of illness ($n = 4$), personal issues ($n = 6$) and lack of engagement ($n = 8$). For purposes of our analysis, these 18 patients were included in the analyses as they received at least one therapeutic intervention during their stay in the programme.

The median monthly rate of hospital admissions after OPTIMA was 0.00 (IQR 0.00), which was significantly different from the median monthly rate in the three years prior to OPTIMA (0.04; IQR 0.06; Wilcoxon signed-rank test $Z = 3.1$; $P = 0.002$). The post-OPTIMA median monthly rate of HTT episodes (0.00; IQR 0.02) was numerically reduced compared with the rate prior to OPTIMA (0.03; IQR 0.06), but this difference did not reach statistical significance (Wilcoxon signed-rank test $Z = 1.5$, $P = 0.136$).

Discussion

These results provide preliminary evidence of the effectiveness of the OPTIMA core programme in reducing hospital readmissions in a group of frequently admitted patients from an inner-city catchment area.

There was no statistical difference in HTT spells of care required before and after the programme. This may reflect the limited sample size and the short follow-up period of this early audit. However, it is possible that when OPTIMA ‘graduates’ do suffer recurrence, symptoms are recognised earlier, and patients are better able to use home treatment, and so hospital admissions are avoided.

The role of specialised programmes has been debated in recent years. Do the long-term benefits of specialised services justify the resources they require and their costs? A growing body of evidence supports the need for and the effectiveness of specialist services, particularly in the case of complex and disabling illnesses, such as bipolar disorder.⁹ In a recent study, Kessing *et al*¹ randomised 158 recently discharged patients with bipolar disorder to the treatment arms of a specialised bipolar clinic or standard care. The specialised intervention consisted of a two-year comprehensive programme that combined individual and group treatments, including group-based psychoeducation, provided by psychiatrists, psychologists, nurses and social workers with relevant training and experience in the treatment of bipolar disorder. Over a period of almost six years, a significant reduction in the rates of readmission was found in the group receiving specialist care. Importantly, there was a significant associated reduction in the financial costs to the care provider, as well as higher patient satisfaction rates. The OPTIMA mood disorders programme used a similar approach, but there were several important differences. First, the OPTIMA mood disorders service provided intensive clinical care to recently discharged patients at any stage in their bipolar illness, but selected them on the frequency of their admissions; the Kessing study focused on those early in their bipolar course. Second, the OPTIMA programme was designed to recruit the Trust’s most frequently admitted patients to our core programme. Third, patients on our core programme were often symptomatic and could not attend our structured group psychoeducation programme; in these cases, individual psychoeducation was provided instead.

Specialised programmes such as OPTIMA provide opportunities for education and research.^{8,10} The South London and Maudsley NHS Foundation Trust comprises a number of clinical academic groups which aim to facilitate the provision of evidence-based treatment, research and training in its clinical services. The OPTIMA programme hosts students, postgraduate students and trainees who wish to learn more about bipolar disorder.

Interpretation of the results of this early audit of a new service is subject to several limitations. The number of patients who completed the programme was small, and the period since discharge is short. Our results are based on an observational design with intra-individual comparisons: there was no control group to compare effects with standard treatment offered by the Trust. Despite these limitations, our initial findings support the importance of frequent specialist post-episode psychiatric review and maintenance phase interventions to stabilise bipolar disorder in frequently admitted patients. Future work will include the expansion of this model of care in the development of an OPTIMA ward liaison service to improve continuity of care from the in-patient to the community setting, and recruitment to the OPTIMA core programme.

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1.5.95 Decision-making in crisis resolution and home treatment teams: The AWARE framework

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Abstract

Aims and method

The aim of the study is to improve patient safety by identifying factors influencing gatekeeping decisions by crisis resolution and home treatment teams. A theoretical sampling method was used to recruit clinicians. Semi-structured interviews to elicit various aspects of clinical decision-making were carried out. The transcripts were thematically analysed using a grounded theory approach.

Results

Patient needs (safety and treatment) was the primary driver behind decisions. The research also revealed that information gathered was processed using heuristics. We identified five key themes (anxiety, weighting, agenda, resource and experience), which were constructed into an acronym 'AWARE'.

Clinical implications

AWARE provides a framework to make explicit drivers for decision-making that are often implicit. Incorporating these drivers into reflective practice will help staff be more mindful of undue influences and result in improved clinical decisions.

Declaration of interest

None.

Contents

- *Decision-making in crisis resolution and home treatment teams: The AWARE framework*
 - *Method*

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- *Discussion*
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Crisis resolution and home treatment teams (CRHTTs) are the interface between acute and community mental health services. Focused on patients' recovery and empowerment, they are an alternative to hospital admission, providing treatment in a less restrictive environment. They are the gatekeepers for in-patient admissions and enable early discharge, reducing hospital bed use.^{1,2} Patients experiencing mental health crisis are assessed by CRHTT practitioners. Outcomes may include home treatment, admission to hospital, back to referrer in secondary or primary care or signposting to other appropriate services.^{3,4}

Now an integral part of mental health services in the UK,⁵ they were introduced in 1992 through the National Service Framework for mental health in England. Similar teams have been implemented in other European countries.⁶ Research has primarily focused on their value as admission prevention service. Some,⁷⁻⁹ but not all,¹⁰ studies indicate reduction in bed use. National guidance¹¹ on acute service provision recommends CRHTTs. A systematic review of 69 studies¹² identified elements influencing CRHTT service quality through models of care and implementation guidelines. Hunt *et al*¹³ has noted that suicide rates in crisis teams are higher than in in-patient settings. CRHTT decisions are at a critical juncture in the care pathway and have a major impact on patient outcomes, but research is scarce and needs development.

Clinical decision-making is a contextual, continuous, evolving process, where data is gathered, interpreted and evaluated to select evidence-based actions.¹⁴ Understanding the rationale behind CRHTT assessment outcomes, such as whether to admit a patient, is pivotal to improving patient safety. We conducted a qualitative study with the aim of identifying intuitive factors influencing clinical decision-making following CRHTT assessments, as a service improvement project.

Method

Setting and participants

A theoretical sampling method was used to identify qualified multidisciplinary team members in a CRHTT of working-age adults in East Anglia. Eighteen interviews were carried out across 12 multidisciplinary team staff (10 nurses, 2 social workers; post-qualification experience: 10–25 years; 6 men, 6 women), who were primary assessors. Six participants were interviewed once and six participants were interviewed twice.

Psychiatrists were not included as their involvement in clinical decision-making in the initial assessment was not routine in this team. Participants volunteered after being informed of project objectives and procedures and provided verbal informed consent. It was only after the conclusion of the clinical interaction that assessors participated in the study, thus there was no direct or indirect influence on patient care. As part of the consent process, interviewees were given specific

instructions not to use any patient-identifiable information. This was in keeping with the organisation's confidentiality policy.

Ethical approval was not deemed necessary and the study was registered within the trust as a service improvement project.

Interviews

Semi-structured, face-to-face interviews (supplementary interview schedule available at <https://doi.org/10.1192/bjb.2018.94>) with open-ended questions to elicit various aspects of clinical decision-making were carried out separately by two psychiatrists working in the CRHTT (M.S. and R.C.). Participants were asked to discuss an assessment from the past 24 h. The interview schedule provided general structure but the discussion was fluid based on the responses, which were probed to gain a deeper understanding of the themes and theories being generated. Each interview lasted about 1 hour. Interviews were audio-typed, transcribed and conducted until saturation of themes was reached.

Data analysis

A grounded theory approach was taken.^{15,16} Data was thematically analysed by the researchers (M.S. and R.C.) working independently, following recommendations by Ritchie *et al.*¹⁷ Initial transcripts were coded manually to support development of a coding framework that was subsequently refined by additional interviews. Codes included purely descriptive ones arising directly from the transcript and more interpretive codes. Then, to ensure trustworthiness of the data, the authors met and agreed themes. Any differences in interpretation of statements was resolved by discussion with the wider research team until consensus was reached. The coded data was synthesised into the final framework. Further confirmation of themes took place through team discussion, with themes validated by an independent researcher (C.L.) and the principal investigator (M.K.R.).

Results

Of the 18 assessments, low mood and suicidality appeared to be the primary cause of referral to CHRTT. Information gathered relating to symptom severity and risk appeared to be the primary basis for decision-making. Information from the referrer was supplemented by electronic patient records or past knowledge about known patients. The principal source was the face-to-face assessment with the person and their carer/s. Patient need (actual or perceived) appeared to be the primary driver behind decisions. This was evidenced in statements such as: 'For her own safety, she was unpredictable, it would have been difficult to manage that in the community at that time... Admission was the right decision' (01). (For all quotations, the numeral refers to the interview serial number.)

However, interviews revealed that the extensive information gathered was not processed in a uniform manner, but often by heuristics (common sense, rule of thumb, stereotyping, educated guess, intuitive judgement). These were noted to be part of the decision-making toolbox for all practitioners and were related to more than just patient presentation (symptoms, risk, aetiology). Below, we describe the most commonly expressed heuristic themes that influenced decision-making (*Table 1*). *Table 1* Heuristic themes (with subthemes) that influenced information processing

Theme	Subtheme
Anxiety	(generated/diffused in)
Patient	Friends/family/carer/Referrer
Triaging/assessing	practitioner
Weighting	(of symptoms elicited)
Diagnosis	(co-morbidity – personality disorder/alcohol or substance misuse)
Course of illness	(acute/chronic/acute on chronic)
Factors considered outside core remit	(relationship/finances/accommodation/employment/family – carer availability)
Agenda	(elicited in)
Referrer	Patient/Family/Practitioner/Team/
Resources	(identified or not)
Beds	Home treatment capacity/
Experience	(of)
Same patient	Other patients from same diagnostic group/
Other patients	from different diagnostic group

Anxiety

Interviews clearly showed the dual role of practitioners. First, to assess and plan the next steps, and second, to diffuse anxiety relating to the crisis under assessment. For the patient and family the anxiety settled when they felt that they got the right support, the referrer felt less anxious knowing someone else was dealing with the crisis and the assessor's anxieties settled if they felt they had brought matters to a safe conclusion either through capturing hope or blanket safety reassurances. In the case of a young, agitated suicidal male with limited protective factors who was referred back to locality team, the practitioner stated, 'Well it was straightforward, he was able to engage in it (the assessment) despite the difficulties with his anxiety' (03). The patient's willingness to engage was indicative of a safe conclusion. It diffused everyone's anxiety and trumped symptoms of agitated depression and the rationale for the decision not to provide additional support. A similar presentation with an ambiguous commitment resulted in higher anxiety all around, bringing forward the diametrically opposite decision to admit: '... There was obviously some urgency to it (admit). He had strong thoughts of taking an overdose the previous day... and his wife had to take time off work because she was concerned about his help-seeking' (15).

Practitioners were consciously eliciting predisposing, precipitating and perpetuating factors as part of exploring risk (increases anxiety), as well as protective factors and the potential willingness to safety plan (decreases anxiety). It was noted that in patients with similar presentations and risk profiles. there could be diametrically opposite clinical decisions. For risk-averse decisions, the focus was on anxiety increasing perpetuating factors. In contrast, anxiety decreasing protective factors were emphasised by the assessor. where they had taken positive risks: '... He was staying with his parents, they were quite supportive, ... housing was a big concern. ... but he's got a good job, and his employer had been really supportive. He also identified his daughter and his father as protective factors' (14).

Weighting

In the decision-making process, weighting of symptoms and risk was influenced by pre-existing diagnosis (personality disorder/substance misuse), course of illness (acute, acute on chronic, chronic) and presence or absence of social factors that were considered to be outside the core remit of CRHTT work. For example, in a suicidal patient who was not taken on, the practitioner stated: 'Not much had changed. He had previously been referred to the [...] service and the [...] service... he'd already been signposted, nothing had changed' (12).

Patients with alcohol and/or substance misuse fell into a similar bracket, with the understanding that these issues needed to be addressed first by other agencies: 'He's a heavy cannabis user, which he uses to self-medicate with his anger difficulties. We gave him advice on alcohol making him impulsive, what else can we do' (02). Nevertheless, substance misuse issues were consistently assessed for, and when identified, appropriate onward referral/signposting took place. In the presence of clear-cut major psychiatric illness, comorbid substance misuse was taken very seriously as it is a factor that significantly contributed to increased risks: '... She has been abstinent for [...] years now but with all the stress going on in the family she had turned to drink, it's only when she drinks she takes an overdose. It makes her feel lower and more impulsive, we had to do something to break the spiral' (05).

The course of the illness also strongly influenced the outcome. Generally, an acute presentation appeared to trump an acute on chronic presentation, which was higher on the pecking order to a chronic deterioration irrespective of the presentation and risk being quite similar; the expectation in the latter being that more should be done by the referrer. 'Acute: '... She was presenting as quite labile... was quite unsettled, agitated, disinhibited... we have to do something' (01). Acute on chronic: '... She's got chronic thoughts of ending her life by an Insulin overdose. There's a change to wanting to put herself in front of a train... previously what stopped her acting was her sons, however this had changed. The intensity had changed and a change in nature. Her protective factors have reduced' (15). Chronic: 'I didn't think it was an appropriate referral because this was a guy who'd only been seen in an out-patient appointment with long-term ongoing problems and I felt more could have been done by the locality team, before referring' (03). 'Although practitioners fully recognised the impact on risk of social factors (accommodation, finances, relationships, employment, carer/family support and availability), those presenting primarily with these issues were often not taken on for acute care interventions. In these circumstances, often the social aetiology behind the crisis was given more weighting than the risk: '... Social support impacted the decision-making... no significant friends or family. She receives no support

from care services with regard to her son...She is single, financially lacking and on benefits, lacking social support. She has physical illnesses with a lot of symptoms...but not for us really...' (16).

Agenda

Agendas (desire to achieve a particular outcome), both stated and perceived, influenced information processing. If an agenda was picked up in a referrer/patient/carer by a practitioner, they often responded to it. This was most obvious when judgement calls were being made about the appropriateness of the referral: '...I felt that the reasons for the referral weren't really appropriate. He was someone that they'd (Locality Team) only seen twice, the reason for referral was that he was being actively suicidal. But I felt the risk was kind of raised so we'd go and see him...' (06).

Sometimes agendas were picked up in patients and carers. There was evidence to suggest that practitioners responded (taking seriously or dismissing) with their gut instinct to the agenda that they perceived: '...Suicidal ideation, in the context of depression...because she has a child, so I think it's always worth having a look when there's a child, I got the clear sense that she was downplaying it as she did not want social services involved, we needed to do something...' (13). Generally carer concerns particularly relating to burnout were taken quite seriously, as delivering successful home treatment is often quite difficult without their support: 'I think her husband felt that she needed to come into hospital...he was quite distressed by what she had done again. He felt it was a heavy load to carry at the moment. Too much to cope with...' (01).

Resources

The research revealed that most practitioners were conscious about the impact of resources on decision-making. Most took the stance that they tried their level best to carry out the assessment independently of the bed state. When directly asked about bed pressures influencing decisions, most practitioners said no; however, most would be aware of it when doing the assessment. Practitioners indicated that if a patient was very unwell they would ensure that they get a bed, but it was also apparent that the threshold for admission dropped if more beds were available: 'We knew there was a bed, actually we knew there were plenty of beds on the ward, so we kind of thought, you know what this lady could just do with a break and some more assessment of her depression' (04).

There were similar findings relating to home treatment capacity, where practitioners denied the effect of resource limitation: 'It had no bearing on the decision (not to take a suicidal patient on for home treatment). What does that mean if we were short staffed we wouldn't have taken him? No it had no bearing on it whatsoever' (03). However, thresholds were noted to fluctuate in a similar fashion to beds when the home treatment team was less busy.

Experience

Past experience of unsuccessful home treatment or an admission that did not benefit the recovery journey of the patient influenced the practitioners reading of current risk. The rationale for not taking a suicidal patient on to home treatment was as '...There were no changes in his social situation from when I'd last seen him [...] years ago...if he feels that the situation is not validated then he will increase his risk behaviours... I felt that we needed to validate his level of distress over that and try and keep it compact (not get another team involved)' (17). It was also apparent that the team put a far higher premium on knowledge held within the team from previously working with a patient than what was being handed over to them in the here and now by the referrer.

Discussion

MacNeela *et al*¹⁸ concluded that nurses strive to ‘know the patient’, while having to ‘work the system’, with implications for patient care and decision-making quality. Interviews revealed that assessing practitioners are often put in very difficult scenarios and need to respond to multiple pressures. It would be unrealistic to expect that they will not be influenced by this. It could lead to formulation of an opinion about what a good outcome would look like early in the process. They try to remain in a rational space and make decisions based on information that they have collated. However, the pressures set up a rationalising environment in which facts get highlighted selectively to rationalise the decision that has been already formulated. This is often an unconscious process and the purpose of the study was to identify and make explicit drivers for decision-making that are often implicit and are captured in hard-to-define terms like ‘gut’ or ‘instinct’. To help assessing staff become more mindful and stay in a rational space rather than rationalising (we see what we want to see to help us deal with our cognitive dissonance¹⁹), we have framed the findings from our qualitative study in an easy-to-remember acronym, AWARE (Anxiety, Weighting, Agenda, Resources, Experience).

If a practitioner is anxious about adversely affecting the balance of hope versus risk and decides not to tease out triggers extensively, this decision should be a conscious choice (rather than unconscious). One can then document the same and handover to the next person, making it clear that there is an outstanding piece of work. The assessor can then mindfully safety plan and systematically attend to warning signs²⁰ that may rise until the next appointment. Further work relating to fluctuating risk can then be taken up when the crisis is more contained at the follow-up. Seeking blanket reassurance by asking patients ‘Can you keep yourself safe?’ only decreases anxiety in the practitioner and does very little to enhance safety.

Embedding reflective practice will keep clinicians mindful about these heuristics. Bhugra *et al*²¹ found in a qualitative study that expert psychiatrists relied upon intuitions and novices took a more analytical approach in making clinical decisions. CRHTTs are multidisciplinary in nature: front-line assessments are done by team members from different backgrounds with different levels of experience. Given the variation, decision-making standardisation becomes a key service issue. Bhugra *et al*²¹ found that uncontrollable factors (time pressures, cost, resources) influenced decisions. This is highly relevant as CRHTTs are often managing bed pressures. It is a highly dynamic setting, and thorough conscious deliberation on findings may not be possible.²² Hunt *et al*²³ reported suicide rates of 14.6 per 10 000 CRHTT episodes compared with 8.8 for in-patient episodes. The national reduction of 17% in mental health bed numbers from 2012 to 2015²⁴ has meant that CRHTTs have an ever-increasing importance in care delivery of acutely unwell patients. Therefore the higher suicide rate in CRHTTs compared with in-patients needs urgent attention. The AWARE framework may provide the foundation for safer care as it seeks to keep assessors in a mindful and reflective space.

Hunt *et al*¹³ found that 49% of CRHTT patients who took their own life had adverse life events, and a further 44% were living alone. Preconceived notions about what is core CRHTT work could be taken up in case-based discussions in a supportive fashion. This could also help reframe the CRHTT gatekeeping agenda. Assessments are about admitting at the appropriate time so that the shortest in-patient stay may be followed up by prompt home treatment. It is not about keeping everyone out. Resource-led decisions²¹⁻²⁵ are never ideal but are inevitable in the real world. Naming the decision for what it is will ensure that practitioners then consciously work toward mitigating the risk the resource-led decision has created, rather than justify (deal with cognitive dissonance¹⁹) their action by selectively highlighting aspects of the presentation.

Given that suicide is a rare outcome, assessors often feel that their judgement calls are safe, and so the threshold for admission/home treatment unconsciously creeps up. Reflective practice could keep staff mindful about small increments in risk-taking. Serious untoward incidents have a considerable detrimental impact on the confidence of practitioners to take positive risks. Threshold awareness supports safety and patients’ recovery journeys in the long run, as without risk there is no recovery.

Limitations

The study findings, particularly in relation to anxiety, are limited to the CRHTT setting as crisis referrals often have an urgency and acuity that might not be present in routine assessments. As an improvement project, the findings are relevant to the service. Before generalising findings to all assessments, AWARE as a framework needs further research. It is also important to acknowledge that, for practical reasons, study participants were recruited from a single team. Although not unusual for CRHTTs, there were no front-line assessors working who had less than 10 years post-qualification experience. Research into decision-making shows that experience level has a bearing.²¹ Also, in most crisis services, initial assessments are carried out by nurses and social workers; however, there are teams where psychiatrists might have oversight. Inter-team variability of this nature limits the generalisability of this study. Another limitation is that interviews were carried out by CRHTT psychiatrists, introducing a potential bias in responses. This was mitigated by assuring participants that this was not an assessment of their decision-making skills and that their participation was voluntary and they could withdraw consent at any point.

Clinical decisions not only affect patient outcomes but also have significant medicolegal implications. Mulder *et al* point out the futility of risk categorisation and how it may confuse clinical thinking.²⁶ This study proposes AWARE as a theoretical framework that supports safer clinical decision-making. To substantiate this claim, research across various contexts and different CRHTT settings is needed in which AWARE is empirically tested and refined.

In conclusion, there is a subjective element to clinical decision-making, as it involves clinical judgement and interpretation of information. However, there needs to be a balance between fact and intuition, and dissecting out intuitive processes might help eliminate certain unhelpful biases. AWARE provides a framework to make explicit some of the drivers for decision-making that are often implicit. This can be used in reflective practice groups as well as for a quick, internal crosscheck post-assessment. It may reduce bias and inter-assessor variability, improve consistency, lead to a more systematic approach and help staff be more mindful of how they could be subject to undue influences, and therefore result in improved clinical decisions and patient safety.

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Supplementary material

For supplementary material accompanying this paper visit <https://doi.org/10.1192/bjb.2018.94>.

[click here to view supplementary material](#)

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1.5.96 The banality of counterterrorism “after, after 9/11”? Perspectives on the Prevent duty from the UK health care sector

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Abstract

Since 2015, the UK healthcare sector sector has (along with education and social care) been re-responsibilised for noticing signs of radicalisation and reporting patients to the Prevent programme. The Prevent Duty frames the integration of healthcare professionals into the UK’s counterterrorism effort as the banal extension of safeguarding. But safeguarding has previously been framed as the protection of children, and adults with care and support needs, from abuse. This article explores the legitimacy of situating Prevent within safeguarding through interviews with safeguarding experts in six National Health Service (NHS) Trusts and Clinical Commissioning Groups. It also describes the factors which NHS staff identified as indicators of radicalisation – data which was obtained from an online questionnaire completed by 329 health care professionals. The article argues that the “after, after 9/11” era is not radically distinct from earlier periods of counterterrorism but does contain novel features, such as the performance of anticipatory counterterrorism under the rubric of welfare and care.

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¹ The underlying research materials for this article can be accessed at <https://warwick.ac.uk/fac/soc/pais/research/researchcentres/irs/counterterrorismintehns/T1/textquoteright>

Introduction

The question “is there an after, after 9/11?” forces us to address whether there has been any return from the exceptionalised, emergency frame which dominated international politics in the aftermath of 9/11. At face value, the direction of travel in Europe and North America is unchanged. The immediate legislative responses to international terrorism of the twenty-first century – the Contest Strategy (UK) and the Patriot Act (USA) – have not been repealed, and the technological advance of counterterrorism surveillance continues unabated.

However, this article argues that Countering Violent Extremism (CVE) policies do represent a distinctive development in the post-9/11 counterterrorism repertoire. CVE frameworks are now employed across the globe by actors such as the United Nations, the European Union as well as individual nation states (Kundnani and Hayes 2018). Their unique selling point is the prevention of terrorism through interventions in “radicalisation processes”, before criminal conspiracy occurs (in the so-called “pre-criminal space”). Here, the resources usually associated with social welfare policies (like mentoring, housing and education) are reframed as terrorism prevention assets (Home Office 2017, 2018). In contradistinction to the emergency criminal justice measures of the immediate 9/11 era, this article focuses on the banality of the Prevent Duty in the UK where social care, education and health care workers are now engaged in the prevention of terrorism (Ragazzi 2017).

The Counter-Terrorism and Security Act of 2015 placed a statutory duty on specified authorities within the UK’s public sector to have “due regard to the need to prevent people from being drawn into terrorism” (Home Office 2015: 2). In practice, this has meant that schools, colleges, universities, prisons, social services, National Health Service (NHS) trusts, NHS Clinical Commissioning Groups² (CCGs) and private health care providers on the NHS standard contract now perform counterterrorism – under the rubric of safeguarding. These providers deliver Prevent-related training to their staff, promote the importance of the Prevent Duty to their staff, and process Prevent referrals made about colleagues, students, patients and clients.

The use of health and education sectors to support counterterrorism is unique to England, Wales and Scotland. The Prevent Strategy has not even been rolled out to the entire UK (given the specific provisions of Good Friday Agreement, the Prevent Strategy does not apply in Northern Ireland). While some European nations utilise community policing and prison services to identify and deter potential radicals, it is much rarer for the non-judicial sectors to be involved in counter-radicalisation. The Netherlands is an exception and has begun encouraging youth workers and educators to promote counter-radicalisation³ agendas. But Britain is alone in making its educational, health and social care sectors legally responsible for counter-radicalisation.

In this unique context of policy implementation, this article explores how counter-radicalisation has been integrated into the health care sector. The authors conducted a 12-month pilot study, funded by the Wellcome Trust, which evaluated the performance of Prevent Duty safeguarding by NHS trusts and CCGs in the Midlands region of England.⁴ Using expert interviews with NHS safeguarding professionals, discourse analysis of the Workshop to Raise Awareness of Prevent (WRAP) training DVD and a survey of staff attitudes ($N = 329$) towards the Prevent Duty, we explored how Prevent is performed within the NHS’ safeguarding remit.

Our study showed that NHS staff are, on the whole, accepting of their new responsibilities under the Prevent Duty and comfortable with the training provided. However, our survey also revealed that staff knowledge of specific “radicalisation indicators” is drawn not from official training but from popular culture representations of ISIS and radicalism. WRAP training encourages staff to intuit the presence of radicalisation in staff and patients, rather than providing details of explicit “signs” to be reported. We found that this has led NHS staff to rely on the media for their understandings of terrorism and radicalisation. Furthermore, despite the popular acceptance of the Prevent Duty as a form of safeguarding, our expert interviewees unanimously commented on the imperfect fit between the Prevent Duty and other forms of safeguarding expected of the NHS.

² Clinical Commissioning Groups (CCGs) are NHS organisations set up after the Health and Social Care Act of 2012 to organise the delivery of healthcare services. Each CCG includes all of the General Practitioner groups in its geographical area, so that GPs and clinicians can influence commissioning decisions for their region.

³ The Netherlands’ “Integrated Approach to Combatting Jihadism” [Actieprogramma Integrale Aanpak Jihadisme Overzicht maatregelen en acties] policy of 2014 outlines the potential for youth workers and educators to prevent radicalisation: <https://www.tweedekamer.nl/kamerstukken/detail?did=2014D2934&id=2014D29343> (last accessed 3 November 2017).

⁴ The Midlands has a population of over 10 million people and is constituted by the counties of Derbyshire, Herefordshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire, Rutland, Shropshire, Staffordshire, Warwickshire and Worcestershire. The biggest cities in the Midlands are Birmingham, Coventry, Leicester, Nottingham and Stoke-on-Trent.

Unlike broader safeguarding protocols, Prevent safeguarding is not restricted to adults with “care and support needs”. NHS England therefore defines all citizens as potentially vulnerable to radicalisers and opens the possibility for care practitioners to intervene upon their lives. This extension of interventions across the entire population (rather than limiting them to those persons with care and support needs) creates a tension with the liberal foundations of British political life. A distinctive feature of counterterrorism “after, after 9/11” is, then, that care can be positioned as an anti-terrorism measure – and counterterrorism as a care intervention; such is the normalisation of the counterterrorism within society “after, after 9/11”.

Prevent in the NHS: academic studies

The majority of academic literature on Prevent in UK public services addresses the performance of the duty in the particular contexts of education (Choudhury 2017; Miah 2013; Thomas 2016), youth work (Lynch 2013; McDonald 2011) and social work (McKendrick and Finch 2017). Studies exploring the role of the health care sector in Prevent are beginning to emerge, but at a slower pace. Research access to the NHS can be a lengthy and complicated procedure involving a primary application to the Health Research Authority, unfamiliar terminologies (social scientific research is often not recognised as “research” but as a “service evaluation”) and secondary research access applications to each local NHS Trust’s Research and Innovation (R&I) department. These difficulties render studies of Prevent in the NHS slower to develop. To date, literature on the Prevent Duty in health care can be divided into two streams: debates in forensic psychiatry about the scientific reliability of extremism risk scoring tools and social scientific research into the NHS as a counter-radicalisation actor. This literature review focuses only on the latter.

In the field of Psychiatry, David Goldberg, Jadhav, and Younis (2017) have recently problematised the use of the term “pre-criminal space” in NHS England Prevent Training and Competencies documentation. To foster acceptance in the health care sector, the term situates the positioning of Prevent as a safeguarding and protection measure. Intervening to protect people in the “pre-criminal” space emphasises the separation of Prevent safeguarding from judicial measures. As Goldberg et al. rightly point out, the obscure term “pre-criminal space” does not appear in Home Office Prevent policies nor in any other NHS safeguarding policy: in policy terms, it is unique to NHS England’s Prevent Guidance. They explore the etymology and usage of “pre-criminal space”, arguing that it operates as both metaphor and analogy – smoothing and bridging the discourses of the health and criminal justice sectors, and persuading NHS professionals to comply with the duty (Goldberg, Jadhav, and Younis 2017).

Other academic research into the Prevent Duty focuses on the mass responsabilisation of health care workers for counterterrorism detection and prevention. Heath-Kelly (2017a, 2017b) has explored how the Prevent Duty expands the application of preventative counterterrorism to the entire population, rather than deploying it upon smaller suspect communities. The training of the 1.3 million NHS workers to report radicalisation demonstrates a transition of security apparatus away from security professionals (such as counterterrorism officers) who possess formal training, towards a far looser type of counterterrorism “expertise”. In the NHS, a 1- or 2-hour training session in front of the “WRAP” DVD qualifies a staff member to detect and report radicalisation. The minimal training for such a sensitive task shows that central government have prioritised large-scale reporting of radicalisation suspicions across the population, rather than targeted and precise counterterrorism measures (Heath-Kelly 2017a, 2017b). Indeed, upon the release of the 2013 Prevent Guidance document “Building Partnerships, Staying Safe”, Director of Nursing Hilary Garratt wrote to all CCG commissioning leads and emphasised that the size of the NHS (which makes 1 million patient contacts every 36 hours), rather than any specific expertise, qualified it as a key partner within the Prevent Strategy (Garratt 2013). Size matters, it seems, in the new Prevent Duty.

Outside these formal studies, various health care professionals have also taken to the pages of academic and professional journals to voice concern, and occasionally support, for the Prevent Duty in the NHS. Derek Summerfield, a consultant at South London and Maudsley NHS Trust, wrote in *BJPsych Bulletin* that compelling medical staff to attend Prevent training is as follows: “a corrosion of the ethics of the doctor-patient relationship, and is to prime us for an activity which is a duplicitous deviation from the medical assessment, advice and treatment that has brought the patient to us. (Summerfield 2016)”

Dr Rosemary Rizq has similar concerns about the conflation of health care and protection with the reporting of terrorist deviance. She argues that surveillance and control insidiously invade the consulting room through the Prevent Duty,

turning the patient requiring health care into an already-securitised risk, and forbidding the free play of speech so essential for therapy (Rizq 2017).

Prevent as safeguarding?

This perceived clash between medical ethics and reporting radicalisation suspicions is complicated by the positioning of the Prevent Duty as a safeguarding measure. Central government policy has explicitly presented the Prevent Duty as an additional patient safeguarding measure which entails no extra responsibilities on behalf of clinical and non-clinical staff (Department of Health 2011: 3). Accordingly, NHS England places responsibility for Prevent training and the processing of Prevent referrals with Trust and CCG safeguarding teams. These safeguarding experts provide WRAP training to staff with the Home Office DVD and script, process Prevent queries (filtering out inappropriate referrals), and determine which queries are referred to Local Authorities and the police. Safeguarding discursively and operationally situates Prevent in the NHS.

While safeguarding is more loosely defined as a “protective intervention” in the educational and social care sectors, safeguarding processes in the NHS are tightly defined. Health care safeguarding is designed *to protect those with care and support needs* (like learning disabilities, severe mental health conditions, dementia, drug and alcohol addiction) from abuse, where they cannot protect themselves. They are a necessary societal protection for those with reduced individual capacity or agency. The Care Act was passed in 2014 to legally enforce the safeguarding of vulnerable people, and it states that local authorities must intervene to support adults in cases: “where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) – (a) *has needs for care and support* (whether or not the authority is meeting any of those needs), (b) *is experiencing, or is at risk of, abuse or neglect, and* (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. (2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult’s case. (Care Act 2014, c.23, section 42, emphasis added)”

If an adult has care and support needs, faces the risk of abuse *and* cannot protect themselves, then the individual’s agency ceases to be a paramount principle. Rightly, the Local Authority becomes duty bound to intervene in these situations.

In the NHS, safeguarding teams take reports about vulnerable patients who are at risk of abuse (physical, sexual, financial) and liaise with the Local Authority, and that patient, to put a care package in place. But under the Prevent Duty, safeguarding protocols are activated in cases where no care and support need exists. In Prevent protocols, the explicit provision regarding “care and support needs” in the Care Act is watered down to a suggestion of “vulnerabilities” – creating concerns that the presumption of adult agency has been side-lined.

Home Office and NHS England policy guidance presents radicalisation as a process of abusive exploitation performed upon “vulnerable” persons. But vulnerability, under the Prevent Duty guidance protocols, is no longer a formal state of reduced capacity (like care and support needs); rather, “vulnerability” is extended to potentially cover the entire population. Anyone, with or without care needs, can be the subject of a Prevent safeguarding inquiry. How is this interference in a person’s agency justified, before the criminal threshold is reached? One’s vulnerability (and the need for safeguarding intervention) is constituted through a circular argument: simply by being associated with a radicalisation referral, a person *must already have been vulnerable* to extremist influence. The assumption plays out that no person with full capacity, or in control of their life, would support political extremism or terrorism – thus any presumed sympathy denotes reduced capacity or “vulnerability”.

While any person can be subject to a Prevent safeguarding referral, regardless of their formal capacity level, the Department of Health does provide some guidance on “factors which put people at risk of exploitation by radicalisers”. Worryingly, these racialise “vulnerability” to extremism. The factors emphasise the migration status of an individual as a point of vulnerability to extremism, their “traditional” family life (in a context where “traditional” acts as a synonym for people of colour), and their “religious/cultural heritage”. For example, the first factor highlighted by the Department of Health as indicating radicalisation vulnerability is “identity crisis”, but this is characterised as follows: “Adolescents/vulnerable adults who are exploring issues of identity can feel both distant from their parents/family and cultural and religious heritage, and uncomfortable with their place in society around them. (Department of Health 2011: 10)”

Identity crisis seems to be associated here with second- or third-generation immigrants, positioned between cultures. Apparently “identity crisis” is not a potential experience that anyone could experience, only specific and racialized groups.

The second factor in the Department of Health’s list of radicalisation vulnerability factors is “personal crisis” (characterised as the “isolation of the vulnerable individual from the *traditional* certainties of family life” [emphasis added]). Following on from the first racialised indicator, this invocation of “traditional family life” reads like a synonym for racialised groups in society. The third factor in vulnerability relates to an individual’s “personal circumstances”. We all have “personal circumstances”, but these are characterised by the Department of Health in terms of cultural, religious and raced identities leading towards radicalisation vulnerability: “Personal Circumstances: The experience of migration, local tensions or events affecting families in countries of origin may contribute to alienation from UK values and a decision to cause harm to symbols of the community or state. (Department of Health 2011: 10)”

Finally, unemployment/underemployment and criminality are listed (without racialised undertones) as factors which may make a person vulnerable to radicalisation (Department of Health 2011: 10).

Without a clinical evidence base or NICE guidance, these factors replace the formal care and support needs which are central to other forms of NHS safeguarding. These “factors” fudge the centrality of care and support needs to safeguarding (Care Act 2014, c.23, section 42) by repeatedly invoking the “vulnerability” of a person experiencing disenfranchisement or ennui, but provide no other basis for the interruption of their agency by a safeguarding action.

Without care and support needs, an adult should be entitled to live uninterrupted by the state unless they request support and assistance. Indeed, NHS safeguarding policy enshrines the principle of agency, in all cases apart from where “coercion and undue influence” might apply: “Adults have a legal right to make their own decisions, even if they are unwise, as long as they have capacity to make that decision and are free from coercion or undue influence. (NHS England 2015: 16)”

Given the usual presumption of agency for adults without care and support needs, Prevent in the NHS stretches normal safeguarding customs and protocols to their limit. The “coercion and undue influence” usually understood to constitute impaired agency are severe situational constraints. For example, people experiencing domestic violence or human trafficking can receive safeguarding assistance despite not necessarily possessing “care and support needs” – because they are experiencing significant coercion and abuse from which they cannot reasonably be expected to protect themselves.

But is it legitimate for Prevent to equate the coercion experienced by human trafficking and domestic violence victims, trapped within appalling situations and experiencing dramatic constraints upon their agency, to those engaging with extreme political opinions and those who voice them? Given the potentially dramatic contrast, it would be far more appropriate to presume that individuals retain agency and can engage with political ideas freely. While the intention of safeguarding practitioners is to keep people safe from travelling to war zones or becoming involved in terrorism, the Prevent Duty involves a significant departure from the presumption of adult agency in cases where there is often no cognitive or coercive impediment.

In the next section, we highlight the testimonies of safeguarding leads within NHS trusts and CCG’s on the imperfect fit between Prevent and Safeguarding. These safeguarding experts experienced significant dissonance between their desire to protect potential victims of radicalisers, and their knowledge that safeguarding interventions explicitly require the recipient to have “care and support needs” to justify the intervention upon agency.

NHS safeguarding experts on the prevent strategy

Our interviews with safeguarding experts shed light on some of the key features of Prevent’s uneasy situation within existing safeguarding infrastructure. Most of the safeguarding experts we interviewed held conflicting views and beliefs with regards to the place, function and broader implications of Prevent referrals made by NHS staff, even if they had come to accept, endorse or re-appropriate the Prevent Duty. These dissonances in how safeguarding experts see their role reveal important tensions and concerns that arise when a counterterrorism reporting structure is embedded within an otherwise evidence-based medical culture.

Normal safeguarding referrals utilise a transparent process which is subject to audit and clinical governance. They follow an approach of person-centred care that presupposes the person’s consent and in line with general professional

guidelines in the NHS, foregrounds patient choice. However, the tension between Prevent and the medical duty to provide care was immediately noted by some of our expert interviewees. One General Practitioner (GP) we spoke to noted that with Prevent the very object and objective of protection changes: “When you do safeguarding, the person sat in front of you is your main concern because you’re trying to protect that person. Whereas with this, you’re protecting the state from that person” (Consultant Psychiatrist B and GP 2, 2017). This underlying shift makes Prevent a controversial subject within the NHS, but also demonstrates an imperfect fit with existing safeguarding structures which necessitates a constant negotiation of the Prevent Duty by health care professionals.

Upon the introduction of Prevent to the NHS, a CCG Prevent Lead (responsible for giving the Prevent training) recalled that the policy “didn’t originally sit very well with [them] or a lot of [their] team” (CCG Prevent Lead B, 2017). These concerns reflect the problematic situation of Prevent within NHS safeguarding. Prevent aims to orchestrate a new way of “seeing” and performing safeguarding by cultivating an “awareness” for vulnerable people being at risk of radicalisation. Prevent sits in tension with the approaches, principles and definitions of safeguarding under the Care Act. These tensions become apparent when one attempts to understand the type of “abuse” upon which Prevent intervenes. Normal safeguarding processes exist to protect vulnerable people from financial, physical and sexual abuse, where they cannot protect themselves. For Prevent interventions, the closest fit would be protection from psychological abuse, *qua* domestic violence safeguarding. But even this fit is imperfect. One expert practitioner of Prevent safeguarding understood radicalisation as a “type of grooming” evident when “people are being harassed, they’re being groomed, they may not have any control over what they’re being drawn into [...]. Particularly if they’re very vulnerable and they don’t recognise it” (Safeguarding Expert P, 2017).

Yet a different Prevent trainer pointed out to us that the notion of “vulnerability” is used and talked about very differently between the safeguarding and Prevent contexts. Instead of a focus on “care and support needs”, what is emphasised is a “complex set of grievances” related to ideology, exclusion and identity. For example, “Prevent, to me, is about finding people who are at the cusp in their lives of not having anything else other than somebody saying, “why don’t you do this?” [...] And for a young Muslim child growing up, I suppose, who has a strong family bond and then suddenly is an isolated teenager, racially abused perhaps, can’t find work, you’re going to start connecting with things that perhaps, you know, you see and hear and read, and to deal with your own feelings of anger: “oh, why haven’t I got a job? Why am I in this position?” And that’s who Prevent is meant to protect, but the fact that it sits under Safeguarding, I don’t think it sits comfortably with Safeguarding. (CCG Safeguarding Expert C, 2017)”

Here, the type of abuse that NHS staff are duty-bound to protect against seems to be exclusion, rather than the existing typologies of abuse within safeguarding regimes.

The introduction of the Prevent Duty as a form of safeguarding protection has led to professional dissonance. During our interviews with safeguarding experts, it was common for them to first make the case that Prevent fits well within safeguarding – on the basis that the professional intuition already developed within safeguarding practice is an appropriate tool for detecting radicalisation. In this regard, the Prevent Duty requirements made sense to staff. Safeguarding professionals were described as having a particular nose for detecting the unfamiliar, understood as a “gut instinct that there’s something, but I don’t know what” (Safeguarding Experts F and J, 2017). But interviewees would then draw out some differences in how this intuition is utilised within Prevent. The safeguarding remit, they acknowledged, is now extended beyond people with care and support needs. Furthermore, in normal safeguarding, the emphasis is on “making the person immediately safe,” which is not the case in Prevent (Ibid).

However, the ways in which Prevent stretches beyond the scope of safeguarding was (despite these inconsistencies) often seen in a positive light. The point was made that in actual practice, normal safeguarding *also* extends beyond the strict definitions of the Care Act. Safeguarding experts F and J framed this work as a banal type of intervention upon society: “like any one of us [...] have been a victim of something, but haven’t got care and support needs, but still need some signposting” (Ibid). In this sense, they argue that “although it’s different, I suppose, [Prevent] is not that different, because some of what we do sits in and out of safeguarding as it sits under the Care Act” (Ibid). Here, Prevent was framed as “early help,” before something “reaches a critical point”. These safeguarding experts saw the Prevent Duty as complementary to the Care Act as “we’re not always working completely in line with the Care Act, because there’s more to it, and we will try and prevent things before they get to that point” (Ibid).

Other safeguarding experts also made similar rhetorical moves which positioned Prevent within the safeguarding regime and existing practice. It is “almost parental care” for an individual rather than being ‘explicit and saying, actually, this is an act ... this is dangerous, this is potentially dangerous (CCG Safeguarding Expert C, 2017). This is interesting,

because it shows how the provisions of the Care Act and the Prevent Duty have been appropriated and renegotiated by health care professionals. Prevent's vagueness on "vulnerability" has been re-appropriated to redirect attention to the needs of, and rectifying the exclusion of, the person. One interviewee used it as a "pathway" – something like a personal care-centred corrective to the Care Act – in order to secure resources for clients who would otherwise have fallen through the safety net of social care (Ibid).

Yet, this negotiation of ambiguities is also practised by Central Government, who have manufactured an overlap between NHS safeguarding and the anticipatory surveillance of potential radicals. Unlike normal safeguarding, Prevent referrals from the NHS are fed directly to the police as a matter of routine. In regular clinical practice, collaboration with the police follows established procedures: in cases where clear threats to personal safety are voiced, the police are called first and concerns about health come second. But Prevent operates before this threshold of explicit threat and involves the police as a matter of course. If a health care professional makes a Prevent referral, it is first screened by the safeguarding team before those cases deemed Prevent-worthy progress to the stage of police disambiguation (Home Office 2017: 5–6). The health care professional as well as the safeguarding team screen for signs of "radicalisation" that stop short of threats to personal safety, before involving the police. But what kind of expertise informs this professional judgement?

Trainers and safeguarding teams are not experts in counterterrorism: they receive the same WRAP training as those they train, while also receiving occasional briefings from the Regional Prevent Coordinator. Interviewees confirmed that there is an "inclination" within the NHS to share information with the police and make a referral in order to avoid risks. However, they also acknowledged that Prevent is an essentially "grey area" in that "what we now get involved with is 'if there's potential' – and this is where it's really grey with Prevent" (CCG Prevent Lead B, 2017). This is particularly worrying as doubt is actively discouraged in the process: as a CCG safeguarding expert noted, what is looked for under Prevent is "a little bit of concern" about someone's behaviour, which will be triaged by the safeguarding team – so the one who makes the referral doesn't have to "own" it (CCG Safeguarding Expert C, 2017). As another CCG Prevent Lead admitted, "I'm not sure that [a referral] will help some people. I think it runs contrary to safeguarding under the Care Act in terms of how that works" (CCG Prevent Lead B, 2017).

Concerns about the potential inaccuracy and stigmatisation involved in this haphazard reporting structure are assuaged through policy discussion of the "pre-criminal space". Prevent documentation, as well as interviewee statements, repeatedly emphasised that referees could come to little harm from the referral process – given that they would not obtain a criminal record or penalty. We also discovered that people referred to Prevent are often unaware that such a referral has been made. Their consent only needs to be obtained if the process reaches the stage where the Local Authority consider involving Channel. While policy documents encourage social care sectors to obtain consent when making Prevent referrals, they are not obliged to do so (NHS England 2017: 15–16). And, given the controversial and sensitive nature of a Prevent-referral conversation, our interviewees consistently left us with the impression that consent is usually sidelined (unlike in normal safeguarding procedures) or is fudged as a vague reference to "concerns" and obtaining unspecified "support" for the patient (CCG Safeguarding Expert C, 2017).

One particular Prevent trainer was particularly explicit about the contradiction they saw between the Prevent brief and normal safeguarding procedures of obtaining consent: "You're supposed to ask their permission [...] I don't know whether anybody does. But you're supposed to ask for their consent. 'I think you're being radicalised, I think you want to blow us up, would you mind if I referred you?' " (Safeguarding Expert A, 2017).

But, regardless of not receiving a criminal record or even not knowing one has been referred, being put through a referral process could be highly stigmatising for individuals and breaks the trust established between health care and local communities. Several expert practitioners noted that "I think it's very difficult to come back from a Prevent referral" (Safeguarding Expert A, 2017), and "that person's life can be blighted [by a Prevent referral] in all sorts of ways. Professionally, personally, if you're a child at school and nowadays, everyone knows you've been referred [...] That label will stay with you, well after the investigation and possible trial" (Consultant Psychiatrist B and GP 2, 2017). The referral process was also thought to have broader negative effects upon the relationship between health care professionals and their local communities: "If that leaks out that you did an inappropriate Prevent referral, you break down your relationship with that community, your patients, that patient's family. They'll talk to other patients. She did the referral to Prevent. She thought I was a terrorist or whatever. It would be a total disaster, where you've worked so hard to create a safe space for these people to come and talk about some really sensitive issues. You have to think before you do that. (Consultant Psychiatrist B and GP 2, 2017)"

In essence, safeguarding experts are aware of the imperfect fit between the Prevent Duty and safeguarding protocols. However, they mitigated those discrepancies by emphasising how their everyday (non-Prevent) safeguarding practice also sometimes exceeds the bounds of the Care Act, and by renegotiating aspects of the Duty. During our interviews, it became clear that some safeguarding experts assuaged their concerns about being implicated in predictive detection, by reframing the Prevent Duty as a way to reallocate resources to those deprived by the economic context of austerity. We now turn away from expert testimony to explore the everyday experiences of NHS staff with Prevent – specifically the training provided to NHS staff on Prevent and their interpretations of it.

Description of the content of WRAP training

One of the many tasks of NHS safeguarding teams is to deliver WRAP training to Trust/CCG staff. The “WRAP” training lasts 1–2 hours and involves the screening of clips from the Home Office provided DVD. Since 2016, WRAP trainers need not attend a “train the trainer” workshop; they are qualified by simply having previously attended a WRAP session and by achieving their line manager’s approval for taking on the role. In an NHS England National Prevent Update, cascaded to all safeguarding teams and prevent leads in the NHS in August 2016, staff were informed that 10.1080/17539153.2018.1494123-UF0001

(NHS England 2016: 2–3)

No specific expertise is required to deliver Prevent training, because the role involves reading from the Home Office approve script for the session and interspersing the monologue with clips from the DVD. But in the course of our interviews with Prevent leads across the Midlands, it became clear that no one found it possible or effective to stick to the script. Some trainers reported that they use jokes about the training to lighten the atmosphere, whereas others integrated discussion of current events into the session.

The “Facilitators Workbook” provided by the Home Office suggests that trainers tailor their session to the level required to “achieve buy-in” from the audience. For management audiences, the Home Office recommend that this might only involve playing the “what is Prevent” clip alongside one of the case studies contained on the DVD. However, the workbook then states that there is a minimum content threshold for the session to be considered a WRAP. The relationship between full WRAP, and the recommended session for management audiences, remains unclear: 10.1080/17539153.2018.1494123-UF0002

(Home Office undated: 2)

After the introduction of Prevent, the Workbook then instructs the trainer to proceed by choosing one of the case studies included on the DVD: either “Al Qaeda”-related radicalisation, or “Far Right”. Emphasis is placed on choosing the clip which “best suits your audience”, and ensuring that the second clip used later reflects a different ideological standpoint. Interestingly, the Facilitator’s Workbook then explicitly scripts the trainer in a fake “trust-building admission”, designed to win over their audience. The trainer is advised to reveal that they once found it hard to accept Prevent as a form of safeguarding, and how they overcame that perspective by “recognising that their conception of terrorism was too narrow”. This, the Workbook advises, will build trust that can later be exploited by “educating the audience” with the iceberg metaphor of terrorism and enable you to “assert your authority for the rest of the session”: 10.1080/17539153.2018.1494123-UF0003

(Home Office undated: 4).

The Facilitator’s Workbook clearly shows that the training package aims to deflect criticism that Prevent does not fit within NHS safeguarding protocols. The aim of the training is not to engage open discussion but to embed the duty to report radicalisation concerns to one’s line manager or safeguarding team.

Similarly, the internal narrative of the Facilitator’s Workbook instructs trainers to control the discussion of case studies from the DVD. Rather than allowing flippant suggestions of vulnerability indicators, or “shouting out”, the trainer is repeatedly instructed to focus the discussion on emotional states that might lead to radicalisation: 10.1080/17539153.2018.1494123-UF0004

(Home Office undated: 6)

Through the policing of discussion possibilities, and the threat of being put on the spot by the trainer, the audience are drilled to accept vague emotional and social states (family upheaval; low self-esteem; social exclusion) as precipitating factors in radicalisation. NHS staff are never trained in specific behavioural signs that indicate radicalisation, but rather instructed to adopt an attitude of suspicion towards emotional states.

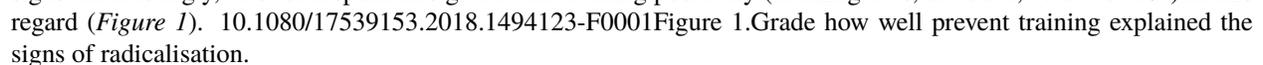
Given the multiple contexts in which family upheaval, low self-esteem and social exclusion are manifest, the indicators of radicalisation are presented in very broad terms within WRAP. So what scenarios do NHS professionals think they are supposed to report? The second stage of our study involved testing NHS staff attitudes towards the Prevent Training through a questionnaire, and asking what scenarios they consider to be reportable as a Prevent query.

Everyday NHS staff attitudes to the prevent duty and WRAP training

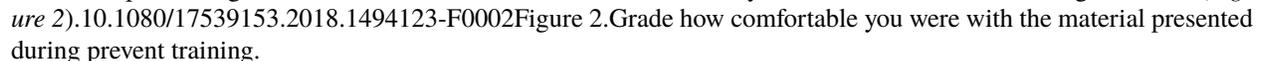
Our questionnaire was developed to capture data around each participant's pay grade, the NHS Trust/CCG for whom they work, their confidence in the WRAP training, the behaviours which they would consider reporting as a Prevent query and their perceptions of the social functions of the Prevent Duty (safeguarding or surveillance). The questionnaire was hosted on a University of Warwick server, gained ethical clearance from the University's Biomedical Sciences Research Ethics Committee, and was distributed to the workforces of each trust and CCG participating in the study by their Head of Safeguarding. In total, 329 NHS staff completed the questionnaire.

The uptake between participating Trusts and CCGs was imbalanced: 76% of responses were drawn from a mental health trust in a non-priority Prevent area of the Midlands; 15% came from an Acute Trust in a non-priority area; 3% came from CCG staff in a non-priority area and the remaining respondents either did not specify their employer or were employed in various other trusts across the UK. These "others" discovered the survey through publicisation by the MEND network (Muslim Engagement and Development). We did attempt to obtain research access to Trusts and CCGs in Prevent priority areas but we were not successful.

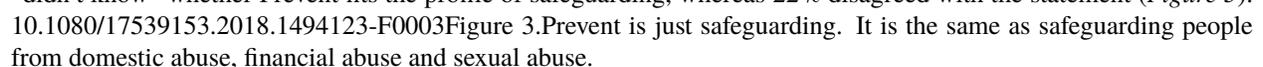
After obtaining contextual details about the participant's pay grade (to establish the degree of seniority they possess) and previous safeguarding training received, we asked respondents to grade how well WRAP (or other forms of Prevent training) explained the signs of radicalisation. We were interested to know how NHS staff felt about the training, given that our content analysis of WRAP demonstrated significant vagueness around the communication of radicalisation signs. Interestingly, 71% of respondents graded the training positively (marking it as, or above, "7 out of 10") in this regard (*Figure 1*). 10.1080/17539153.2018.1494123-F0001



We interpret this positive reaction to the training's communication of radicalisation indicators as also being an endorsement of radicalisation as the interruptible process which leads to terrorism. If a respondent was unconvinced by the radicalisation narrative put forth by government and media, then we argue that they would have marked the training as "bad" or "extremely bad" on this scale. Similarly, positive results were obtained when we asked participants to reflect on their comfort or discomfort with the material presented during their Prevent training. About 72% of respondents graded themselves as "comfortable" or "extremely comfortable" with the training materials (*Figure 2*). 10.1080/17539153.2018.1494123-F0002



At first glance, these findings tend to support the conclusions of a study which explores the roll-out of Prevent in education – specifically, that the majority of public sector respondents accept the core government narrative that Prevent should be understood as part of their safeguarding duties (Busher et al. 2017). However, when we directly asked health care professionals whether they understood the Prevent Duty to be a form of safeguarding, our results became far more ambiguous. Only 47% reported agreement with the statement that "Prevent is just safeguarding. It is the same as safeguarding people from domestic abuse, financial abuse and sexual abuse". Slightly over 30% of people "didn't know" whether Prevent fits the profile of safeguarding, whereas 22% disagreed with the statement (*Figure 3*). 10.1080/17539153.2018.1494123-F0003



This move towards ambiguity when directly questioned about Prevent's status as safeguarding is very interesting. When compared to similar research in the education sector (Busher et al. 2017), it suggests that the context of safeguarding in health affects respondents' attitudes towards the Duty. In health care, unlike education, safeguarding is associated with

protective intervention upon adults with “care and support needs”. Our results show that the majority of health care professionals (in our study) are accepting the Prevent Duty’s place in health and are comfortable with its requirements; however, this acceptance does not signify a similar acceptance that Prevent is safeguarding. Results for that question were significantly split, with less than 50% of respondents agreeing with the Department of Health’s framing of Prevent as safeguarding.

Our survey continued by exploring health care professionals’ attitudes towards various scenarios and whether they would constitute grounds for making a Prevent query. We developed these questions to probe deeper into the pedagogical effects of WRAP training. WRAP is quite vague on specific indicators of radicalisation and instead emphasises the wide-ranging emotional states which “make a person vulnerable” to extremism, like family upheaval, low self-esteem and social exclusion (Home Office undated: 6).

One of the most significant findings was that health care professionals’ confidence in their ability to spot radicalisation fell away when we introduced mildly complex scenarios. For example, we asked respondents to grade their confidence in distinguishing radicalisation from someone’s interest in Middle Eastern politics and wars. Only one in three respondents reported having any degree of confidence that they could make the distinction; 56% of participants stated that they “didn’t know” if they could distinguish interest in Middle Eastern politics and wars from radicalisation and 11% were explicitly unconfident to tell the difference (*Figure 4*). 10.1080/17539153.2018.1494123-F0004Figure 4. Grade how confident you feel to tell the difference between someone experiencing radicalisation and someone with an interest in middle eastern politics and wars.

This represents significant ambiguity about the character of radicalisation and its relationship to someone’s general interest in current and/or political affairs. This finding was also apparent when we asked health care professionals’ to consider whether someone’s possession of radical philosophy necessitated making a Prevent Duty query. We deliberately did not qualify what we meant by “radical Islamic/anarchist philosophy” in the survey, to see if respondents queried the definition. It is notoriously difficult to classify philosophy as radical or non-radical. However, health care professionals felt extremely confident to understand the difference, without specific training on the matter. Only one respondent (from a sample of 329) left comments on the survey about potential difficulties in distinguishing radical from non-radical philosophy.

Leaving aside the unspecified nature of radical philosophy, 70% of respondents were “somewhat likely” or “very likely” to make a Prevent referral about someone on the basis of radical philosophy possession. Only 22% were “unlikely” or “extremely unlikely” to make such a referral. 8% said that they “didn’t know” if they would make such a referral (*Figure 5*). 10.1080/17539153.2018.1494123-F0005Figure 5. If a patient or staff member possessed books about radical Islamic philosophers or radical anarchism, how likely is it that you would make a safeguarding query?.

We conclude from this that health care professionals feel inappropriately confident to judge whether philosophical books are radical, and that they are worryingly inclined to suspect radicalisation solely from the possession of radical philosophy. Academic research suggests that the philosophically and religiously literate are actually less susceptible to radicalisation (Coolsaet 2015; Roy 2011), and WRAP training makes no mention of philosophy books as an indicator of concern, so we believe that respondents are drawing their attitudes from popular culture rather than official training or academic research.

Our suspicion that respondents are drawing their understanding of radicalisation from popular culture is further confirmed by their association of beheading videos with signs of concern. Beheading videos are not mentioned in Prevent training, so the association of viewing such videos with radicalisation comes from popular media. When asked if they would make a Prevent query about someone who watched beheading videos, 74% of respondents said “yes” (without any reference to the “care and support needs” generally needed for a concern to become relevant to safeguarding procedures); 21% “didn’t know”; and only 5% said they wouldn’t make a Prevent referral on this basis (*Figure 6*). 10.1080/17539153.2018.1494123-F0006Figure 6. If you saw a patient or staff member watching video clips of beheadings, would you make a safeguarding query?.

Other criteria which health care staff strongly associated with radicalisation included hate speech about ethnicities, sexualities and other minority groups. An enormous 82% of respondents reported that they would be “very” or “somewhat” likely to make a Prevent query upon hearing such hate speech. Only 15% were “not likely” or “very unlikely” to make such a referral (*Figure 7*). While it is important to challenge hate speech in the workplace, the Prevent training does not specify that such illiberal opinion indicates radicalisation. However, upon the launch of the Prevent Duty, Ed-

education Secretary Nicky Morgan did identify vocal homophobia as a potential sign of radicalisation (BBC News 2015). [5]_10.1080/17539153.2018.1494123-F0007Figure 7.If a patient or staff member made hateful statements against an ethnicity, sexuality, or another minority group, how likely is it that you would make a safeguarding query?

However, interests in political events, possessing unpleasant opinions, or reading religious philosophy are not necessarily indications of radicalisation. NHS England has itself emphasised this in the most recent policy guidance for implementing the Prevent Duty: “Professionals should also have due regard to the Public Sector Equality Duty and be sensitive in their considerations. Outward expressions of faith or an interest in global or political events, or opinions that may seem unpleasant, in the absence of any other indicator of vulnerability or risk are not reason to make a referral to Channel. (NHS England 2017: 14)”

And yet, our study indicates that NHS health care professionals in the Midlands are inclined to draw such conclusions and to potentially make Prevent referrals on these grounds.

Conclusion

In the era of “after, after 9/11” in the UK, terrorism prevention has come to be framed as the extension of safeguarding. This framing of peer-to-peer counterterrorism surveillance as a banal measure of care has ensured the successful rollout of the Prevent Duty throughout the public sector. However, upon examination, there is an imperfect fit between Prevent and safeguarding in the health care sector (where Prevent is applied to people with formal care and support needs). We have raised concerns that the Prevent Duty deemphasises the formal care and support needs which legitimate protective intervention in an adult’s life, replacing them with vague (and circular) notions of vulnerability to extremist rhetoric. We also showed the various strategies health care professionals deploy to negotiate the tensions of Prevent in the NHS, including the highlighting of “grey areas” in normal safeguarding practice and the reframing of Prevent pathways as a way to redistribute care resources to those excluded by society.

Outside the realm of formal definitions and their interpretation by safeguarding experts, we also discussed the everyday experience of NHS staff with Prevent. After describing the content and pedagogy of the WRAP training product, we analysed the attitudes of 329 NHS staff to the Prevent Duty and their conceptions of radicalisation. Here, we found that the majority of those surveyed approved of the Duty, but were somewhat unconvinced of its status as genuine safeguarding. More concerning were the prominent trends within survey data which showed how staff associate radicalisation with philosophy possession and with hate speech. Illiberal attitudes and beliefs are being associated with radicalisation. Finally, we expressed grave concerns that only one in three respondents considered themselves confident to tell the difference between radicalisation and an interest in Middle Eastern wars and politics. Our survey results raise concerns that WRAP training generates a significant number of inappropriate referrals, some of which are removed from the system by the local safeguarding team, whereas others are deemed “misguided” by the Police Prevent Lead or Local Authority.

No figures exist for referrals which are deemed irrelevant or misguided by safeguarding teams or police. These fail to reach the Prevent Case Management system. But the figures for those referrals which do reach the Prevent Case Management system demonstrate a remarkably high attrition rate. Only 5% of formal Prevent referrals in 2016 and 2017 were allocated a deradicalisation mentor (Home Office 2017, 2018). Instead, the figures for 2017 show that 36% of formal referrals were abandoned,⁶ and 45% were given support from housing, education or health services. The remaining 19% were discussed at Channel Panel, of which a minority (5% of all formal referrals) received mentoring (Home Office 2018).

6

No figures exist for informal referrals which are removed from the pipeline by safeguarding teams or the initial police check. The real attribution rate for Prevent referrals is thus much higher.

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Before the statutory duty was introduced in 2015, this figure for mentoring (and thus the formal accuracy of Prevent referrals) was much higher. About 20% of referrals went on to receive mentoring support from Channel. But since the introduction of the Prevent Duty, the total number of referrals has jumped from 500–1000 per year to 7631 in 2015/16 (Home Office 2017). As Thomas Martin argues, this enormous increase in referral numbers – and the drop to 5% receiving Channel mentoring – reflects the responsabilisation of the public sector for counter-radicalisation and the prospect of censure for non-compliance (Martin 2018). Legal obligation has increased the numbers of referrals but not their quality.

This remarkably high failure rate of the Prevent Duty to identify subjects who require deradicalisation mentoring also speaks to the impact of the safeguarding framing and economic austerity. The provision of normal safeguarding support (housing, mental health care, education) to 45% of Prevent referrals distracts attention from the small number of people deemed to actually require deradicalisation intervention. But why could not these outcomes be obtained through normal social service provision, rather than a counterterrorism pathway? The context of economic austerity in the United Kingdom has diminished the capacities of the public sector to respond to social needs, and we find that the Prevent Strategy is gradually filling the gap – while simultaneously enabling surveillance (Heath-Kelly 2017a).

Supplementary Material

Supplemental Material

Charlotte Heath-Kelly is an Associate Professor of Politics and International Studies at the University of Warwick. She has published one monograph on war-on-terror memorialisation, ‘Death and Security: Memory and Mortality at the Bombsite’ (Manchester University Press, 2016), and one monograph on ex-militant testimony and the post-conflict politics of memory in Southern Europe, ‘Politics of Violence: Militancy, International Politics, Killing in the Name’ (Routledge, 2013). Her research interests include counter-radicalisation policies, memorialisation and critical studies on terrorism.

Erzsebet Strausz is an Assistant Professor of Politics and International Studies at the University of Warwick. Her monograph, ‘Writing the Self and Transforming Knowledge in International Relations: Towards a Politics of Liminality’, was recently published by Routledge (2018). Her research interests include continental philosophy, aesthetics and critical pedagogy.

Disclosure statement

No potential conflict of interest was reported by the authors.

Interviews

Interview with CCG Prevent Lead B; 11 November 2017.

Interview with CCG Safeguarding Expert C; 1 October 2017.

Interview with Consultant Psychiatrist B and GP 2; 19 November 2017.

Interview with Safeguarding Expert A; 20 March 2017.

Interview with Safeguarding Expert P; 14 October 2017.

Interview with Safeguarding Experts F & J; 21 October 2017.

1.5.97 A retrospective study comparing the length of admission of medium secure unit patients admitted in the three decades since 1985

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date

2019-8

Abstract

Aims and method

Admissions of patients to secure forensic hospitals are often lengthy. Previous research has examined factors associated with prolonged admission, but studies analysing admission data at a single medium secure unit (MSU) over a prolonged time period are lacking. We compared admission data for all patients admitted to a MSU in England during the years 1985, 1995, 2005 and 2012.

Results

The median length of admission increased from 167 days in 1985 to 580 days in 2012, though not in the intervening cohorts. There have been changes in the discharge destination of patients, away from independent accommodation in the community towards further care or supported accommodation.

Clinical implications

The results suggest a change in the delivery of care. Further studies should be performed to assess whether the same trends exist at other sites. If these trends are also found elsewhere, this should trigger a specialty-wide discussion about admission length and its effects on bed availability.

Declaration of interest

None.

Contents

- *A retrospective study comparing the length of admission of medium secure unit patients admitted in the three decades since 1985*
 - *Materials and method*
 - *Results*
 - *Discussion*

Forensic hospitals, including high, medium and low secure services, have important roles in the treatment of psychiatric patients with a criminal history. Patients are admitted to these specialised services when it is felt they pose a risk to others, often due to a history of serious violence or other offending behaviours. The care of these patients, now more than ever, involves a multidisciplinary approach.^{1,2}

There is an expanding body of literature analysing the outcomes of admission to medium secure units (MSUs). These studies suggest that patients are at significant risk of readmission and, sadly, at significantly increased risk of death compared with the general population.³⁻⁶ Admissions to MSUs are now often lengthy,⁷⁻⁹ findings that were echoed by a recent study analysing length of stay data in high secure units across Europe.¹⁰ Factors identified as associated with a longer length of stay include a diagnosis of a psychotic disorder, detention under a restriction order – in particular, those under section 37/41 (Section 37 is a court-issued order that means the patient will be sent to hospital rather than prison, and Section 41 is a so-called ‘restriction order’ that is designed to reduce the risk to the general public) of the Mental Health Act 1983 (amended 2007) – poor treatment response and the seriousness of the index offence.⁸ However, data from single sites over a prolonged period of time are lacking.

The objective of our study was to observe trends in the diagnoses, length of stay and discharge of patients admitted to a local MSU in the years 1985, 1995, 2005 and 2012. We also considered what factors or changes in service provision over the study period had affected the length of admission and discharge locations of our medium secure service.

Materials and method

Ethical approval for this study was gained from the local clinical audit department as a service evaluation and did not require approval from the local Research Ethics Committee. Non-anonymised data required by the study were gathered by one author (D.T.), and anonymised data were subsequently analysed by the remaining authors.

All male and female patients admitted to the MSU during the years 1985, 1995, 2005 and 2012 were included in the study. The admission year of 2012 was chosen (rather than a later year) as it provided sufficient time from admission to the date of data collection for treatment courses and possible discharges to be assessed.

One hundred and seventy-nine patient records were included in this study. The date of data collection was 4 April 2016. No patients were excluded from the study. Electronic records were analysed for a variety of criteria, including age on admission, date of admission, date of discharge, diagnosis, source of admission, location of discharge and convictions on admission. In the 2012 cohort, four patients had not yet moved on from the MSU on the date of data collection. Their discharge date was recorded as the date of data collection to give a minimum median length of stay for the 2012 cohort. These patients were excluded from the analysis of discharge destination.

Data compilation and analysis were performed in Microsoft Excel (Microsoft Corporation, Redmond, WA, USA). Statistical analysis comparing length of admission of different cohorts was performed with one-way ANOVA using an internet-based calculator (<http://www.statisticslectures.com/calculators>).

Results

There were 47, 65, 37 and 30 patients admitted to the MSU in 1985, 1995, 2005 and 2012, respectively. The majority of these patients were diagnosed with paranoid schizophrenia. The primary diagnoses of patients included in the different cohorts are shown in *Table 1*. The average age of the patient population varied little over the time period included in our study. *Table 1* Diagnoses of patients admitted to our medium secure unit during 1985, 1995, 2005 and 2012

Diagnosis	1985	1995	2005	2012
Paranoid schizophrenia	32 (67%)	60 (92%)	26 (70%)	24 (80%)
Schizoaffective disorder	1 (2%)	0 (0%)	5 (14%)	3 (10%)
Mood disorder, manic episode	0 (0%)	0 (0%)	0 (0%)	1 (3%)
Bipolar disorder	7 (15%)	2 (3%)	2 (5%)	0 (0%)
Depressive episode	0 (0%)	1 (2%)	1 (3%)	1 (3%)
Recurrent depressive disorder	0 (0%)	0 (0%)	1 (3%)	0 (0%)
Affective mood disorder	0 (0%)	0 (0%)	0 (0%)	1 (3%)
Antisocial personality disorder	2 (4%)	0 (0%)	0 (0%)	0 (0%)
Emotionally unstable personality disorder	0 (0%)	0 (0%)	1 (3%)	0 (0%)
Organic	1 (2%)	1 (2%)	0 (0%)	0 (0%)
Undetermined	5 (10%)	1 (2%)	1 (3%)	0 (0%)

The median length of admission increased dramatically in our final cohort, from 167 days in 1985 to 580 days in 2012 (*Table 2*). According to a one-way ANOVA test, the median durations of the first and last cohorts, but not the intervening cohorts, differed significantly from one another ($P < 0.01$). *Table 2* Median duration of admission of patients in the medium secure unit in each of the years included in the study. The minimum and maximum duration of stay are also included

Year	1985	1995	2005	2012
Median duration of admission, days \pm s.d.	167 \pm 299	114 \pm 425	110 \pm 566	580 \pm 453
Minimum duration, days	11	33	13	33
Maximum duration, days	113	33	133	580

days166219522297Unknown^{a1}

The discharge location also showed changes over the study period (*Table 3*). Fewer patients were discharged directly to their home (54% in the 1985 cohort and 13% in the 2012 cohort), and more patients were discharged to other forms of psychiatric hospital, such as other MSUs (0% in 1985, 3% in 1995 and 2005, 17% in 2012) or to low secure units (10% in the 1985 cohort compared with 33% in the 2012 cohort). *Table 3* Discharge location of patients discharged from our medium secure unit (MSU) in the 1985, 1995, 2005 and 2012 admission cohorts

Discharge location	1985	1995	2005	2012
Police custody	0 (0%)	0 (0%)	0 (0%)	1 (3%)
Prison	5 (10%)	7 (11%)	6 (16%)	3 (10%)
Low secure psychiatric hospital	5 (10%)	4 (6%)	8 (22%)	10 (33%)
Other MSU	0 (0%)	2 (3%)	1 (3%)	5 (17%)
High secure psychiatric hospital	4 (8%)	5 (8%)	1 (3%)	1 (3%)
Remained in our MSU	0 (0%)	0 (0%)	0 (0%)	4 (13%)
Supported accommodation	8 (17%)	28 (43%)	10 (27%)	2 (7%)
Home	26 (54%)	17 (26%)	9 (24%)	4 (13%)
Died	0 (0%)	0 (0%)	2 (5%)	0 (0%)
No information	0 (0%)	2 (3%)	0 (0%)	0 (0%)

Discussion

The main finding of this study is that the duration of admission has increased significantly in the three decades since the initial cohort, with patients now remaining for a median of close to two years in the MSU. This correlates with a reduction in the number of new admissions per year, down from a peak of 65 in 1995 to 30 in 2012. The duration of admission appears to have been relatively stable in the decades prior to the 2012 cohort; only in this cohort did the length of admission increase significantly.

The four patients in the 2012 cohort still in the MSU on 1 April 2016 each had a length of stay of at least three years and three months. Their final length of admission may be significantly longer, and we cannot know by how much the median length of stay is an underestimate.

Recommendations regarding treatment of mentally disordered offenders were made in the Glancy and Butler reports.^{11,12} These reports informed the development of the regional secure units (now known as MSUs) to complement the existing special hospitals (now known as high secure hospitals). An upper limit for length of stay of two years in the regional secure units was suggested, but this is now regularly exceeded, as this study shows. The increasing length of stay in MSU has been criticised, being deemed ‘too long in very expensive and often unsuitable provision’ in a report by the Schizophrenia Commission.¹³

Despite the aforementioned criticism of the increasing length of stay and the undoubted expense of a medium secure bed, these services have the potential to save society a significant financial burden. One report suggests an average saving of over £600 000 per patient transferred from prison to psychiatric units.

Information regarding the length of stay at a single site has been investigated previously.^{14–17} However, no studies have investigated how the length of stay has changed over a prolonged period of time. Therefore, we feel that the data provided by our study add to the literature and provide a primary example of how length of admission has changed across a significant period of time. When comparisons were made with these early studies, the length of admission was comparable with that of the earliest cohort of our study. For example, in one paper published in 1981, the vast majority of patients were discharged in less than one year, which fits with the length of stay of the 1985 cohort in our study.¹⁴ It would be interesting to see modern studies in these other hospitals, to identify whether they have witnessed similar increases in length of stay.

One of the major changes since 1985 is in how patients are treated. In the older cohorts, the principal role of the forensic mental health service was to ensure that the symptoms of the patient’s mental illness had reduced or resolved;

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The maximum duration is unknown for this cohort owing to ongoing admission.

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offending risk related to other factors such as personality, substance misuse, social circumstances or life choices was often not felt to be the domain of mental health services. This underwent a significant change in the following decades. Mental health services now provide far broader care to address these other aspects, as evidenced by the essential roles of the multidisciplinary team^{1,2} and the adoption of recovery principles. These important changes are time and labour intensive, and as such may be a contributing factor to the increased length of stay.

In the analysis of the discharge locations and admission sources of these patient cohorts, certain patterns emerged. Far fewer patients are discharged directly to their home. Our patients are often discharged to long-term MSUs, lower security psychiatric units or supported accommodation. Notably, therefore, despite the increasing length of stay, fewer patients are discharged directly into independent accommodation in the community. Numerous studies have provided detailed analysis of the follow-up of patients discharged from forensic psychiatry units.³⁻⁶ Given the risks inherent in these patients returning to day-to-day life, further care in supported environments may reduce risk to others at a population level. Responses to serious untoward incidents have changed over time^{18,19} and may now be more likely to lead to greater restrictions for patients. This in turn may contribute to the increasing lengths of stay described above.

There are limitations to our study. As our cohort was from a single MSU, the general applicability of our findings may be limited. It is recommended that further research be undertaken to examine whether the trends identified here are reproduced in other MSUs.

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1.5.98 'Prescribing' psychotropic medication to our rivers and estuaries

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2019-8

Abstract

Summary

The influence of pharmaceuticals on the environment is an increasing concern among environmental toxicologists. It is known that their growing use is leading to detectable levels in wastewater, conceivably causing harm to aquatic ecosystems. Psychotropic medication is one such group of substances, particularly affecting high-income countries. While these drugs have a clear place in therapy, there is debate around the risk/benefit ratio in patients with mild mental health problems. Therefore, it is necessary to evaluate the wider implications as risks could extend beyond the individual to non-target organisms, particularly those in rivers and estuaries.

Declaration of interest

None.

Contents

- *'Prescribing' psychotropic medication to our rivers and estuaries*
 - *Psychotropic drug use patterns*
 - *Pharmaceuticals as emergent pollutants*
 - *The effects of psychotropic drugs on the aquatic environment*
 - *The solutions*
 - *Reflections for policy and practice*

Psychotropic drug use patterns

Adequate psychiatric service provision is central to health and quality of life, and the use of psychotropic medication can be invaluable in the treatment and management of mental health problems. The uses of these drugs have been evident since their introduction, and they have a well-established place in clinical practice. However, within the medical fields, there has been a debate in recent years about the over-reliance on drugs such as antidepressants, anti-anxiety drugs and antipsychotics.¹⁻⁴ Data from a number of countries have indicated rapid rises in prescriptions, with as many as 10% of the population taking such medications, particularly in high-income countries such as the UK.³ Within the field of environmental toxicology, the effects of these drugs have recently started to generate some interest too.

Pharmaceuticals as emergent pollutants

Currently, pharmaceuticals mainly enter the environment through wastewater after their excretion, either in their original form or as metabolites. This has long been known,⁵⁻⁶ with the first reports of these substances entering the environment dating back to the 1960s.⁷ However, sewage treatment plant processes do not adequately remove pharmaceuticals. With the sheer number of different medications being prescribed and the inability of even quite modern sewage treatment processes to fully break them down, it could be argued that our aquatic life is bathing in a soup of multiple drugs.

Toxicity levels of pharmaceuticals in the environment do not necessarily relate to high concentrations, but to their constant low-level discharge, persistence in ecosystems and highly active biological functions. In this way, pharmaceuticals that are found in relatively low concentrations could be extremely potent and very persistent, and able to significantly affect non-target organisms. For example, low concentrations of antidepressants and other psychotropic drugs can cause disruption to the normal functioning of aquatic organisms.⁸

The concept of environmental relevance, therefore, becomes important. For example, selective serotonin reuptake inhibitors, selective serotonin–noradrenaline reuptake inhibitors, serotonin antagonist reuptake inhibitors, tricyclic antidepressants and benzodiazepines have all been detected in urbanised waterways, mostly in the ng/L range, but also in concentrations up to g/L.⁷ What is particularly starting to interest scientists is that these antidepressants can cause disruption to the normal functioning of aquatic life in laboratory experiments at low concentrations. The uptake of these compounds appears to be highly dependent on the organism's mode of feeding.⁹ In terms of presence in the environment, for example, diazepam has been found in all matrices – wastewater, surface, ground and drinking water, soils, bio-solids and tissues¹⁰ – and in concentrations as high as 10 ng/L in rivers and potable water.¹¹

Pharmaceuticals are not present in isolation in the environment, and the widespread high use of a wide variety of drugs leads to multiple substances being found together, in a situation where synergistic or antagonistic effects can occur.⁷ In addition, exposure of some non-target organisms to these substances takes place for the entirety of their life cycle.¹²

Currently, pharmaceuticals and their active metabolites are globally considered to be an important emergent group of pollutants that are intrinsically bioactive, causing adverse drug reactions and previously undocumented effects on non-target organisms.⁷

The effects of psychotropic drugs on the aquatic environment

The notion that drugs prescribed to humans might be affecting wildlife first came to light in the 1990s, when scientists highlighted that natural and synthetic oestrogens from contraceptive pills and hormone replacement therapy in wastewater effluent could feminise fish at very low concentrations.¹³ Growing incidences of reproductive and other abnormalities developed into an interdisciplinary field, linking human and environmental toxicology to the study of endocrine-disrupting chemicals. As improved analytical techniques become available and interest in this field increases, the influence of pharmaceuticals on the environment is increasingly being documented. Identified cases where pharmaceuticals are causing detrimental effects are therefore becoming more common. For example, the veterinary use of the non-steroidal anti-inflammatory drug diclofenac has recently been linked to widespread (over 90%) declines in vulture species in some countries¹⁴ and serves as a reminder that, sometimes, the effects of biologically active drugs can have far-reaching consequences.

While the potential for pharmaceuticals to lead to toxicity in non-target organisms exists across all therapeutic groups, the case of psychotropic medication is particularly concerning. This is because these drugs, which are among the most commonly detected in aquatic environments, affect not only the central nervous system but are also linked with reproduction, growth and immune functions.^{13,15} In this way, psychotropic drugs such as antidepressants modulate neurotransmitters serotonin, dopamine and noradrenaline, having multiple physiological effects in humans such as weight gain, fatigue and sexual dysfunction.

The ability of psychotropic medication to disrupt the normal biological systems of abundant and ecologically important groups of non-target organisms in aquatic environments is extensive. Since reuptake transporters and receptors evolved in invertebrates such as molluscs and Crustacea, release of neurohormones would be expected to have multiple biological effects on these invertebrates, in addition to vertebrates such as fishes. Therefore, any compounds in the environment at a sufficient concentration able to alter neurohormones have the capacity to affect a wide range of biological processes,¹⁶ leading to salient effects on critical life cycle events. Processes affected include reproduction, growth, maturation, metabolism, immunity, feeding, locomotion, colour physiology and behaviour. Examples of adverse effects that have been observed include photo- and geotactic behaviour, abnormal activity patterns, aggressive behaviour, developmental and metabolic abnormalities, and reproductive abnormalities. Interestingly, some of these effects are only exhibited at low concentrations, rather than being dose dependent as may have been expected.¹⁶

For example, Guler and Ford¹⁷ studied the effects of a variety of pharmaceuticals and the hormone serotonin on the preference for light versus dark choice chambers in amphipods. They reported a significant preference for light and response to gravity in terms of position in amphipods exposed to fluoxetine and serotonin. The dose response was linear for serotonin, whereas for fluoxetine the response was not dose dependent and the behaviour was induced only at lower concentrations (10–100 ng/L). Similarly, when crabs were injected with serotonin, photonegative behaviour was reduced and they spent substantially less time hidden.¹⁶ This would have consequences for aquatic life, as preference to light has been demonstrated to increase the likelihood of predation.

Other studies found that while 1 ng/L fluoxetine influenced learning in the cuttlefish, 100 ng/L did not, but did significantly influence the retention of memory. Effects observed include fluoxetine influencing on learning and memory in cuttlefishes at concentrations between 1 and 100 ng/L.¹⁸ Swimming activity has been observed to be altered in amphipod crustaceans at levels as low as 1–100 ng/L,¹⁹ and gonadal aberrations in zebra mussels have been induced in ranges as low as 20 ng/L. Moreover, fluvoxamine was found to induce egg deposition in zebra mussels at ~318 ng/L,²⁰ and exposure to venlafaxine has caused foot detachment (an inability to cling to the side of a tank) at levels as low as 313 pg/L and 31.3 ng/L.^{21,22} Further effects on reproductive output in terms of frequency of broods, offspring production, gamete release and gene expression have been demonstrated in the ng/L concentrations.

Induction of hyperglycaemic responses in a variety of crustaceans has also been observed. The regulation of blood glucose through crustacean hyperglycaemic hormone is under the control of a variety of neurohormones.²³ There have also been reports that dopamine, serotonin, noradrenaline and adrenaline are all effective in inducing hyperglycaemic

responses in a variety of crustaceans.²⁴ The release of crustacean hyperglycaemic hormone has been shown to be promoted by injection with serotonin in a variety of species.²³ Interestingly, studies with crabs have shown that both serotonin and fluoxetine can stimulate crustacean hyperglycaemic hormone and suppress moulting hormones.²⁵ In terms of pigmentation, serotonin has been shown to influence red pigment-dispersing hormone, while dopamine influences red and black pigment-concentrating hormones in shrimp. It has also been found that noradrenaline triggers release of black pigment-dispersing hormone.²³ Therefore, any drugs with the capability to modulate these neurohormones can conceivably interfere with the camouflage abilities of aquatic invertebrates.

Perhaps it is not surprising that fish exposed to antidepressants or antianxiety medication display altered behaviours when one considers how evolutionarily conserved the nervous system is among the vertebrates. Furthermore, because of this conserved ancestry, fish are now more commonly used in drug discovery, with behavioural tests commonly used in rats and mice being translated to fish models.²⁶⁻²⁷ For example, the novel tank test measures the 'normal' reluctance of a fish to venture in the open surroundings of a new tank, which can be altered by antianxiety medication.²⁸⁻²⁹ Other studies within the field of environmental toxicology have observed a wide range of altered behaviours in fish, including aggression towards conspecifics,³⁰⁻³¹ reproduction,³²⁻³³ predator avoidance³⁴ and feeding.³⁵

A body of evidence is therefore building which suggests that antidepressants in particular, at concentrations found in surface, waste and ground waters, can cause a wide variety of effects. Whether these are occurring in the field downstream of wastewater treatment plants (WWTPs) represents an important and challenging question to address, as the ability to measure abnormal behaviour *in situ* remains a logistical and technological challenge. Moreover, while the underlying role of neurotransmitters has been described in vertebrates, there is considerable paucity of data on their role in invertebrates.¹⁶ The non-monotonic dose responses shown by some drugs,¹⁷⁻¹⁸⁻³⁶⁻³⁸ for which pharmacological effects are not dose dependent and a response is triggered by a low concentration, with no response to higher concentrations, poses questions which are difficult to ignore.³⁹ While some studies have been conducted on the toxicology of antidepressants such as fluoxetine,¹⁶ these are few and far between. Given the evidence on the influence of pharmaceuticals, particularly psychotropic drugs, on the environment, it can be argued that greater emphasis should be placed on how they may be affecting aquatic life.

The solutions

The solutions to these problems, as might be expected, are multifactorial and somewhat influenced by historical decisions. For example, some WWTPs may have historically serviced small towns and villages which later grew in population into large towns and cities. If these WWTPs historically discarded their effluent into small (low flow) rivers, then the effluent to river water ratios could change over time. Changes in water usage upstream, for example, water extraction for farming, could further confound the problem. Advanced treatment at wastewater treatment facilities would reduce many of the potentially harmful pharmaceutical waste products and their breakdown metabolites. Where technological improvements of sewage treatment have been implemented, there have been reductions in intersex (feminised) fish caused by steroid oestrogens and their mimics, as well as improvements in river biodiversity.⁴⁰⁻⁴¹ These improvements, however, are costly. Owen and Jobling (2012)⁴² estimated that upgrading all the WWTPs in England and Wales to comply with EU regulation to bring synthetic oestrogens below an average of 0.035 pg/L ethinylestradiol per annum would cost an estimated £26 billion.

Another solution to this complex problem is to change behaviours whereby people would traditionally flush their unwanted medications down the toilet or dispose of them in the bin. 'Take back' programmes vary in their popularity across Europe, but serve as one means to prevent unwanted medication entering aquatic systems directly following wastewater treatment or indirectly through underground seepage from landfills. The question of green pharmacy has also been raised, whereby the pharmaceutical industry considers the cradle-to-grave approach of their products and designs drugs which readily break down. However, this is extremely difficult to achieve for most drugs, owing to the need to produce pharmacologically active pharmaceuticals in suitable formulations.⁴³

Reflections for policy and practice

Mental healthcare services are provided through complex systems, which are generally based around the use of medication, with training in psychiatry covering vast areas to enable the provision of quality care to patients. However, there is no inclusion of aspects of pollution and the effects of psychotropic medication, and how this could affect aquatic environments. Could educating the medical profession help improve the utility of take back programmes and patient behaviour with regard to drug waste? These substances are not currently covered by existing regulations with regards to sewage management, and analytical methods for detection are just now becoming available. Adequate resources for the diagnosis and management of mental health conditions could help reduce the need for medication and the documented toxic effects of the use of these drugs on non-target organisms. ‘Prescribing’ psychotropic medication for our rivers and estuaries poses a potential risk to aquatic life. Further knowledge and education on adequate therapeutic choices, and improved resources for diagnosis, could support prescribers and practitioners to make environmentally sensible choices, based on evidence of efficacy and safety.⁴⁴

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1.5.99 Reforming care without bureaucracy

: Commentary on... Care Programme Approach

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2019-6

Abstract

The Care Programme Approach was a valiant attempt to improve the aftercare of people with severe mental illness after discharge from hospital. It was introduced as a response to a scandal, not an advance in knowledge, and has always suffered by being a reaction to events rather than a trailblazer for the future. It may have dragged the worst of care upwards, but at the expense of creating a bureaucratic monstrosity that has hindered good practice by excessive attention to risk, and vastly

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increased paperwork with intangible benefit. It needs to be simplified to allow practitioners greater scope for collaborative solutions, less minatory oversight and better use of strained resources.

Declaration of interest

None.

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 - * *What is the solution?*

The article by David Kingdon,¹ who is over-modest about his own role in creating the Care Programme Approach (CPA) for mental health services, is a welcome suggestion to a system that needs changing. To understand the CPA it is necessary to understand the full history behind it. As David Kingdon indicates, it came about not following new research evidence but – like most reforms in the National Health Service (NHS) – through scandal, and all should be sceptical about its benefits under these circumstances until independent evidence becomes available.

So picture the situation in 1988, when the Spokes Inquiry² made recommendations following the murder of a social worker by an ex-patient in her offices in Bexley. The patient, Sharon Campbell, had apparently been discharged without adequate supervision and the report sent a shudder through the corridors of the NHS hierarchy and the Royal College of Psychiatrists. How many other potentially dangerous patients were similarly being treated, or even untreated, as a consequence of the decision to close hospitals and move towards community care?

The Spokes Inquiry

The Spokes Inquiry² made appropriate and reasonable recommendations that could be summarised as ‘when psychiatric patients, particularly those with severe mental illness, are discharged from hospital there needs to be an after-care plan in place for both health and social services’. The implementation of these plans was not specified exactly and the Royal College of Psychiatrists was asked to create such an aftercare policy. There already was a system called case management, which had devotees, but most of the evidence was imported unwisely from the USA where the notion of universal care was anathema to the land of the free market.

So the CPA was introduced as a diluted form of case management appropriate for the NHS. Note the wording. It was not a mandatory requirement for practitioners to do this or that, but a gentle nudge to ensure a coordinated system of care, an approach rather than a directive. It certainly worked to a point; consultants could no longer discharge patients to follow-up by the general practitioner without some sort of care plan in place. The CPA was introduced so gently that its implementation was almost imperceptible, allowing a randomised trial to take place using the old system of care as the comparator. The results showed that many fewer patients were lost to follow-up, but readmissions were much more common once good follow-up was in place.³

Early years of the CPA

The notion of care plans – and the need for a single person, the care coordinator, to synthesise care with the parties involved – is a sensible one and many health professionals felt they were doing it already. It was held together successfully at first through the efficiency and cooperation of community psychiatric teams, whose contribution and value, including a reduction in deaths,⁴ has been somewhat underestimated as these teams have never had the glamour of assertive outreach and crisis resolution teams. Where it began to fail was not a fault of the approach but a lack of resources to implement it properly, so it was never applied universally. It is very odd that no organisation within the healthcare system made any attempt to cost the full implementation of the CPA. What may also not have been anticipated was the rapid growth of managers once cost pressures increased,⁵ and whose attempts to improve integration of care were often resented by practitioners as undue interference.⁶

Thus, 15 years after its introduction, Simpson *et al*⁷ concluded after a careful review in 2003: “‘The CPA was a flawed policy introduced insensitively into an inhospitable environment. It was destined to fail and after more than a decade remains ineffectively implemented. Changes introduced recently may have contradictory influences on the ability of services to provide effective case management but remain to be evaluated.’”⁷

Standard and Enhanced CPA

In 2008 the Enhanced CPA was subsequently introduced for people ‘who need: multi-agency support; active engagement; intense intervention; support with dual diagnoses; and who are at higher risk’.⁸ It was also emphasised that acceptance for enhanced care ‘should *not* be used as a “gateway” to social services or as a “badge” of entitlement’⁸ to other services. But of course it was used that way, as it was bound to be; thus it merely added another layer of bureaucracy to an over-burdened system.

The consequence has been an increasing transfer of face-to-face clinical care to a paper-based cynical affair that does no credit to anybody, least of all the patients, who all too frequently see a technocrat facing a desk instead of a sympathetic carer across the room. The tick box has now become the kick box, an exercise to get a patient off one team’s case load and on to another, promoting discontinuity and disruption of care.

What is the solution?

There are many lessons to be learned about the CPA. First, it has to be accepted by all health professionals, politicians and society at large that suicides and violent deaths in the community perpetrated by psychiatric patients can never be prevented altogether. Putting this another way: extreme statistical outliers should not determine policy. Second, and probably most importantly, good psychiatric and social care is flexible and collaborative and can never be prescribed by statute. I recently discharged myself from hospital prematurely against medical advice. But I insisted the record was not recorded as ‘against advice’ by writing in detail in the hospital notes why it was better for me to leave hospital as my aftercare was well arranged and would lead to cost savings. (They accepted this and were probably pleased to see me go.)

Third, allow practitioners and patients, working together, to do what is best and not to be too risk averse. Kingdon recommends that we should develop ‘more individualised and sophisticated pathway-based systems’.¹ This is in itself a telling criticism of the CPA. Once we have such individualised systems, we leave the directives behind; we use a combination of skills and resources to produce a plan that is, more often than not, unique and cannot be classified. Such plans can never be truly evidence based.

So, in summary, the CPA needs reform by becoming simpler rather than more complicated. It is there to prevent poor care, not to interfere with care that is already competent or good. Its wording should be chosen with care to allow good clinicians to be reinforced and praised in their tasks, for nervous ones to be encouraged and for those who are under par to receive a gentle rap on the knuckles to improve their game. It can also be a great deal shorter.

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1.6 2017

1.6.1 The access and waiting-time standard for first-episode psychosis: an opportunity for identification and treatment of psychosis risk states?

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Abstract

Expansion of early intervention services to identify and clinically manage at-risk mental state for psychosis has been recently commissioned by NHS England. Although this is a welcome development for preventive psychiatry, further clarity is required on thresholds for definition of such risk states and their ability to predict subsequent outcomes. Intervention studies for these risk states have demonstrated that a variety of interventions, including those with fewer adverse effects than antipsychotic medication, may potentially be effective but they should be interpreted with caution.

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- *The access and waiting-time standard for first-episode psychosis: an opportunity for identification and treatment of psychosis risk states?*

With the advent of the new access and waiting-time standard for first-episode psychosis published by NHS England in February 2015, ¹ there is now a definite move to adopt service models aimed at preventing transition to psychosis

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in vulnerable individuals, as originally developed in 1994 by the Personal Assistance and Crisis Evaluation clinic in Melbourne.² There is an expectation that early intervention in psychosis services will now also offer interventions for at-risk mental state for psychosis (ARMS), based on our evolving understanding of best practice in this area.

This move is exciting for a number of reasons. It represents a commitment from the Government to support mental health service development and reform, especially preventive approaches, at a time when many services are experiencing cuts. Cost-effectiveness of ARMS services has been demonstrated.³ Second, as a treatment paradigm the preventive strategy represents a possibility that we can alter the trajectory of a potentially serious condition and improve outcomes in all domains, including symptoms and functioning. Third, we may be able to use, at an earlier stage of illness, more benign treatments that are potentially less costly, less stigmatising and better tolerated.² This preventive model also represents an opportunity to broaden treatment paradigms within mental health, not just for psychosis but for other disorders, fitting perfectly with another current health development strategy – low-stigma, accessible and responsive youth mental health services. Debate continues as to whether such services are appropriately placed within established early intervention for psychosis or whether new, dedicated teams with a more public health emphasis should be created. However, existing services have expertise in both defining first-episode psychosis thresholds and offering relevant clinical support packages for both ARMS and first-episode psychosis.⁴

The criteria commonly used in the UK for ARMS depend on the presenting clinical features, relative functional impairment and help-seeking.² Consistent quantification of distress relating to these features is currently lacking. It also remains unclear how these clinical risk features differ from more widespread psychotic phenomena in the general population. Psychotic experiences in non-help-seeking populations appear relatively common, affecting about 5%,⁵ and higher in child and adolescent samples;⁶ there is apparent sharing of aetiological risk factors with schizophrenia. Clinical outcomes of this non-help-seeking group are unknown. Psychosis transition threshold is commonly defined by three Positive and Negative Syndrome Scale items (delusions, hallucinations or conceptual disorganisation) achieving adequate severity for at least 7 days,⁷ but such psychosis thresholds are not without controversy.⁸ The large majority of those identified as ARMS do not cross this severity threshold within 3 years of follow-up, although many remain functionally impaired or develop other disorders.² Whether other transition criteria, or modifications of existing criteria, are better able to predict longer-term outcome remains to be established. The reliability of identifying such thresholds in clinical practice is also less than in research settings,⁹ despite using widely available tools.² This is further complicated by concurrent substance misuse, common in such clinical populations. However, the definition and adoption of such thresholds is clearly necessary to educate clinicians, decide when to appropriately intervene and support research. The complexity of the psychosis sub-syndrome groups (including individuals with a family history of psychotic illness, those with schizotypal disorder or the attenuated psychosis syndrome, those with brief limited intermittent notable severity psychotic episodes and those help-seeking or not) and their undetermined probable outcomes may lead to services primarily adopting a more discrete threshold for inception, such as the DSM-5 research-appendix-defined attenuated psychosis syndrome, which has marked clinical overlap with ARMS-defined populations.⁹

Without clear diagnostic robustness of a condition, and with a wide variation in clinical outcome, interpretation of intervention studies is problematic. Initially, randomised studies of diverse interventions for operationally defined ARMS (termed ultra high risk for psychosis) seemed to show similar beneficial effects *v.* control. Reviews pooling outcomes of these studies clearly advocated intervention.^{7,10} More recent randomised studies have demonstrated less clear benefits over control than earlier studies, as is often seen in health research (arguably ‘active’ controls were used in many of these studies). Primary intervention recommendations of supportive counselling/case management for this clinical group have emerged, as previously used as a control intervention. Several factors will need to be considered, with future investigations including previous low sample size due to recruitment problems, use of robust and consistent thresholds for group inclusion, and transition to psychosis to reduce heterogeneity of outcome, consistent inclusion of functional outcomes, translation of findings to usual clinical care (away from research clinics), ensuring timely publication of results and the importance of replication of existing findings.

While considerable progress has been made in this area, we remain at the early stages of defining a risk syndrome for psychosis. The currently adopted clinical threshold for ARMS seems to be a valid construct to identify clinical need but the heterogeneity of subsequent clinical outcomes is wide. Specific interventions for ARMS are unclear, aside from those for commonly identified comorbidities (such as anxiety, depression and substance misuse). Intervention studies to date highlight the importance of methodological rigour and consistency of diagnostic thresholds used, to which end the DSM-5 attenuated psychosis syndrome may be a positive step.⁹ Biological models for psychosis risk need replication, clinical validation and combining with clinical markers in larger, longitudinal studies to enhance risk

determination.^{2,11,12}

Despite these caveats, this field of study represents an important advance in the development of preventive psychiatry. The current move to incorporate earlier psychosis states in more widespread clinical services, with appropriate threshold definition and outcome monitoring, may also have important societal impact.

1.6.2 Plans, hopes and ideas for mental health

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date

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Abstract

Mental health and the failings of the mental health services are in the spotlight as never before. Nowhere is this more apparent than in the often dire situation with regard to child and adolescent mental health. At the same time, there is a renewed interest in the scope for prevention of mental illness and distress, and in population approaches to mental well-being. It may come as a surprise to some that others have given such serious consideration to strategic approaches to public mental health as long ago as the 1950s. It appears that such consideration was squeezed out by the dominant concerns of serious and enduring mental illness and a prevailing biological view of psychiatry. The time is right to engage with this agenda in recognition of the importance of public mental health, not only for the individual and for families, but also for society as a whole and for the economy. The publication of a review of the subject by the Faculty of Public Health and the Mental Health Foundation is to be commended. Let us make sure it leads to action.

Contents

- *Plans, hopes and ideas for mental health*

The recent announcement by UK Prime Minister David Cameron of a new initiative for mental health, with a particular emphasis on parenting classes,¹ is most welcome. It comes at the end of a year in which there has been an increasing concern for the state of the nation's mental health, with a flurry of documents and reports, a campaign led by *The Times* newspaper² and an increasing demand for parity of resourcing between mental and physical health. Interestingly, some of the pressure to do something specifically about child and adolescent mental health is coming from the independent schools sector. The schools have been expressing increasing concern about the mental well-being of the young people in their care, faced by an apparently steady increase in the incidence of distress manifested by levels of general anxiety and depression, and specifically the levels of eating disorder, self-harm and other behavioural manifestations. Not for the first time in public health, something that has long been a problem for the most disadvantaged in society is being taken seriously once it becomes an issue for the privileged. Nor should we ignore the opportunity presented for progress by the mobilisation of enlightened self-interest by those in positions of power and influence. After all, in Victorian times, the fact that cholera knew no social boundaries led to sanitary reform which was of benefit to rich and poor alike. More recently, once it became apparent that HIV/AIDS was not only a disease of stigmatised minorities, the research dollars rolled in.

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As a public health physician who began his career as a psychiatrist and family doctor and is finishing as President of the UK's Faculty of Public Health, I find particular poignancy in returning to the theme of public mental health for my swansong year, a theme which I have chosen for the Faculty to focus on in 2015–2016. I appreciate and welcome this opportunity to share some thoughts with clinical colleagues in psychiatry based on 40 years of trying to make sense of some of the questions raised within a public health paradigm.

My journey from psychiatric registrar in Newcastle in the 1970s offers some perspective. As a student I was one of those medics whose interests spanned the humanities as well as the sciences. History and politics were always as interesting to me as biology, and when I came across the prospectus for the public health masters course at the London School of Hygiene & Tropical Medicine sometime in third year, it was clear to me that sooner or later I would be signing up. For the next 10 years I would religiously send for the latest edition. Fortunately, my interest was nurtured and kept alive by the remarkable social orientation of the Newcastle course, not just in family and community medicine but also in such mainstream clinical areas as paediatrics, psychiatry and obstetrics. The school was imbued with the spirit not just of the pioneering, community-oriented paediatrician Sir James Spence, but also that of Aberdonian obstetrician Dugald Baird through his Newcastle disciples. The strong social and community base was reinforced by a series of Deans of Medicine, who, while hard-nosed neurologists and endocrinologists themselves, supported the work of those such as Donald Irvine, who was centrally involved in establishing the country's first general practice training programme and later oversaw the General Medical Council. When I signed up for the psychiatric training rotation under the formidable Sir Martin Roth, amazingly comprehensive and intellectually stimulating as it turned out to be with placements in all aspects of mental health services, I found myself frustrated at the failure of those services to focus upstream to prevention and the promotion of mental health.

While as a registrar in the heady years of the challenges posed to orthodox practice by the likes of R.D. Laing and Thomas Szasz, I was exposed to the whole spectrum of ideas, from Freud and Jung to Kraepelin, Sargent and Eliot Slater. Although we had opportunities to cut our teeth on individual, group and marital therapy, the broader public health agenda remained elusive. I came to the conclusion that what was on offer was all too little and too late, and as soon as I had finished my training I moved into general practice in the hope of finding more fertile soil for prevention.

My next move took me to Southampton, where the pioneering dean of the new medical school, Donald Acheson, had created an exciting opportunity which seemed tailor-made for somebody like myself. In a university-run health centre in the local community, based on lines recommended by the celebrated Birmingham professor of public health Thomas McKeown, there were to be specialoid general practitioners – GP paediatricians, GP mediatrians (caring for grown-ups), GP geriatrians and a GP psychiatrist (me). Part of the time we would teach medical students, and the remainder was spent providing a combination of general practice, including out-of-hours services, and specialist expertise to the practice patients as well as supporting each other. As far as possible, we would look after the population of the Aldermoor estate (a public health notion), and consume our own smoke.

It was a stimulating time, but there were problems reconciling the competing claims of medical school and service as well as staffing issues. Southampton was within spitting distance of the London School of Hygiene & Tropical Medicine, so it was time to make the logical step into public health, and it was quite clear that I had made the right move. Validation came from, among others, John Wing and Julian Leff from the Maudsley, who also taught social psychiatry at the school, from visiting teachers from the London School of Economics (LSE), such as Bryan Abel Smith, who confirmed what students suspected, namely that 'public health is the political wing of medicine' and that 'Parliament is the dispensary of public health', and others that placed population health at the centre. It was one of those group learning experiences which stays with you down the ensuing years as a highlight and a transformational experience. Yet there was something missing.

In those days students on the public health masters courses at the School had the enormous privilege of a 2-year course, 1 year spent in the classroom and 1 year on a dissertation. The dissertation was a kind of blank cheque that enabled you to pursue something of special interest that would hopefully be built on in future years. And this is where my problem reasserted itself. What would be a suitable dissertation that majored on prevention and mental public health? I was already a member of the social psychiatry section of the Royal College of Psychiatrists and I took advice from as many people as I could find, including Sir Martin Roth. I drew a blank. The nearest anybody could get was early diagnosis and treatment in the community, what I now knew to be secondary prevention in public health, tertiary prevention being rehabilitation. Primary prevention was nowhere to be found.

And so in the end I hit on planned parenthood, something much better understood in a holistic sense in global health

circles, and I carried out a series of studies into family planning and abortion at the population level of Wessex. In my subsequent career as a public health academic, as a regional and county director of public health, as an adviser to the World Health Organization on the Healthy Cities project, and most recently, as President of The UK's Faculty of Public Health, I have reconciled my angst that as a generalist with a population and environmental focus, all my work has ultimately to be judged by its impact on mental health and well-being. So what have I learned and what observations can I make faced with the promise that finally mental health is to be taken seriously?

One of the problems with mental health, as with physical health, is that the dominant approach is to work backwards, from a focus on treatment towards an interest in prevention. The exception is when there is an emergency, a disaster or a war, when needs must apply a public health population-based triage model if harm is to be minimised.

In the 1980s I attended a short course at the School for would-be volunteers to work in refugee camps in the Horn of Africa. One message stays with me almost 40 years later. If a small group of volunteers (doctors, nurses, engineers and so on) is deployed into a camp of 12 000 women and children in dire circumstances (the men are likely to be either already dead or off fighting somewhere), the first thing to do is not to start treating sick patients. Rather, it is to carry out a quick census of who is there and what skills they have, and to set about mobilising the expertise and supporting it.

This is not our traditional medical model, based as it is on putting up your plate outside a consulting room and offering services to those who can afford to pay, with no concern for the denominator of those with unmet need. Take the example of child and adolescent psychiatry. The large community surveys such as those on the Isle of Wight and in South London found that around 10% of children and adolescents suffer from such a level of emotional or conduct disorder as to require specialist help.³ In a borough of 500 000 population (about 70 000 children and adolescents), this will equate to about 7000 potential patients. In a fortunate district perhaps, optimistically, 1000 of those could be adequately managed by a typical child and adolescent mental health service (CAMHS). No district will ever have that kind of establishment. At the risk of being written off as a loony baby boomer, I would quote Mao Zedong: who is said to have claimed that 'If the practice doesn't work, the theory is wrong'. We are starting at the wrong end of the telescope or focusing on the wrong part of the pyramid of needs. So what would public health say and what is to be done?

In 1961 Gerald Caplan published a book titled *An Approach to Community Mental Health*. Caplan was educated at Manchester medical school and worked at the Tavistock Institute in London and the Hadassah Centre in Jerusalem before moving to the USA, where his work was hugely influential, not least with the programme of community mental health centres under President Kennedy. I came across his book in the 1980s and have carried it round with me ever since.

Reading it again now, it is as relevant and fresh today as it was when it was written, and it is a mystery to me why it has not been a blueprint for how we have approached mental health during the intervening years. Perhaps it is because it includes a (very sensible) chapter on ego psychology, when British psychiatry has for so long been under the shadow of organic theorists and psychopharmacology? In essence, what Caplan proposes is a comprehensive community approach to preventive psychiatry and the provision of services which builds on individual and community assets including those of what he calls 'caretaking agents' and those in special positions in everyday life. He includes in this not just doctors and nurses but clergy, teachers, policemen and so on, and advocates a system built on up-skilling those in a position to play a protective and supportive role in everyday life as a first line.

Caplan describes administrative actions that can protect and support good mental health as well as personal and clinical interactions and redefines the role of those with specialist psychiatric expertise in building and supporting both capacity and capability for mental health and well-being. For me, using the example of child and adolescent mental health, this translates into a life cycle approach that starts with planned parenthood, builds on it with the Prime Minister's parenting classes, and ensures that all those in key interactions with parents and children have adequate skills to promote mental health and respond quickly to signs of distress. This extends to children themselves having the opportunity at school to develop mental resilience and skills for mutual mental health assistance with their peers. The administrative part includes key action on wider determinants of health such as economic and social security, housing and access to good educational and work opportunities. If all this is implemented, the question then arises as to what the formal system should be offering in primary care, building on recent developments in Improving Access to Psychological Therapies (IAPT) and how serious breakdown and risk can be handled for the whole population of patients for whom this becomes necessary.⁴

One of the enemies of adopting this kind of comprehensive approach to mental health is the prevailing narrow and reductionist model of scientific evidence as illustrated by recent controversy over the concept of mental well-being as a researchable paradigm.⁵ For Caplan, ““Our lack of knowledge in regard to the significance of the different factors has to be remedied by a continuation of existing research into aetiology. But, meanwhile preventive psychiatrists have been able to learn a lesson from public health colleagues in regard to handling of the problem of the multifactorial nature of the picture ... The incidence of cases of clinical tuberculosis, for example, in any community is no longer conceived of in public health circles as being merely dependent upon the single factor of the presence or absence of the tubercle bacillus. It is recognised that there are many complicated issues that will determine whether a particular person exposed to the germ will contract the clinical disease: issues involving virulence of the germ, host susceptibility and various environmental factors’.”⁶ In public health we have learned to take a whole-systems approach to whole and sub-populations and to use multiple interventions acting on the health ‘field’.

The list of factors of interest to those concerned with protecting and improving mental health, mental well-being and resilience, in addition to the proximal factors of those aspects of personal security already mentioned and the managed challenges that enable people to grow and thrive, includes a set of constructs such as locus of control, self-esteem and coherence. These can be difficult constructs to operationalise for research purposes, especially when they interact in complex systems, but tools can be developed, for example the Rosenberg Self-Esteem Scale,⁷ and in recent years mixed-methods and compound outcomes such as those used in Social Return on Investment⁸ have paved the way for practical interventions based on pragmatic considerations.

We must be careful to avoid the dangers of scientism. When John Snow took the handle from the Broad Street pump during the 1854 cholera epidemic in Soho, the cause of cholera was still believed to be the miasma. This was 20 years before Pasteur’s ground-breaking research. And still nowadays a whole system of education based on the evidence-free assumption that team sports are character forming underpins the British public schools system.

Caplan’s book concludes with a remarkably contemporary proposal for the development of comprehensive community psychiatry based on 11 concepts and assumptions that could well provide the starting point for a consideration as to how any new government funds might be committed. For myself, I have come to the conclusion that in addition to those things which government can and should do through ‘the pharmacy of public health’, there are three approaches, tried and tested in recent years, that should be regarded as delivery systems.

1. ‘Total place’ and ‘defined population’ as developed through Healthy Cities, Healthy Schools, Healthy Prisons and other settings.⁹
2. Asset-based community development as proposed by John McKnight and colleagues in Chicago.^{10,11,12,13} This approach maps and mobilises the gifts and talents of individuals, families and communities on the basis that:
 - they are half-full, not half-empty
 - it takes a village to raise a child
 - 90% of health and social care is lay care
 - unless professional practice supports self-efficacy it can be part of the problem rather than part of the solution.
3. Community-oriented primary (and secondary) care based on an epidemiological understanding of populations and responsibility for them, as practised by Sidney Kark and his colleagues over many years at the Hadassah Medical School in Jerusalem.¹⁴

In conclusion, I am optimistic that we have an opportunity to re-launch mental health in this country at the same time as developing parity and integration with physical health. The Faculty of Public Health is playing its part by launching a new public mental health report in June to share best practice among public health practitioners.¹⁵

There is a particular opportunity to pursue this approach in England, where NHS England’s *Five Year Forward View*¹⁶ with its integrated ‘new care models’ is driving transformational change. However, the paradigm shift to a public health model with co-production at its heart is a precondition. More of the same just won’t do.

1.6.3 Capacity *in vacuo*: an audit of decision-making capacity assessments in a liaison psychiatry service

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Abstract

Aims and method We aimed to audit the documentation of decision-making capacity (DMC) assessments by our liaison psychiatry service against the legal criteria set out in the Mental Capacity Act 2005. We audited 3 months split over a 2-year period occurring before, during and after an educational intervention to staff.

Results There were 21 assessments of DMC in month 1 (6.9% of all referrals), 27 (9.7%) in month 16, and 24 (6.6%) in month 21. Only during the intervention (month 16) did any meet our gold-standard ($n = 2$). Severity of consequences of the decision (odds ratio (OR) 24.4) and not agreeing to the intervention (OR = 21.8) were highly likely to result in lacking DMC.

Clinical implications Our audit demonstrated that DMC assessments were infrequent and poorly documented, with no effect of our legally focused educational intervention demonstrated. Our findings of factors associated with the outcome of the assessment of DMC confirm the anecdotal beliefs in this area. Clinicians and service leads need to carefully consider how to make the legal model of DMC more meaningful to clinicians when striving to improve documentation of DMC assessments.

Contents

- *Capacity in vacuo: an audit of decision-making capacity assessments in a liaison psychiatry service*
 - *Method*
 - *Results*
 - *Discussion*

All doctors are often required to make assessments of their patients' decision-making capacity (DMC). This role is prominent in liaison psychiatry services, as psychiatrists may be asked to provide a second opinion on DMC for other medical specialties (e.g. regarding consent for a surgical procedure). In the UK, psychiatric second opinion tends to be requested following refusal of treatment by a patient,¹ but also when the assessment is likely to be highly complex or

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is driven by an underlying psychiatric disorder.^{1,2} DMC is also routinely assessed in the UK in psychiatric patients in emergency settings such as accident and emergency (A&E) departments. At the time of the audit guidance by the Care Quality Commission³ recommended that assessments regarding DMC to consent to treatment and admission should be made on all patients at the point of admission to a psychiatric hospital to clarify whether it was an admission authorised through the consent of a patient with DMC or under the 'best interests' procedures in a patient who is assenting but lacking DMC.

In England and Wales the legal criteria through which DMC is assessed are provided by the Mental Capacity Act 2005, with further guidance in its Code of Practice.⁴ Under the Act, for a person to lack DMC evidence is required that they suffer from 'an impairment of, or a disturbance in the functioning of, the mind or brain' (Section 2(1)), and that as a consequence of this they are unable to perform at least one of the following tasks: '(a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate [their] decision' (Section 3(1)). DMC is 'decision specific' rather than a 'blanket' or global ability: it is tailored to the specific decision at hand and recognises that different factors may influence different decisions.

There are additional considerations during the assessment of DMC, in that the assessor must also take heed of the principles of the Mental Capacity Act 2005 which include that 'A person must be assumed to have capacity unless it is established that he lacks capacity' and 'A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success' (Section 1). Recently the House of Lords Select Committee on the Mental Capacity Act 2005 heavily criticised the implementation of the Act: 'Our evidence suggests that capacity is not always assumed when it should be. Capacity assessments are not often carried out; when they are, the quality is often poor. [...] The presumption of capacity, in particular, is widely misunderstood by those involved in care'.⁵

We know that patients lacking DMC to consent to treatment are common in both general medical in-patient (around 40%)⁶ and psychiatric in-patient settings (around 60%).⁷ An assessment and decision regarding DMC has significant repercussions for the patient, either respecting autonomy or paving the way to surrogate decision-making under 'best interests'. It is therefore important to document clear justification for a decision reached, under the statutory criteria of the Mental Capacity Act 2005. Previous work in the USA has shown poor documentation of DMC in a retrospective study of in-patient lumbar punctures authorised by a surrogate decision-maker (3 patients had DMC documented out of 25 procedures authorised by a surrogate, although in 21 cases there was enough information to 'infer' lack of DMC).⁸

Our aim was to audit the documentation of DMC assessments provided by our liaison psychiatry service against the Mental Capacity Act 2005 and its Code of Practice, and the guidance issued by contemporary literature.⁹ Subsequently, we employed an educational intervention in our service to see whether this improved documentation of the assessments. We collected detailed information on the factors influencing the assessment of DMC to see whether this had an impact on the quality of DMC assessment or of the intervention.

Method

All new referrals received by the King's College Hospital Liaison Psychiatry Team, South London and Maudsley NHS Foundation Trust (SLaM), during the month of November 2011 were collated. The team is split into the accident and emergency team and the general in-patient team covering all referrals. In working hours there are also specialist child and adolescent mental health services (CAMHS), older adults, neuropsychiatry and perinatal psychiatry teams. All referrals outside of working hours are taken on by the general service. CAMHS referrals were excluded from this audit.

Assessments of DMC performed by members of the team are completed without a formal template or form and were documented in the SLaM electronic medical record (EMR) as free text. All patient contacts by the team need to be recorded in the SLaM EMR.

The EMR was searched for documentation of assessments of DMC by searching for the word 'capacity' and any statement declaring that the patient had or lacked DMC was taken to be an assessment of DMC. The entire duration of the patient episode related to that referral was audited. Statements that suggested the patient may or may not have DMC but that did not make formal declaration were taken by this audit to be an assessment of DMC. The exception to this were statements that suggested the person may lack DMC, but that formal assessment could be delayed.

We set our gold-standard to require documentation of: (1) justification of the timing of the assessment/attempts to maximise DMC in accordance with the principles of the Mental Capacity Act 2005 and; (2) the full statutory criteria of DMC (presence or absence of a disorder of ‘mind or brain’, and performance on the four key abilities). We excluded the need for an explicit statement linking psychopathological features of the disorder of ‘mind or brain’ to any deficit found in the four key abilities given that some patients were found to not have a disorder of ‘mind or brain’.

Further information was gathered, including: basic demographic information, whether the assessment took place in or out of hours, the decision for which DMC is being assessed, the professional background of the assessor, and whether the person agreed or objected to the intervention/option proposed. The severity of potential consequences to the patient regarding refusal of the intervention for which DMC was assessed was also quantified, and classed as mild, medium and severe risk of adverse outcome (by a psychiatrist with experience of DMC assessments and patient management in this clinical environment). An example of a severe risk is a refusal of admission into a psychiatric hospital by a patient with florid psychosis or refusal of life-sustaining medical treatment; an example of mild risk is a refusal to contact relatives for information-sharing regarding the patient’s clinical episode.

Following the audit in November 2011 (month 1), we analysed the initial results. Given that none had met our gold-standard (see below), we designed an educational intervention to improve clinicians’ understanding of the legal framework of the assessment of DMC and how to document this appropriately. The intervention took place during the week psychiatrists in training (senior house officers (SHOs)) change jobs (February 2013, month 16), and continued for the following 4 weeks. It involved the lead auditor (B.S.) meeting with the medical (SHO) and nursing (psychiatric liaison nurses (PLNs)) members of the liaison team and explaining the gold-standard of DMC documentation; presenting this to the on-call SHOs during their induction as they may cover the team out of hours; and emailing the SHO cohort and the senior doctors on call (specialist registrars (SpRs)) on a weekly basis with the guidance. Posters with the guidance were put up in the departmental offices seen by the PLNs and SHOs.

The 4-week period in February 2013 (month 16) during which the intervention was applied was audited, along with the month of July 2013 (month 21), using the methods described above. This audit was reviewed and approved by the trust Psychological Medicine Audit Committee in January 2012.

Results

In month 1, there were 21 (6.9%) assessments of DMC for 306 referrals, in month 16 there were 27 (9.7%) assessments for 278 referrals, and in month 21 there were 24 (6.6%) assessments for 365 referrals (*Table 1*). Overall, DMC was assessed in 72 (7.6%) out of a total of 949 referrals.

Frequency of DMC assessments, demographics, and number meeting audit standards by month *a*

	Month 1	Month 16	Month 21	Total sample
Total referrals, <i>n</i>	306	278	365	949
DMC assessments, <i>n</i> (%)	21 (6.9)	27 (9.7)	24 (6.6)	72 (7.6)
Age, years: mean (s.d.)	45.2 (14.8)	39.3(15.4)	45.6 (15.0)	43.1 (15.2)
Female, <i>n</i> (%)	12 (57.1)	14 (51.9)	14 (58.3)	40 (55.6)
Patients found to have DMC, <i>n</i> (%)	6 (28.6)	16 (59.3)	14 (58.3)	36 (50)
Assessments documenting the statutory criteria, <i>n</i> (%)	2 (9.5)	6 (22.2)	2 (8.3)	10 (13.9)
Assessments meeting the audit gold-standard, <i>n</i> (%)	0	2 (7.4)	0	2 (2.8)

Some patients had more than one DMC assessment. There were no significant differences between months.

None met the gold-standard in months 1 or 21, however, 2 (7.4%) did during the intervention in month 16 (*Table 1*) and both of these assessments were performed by the SHOs who had received the educational intervention. Results were similar when using our lower standard of documentation of the full statutory criteria: $n = 2$ (9.5%) in month 1, $n = 6$ (22.2%) in month 16 and $n = 2$ (8.3%) in month 21. The majority of those failing this standard missed out several elements; only 3 (4.2%) assessments missed reaching the standard through missing only one of the four key abilities, whereas 38 (52.8%) assessments documented none of the four key abilities. We therefore cannot conclude the educational intervention had any impact at all.

Where recorded, we looked at how frequently the key abilities to be tested were lacking in people who lacked DMC. Lacking the ability to 'use or weigh' information was most common ($n = 19$, 73.1% where recorded), followed by 'understanding' ($n = 10$, 43.5% where recorded), 'retaining' ($n = 8$, 57.1% where recorded) and 'communication' ($n = 4$, 33.3% where recorded).

The majority of assessments of DMC were performed by doctors ($n = 51$ (70.8%) *v.* $n = 21$ (29.2%) assessments performed by the PLNs). Of the PLNs' assessments only 3 (14.3%) patients were found to lack DMC, whereas of the doctors' assessments 33 (64.7%) patients lacked DMC (*Table 2*). PLN assessment was significantly more likely to result in a positive DMC than a doctor assessment (OR = 11.0, 95% CI 2.9 to 42.5). The doctors met the gold-standard ($n = 2$, 4%) and full statutory criteria ($n = 9$, 18%) more often than the PLNs ($n = 0$ and $n = 1$, 5% respectively).

Outcome of DMC assessment based on assessing clinician

	DMC present		
Assessing clinician, n (%)			
PLN	3 (14)	18 (86)	21 (29)
Doctor	33 (65)	18 (35)	51 (71)
Total, n	36	36	72

DMC, decision-making capacity; PLN, psychiatric liaison nurse.

We separated the types of decisions to be made by the patient into those that involved 'psychiatric admission or treatment' and 'medical admission or treatment'. For the purposes of the audit, decisions to start a new admission in hospital or discharge oneself from a current admission were seen as interchangeable. Medical and psychiatric decisions were not mutually exclusive and a proportion of patients were assessed for both. There were assessments of DMC that did not focus on these decisions, but they were a minority and focused on decisions not normally tested in this setting, such as DMC to make a decision around ongoing homelessness ($n = 1$) and ongoing abusive relationship/domestic abuse ($n = 2$). These non-treatment-focused assessments of DMC all occurred as part of the psychiatric assessment by a PLN or doctor rather than following a request for second opinion from the medical teams.

We found that the proportion of assessments of DMC for medical admission or treatment formed the majority of assessment at the start of the audit month 1 ($n = 17$, 81%), but this reduced over the course of the audit in month 16 ($n = 12$, 44%) and month 21 ($n = 8$, 33%; Pearson's $\chi^2 = 9.91$, $P = 0.007$) (*Table 3*). Conversely, assessments for psychiatric admission or treatment were the minority at the start of the audit ($n = 5$, 24%) and increased in month 16 ($n = 13$, 48%) and month 21 ($n = 13$, 54%), although the differences were not statistically significant.

Decisions for which DMC was assessed and numbers agreeing with the intervention by month

	Month 1	Month 16	Month 21	Total sample $n = 72$
Decisions to be made, n (%)				
Medical admission or treatment	17 (81) ^a	12 (44) ^a	8 (33) ^a	37 (51)
Psychiatric admission or treatment	5 (24)	13 (48)	13 (54)	31 (43)
Agreement status, n (%)				
Agreeing	5 (24)	15 (56)	12 (50)	32 (44)
Not agreeing (or unable to express a choice/not documented)	16 (76)	12 (44)	12 (50)	40 (56)

DMC, decision-making capacity.

Pearson's $\chi^2 = 9.91$, $P = 0.007$.

We separated the choices of people who were having their DMC assessed into agreeing with the intervention proposed by the assessor/medical team and objecting/unable to express a choice/unknown. Fewer people were assessed who agreed with the intervention in month 1 ($n = 5$, 24%), but in months 16 and 21 they made up half of those assessed (Table 3). Agreement with the intervention was strongly associated with a finding of DMC: 26 (81%) of those agreeing with the intervention were found to have DMC, compared with only 10 (25%) of those who did not agree (either objecting or otherwise) (Table 4). This was highly statistically significant (Pearson's $\chi^2 = 22.50$, $P < 0.001$). Most assessments made by the PLNs were done in patients agreeing to the intervention ($n = 15$, 71%), contrary to doctor assessments ($n = 17$, 33%).

Outcome of DMC assessment based on agreement with the proposed intervention a

	DMC present		
Agreement status, n (%)			
Agreeing	6 (19)	26 (81)	32 (44)
Not-agreeing (or unable to express a choice/not documented)	30 (75)	10 (25)	40 (56)
Total, n	36	36	72

DMC, decision-making capacity.

Pearson's $\chi^2 = 22.50$, $P < 0.001$.

A logistic regression was performed to ascertain the effects of the assessor (PLN or doctor), agreement with the intervention and consequences of the decision. Initial models also included decision to be made and underlying mental disorder, however, these were removed from the final model as they had no effect.

The final regression model was statistically significant (Pearson's $\chi^2 = 45.81$, $P < 0.001$). The model explained 64.7% of the variance (Nagelkerke R^2) and correctly classified 81.2% of the outcome of the assessments of DMC.

Factors associated with the finding of lack of DMC were: more severe consequences of the decision (OR = 24.4, 95% CI 3.47 to 171.8), not agreeing with the intervention (OR = 21.8, 95% CI 4.0 to 118.8), and assessment by doctor rather than PLN (OR = 14.9, 95% CI 2.1 to 104.5).

Discussion

We have shown evidence that documentation of 72 DMC assessments in 3 sampling months in a liaison setting was poor, with only 2 assessments reaching our gold-standard. The impact of a legal education intervention was very limited and was not sustained beyond the month in which it was applied.

There are several possible reasons as to why the proportion of assessments meeting our gold-standard was so low, even after the educational intervention. Clearly, a lack of documentation of all components of the assessment of DMC does not necessarily equate to these components not having been considered by the clinician assessing DMC. However, there is limited documentary justification of the nature of the clinical assessment and the legal model of DMC. Perhaps elements of the education intervention itself (design, style, length etc.) may not have been an effective means of conveying the information, although our audit was not designed to evaluate this. The explicit reference to the principles of the Mental Capacity Act 2005 in our gold-standard might have set the standard too high, but even our more lenient 'full statutory criteria standard' was only achieved in 13.9% of assessments during the course of the audit.

Where lies the difficulty in translation of the legal model to clinical assessments? In situations where evidence is presented to the Court of Protection (the civil court in England and Wales with the jurisdiction for cases in which an individual lacks DMC), the Court requires completion of prescribed forms that demand a level of evidence similar to our gold-standard. In a busy clinical environment it is easy to see how documentation of the presence or absence of DMC could be considered to be sufficient by clinicians. A process that might slow the system down (or be perceived as such) can be expected to be powerfully resisted.

It is interesting that the assessments of DMC by PLNs result more often in the patient being concluded to have decision-making capacity. This finding needs to be approached with caution given that DMC assessments were triggered by several different reasons in our audit, including either: (1) a second opinion assessment of DMC, usually in the context of a patient refusing treatment, in which the assessment would be performed by a doctor; or (2) an assessment of DMC in the context of admission to psychiatric hospital performed by any clinician.

As doctors performed all second opinions of DMC assessment, usually in the context of a patient refusing treatment, and they assess all patients who will need compulsory admission to hospital, there is a referral bias. The majority of DMC assessments performed by the PLNs were in the context of a patient agreeing with the suggested intervention, and hence were used to support the clinical assessment. If there is no dispute around the intervention offered, then DMC assessment has little consequence and it is easier to presume DMC.

The strong association between lack of DMC, high severity of outcome, refusal and lack of assent is striking. To our knowledge this is the first piece of work that has clearly demonstrated this association in real clinical practice. It would seem to suggest that clinicians when assessing DMC in practice use an outcome test of DMC rather than the functional test the law requires. Kim *et al*¹⁰ have shown that assessments of DMC by clinicians using video simulations of consent discussions around involvement in research are risk sensitive. This echoes early work on conceptualising DMC as necessarily risk sensitive.² Owen *et al*¹¹ reported an association between treatment refusal and DMC assessed using the MacArthur Competency Assessment Tool for Treatment. Although the association is striking, we consider it to be largely expected, given the selection bias that assessments of DMC performed as a second opinion by our service are normally prompted by treatment refusal in the context of a possible mental disorder, when refusal is likely to result in significant harm to the patient. It is reassuring that there are a proportion of assessments where people are found to have DMC despite the refusal and high severity of consequences, and we submit that this is evidence of careful clinical consideration of each case on its own merits.

Our audit has shown that there are limitations in the recording of assessments of DMC, and that uptake of an educational intervention was limited. We consider that this is likely due to the perceived disconnect between the legal assessment and clinical assessment. We would recommend that the next step in the audit cycle should include an educational intervention on the assessment of DMC with a formal evaluation, with exploration and focus on clinical factors and their relationship to legal criteria in order to be more acceptable for clinicians.

In conclusion, we have found evidence for the anecdotal belief on the impact of severity of consequences and agreement status of the patient on the outcome on their assessment of DMC. Reassuringly, these factors were not totally deterministic of the outcome but they do suggest that, in practice, the functional test of DMC is yet to fully bed down.

We would like to thank Dr Lisa Conlan for her support and advice during the audit process.

1.6.4 Personality disorder: still the patients psychiatrists dislike?

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Abstract

Aims and method In 1988, Lewis and Appleby demonstrated that psychiatrists hold negative attitudes towards patients with personality disorder. We assessed the attitudes of psychiatry trainees towards patients with borderline personality disorder and depression, expecting an improvement. 166 trainees were block randomised to receive one of four case vignettes that varied by diagnosis and ethnic group. We used Lewis and Appleby's original questionnaire and the Attitudes to Personality Disorder Questionnaire (APDQ).

Results We received 76 responses. Lewis and Appleby's questionnaire showed more negative attitudes towards personality disorder than depression, with no significant patient ethnic group effects, and the APDQ also showed a (weak) trend towards more negative attitudes to personality disorder. In subgroup analysis, only in the White British patient group were there significantly more negative attitudes to personality disorder. Factor analysis showed significantly less sense of purpose when working with personality disorder.

Clinical implications The perceived greater lack of purpose in working with personality disorder should be the target of clinical training and intervention. Targeted interventions that include training in managing personality disorder, supervision and practice in non-specialist, general psychiatry settings are important.

Contents

- *Personality disorder: still the patients psychiatrists dislike?*
 - *Objectives*
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 - * *APDQ*
 - *Discussion*

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* *Limitations*

* *Recommendations*

Personality disorder is characterised by an enduring dysfunctional and distressing pattern of inner experiences, behaviours and interpersonal interactions.¹ Almost a quarter (24%) of people seen in primary care² and 50% of people in secondary mental health services meet the criteria for a diagnosis of personality disorder.³ Patients with personality disorder have high rates of comorbidity⁴ and service utilisation.⁵ A meta-analysis, which identified 391 relevant publications and finally included 14, showed significant differences in prevalence between Black and White groups (although no differences between Asian or Hispanic groups compared with White groups), raising the question of whether there is a neglect of diagnosis in some ethnic groups.⁶

Although there is good evidence that borderline personality disorder (BPD) is a helpful diagnostic construct,⁷ some studies contest the validity (but not the clinical utility) of the diagnosis.⁸ Potter¹ stresses that the psychological and interpersonal dynamics that patients with BPD bring to the clinical setting cause frustration and consternation among clinicians, such that BPD is now a diagnosis that can carry pejorative connotations and compound the stigma that such patients already face. Many patients with BPD feel rejected and disbelieved by clinicians.⁹ Improving clinicians' attitudes toward patients with BPD could bring them clinical benefit.¹⁰

Against this background, there have been systematic efforts to study clinicians' attitudes to personality disorder. A systematic review of the literature shows that healthcare professionals in general have negative attitudes towards such patients.^{11,12} A large study⁷ demonstrated that the clinician's occupational subgroup was significantly related to the attitude they adopted towards patients with BPD: staff nurses had the poorest self-ratings on overall caring attitudes, whereas social workers had the most caring attitudes. Social workers and psychiatrists self-rated highly on treatment optimism, whereas staff nurses rated poorly on empathy and treatment optimism. Overall, the authors suggested that education about the nature and treatment of BPD can lead to more positive attitudes, but also that clinicians with greater levels of experience in terms of both number of BPD patients and years of practice were more likely to express positive attitudes towards such patients. Bodner *et al*¹³ demonstrated that psychologists were less likely than psychiatrists and nurses to express antagonistic judgements towards patients with BPD and suicidal tendencies, whereas nurses were less likely to show empathy than psychiatrists and psychologists. They identified a number of factors influencing attitudes, including motivation to improve diagnostic skills, seniority, training and supervision, gender and familiarity with treatment modalities.

In 1997, Bowers *et al*¹⁴ developed a new instrument called the Attitude to Personality Disorder Questionnaire (APDQ). The APDQ is a reliable and valid measure of attitude to personality disorder, and is useful for outcome studies. It was tested among nurses and prison officers.¹⁵⁻¹⁷ One of these studies¹⁶ revealed that psychiatric nurses' attitudes were more negative than those of prison officers. Prison officers more often liked and showed an interest in prisoners with personality disorder, and they showed less fear and helplessness, less anger, more optimism about treatment and less frustration. The other studies found that nurses considered people with personality disorder difficult to treat; they were pessimistic about the efficacy and outcome of treatment and felt they were poorly trained to care for such patients.

Over 20 years ago Lewis & Appleby¹⁸ demonstrated that psychiatrists hold negative attitudes towards patients with a diagnosis of personality disorder, and that the diagnostic label was more influential on their attitudes than the patient's gender or class. Patients given a previous diagnosis of personality disorder were seen as more difficult and less deserving of care than controls. The authors concluded that a diagnosis of personality disorder carries enduring negative sentiments and is not used to guide effective treatment. For example, people with this diagnosis may experience difficulties when seeking help for psychiatric symptoms such as depression. The authors proposed that the concept of personality disorder be abandoned.

In 2002 the National Personality Disorder Development Programme was introduced in the UK, accompanied by the publication of *No Longer a Diagnosis of Exclusion*¹⁹ and *Breaking the Cycle of Rejection*,²⁰ policy attempts that aimed to improve the evidence base of effective interventions for patients with personality disorder in specialist personality disorder services and, it was hoped, would also mitigate stigma.

Given the above, it seemed timely to see whether the attitudes of psychiatrists towards BPD showed any change. We selected psychiatric trainees, despite the difference in seniority/experience compared with Lewis & Appleby's original study (mean 16.5 years of psychiatric practice), as they are on the front line of service provision and are the next

generation of consultant psychiatrists. Considering the findings of McGilloway *et al*⁶ and the multi-ethnic patient population in east and north-east London our sample was drawn from, we also examined the impact of ethnicity on attitudes.

Objectives

The objectives of the study were: to assess the attitudes of psychiatry trainees towards patients with BPD compared with depression to assess the impact of patient ethnicity on the attitudes of trainees to BPD.

Method

The study population consisted of the cohort of doctors training in psychiatry on the north-east London rotations (East London NHS Foundation Trust and North East London NHS Foundation Trust) between February and July 2013: core trainees 1–3, specialist trainees 4–6, general practice vocational trainees and foundation year 2 doctors. Overall, 166 doctors in training were block randomised in blocks of 8 to receive one of four different case vignettes (*Box 1*) that varied by previous diagnosis (BPD or depression) and ethnic group (White British or Bangladeshi). The case vignettes were modified versions of those used by Lewis & Appleby.¹⁸

Box 1 Case vignettes used in the study

Case 1

A 25-year-old White British woman is seen in out-patients. She complains of feeling depressed and crying all the time. She is worried she may be having a ‘breakdown’ and is requesting admission. She says she has thought of killing herself by taking an overdose of tablets at home. She has a history of an overdose 2 years ago after a relationship break-up, following which she saw a psychiatrist who diagnosed her with depressive episode. She recently lost her job and is worried about how she will pay the bills. She is finding it difficult to sleep and her GP prescribed nitrazepam, which she says has been helpful and which she would like to continue.

Case 2

Same as case 1, but the patient is Bangladeshi.

Case 3

Same as case 1, but the previous diagnosis is borderline personality disorder.

Case 4

Same as case 3, but the patient is Bangladeshi.

We used the following tools to measure attitudes:

Lewis & Appleby’s 22 semantic differentials on a 6-point scale. Using the original scoring conventions, the semantic differentials were scored so that a higher score represented responses that were more rejecting or that indicated lack of active treatment.

APDQ: a questionnaire that consists of 37 affective statements about patients with personality disorder (e.g. ‘I like personality disorder people’, ‘I feel drained by personality disorder people’, ‘I feel patient when caring for personality disorder people’). Respondents rate the frequency of their experiences of these feelings on a 6-point Likert scale: never, seldom, occasionally, often, very often and always. The responses can be summed to give a total score; the higher the score, the more positive the attitude towards patients with a personality disorder. Five subfactors can be scored: factor 1, enjoyment: warmth, liking for and interest in contact with patients with personality disorder factor 2, security: the lack of fears, anxieties and helplessness in relation to patients with personality disorder factor 3, acceptance: the absence of anger towards patients with personality disorder and a sense of being different from them factor 4, purpose: feelings of meaning and purpose in working with patients with personality disorder factor 5, enthusiasm: energy and absence of tiredness.

For the purposes of this study we modified the affective statements to ‘I like these patients’, ‘I feel drained by these patients’ etc. to correspond to the case vignette of either personality disorder or depression.

Analysis

As regards Lewis & Appleby’s 22-item semantic differentials, we compared mean and s.d. scores on items. We assessed the structure of the items by running a principal components analysis. We summed scores of the most dominant factors that explained most of the variance and compared them by diagnosis and by ethnic group.

The APDQ scores (mean, s.d.) were compared for trainees across the four case vignettes. These were compared as groups that differed by diagnosis or by ethnic group in logistic regression analyses, to assess the role of diagnosis and ethnic group. We used the original APDQ factors as an additional variable to assess differences by patient ethnic group and diagnosis.

The study was granted ethical approval by the South West London REC 3 (ref. 10/H0803/159). We obtained the names and positions of all trainees in the rotation from the core training scheme manager for the north-east London rotations. We contacted all trainees via email asking them to complete questionnaires online (on the SurveyMonkey platform, www.surveymonkey.co.uk). All respondents gave informed consent and all responses were anonymous.

Results

We received 76 responses (response rate 46%). However, a small number of respondents failed to answer a number of questions. We thus analysed data from 73 responses to Lewis & Appleby’s questionnaire ($n = 19$ for case 1, case 3 and case 4, and $n = 16$ for case 2) and 68 responses to the APDQ (17 for case 1, 15 for case 2, 20 for case 3, and 16 for case 4). Respondent characteristics are given in *Table 1*.

Respondent characteristics

	Depression	Borderline personality disorder				
Gender						
Female	12	10	22	13	8	21
Male	5	5	10	7	9	16
Unknown	3	1	4	0	3	3
Ethnicity						
White	8	6	14	11	9	20
Black/Asian/mixed/other	6	7	13	6	4	10
Unknown	6	3	9	3	7	10
Qualification in UK						
Unknown	10	8	18	11	8	19
	3	1	4	1	3	4
Current level						
GP/FY	2	5	7	4	0	4
CT1–3	10	5	15	11	12	23
ST4–6	5	3	8	5	5	10
Unknown	3	3	6	0	3	3

GP, general practice vocational trainee; FY, foundation year; CT, core trainee; ST, specialist trainee.

Lewis & Appleby's 22-item semantic differentials

The scale was subject to principal components factor analysis followed by an orthogonal rotation to identify 16 of the 22 items loaded (loading of greater than 0.5) on the first factor (eigenvalue 10.42, explaining 71% of the variance), with two further candidate factors (eigenvalue 1.68, explaining 11.5% and eigenvalue 1.00, explaining 6.1%, respectively) (*Table 2*). Only items from the first factor were summed to compare attitudes, as the second and third factors were accounted for by 3 items each and did not show a clear conceptual distinction between each other. The mean and s.d. score of factor 1 was compared by diagnosis and by ethnic group (case 1: mean 42.42, s.d. = 8.54; case 2: mean 48, s.d. = 8.71; case 3: mean 53.68, s.d. = 11.99; case 4: mean 51.53, s.d. = 10.51). The scores did not vary by ethnic groups. The rank sums showed significant differences by diagnosis, with higher scores (more stigma) towards personality disorder than depression (overall Kruskal–Wallis $\chi^2 = 11.38$, d.f. = 3, $P = 0.01$) (*Table 3*).

Principal components analysis

	Mean (s.d.)	Loading					
F actor 1 (eigen value 1 0.42)							
Poses difficult management problem	3.25 (1.18)	4.20 (1.30)	0	0	0	0	0
Unlikely to improve	2.17 (0.94)	3.64 (1.48)	0	0	0	0	0
Cause of debts under patient's control	3.67 (1.22)	3.28 (1.31)	0	0	0	0	0
No mental illness	2.53 (1.38)	3.00 (1.57)	0	0	0.041	0	0
Case does not merit NHS time	2.64 (1.15)	2.97 (1.06)	0	0	0	0	0
Unlikely to complete treatment	2.67 (1.15)	3.95 (1.23)	0	0	0	0	0
Unlikely to comply with advice and treatment	2.89 (0.95)	3.56 (1.27)	0	0	0	0	0
Suicidal urges under patient's control	2.91 (1.00)	2.64 (1.40)	0	0	0	0	0
Likely to become dependent on one	4.08 (1.11)	4.72 (0.79)	0	0	0	0	0
Condition not severe	3.25 (0.94)	3.54 (0.91)	0	0	0	0	0
Admission not indicated	3.25 (1.50)	3.55 (1.40)	0	0	0	0	0
Not a suicide risk	2.56 (0.99)	3.00 (0.99)	0	0	0	0	0
Does not require sickness certificate	2.42 (1.59)	3.08 (1.51)	0	0	0	0	0
Dependent on BZs	3.29 (1.18)	3.08 (1.23)	0	0	0	0	0
Psychotherapy referral not indicated	1.91 (1.16)	1.95 (1.11)	0	0	0	0	0
Antidepressants not indicated	1.83 (1.16)	3.47 (1.59)	0	0	0	0	0
F actor 2 (eigen value 1.68)							
Manipulating admission	2.91 (0.95)	2.68 (1.32)	0	0	0.208	0	0
Unlikely to arouse sympathy	2.46 (1.09)	3.08 (1.36)	0	0	0	0	0
Would not like to have in one's clinic	2.86 (1.40)	3.36 (1.55)	0	0	0	0	0
F actor 3 (eigen value 1.00)							
Taking an overdose would be attention seeking	2.97 (1.03)	3.64 (1.35)	0	0	0	0	0
Should be discharged from out-patient follow-up	1.61 (1.10)	1.82 (0.93)	0	0	0	0	0
Likely to annoy	3.11 (1.28)	3.64 (1.48)	0	0	0	0	0

BPD, borderline personality disorder; BZ, benzodiazepine; NHS, National Health Service.

Means: higher values indicate greater agreement with statement; there was a 6-point scale between the two statements of the semantic differential.

Attitudes to BPD based on the four test vignettes (factor 1: Kruskal–Wallis equality-of-populations rank test)

Case vignette	Respondents, <i>n</i>	Rank sum
1	19	460.50
2	16	564.50
3	19	860.50
4	19	815.50

$\chi^2 = 11.38$, d.f. = 3, $P = 0.01$

APDQ

Multiple regression analysis of overall scores showed a weak trend towards lower scores in assessment of attitudes towards patients with a previous diagnosis of BPD compared with patients with a previous diagnosis of depression (lower scores indicate more negative attitudes in the APDQ and this is consistent with findings from the Appleby measure); however, this difference fell just short of statistical significance ($z = 1.75$, $P = 0.08$). There was no significant ethnic difference in attitudes towards patients. In subgroup analysis, only among White British patients with a previous diagnosis of BPD was there a lower overall score compared with White British patients with a previous diagnosis of depression ($z = 1.98$, $P = 0.047$).

This outcome had already been subjected to factor analysis by the original inventors of the measure. When we assessed scores on the basis of the five factors (using Kruskal–Wallis equality-of-populations rank) there was no statistically significant difference in scores for factors 1 (enjoyment), 2 (security), 3 (acceptance) and 5 (enthusiasm). However, there was a statistically significant ($P = 0.03$) difference found for factor 4 (purpose), with higher scores in attitudes (more positive) towards patients with depression (mean 4.60) compared with patients with a previous diagnosis of BPD (mean 4.15).

Discussion

Since the original study of Lewis and Appleby nearly 30 years ago, a number of studies spanning from 1993 to 2012, as summarised in the introduction, have consistently shown that clinicians hold negative attitudes towards personality disorder. Our finding of more negative attitudes towards personality disorder compared with depression among psychiatric trainees, using the same instrument as Lewis and Appleby, is in line with previous research. However, it is difficult to show and theorise a sense of longitudinal change. This is mainly because different studies have looked at different professional groups, including nurses, prison officers, social workers, psychologists and psychiatrists, with varying training and levels of experience, and in different countries and/or care settings. In addition, our study examined the attitudes of a less experienced sample of psychiatrists than the Lewis and Appleby study, and this has to be taken into consideration when comparing current attitudes with previous ones. However, the ongoing finding of more stigma towards patients with personality disorder, almost 14 years after the introduction of the National Personality Disorder Development Programme, is disheartening.

More encouraging is the lack of evidence of differences in attitudes to patients with personality disorder of different ethnicity. The greater negative attitudes to personality disorder than depression in White British but not in Bangladeshi

patients raises questions of differences in how clinicians may view the disorder in different ethnic groups, especially given that culture influences significantly what is considered to be a person and personality. Culture influences a number of factors relevant to the construct of personality disorder, such as learning inside and outside the family, the threshold when personality vulnerability cannot be compensated for by the person, and the social threshold when such decompensations are labelled pathological.^{21–23} If one accepts personality pathology as universal,²⁴ perhaps this finding can also raise further questions regarding under-diagnosis of personality problems in certain ethnic groups, although supporting such a link is beyond the scope of this paper and further research is needed looking into both the universality of personality disorder and issues of under-diagnosis or misdiagnosis.

The question of why psychiatrists stigmatise personality disorder is complex and not simple to answer. In addition to the issues discussed above in relation to caring for these often emotionally draining patients, it is of relevance that specific features of BPD can cause negative attitudes. It is known that a wide range of impulsive and potentially self-damaging behaviours are observed, especially early in the course of the disorder.^{25,26} These include gambling, irresponsible money handling, reckless driving and unsafe sexual practices,²⁷ as well as problematic substance use, self-harm, suicidal behaviour and disordered eating.^{28–31} Most of these behaviours carry strong moral connotations, sometimes challenging social norms, and can thus provoke negative reactions, triggering clinicians' implicit beliefs and possibly prejudices towards such behaviours.

While mounting anti-stigma campaigns may be required, the finding of a greater lack of purpose in clinicians in working with personality disorder allows for more modest and targeted intervention. Lack of purpose and therapeutic pessimism raise the importance of designing targeted interventions which may include training in personality disorder. As personality disorder is prevalent in all psychiatric settings, this is an important part of training for all psychiatrists.

Limitations

Limitations of the present study include the small sample numbers, which, despite a reasonable response rate for a questionnaire study, makes it difficult to rely on comparisons between the groups, and thus compromises the power of the study. Our study population is taken from only two mental health trusts in the UK. However, the trusts cover both inner and outer London areas, and the training programmes are similar to those of others in the UK, as there is a specific framework for postgraduate training in psychiatry.

Recommendations

Increased training in evidence-based practice for generalist mental health professionals in borderline personality disorder may address the issue of clinicians' lack of sense of purpose. The emphasis is thus on increasing the skills of clinicians in managing personality disorder in general psychiatric settings, which usually lack the structure, training and resources to deal with these complex patients. The difficulties faced by general psychiatry clinicians have been acknowledged in the literature, and in that respect 'structured clinical management' has been discussed as an effective way of working with BPD patients in non-specialist settings, as long as certain principles are followed and interventions implemented.³²

It has been shown that people with personality disorder present specific challenges to the therapeutic alliance.^{33–35} Training and supervision^{36–39} as well as participation in a Balint group⁴⁰ can improve negative attitudes.

Patients with personality disorder can provoke strong countertransference reactions, there is thus an ongoing need for clinicians to monitor their countertransference when working with such patients. This highlights the ongoing need for psychotherapy training. Evidence-based psychotherapy treatments have a documented applicability as a useful model for general psychiatrists.⁴¹ Supervision and further training is also necessary for consultants, as they often supervise trainee doctors and inevitably influence them through their own attitudes to these patients.

Recent research on stigma reduction has identified certain key ingredients that anti-stigma initiatives should take into consideration: a recovery emphasis and having multiple forms of social contact are especially important for maximising outcomes.⁴² These key ingredients can be taken up to introduce specific initiatives to reduce stigma against personality disorder. For example, Knaak *et al*⁴³ found that a 3-hour workshop on BPD and dialectical behavioural therapy (DBT)

was successful at improving attitudes and behavioural intentions towards persons with BPD. This is in line with those studies that show that training and education programmes tend to improve attitudes.

1.6.5 Pokorny's complaint: the insoluble problem of the overwhelming number of false positives generated by suicide risk assessment

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Abstract

Alex Pokorny's 1983 prospective study of suicide found that 96.3% of high-risk predictions were false positives, and that more than half of the suicides occurred in the low-risk group and were hence false negatives. All subsequent prospective studies, including the recent US Army Study To Assess Risk and Resilience in Servicemembers (STARRS), have reported similar results. We argue that since risk assessment cannot be a practical basis for interventions aimed at reducing suicide, the alternative is for mental health services to carefully consider what amounts to an adequate standard of care, and to adopt the universal precaution of attempting to provide that to all of our patients.

Contents

- *Pokorny's complaint: the insoluble problem of the overwhelming number of false positives generated by suicide risk assessment*
 - *Pokorny's pioneering study*
 - *Other prospective studies of suicide*
 - *Implications for mental health services*

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Pokorny's pioneering study

It is over 30 years since the publication of Alex Pokorny's landmark prospective study of suicide among consecutive first admissions to the Houston Veterans Administration Medical Center.^{1,2} Pokorny examined a cohort of 4800 men using a comprehensive array of relevant and reliable rating scales and assessed 803 (17%) to be at high risk of suicide because of the presence of a combination of risk factors. In the next 5 years, 30 (3.7%) high-risk patients and 37 (0.9%) of the 3997 lower-risk patients died by suicide, an odds of suicide that was 4 times greater in the high-risk group.

The 37 suicides among lower-risk patients were in effect false negatives. Pokorny considered false negatives to be inevitable because patients sometimes conceal their suicidal plans and their circumstances change over time. What concerned him more was the overwhelming proportion of false positives, because 96.3% of the patients categorised as high-risk did not commit suicide. He concluded: "We might tolerate 50% false negatives; if we could apply a screening test that would correctly identify only half of the future suicides without false positives that would be very helpful. However, with currently known tests to identify the actual suicides, we will also have to make a great many false-positive identifications, labeling up to a quarter of the total group as future suicides when only 1% to 5% actually are. From a cost-benefit standpoint, the application of such a test is simply not feasible."¹

Other prospective studies of suicide

There have been relatively few prospective studies of the factors associated with subsequent suicide, probably because of the methodological and logistical difficulties involved. Not long after Pokorny, Goldstein *et al*³ followed up a cohort of 1906 patients diagnosed with affective disorders and found that none of the 46 suicides occurred among the group, albeit smaller than in Pokorny's study, defined as being at high risk. More recently, two prospective studies examined the proportion of suicide deaths among those considered to be at high risk.⁴⁻⁶ Madsen *et al*^{4,5} reported a suicide rate of 0.14% among those defined as high risk in a national study of the suicide of psychiatric in-patients in Denmark, and Steeg reported the suicide of 0.5% of patients identified as being at high risk among a large cohort of people who presented to emergency departments in three English counties after self-harm.⁶

Faced with growing concern about suicides among veterans and current serving members of the U.S. Armed Forces, the U.S. Department of Veterans Affairs and the U.S. Department of Defense included the use of risk stratification in clinical practice guidelines.⁷ As part of the Study to Assess Risk and Resilience in Servicemembers (STARRS), Kessler and associates then examined factors associated with suicide among 53 769 American soldiers in the 12 months after discharge from military psychiatric hospitals,⁸ with the benefit of the very detailed longitudinal US Army personnel database and highly sophisticated statistical techniques derived from artificial intelligence research. They identified a high-risk group comprising 2689 admissions, or 5% of the sample, from which there were 36 suicides, corresponding to a 22 times increased risk of suicide in that group. However, in other respects the results were eerily familiar, as nearly half of the suicides occurred among the 51 080 low-risk patients, and only 1.3% of the high-risk group died by suicide, leaving an overwhelming number of false positive cases.

The problem remains of the disturbingly high suicide rates among psychiatric patients as a whole. For example, in the Madsen study, the rate of suicide of psychiatric in-patients was 72 times that of the general community, at 860 per 100 000 patient years, and in the Steeg study the suicide rate among all patients presenting to hospital after self-harm was 622 per 100 000 patient years. Hence, although we know that all of the patients under our care are at greatly increased risk of suicide compared with the wider community,⁵ our ability to distinguish between groups of patients with respect to the probability of subsequent suicide risk is, at best, quite modest.

Implications for mental health services

This observation has important implications for mental health services, given the unrealistic expectations for risk assessment to prevent serious adverse events, and the way risk assessment has changed professional practice.⁹ If risk stratification is to be a part of how mental health services approach suicide prevention, we need to carefully consider the interventions offered to patients believed to be at high risk but denied to those assessed to be at lower risk. Because the vast majority of high-risk patients will not die by suicide, any intervention has to be shown to be somewhat effective, but also benign enough so as not to infringe on the rights of the many with false positive assessments. However, if we do have an effective and benign intervention, it is then hard to justify denying this to low-risk patients, who, after all, are still many times more likely to die by suicide than the general community.

If there is no effective and yet benign intervention to justify offering different treatments to groups of patients on the basis of risk stratification, how can mental health services respond to the knowledge that our patients are at greatly increased risk of suicide compared with the wider community?

The alternative is the application of universal precautions to all patients, including the design of in-patient facilities that minimise the opportunity to attempt suicide,¹⁰ the provision of community treatment for all patients in the weeks after discharge from hospital,¹¹ and safety planning at the point of contact in emergency departments.¹² Most importantly, every patient should have access to timely, individualised, high-quality treatment for psychiatric disorder. Modifiable factors associated with suicide should be addressed in all patients, not only those considered to be at greatest risk. Moreover, no intervention can be justified on the basis of the assessed risk alone. We go so far as to suggest that the assessed risk of suicide on its own is not a sufficient reason for restrictive interventions such as involuntary detention in hospital or other coercive treatment,^{13,14} which would then need to be justified on additional grounds, including the patient's inability to recognise the potential benefit of treatment and their particular circumstances and treatment needs. In any case, preventive detention in hospital of all patients assessed to be at high risk of suicide would be impossible, because of the huge numbers of patients identified and the long duration of secure detention that would be required to protect such patients.

Addressing the modifiable risk factors in populations of patients involves ensuring the adequate identification, assessment and treatment of patients with a range of mental disorders, addressing substance use and, wherever possible, limiting the availability of potentially lethal means to die by suicide. Treatment should be with the patient's consent, or provided on the basis that the patient lacks the capacity to consent, rather than being based on perceived risk, which we now know we are not able to reliably assess.

A further implication for mental health services of the demonstrated limitation of risk assessment is in responding to lawsuits for failing to predict the suicides of individual patients. While the suicide of any patient might be foreseeable in the legal sense of being not fanciful or far-fetched, mental health services cannot be reasonably expected to be able to identify which patients will die by suicide. Expert evidence in one recent case on the estimated probability of suicide after discharge included absurdly high estimates of between a 5 and 70% chance of suicide within days of discharge.¹⁵ Instead of guessing the probability with the help of hindsight bias,¹⁶ negligence claims after suicides should hinge on the accepted standard for care of people with various psychiatric disorders, regardless of the presence of known risk factors. Services should be concerned about the adverse consequences of failing to provide an adequate standard of care to any patient they assess or treat, not only those considered to be at high risk.

Pokorny's complaint that the overwhelming number of false positives renders suicide risk assessment unfeasible is just as valid in 2016 as it was in 1983. His finding, which has been replicated in all subsequent studies, poses a challenge to military and civilian mental health services that have been developed around a model of identifying and managing risk. In response, we recommend abandoning attempts to design interventions based on risk stratification and instead aim to provide an adequate standard of care to all of our patients.

1.6.6 Juvenile delinquency, welfare, justice and therapeutic interventions: a global perspective

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Abstract

This review considers juvenile delinquency and justice from an international perspective. Youth crime is a growing concern. Many young offenders are also victims with complex needs, leading to a public health approach that requires a balance of welfare and justice models. However, around the world there are variable and inadequate legal frameworks and a lack of a specialist workforce. The UK and other high-income countries worldwide have established forensic child and adolescent psychiatry, a multifaceted discipline incorporating legal, psychiatric and developmental fields. Its adoption of an evidence-based therapeutic intervention philosophy has been associated with greater reductions in recidivism compared with punitive approaches prevalent in some countries worldwide, and it is therefore a superior approach to dealing with the problem of juvenile delinquency.

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Recent years have seen sustained public and academic interest in criminality and mental health, with attention often focused on antisocial behaviour by children and adolescents. The scale of the problem of juvenile delinquency has provoked mixed responses from governments and the media across the world, with calls for improved rehabilitation and support for juvenile offenders competing with voices advocating more punitive approaches.¹ Meanwhile, decades of rigorous academic scrutiny have shed light on the complex and diverse needs of children who come into conflict with the law.²⁻⁵ Much of the growing body of literature on juvenile offenders shows considerable overlap between criminological, social and biomedical research, with a consensus emerging around the significance of a developmental understanding of the emergence of juvenile delinquency.

Importantly, juvenile offenders have consistently been identified as a population that suffers from a markedly elevated prevalence and severity of mental disorder compared with the general juvenile population.^{6,7} Meeting the needs of these young offenders presents practical and ethical challenges concerning treatment and management, including liaison with other agencies.

What is juvenile delinquency?

Who counts as juvenile?

Juvenile delinquency is a term commonly used in academic literature for referring to a young person who has committed a criminal offence, although its precise definition can vary according to the local jurisdiction. The specific reasons underlying these differences are unclear, but they may arise from the lack of an agreed international standard.⁸

A ‘juvenile’ in this context refers to an individual who is legally able to commit a criminal offence owing to being over the minimum age of criminal responsibility, but who is under the age of criminal majority, when a person is legally considered an adult. The minimum age of criminal responsibility varies internationally between 6 and 18 years, but the age of criminal majority is usually 18 years.

In some cases individuals older than 18 years may be heard in a juvenile court, and therefore will still be considered juveniles; indeed, the United Nations (UN) defines ‘youth’ as between 15 and 24 years of age. The term ‘child delinquents’ has been used in reference to children below the age of 13 who have committed a delinquent act,⁹ although elsewhere ‘children’ are often defined as being under 18 years of age. The term ‘young offenders’ is broad, and can refer to offenders aged under 18 years or include young adults up to their mid-20s.

What is a crime?

A ‘delinquent’ is an individual who has committed a criminal offence. Delinquency therefore encompasses an enormous range of behaviours which are subject to legislation differing from one jurisdiction to another, and are subject to changes in law over time. Whereas acts of theft and serious interpersonal violence are commonly considered to constitute criminal offences, other acts including alcohol consumption and sexual behaviour in young people are tolerated to very differing degrees across the world. Sometimes these differences arise as a consequence of historical or cultural factors, and they may be underpinned by traditional religious laws, such as in some Middle Eastern countries. Some offences may be shared between jurisdictions but be enforced to differing standards – for instance, ‘unlawful assembly’, often used to prevent riots, is applied in Singapore to young people meeting in public in groups of five or more as part of police efforts to tackle youth gangs. Furthermore, ‘status offences’ – acts that would be permissible in adults but criminalised in children, such as consumption of alcohol or truancy – not only vary between jurisdictions, but contribute to discontinuity when comparing juvenile delinquency with adult populations in the same jurisdiction.

Lack of clarity can also arise in jurisdictions where a young offender is processed via a welfare system rather than a youth justice process. Countries with a high minimum age of criminal responsibility may not technically criminalise young people for behaviour that would normally be prosecuted and therefore classed as ‘delinquent’ elsewhere.

Not all incarcerated juveniles are ‘delinquent’, since some may be detained pre-trial and may not be convicted of an offence. Even if convicted, it would be wrong to assume that every ‘juvenile delinquent’ meets criteria for a diagnosis of conduct disorder; offences vary considerably and may not be associated with a broad repertoire of offending behaviour. Also, most ‘juvenile delinquents’ do not pose an immediate risk of violence to others, and the vast majority of convicted juveniles serve their sentences in the community.

To meet the diagnostic criteria of conduct disorder requires evidence of a persistent pattern of dissocial or aggressive conduct, such that it defies age-appropriate social expectations. Behaviours may include cruelty to people or animals, truancy, frequent and severe temper tantrums, excessive fighting or bullying and fire-setting; diagnosis of conduct disorder can be made in the marked presence of one of these behaviours.¹⁰

Overall, the term ‘juvenile delinquent’ is used extensively in academic literature, but requires some care. It can be a potentially problematic term, and in some contexts can strike a pejorative tone with misleading negative assumptions. For several years the UN has used the phrase ‘children in conflict with the law’ to describe the breadth of the heterogeneous group of individuals under the age of 18 who have broken the law or are at risk of doing so.

General principles of juvenile justice

Welfare v. justice models

The sentencing of an individual convicted of a criminal offence is largely driven by three key considerations: retribution (punishment), deterrence and rehabilitation. In the case of juvenile offenders the principle of rehabilitation is often assigned the greatest weight.¹¹

Special consideration for juveniles within the criminal justice system is not a new concept. In Roman law, the principle of *doli incapax* protected young children from prosecution owing to the presumption of a lack of capacity and understanding required to be guilty of a criminal offence. Most countries have some provision for special treatment of children who come into conflict with the law, however, the degree to which this is provided varies across the world.^{1,12} In some countries a ‘welfare’ model prevails, which focuses on the needs of the child, diagnosis, treatment and more informal procedures, whereas other countries favour a ‘justice’ model, which emphasises accountability, punishment and procedural formality.

Belgium is frequently cited as an example of a country with a strong welfare process, supported by a high minimum age of criminal responsibility of 18 years. Similarly, France built a strong welfare reputation by placing education and rehabilitation at the centre of youth justice reforms in the 1940s. New Zealand in 1989 established the widely praised system of Family Group Conferencing as an integral part of youth justice, with a focus on restoration of relationships and reduction of incarceration that would be considered part of a welfare approach. In contrast, the UK and the USA

have traditionally been associated with a justice model and low age of criminal responsibility – 10 years in England and Wales, and as low as 6 years in several US states.

Within welfare or justice models, a young person may at some point be ‘deprived of liberty’ – defined as any form of detention under official authorities in a public or private location which the child is not permitted to leave. Locations in which children may be deprived of liberty include police stations, detention centres, juvenile or adult prisons, secure remand homes, work or boot camps, penitentiary colonies, locked specialised schools, educational or rehabilitation establishments, military camps and prisons, immigration detention centres, secure youth hostels and hospitals.¹³

Between the less and more punitive systems

The UN supports the development of specialised systems for managing children in conflict with the law. When the first children’s courts were set up in the USA in the 1930s, they were widely praised as a progressive system for serving the best interests of the child. Although informality was championed as a particular benefit, in the 1960s substantial concerns arose about due process and the protection of the legal rights of minors. The subsequent development of formal juvenile courts occurred in the context of a continuing ethos of rehabilitation of young people, with a move away from incarceration of juveniles in the 1970s, especially in Massachusetts and California. However, following a marked peak in juvenile offending statistics during the 1980s and 1990s, public and political opinion swung firmly in a more punitive direction. This was accompanied by legal reforms that increased the severity of penalties available to juvenile courts and lowered the age threshold for juveniles to be tried in adult criminal courts.

When the UN Convention on the Rights of the Child entered into force in 1990, the USA was not a signatory owing to 22 states permitting capital punishment of individuals who had committed their crimes as juveniles. It is reported that 19 juvenile offenders were executed in the USA between 1990 and 2005. Although this number may represent a small percentage of the total who faced the death penalty in the USA during that period, the practice was widely criticised by international bodies and organisations.¹⁴ A landmark ruling in the US Supreme Court¹⁵ outlawed the execution of juvenile offenders in the USA, but to date a small number of countries worldwide still implement this practice, sometimes as a result of religious laws.

However, it would be wrong to assume that welfare systems are automatically preferable to a juvenile justice approach, since welfare arrangements can be equally coercive in terms of deprivation of liberty of juveniles. They may lack due process, safeguards for obtaining reliable evidence from young people, processes for testing evidence, and procedures for scrutiny or appeal following disposal.

Trends in youth crime

The USA witnessed a dramatic increase in arrest rates of young people for homicide and other violent crimes in the 1980s and 1990s, sometimes referred to as the ‘violence epidemic’.¹⁶ The ensuing moral panic led to harsh and punitive policy changes in juvenile justice and, although official statistics document a subsequent fall of 20% in court case-loads between 1997 and 2009, victimisation surveys have indicated a degree of continuity in high levels of offending, consistent with a reported increase in juvenile offending between 2000 and 2006.¹⁷

In common with the USA and several other high-income countries, the UK also experienced a rise in juvenile offending in the 1980s and 1990s, but figures from the Youth Justice Board for England and Wales appear to indicate a general improvement in recent years. Between 2009/2010 and 2014/2015 a 67% reduction has been observed in the number of young people entering the juvenile justice system for the first time, a 65% reduction in the number of young people receiving a caution or court disposal and a 57% reduction in the number of young people in custody.¹⁸ These figures support an overall decrease in juvenile offending noted since the early 1990s.¹⁹

Youth crime figures from Australia have documented a 4% reduction in the overall number of young offenders in 2013/2014,²⁰ although the number of violent offences committed by young people in the urbanised and densely populated region of Victoria has increased by 75% between 2000 and 2010.²¹

The Nordic countries have witnessed an increase in the number of law-abiding youths from 1994 and 2008.²² In Sweden, both objective levels of juvenile crime²³ and self-reported involvement in juvenile crime²⁴ have fallen between 1995

and 2005. Similarly in Finland, where, despite fluctuating trends in juvenile drug use, juvenile property and violent crime is reported to have decreased between 1992 and 2013.²⁵

To summarise, whereas regional and annual trends in juvenile offending are observed and expected, a global trend characterised by decreased juvenile offending appears to have emerged in recent years. Indeed, UN data from a sample of 40 countries lend support to this conclusion, indicating a decrease in the proportion of juveniles suspected (10.9% to 9.2%) and convicted (7.5% to 6%) of crime between 2004 and 2012, respectively.²⁶

Juvenile gang membership

Influence on crime involvement

One of the features of urbanisation across the world has been the rise of youth gangs, groups of young people often defined by geographical area, ethnic identity or ideology; recent reports indicate a rise in groups with extremist views. Explanatory models for the rise in youth gangs include factors such as economic migration, loss of extended family networks, reduced supervision of children, globalisation and exposure to inaccessible lifestyle 'ideals' portrayed in modern media.

Authorities in Japan attributed a surge in serious youth crime in the 1990s primarily to juvenile bike gangs known as 'bosozoku', who were deemed responsible for over 80% of serious offences perpetrated by juveniles, putatively bolstered by a crackdown on yakuza organised crime syndicates.²⁷ Although difficult to quantify, gang involvement appears to feature in a large proportion of juvenile offences, and there is evidence that gang membership has a facilitating effect on perpetration of the most serious violence including homicide.²⁸

Mental health

Compared with general and juvenile offender populations, juvenile gang members exhibit significantly higher rates of mental health problems such as conduct disorder/antisocial personality disorder, post-traumatic stress disorder (PTSD), anxiety disorders and attention-deficit hyperactivity disorder (ADHD).²⁹ Gang members, compared with non-violent men who do not belong to a gang, are far more likely to utilise mental health services and display significantly higher levels of psychiatric morbidity, most notably antisocial personality disorder, psychosis and anxiety disorders.³⁰ Gang membership has also been positively correlated with an increased incidence of depressed mood and suicidal ideation among younger gang members.³¹ Prevalence of ADHD is significantly greater in incarcerated youth populations (30.1%) than in general youth population estimates (3–7%),³² therefore it may be reasonable to expect a similarly increased prevalence in juvenile gang members. ADHD has also been associated with a significantly increased risk of comorbid mood/affective disorder.³³

Forensic child and adolescent psychiatric services

Increased awareness of constitutional and environmental factors that contribute to juvenile offending has strengthened a public health perspective towards the problem, and in the UK entry into the youth justice system has been adopted as an indicator of general public health.³⁴

Dictionaries frequently define 'forensic' as meaning 'legal', implying a relationship with any court of law. Indeed, many forensic psychiatrists, particularly in child and adolescent services, undertake roles that encompass multiple legal domains relevant to mental health, including criminal law, family and child custody proceedings, special educational tribunals, and immigration or extradition matters.

Specialist forensic psychiatric services vary considerably between countries,³⁵ but usually forensic psychiatrists assess and treat individuals in secure psychiatric hospitals, prisons, law courts, police stations and in the community under various levels of security, supervision and support. In some countries there has been a trend towards forensic psychiatrists working almost exclusively with courts of law, providing independent specialist opinion to assist the court.

In the UK, forensic child and adolescent psychiatry has emerged as a clinical subspecialty. Some services are based in specialist secure hospitals for young people and cater for the relatively small number of high-risk young offenders with the most severe mental disorders. In the absence of such specialist resources, young people may be managed in suboptimal environments such as juvenile prisons, secure residential placements or secure mental health wards for adults, or even fail to receive treatment at all.

In light of growing evidence-based interventions for juvenile offenders within a public health framework,³⁶ the role of child and family mental health services may increase over time. Aside from direct clinical roles, practitioners in forensic child and adolescent psychiatry are also well placed to work with a wide range of partner agencies on the planning and delivery of broader interventions for the primary and secondary prevention of juvenile delinquency.

Treatment

Prevalence of mental health problems among juvenile offenders

Rates of mental health problems among juvenile offenders are significantly higher than in their non-offender peers, with two-thirds of male juvenile offenders in the USA suggested as meeting criteria for at least one psychiatric disorder.³⁷ One in five juvenile offenders is estimated to suffer severe functional impairment as a result of their mental health problems.³⁸ Paradoxically, these needs are often unmet,^{39,40} despite evidence of increased contact with mental health services, particularly among first-time juvenile offenders.^{41,42} Of additional concern are the reported associations between mental health problems and mortality in incarcerated juveniles,⁴³ including an elevated suicide rate for males.⁴⁴ Mental health problems must be a target in interventions for juvenile offenders; however, treatments which focus solely on clinical problems are unlikely to result in benefit for criminogenic outcomes.⁴⁵ There is therefore a clear need for effective interventions which address both the clinical and criminogenic needs of these individuals.

Evidence-based treatments for mental health problems

Treatment of PTSD

Estimates regarding the prevalence of PTSD among juvenile offenders suggest that 20 to 23% meet the clinical criteria,^{46,47} with prevalence rates significantly higher among females than males (40% v. 17%).⁴⁶ Moreover, with 62% experiencing trauma within the first 5 years of life⁴⁷ and up to 93% experiencing at least one traumatic event during childhood or adolescence,⁴⁸ this should be a target for intervention.

Cognitive-behavioural therapy (CBT) is regarded as the most effective intervention for adults with PTSD⁴⁹ and also has demonstrated efficacy for juvenile non-offenders.^{50,51} There is limited evidence suggesting a significant reduction in self-reported symptoms of PTSD following group-based CBT in male juvenile offenders,⁵² and of an adapted version of CBT, cognitive processing therapy,⁵³ also resulting in a significant reduction in self-reported symptoms of PTSD and depression compared with waitlist controls.⁵⁴

A trauma-focused emotion regulation intervention (TARGET) has received preliminary empirical support for use in this population. TARGET resulted in nearly twice as much reduction in PTSD symptom severity as treatment as usual (TAU),⁵⁵ in addition to significant reductions in depression, behavioural disturbances and increased optimism.⁵⁶

Mood/anxiety disorders and self-harm

Juvenile offenders in the UK present with a high prevalence of mood and anxiety disorders (67% of females, 41% of males), self-harm (11% of females, 7% of males) and history of suicide attempts (33% of females, 20% of males).⁵⁷ Similarly high prevalence has also been observed cross-culturally, namely in the USA,^{37,58} Switzerland⁵⁹ and Finland.⁶⁰

Despite such high prevalence, there appears to be a paucity of high-quality evaluations regarding the effectiveness of interventions for juvenile offenders with mood and/or anxiety disorders, or problems with self-harm. However, the limited evidence that is available suggests that group-based CBT may aid symptom reduction.⁶¹ Recovery rates for major depressive disorder following group-based CBT are over double those for a life skills tutoring intervention (39% v. 19%, respectively), although no significant difference was noted at 6- or 12-month follow-up. CBT also resulted in significantly greater improvements in self- and observer-reported symptoms of depression and social functioning.⁶²

However, group-based CBT is not reported to be significantly different from TAU in reduction of self-harm,⁶³ whereas individual CBT is not significantly different from TAU in outcomes for depression, anxiety, conduct disorder or PTSD.⁶⁴ Yet recruitment to and retention in intervention seems good, suggesting that CBT is feasible to implement in juvenile offender populations.⁶⁴

Evaluations of alternative interventions have posited muscle relaxation as effective in improving juvenile offenders' tolerance of frustration.⁶⁵ Dialectical behaviour therapy (DBT) has also been reported to significantly reduce incidences of physical aggression in a juvenile offender population⁶⁶ and among juvenile non-offenders expressing suicidal ideation.⁶⁷ It significantly reduced serious behavioural problems and staff punitive actions among juvenile offenders within a mental health unit, although no similar significant reductions were observed for those without mental health problems.⁶⁸

Evidence-based treatments for conduct disorder: family approaches

Relationships with family and peers are recognised as key factors in the criminogenic profile of juvenile offenders.⁶⁹ Multisystemic therapy (MST) is a family-focused intervention targeting characteristics related to antisocial behaviour, including family relationships and peer associations,⁷⁰ with evidence from US and UK studies suggesting MST is a beneficial intervention for juvenile offenders. When compared with conventional services offered by juvenile offending services, MST was associated with a significant reduction in the likelihood of reoffending,⁷¹ maintained 2 and 4 years post-treatment.^{72,73} Offenders engaging in MST are reported to be significantly less likely to become involved in serious and violent offending.^{73,74} Significant improvements have also been observed in both self- and parent-reported delinquency,⁷⁴ family relations and interactions,⁷³ and home, school, community and emotional functioning.⁷¹ A cost offset analysis of MST among UK juvenile offenders suggested that combining MST and conventional services provides greater cost savings than conventional services alone, as a result of its positive effects on recidivism.⁷⁵ Qualitative impressions of MST from juvenile offenders and their parents indicate that key components of a successful delivery of MST include the quality of the therapeutic relationship and ability to re-engage the offender with educational systems.⁷⁶

Some evidence also exists regarding the efficacy of MST when delivered to non-offender antisocial juvenile populations outside the USA and the UK. Compared with TAU, MST resulted in a significantly greater increase in social competence and caregiver satisfaction, and a significant reduction in referrals for out-of-home placements, in Norwegian juveniles exhibiting serious behavioural problems.⁷⁷ However, no significant difference between MST and TAU was reported in outcomes for antisocial behaviour and psychiatric symptoms in Swedish juvenile offenders.⁷⁸ MST was also found to have no significant benefit over TAU in outcomes including recidivism in a sample of Canadian juvenile offenders.⁷⁹ These differing outcomes have been posited as the result of barriers in transferring MST from US and UK populations owing to differing approaches to juvenile justice between countries (i.e. a welfare v. justice approach).⁷⁸ The heterogeneous nature of studies concerning MST in juvenile offender populations prevent a firm conclusion being drawn as to its superiority over alternative interventions, although this does not diminish the positive outcomes which have been observed.⁸⁰

Substance misuse

Motivational interviewing represents a promising approach for juvenile offenders, particularly as a treatment for substance misuse.⁸¹ Group-based motivational interviewing has received positive feedback from participants when implemented with first-time juvenile alcohol or drug offenders,⁸² and compared with TAU, juvenile offenders in receipt of motivational interviewing have greater satisfaction and display lower, though not statistically significant, rates of recidivism at 12-months post-motivational interviewing.⁸³ There is therefore preliminary evidence for the acceptability and feasibility of motivational interviewing for substance-misusing juvenile offenders, but future research regarding long-term outcomes is warranted. To date, motivational interviewing for difficulties faced by juvenile offenders beyond that of substance misuse does not appear to have received much research attention. Juvenile offenders are known for their difficulty to engage in rehabilitative services, therefore further investigation of the effectiveness of motivational interviewing in encouraging engagement is warranted.

Preliminary investigations have also developed a conceptual framework for the delivery of mindfulness-based interventions (MBI) to incarcerated substance-misusing juveniles, with qualitative impressions suggesting this is a potentially feasible and efficacious intervention.⁸⁴ Although literature regarding the effectiveness of MBI in juvenile offenders is scarce, qualitative feedback has indicated positive reception of this style of intervention, with particular improvements in subjective well-being reported by juvenile participants.⁸⁵

Employment and education

Engaging juvenile offenders with education and skills-based training is an important component of successful rehabilitation, with positive engagement in meaningful activities associated with improvements in areas such as self-belief⁸⁶ and protection against future participation in criminal activities.⁸⁷ It is concerning therefore that an evaluation of the use of leisure time over a 1-week period by probationary juvenile offenders in Australia indicated only 10% of this time was spent engaging in productive activities, such as employment or education, with 57% used for passive leisure activities, a level 30% higher than that of their non-offender peers.⁸⁸

Efforts to engage juvenile offenders in vocational and/or occupational activities have shown benefits in a number of areas. A specialised vocational and employment training programme (CRAFT) emphasising practical skills was evaluated against conventional education provision to juvenile offenders in the USA. Over a 30-month follow-up period, those engaged in CRAFT were significantly more likely to be in employment, to have attended an educational diploma programme and to have attended for a significantly longer period of time.⁸⁹ Benefits have also been reported with regard to risk of reoffending, with an after-school programme in the USA incorporating practical community projects, educational sessions and family therapy resulting in a significant reduction in recidivism at 1-year follow-up.⁹⁰

Qualitative investigations of US juvenile offenders suggest there is not a lack of interest in pursuing education among this population, but rather a disconnection with educational systems when education providers are perceived not to care about students' progress.⁹¹ Ensuring education providers are perceived as proactive and caring in this regard may therefore be an important consideration for efforts to engage juvenile offenders with educational systems. Significant barriers to engagement include difficulties in obtaining accurate information regarding the offender's educational history, in addition to identifying community-based education providers willing to accept previously incarcerated juveniles on their release.⁹²

Language and communication

Difficulties with language and communication skills appear to be prevalent among juvenile offenders, with estimates of those falling into the poor or very poor categories ranging from 46 to 67%; overall, up to 90% of juvenile offenders demonstrated language skills below average.⁹³ Specifically, high rates of illiteracy are reported in this population,⁹⁴ with evidence to suggest that an awareness of such problems among juvenile offenders themselves is associated with dissatisfaction and poor self-esteem.⁹⁵ These difficulties may act as barriers to engagement in therapeutic interventions, particularly those delivered in group settings, as well as re-engagement with educational systems. Awareness of the challenges these young people face with regard to confidence and ability to communicate is important, and potential involvement of a speech and language therapist could be considered. Preventing deficits in language and communication through effective schooling and appropriate support in the early years of life may serve as an aid to effective engagement in rehabilitative interventions, and may also mitigate the risk of engagement in criminal activities in the first instance.

Delivery of therapeutic services

Common challenges to a therapeutic youth justice pathway

There are common obstacles to smooth care pathways between different parts of systems, such as in transitions between secure settings and the community, between prisons and secure psychiatric settings, and between child and adult services. In some jurisdictions individuals can only be treated pharmacologically against their will in a hospital setting, a safeguard which limits the extent to which individuals can be treated in prison, but there is still great scope for intervention by prison mental health teams in juvenile prisons.

Factors associated with good outcomes

A meta-analysis has revealed three primary factors associated with effective interventions for juvenile offenders: a 'therapeutic' intervention philosophy, serving high-risk offenders, and quality of implementation.⁹⁶ These findings are consistent with factors posited as correlating with good outcome in residential centres for troubled adolescents and juvenile offenders: good staff-adolescent relations, perception of staff as pro-social role models, positive peer pressure, an individualised therapeutic programme approach, developmentally appropriate programmes and activities, clear expectations and boundaries, and placement locations which allow for continued family contact.^{97,98}

In the community, coercive styles of engagement have been found to be less successful at achieving adherence among juvenile offenders than a client-centred approach.⁹⁹

Factors associated with poor outcomes

'Scared Straight' programmes expose juveniles who have begun to commit offences to inmates of high-security prisons, yet these approaches have been discredited due to evidence that risk of recidivism may in fact increase following such exposure.¹⁰⁰ Similarly poor outcomes have been observed in programmes modelled on military boot camps, in which harsh discipline is considered to be of therapeutic benefit,¹⁰¹ and initiatives such as curfew, probation and hearing juvenile cases in adult court were also shown to be ineffective in reducing recidivism.¹³

Over recent years it has been repeatedly demonstrated that exposure to juvenile court itself appears to have a detrimental effect on juvenile offending.¹⁰²⁻¹⁰⁴ This may be partially explained by effects of labelling, stigma and negative self-image associated with a criminal conviction, but also the practical consequences of sentences, including assortment of delinquent peers in community or prison sentences. Incarceration presents several additional harms, including disturbance of care and pro-social relationships, discontinuity in education, association with delinquent peers, and exposure to violence. Half of detained young offenders in the UK reported victimisation during their current prison term,⁵⁷ while 12% of incarcerated youth in the USA reported sexual victimisation in the previous year.¹⁰⁵ International agreements state that deprivation of liberty (such as juvenile prison) should be used as a last resort and for the shortest time necessary, so should be reserved for the highest-risk offenders. The cost of juvenile antisocial behaviour is known

to be high, and to fall on many agencies.¹⁰⁶ The current climate of austerity in public services demands that any interventions should be not only effective, but also cost-effective, raising a clear challenge – and opportunity – for the implementation of interventions for this population of vulnerable young people. For example, parenting programmes have demonstrated sustained benefits for this population,^{107,108} with economic analysis indicating gross savings of £9288 per child over a 25 year period.¹⁰⁹ Considered together with wider costs of crime, these gross savings exceed the average cost of parenting programmes (£1177) by a factor of approximately 8 to 1.

Conclusions

Many argue that we have a long way to go before arriving at ‘child friendly’ juvenile justice.¹¹⁰ Around the world there are variable and inadequate legal frameworks that are not age-appropriate, there is a lack of age-appropriate services and establishments, and a lack of a specialist workforce, leading to challenges around training and supervision to work with this vulnerable population. In the UK and other high-income countries worldwide, forensic child and adolescent psychiatry is a multifaceted discipline incorporating legal, psychiatric and developmental fields. This approach has navigated clinical and ethical challenges and made an important contribution to welfare and justice needs by its adoption of an evidence-based therapeutic intervention philosophy.

1.6.7 ‘Doc, can I fly to Australia?’ A case report and review of delirium following long-haul flight

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date

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Abstract

Air travel is now a common feature of most of our elderly population’s lives. There is little by way of warnings, rules or recommendations for our patients with psychiatric diagnoses, in particular dementia, who intend to travel by plane, in contrast to other specialties. In this article I highlight an adverse outcome of long-haul air travel as a result of delirium and resulting accelerated decline in overall cognitive function. I review literature related to the topic and suggest ways to minimise precipitating factors for stressors prior to and during flights. This article suggests that more thought should be given to the title question.

Contents

- ‘Doc, can I fly to Australia?’ A case report and review of delirium following long-haul flight
 - Case presentation
 - * Outcome

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- *Discussion*
- *Recommendations*

Short-haul and long-haul air travel are now commonplace among the elderly population. Evidence suggests such travel is on the increase from the late 1990s, with as many as 1 in 5 people above the age of 65 passing through the main UK international airports in 2014.^{1,2} Little thought is given to short weekend breaks abroad or long-distance holidays with family with mental and physical impairments. In-flight adverse events are difficult to ascertain from information and figures produced by airlines, and apart from the well-recognised morbidity they are not well reported.³ Syncope, respiratory problems and vomiting continue to provide the bulk of in-flight emergencies, with around 1 medical emergency occurring in every 600 flights.⁴ There are no data focusing on the elderly population or people with a diagnosis of mental illness, although one recent source cited ‘anxiety’ as a reason for non-traumatic in-flight complaints.⁵

In this case report I highlight an incident where a delirium has had a significant impact on an elderly patient, resulting in an accelerated decrease in function, long-term impairment and associated symptomatic control with medications that otherwise could have been avoided. I will highlight ways of minimising chances of negative outcomes following air travel in the elderly population.

Case presentation

A 73-year-old man was initially referred to the memory clinic in December 2013 with a history of gradual deterioration of short-term memory and increased dependence on family over an approximate 18-month period. This was with a background of stable multiple sclerosis with no other medical history of note. He was functioning well owing to a supportive family and positive routine activities undertaken mostly with his wife and had a strong academic background which could have contributed to masking of cognitive defects. He was given a diagnosis of a mild cognitive impairment based on impaired short-term memory, as evidenced by clinical evaluation and formal cognitive testing. He scored 80/100 on the Addenbrooke’s Cognitive Examination III; most points were lost in the memory parts (where he scored 10/26) and less so in the fluency part (scoring 10/14) of the test. He was referred to neuropsychology, for brain imaging and was to be seen back in the clinic in 6 months’ time. There were no treatable cardiovascular risk factors at this point; however, the patient was counselled on exercise and diet as well as basic activities to promote cognitive training in keeping with present guidance. The patient and his wife were informed it was difficult to give prognosis and although evidence is varied, a person with amnesic (memory loss) mild cognitive impairment would be at around 1 in 5 risk of being diagnosed with dementia at a later stage. From this presentation and clinical evaluation, it was thought that an Alzheimer’s dementia was the most likely future diagnosis.

The patient then travelled by plane from Scotland to Australia, which involved a short connecting flight to London. On descent from the air to Australia, he experienced an episode of agitation and bizarre, nihilistic delusions about Nazis taking over the plane. After landing, he was admitted to a large, well-known teaching hospital in Australia. He continued to exhibit challenging behaviours such as agitation, wandering and resistance to attempts at basic care from nursing staff. The patient required assistance with feeding and one-to-one nursing care for the majority of the in-patient stay.

The patient’s medical investigations included a positron emission tomography (PET) scan, magnetic resonance imaging (MRI) brain scan, lumbar puncture, electrocardiogram (ECG), chest X-ray, urinalysis, basic blood tests and whole-body computed tomography (CT) over the course of admission without an obvious cause being found for such a dramatic decline and previously unseen behaviours. Of note, any cerebrovascular accident, pneumocephalus, acute kidney injury, external and middle-ear disease and sepsis were ruled out on admission. It was noted that there were no particular risk factors in terms of family history, smoking, hypertension, dyslipidaemia and diabetes which could have increased the risk of most of the proposed diagnoses. Basic observations, including oxygen saturations, were largely unremarkable throughout his admission. He was reviewed by both the neurology and neuropsychiatric teams who came to a joint conclusion that he was experiencing a delirium and previously undiagnosed Alzheimer’s dementia.

He was treated with antipsychotics and given a short trial of intravenous steroid given the history of multiple sclerosis (although not indicated by way of imaging) without any improvement in clinical state.

The patient stabilised enough for repatriation to the UK with a nurse escort after approximately 4 months of in-patient care. At this stage he showed significant deterioration in executive functioning from baseline assessment, limited capacity for new learning, confabulation and required assistance with all personal needs. On descent of the aircraft the patient again deteriorated, with disorientation, agitation and paranoid features once again predominant. Admission to hospital and further investigations gave us no obvious clues to an ongoing acute event. Brain imaging in both Australia and the UK remained unchanged with CT showing generalised atrophy and MRI revealing a minor degree of small vessel disease and smaller than expected hippocampal volume, and suggested Alzheimer's as the only radiological explanation for the presentation.

Outcome

The episode has had a significant effect on the patient's level of functioning and a sizable knock-on effect on his family. He is now a patient in a National Health Service (NHS) long-term care facility requiring assistance with all basic activities of daily living and without much by way of coherent or meaningful conversation. He continues to be managed with antipsychotic medications and benzodiazepines which allow him to be settled on the ward and nursing staff to assist with his needs. It is difficult to ascertain whether there has been any further deterioration in the patient's disease process, however, there has not been any improvement seen. His family continue to harbour feelings of guilt at the original decision to fly to Australia without consultation with medical staff and disappointment at being unable to care for the patient in their home.

My overall aim for writing this case is for the reader to acknowledge the case of a patient with a likely dementia who has had a stark and accelerated decline in function as a result of a change in environment and residual delirium after going on two long-haul flights. Pinpointing the precise mechanism for the delirium continues to be a challenge owing to the number of medical staff involved and the difficulties with communication between continents. Prolonged hypoxia or changes in cabin pressure would seem to be the most obvious causative factors for the delirium given the collateral history, with particular focus on symptoms becoming pronounced on descent. However, this is without any firm scientific basis and is not backed up by anything discovered on clinical examination or investigation.

Discussion

Air travel has become a normal part of everyday life in the UK, with Heathrow, the third-busiest airport in the world, estimated to see approximately 1300 take offs and landings in an average day.⁶ The advent of 'no frills' airlines in the mid 1990s has seen a marked rise in short-haul flights and regional airports have expanded as a result. Combined with the total standardised prevalence of dementia syndrome in the 65+ population, which is thought to be 7.1% at most recent estimates,⁷ air travel is now a common component for a sizable amount of the older population.

From a literature search it would appear that air travel in the elderly population is a safe practice, given that there is little evidence to suggest otherwise. However, there have been a number of reports recently of people with dementia getting lost in airports resulting in national press- and social media-aided searches.^{8,9} Roberto Castiglioni, an adviser to the UK Civil Aviation Authority, has described the impact dementia could have on air travel as 'a ticking time bomb that medical research and the travel industry are yet to address'.¹⁰

There is one reported case of an older man in Australia, a seasoned traveller, who in 2009 developed delirium on a long-haul flight and spent a long period of time as an in-patient as a result.¹¹ The authors state that the patient's decline was precipitated by air travel, but they do not expand on this. They propose that a brief cognitive screening tool to be used prior to travel be developed.

A useful review, also from Australia,¹² summarises the physical hazards associated with air travel and states that people with early dementia may be more prone to developing delirium in flight. It sets out practical ways to minimise this risk.

In contrast to the above there are strict criteria for air travel for physical ailments which are well publicised and adhered to by all the major airlines. For example, the Civil Aviation Authority suggest 14 days have passed prior to air travel following a coronary artery bypass grafting (CABG) procedure and most airlines will not allow women with single pregnancies beyond 36 weeks to travel with their companies. Compare this with the less stringent statement that they would have 'concern' (rather than instruction not to travel) with patients who may exhibit or develop 'disorganised and

disruptive behaviours' in flight, as set out in the Civil Aviation Authority's 'fitness to fly' guidance.¹³ This is a likely reflection on the lack of morbidity and mortality figures available on the topic combined with the unpredictable course and variable stages of dementia and degree of severity of delirium.

It should also be noted that not only this case described but the others mentioned in the discussion involved movement to and from Australia. It would seem unlikely that this alone is a causative factor and indeed it is the length of flight or descent from high altitude that increases the likelihood of deterioration, but it is worth bearing in mind if the overall topic expands, as some have predicted.

Recommendations

Table 1 sets out practical ways to help minimise any air travel-related situations which may potentially cause upset to a patient. These can be addressed prior to travel by input from general practitioners (GPs) and optimising control of pre-existing conditions as well as assistance with travel insurance practicalities. Contact with airports and airlines with the aim of reducing transit time through airports and assistance getting on the plane as well as sensible seating choice (i.e. more leg room, access to lavatory) may also aid in reducing potential stressors.

A summary of recommendations

Pre-flight	In-flight
Attend GP	Stay well hydrated
Optimise chronic conditions	Comfortable clothing
Travel insurance	Familiar distractions
Consider group tours	Inform cabin crew
Assistance in airport	Assistance on/off flight
Extra leg room request	Avoidance of alcohol/unfamiliar foods
Minimise time through security checks	Aisle seating request

GP, general practitioner.

I believe GPs and old age psychiatrists should consider more extensive counselling when the title question is asked and indeed any questions around travel could be pre-empted by medical staff. Patients and carers should be made aware of the dangers posed by hypoxia, changes in pressure environments and barotrauma and the potential for adverse outcomes that these can have on mental state, particularly in those with pre-existing respiratory and ear, nose and throat (ENT) conditions. Little research has been carried out into the overall use, benefit or otherwise of anxiolytics in elderly (or indeed anxious) flyers and this should be explored. Informal discussions with colleagues in the community would suggest the use of benzodiazepines is accepted and relatively common.

1.6.8 Mental capacity and borderline personality disorder

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Abstract

The use of the Mental Capacity Act 2005 in assessing decision-making capacity in patients with borderline personality disorder (BPD) is inconsistent. We believe this may stem from persisting confusion regarding the nosological status of personality disorder and also a failure to recognise the fact that emotional dysregulation and characteristic psychodynamic abnormalities may cause substantial difficulties in using and weighing information. Clearer consensus on these issues is required in order to provide consistent patient care and reduce uncertainty for clinicians in what are often emergency and high-stakes clinical scenarios.

Contents

- *Mental capacity and borderline personality disorder*
 - *Applicability of the Act in borderline personality disorder*
 - *How does BPD affect capacity?*
 - *How this affects clinical practice*
 - *Conclusions*

Borderline personality disorder (BPD) is a severe mental disorder affecting around 1% of the population.¹ It is associated with significant psychiatric comorbidity,² impairment in social function³ and a high rate of service utilisation.⁴ Personality disorder as a whole is associated with reduced life expectancy.⁵ People with BPD may engage in self-harming behaviour as a way of regulating negative affect, particularly at times of crises.⁶ Assessing decision-making capacity in a patient with BPD who requires medical treatment following an act of self-harm is particularly challenging.⁷ In the overlap between the Mental Health Act 1983 and Mental Capacity Act 2005 (the Act), it is the decisions around physical healthcare treatment without consent, i.e. those that the Mental Health Act cannot be used to enforce unless treatment is recognised as treatment for mental disorder, that in our experience generate considerable anxiety. This is particularly true in a general hospital setting as exemplified in the tragic case of Kerrie Woollorton.⁸

The Mental Capacity Act is the legal framework used in England and Wales for assessing capacity. It also provides protection to a clinician who makes decisions on behalf of an incapacitous patient, providing its terms are satisfied and the clinician is acting in the patient's best interests. Assessment of capacity is time- and decision-specific, however, in our clinical experience there is inconsistency surrounding the use of the Act with BPD patients. This is partly the result of disputes relating to the nosological status of personality disorder as a whole.^{7,9} Such disputes are discordant with

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increasing knowledge about the natural history of BPD and its neurobiological abnormalities and treatability. In this article we explore the key reasons for inconsistency on whether BPD has the potential to give rise to the ‘impairment of, or disturbance in the functioning of, the mind or brain’ criterion of the Act, as well as highlighting the need for clearer guidance on the use of the Act with such individuals.

Applicability of the Act in borderline personality disorder

As indicated by Section 2(1) of the Act, patients must demonstrate an ‘impairment of, or disturbance in the functioning of, the mind or brain’ for the Act to apply – sometimes known as the ‘diagnostic threshold’. Applicability to patients with a psychotic illness or a severe affective disorder is rarely questioned, presumably because these conditions are clearly described and widely accepted as constituting mental disorders that have the potential to impair or disturb function.⁷ However, in one of the few discussions of the impact of personality disorder on competence to refuse treatment, Winburn & Mullen¹⁰ point out that personality disorder, although classed as such under the Mental Health Act 1983, ‘has always been considered to be at the margins of what constitutes mental disorder’. Although it is by no means an exhaustive list, paragraph 4.12 of the Mental Capacity Act Code of Practice¹¹ does not include personality disorder among the other conditions it recommends as having the potential to cause impairment or disturbance in the functioning of the mind or brain. Indeed, as recently as the past decade, lingering doubts about the nosological status of personality disorders in general were still being voiced by senior figures in academic psychiatry.⁹

Over the past 10–15 years, the empirical evidence base for personality disorders in general and particularly for BPD has expanded substantially. Robust longitudinal studies have charted the natural history of BPD¹² and shown that while symptomatic improvement is common, enduring impairment in social functioning³ is a defining feature of the condition. Cost of illness studies have shown that the costs of managing people with BPD exceed the costs associated with managing people with depression.⁴ Other studies have shown that the life expectancy of people with personality disorder is markedly reduced and that the loss of lived years is at least equivalent to that seen in schizophrenia.⁵ There is also growing evidence of underlying neurobiological abnormalities associated with BPD.^{13,14} Finally, the increasing number of well-conducted clinical trials which show that effective treatment is possible provides further evidence supporting the validation of the construct of BPD.¹⁵

In summary, as a result of considerable research endeavour, we now know that BPD is, without doubt, a valid category of mental disorder. As such, it must be considered ‘an impairment of, or a disturbance in, the functioning of the mind or brain’. Therefore, not only is the Mental Capacity Act framework applicable to people with BPD, but it is clinically inappropriate not to consider its relevance when assessing people with BPD. There is a need for greater consensus regarding this, to eradicate the assumption that capacity assessments, *tout court*, cannot apply to such patients.^{7,11}

Perhaps another reason why this assumption has been so pervasive relates to Parsons’s notion of the ‘sick role’.¹⁶ This illustrates the link between illness and its social benefits: among these, the absolution of responsibility.¹⁷ The doctor’s role is key, as it is the doctor who confers this role on the patient and provides social sanction for receipt of those benefits.¹⁶ Doctors are often divided as to whether patients with BPD can be thought of as being ill and thus entitled to a sick role.^{9,18} As the Act requires the presence of an ‘impairment’ or ‘disturbance in function’ to be applicable, one might view its application to BPD patients as being synonymous with sanctioning an adoption of the sick role. Such a view may not sit comfortably with a clinician who may view a volitional act of self-harm as being ‘manipulative’.^{9,18}

The issue of volitional control and, by inference, manipulation, therefore seems the crux of the matter. Pickard¹⁹ points out that it is hard to accept that patients with a personality disorder completely lack control over their actions. She qualifies this by pointing out they ‘may not always have full conscious knowledge of why they are behaving as they do’.¹⁹ Similarly, Szmukler has speculated that suicidal impulses may sometimes stem from ‘an inner disturbance the [person] finds difficult to describe’.⁷ The question for clinicians is that, in situations where high-stakes decisions must be made, how does the phenomenology of BPD impair an individual’s ability to understand and reflect on both the risks and benefits of treatment, and also the motivation underlying their behaviour?

How does BPD affect capacity?

Fuchs²⁰ identified that, at the extremes of emotional dysregulation, BPD patients become enveloped in that mental state to the extent that they are unable to view things objectively. Over time, repetition of this cycle leads to the chronic feelings of emptiness that characterise the disorder, meaning that patients ‘miss the experience of agency or authorship of their life’.²⁰ Broadly speaking, this key concept can be illustrated in two general clinical scenarios.

The first is a patient presenting as an emergency at the extreme of an episode of emotional dysregulation. Self-harming behaviours may serve an affect regulation function⁶ and assessment of capacity to accept or refuse treatment following a severe episode of self-harm is a common clinical scenario. The framework for decision-making, per the Act, requires the patient to understand the pros and cons of treatment for their condition. If the self-harm is life threatening, accepting treatment would therefore be life saving, and to refuse, by inference, a decision likely to result in death.

To ‘use or weigh’ relevant information about options in the process of deciding is the element of the capacity test that causes most interpretative difficulty in BPD. As Principle 4 of the Act states: ‘a person is not to be treated as unable to make a decision merely because he makes an unwise decision’. Deciding to refuse life-saving treatment may be unwise, but it is not the decision *per se* that we are assessing, rather how ‘accountable’ the patient is for the decision.^{21,22} Elliot has argued that in depression, even though patients may understand the risks, ultimately the disorder may affect whether they ‘care’ about that risk, thus reducing the ‘authenticity’ of the decision.²² If depression can lead to a pathological lack of ‘care’ about one’s own interests, could the drive to emotionally regulate via self-harm lead to a pathological ‘resistance’ to acting in one’s own best interests that robs BPD patients of decision authenticity?

Research has suggested that key interpersonal schemas in BPD include sadomasochistic behaviour, where patients hurt themselves in an internalised ‘punitive parent’ mode.²³ The relevance to treatment refusal here seems clear. In addition, as Szukler points out, any capacity assessment is essentially a dynamic between the patient and the doctor.⁷ Refusal of the doctor’s recommendation could also be viewed within this sadomasochistic paradigm. This is surely the source of the sense of ‘manipulation’¹⁸ frequently felt by doctors treating these patients.

The great trap in these scenarios is assuming that refusal of life-saving treatment is equivalent to a wish to die and an acceptable ‘unwise’ decision. While this may indeed be the case in some instances, this *de facto* assumption endangers the lives of some BPD patients, as in some cases the decision to refuse *per se* may simply be a manifestation of the disorder, rather than a carefully considered wish to die. The risk to these patients is compounded by an intolerance of ‘manipulation’ felt by the doctor, who in turn may take this as evidence that the patient has full insight into the situation and accept their refusal as an unwise but capacitous decision. In summary, as a direct consequence of the mental disorder itself, BPD patients may unwittingly become caught up in a destructive iatrogenic cycle of harm.

A second clinical example which aptly illustrates the lack of ‘authorship’ of life¹⁹ that may occur for people with BPD while dealing with doctors has been provided by Winburn & Mullen.¹⁰ They describe the case of a BPD patient who was judged incapacitous to refuse a potentially life-saving blood transfusion. Her decision to refuse treatment was viewed as a consistent, chronic behavioural pattern and overall constituted a ‘disturbed form of engagement ... rather than an effort to disengage’. Case law reflects these views, as seen in the case of *B v Croydon Health Authority*,²⁴ where a young woman with BPD was starving herself to the point where enforced nasogastric feeding was considered. Lord Justice Hoffman wrote in his judgment that he found it difficult to conclude that the patient had capacity, despite her seeming to have a good understanding of the risks and options. It was this that made him question whether her choice was truly autonomous, because, while being able to make cogent and articulate statements about her wishes, it was hard for him to deem someone capacitous when she is ‘crying inside for help but unable to break out of the routine of punishing herself’.

How this affects clinical practice

The assessment of mental capacity in BPD patients is complex and may therefore cause clinicians significant anxiety where high-stakes decisions are to be made. It is conceivable that such anxiety may lead to risk-averse practices. In her review of suicide risk management in BPD patients, Goodman²⁵ highlighted the influence of medico-legal concerns on clinicians, by referring to a survey²⁶ that had shown that 85% of clinicians working with BPD patients had, within the past year, practised in a way ‘that would relieve their anxiety over medicolegal risks’. In our example of the BPD patient refusing life-saving treatment following self-harm and where capacity is marginal, risk-averse practice would presumably involve erring on the side least likely to result in death, i.e. a judgement of incapacity, detention and enforced treatment.

However, Pickard¹⁹ points out that it is particularly in the interests of patients with BPD that we attribute decision-making responsibility to them where possible, as this is the basis of some of the most effective psychological treatments for BPD, where self-control and mentalisation development are key. Szmukler suggests that when capacity could be argued from both sides, ‘one might conclude that ... the patient’s account, although not the one preferred by the clinician, is an adequate one, and sufficient to demonstrate that the patient has capacity’.⁷ Law states that ‘with regard to the degree of incapacity the nearer to the borderline the more weight must in principle be attached to [the patient’s] wishes and feelings’.²⁷ In application to BPD this would appear to imply that if the incapacity is only marginal the patient should, in effect, be approached as if with capacity.

So how do we balance over- and under-attributing capacity to BPD patients in clinical practice? Buchanan’s work²⁸ is relevant to this problem. He describes that when capacity is in doubt, we may vary our threshold for deciding what constitutes true incapacity, based on the stakes of the decision. Thus, when the negative consequences of a decision are likely to be severe, the clinician would require a more robust demonstration of capacity.²⁸ In essence, the clinician is balancing possible infringement of autonomy with negative consequences of the outcome of the decision. Ultimately, capacity is judged legally to be either present or absent, but as Lord Donaldson pointed out in the case of *Re T (Adult: Refusal of Treatment)*,²⁹ doctors should consider whether the capacity that is there is ‘commensurate’ with the seriousness of the decision.

One might argue that proportionality merely reflects the clinicians’ increasing anxiety about higher-stakes situations, thus not addressing the underlying problem: that there is little consensus and guidance on whether and how BPD may affect decision-making. Clearer guidance and consensus on how BPD may affect decision-making abilities in different clinical scenarios will reduce anxiety for clinicians and may help the Act become more predictable in its application.

Conclusions

Borderline personality disorder is a mental disorder. The use of the law in treating patients with BPD should be predictable and its application to clinical scenarios reproducible. The current use of the Mental Capacity Act 2005 in assessing decision-making capacity in such patients is lacking in these respects.

While BPD should be viewed as a mental disorder, this only means the Act is applicable; it is not synonymous with the view that people with BPD necessarily lack capacity for decision-making or responsibility for their actions. The psychopathology of BPD and specifically the way this affects the ‘using and weighing’ element of decision-making capacity is extremely complex and not acknowledged widely enough either in clinical practice or within the Mental Capacity Act itself. This leads to inconsistency in patient care. Further research into this field, along with clearer clinical consensus and legal guidance, is urgently required.

1.6.9 Perceptual distortions and deceptions: what computers can teach us

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Abstract

The nature of perception has fascinated philosophers for centuries, and has more recently been the focus of research in psychology and neuroscience. Many psychiatric disorders are characterised by perceptual abnormalities, ranging from sensory distortions to illusions and hallucinations. The distinction between normal and abnormal perception is, however, hard to articulate. In this article we argue that the distinction between normal perception and abnormal perception is best seen as a quantitative one, resting on the degree to which the observer's prior expectations influence perceptual inference. We illustrate this point with an example taken from researchers at Google working on computer vision.

Contents

- *Perceptual distortions and deceptions: what computers can teach us*
 - *The problem of perception*
 - *Expectation is necessary for perception*
 - *Tipping the balance*
 - *Contemporary accounts of hallucinations*
 - *Limitations*
 - *Conclusions*

No mental state examination would be complete without a statement relating to abnormalities of perception. According to Fish, perceptual abnormalities may be classified as either sensory distortions (e.g. hyperacusis and dysmegalopsia) or sensory deceptions (e.g. illusions and hallucinations), with both categories deviating from veridical perception.¹ The clean simplicity of this definition underlies part of its clinical utility, but also gives the impression that the characteristics of 'normal' veridical perception are well understood. The nature of perception, however, has troubled philosophers for centuries,^{2,3} and has been the focus of intense investigation by neuroscientists and psychologists in recent decades.⁴⁻⁷ Just how does the brain transform the light hitting the retina into the infinitely complex three-dimensional world that we see when we open our eyes? How much of what we perceive is really present in the sensory data hitting our eyes, and to what extent do our prior expectations shape our perception? Do we perceive the world as it really is, and if not, does that mean that our normal perceptions are distorted or deceptive? If so, in what way does normal perception differ

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from abnormal perception? These questions may seem to be only of philosophical relevance, but researchers working in the fields of perceptual neuroscience and computer vision are regularly confronted by them.

In this article we outline some exciting insights into how the brain may construct reality. Intriguingly, these findings have come from the field of machine learning, a branch of computer science and robotics.

The problem of perception

How does your visual system construct a representation of the world? Perhaps most readers would reply that the brain extracts the information about the physical world that is contained within incoming sensory signals. Much of the neuroscience of the past half-century has investigated perceptual processing starting from this assumption.^{4,8} The account of perceptual processing found in most undergraduate textbooks states that the sensory processing pathway (including the sensory epithelia, subcortical nuclei, thalamus, sensory cortices and heteromodal association cortices) extracts information from incoming sensory data in a stepwise manner. If all goes smoothly we perceive the world ‘as it really is’.

There are several problems, however, with the view that perception proceeds by extracting information from the incoming signals alone. Perhaps the most damning consideration was recognised by George Berkeley in the 18th century as the ‘inverse optics’ problem,^{2,4} which states that information collected by the sensory epithelia is insufficient to allow an unambiguous mapping back on to real-world sources. The light hitting the retina, for example, forms a two-dimensional image, which has an infinite number of possible three-dimensional ‘real-world’ sources. The image conflates information about object illumination, reflectance and transmittance.⁴ Computer vision faces similar problems. A car, for example, looks different from different viewing angles and distances, and in different lighting conditions. The problem of inferring the state of the world from sensory data alone is (mathematically) ill-posed.⁹ One powerful illustration of this principle is demonstrated by the famous Necker cube illusion,⁵ where the sensory information alone is insufficient to resolve the question of the orientation of the wire cube and there is no simple mapping between sensory data and perception (*Fig. 1*).

Expectation is necessary for perception

If sensory data alone cannot support perception, how does the brain create accurate perceptual representations of the world? It is now appreciated that ill-posed problems such as vision can be made tractable by using contextual information to impose constraints on the interpretation of ambiguous data. In the case of vision, for example, past experiences of seeing similar visual scenes sets up expectations about the likely current state of the world, and any new sensory data are interpreted in light of these expectations. Consistent with this hypothesis, the sensory processing pathways in the brain do not just support one-way ‘bottom-up’ information flow (from low-level data in the primary sensory cortex to more complex representations in heteromodal association cortices), but also support ‘top-down’ information flow, whereby information about the current expected state of the world cascades down from high cortical areas to influence information processing in low sensory areas.^{9,10} Some have argued that the ‘heavy lifting’ of perceptual processing is performed by these top-down pathways, which make predictions about the state of the world that are tested against sensory data.¹⁰

The ability of the brain to make sense of sensory information has inspired computer scientists working on computer vision and similar problems to take a similar approach. Recently, researchers at Google created an impressive visual recognition system using a processing architecture inspired by the human brain, called an ‘artificial neural network’ (ANN).¹¹ ANNs consist of artificial ‘neurons’ that are organised into layers, reminiscent of the brain’s hierarchical organisation. These networks are particularly good at detecting features and patterns in new data, and using these features to perform classification tasks. This is similar to what the brain does when engaged in perceptual inference, which may be thought of as the detection of objects and meaningful patterns in sensory data. New data enter the ANN at the lowest ‘input’ layer (analogous to light hitting light-sensitive neurons in the retina) and is processed sequentially by progressively higher layers of the network. At each layer the network attempts to extract patterns and features from these data, with higher layers of the network extracting increasingly more abstract features. At the highest layer a ‘decision’ is made about what the data represent.

Importantly, a new ANN must be adequately ‘trained’ before it can perform successful pattern detection and classification tasks. During training the network is exposed to many different data-sets (e.g. images) and attempts to classify the data appropriately. The network is able to self-calibrate, guided by its successes and errors, in a process analogous to synaptic plasticity. After exposure to thousands of images of, say, cats, the network learns to recognise cats in images to which it has never before been exposed.

The well-trained ANN is primed to recognise salient features and patterns in new data in much the same way that the brain is primed to recognise the patterns in sensory data that are most important for detecting behaviourally relevant objects. Prior to training, the ANN is essentially blind to meaningful patterns in new data. In both the well-trained ANN and the mature human visual system the final decision about what a new image represents is the product of a delicate balance between the information contained within the image itself and the readiness of the network to detect certain features within new data.^{9,10}

Tipping the balance

Perception is therefore the product of two sources of information: the sensory data and prior expectations about the sort of information that the sensory data contain. What happens, however, when prior expectations are given too much weight?

The Google researchers provide an intuitive example of the problems that inappropriately strong prior expectations can cause in their ANN.¹¹ As mentioned previously, the highest layers of the ANN contain latent representations of objects that the network has been trained to see. The Google researchers asked a network trained to see bananas to detect and enhance ‘banana-like’ features in an image that contained only meaningless noise. This manipulation inappropriately weighted prior expectation relative to sensory data. The result was that the network was able to ‘perceive’ objects where none existed in the image itself (akin to a ‘guided hallucination’) (see the Google Research Blog article for examples¹¹). Although the mechanisms employed by this simple network manipulation are not intended to be biologically plausible, the simple experiment demonstrates the power that inappropriately held prior expectations might have on resulting perception.

To what extent can inappropriately held prior expectations influence human perception? This question has relevance to descriptive psychopathology and psychiatry. Karl Jaspers, the father of descriptive psychopathology, postulated that ‘illusions due to affect’ and ‘illusions due to inattentiveness’ may arise when a person has a strong prior expectation about the state of the world and is confronted with noisy and ambiguous sensory data.¹² This exaggerated prior expectation may be informed by the semantic context of a situation (in what have come to be termed ‘completion illusions’), the observer’s current emotional state¹³ (in ‘affect illusions’), or active imaginative processes acting on inherently ambiguous sensory data (in ‘pareidolic illusions’).^{1,12,14,15} It may be argued that in these situations the observer comes to impose their prior expectations on the ambiguous sensory data.

Contemporary accounts of hallucinations

We have argued that perceptual inference always relies on both incoming sensory data and a prior expectation about what these data are likely to represent. Additionally, we have outlined the hypothesis that illusions and hallucinations may be the result of an imbalance between these two sources of information. This simple account is consistent with contemporary theories of illusions and hallucinations, which also implicate a miscalibration between these two sources of evidence.

One of the most influential contemporary accounts of perceptual inference is that of hierarchical predictive coding.^{9,16,17} At the heart of the predictive coding account is the notion that the brain maintains a dynamic representation of the world, which is the brain’s best prediction about the state that the world is likely to be in. Incoming sensory data are compared against this representation. If there is a good match between the prior prediction and the sensory data the current representation of the state of the world is reinforced. If there is a mismatch, a ‘prediction error’ signal drives an updating of the brain’s current representation of the world, which is subsequently re-tested against the real-world data. The iterative process of matching the brain’s predictions to sensory signals underlies perceptual inference.^{10,16,17} This process can become disrupted when the balance between prior predictions and incoming sensory data is changed. The brain’s internal representation of the world will be resistant to change, and thus dominate perceptual inference, if the

prior prediction is given a greater weight than the incoming sensory data, as may happen when the incoming sensory data are noisy.^{9,16,17} It has been proposed that in some pathological states the brain may mistake its own prior predictions for new incoming sensory data, resulting in perceptual and cognitive abnormalities that share some similarity to acute psychosis.¹⁸

Another influential account of complex visual hallucinations is the perception and attention deficit (PAD) model, which was developed after studying clinical populations who experience recurrent complex visual hallucinations.¹⁹ It was found that people in these populations had combined deficits in low-level sensory processing and attention. The PAD model proposes that in order to perceive an object, the perceptual object must first be selected from a pool of candidate ‘proto-objects’, in a process guided by sensory data, prior expectations and attentional processes. In people who have a combined deficit in sensory processing and attention it is conceivable that proto-objects from a misrepresentative pool become inappropriately bound to the visual scene, resulting in a hallucination.¹⁹

Both the predictive coding and PAD accounts of illusions and hallucinations propose that an overweighting of prior expectation relative to sensory data may underlie certain perceptual abnormalities. This overweighting may be a direct result of inappropriately held prior expectations (as can occur in states of high emotional arousal), or may be secondary to a decrease in the quality (or precision) of incoming sensory data (as may occur in states of low attention, fatigue or sensory impairment).^{19,20}

Limitations

There are several limitations and unanswered questions in this ‘expectation-based’ model of hallucinations and illusions. First, although Google’s ANN provides a nice visual example of the power of overweighted prior expectation, it has key structural and functional differences when compared with the human visual system. Among these are the fact that Google’s network hierarchy has many more layers than our current best estimates in the primate brain.^{11,21} Moreover, Google’s network was trained to ‘see’ objects in a ‘supervised’ way, whereby it was told what the images actually represented during training. This bears little resemblance to the ‘unsupervised’ learning that occurs in the brain.

Perhaps more importantly, expectation-based accounts of illusions and hallucinations fall short of explaining some of the most frequently encountered perceptual abnormalities in clinical practice. The hallucinations recounted by patients with psychosis or organic disorders are often bizarre, and seem entirely unexpected given the environmental context.¹⁹ Furthermore, although the account of hallucinations given above applies to all sensory modalities, it is unclear why perceptual abnormalities often occur preferentially in one sensory modality in clinical populations (e.g. auditory verbal hallucinations in schizophrenia).¹⁵ These questions remain unanswered, and pose an ongoing challenge for computational accounts of perceptual abnormalities in psychiatry.

Conclusions

Although psychiatrists ask patients about perceptual abnormalities on a daily basis, it is not often that we stop to ponder what actually distinguishes normal perceptions from perceptual distortions and deceptions. Current work in psychology, neuroscience and computer science paints a picture of normal perception as being inextricably linked to prior expectations about the state of the world. Perception depends on a delicate balance between the sensory information that we are confronted with, and the prior expectations we have about the world. If the balance is disturbed then perceptual inference becomes disrupted. Without prior expectations, perception is a mathematically ill-posed problem^{4,9} (as illustrated by *Fig. 1*), yet when prior expectation dominates the perceptual process, humans (and ANNs) can come to perceive objects which do not exist in the sensory data. As a result, the division between veridical perception and perceptual distortions or deceptions is more subtle than one of clear qualitative difference.

1.6.10 Adherence to medication in the community: audit cycle of interventions to improve the assessment of adherence

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Abstract

Aims and method To investigate whether medication adherence is monitored during follow-up in out-patient reviews. A retrospective audit was carried out with a sample of 50 follow-up patients with a diagnosis of schizophrenia or schizoaffective disorder. Following this, interventions were made prior to the re-audit (including text messaging clinicians and prompt sheets in the out-patient department to encourage adherence discussions).

Results There was an improvement on all the standards set for this audit following the interventions. More doctors had discussed medication adherence (62% second cycle v. 50% first cycle) with their patient and there was increased discussion and documentation regarding medication side-effects (60% second cycle v. 30% first cycle). More clinicians discussed the response to medication (60% second cycle v. 46% first cycle).

Clinical implications Treatment adherence is not regularly monitored or recorded in clinical notes in routine psychiatric out-patient appointments. This highlights the need for regular training to improve practice.

Contents

- *Adherence to medication in the community: audit cycle of interventions to improve the assessment of adherence*
 - *Aims*
 - *Method*
 - *Results*
 - * *Audit cycle 1*
 - * *Re-audit*
 - *Discussion*

The World Health Organization defines adherence as the extent to which a person's behaviour – taking medication, following a diet, and/or executing lifestyle changes – corresponds with agreed recommendations from a healthcare provider.¹ Although often used interchangeably with the term 'compliance', adherence is preferred by many as it

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acknowledges the patient's role in the decision-making process.² It has been claimed that increasing the effectiveness of adherence interventions may have a far greater impact on the health of the population than any improvement in specific medical treatments.³

Non-adherence to treatment is a major barrier to effective treatment in psychiatry, particularly in individuals with psychotic disorders. Rates of non-adherence vary between 24 and 40% based on medication refill rates available from pharmacy records.^{4,5} This is understandable in view of the different populations, variety of diagnoses, variable follow-up periods and, most importantly, the different definitions and measurement methods used in research.⁶ It has been reported in the literature that non-adherence rates to medication for bipolar disorder typically range between 20 and 60%, with an average of 40%.⁷⁻⁹ In schizophrenia, a systematic review of 39 studies reported a mean rate of medication non-adherence at 41%.¹⁰ When the analysis was restricted to the five methodologically most rigorous studies, which included defining adherence as taking medication at least 75% of the time, the non-adherence rate increased to 50%.¹⁰ Non-adherence to treatment in schizophrenia is often associated with potentially severe clinical consequences.^{11,12} It is also estimated that up to 40% of the total annual cost of schizophrenia, which amounts to £400 million in the UK, could be due to non-adherence to treatment.¹³

The National Institute for Health and Care Excellence (NICE) guidelines^{14,15} recommend that treatment adherence be regularly monitored in patients with schizophrenia but there is relatively little information about how this is done in clinical practice. In general, doctors uniformly underestimate the degree of non-adherence in their patients.¹⁶

Aims

This audit was aimed at investigating whether medication adherence is monitored during the follow-up of patients diagnosed with schizophrenia or schizoaffective disorder. We also evaluated the ways in which medication adherence is discussed during out-patient reviews and recommend practice improvement.

Method

We conducted a retrospective audit in 50 patients presenting to the out-patient follow-up clinic in two UK community mental health teams providing treatment for patients within the complex care team. The clinics were based in the Black Country Partnership NHS Foundation Trust. Only patients with a diagnosis of schizophrenia or schizoaffective disorder who were currently under out-patient follow-up were included. A random sample of patients was generated by taking every fifth patient from the list provided by the clinic administrator. The last clinic letter was reviewed to collect data via the medical notes and electronic healthcare records.

The standards were identified using the NICE guidelines on medicines adherence and treatment of psychosis and schizophrenia.^{14,15} The guidelines have emphasised what should be reviewed and discussed in out-patient clinics. Specifically, they recognise that the treatment should be regularly and systematically reviewed to monitor treatment adherence. During the titration of treatment the following should be regularly monitored: response to treatment, including changes in symptoms and behaviour side-effects of treatment emergence of movement disorders weight waist circumference pulse and blood pressure adherence overall physical health.

The NICE guideline on treatment adherence explicitly states that when reviewing medication the clinician should enquire about adherence: "If non adherence is identified, clarify possible causes and agree any action with the patient. Any plan should include a date for a follow up review."¹⁵ As a consequence, the standards set out for this audit were that: 100% of patients should have a discussion with the doctor regarding the medication, including response and side-effects 100% of patients should have a discussion with the doctor regarding adherence to medication if medication is stopped, reasons for this should be explored. In light of this we constructed a data collection tool for the audit (*Box 1*).

Box 1 Information gathering tool for the audit

- Was adherence to medication discussed?
- Did the clinician ask the patient about any periods when they had missed taking medication?
- Did the patient mention missing any medication and was this discussed with the patient?

- Had the patient missed any medication over the past month?
- Were side-effects of the medication discussed?
- Did the clinician ask the patient whether these side-effects had impact on their adherence?
- If non-adherence was noted to be a significant problem, were any strategies to improve adherence discussed?
- Was the response to medication discussed?
- If medication was stopped, were reasons for this explored?

Results

Audit cycle 1

Data were collected over a period of 4 weeks. The results showed that adherence was discussed and documented only in 50% of consultations, side-effects were discussed only in 30% of consultations and response to medication was discussed in 46% of cases. Further questioning in terms of assessing adherence appeared to be poorly done, with less than 10% of consultations assessing adherence in greater detail.

The results of this initial audit highlighted either a gap in clinical practice or poor documentation. The results were discussed with colleagues in the weekly audit meeting in the hospital and recommendations were made to improve the practice (*Box 2*)

Box 2 Recommendations following the first audit cycle

1. Provide formal training to doctors regarding assessing adherence during the induction for junior trainees and through a session delivered in the local teaching programme for the rest of the clinicians.
2. Provide a list of questions to be asked regarding adherence in clinics.
3. Provide a text reminder to doctors on clinic days to remind them to assess adherence.
4. Re-audit following implementation of changes.

As a consequence of the initial audit, a change in practice was brought about by introducing information sheets in each clinic room with possible questions concerning adherence to ask when assessing patients in clinic. A brief session on adherence was also added to the junior doctor induction. Then, a text message reminder was sent to colleagues. This included consultants, specialty doctors and trainees (core and foundation year 2) at the start of each clinic for a period of 3 months. The text message was very brief, reminding colleagues to discuss adherence with their patients in clinic. The colleagues' consent was sought prior to this 3-month trial. We initially planned to send the text reminders using [NHS.net](#), which provided such a service, but that stopped in early 2015. As a result, we sent out a group message using the work mobile phone.

Following this period a re-audit was carried out. It again focused on patients with schizophrenia and schizoaffective disorder but only spanned the intervention period of the prior 3 months.

Re-audit

As before, a random sample of 50 patients was selected. A similar procedure was carried out, but only patients reviewed after the initial audit were included. The same data collection tool was used (*Box 1*). The results are illustrated in *Fig. 1*.

Fig. 1: Comparison of key audit results.

The results indicated an improvement in all three key comparisons. More doctors had discussed medication adherence with their patient over the past 3 months (62% v. 50%, $P = 0.22$), and there was increased discussion with patients and

documentation of side-effects (60% v. 30%, $P = 0.0025$). More clinicians discussed the response to medication with their patients in the second audit (60% ($n = 30$) v. 46% ($n = 23$), $P = 0.16$). The results regarding further questions about adherence continued to be poor, with only 4% ($n = 2$) asking about whether the patient had missed any doses of medication. However, it was felt this may be secondary to a lack of documentation rather than being a true reflection of practice.

P -values revealed a significant difference in the two audits for the discussion about side-effects, with an improvement noted following the interventions. However, there was no significant difference on discussions about adherence and response to medication between the two audits.

Discussion

Improving treatment adherence is at the heart of clinical psychiatry. It requires building a therapeutic relationship with patients, understanding their needs and tailoring treatment accordingly. Monitoring treatment adherence is a continuous process during which the need to continue medication in the long term is regularly stressed. We need to identify the barriers and help patients and carers to overcome these. This can only be achieved if the treatment is regularly monitored for its efficacy, side-effect burden and acceptability to patients.

This audit presents a rather disappointing picture of the conversation about treatment adherence, which is not common in clinical encounters. Such discussions took place in just half of the consultations, whereas questions about possible side-effects and response to medication were raised even less frequently. The first variable improved to about 60% after regular reminders and inclusion of this topic in the junior doctor induction, but this result was not statistically significant. However, the results were statistically significant concerning discussions about side-effects, with a significant improvement noted following the interventions. This perhaps highlights the need for regular training to improve the monitoring of treatment adherence.

It has been shown that simple questions about different aspects of medication-taking behaviours can be effective in improving treatment adherence.¹⁷ Most of the information regarding assessment of adherence is based on clinical experience or limited research. Clinicians can start by asking patients 'Have you missed any pills in the past week?' A positive response indicates there may be a problem with adherence. Clinicians should bear in mind that patients tend to overestimate their actual adherence to therapy and that the accuracy of the self-report depends on the patient's cognitive abilities, attitudes and openness towards the therapist.⁶ Some simple questions that can be asked in routine clinical care include: 'How are you taking your medications?', 'Have you ever forgotten to take your medications?', 'Are you experiencing any adverse drug reactions?', 'How are you feeling since you started the medication?'⁶

The results of the audit should be interpreted in the light of some limitations. It is possible that these questions are asked but not regularly documented. Patient medication adherence was not directly measured in the audit. The study had a small sample size that represents a snapshot of clinical encounters, which may not be generalisable. The discussion about treatment adherence may have taken place in different settings such as the in-patient setting or with other members of the multidisciplinary team such as the community psychiatric nurse. We used text message reminders, which has helped the clinicians ask about adherence. Text messages have often been used to remind patients about medication, but they have not been commonly used to alter the clinicians' behaviour, and can prove a simple and effective method for improving adherence with good practice.

1.6.11 Training in quality improvement for the next generation of psychiatrists

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Abstract

Quality improvement (QI) projects have been shown to positively influence patient care. They provide opportunities for trainees to present and publish their work locally and nationally, and to gain valuable leadership and management experience. We describe a pilot project to engage in QI trainees across a National Health Service trust and a school of psychiatry. After the first year of this programme over half of psychiatry trainees in the school (58% of core trainees and 47% of advanced trainees) are participating in 28 individual QI projects and QI project methodology is to become embedded in the core psychiatry training course. Specialty doctors, consultants, foundation doctors, general practitioner trainees, medical students and the wider multidisciplinary team have all become engaged alongside trainees, working with patients and their families to identify problems to tackle and ideas to test.

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- *Training in quality improvement for the next generation of psychiatrists*
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 - * *Implementing and spreading changes*
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 - * *Results so far*
 - * *Future plans*

Foundation doctors and core medical trainees are being trained to undertake quality improvement (QI) projects and are doing so competently and effectively.^{1,2} QI projects have been embedded in the Foundation Programme curriculum,³ with an expectation that trainees plan, implement, complete and present a QI project as part of their training, using the results to improve patient care. QI projects have been widely adopted across medicine and are in many areas superseding traditional audit as a way to develop services. However, the development of this methodology has been slower in the mental health field and QI projects are new to most psychiatrists. Here we outline and summarise in simple steps how to undertake a QI project. We also describe our cross-deanery project led in Avon and Wiltshire Mental Health Partnership NHS Trust and the Severn School of Psychiatry, which aims to train and support psychiatrists of the future to become actively engaged in QI projects.

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What is a QI project?

QI projects aim to improve patient safety, treatment effectiveness and efficiency, and the patient experience. They are real-time, dynamic processes involving focused, progressive, small-scale changes through a simple structured framework, which enable visible and effective change over a short period of time. QI projects are becoming increasingly important because of the limited resources available in the National Health Service (NHS). They can support service change and to achieve this may engage all professional groups, including trainees. Increasingly, evidence of QI is becoming a training requirement and is taking the place of audit as a subject to discuss at trainee reviews and job interviews.

Often the relationship between audit and QI projects is not clearly understood. Audit is also generally about quality improvement, beginning with identifying an audit subject, selecting audit standards and measuring the level of performance, then making improvements and re-auditing (*Fig. 1*). The focus is therefore on data collection.⁴ This area of practice has been criticised, as often the audit cycle has been left incomplete and the improvement part of the cycle left neglected.^{5,6} QI projects are advantageously placed as they can be seen as part of the improvement element of the audit cycle, where the focus of the project is explicitly on making a service improvement instead of collecting data.⁷ Although more complex than an audit, QI projects focus on changing complex adaptive systems and can empower doctors to investigate problems, identify solutions and work within a team to raise standards.

Practical steps to carrying out a QI project

The first step in developing a QI project is identifying a specific aspect of clinical practice that could be improved. This may be something that has been highlighted by an audit or identified by the wider team. It may be aligned to the local trust's quality and safety agenda, something that has been identified as a clinical incident or near-miss, or raised by patients or their families as a problem or idea to test. Finally, it may simply be an area recognised by local clinicians as something which is time consuming or frustrating and which could be improved. The project has a small focus initially, so rather than looking at 100 patient notes one might begin with just a single patient, or instead of trying to improve a whole hospital the focus may be on a single ward. Once an improvement has been proven to work on a small scale, it can be then tested on another patient or another ward, gradually being systematically scaled up and spread to become embedded in an entire hospital or trust. Depending on complexity, the projects can be undertaken within a 6-month training post.

The Institute for Healthcare Improvement recommend asking three questions⁹ based on the 'model for improvement' when planning a project: What are you trying to accomplish? This helps to set the aim of the project, which should be SMART (specific, measurable, achievable, realistic and timely). How will you know that a change is an improvement? This helps to think about what can be measured to illustrate the impact of the change. What would be an easy measurement? This needs to be done at baseline and then repeated at regular intervals so that the change can lead to learning and to show that it works. What changes can we make that will result in improvement? Possible ideas of changes to implement to make an improvement can be brainstormed. The current sequence of events already used can be examined and areas for improvement identified, for example by eliminating unnecessary tasks or steps, clarifying roles within the process, or by reducing delays and duplication.

Testing changes: the 'plan, do, study, act' (PDSA) cycle

The 'plan, do, study, act' (PDSA) cycles can be used as a way to develop, test and then implement a change on a small scale and in a real work setting (*Fig. 2*).^{9,10} Multiple PDSA cycles will be required to fully implement a QI project.

Stage 1: plan

The first stage is about planning a test of change. This involves taking a single idea and making a prediction as to what might happen when the change is implemented. A test and way of measuring whether what actually happens meets that prediction needs to be designed so that the impact of the change can be evaluated and learned from. This might be numerical data, such as increasing numbers of reviews of patients, or reducing numbers of critical incidents, and may also include patient and/or staff satisfaction scores or comments. Once you have determined what you are going to measure, make a baseline measurement. Determine what target you are aiming for: is it realistic? Plan the time you have available: for example, do you want to complete the project within the time frame of a training post? The planning stage can take time, but good planning will ensure a more successful project.

A useful tool for the early stages of planning a QI project is a driver diagram (*Fig. 3*), which can help to identify what steps could be taken to make an improvement. This has three columns: outcome (the aim of the project) and primary and secondary drivers. Primary drivers are the overall improvement areas that need to be addressed to achieve the desired outcome. Secondary drivers are the specific areas where changes or interventions can be made, motivated by the primary drivers.

Stage 2: do

Following careful planning, one small area of change can be identified. The second stage of the PDSA cycle is where the change is actually implemented. Measures of the impact of change should be taken from an early point and frequently to monitor the effect of the change. Any problems or unexpected results are noted while the change is carried out.

Stage 3: study

The third stage involves analysing collected data and comparing that with the predictions made. A graphical representation of the measurements taken can be a useful way of plotting results to illustrate the pattern observed as changes are made.¹² A goal line can be shown so one can see at a glance where the work is in relation to achieving the aim. Changes or improvements that are made (in repeated PDSA cycles) can annotate the graph to clearly demonstrate the impact of those changes (*Fig. 4*).

Stage 4: act

In the final stage of a PDSA cycle you can ask whether the change you made achieved your aim. If not, what modifications to the change could be made? Or what other ideas can be put in place? When you are ready to make another change, the next PDSA cycle can be outlined.

Implementing and spreading changes

By going through several PDSA cycles a small change can be tested and refined. Once a successful improvement has been proven on a small scale, it can then be tested on a larger scale. This might be across several wards or across several community teams. Once these pilot changes are proven to be successful, they can be embedded in everyday practice and incorporated into local trust policy.

Training in QI for the next generation of psychiatrists – a pilot programme

This is the first year of a pilot developed in the Severn Deanery to support core and advanced trainees to become involved in QI. The programme is being led by an advanced trainee (E.E.) as part of an Educational Fellowship awarded by the Deanery.

Until 2015 it has been a deanery requirement of trainees to carry out an audit project annually. This was amended so that all trainees are to be involved in either an audit or a QI project each year, and if an audit is undertaken trainees are encouraged to use QI methodology for the implementation of change part of the cycle. The structure of training and supporting trainees to undertake their own QI projects was adapted from the local Foundation School¹ and the Royal College of Physician's 'Learning to make a difference' programme.² A half-day training session was developed to teach trainees about QI and project methodology, including using PDSA cycles in practical examples, so that they could undertake their own projects. This was delivered by E.E. alongside the local trust audit and QI department lead. Trainees were encouraged to come up with their own ideas for projects and to work with other trainees to implement changes, under the supervision of a higher trainee, specialty doctor or consultant. They were supported in including the wider multidisciplinary team in developing and implementing projects, as it was felt that this would be more likely to lead to successful and sustainable changes being made.

Training was initially targeted at trainees, but a growing number of specialist doctors and consultants requested to attend and they were invited to a second training session. A resource handbook was developed and a series of short follow-up sessions put in place to provide further advice about QI methodology and to help support trainees' projects. Trainees were asked to register their projects by completing a short online form on the local trust audit and QI academy webpage so the trust can monitor participation.

Results so far

In the first year of this programme, QI projects (28 in total) are being undertaken by 58% of core trainees (21 of 36) and 47% of advanced trainees (16 of 34). A growing number of specialty doctors (6 of 54; 11% of the Trust's total), consultants (24 of 111; 22%) and colleagues from the wider multidisciplinary team, as well as foundation doctors and medical students, are becoming involved in projects. Examples of current projects being undertaken by trainees in the Deanery are shown in *Box 1*. Some trainees have chosen to undertake educational QI projects, which are being used to improve training and trainee representation in their organisations and are felt to be a way of engaging trainees in the trust.

Evaluation of the programme so far through post-course questionnaires and semi-structured interviews held at the end of projects has shown globally positive feedback from consultants and high engagement and enjoyment from trainees. Trainees report high satisfaction owing to being able to choose their own QI projects rather than being instructed what to do. All trainees report that training sessions and follow-up advice has been helpful, and feel that this should be provided to all staff across the multidisciplinary team. One trainee fed back that 'the quality improvements often end up involving other team members so it would be good to get them on side', whereas another trainee highlighted that 'training is needed for senior staff members who we may need to get on board.' Additionally, trainees reflected that most projects needed senior input to facilitate implementation and sustainability of successful changes, and several projects have needed advice on governance issues, which has been provided by the Trust's Quality Academy, responsible for audit and QI projects.

We have found that owing to the nature of our work in mental health, QI projects sometimes need to be structured in a different way than they would be in an acute hospital setting. Careful consideration is needed to find the most appropriate method of change measurement, as frequently qualitative data may be available and innovative methods of quantitative data have been required. We have also found that QI projects have often had to run over a longer period than they perhaps would in an acute hospital, perhaps owing to the longer in-patient stay in a psychiatric hospital.

During the pilot we found that forming close links with the trust Quality Academy provided invaluable assistance in setting up the scheme. The Academy has a QI project lead, who provides advice and training for trainees; they have been particularly helpful with guidance regarding governance and what permissions might need to be sought. Support

from trust medical management leads, including the medical director and director of medical education, has also been key.

As well as positively influencing patient care, trainees report that projects are providing them with invaluable opportunities for leadership and management experience. One advanced trainee leading a QI project reported they had gained ‘experience of leading a team as well as networking with other teams, management experience through attending meetings and presenting ideas, plus the project has provided opportunities to present at a departmental and regional level, as well as an opportunity for publication. This is in addition to positively influencing the future of mental health services’. Many trainees are beginning to present and publish their work and we encourage trainees to do so even if a project has not been fully successful, as much will have been learned by the trainees, and can be learned by the Trust, from all projects.

Box 1 Quality improvement projects being undertaken by trainees across the Severn Deanery

- Improving handover between trainees
- Ensuring physical health monitoring of patients prescribed antipsychotics
- Improving the quality of letters written to general practitioners
- Ensuring timely access to radiology results
- Promoting awareness of mental health in an acute hospital
- Providing support for new consultants
- Advance care planning in later life
- Improving the quality of ward rounds in forensic services
- Training nursing staff about physical healthcare issues
- Providing patients and their families with information regarding child and adolescent mental health services (CAMHS)
- Improving the local academic programme
- Developing an out-of-hours handbook for trainees on call
- Ensuring physical health assessments for patients in early intervention in psychosis
- Improving access to mental health assessments for women during the antenatal period
- Improving trainee representation across the mental health trust

Box 2 Useful resources

- The Institute for Healthcare Improvement website (www.ihl.org) provides many free resources to guide professionals through a quality improvement (QI) project (e.g. short videos which describe the steps involved).
- BMJ Quality (<http://quality.bmj.com>) has an online guide to implementing a QI project and then writing it up, producing a publishable paper as a result. It can be useful to buy a licence to do this and follow the steps (licences last for 1 year so in the case of longer-term projects it may be prudent to sign up later rather than at the start of a project). Note that demonstration of clear ‘plan, do, study, act’ (PDSA) cycles is required for successful publication. There is a growing database of published QI projects which may prove inspirational for ideas that can be developed in psychiatry.
- Local audit departments may be able to support projects directly and help identify potential QI project areas. Health Education England also publishes innovative ideas which can provide further inspiration (<http://hee.nhs.uk/>). Service user groups can be another source of ideas for QI projects.

Future plans

The training course is to be incorporated into the Deanery core trainees' course and it is expected that all new core trainees who have joined the Deanery in the 2015 summer intake will participate in a QI project each year. Formal evaluation of the impact of training and QI projects is to be undertaken for this cohort. Those trainees who have successfully completed a QI project will be encouraged to become mentors and local QI leads in their area for future projects, providing sustainability for the projects as well as supervision, teaching and leadership experience for trainees.

QI projects undertaken by trainees and their seniors are to be regularly presented at the Trust's Medicines Advisory Group meetings, which will not only spread innovative ideas but further encourage psychiatrists to become involved in projects. Connections are being developed with service user groups and local patient safety programmes to help trainees define problems to tackle and ideas to test. Links have been made with the West of England Academic Health Science Network and the Royal College of Psychiatrists' South West Division E-volution programme (www.rcpsych.ac.uk/workinpsychiatry/divisions/southwest/innovationinthesouthwest.aspx) to promote the wider spread of quality improvement and innovation.

We have compiled a list of useful resources (*Box 2*) and tips for developing a QI project (*Box 3*) drawing on our own experience in the Trust.

Box 3 Top tips for completing a quality improvement (QI) project

- **Take time to plan your project.** You may be keen to start putting in place changes and improvements, but ensuring careful planning will mean that a project is more likely to be successful.
- **Have a SMART aim.** Be clear and focused. Have a clear aim so that everyone knows what you are trying to achieve. Make your aim SMART (specific, measurable, achievable and agreed, relevant and time-bound).
- **Keep it small.** This will help ensure an improvement works. Once it is proven to work on a small scale, it can be rolled out more widely.
- **Think outside the box.** Get a group of interested trainees, consultants and the wider multidisciplinary team to think about the project with you and help brainstorm ideas for improvements. This will engage others and help the project to be a success. Get advice from your audit department.
- **Work in a team.** This is more fun, you will come up with more ideas and will feel more motivated.
- **Involve key stakeholders.** Who needs to know about the project for it to be a success? Do you need any approval to carry out changes? This might be a team consultant and team or ward manager, or it could include your clinical director, medical director or director of medical education or head of school. You could present your idea at a local academic meeting.
- **Sustainability.** Think about how you can make your improvements continue, especially if you are in a training post and will be moving on in 6 months or a year. You will need to involve your multidisciplinary team and local team managers.
- **Organise your time.** Think about how much time you have available to complete the project. Set yourself a time frame and stick to it. If you will be moving from a training post, think about whether you want to continue making changes after you leave or whether you need to do some succession planning.
- **Make the most of the opportunity.** After all that hard work, make sure you get some rewards! Present your work locally, submit a poster to a conference, and write up your work and get it published. QI projects frequently provide leadership and management experience, and often teaching opportunities which you can mention at your annual review of competence progression (ARCP), annual appraisals and at job interviews.

We are grateful to Janet Brandling and Emma Adams (AWP Quality Academy), Bridget Kelly (AWP Medical Education Project Manager) and Katherine Finucane (Consultant and QIP Lead, North Bristol Trust) for guidance and support in developing QI projects across the Severn Deanery.

1.6.12 The most important things I have learnt in my career as a psychiatrist

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date

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Abstract

This paper is something of a patchwork, incorporating many issues that have intrigued me during 34 years of research. I have included the importance of maintaining a solid base in clinical work, alongside research activities, and being alert to the possibility of a somatic condition contributing to psychiatric symptoms. I stress the value of careful observation of patients, their response to treatments and reasons for dropping out. In addition, I have included 14 more lessons, learned from my experience of research, which I hope will be of use to those readers who aspire to become researchers.

Contents

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 - *Lesson 2: make careful observations on patients and their response to treatments*
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- *Lesson 16: writing up the results*
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- *Maintaining safety*
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I was attracted to psychiatry by my experience as a medical student at University College Hospital. Students on the psychiatry firm were expected to take on a psychotherapy patient, supervised by one of the senior therapists. This was the first time in my medical training that I felt valued as a clinician and treated as a responsible adult. (There is an important lesson here for improving the very low recruitment of medical students to psychiatry.)

Having graduated as a doctor I was keen to begin my study of psychiatry and sought advice from Sir Martin Roth, president of the Royal College of Psychiatrists at that time. He was adamant that I had to obtain the Membership of the Royal College of Physicians before applying for training in psychiatry. This was daunting as the Physicians' exam had a very low pass rate. I spent 3 arduous years as house officer in hospitals in London's East End before passing the exam. However, in a strange way it felt like coming home. This was because my father and his family lived in a house in the East End, at least until it was completely destroyed by a German bomb. By working with East Enders I learned to appreciate the fortitude and strength of people in the lowest stratum of society, and I never forgot that.

Throughout my career I always continued with clinical work alongside my role as director of two research teams, holding weekly out-patient clinics and having consultant responsibility for half an acute admission ward at the Maudsley Hospital and later at Friern Hospital. In addition, I supervised community mental health teams for their work with families. In this paper I will present the important things I have learned from both my clinical and my research activities.

Becoming a Fellow of the Royal College of Physicians (FRCP), I applied to the Maudsley training scheme and was accepted. When I met the other trainees in my intake, I found to my chagrin that only half of them had passed the Physicians' exam. There was one occasion in my psychiatric practice when my medical expertise proved its value. An out-patient in my clinic was complaining of anxiety and breathlessness, specifically when leaving her home and being in crowds. Naturally, I diagnosed a phobic condition and prescribed an anxiolytic. As she was about to leave the clinic, she said, 'By the way, doctor, I have a rash on my legs'. I asked her to show it to me and immediately recognised the raised purplish bumps of erythema nodosum. I referred her to the medical specialists who took over the treatment of her medical condition and cured her of her breathlessness.

Lesson 1: always bear in mind the possibility of an underlying medical condition

There is an expanding literature on comorbidity between psychiatric and medical conditions that partly contributes to the high mortality rate in psychiatric patients.

Lesson 2: make careful observations on patients and their response to treatments

Observant clinicians remain curious about puzzling aspects of everyday psychiatry, and this attitude can stimulate research projects which have the potential to lead to breakthroughs in psychiatric treatments. For example, my concern about the failure of antipsychotic medication to suppress auditory hallucinations in one in four patients led me to develop avatar therapy,¹ a novel and effective treatment for this debilitating condition.

Lesson 3: always listen carefully to the patient's narrative

Do not dismiss the patient's belief about the cause and nature of their illness. It has been shown that the greater the disparity between the patient's and the physician's understanding of the patient's illness, the less likely the patient is to adhere to the prescribed treatment. The same caveat applies to the family carers' beliefs about the patient's illness, even if they depart widely from your own understanding. UK psychologists were the first to adapt Beck's cognitive therapy for depression to treat psychosis (CBTp). My experience of working with family carers of people with schizophrenia taught me that many low expressed emotion family carers had developed effective coping strategies for dealing with the patient's difficult behaviour, for example, distraction, reality testing and time out, which closely resembled CBTp. If professionals had listened to these family carers, and given credence to their narratives, they would have introduced CBTp much earlier, saving considerable suffering. While CBTp alleviates the anxiety of patients with persecutory auditory hallucinations, it has little impact on their frequency or volume, as opposed to avatar therapy.¹

Lesson 4: the value of qualitative studies

Qualitative studies provide information of a different nature to quantitative studies, such as patients' experience of novel therapies, but they are of equal importance. Quantitative and qualitative studies are not in competition, but complement each other and are very informative when employed in tandem. An example is the current large-scale replication study of the value of avatar therapy.² Standard quantitative measures of the participants' assessment of the power and malignancy of their persecutory voices are augmented by the participants' accounts of their experience of standing up to the avatar they have created as a proxy for their persecutor.

Lesson 5: it is all too easy to become fascinated with esoteric research and to allow its demands to divert you away from basic clinical work

Working with patients is the crucible that generates the questions that inspire research projects. I cannot emphasise enough the importance of maintaining contact with everyday psychiatric patients, and not being lured exclusively by the glamour of exotic conditions. When I was granted a chair, I was the only professor in the Institute of Psychiatry (now Institute of Psychiatry, Psychology and Neuroscience (IoPPN), King's College London) who held clinics for local patients. Happily, that situation has now changed.

My research career began in earnest in 1968 when I was offered a position in John Wing's Medical Research Council Social Psychiatry Unit at the Institute of Psychiatry. I spent 34 years as a researcher, focusing mainly, but not exclusively, on psychosis. Many of the important lessons I learned were as a result of my research experiences, and it is these I wish to share with you, in the hope that they will inspire you to undertake your own research projects. There are so many unanswered questions in psychiatry that we need many more researchers to tackle these. Sir Aubrey Lewis, who founded the Institute of Psychiatry, was dedicated to promoting research and insisted that trainees conduct their own research project in order to pass their final exam. Sadly this requirement lapsed after Sir Aubrey retired.

Lesson 6: formulating a question

Junior colleagues would often approach me, eyes shining with excitement, saying that they wanted to do research 'with a capital R'. I would then ask them what they would like to do their research on and would be met by a baffled silence, clearly expecting me to spell out a project for them. If a topic engages your curiosity, you need to do some hard thinking and formulate a question that you want to answer. A well-constructed question can be developed into a series of hypotheses, which will determine the trajectory of your research project. A well-designed research study will always generate new unanswered questions that will then form the basis for the next study. The results of a research project you did not expect are as important as those you anticipated, and should lead you on to a new study. Consider the following sequence.

When Christine Vaughn joined the Social Psychiatry Unit, she decided that she wanted to embark on a PhD to replicate the findings of Brown, Birley and Wing that high expressed emotion in family carers significantly predicted relapse of schizophrenia.³ This pioneering study was surprisingly neglected by the psychiatric community, probably because of

the prevailing adherence to biological explanations for schizophrenia. Christine and I decided that a replication would attract the attention these findings deserved.

We discussed collaborating on this project and I suggested that it would add value to the research if we included a group of patients with depressive disorder to ascertain whether expressed emotion was a specific predictor for schizophrenia or whether it would predict relapse of depression as well. In the event it turned out to be a more potent predictor for relapse of depression than for relapse of schizophrenia, as shown by Jill Hooley in her PhD in the USA.⁴ In addition, our study replicated the protective effects of medication and low contact with the carer against the stress of high expressed emotion that the earlier study had revealed. This stimulated me to consider the possibility of intervening in high expressed emotion families to lower expressed emotion and contact between the patient and the family carers. There were two compelling reasons for this: primarily, to determine the direction of causality (do high expressed emotion attitudes cause relapse of schizophrenia or does the patient's disturbed behaviour provoke high expressed emotion attitudes?); and also to determine whether our family interventions could improve the outcome of schizophrenia.

For this project I assembled a team of therapists with different areas of expertise: a cognitive-behavioural therapist with experience of working with groups, a psychodynamic psychiatrist, a psychiatrist from Germany who was a trained psychoanalyst and myself as an eclectic therapist with no strong adherence to any one theory of family functioning. The therapy used by this heterogeneous team was remarkably effective, succeeding in reducing the patients' relapse rate over 9 months from 50% to less than 10%.⁵ The success of this trial led to two more randomised controlled trials (RCTs), including a cost-benefit study. The accumulation of this evidence plus ten replications in different countries led the National Institute for Health and Clinical Excellence (NICE) to recommend that family carers of a patient with schizophrenia must have professional input. This outcome justified the 15 years it took to complete the sequence of RCTs.

Lesson 7: the danger of linear thinking

Linear thinking results from the idea that causal action flows in one direction only, from cause to effect, from producer to produced, analogous to a series of billiard balls in motion. The issue of linear thinking in the social sciences, including psychiatry, merits some discussion.

Linear thinking forms the basis of almost all biological research in psychiatry. It has a long history, having been first formulated by the Greek philosophers Anaximander and Plato. In the modern era, Von Bertalanffy was the first to challenge linear thinking.⁶ He stated that we must think in terms of systems of elements in mutual interaction. At that time, the development of cybernetics promoted systems thinking. The process of feedback whereby missiles could monitor and correct their trajectory was recognised as analogous to the biological system's capacity to maintain and organise itself in nature. This formulation was seen as very relevant to the process of family therapy. The family theorist Gregory Bateson wrote: 'I think that cybernetics is the biggest bite out of the Tree of Knowledge that mankind has taken in the last 2000 years'.⁷ It is ironic that a technology developed to destroy human beings should contribute to our understanding of family relationships.

Homeostasis is a concept fundamental to systems theory. It is achieved by negative feedback loops, which stabilise the system by reducing deviation between goal and performance (cf. missiles). By contrast, positive feedback loops reinforce or amplify deviations, producing novelty and instability and an increase in the complexity of the system, leading to new properties. Applying this understanding to social relationships, which are of central importance to psychiatry, feedback represents the direct perceptual report of the effect of one's behaviour on others, for example, the perception of a smile in response to one's own smile.

Robert Dubin considers that the difficulty of avoiding linear thinking stems from our propensity to look for isolatable one-way causes.⁸ Feedback processes can easily be overlooked, not only because the linear perspective is the dominant mode, but also because they tend to be unnoticed owing to their very pervasiveness.

Earlier I stated that one compelling reason for working with high expressed emotion families was, I quote myself, 'to determine the direction of causality'. You will now recognise this as a prime example of linear thinking. In actuality I was aware that there were multiplex interactions between patients and their family carers, but this was too complex to investigate at that time.

Now I will give you some practical advice on initiating research and carrying it through to publication.

Lesson 8: searching the literature

Electronic databases have made this much simpler and more efficient. Decide on the criteria for your search, and be overinclusive rather than underinclusive (obviously, irrelevant papers can be deleted without needing to read them). Summarise what has been established. This requires a critical attitude to research by others, however eminent they may be. Weigh up the evidence and come to a conclusion. This may be that the question you formulated has been adequately answered, in which case, back to the drawing board!

Lesson 9: focus on a single topic

Avoid being too ambitious. If your initial project produces useful results, you can always extend it. Seek advice from experienced colleagues. They can warn you about pitfalls in your chosen area of research.

Lesson 10: applying for funding

When applying for funding, choose the funding body carefully, paying close attention to their mission statement. It is often worthwhile beginning with a pilot study which can be mounted with minimal or no costs. For instance, determining whether your catchment area will provide sufficient patients for your study. This will show potential funders that you are a serious contender.

Lesson 11: anticipate the concerns of the ethics and research and development committees

Gaining approval from these committees is now an obligatory hurdle to surmount. There are a number of actions you can take to improve your chances of being approved. Anticipate objections from committee members, and be prepared to be able to counter them. In my recent trial of avatar therapy, I anticipated that there would be anxiety in the committee about patients' response to being faced with their persecutor in the shape of the avatar. Therefore, with the aid of my IT specialist, we constructed a bright red 'stress button' which the patient could press in case of high anxiety or for any other reason. This switched off the avatar image on the monitor, which was replaced by an image of a tropical beach with *The Four Seasons* by Vivaldi playing in the background. In the event, only 2 patients out of 18 pressed the stress button, and both were able to continue with the session after reassurance.

Lesson 12: appreciate the value of user-researchers

Involve service users in your study. They should certainly be asked to read the instructions for potential participants, and to suggest changes to the wording. Users can be recruited to play a more important role in your study. The IoPPN has established a list of user-researchers. These are users who have largely recovered from a psychiatric illness and are willing and able to be trained in research procedures. For example, in my avatar therapy trial, I employed a user-researcher who had heard voices himself 8 years previously and was now completely well. I trained him in the assessment tools and he achieved high interrater reliability with me, enabling him to undertake the role of an independent assessor, for which of course he was paid. The employment of users will be greatly appreciated by the ethical committee. If you do appoint a user-researcher, they must be included as an author.

Lesson 13: team building

If you are ambitious and wish to undertake a major study you will need a team, preferably multidisciplinary in nature. Diversity of professional expertise is an asset, as we experienced in our development of working with families. Consult a statistician early on in designing the study. Statisticians are understandably grumpy if they are asked at the last minute to conduct the data analysis without having given any prior input. Develop a cohesive group and deal with rivalry. The media often depict research as a gentlemanly pursuit of the truth. That is a fallacy. There are glittering prizes to be won through research, and the world of research is as competitive and cut-throat as multinational capitalism.

Be fair to junior members of the team. Encourage and support them and give them experience in presenting and appropriate representation in publications. In mid-career I left the Maudsley to take charge of a dysfunctional research group working in a traditional psychiatric hospital. It had been managed by two absentee directors and was in a state of anarchy, with one member of staff suing the directors. The aggrieved staff member left and I had to dismiss another member of staff. I knew my intervention would be resented so introduced a Friday lunch-time picnic in the extensive grounds of the old psychiatric hospital, followed by a game of croquet on the lawn next to the former medical superintendent's villa. I reasoned that being able to knock my balls around would diffuse aggression, and so it did.

There were two reasons for my leaving the Maudsley to work in Friern, a typical 19th-century asylum. One was to emerge from the shadow cast by John Wing, the director of the Medical Research Council Social Psychiatry Unit. Although John left me to pursue my own research interests, he was nearing retirement and I knew that to stand a chance of taking over the directorship of the Unit, I would have to prove that I was capable of mounting important research independently from him. The other reason was the split in the profession of psychiatry between the academics and psychiatrists working in provincial hospitals; the latter felt overburdened by their workload and disregarded by the academics, whom they saw as existing in a 'cloud 9' environment, protected from the realities of jobbing psychiatry. Given that in that era the great majority of psychiatrists were working in antiquated buildings, with insufficient support from psychologists, occupational therapists and other ancillary staff, I felt that I needed to experience the reality of life in an asylum.

It felt to me like another world. The Italianate Gothic frontage was forbidding, as was the original plaque designating the building as the West Sussex Pauper Lunatic Asylum. The entrance corridor was a third of a mile long. At that time it was the longest hospital corridor in Europe. It had windows throughout its length, but they were so low I could only see through them by stooping uncomfortably. At the end of the corridor was a faint glimmer of light from the world outside. Despite the gloom that descended on me, in time I began to appreciate the good qualities of Friern. It was set in extensive grounds, which included a football field and a 9-hole golf course, on which I never saw anyone playing. There was a chapel and a synagogue, and a factory outlet where low-cost clothes were available. Although the main gate was always open, very few patients ventured out into the street. Patients wandered around the grounds unhindered and sexual liaisons were undoubtedly formed, as one of the long-stay patients in my care regularly developed gonorrhoea. I began to appreciate how easy it would be to become accustomed to the environment of the asylum and to forget the existence of the outside world.

Lesson 14: the staff in an institution are often more institutionalised than the patients

Not long after I moved to Friern Hospital the Regional Health Authority decided to close Friern and Claybury hospitals in accord with the government policy of that time. I realised that this was a unique opportunity to evaluate this policy. I succeeded in obtaining funding from the Regional Health Authority, later supplemented by funding from the Department of Health. This enabled me to form a group of researchers under the title of TAPS: The Team for the Assessment of Psychiatric Services. Friern Hospital had been opened in 1851 with 1000 beds. The number of patients grew exponentially, reaching 2500 in the 1940s. The discharges of many patients between 1940 and the beginning of the TAPS programme had reduced the number of long-stay patients to 800.

The first step in the TAPS project was to conduct a comprehensive assessment of the symptoms and the problem behaviours of all the remaining patients in the two hospitals who did not have dementia. Complete data on all 700 patients were collected by the team, a mammoth undertaking. A 5-year follow-up was conducted on this group of patients, of whom only a tiny number were lost to the study, thanks to the efforts of the excellent administrative assistant who made regular checks on the patients' locations in the community. Meanwhile, an extraneous researcher, not a TAPS

member, carried out a survey of all the nursing staff looking after the remaining patients, asking them to estimate the number of patients who could be resettled in the community. The total percentage estimated by the nursing staff was one-third. If this was accurate, the possibility of closing the two hospitals within the 10-year limit set by the managers was negligible. However, the TAPS team had already begun asking individual patients for their preferences when the hospitals closed: one-third wanted to leave the hospital and live in the community, one-third opted to stay in the hospital and one-third were uncertain. In the event, all the patients considered suitable to live in the sheltered homes in the community by the resettlement teams adapted well to life in the outside world, and when asked where they would prefer to live a year later, 84% wanted to stay where they were.⁹

Friern hospital did close on time 10 years after the decanting began. The Claybury closure was delayed because the consultants there went on strike against the closure decision, but the strike collapsed after 6 months and the closure went ahead. So psychiatrists can be as institutionalised as nursing staff.

Lesson 15: presenting at conferences

Always try out your presentations with a sympathetic audience and take note of their criticisms and comments. The golden rule for slides is ‘never put more on a slide than you can get on a T-shirt’. I am often amazed at seeing experienced researchers cramming a slide with illegible lists of data and *P*-values and then saying to the audience, ‘You probably won’t be able to read this but what it shows is ...’ – if it can’t be read, don’t show it!

Lesson 16: writing up the results

Avoid the pall of conventional scientific writing. Break through the conventional anonymity of the passive voice. Humanise your writing to make it attractive to the reader. Keep the language simple and avoid too many technical terms. Always spell out abbreviations the first time they appear in a paper, including the abstract. Pay special attention to the clarity and layout of tables and figures – ensure that they are essential for the understanding of your results. Editors dislike large numbers of tables and figures since they occupy space that could be used to publish another paper. Avoid duplicating results in the text as well as in tabular form.

Lesson 17: submission to a journal

Choose the journal carefully, surveying past issues for the types of papers published. Always read instructions to authors with great care and observe them, particularly the word limit – if you exceed this, your paper will bounce back rapidly. Find out the proportion of submissions accepted, if possible. Always treat the reviewers’ comments seriously and couch your responses respectfully, even if you think the reviewers are idiots. Don’t give up at the first rejection, but look for alternative journals. There are so many journals being published now that there is considerable overlap in their remit. If you are inexperienced, do not be too ambitious in choosing a journal with a high impact factor. I sent my recent paper on avatar therapy serially to *Nature*, *New Scientist* and *Archives of General Psychiatry*, all of which rejected it without sending it for review. So much for hubris! It was eventually published in the *British Journal of Psychiatry*. I was mollified when following a press conference the paper went global.

Maintaining safety

I am interpolating this issue, not to raise your anxieties, but to convey the important advice I received from a senior colleague early in my clinical career. What he said was ‘never let the patient get between you and the exit door of your clinic’. A colleague and friend of mine at the Maudsley Hospital was unaware of this advice and preceded the patient into his clinic; the patient then stabbed him in the back with a pair of scissors. Fortunately, the wound was superficial.

Finale

Do not be put off by the hard work and inevitable disappointments. They are more than compensated for by the intellectual excitement generated by research and the knowledge that you are improving the lives of your patients.

1.6.13 Dudleigh Oscar (John) Topp FRCPsych, MBBS, MFCM, DPM

: Formerly Principal Medical Officer, HM Prison, Brixton

John Topp

date

2017-2

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- *Dudleigh Oscar (John) Topp FRCPsych, MBBS, MFCM, DPM*
- : *Formerly Principal Medical Officer, HM Prison, Brixton*

John Topp, who died on 23 February 2016, was a Principal Medical Officer who was one of the first to draw attention to the increased rate of suicide among the prison population. In the late 1970s, he showed that suicide was three times as common in prisoners as in the general population, that it was most common in those with sentences longer than 18 months and that the greatest risk was in the first few weeks in custody.¹ He subsequently advised on suicide prevention in prisons.

Topp always felt deeply that the prison medical services were often unfairly maligned. He knew that the antiquated estate and restrictive budget did nothing to enhance the practice of modern medicine; yet, he felt that on the whole prisoners were given good care within these constraints. He found the hospital officers of the Prison Medical Service to be generally excellent but felt that many were denied opportunities to achieve the nursing qualifications they desired. Much criticism, he felt, would have been spared if training had been far better resourced and achievement suitably rewarded. Nevertheless, his view was that although the service was not superficially attractive, for those prepared to put effort and interest into it, there could be considerable work satisfaction – something he enjoyed himself despite much frustration.

Dudleigh Oscar Topp, always known as John, was born on 11 September 1924 in Hove, the son of a bank manager. A practising Roman Catholic, he was educated at the Xaverian College in Brighton and attended King's College London, from where he went to Charing Cross Hospital Medical School, qualifying in 1949. After house posts at Oldchurch Hospital, Romford, he served as a captain in the Royal Army Medical Corps in Northern Ireland. He joined the Prison Medical Service in 1953 at Wakefield prison and later became Senior Medical Officer at Brixton prison, from where he was promoted to Principal Medical Officer to serve regionally and centrally, administering various aspects of the prison medical services.

He retired on medical advice in 1984 but remained actively interested in prison affairs and wrote books on the history of the Prison Medical Service. His particular regret was that the Prison Medical Association, which he founded towards the end of his career with the object of promoting the highest standards of medical care in English prisons, did not survive his retirement. However, he lived to learn of the inception of an Academy of Prison Medicine which naturally had his full approval.

Living latterly in Weymouth, where he had the close companionship of two local retired hospital chief officers, he became the founder president of the Pickering Society, a nationwide group of retired hospital prison staff of all categories. It was named after a respected director of prison medical services under whom most of them had served.

Soon after qualifying, John married his childhood sweetheart Joyce Stoner, a nurse from Brighton. They had four daughters, three of whom trained as nurses at the Westminster Hospital, where two of them met and married doctors. There are now eight grandchildren and five great-grandchildren. Tragically, Joyce died in 1975 of carcinoma of the stomach, following which he married her friend Peggy Lange, then a Principal Nursing Officer in Sunderland.

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1.6.14 Anthony Carl (Tony) Kaeser FRCP, FRCPsych

: Consultant in Old Age Psychiatry, Basildon sector, Thameside Community Healthcare NHS Trust

Mike Lowe

date

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- *Anthony Carl (Tony) Kaeser FRCP, FRCPsych*
 - : *Consultant in Old Age Psychiatry, Basildon sector, Thameside Community Healthcare NHS Trust*

Tony Kaeser, who recently died aged 84, was one of the pioneer consultant psychiatrists who from the 1960s onwards developed departments of psychological medicine in district general hospitals at the time when long-stay mental asylums were being phased out. In the years following his appointment in 1969 as a general adult psychiatrist to Runwell Hospital, he was involved in innumerable planning meetings with the then North East Thames Regional Health Authority to advance the new purpose-built department of psychological medicine at Basildon District General Hospital. This was eventually opened in 1977. It was Tony's attention to detail which improved the ward day areas for the patients – initially they were going to look out on to industrial sites, but with some reconfiguring of the layout the views were transformed to field and countryside vistas.

In the 1980's Tony was appointed convenor for training approval visits for the East Anglian Division of the Royal College of Psychiatrists. He provided liaison psychiatry services at Basildon District General Hospital and was the consultant psychiatrist for the Regional Plastic Surgery and Burns Unit at St. Andrew's Hospital, Billericay for 11 years. He was Chairman of the Basildon General Hospital District Consultant Staff Committee. For the last 7 years of his career he chose to work full time in psychogeriatrics. Despite his heavy clinical load, his professional services were extended willingly to staff and their families from all areas of the National Health Service (NHS) in South Essex.

He was a Foundation member of the Royal College of Psychiatrists. The College recognised his abilities by inviting him in 1984 to act as convenor leading the first team to visit the large Hong Kong training scheme. Shortly before retiring, Tony became a General Medical Council Examiner for doctors with health problems and for a number of years in retirement was one of two Lord Chancellor's Visitors for England. He was also an Area Visitor for the Royal Medical Benevolent Fund until he reached their retirement age.

Tony was born in London in 1932. He qualified at St. Mary's Hospital in 1957 and after house jobs in general medicine he obtained the MRCP and entered the Maudsley training scheme. After obtaining the DPM he was appointed senior

registrar at the Maudsley and Institute of Psychiatry. From there he was appointed consultant psychiatrist to Runwell Hospital.

A gentle, kindly, impressively ethical doctor, he was considered in his thinking and conversation but precise, soundly analytical and unfailingly wise. His manners to everyone he encountered were impeccable and right to the end he retained his genuine interest in people. When he became ill himself, he wanted to know about the lives of his carers.

His personal life was varied and fulfilling. He inherited his father's stamp collection. He loved a wide range of music and enjoyed playing his pianola. He joined in regular contract Bridge sessions with medical colleagues throughout his career and retirement, and these only came to an end 4 years before his death. Tony had a great sense of fun and participated in the staff Christmas show for patients. His performances in playing the femme fatale were such a success that he resigned himself to being typecast. He took delight in the achievements of the members of his family. His wife Wendy was an NHS health visitor and they had 2 children and 6 grandchildren, one of whom is a dancer with the Royal Ballet.

In the latter years of his retirement he experienced gradually declining health. He had been diagnosed with a rare hereditary form of amyloid heart disease and although his cognitive faculties were largely undiminished, progressive cardiac failure slowly developed and he died on 18 May 2016. In line with his commitment to humanistic principles, Tony donated his body tissues for the benefit of others and his brain for research into amyloid disease.

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1.6.15 Klaus Minde MD FRCP(C)

: Formerly Chairman, Division of Child and Adolescent Psychiatry, McGill University, Montreal

Philip Graham

date

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- *Klaus Minde MD FRCP(C)*
– : *Formerly Chairman, Division of Child and Adolescent Psychiatry, McGill University, Montreal*

Klaus Minde, who recently died at the age of 82, was an academic child and adolescent psychiatrist renowned for his pioneering work in a variety of fields – especially infant psychiatry – and for the development of child mental health services in low-income countries. His early research was in the field of hyperactivity in children. Working with Gaby Weiss and John Werry, he was one of the first to carry out studies of medication in this condition.

In 1961, shortly after he had started his training in child psychiatry, his first child Thomas was born prematurely; he and his wife Nina, a psychologist, were not allowed to touch him – they could only gaze at him through the window of the nursery until they could take him home when he was 4 weeks old. This distressing experience stimulated Klaus' interest in the development of premature babies and the ways parents could be involved in their care. He carried out a number of observational studies¹ which – allied with the development of ideas on mother-infant bonding promoted

by two paediatricians, Marshall Klaus and John Kennell – helped to change practices in the nursing care of premature babies.

From 1971 he spent 2 years on secondment setting up a child psychiatric clinic at Makerere University, Uganda. As well as establishing a service, he carried out a significant amount of research, conducting comparative studies of disorders in Canada and Uganda.² Idi Amin, the brutal, idiosyncratic president of the country, was in power at the time. Klaus described how Amin, as chancellor of the university, required every professor to be present when he had decided to address them. While everyone was waiting for him, 3 empty limousines would arrive, followed – 3 minutes later – by Amin on a bicycle that he had mounted just before entering the university.

In 1983 he spent a sabbatical year in London, where he met John Bowlby, whose work on attachment had so impressed him. He was able to persuade Bowlby to visit Canada to talk about his ideas. After his official retirement from his chairmanship in 2000, he and his wife spent a year in Johannesburg, South Africa, where they worked with very disadvantaged children and families in the townships of Alexandra and Soweto. Once again he carried out research, this time on the assessment of attachment.³ In addition, Nina and he organised a mutual support group of grandmothers looking after their grandchildren (orphaned by the country-wide epidemic of AIDS), which became a model for similar groups in the area.

Klaus always had a strong interest in the plight of disadvantaged children and their need for psychiatric services. From 1994 to 1999 he worked with native Canadian children, acting as a consultant to the Cree Board of Health in Mistissini, Quebec; from 2009 to 2015 he was a consultant to Dans La Rue, an organisation caring for street children in Montreal.

Klaus was born in Leipzig in 1933 in the same year as Hitler came to power in Germany. His father was technical director of Germany's public radio and strongly opposed the Nazi movement. As one of the few senior people who had refused to join the Nazi party, his father was promoted after the war but was later sacked when a communist state was imposed in Eastern Germany in 1949. Klaus attended a humanist school and also rebelled against the ruling party. He wanted to study medicine but given his family background and outspoken political views, he had no chance of entering an East German medical school. Leaving his family behind – it was many years before his mother could join him – he travelled to West Germany and obtained a place to read medicine in Munich. After qualification he won a Fulbright scholarship which enabled him to go to New York and gain experience in paediatrics at Bellevue Hospital and psychology at Columbia University. He then undertook residency training in psychiatry at McGill University in Montreal, remaining in Canada, except for his sabbatical periods, for the rest of his professional life. He was Director of Research at the Hospital for Sick Children, Toronto, from 1973 to 1986 and after a spell at Queen's University in Kingston, Ontario, he was appointed Chairman of the Division of Child and Adolescent Psychiatry at McGill University from 1989 to 2000.

With his boundless energy and enthusiasm, Klaus could set audiences alight with his rhetoric, promoting the cause of better care not just for newborn babies but for children with physical and mental disabilities and for the socially disadvantaged. His whole body, especially his gesticulating arms and plentiful hair, seemed to be engaged in getting over his messages to his audiences, who loved it!

After retirement he continued to mentor colleagues and see patients until he suffered a major stroke shortly before his death on 6 July 2016. He is survived by Nina, his three sons and four grandchildren.

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1.6.16 College Members whose deaths were reported at Council meetings between October 2015 and October 2016

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- *College Members whose deaths were reported at Council meetings between October 2015 and October 2016*

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Cheyne, Alexander Ian, *Fellow*, Kippen, Stirling, UK
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Discombe, Anne-Marie, *Member*, Glasgow, UK
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Forrest, Derek William, *Fellow*, Wirral, UK
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1.6.17 A Practical Guide to the Mental Capacity Act 2005: Putting the Principles of the Act into Practice

Martin Curtice¹

date

2017-2

¹

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- *A Practical Guide to the Mental Capacity Act 2005: Putting the Principles of the Act into Practice*

The Mental Capacity Act 2005 (MCA) – which applies specifically to England and Wales – pervades several aspects of daily clinical care within many clinical as well as non-clinical environments, such as care homes.

The authors of *A Practical Guide to the Mental Capacity Act 2005* – whose backgrounds are social work and advocacy – observe that ‘Seven years on [...] the MCA is still not being adhered to nor fully embraced within practice’. Their aim was to produce a ‘theory-to-practice breakdown of the MCA’ and this was readily achieved with a fluent and erudite style of writing and continued emphasis on the practical aspects of implementing the MCA. There were useful case studies and checklists for practice, as well as practical top tips such as videotaping advance statements. A minor gripe would be that, if anything, such checklists and top tips could have been used more often throughout the book; for example, at the end of each chapter. The most useful chapter was that on best interests – very salient practical advice was afforded on the best interests process and assessments, including how to chair meetings and using documentation. This chapter tried to demystify the abstract concept of best interests by conceptualising such decisions as complex and less complex. Another strong chapter – probably reflecting the authors’ expertise in this area – was on advocacy and empowerment, which examined the various roles of the independent mental capacity advocate within the MCA process.

The undoubted highlight was the evocative account of the 2004 case of *HL v UK* which was the catalyst for the introduction of Deprivation of Liberty Safeguards (DoLS) legislation, to plug the now legally infamous ‘Bournewood gap’. HL was a patient with autism and challenging behaviour who was admitted to hospital on an informal basis. He was regarded as being compliant with care but unable to consent to admission; however, this was found to be a contravention of Article 5 of the European Convention on Human Rights (the right to liberty). The account is written by HL and his carers Mr and Mrs E. Although events regarding HL and his carers began in 1993, the account is a fascinating perspective of one of the most, if not the most, important mental health cases in legal history in terms of its potential impact on tens of thousands of people, carers and clinicians on a daily basis. The authors provide useful views on how and why the DoLS legislation has not been implemented well so far.

Overall, this is an excellent short text which should be required reading for those involved in care touching upon the use of the MCA, and would be ideal for medical and nursing students. But with the Court of Protection seemingly currently engaged in trying to crystallise the core essence of DoLS legislation – and with further recent key judgments emerging in the areas of best interests, end-of-life care and DNACPR (do not attempt cardio-pulmonary resuscitation) – it seems likely that this, as well as other similar guides, will need to be updated again in the near future to keep the readership up to date with key developments.

1.6.18 A Clinician’s Brief Guide to the Mental Capacity Act (2nd edn)

Martin Curtice¹

date

2017-2

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Contents

- *A Clinician's Brief Guide to the Mental Capacity Act (2nd edn)*

This book aims to provide a comprehensive overview of the Mental Capacity Act 2005 (MCA) – which applies specifically to England and Wales – and its implementation in practice.

The authors are all practising psychiatrists and although the style and content is tailored for a medical readership, the guide is suitable for all grades of doctors and all specialties, not just psychiatry. It is also ideal for medical and nursing students. With a punchy and concise writing style, the book has copious amounts of practical advice for clinicians throughout, and at times uses a common sense question-and-answer format with questions that clinicians are likely to pose, which reflects real-life practice.

Importantly, this work sought to translate lengthy and wordy court judgments into concise and simplified reviews outlining key basic principles for clinicians to use in daily practice. Possibly the most interesting chapter was that regarding the role of the Court of Protection. This busy court – which according to the authors hears approximately 23 000 cases annually, a figure that will surely inevitably rise – is often referred to in the media as the secretive court. However, this excellent chapter goes a long way in debunking various perceptions. It also explains the court process and is infused with sage, detailed and practical advice, from how to handle requests for assessments, writing reports and interviewing patients to giving evidence in court and even finding your way there if you need to! The authors suggest that Court of Protection proceedings tend to be more ‘informal and inquisitorial than formal and adversarial’ but that they can still be stressful, which is why they wish readers ‘good luck’. But despite the suggestion that a degree of luck might be needed, anyone new to such court proceedings will be far more prepared having read this chapter than not.

Needless to say, the thorny issue of implementing Deprivation of Liberty Safeguards (DoLS) was discussed at length in a chapter that provided important context by describing the evolution of this legislation and case law. Notwithstanding, owing to a glut of more recent key DoLS judgments, the book is already a little out of date as DoLS case law and guidance have evolved rapidly. It seems likely that an update will be needed soon to keep readers informed of key developments. Nevertheless, there was a good description of practical issues in using and applying DoLS since the *Cheshire West* case in 2014, a case which triggered an upsurge in the use of this legislation. The authors aptly summed up the state of DoLS understanding from further case law since *Cheshire West* by saying it did ‘little to ease the quandaries of health and social care staff in their decision-making in relation to deprivation of liberty’.

Another notable chapter was the one on the assessment of capacity, which provided comprehensive and practical advice, breaking the process down into its components and getting into its minutiae, thus challenging the reader to re-evaluate their own methods for assessing capacity. Other useful sections included advice on how to resolve conflict emanating from complex best-interests meetings and on seeking consent. Although not concluded at the time of publication, the latter resonates with the 2015 seminal Supreme Court case of *Montgomery v Lanarkshire* which has redefined the rules of seeking consent and has implications for how clinical negligence will hence be assessed.

All in all, this is an excellent guide which would aid those involved in care touching upon the use of the MCA.

1.6.19 Motivational Interviewing: A Guide for Medical Trainees

Ed Day¹

date

2017-2

Contents

- *Motivational Interviewing: A Guide for Medical Trainees*

I first encountered motivational interviewing as a trainee when I read Miller and Rollnick's classic 1991 book *Motivational Interviewing: Preparing People to Change Addictive Behavior* and the key concepts have always resonated with me. Although it seems obvious that a man requiring major surgery due to cardiac disease should stop smoking, it is rarely helpful to insist that he does so. People have ambivalent feelings when it comes to changing entrenched behaviours and it is often better to elicit their own reasons for change. After all, it has been said that people believe what they hear themselves say. Perhaps because of its apparent simplicity, motivational interviewing has become an important technique for most UK addiction therapists and its influence has gradually spread to other areas of practice. Therefore, does the world need another book on motivational interviewing?

This book is written by a group of trainees spanning all specialties of medicine, with the goal of demonstrating how motivational interviewing can fundamentally improve the doctor-patient relationship. Motivational interviewing is a way of being rather than an intervention and the book reminded me of its roots in Carl Rogers' person-centred approach to therapy, based on building empathy, congruence and positive regard. As someone who bemoans the biomedical nature of British psychiatry, I was surprised that it succeeded in reawakening my interest in interviewing skills that not only elicit information but also provide therapeutic insights and direction.

Like the practice of psychiatry, motivational interviewing is straightforward to do but hard to do really well. It is not easy to learn from books and so the editors provide lots of dialogue to illustrate key points, and a series of videos on a linked website. They add personal reflections, as well as illustrations of the integration of motivational interviewing into electronic case records and its use in less familiar settings such as paediatrics. There is also a practical emphasis on how to teach and supervise motivational interviewing in the real world. Their enthusiasm for the subject was infectious and I was left in agreement that learning motivational interviewing should be a priority in medical education.

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1.6.20 Waking Up: Searching for Spirituality without Religion

Matthew M Nour¹

date

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- *Waking Up: Searching for Spirituality without Religion*

Sam Harris has been waiting to write this book for over a decade. This may surprise some. The subject matter – dealing reverently with human spiritual experience – is at odds with Harris’ (in)famous public persona as a strident critic of religion. Yet, for the past 20 years Harris, who has degrees in philosophy and neuroscience, has been on a personal quest in search of ‘transformative insights about the nature of one’s own consciousness’.

Harris defines spiritual practice as the efforts people make, through meditation, use of psychedelics or other means, to fully bring their minds into the present. This practice leads to the insight that our sense of having a unified self is an illusion and that this illusion causes us much psychological suffering. Harris aims to convince his reader of this using philosophical thought experiments, discoveries of contemporary neuroscience and personal experience. He also encourages his reader to test these hypotheses about human consciousness ‘in the laboratory of your own mind’, through meditation practices inspired by Buddhist Dzogchen and Vipassana teaching. He argues that these spiritual insights can be accepted independently of the metaphysical baggage of traditional religion, and laments that until recently they have been under-investigated by an ‘impoverished’ neuroscience.

The resulting book is an ambitious mosaic: part memoir, part neuropsychology text and part meditation guide. A key strength is Harris’ clear, lively and personal writing style, which instils the prose with an endearing conversational air. Many readers will feel, however, that by focusing almost exclusively on solitary meditation practices and psychedelic drug-induced experiences, Harris has omitted important dimensions of human spiritual experience, such as the self-transcendence which may be arrived at when contemplating art or engaging in communal ceremonial practices. Moreover, the occasional barbed criticism of monotheistic religion will deter some readers, but play well to the Harris faithful.

Waking Up is a book for the general public and is not intended to have a clinical application. Why, then, is it being discussed in the pages of this journal? My answer is twofold. First, as psychiatrists we are interested in all dimensions of human experience. Consequently, the growing scientific interest in the mystical/spiritual experience and its potential therapeutic implications is of great importance for our specialty. Second, psychiatrists are humans and all humans may benefit from being reminded from time to time that our conventional sense of a unified self sitting some 2 inches behind the eyes is likely to be a pernicious illusion.

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1.6.21 Deconstructing the OSCE

Deborah Cooper¹

date

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- *Deconstructing the OSCE*

This volume contests that it is possible to develop a generic way to approach different Observed Structured Clinical Examination (OSCE) scenarios, regardless of medical specialty. Perhaps surprisingly, it is not filled with possible exam scenarios, but rather looks at the underlying barriers to good performance. In this regard, it provides a behavioural and psychological schema for approaching the OSCE. The book makes no apologies for aiming at those who have already had a previous attempt at passing the OSCE, and given that pass rates for membership exams are generally around 50–60%, it is a resource available to a great number of doctors in training.

The initial chapters look at the common emotional and cognitive responses which typically follow an unsuccessful examination attempt – they do a good job of validating these experiences and feelings. Subsequent chapters aim to improve general exam strategy. These include the perhaps more neglected areas of good exam performance; for example, how to establish rapport with the actor or patient, and how to run a good study group and learning environment. An especially useful chapter is that which explores challenging scenarios such as ‘the angry relative’ or ‘the crying patient’. Although these passages are brief, practical tips are given to aid communication in these often difficult situations.

In addition, there are worksheets that support the doctor in understanding that the way they think about the exam influences their emotions and, ultimately, their exam performance. The psychiatry trainee will be no stranger to this process; however, I wonder whether trainees from other specialties might find the experience alienating.

This work undoubtedly highlights that poor exam performance is often not related to lack of knowledge, but to cognitive and emotional barriers. As a result, it may provide a good starting point for ongoing study where examination performance has proven problematic.

1.6.22 Schizophrenics can be good mothers too

Duncan Double¹

1

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Contents

- *Schizophrenics can be good mothers too*

To protect her children the author of this book chose to publish it under a pseudonym, Q. S. Lam. However, it's easy to break her anonymity and she accepts it can only be partial. She is a British Bangladeshi artist who has had several psychotic episodes, including postpartum. She has been diagnosed with schizoaffective disorder but prefers to describe herself as having a different sort of brain.

Her friend Stephen Fry has described the book as 'brilliant' – an endorsement displayed on the book cover – and Alastair Campbell has tweeted the same. Artwork and poetry complement the narrative of the author's personal and family history, which includes episodes of psychosis, and the description of the dissociated parts of herself and how she recovers. She does not take antipsychotic medication.

She makes remarks – not always very complimentary – about each mental health practitioner that she has seen over the years, dating back to the time when she first sought help. Also discussed is the impact of her mental health problems on her husband and children. She moved to Brussels, as her husband works there.

The psychiatrist she has most identified with is Erik Thys, who is also an artist. He did not advise Q.S. not to have a second child; instead, he said it was 'doable'. Q.S. openly questions whether it was fair on her children that she became a mother and dedicates the book to them.

The strength of this book is its honesty. Q.S. has experienced multiple sexual assaults by men and considers whether her mental health issues are a sane response to an insane situation. She reveals her heart and mind, truthfully expressing what she feels and thinks, and I found the directness of the book attractive. As Q.S. notes, doctors generally don't like their authority to be challenged. However, in my opinion there needs to be an open discussion about the stigmatisation of mothers with mental health problems.

1.6.23 Epistemic injustice in psychiatry

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2017-4

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Abstract

It has been argued that those who suffer from medical conditions are more vulnerable to epistemic injustice (a harm done to a person in their capacity as an epistemic subject) than healthy people. This editorial claims that people with mental disorders are even more vulnerable to epistemic injustice than those with somatic illnesses. Two kinds of contributory factors are outlined, global and specific. Some suggestions are made to counteract the effects of these factors, for instance, we suggest that physicians should participate in groups where the subjective experience of patients is explored, and learn to become more aware of their own unconscious prejudices towards psychiatric patients.

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Epistemic injustice is a harm done to a person in her capacity as an epistemic subject (a knower, a reasoner, a questioner) by undermining her capacity to engage in epistemic practices such as giving knowledge to others (testifying) or making sense of one's experiences (interpreting). It typically arises when a hearer does not take the statements of a speaker as seriously as they deserve to be taken. The prime case of epistemic injustice is testimonial: the hearer deflates the level of credibility she gives the speaker because she is (often unconsciously) prejudiced against the social group to which the speaker belongs. Common examples include sexism and racism. In such cases the testimony of a woman or a person from an ethnic minority background will be given deflated credibility, based on the prejudicial associations between that group and negative stereotypes. The reason we chose this approach is that epistemic injustice provides an account for why, despite the best intentions, physicians often do not believe what psychiatric patients tell them. Clarifying some of the reasons for this common prejudicial stereotype of patient unreliability may make it possible to explore ways of overcoming the epistemic injustice that we suggest patients, and in particular psychiatric patients, are vulnerable to.

It is worth noting here that it is prejudicial or negative stereotypes, not stereotypes *per se*, which often give rise to epistemic injustice. We rely on stereotypes as heuristic aids in making credibility judgements because they are often empirically reliable generalisations. However, negative attitudes towards people with a mental illness may lead to negative stereotypes and to generalisations which are resistant to counter-evidence, owing to what philosopher Miranda Fricker calls an 'ethically bad affective investment'.¹ It is these kinds of stereotypes that may lead to epistemic injustice.

Epistemic injustice and psychiatric patients

Epistemic injustice is important in psychiatry because of the persistent negative stereotypes that affect people with mental disorders in particular and lead to a credibility deficit. The consequence is that patient testimonies and interpretations are not acknowledged as credible, and patients are thus undermined in their capacity as knowers and contributors to the epistemic effort to reach a correct diagnosis and treatment. We suggest that people with mental disorders are even more susceptible to epistemic injustice than those with physical illnesses, for reasons that are detailed below.

We have argued in the past that people with physical illnesses are vulnerable to epistemic injustice.^{2,3} Here we suggest that people with mental disorder may be susceptible to even greater epistemic injustice than people with physical illnesses. This is mainly owing to the high prevalence and great power of negative stereotypes of psychiatric illness. As a consequence, the patient may be telling the truth, but the doctor deflates the level of credibility which she gives to the patient ('credibility deficit') and thereby does the patient a distinctive kind of injustice, namely epistemic injustice, which undermines the patient specifically in her capacity as a giver of knowledge. This has detrimental effects on individual psychiatric patients, but also on the funding of psychiatric services and the public perception of mental disorder. Many people are influenced by negative stereotypes about mental disorders, are ill informed about their true nature, and have little understanding of how to treat them. Some measures to improve the current situation are suggested below.

Measures to counter epistemic injustice

The notion of epistemic injustice has been developed by Fricker.¹ She was interested in how social identity and power affects people's status as knowers. She gives the example of a White police officer who stops a Black car driver and asks him whether the car belongs to him. If the driver truthfully says that the car is his, but the policeman does not believe him because of racial prejudice, then he does the driver an injustice in his capacity as a knower.⁴

The main type of epistemic injustice that Fricker discusses is 'testimonial injustice'; it emerges from the fact that testifying, i.e. giving information to others, depends crucially on one's perceived credibility. If a person is seen as lacking credibility, her testimony will be ignored or treated with suspicion, or it might not be solicited at all. Of course, she may lack credibility for a good reason, for instance if she is a known liar. However, testimonial injustice occurs when a person suffers a 'credibility deficit' owing to some negative stereotype or prejudice associated with her social group (e.g. gender or race). This credibility deficit is unjustified and hence constitutes an epistemic injustice. Fricker analyses how negative racial and sexist prejudices unfairly deflate the credibility of people of Black and minority ethnic background and women, such that what they say is ignored, marginalised or otherwise excluded from epistemic consideration. Since being able to give information to others is essential to social life and agential action, testimonial injustice harms those who experience it.

Carel and Kidd have argued that people with physical illnesses are more vulnerable to epistemic injustice than healthy people.^{2,3} The testimonies of patients are often presumed to be irrelevant, unreliable, confused or otherwise lacking in credibility, owing to negative stereotypes associated with ill persons. Such stereotypes include viewing ill persons as cognitively impaired or emotionally compromised, owing either to their somatic condition or to their psychological reactions to it; or as existentially unstable, gripped by anxieties such that they 'cannot think straight'; or as psychologically dominated by their illness in a way that warps their capacity to accurately describe and report their experiences (e.g. 'the moaner' or 'the drama queen' stereotype). Because illness often evokes strong feelings in those affected, their emotions are often taken by health professionals to have a detrimental effect on patients' thinking, distorting the accounts they give of their illness. This pattern may be more acute in cases where subjective symptoms are driving the clinical encounter, such as unexplained breathlessness (see www.lifeofbreath.org), chronic pain, or other medically unexplained symptoms.⁵

Of course, the credibility of an individual is context dependent: if someone is talking about a subject on which she is an acknowledged expert then she is much more likely to be believed than if she is talking about something she is known to have little knowledge of.

Epistemic injustice – real-life situations

We are sufficiently aware of the existence of people's unconscious desires and beliefs to know that they can be mistaken about their own desires and beliefs, but it is also the case that they have exclusive access to many of their desires and beliefs. In the interests of epistemic justice, physicians should accept what people with mental disorders say about these matters as true unless there is good reason not to. Moreover, psychiatric patients who have experience of psychiatric services become reluctant to disclose psychotic symptoms because they know it might make them more likely to be diagnosed with a psychotic illness, and in some cases detained in hospital and medicated against their will. If they nonetheless disclose such symptoms, then psychiatrists might conclude that the symptoms are more severe in the sense that the patients are unable to inhibit their expression and/or that their executive function is also impaired.

Here we give three examples of epistemic injustice affecting psychiatric patients (Boxes 1, 2 and 3). Their purpose is to show that epistemic injustice can be a real problem in psychiatry, with possibly devastating effects on the individuals who are telling the truth. The personal details of the patients concerned have been altered to preserve their anonymity.

One of the important factors which can predispose to epistemic injustice is a widespread misunderstanding of the relationship between emotion and cognition, and the positive contribution made by emotional input to a broader conception of rationality.⁶ A consequence, in a medical and psychiatric context, is that the 'soft evidence' offered by patients is often met by credibility deflation. In practice this may lead to patient reports being ignored or discounted, especially when time pressure and other constraints are at play. Conversely, if the 'hard evidence' provided by objective investigation (e.g. blood tests) is regarded as more reliable, then the opinions of health professionals who can access and interpret that evidence may enjoy credibility inflation. In some cases it may be better for the doctor to try to treat on the basis of the symptoms reported by the patient rather than on the basis of an abnormal blood test result or an abnormal scan alone. An example of this is the PSA (prostate-specific antigen) test, which is a notoriously unreliable guide for the treatment of prostate cancer.

Box 1 Example of epistemic injustice in psychiatry 1

When one of the authors (P.C.) was a medical student in Munich, Germany, he saw a young man on an acute psychiatric ward who said he was a relative of the then Soviet leader. The responsible consultant took this to be a grandiose delusion, and therefore as evidence of a psychotic illness; it later turned out to be true.

Box 2 Example of epistemic injustice in psychiatry 2

The second example is of a woman in her early 50s, a former nun. The police contacted mental health services because they had been alerted by someone doing work on her house. They found evidence of smoke damage to the house, but not of fire damage. She was admitted to a psychiatric ward and detained under section 2 of the Mental Health Act. She claimed that she had been burning incense in the house for many years to drive away evil spirits. During the week she had spent on the ward there was no evidence of her trying to ward off evil spirits or attempting to start a fire, or of any psychotic symptoms. The mental health tribunal members concluded that her beliefs about incense and evil spirits were compatible with her religious faith, that there was no evidence of a psychotic illness, as had been claimed by the psychiatrist and one of the psychiatric nurses, and that section 2 should therefore be rescinded.

Box 3 Example of epistemic injustice in psychiatry 3

The third example is of a young man who was admitted to psychiatric hospital on section 2 despite the fact that he had agreed all along to be admitted and remain in hospital as a voluntary patient. He had been standing near the edge of a high cliff for about an hour until passers-by called the police. The staff involved in his care on admission did not believe that he could be trusted to remain in hospital on a voluntary basis and argued in the tribunal for the maintenance of the section. His community psychiatric nurse attended the tribunal, stating that he should never have been placed on a section, because he had had suicidal thoughts for many years, had gone to the same cliff many times in the past, had been admitted to hospital on several occasions as a voluntary patient, and had misgivings about the stigma attached to being placed on a section. All this had been documented in the hospital notes. She conceded that there would always be a risk of self-harm, but that it was a matter of managing the risk without compulsory detention and with the help of his friends and family. After hearing this evidence the tribunal members decided to rescind the section.

A psychiatric example is to do with making a diagnosis of epilepsy. Here a patient may have some epileptiform waves on the electroencephalogram (EEG), but unless there is also clinical evidence of altered consciousness and/or involuntary

movements which fit into a recognised pattern, a diagnosis of epilepsy cannot be made. An EEG can confirm but cannot exclude the diagnosis, which is essentially clinical.⁷

In very general terms, there are two types of contributory conditions for epistemic injustice affecting people with mental disorders: global and specific. Global factors are those that can affect any patient at risk of psychiatric disorder or those diagnosed as having psychiatric disorders. The fear of stigma among those at risk can make early intervention difficult and those who have been diagnosed may avoid service use and relapse more frequently.

Global contributory conditions for epistemic injustice

There are three global contributory conditions for epistemic injustice in psychiatric illness: problems associated with, and partly caused by, the mental disorder; the higher value placed by health professionals on ‘hard’ or objective evidence compared with patient reports; the entrenched negative stereotypes associated with mental disorders.

1. Problems related to mental disorder

Psychiatric patients are often disadvantaged – cognitively, socially and economically – and these disadvantages are frequently thought to be the patient’s fault. People with mental disorders are often badly educated because the illness has interrupted their education (‘dropouts’); they are often financially impoverished because the effects of the illness may make them unemployable (‘lazy’, ‘dependence culture’); and they are frequently socially isolated (‘loners’). They may become dependent on substances such as nicotine, alcohol and street drugs (‘lack of willpower’) and frequently experience physical illnesses. Causes of physical illnesses include substance misuse, self-neglect secondary to mental disorder and/or substance misuse, and psychotropic medication, such as atypical antipsychotics causing cardiovascular problems (‘down to lifestyle’).

People with mental disorders are thus often seen to have largely brought these disadvantages on themselves and are stigmatised and held responsible for them,¹ even though some conditions contributing to mental disorders, such as genetic factors and a dysfunctional environment, are outside the person’s control. To the extent that such negative stereotypes are shared by their voters, politicians, who often look to save public money, will not be motivated to redress the imbalance in mental health funding: in 2010/2011 mental health services were allocated only 10.8% of the National Health Service (NHS) budget, although mental disorders constituted nearly 22.8% of the disease burden in the NHS.⁹ Simon Wessely, the president of the Royal College of Psychiatrists, notes that despite rising demand, spending on adult mental health by NHS trusts has fallen by 8% since 2010.⁹ A recent parliamentary report advocates ‘whole person’ care, which includes mental and physical health, and highlights some of the barriers to parity of esteem for mental health.¹⁰

2. Hard v. soft evidence

Health professionals are trained to place higher value on ‘hard’ or objective evidence, namely the results of investigations, than on ‘soft’ or subjective evidence provided by patients. In fact, some such objective evidence (e.g. from X-rays or magnetic resonance imaging (MRI) scans) is heavily dependent on interpretation, for instance by a radiologist. This gives health professionals epistemic power, because only they have access to this evidence and have the training to interpret it. Montgomery¹¹ has argued that medicine is not itself a science but rather an interpretive practice that relies on clinical reasoning. A physician looks at the patient’s history along with the presenting physical signs and symptoms and juxtaposes these with clinical experience and empirical studies to construct a tentative account of the illness with what Montgomery calls ‘clinical judgment’. In psychiatry, there is virtually no hard evidence and diagnoses have to be made mainly on the basis of what patients say and how they behave. However, some psychiatrists regard their patients as objects of their epistemic enquiry rather than participants in an epistemic search for the correct diagnosis and best treatment. Anthropologist Tanya Luhrmann¹² argues that insurance companies exercise a more powerful influence over the content of healthcare than do doctors, in that they promote a biological approach to psychiatry because it yields explicit therapeutic rationales, targeted treatments and quantifiable outcomes that can be audited more easily.

Despite the lack of objective evidence in psychiatry, many psychiatrists are influenced by their general medical training and import this bias into the field. Although many acknowledge the biopsychosocial model of mental disorders, they often retain their biological orientation.¹³ Biological psychiatry has been dominant since the 1950s, when the first antipsychotic drugs were introduced, and there is little evidence that this is changing in any significant way. This is partly because the biological approach has practical benefits (e.g. psychiatrists can save time by focusing on drug treatments). Based on his experience working as a liaison psychiatrist in a large medical hospital, one of the authors (P.C.) believes that psychiatry itself is stigmatised within medicine and that some psychiatrists feel that they will be more respected by their medical colleagues if they approach mental disorders from a biological perspective. P.C. also senses that some patients might prefer this attitude, feeling exonerated if they are told that their mental disorder is caused by a 'chemical imbalance in the brain' which can be ameliorated by a drug.

3. Negative stereotypes

People with mental disorders are socially stigmatised and are frequently described with derogatory terms such as 'mad', 'crazy' or 'weird'. The term 'stigma' comes from the ancient Greek word denoting the mark made on slaves by a pointed instrument. Stigma involves negative associations that attach to a social group. Sociologist Erving Goffman¹⁴ argued that stigmatised people are considered abnormal by society and are not fully socially accepted. As a consequence, they constantly try to adjust their social identities. These additional cognitive and social burdens increase the pressures on stigmatised people, exacerbating their already difficult social and cognitive situation. Thornicroft¹⁵ points out that patients often describe the stigma they encounter as worse than the mental disorder itself. Stigma affects every aspect of their lives, including employment, accommodation, financial resources and sense of citizenship. It is a major problem throughout the world.

One of the negative stereotypes associated with mental illness is that people with a mental illness are responsible for their condition. For example, people diagnosed with depression are often told to 'get a grip' or to 'pull themselves together'. Illness, not only mental illness, is often seen as a mark of moral, social and epistemic failure (e.g. drug/alcohol dependence is sometimes seen as weakness of will). Such failures are shaped by group-specific values and commitments – for instance, certain religious groups regard depression as a punishment by God for their sins.¹⁶

However, in a legal setting, the poor insight of patients into their mental state may be recognised by the court as a factor which reduces the patient's responsibility for their actions. Although this diminishes their epistemic status, it also protects them, so recognition of their diminished responsibility may lead to them being treated in hospital rather than imprisoned.

Thus, those who are influenced by negative stereotypes about psychiatric patients may feel justified in cutting funding for mental health services because they think that many psychiatric patients are to blame for their mental health and other problems. In the case of depression, many people who have no personal experience of the illness tend to think that depressed people only need to think more positively for their depression to disappear.^{17,18} The fact that psychiatric services are more poorly funded than other services in the NHS suggests that negative stereotypes about mental disorders may have a role in funding distribution. These negative stereotypes are also influential in the broader context of widespread ignorance about the true nature of mental disorders and their treatment.

Types of stigma and their effects

General stigma

General stigma has negative effects on the prevention, early intervention and treatment of mental disorders. The formulation of a diagnosis has the advantage of making resources available for treatment, as well as providing the best available treatment. Moreover, there is evidence that early treatment improves the prognosis (e.g. in schizophrenia).⁷ On the other hand, having a diagnosis also leads to stigma and discrimination, which can act as a barrier to recovery, for instance making it more difficult to find employment and accommodation.¹⁵

Self-stigma

People with mental illness often accept and internalise negative stereotypes, and this in turn leads to low self-esteem, shame, demoralisation, confidence loss and giving up goals.

Structural stigma and discrimination

Patients typically report that they feel their views are not sufficiently elicited or considered by those who plan and organise psychiatric services.¹⁹ We have already seen that psychiatric provision for approaches other than the biopsychosocial model is severely under-resourced.

Specific contributory conditions

So far we have discussed global contributory conditions for epistemic injustice. In addition to these global conditions, there are specific problems which can lead to further kinds of epistemic injustice as a consequence of the particular nature of the mental disorder in question. Here are two examples, which illustrate how the symptoms of particular disorders may reduce the credibility of what patients report about their own experiences to an extent that constitutes epistemic injustice.

Dementia

The first example is dementia, an acquired impairment of cognitive function without impairment of consciousness. The central feature of its commonest form, Alzheimer's disease, is memory loss, especially of episodic memory, but there can be a wide range of other cognitive impairments as well. The main negative stereotype associated with dementia is the belief that the impairment of cognitive function is severe and global; that the person has or will rapidly and inevitably become a 'vegetable'. In fact, this is hardly ever the case, except perhaps in the final stage of the illness.²⁰

The personality of the individual and some cognitive functions are often well preserved. Thus, patients with mild to moderate dementia can be much more reliable informants than they are often thought to be. There is a need for careful neuropsychological assessment to establish the severity of the impairment. If a person's memory is badly affected, much can be gained by staying in the present in conversations, thereby minimising the occurrence of behavioural markers of epistemic incapacity that can exacerbate the risk of epistemic injustice.²⁰

Schizophrenia

The second example is schizophrenia. Perhaps the most common stereotype associated with it is that because of their delusional beliefs, people with schizophrenia are unpredictable and violent. This may diminish their status as truth-tellers because it may be concluded from one false (delusional) belief that none of their beliefs are credible. In fact, although violent behaviour can occur in schizophrenia, it is much rarer than is thought. There is a small but significant increase in violence in patients with schizophrenia (in any one year 8% of such patients will commit an act of violence compared with 2% of the general population). There is, however, a much stronger association between violence and substance misuse than with schizophrenia. The proportion of all violent acts committed by those with schizophrenia is 3–4%. This leaves 96–97% of all violent acts committed by people who do not have this disorder. The risk of an individual patient with schizophrenia committing homicide is less than 1 in 3000. Moreover, the rates of suicide are much higher than homicide rates in psychiatric patients as a whole.²¹ Thus, although the risk of violence is much higher in patients with schizophrenia than in the general population, the risk is lower than is suggested in the media.²¹ It also seems likely that other factors apart from the illness itself may play a part, such as the influence of alcohol and illicit substances at the time of the offence, and social factors.

Such negative stereotypes are problematic for several reasons, beyond their empirical inadequacy. They encourage unwarranted attitudes of suspicion and distrust towards people with schizophrenia, which, in turn, can contribute to

their social isolation; this is in itself epistemically impairing. Many of our epistemic practices are intrinsically social, such as testifying (giving information to others) and interpreting (making sense of one's experiences), and it is no coincidence that Fricker focuses her analysis of epistemic injustice on those two practices.¹ Social isolation and epistemic impairment can be mutually reinforcing.

In the case of schizophrenia, this problem takes on a specific form: it is integral to our social and epistemic agency that other people perceive us as a person – an agent – capable of engaging, in a sustained and reasonable way, in testifying, interpreting and other epistemic practices. A self is a locus of epistemic and social agency. Yet stereotypes about schizophrenia abide, typically the widespread but mistaken notion that schizophrenia is chiefly characterised by a personality split, as in the good Dr Jekyll and the evil Mr Hyde. The term 'schizophrenia' was coined by the psychiatrist Eugen Bleuler to capture a split between components of the mind – knowledge, emotion and will. This idea of a split has been abandoned in modern diagnostic criteria.²² However, the stereotype of 'split personality' is, of course, a perfect example of a fragmented epistemic self with whom one cannot effectively engage either socially or epistemically.

The rare cases of homicide by patients with schizophrenia are given intense coverage in the press. Examples include Christopher Clunis, who killed a stranger who happened to be standing on the same platform at Finsbury Park tube station in London in 1992; and Matthew Williams, who had a diagnosis of paranoid schizophrenia and killed a young woman in an act of cannibalism in 2014. This creates the impression that violence on the part of patients with schizophrenia is much more common than in fact it is, a phenomenon described by psychologist Daniel Kahneman as 'what you see is all there is', namely jumping to conclusions from limited evidence: another feature of prejudice that might lead to epistemic injustice.²³ Such jumping to conclusions on limited evidence can lead to prejudice ('people with schizophrenia are violent') and hence to epistemic injustice, if a patient says she does not have violent thoughts and is not believed.

As demonstrated in this section, the specific deficits found in dementia and schizophrenia can increase the susceptibility of such patients to epistemic injustice, in addition to the global factors which apply to all mental disorders.

Possible ways of overcoming epistemic injustice

One effective way to integrate the subjective perspective of patients into medicine and psychiatry may be changes in medical and psychiatric training with a view to emphasising the psychological aspects of patient care. 'Schwartz rounds', which allow health professionals to focus on the existential, ethical and personal aspects of a medical case, are growing in popularity in the UK. We suggest that this approach should not only be taught to medical students but should become part of clinical practice.²⁴ Regular interpersonal dynamic meetings with members of a multidisciplinary team, which create a forum for discussing problematic emotional contacts with patients, can enhance understanding of these aspects of patient care and reinforce their importance.¹³

Medical students should be taught to believe what psychiatric patients tell them, unless there is good reason not to do so. Students are frequently told to put patients first, but the experience of many patients is that they are often treated as cases rather than people, and that what is important to doctors is different to what is important to patients. By listening carefully to what patients tell them, doctors can make a conscious effort to imagine how things seem from the patient's perspective. In this way the relationship can become a genuinely collaborative one, rather than one in which the doctor decides what is in the patient's best interests.²⁵

Fricker¹ notes that hearers, in this case the physicians, need to practise giving more credibility to members of groups they fear they may be giving too low levels of credibility to: in this context, to psychiatric patients. Hearers may become aware of a cognitive dissonance: they may notice that on occasions they fail to live up to their belief that members of these groups are to be taken seriously, and then make a conscious effort to give them a higher level of credibility. The hope is that, with time, this corrective policy will become second nature.

Conclusions

We have suggested that there is even greater risk of epistemic injustice in psychiatry than in general medicine. There is a need for psychiatrists to be trained to listen carefully to what patients are telling them and to engage with them in collaborative decision-making, to allow patients to have a greater epistemic role and to overcome the risk of epistemic injustice. Changes are also required in the social and political arena. Media editors should reduce the stigmatisation of psychiatric patients in media reports, especially if epistemic failure (such as reliance on negative stereotypes) can be a cause of moral failure (such as treating persons with mental disorders in an unfairly hostile or suspicious manner). Similarly, politicians should ensure that there is a fairer distribution of healthcare resources, not merely to mitigate the economic cost of mental ill health.

Prejudices against people with mental disorders are entrenched in our society in what Fricker calls the ‘collective social imagination’.¹ They go unchecked because they operate below the radar of the conscious scrutiny of our own beliefs. Those who are in a position to influence public opinion have a special responsibility to oppose these prejudices. We hope that this editorial will increase awareness of the risks of epistemic injustice in psychiatry and thus contribute to this goal.

We are grateful to two anonymous referees for their helpful comments. Havi Carel is grateful to the Wellcome Trust for awarding her a Senior Investigator Award to support her research (grant number 103340).

1.6.24 Psychiatry and the geriatric syndromes – creating constructive interfaces

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Abstract

Integrating mental and physical healthcare is difficult to achieve because of professional and organisational barriers. Psychiatrists recognise the problems resulting from fragmentation of services and want continuity of care for patients, but commissioning and service structures perpetuate these problems. One way forward may be to follow the syndromic model employed by geriatricians as a means of avoiding over-emphasis on diagnosis above the pragmatics of implementing multi-component, co-ordinated care. Commissioners need to be made aware of the overlap and complementarity of skills possessed by old age psychiatry and geriatric medicine to create joint services for people vulnerable to dementia and delirium. A re-forged alliance between the two specialties will be necessary to turn integrated care for frail, elderly people from rhetoric into reality.

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People with severe mental illnesses such as schizophrenia die younger than expected, losing an average 15 years of their lives to cardiovascular and other diseases.¹ This has led to calls for a more integrated approach to care, with greater emphasis on physical health. In this article, we examine some current issues in the care of older people with severe mental illnesses such as dementia and delirium. We argue that existing systems compartmentalise care and lack the sophistication to deal with the complexity of these illnesses. We suggest that a more collaborative approach between old age psychiatry and geriatric medicine in both hospital and community settings could yield benefits.

Geriatric medicine occupies a position of unfashionable scepticism about the ‘medical model’ of care and its corollary of single-mode interventions. Under the banner of ‘comprehensive geriatric assessment’ attention is paid to function, mental health, and social and environmental factors as well as (usually multiple) acute and chronic medical diagnoses. Elements of prevention, rehabilitation, palliation and mental health models are used flexibly. Care often includes cessation of medicines, recognition of burdens placed on patients by medical intervention, and the prioritisation of comfort, rather than an expectation that death is delayed.² Old age psychiatry can learn from geriatric medicine by embracing complexity, comorbidity and the ultimate inevitability of deterioration, signalling a return of old age psychiatry to its origins.³

What is a geriatric syndrome?

Geriatric syndromes are states of ill health which occur with high frequency in older people but which do not fit into discrete disease categories. They are typically explained by a range of organ dysfunctions and diseases, have functional and social implications, and therefore require care that is complex and traverses traditional disciplinary boundaries. Delirium, falls, immobility and urinary incontinence have been described as geriatric syndromes, but the term is loose and may also include pressure sores and sarcopenia. Dementia and other mental health problems can be thought of in similar terms.⁴

Dementia as a geriatric syndrome

Dementia is common towards the end of life; 6% of people who die aged 65–69 years and 58% of those who die aged 95 or over have dementia.⁵ The aetiology of late-onset dementia is often multifactorial.⁶ Dementia causes functional decline, and contributes to falls and incontinence. Multi-morbidity is usual⁷ and the symptom burden in the last year of life of people with dementia exceeds that of people dying with cancer.⁸ Dementia causes problems with safety awareness and loss of independence, and is a source of much carer strain. Crises are frequent, and usually have physical, mental, social or care-system contributors. People with dementia frequently transit between home, hospital and care home. These ‘unique and changing personal, psychosocial and physical needs’ are acknowledged in the Memory Services National Accreditation Programme,⁹ but secondary care memory clinics are unlikely to be the only way to address them.^{10,11}

A more comprehensive and accessible form of engagement is needed, in the form of primary care liaison psychiatry or

rapid response community mental health teams (CMHTs). CMHTs for older people led the way in delivering dementia care within communities (long before community geriatrics was a tangible entity).¹² These teams are under threat, with proposed merger into 'ageless' community teams. This would require increasing focus on psychopathology and behaviour, with a likely prioritisation of single (psycho)pathologies. Failure to recognise and appreciate the special needs of patients with dementia and the skills of CMHTs in addressing them risks diminishing patient care.¹³ At the same time, the need to address physical and functional comorbidity suggests that an overt alliance between old age psychiatry and geriatric medicine is needed.

Delirium as a psychiatric syndrome

Delirium and dementia frequently co-occur in older people in the general hospital. Dementia has achieved a high national profile in the UK. By contrast, delirium barely enters public discourse. Two-thirds of elders acutely admitted to hospital with delirium have underlying dementia^{14,15} and half of people with dementia in acute hospitals have delirium.¹⁶ Informant history is vital in identifying the two syndromes, but persistent, subacute and subsyndromal delirium is common and the syndromes can be difficult to distinguish, especially where prior dementia was undiagnosed, leading to the coining of the term 'cognitive spectrum disorders' to cover both.¹⁷ Between 10 and 20% of delirium in older people does not have an identifiable precipitant¹⁸ and the cognitive impact of delirium may persist for months or merge into the onset of a dementia syndrome.¹⁹ Some survivors develop post-traumatic stress disorder. Uncertainties also exist as to the division of clinical responsibility between geriatricians and psychiatrists. Arguably, neither specialty can do it well in isolation.

The development of health services in the UK over the past 20 years has seen psychiatrists focus on patients in the community while geriatricians have increasingly assumed responsibility for the acute medical intake, militating against collaboration. The diagnostic uncertainties and sequelae of delirium imply the need for systematic follow-up, which geriatric medicine is poorly placed to provide. Psychiatry has a role in working with the third sector and primary care to highlight the malign effects of delirium even in the context of successfully treated acute physical illness.

The publication of delirium guidelines from the National Institute of Health and Care Excellence (NICE) has been a major advance in the promotion of delirium management,²⁰ but evidence is weak that any specific intervention or programme of delirium care improves outcomes.²¹ Conversely, there is evidence that multi-component interventions aimed at preventing delirium can reduce its incidence and improve outcomes.^{22,23}

Establishing a role for delirium prevention in hospitals and community settings is a challenge given the low profile of delirium training in medical and nursing schools, poor recognition by clinicians, and competing imperatives for healthcare organisations. Conceptualising delirium as both a safety risk to individual patients and an organisational risk due to increased length of stay and adverse health outcomes provides an incentive for change. Old age psychiatrists, with their emphasis on the importance of assessing mental health alongside physical health, can valuably contribute to both delirium care and education.²⁴

Why is delirium prevention not taken more seriously in community psychiatry?

Prevalence studies of delirium in any setting are fraught with the problem of distinguishing delirium from dementia.²⁵ A Swedish study of very elderly people found that 52% of people with dementia had experienced delirium within the previous month compared with 5% of those without dementia.²⁶ Work in the Netherlands revealed a delirium prevalence of 9% in care homes.²⁷

The evidence for the value of delirium prevention programmes in care homes has yet to be established, but there is evidence that coordinated programmes to reduce the prescribing of culprit medications are effective in preventing delirium.²⁸ A trial of the effectiveness of multi-component delirium education in preventing the disorder in care homes is underway in the UK.²⁹

People with dementia who are living in their own homes and are in receipt of care from CMHTs are also at high risk of delirium. Behavioural and psychological symptoms in dementia (BPSD) are associated with morbid – ities that contribute to delirium, such as falls, nutritional deficits and polypharmacy. Delirium can cause a similar range of symptoms, which may become chronic and constitute BPSD.³⁰ Delirium is triggered by physical illness, injury,

medications or medication withdrawal, and rightly remains the domain of primary care and geriatricians, but unless psychiatry co-owns the delirium agenda, the cross-over of skills from the management of BPSD will fail to shape delirium prevention, assessment and management. The similarities between delirium prevention programmes and those for the non-pharmacological management of BPSD are striking.^{31,32}

Frailty

Frailty is a state of vulnerability to decline in the face of stressors, in the context of precarious multisystem physiology and social adversity.³³ Epidemiological evidence highlights the importance of frailty in elderly populations. It has proven difficult to operationalise, but recognisably overlaps with dementia in cross-sectional studies.³⁴ One view conceptualises it as the effect of cumulative deficits³⁵ and the other as a phenotype characterised by three or more of the following factors: unintentional weight loss, self-reported exhaustion, poor grip strength, slow walking speed and low physical activity.³⁶ However, geriatricians recognise that frailty will often manifest through geriatric syndromes – falls, immobility (‘off legs’), delirium (‘more confused’), urinary or faecal incontinence (often associated with delirium, dementia and immobility) and susceptibility to drug side-effects (antidepressants making a patient ‘very drowsy’).³⁷ The maturation of old age psychiatry as a specialty has been facilitated by the advent of specific therapies for Alzheimer’s disease, but an emphasis on prescribing for Alzheimer’s disease has selected against attendance by frail elders and those with non-Alzheimer pathology (particularly vascular dementia) and cognitive deficits outwith a full-blown dementia syndrome.

Comprehensive geriatric assessment aims to consider the full range of factors contributing towards frailty (*Table 1*). Its implementation is linked to better outcomes.³⁸ It has parallels with biopsychosocial assessment, although this does not have similar evidential weight behind it, and indeed has been criticised by the psychiatric profession as ‘mere eclecticism’.³⁹ The accusation of vagueness laid against biopsychosocial assessment suggests that it needs to find a home within an operationally defined, evidence-based structure such as comprehensive geriatric assessment. The two processes differ only in the emphasis and differential expertise of the clinicians undertaking them. Geriatricians recognise that they tend to neglect the mental health dimension, which may be reduced to a brief cognitive assessment or screening test for depression. There is therefore a fertile opportunity for mutual learning between geriatrics and psychiatry in the area of the assessment of frailty.

Components of comprehensive geriatric assessment

Domains	Items to be assessed
Medical	Co-morbid conditions and disease severity
	Medication review
	Nutritional status
	Problem list
Mental health	Cognition
	Mood and anxiety
	Fears
Functional capacity	Basic activities of daily living
	Gait and balance
	Activity/exercise status
	Instrumental activities of daily living
Social circumstances	Informal support available from family or friends
	Social network such as visitors or daytime activities
	Eligibility for being offered care resources
Environment	Home comforts, facilities and safety
	Use or potential use of telehealth technology etc.
	Transport facilities
	Accessibility to local resources

Reproduced from Martin, 2010.⁴⁰

Sustainable integration

The needs of older people with mental health disorders are not well served by a retreat to psychiatric specialisation, restrictive referral criteria or commissioning models based on activity alone. Geriatric medicine recognises and embraces complexity and uncertainty, and responds by flexibly utilising a variety of models, albeit at times with tensions between them. Old age psychiatry can learn from comprehensive geriatric assessment. Geriatric medicine needs to take mental health more seriously, to increase the depth and sophistication with which it assesses the mental state, and can learn from person-centred care and recovery models. The logical future for both disciplines is in collaboration and integration that transcends organisational and cultural barriers.

A sustainable integration of physical and mental healthcare for older people will require more than cooperation between clinicians. The joining of forces between psychiatrists and geriatricians can take place at an organisational level when mental health and community trusts merge. However, we also need a flexible, accessible, consultative model of psychiatry that seeks to empower a broad range of community practitioners and will be the means to generate influence on problems that are just too common and multi-morbid to be addressed solely by clinic-based approaches or a single professional discipline. This reinforces the need for CMHTs for older people, and highlights the need to change the commissioning model from one based on activity defined by clinic attendances. Crises in care homes, for example, often represent a complex interplay of medical, mental, social and environmental issues best addressed by timely multi-disciplinary input rather than transferring responsibility on to a single discipline. Accessible advice on a broad range of cases managed primarily by other teams ('liaisons') allows for teaching and upskilling while preserving specialty provision for patients with more severe, less tractable mental health problems. These teaching and support roles need a commissioning model.

CMHTs are in a good position to identify dementia and promote delirium prevention measures. Working alongside community geriatrics will strengthen old age psychiatry by allying it with the developing evidence base and increasing its workforce.

The Rapid Assessment Interface and Discharge (RAID) model developed in Birmingham has captured the attention of policy-makers through its widely publicised potential financial savings. But it also demonstrates the total immersion of mental health practitioners in the multi-professional melee that is acute hospital care.⁴¹ Why not import this style of working into primary care and scale down the centralised psychiatric clinic? This has been tried in Gnosall, Staffordshire, where a model of primary care liaison psychiatry has created a well-received, effective service for people with dementia.⁴²

Conclusion

Psychiatrists must lobby commissioners to recognise the plight of those frail, elderly patients who are not living well but dying with the multiple comorbidities of dementia within a healthcare system that fails to accommodate complexity. People with dementia are prone to crisis and comorbidity, necessitating attention to physical health (parity of esteem) equal to that developing for other severe mental illness. Emphasising geriatric syndromes (and the importance of sound mental health assessment within comprehensive geriatric assessment) is a good way to defend old age psychiatry while at the same time developing integrated physical and mental healthcare for older people. An invigorated liaison psychiatry, underpinned by a re-forged alliance between old age psychiatry and geriatric medicine, gives a pointer to how integration might work, and enables parity of esteem for mental and physical health.

1.6.25 Police liaison and section 136: comparison of two different approaches

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Abstract

Aims and method Two police liaison and section 136 schemes were developed alongside police services at different sites within the same NHS trust. In one, a mental health nurse worked with frontline police attending incidents related to mental health. The other involved nurses providing advice from the police control room. Section 136 detentions were measured over two 6-month periods (6 months apart) before and after practice change. Data analysed included total numbers of section 136 assessments, outcomes following subsequent assessment, and relevant diagnostic and demographic factors. Association of any change in section 136 total numbers and proportion subsequently admitted was investigated in both sites.

Results The model involving a nurse alongside frontline police showed significant reduction in section 136 numbers (38%, $P < 0.01$) as well as greater admission rates ($P = 0.01$). The scheme involving support within the police control room did not show any change in section 136 detention but showed a non-significant ($P = 0.16$) decrease in subsequent admission.

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Clinical implications Mental health nurses working alongside frontline police officers can help improve section 136 numbers and outcomes.

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Section 136 of the Mental Health Act 1983 enables an individual police officer to remove any person found in a place to which the public have access appearing to have a mental disorder and to be in immediate need of care or control to a place of safety, such as a hospital, police station or a purpose-built section 136 unit. The section can only be used if the officer believes it is in the interests of that person or necessary for the protection of others. Although section 136 can be an important care pathway to enable an individual to receive appropriate support, it can also be a very distressing experience for them – some report feeling criminalised and punished for having a mental illness.¹ Its use is also costly given that it requires the input of an approved mental health professional (AMHP) and two doctors for the assessment, plus police and often nursing time to manage the detained person and staff the place of safety.

Background and aims

The Mental Health Act Commission has highlighted the challenge of collating data on the use of section 136,² but figures have only been gathered at a national level by the Health and Social Care Information Centre over the past 5 years.³ These combine police and mental health records on section 136 detentions but have limited detail on outcomes. At a national level the rates of section 136 detentions to places of safety between 2010/2011 and 2014/2015 increased from 14 111 to 19 406.³ Attempts to combine inconsistently recorded data have shown a steady upward trend at a rate greater than has been seen with use of the other Mental Health Act sections for detention.⁴

Significant variation is seen regionally in section 136 use. Outcomes from such detentions, often seen as markers of how appropriately the detention has been applied, are also seen to vary from region to region: from areas where around 60% are admitted to hospital⁵ to those where 68% are discharged.⁶ While theories to explain these variations have included a rural/urban divide, police culture, socioeconomic deprivation and diagnostic factors,⁷ the available data have been limited in both accuracy and detail.

In response to concerns about the growing use of this police power and regional variation, there has been a national drive to improve inter-agency working between police and mental health services. Both the Bradley Report⁸ and the Crisis Care Concordat⁹ placed emphasis on local agencies working more closely to improve the experience of individuals in a mental health crisis and to intervene as early as possible within the criminal justice system. Areas have responded differently to the challenge. This paper analyses various aspects of section 136 and changes observed with different ways of inter-agency working within two areas of the same National Health Service (NHS) trust, in Ipswich and Norwich.

The local response in Ipswich has been a Commissioning for Quality and Innovation (CQUIN)-funded pilot scheme developed in partnership between Norfolk and Suffolk NHS Foundation Trust (NSFT) and Suffolk Constabulary. The scheme commenced in April 2014 and involves two experienced mental health nurses working on alternate shifts alongside frontline police officers, 7 days a week from 14:00 until 00:00, to help assess and appropriately divert members of the public who present with potential mental health-related emergencies. Accompanied by a police officer (individuals vary with police rota), they are seen as the initial point of contact for officers attending a potential mental health-related event. They are able to perform face-to-face assessments in a dedicated police car but can also provide advice to other officers over the phone.

Norwich was chosen as the control site as it was closely matched by size, ethnicity and measures of deprivation (*Table 1*). Norwich also established a police liaison service (funded by the police service) to address the same national concerns. It employed 4 mental health nurses on rotation providing support to the local police force between 8:00 and 22:00, 7 days a week. However, they were based in the police control room and offered telephone advice to police officers without face-to-face contact with the public.

Results: population parameters^a

	Ipswich	Norwich
Population	442 000 ^b	483 000 ^c
Index of deprivation ranking ^d	72	61
White British, %	82.94	83.65

2011 census data.¹⁰

Ipswich, Suffolk Coastal, Babergh and Mid-Suffolk local authorities.

Norwich, North Norfolk, South Norfolk and Broadland local authorities.

Lower value indicates higher deprivation.

The aims of this study were to examine changes in and between Ipswich and Norwich regarding section 136 detentions and hospital admission rates of detained individuals. This would enable us to build on past research and consider what factors were driving the use of section 136 locally, and in turn better understand any impact the police liaison projects may have had.

Method

This retrospective study compared numbers and outcomes of section 136 assessments, characteristics of detained individuals and some follow-up data. Information was obtained prior to and following differing changed practices within the trusts for the two areas. Numbers of section 136 detentions were gained from local section 136 suite records and cross-referenced with data gathered at trust level in an attempt to capture all section 136 assessments in Ipswich and Norwich. Further data pertaining to each individual were then collected retrospectively from hospital records using electronic notes (Epex in Ipswich and Carenotes in Norwich). Data were gathered for two 6-month periods: 1 June – 30 November 2013 and 1 June – 30 November 2014. This was to limit any impact on results of the preparation for and introduction of services. This also allowed for comparison of the same 6-month cycle (a year apart) pre- and post-intervention in both areas and between areas.

The project was viewed as service evaluation by the trust's research and development department and thus did not require ethics approval. The exact information gathered and hypotheses to be tested were agreed at the planning stage. Data were entered into Minitab (version 16) to allow for appropriate statistical analysis. The exact data collection questions can be found in *Box 1*.

Such a study set-up meant that each location had a control group prior to intervention and an experimental group post-intervention. Analysis was conducted pre- v. post-intervention in both locations and between the locations. Null hypotheses were that there were no differences between locations or between pre- and post-intervention. Population

sizes covered by each section 136 suite were established by combining police force estimates of the locality from which officers were detaining people and the 2011 census local authority population sizes.¹⁰ Chi-squared statistical tests were used where appropriate. We used *t*-tests when comparing section 136 numbers per 100 000 population, Fisher's exact test for comparing proportions, and the Mantel–Haenszel procedure to identify possible confounding factors.

Results

Demographics

As seen in *Table 2*, there were no significant differences in the study participants' age or gender pre-intervention compared with post-intervention in either area individually or between the areas. There were no significant differences in ethnicity either, with the overwhelming majority of individuals assessed being of White British background.

Results of section 136 assessments in two study areas *a*

Measure	Ip swich	No rwich	Be tween -area d ifference, <i>P</i>						
Se ction 136 as sessm ents, <i>b n</i> (%)	169 (77)	104 (47)	0.01 <i>c</i>	87 (36)	93 (39)	0.82 <i>c</i>	<0.01	0.39	0.01
Age, y ears: mean (s.d.)	34.7 (13.3)	37.5 (14.9)	0.12 <i>d</i>	37.7 (14.0)	37.7 (14.0)	0.98 <i>d</i>	0.10 <i>d</i>	0.94 <i>d</i>	0.15 <i>d</i>
M ales, %	58.0	51.0	0.26	47.6	52.7	0.50	0.12	0.80	0.30
Co ntact with CMHS in past 2 w eeks, <i>n</i> (%)	82 (48.5)	52 (50.0)	0.53	52 (65.0)	40 (44.0)	0.01	0.01	0.40	0.33
Admi tted, <i>n</i> (%)	40 (23.7)	39 (37.5)	0.01	29 (33.3)	22 (23.7)	0.16	0.10	0.04	0.89
Adm itted under M ental H ealth Act, <i>n</i> (%)	23 (57.5)	23 (59.0)	0.89	16 (55.2)	17 (77.2)	0.10	0.85	0.15	0.46
Ass essed d uring 'pre sumed t riage ho urs', <i>n</i> (%)	122 (72.2)	72 (69.2)	0.15 <i>e</i> < #TFN1 0>`_	-	-	-	-	-	-
Admi tted, <i>n</i> (%)	31 (25.4)	28 (38.9)	<0.01 <i>e</i> < #TFN1 0>`_	-	-	-	-	-	-
Ass essed and adm itted in ' non-t riage ho urs', <i>n</i>	19.1)	11 (34.4)	<0.01 <i>e</i> < #TFN1 0>`_	-	-	-	-	-	-

CMHS, community mental health services; MHS, mental health services. Bold denotes significance.

² tests unless indicated otherwise.

Per year per 100 000 population.

Fisher's exact test for equality of two proportions using figures per 100 000 population per year.

Two-sample *t*-test of difference of mean with null hypothesis of no difference.

Fisher's exact test for equality of two proportions using the percentage figures.

Numbers of section 136 assessments

There was strong evidence to suggest, over the total time periods, that Norwich had proportionately fewer section 136 assessments per 100 000 population than Ipswich ($P = 0.01$). This difference was greater in the pre-intervention period. Between the two 6-month periods there was a small, non-significant increase in those detained under section 136 in Norwich but a large reduction in section 136 assessments in Ipswich post-intervention ($P = 0.01$) (Table 2 and Fig. 1).

Fig. 2: Section 136 assessments and subsequent admissions.

Box 1 Survey questions

1. Pre- or post-intervention?
2. Ipswich or Norwich?
3. Date of assessment?
4. Time of assessment?
5. Gender?
6. Age?
7. Ethnicity?
8. Broad ICD-10 category?
9. Number of section 136 assessments the individual had in the previous 6 months?
10. Any contact with mental health services in past 2 weeks?
11. If so, what type of contact?
12. Main reason for section 136?
13. Any specified location?
14. Was the individual admitted?
15. If so, was this under detention?
16. If admitted, what was the length of admission?
17. If not admitted, was follow-up offered by secondary mental health services?
18. If so, was the first appointment complied with?
19. If not admitted, was the individual subject to a further section 136 assessment within the subsequent 4 weeks?

Admission

Over all the data collected, there was no significant difference in admission to hospital following section 136 assessment between Ipswich and Norwich. Prior to intervention, although admission was less likely in Ipswich than in Norwich, this was non-significant. In Ipswich there was a significant change in admission post-intervention ($P = 0.01$), with a higher conversion to admission. Post-intervention, there was a difference between Ipswich and Norwich ($P = 0.04$), with higher admission in the former. Thus the interventions were associated with a proportionate increase in admissions following section 136 in Ipswich. Although data suggested that the admission proportion decreased in Norwich, this was non-significant ($P = 0.16$).

Apart from weak, non-significant evidence to suggest that in Norwich those admitted post-intervention were more likely to have been detained than pre-admission ($P = 0.10$), there was no other association between detention under the Mental Health Act following admission and pre- and post-intervention status.

Contact with community mental health services

Any contact with community mental health services (CMHS) in the 2 weeks prior to section 136 assessment was measured. In Norwich, data provided strong evidence that in the pre-intervention period there were more individuals who had some contact with CMHS than in the post-intervention period ($P = 0.01$) and when compared with Ipswich ($P = 0.01$). In Ipswich there was no evidence of any difference between contact pre- v. post-intervention.

For those individuals who were not admitted to hospital following section 136 assessment, the proportion that had at least one subsequent 136 assessment in the following 4 weeks decreased in both sites, but the change was significant only in Norwich ($P < 0.01$ v. $P = 0.14$ in Ipswich).

In Ipswich there was moderate evidence to suggest that, if not admitted, people were more likely to be offered follow-up from secondary mental health services post-intervention than pre-intervention ($P = 0.04$). If follow-up was offered in Ipswich, there was strong evidence to suggest that the first follow-up contact was more likely to be kept post-intervention than pre-intervention ($P < 0.01$). In Norwich there was evidence that a person was more likely to be offered follow-up prior to as opposed to after the intervention ($P = 0.02$), but no evidence to suggest any difference between compliance rates pre- v. post-intervention.

Diagnosis

There was weak non-significant evidence to suggest that people assessed in Ipswich were more likely to have been deemed to have 'no mental illness' prior to the intervention compared with post-intervention ($P = 0.08$), but in Norwich there was strong evidence to the contrary ($P < 0.01$).

Counts of pre- and post-intervention broad ICD-10 categories of individuals assessed from each site are shown in *Fig. 2*.

Time of day

We were unable to obtain the exact time of implementation of the actual section 136 order for individuals. Time between implementation and assessment following the order is influenced by many factors. Trust policy states that this should happen within 3 hours.

In Ipswich the triage service was funded for 10 hours per day (between 14:00 and 00:00). As an estimate within this study, following implementation of the order, individuals who were assessed between 15:00 and 03:00 were deemed to have been assessed in a time period in which the triage service was operating. Within these time periods, the numbers assessed and numbers admitted are shown in *Table 2* (numbers admitted following assessment out of these time periods are also shown). Thus, a similar proportion were assessed within the triage hours both pre- and post-intervention (72.2% and 69.2%).

As stated above, admission following section 136 in Ipswich was more likely after the triage service commenced. On further analysis this effect was seen to be confounded by assessment within/outside triage times (Mantel-Haenszel odds ratio 5.44, $P = 0.02$) with a significant association in the triage times ($P = 0.05$). This indicated that the triage service intervention had most association with differing admission rates within the triage times.

Unfortunately, due to a large number of missing assessment time data in Norwich, a similar analysis was not deemed feasible.

Discussion

This retrospective study evaluated the impact of two recently developed police liaison schemes based in closely matched semi-rural areas within a single mental health NHS trust, with a focus on section 136 rates and outcomes before and after the projects were established.

The pre-intervention findings show that Suffolk Constabulary was detaining significantly higher numbers of people for assessment in the Ipswich area than the police force in Norwich. This difference matches the only data available prior to 2013/2014 on section 136 rates for the two regions, from 2005/2006, in which the Independent Police Complaints Commission (IPCC) analysed regional variation across England and found Suffolk to be a medium-rate user and Norfolk a low-rate user of section 136 detentions to police custody.¹¹

Well-matched local population demographics and demographic profiles of those detained would indicate that differences are not linked with variation in race, gender or age. The diagnostic profiles of those detained also show little variation between sites. These observations are significant given that a number of studies have identified common factors pertaining to those detained under section 136, such as Black men being over-represented, and the typical individual tending to be a young male, unemployed, with a psychiatric history and diagnosis of schizophrenia.¹²

As police officers are the sole implementers of S136 detentions, their attitudes and training around mental health can be considered an important variable. Qualitative studies have identified high rates of concern among police officers over inadequate training in relation to mental illness,¹³ and poor understanding of their role in relation to section 136.¹⁴ Informal feedback from the two police forces involved in this study indicates that mental health training is similar and thus would be an unlikely source of variation.

The IPCC report also observed that low-rate forces used alternative powers such as breach of the peace and that well-known 'suicide spots' such as seaside cliffs were observed in police force areas with high rates.¹¹ Data we have gathered on both police forces show a similar arrest rate (15 v. 16 per 1000 population) but a slightly higher crime rate (49.76 v. 43.98 per 1000 population) in Suffolk compared with Norfolk.¹⁵ However, there are also lower levels of policing per 1000 of population in Suffolk (3.11 v. 3.33).¹⁵ The impact of these slight differences is hard to interpret. Ipswich has a locally well-known 'suicide spot' but numbers of detentions relating to its locality were not significant.

Findings from the post-intervention data support the theory that a mental health liaison service to the police can have a significant impact on section 136 rates and also suggest which model is more effective. The Ipswich site showed a 38% reduction in the use of the police power during the post-intervention study period. In that time, there were no other significant changes to police or mental health policy or resourcing locally. This reduction is in contrast to the steady increase in the use of section 136 nationally.¹⁶ The Norwich site with support based solely in the police control room, by contrast, showed no significant change in overall numbers of section 136 detentions. The data provide some possible explanations for this observed difference between the sites.

It could be speculated that the impact of a liaison service with experienced mental health nurses in Ipswich, where rates were higher 10 years ago¹¹ and pre-intervention rates were high in this study, was to enable the local constabulary to achieve a greater level of confidence in dealing with mental health-related crises that is already present in Norwich. The detention outcome data in Ipswich may be seen to lend weight to this idea. Post-intervention we observed a proportionate increase in admission rates, an increase in offer of community support if discharged and a reduction in those deemed to have 'no mental illness'. These outcome measures can be interpreted as markers of a service better able to identify those with mental health needs and, combined with an increase in engagement, suggest it is better at signposting to appropriate services.

By contrast, the Norwich data post-intervention show a proportionate decrease in admission rates, decrease in follow-up being offered and increase in 'no mental illness' assessments despite overall numbers remaining approximately the same. It could be inferred that support based in the police control room is only effective for individuals known to mental health services, whereas members of the public unknown to services need to be assessed face-to-face to provide effective input from a specialist service. Our recording of those who had contact with mental health services in the 2 weeks prior to detention showed that for both areas approximately 50% were either known to or actively open to mental health services, which is lower than estimates from previous research of around 75–84%.¹² The near equal percentage of those in contact with mental health services prior to detention in Ipswich could further suggest that the face-to-face liaison service is able to affect detention rates for both those known to mental health services and those not known.

The data relating to time of assessments in Ipswich suggested that while the liaison service had a greater impact on conversion to admission rates during their working hours, there was a near-even drop in section 136 rates across all hours. This could indicate that multi-agency working has promoted an ability among the local police force to better identify those who should be detained for further assessment. Lending further weight to this perception is the fact that the service in Ipswich was only in operation 76% of the time due to planned leave and sickness.

A follow-up to the Bradley Report claims that similar schemes are producing positive results, including reduced section 136 rates.¹⁷ We believe that our study provides an evidence base for these as yet unpublished findings, and lends weight to the value and impact of closer inter-agency working between police and mental health services. The breadth of data and comparison of models available in this study may help to guide the development of future schemes and their refinement.

Limitations

Within this study we gathered data regarding individuals detained to places of safety under section 136 within the two main urban areas in Norfolk and Suffolk, namely Norwich and Ipswich. There will have been a few occasions where these sites were occupied and people were subsequently taken to other localities. Although we can say that both areas are equally resourced and from experience know these numbers to be small, this should be acknowledged as a weakness. Estimations of section 136 rates per population size in each area must be viewed with caution as the local authority boundaries do not equate to areas that the 136 suites serve, and it was difficult to achieve clarity on this. The study could not define the areas where the section 136 detention was made and this may have been outside the area covered by the triage services, which may have led to an underestimate of the impact of either service.

While this study builds towards a better understanding of the model that is most effective in police liaison work, it lacked a detailed analysis of the work done directly by the mental health nurses and police officers involved. Any future studies should include these data alongside qualitative feedback from relevant professionals and individuals to enable a fuller understanding of the impact of such a service.

1.6.26 Online media reporting of suicides: analysis of adherence to existing guidelines

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date

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Abstract

Aims and method To assess the compliance of contemporary online media output with guidelines for the responsible reporting of suicidal acts. A search engine was used to identify online media reports of suicide from UK sources over the course of 1 month. Each article was assessed against guidelines for the responsible reporting of suicide produced by the Samaritans, a UK mental health charity.

Results We identified 229 articles, of which 199 failed to comply with at least one of the Samaritans' guidelines. Failure to mention support sources, excessive detail about the method used and undue speculation about the trigger for suicide were the most commonly breached guidelines. Significant differences were found between the quality of local and national media sources, with local media sources being broadly more compliant with guidelines.

Clinical implications This study highlights the urgent need for the implementation of responsible reporting guidelines in online media articles as a component of suicide prevention efforts.

Contents

- *Online media reporting of suicides: analysis of adherence to existing guidelines*
 - *Method*
 - *Results*
 - * *Compliance with the responsible reporting guidelines*
 - * *Additional features of online media*
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 - * *Local v. national media sources*
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 - * *Next steps*

Responsible media reporting of suicide is considered to be key to current international suicide prevention efforts.¹ Previous studies suggest that media reports of completed suicide can influence the rate of future suicidal acts and the method chosen.²⁻⁶

Guidelines to promote responsible reporting practices exist in a number of countries.⁷ Studies suggest that they can alter the content of media reports,⁸ although the general awareness and use of the guidelines has been found to be poor.⁹ In the UK, the 2012 Editors' Code of Practice from the Press Complaints Commission prohibits the reporting of suicide with excessive detail about the method used,¹⁰ but established responsible reporting guidelines tend to include additional features in an attempt to prevent copycat behaviour.¹¹

After a detailed literature review, no studies could be found comparing a significant number of contemporary UK media reports of suicide against responsible reporting guidelines, despite the fact that the media have been implicated in the phenomenon of 'suicide clustering' observed in the UK.¹² Other studies have focused on newspaper and television

the original work is properly cited.

The Authors own the copyrights to the individual articles.

reports, and scant attention has been paid to online media sources, despite the fact that 84% of households in the UK have access to the internet and 55% of adults use the internet to access news.¹³ This is the most rapidly growing method of accessing news media, particularly for younger individuals,¹³ who may be more vulnerable to the content of media reporting.^{14,15}

This study sought to evaluate the compliance of online media reports of suicidal acts from UK-based sources with responsible reporting guidelines, and to identify the prevalence of the inclusion of other potentially harmful features of online media, namely comments sections and links to other internet features, for example pro-suicide websites.

Method

A search was performed on the Google News UK search engine using the keyword ‘suicide’ with the location filter set to include articles of UK provenance only. The analysis included reports which made reference to an attempted or completed suicide published by local and national media sources during 28 consecutive days in November 2014. Articles about suicide bombing and euthanasia were excluded, as were those behind a media paywall.

Each report meeting the inclusion criteria was assessed against an adapted version of the ‘Ten things to remember when reporting suicide’ contained in the document issued by the Samaritans.¹⁶ This is one of the more prominent and widely used sets of guidelines for journalists in the UK.¹⁷ As a direct search for articles was undertaken, it was not possible to assess whether each article was given undue prominence, for instance a homepage splash, so this criterion from the Samaritans’ guidelines was not used, leaving nine criteria for article comparison (*Box 1*).

Data were collected on compliance with each section of the guidelines and those meeting all criteria were considered to be compliant with responsible reporting of suicide. Analysis was undertaken to determine the overall compliance with guidelines, the frequency with which each guideline was breached, and whether there were any differences based on whether articles originated from a local or a national media source. Differences between local and national media sources in the proportion of articles breaching any guidelines were calculated using the chi-squared test. Data analysis was performed in STATA 11 for Windows XP.

Box 1 Guidelines for the reporting of suicide assessed in the study. Adapted from the Samaritans¹⁶

1. Leave out technical details about the method of suicide, such as describing the type of ligature used or the number and types of pills taken in an overdose. Never suggest that a method is quick, easy, painless or certain to result in death.
2. Language matters. Avoid dramatic headlines and terms such as ‘suicide epidemic’ or ‘hot spot’.
3. Include references to support groups and places where suicidal people can find help.
4. Treat social media with particular caution and refrain from mentioning websites or networks that promote or glamorise suicide.
5. Avoid dramatic or sensationalist pictures or video. Refrain from including content from suicide notes.
6. Do not give undue prominence to photographs of a young person who has died and avoid repeated use of images such as galleries.
7. Do not brush over the complex realities of suicide and its impact on those left behind.
8. Speculation about the ‘trigger’ for a suicide, even if provided by a close family member, should be avoided.
9. Use statistics with caution. Make sure you have the most recent data and are comparing like with like.

In addition to comparison against the Samaritans’ guidelines, the inclusion of user-generated comments, threads and internet links to other articles was noted.

Results

Overall, 229 articles met the inclusion criteria: 68 articles from local media sources and 161 articles from national media sources. The majority (214 articles) came from media organisations which offer both a print and online platform, with national publications such as the *Guardian*, the *Telegraph* and the *Daily Mail* making up the bulk of national media output, and an array of smaller local outlets each contributing a smaller number of articles to the total. Fifteen articles were found in a range of online-only outlets such as the International Business Times, Yahoo UK, The Huffington Post and Wales Online. Ten articles were found on the websites of media network providers such as the BBC, ITV and STV.

Compliance with the responsible reporting guidelines

Of the 229 online articles included for analysis, 199 (86.9%) breached at least one of the Samaritans' guidelines. The mean number of guideline breaches per article was 2.2, with only a small variation between local and national media sources (2.1 v. 2.2 breaches per article, respectively; $P = 0.08$).

The most commonly breached aspects of the guidelines were a failure to include reference to sources of support for those considering suicide (69.4%), the inclusion of excessive technical detail about the method used (31%) and undue speculation about the reasons for suicide (30.1%) (*Table 1*). The other guidelines were breached in less than 25% of articles, with just 2 articles mentioning organisations that promote suicide and 1 article using statistics irresponsibly, telling readers the proportion of people completing suicide after jumping from a well-known landmark.

Compliance with reporting guidelines

	All sources	Local	National	Difference between local and national <i>P</i>
Articles, <i>n</i>	229	68	161	–
1 breach, <i>n</i> (%)	199 (86.9)	55 (80.9)	144 (89.4)	0.08
Breaches per article, mean	2.2	2.1	2.2	–
Specific guideline breaches, <i>n</i> (%)				
1. Excessive technical detail about the method	71 (31.0)	25 (36.8)	46 (28.6)	0.22
2. Sensationalist or irresponsible language	38 (16.6)	20 (14.7)	28 (17.4)	0.04* <#TFN1>`_
3. No sources of support	159 (69.4)	48 (70.6)	111 (68.9)	0.81
4. Mentioning places that promote or glamorise suicide	2 (0.9)	0 (0)	2 (1.2)	0.36
5. Dramatic pictures, videos, content of suicide notes	41 (17.9)	6 (8.8)	35 (21.7)	0.02* <#TFN1>`_
6. Picture galleries	30 (13.1)	1 (1.5)	30 (18.6)	0.001** <#TFN2>`_
7. Narrative brushes over the complex realities of suicide	20 (8.7)	5 (7.4)	15 (9.3)	0.63
8. Undue speculation about the triggers	69 (30.1)	18 (26.4)	51 (31.7)	0.43
9. Irresponsible use of statistics	1 (0.4)	0 (0)	1 (0.6)	0.52

P < 0.05,

$P < 0.01$.

Additional features of online media

Sixty-four articles included additional features which could contribute to readers encountering unsuitable material, such as the inclusion of user-generated comments sections and links to other articles which may similarly be poorly adherent to reporting guidelines (Table 2).

Articles with additional adverse features

	All sources <i>n</i> (%)	Local <i>n</i> (%)	National <i>n</i> (%)	<i>P</i>
Articles with additional adverse features	64 (27.9)	11 (16.2)	53 (32.9)	*0.01
Links to other articles about suicide	37 (16.2)	5 (7.4)	32 (19.9)	*0.02
User-generated comment threads	39 (17)	7 (10.3)	32 (19.9)	0.08

$P < 0.05$.

Discussion

This study evaluated the compliance of 229 online reports of suicide with the guidelines issued by the Samaritans. To our knowledge, this is the first study looking at the content of online media reports of suicide and the first in the UK looking at a selection of contemporary media output. Of note, the majority of articles included in the study failed to meet the Samaritans' guidelines for the responsible reporting of suicide. The results support findings from the limited number of studies undertaken elsewhere in the world that suggest media reporting of suicide is poorly compliant with available guidelines.^{18–21}

Of particular concern is the finding that 69.4% of reports failed to include a reference to a potential source of support for those readers who may be experiencing suicidal thoughts themselves; this was consistent across local and national sources. Lack of responsible information awareness and signposting support undermines suicide prevention efforts and fails to provide an alternative perspective to the often distressing narrative of articles. The finding that most articles omit references to support groups has been replicated in other studies from around the world: just 1% of Indian newspaper sources,¹⁹ 3% of US sources²¹ and 8.6% of Chinese sources⁸ included a reference to a support group.

Our finding that 31% of articles contained an excessive level of detail about methods used to complete a suicide is a significant cause for concern. The experience in other countries supports the idea that publication of suicide methods can perpetuate attempts and trends in methods chosen by others in 'copycat suicides'.^{2–5,22} In the course of assessing media reports for this study, the inclusion of details about the blood concentration of cyanide to achieve death, and the exact location and time of suicides by train, as well as details of places where suicides by jumping were completed, were all noted.

The finding that 30.1% of articles engaged in speculation about the reason for suicide was also a cause for concern. The journalistic tendency to simplify the reasons behind a suicidal act or engage in undue speculation about the surrounding circumstances can have a damaging impact on the bereaved family¹⁷ as well as readers who may over-identify with the person mentioned in the article, potentially increasing the deleterious impact for vulnerable individuals. This tendency to make articles more 'readable' may also be reflected in the fact that 8.7% of articles brushed over the complex realities of suicide, often failing to mention the family left behind or the impact of the suicidal act on others.

That being said, only one report included the irresponsible use of statistics and only two reports directed readers towards pro-suicide websites.

A qualitative observation was that where a particular fact about a suicide attempt is known, it will usually feature in other articles from other outlets about the same act. For example, very specific details about a method used were usually re-reported in all articles discussing the same event without due regard for the reporting guidelines.

Local v. national media sources

When comparing reporting by national and local media sources, local sources were overall more compliant with guidelines, with significant differences in the use of sensationalist language, dramatic pictures, videos or the content of suicide notes and the use of galleries, as well as the use of additional features of online media. The exact reason for the broadly better compliance with guidelines among local sources is not fully understood, but it may be because local media sources are closer to the subject of the article and local reporters may be more sensitive to the feelings of the bereaved family and local community.

Additional features of online media

The unique additional features of online media (compared, for example, with newspaper articles or television reports) could also compound their negative impact on readers; 16% of articles included links to other reports of suicide. Our finding that a majority of articles about suicide fail to meet responsible reporting guidelines and that the mean number of guideline breaches is 2.2 per article raises the possibility that the negative impact of irresponsible reporting is likely to be amplified by the inclusion of links to other potentially non-compliant reports.

Previous findings that discussion forums can increase suicidality among younger users²³ suggest that the addition of comments sections which can facilitate discussion should be avoided with online reports of suicide. Despite this, 17% of analysed reports had a comments section for user-generated content, and concerning comments such as the deceased person being 'brave' or 'at peace now' were frequently a feature of these.

Policy considerations

There is an evident need to evaluate the reasons for journalistic non-compliance with the existing guidelines of suicide reporting in the UK. Given the increasing use of online media and the apparent poor quality of reporting, there is a need to focus efforts on increasing the compliance of reports with responsible reporting guidelines. Suitable measures should also be established for non-compliant and potentially harmful articles to be flagged for urgent review.

Limitations

Although a standardised tool was used to identify breaches of media guidelines, judgements about breaches were not cross-checked between researchers. In addition, although the search sought to capture publications over a period of time, this work cannot account for potential seasonal changes in data.

Next steps

The present study uncovers an urgent need to address the fact that the majority of online articles assessed do not comply with existing guidelines on the responsible reporting of suicide. It highlights a significant public health concern because potentially vulnerable people have access to material which may provoke suicidal behaviours and which does not signpost them to support resources. Given the increasing weight of evidence that media reporting can affect suicide rates, there is an urgent need for the implementation of responsible reporting guidelines in online media articles. We propose that work be done to clarify and publicise the guidelines, and to train and encourage journalists to use them, and that a strong consideration be given to the role of more formal regulation and monitoring.

1.6.27 Caregiver burden and distress following the patient's discharge from psychiatric hospital

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2017-4

Abstract

Aims and method Caring for someone with a mental illness is increasingly occurring within the community. As a result, family members who fulfil a caregiving role may experience substantial levels of burden and psychological distress. This study investigates the level of burden and psychological distress reported by caregivers after the patient's admission.

Results This study found that the overall level of burden and psychological distress experienced by caregivers did not differ according to the patient's legal status. However, the caregivers of those who were voluntarily admitted supervised the person to a significantly greater extent than the caregivers of those who were involuntarily admitted. Approximately 15% of caregivers revealed high levels of psychological distress.

Clinical implications This study may emphasise a need for mental health professionals to examine the circumstances of caregivers, particularly of those caring for patients who are voluntarily admitted, a year after the patient's admission.

Contents

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 - *Method*
 - * *Participants*
 - * *Informed consent*
 - * *Psychometric instruments*
 - * *Setting*

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One in four families worldwide is affected by mental illness.¹ With the onset of illness, a family member may assume a caregiver role for their unwell relative, which may result in positive and negative experiences for the caregiver.² While caregivers convey a sense of satisfaction and well-being from their caregiving relationship, they also report feeling burdened.³ Such burden may be characterised by both objective difficulties, such as being unable to leave the family home and work, and subjective difficulties, such as psychological distress.⁴

Should a patient become severely unwell, it is often the caregiver who intervenes to initiate emergency psychiatric treatment.⁵ Caregivers can experience significant obstacles in gaining the assistance of a mental healthcare team for their relative⁶ and involuntary admission in particular can be associated with high levels of caregiver burden.⁷ This is important, as the level of burden experienced by caregivers can significantly predict treatment adherence and outcome in the patient.⁸ Furthermore, caregivers who experience high levels of burden reveal an increased incidence of physical and mental health problems and health-related risk behaviours.⁸ However, less is known about the level of burden or psychological distress that caregivers experience in the period following admission. Additionally, the limited research to date has focused on caregivers of involuntarily admitted patients and there is very little known about the caregivers of those admitted voluntarily.

For this reason, we aim to determine the level of burden and psychological distress reported by caregivers approximately 18 months after the patient's admission to an acute mental health unit. We also aim to determine whether clinical (specifically legal status) and demographic factors were associated with the level of burden and psychological distress reported by caregivers.

Method

Participants

Participants consisted of caregivers of either involuntarily or voluntarily admitted patients. Caregivers were recruited from two concurrent studies: the Service Users' Perspectives of their Admission (SUPA) study⁹ and the Prospective Evaluation of the Operation and Effects of the Mental Health Act 2001 from the Viewpoints of Service Users and Health Professionals study. The former was conducted in south-east Dublin and North Wicklow and involved both involuntarily and voluntarily admitted patients. The latter was conducted in Galway and Roscommon and included involuntarily admitted individuals and individuals who were brought to hospital under the Irish Mental Health Act, 2001, but were not subsequently involuntarily detained (i.e. they accepted a voluntary admission).

As patients were recruited before caregivers in these studies, our inclusion and exclusion criteria for caregivers stemmed from those applied to patients (*Fig. 1*). Patients were excluded if they could not provide informed consent, had a diagnosis of dementia or had a moderate to severe intellectual disability that rendered them unable to participate in the study. Patients who received a sole diagnosis of a personality disorder or substance misuse were also excluded from participating, as these individuals cannot be admitted involuntarily under the Irish Mental Health Act, 2001. Caregivers who were younger than 18 at the time of interview or who had a moderate to severe intellectual disability that impeded their ability to consent were similarly excluded from participation in the study.

Informed consent

Informed consent was obtained from all individual participants included in the study. The consent process consisted of three steps. First, patients were asked to consent to their caregiver being contacted and informed of the study approximately 1 year after their discharge. Second, caregivers were contacted by telephone by a researcher who introduced the study and arranged a time of interview. Finally, informed consent was sought from caregivers at interview.

Psychometric instruments

The Involvement Evaluation Questionnaire (IEQ) was employed as a measure of caregiver burden and caregiving.¹⁰ It consisted of 27 core items divided into four sections: urging, supervision, tension and worrying. Scores on the IEQ ranged from 0 to 108, with larger figures representing a higher level of caregiver burden. The IEQ is a reliable instrument, with Cronbach's alpha 0.74–0.85 for each subscale and 0.90 for the total score.¹¹ The IEQ also included a short, 12-item General Health Questionnaire (GHQ-12) that measured psychological distress. Scores on the GHQ-12 ranged from 0 to 12, with higher scores indicating that the caregiver was experiencing emotional difficulties.¹² The GHQ-12 is a reliable measure of psychological distress with an alpha coefficient of 0.87.¹³ Finally, diagnostic and clinical information pertaining to the patient was taken from a Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID).¹⁴

Setting

The study included caregivers of individuals admitted to an acute mental health unit in one of five hospitals in Ireland that covered a combined urban and rural catchment population of over 590 000 individuals.

Ethical approval

The study received ethical approval from the governing ethical committees in all of the study sites: St John of God Hospitaller Order Provincial Ethics Committee, Newcastle Hospital Ethics Committee and University Hospital Galway Ethics Committee.

Statistical analysis

All data were entered into a Microsoft Access database and analysed using SPSS Version 22 for Mac. As the data were not normally distributed, multiple Mann–Whitney U and Kruskal–Wallis tests were used to determine whether burden and psychological distress scores differed between caregivers of involuntarily and voluntarily admitted individuals, and according to clinical and demographic factors. Effect sizes (r) were used to measure the magnitude of differences between scores. A small, moderate or large effect size corresponded with values equal to or less than 0.10, 0.30 and 0.50, respectively.

Results

Demographic and clinical characteristics

Sixty-five caregivers participated in the study; 42 (65%) were female. The mean age of caregivers was 54 years (s.d. = 15). The majority of caregivers were married ($n = 49$, 75%), 5 (8%) were single, a further 5 (8%) were divorced and the remaining 6 (9%) were widowed. Most caregivers were the person's parents ($n = 37$, 57%), 11 (17%) were spouses or partners, 8 (12%) were siblings, 6 (9%) were children and 3 (5%) were other relatives. The mean length of time between caregiver and patient interviews at baseline was 584 days (s.d. = 165). The median duration of the index admission was 34 days (interquartile range (IQR) 17.5–50) and 24 (36.9%) patients were readmitted within 1 year of the index admission.

Forty-six (71%) individuals were involuntarily admitted and 19 (29%) were voluntarily admitted. The majority were male ($n = 33$, 51%). The mean age of patients was 39 years (s.d. = 12). The majority of patients were single ($n = 41$, 63%), 16 (25%) were married and the remaining 8 (12%) were divorced.

Caregiver characteristics across legal status are given in *Table 1*.

Comparison of caregiver characteristics across legal status

Characteristic	All caregivers	Caregivers of involuntarily admitted patients	Caregivers of voluntarily admitted patients	Statistical test	<i>P</i>
Age, years: median (IQR)	54 (43–67)	54 (43–66)	54 (39–68)	$U = 340$	0.94
Gender, <i>n</i> (%)					
Male	23 (35)	14 (30)	9 (47)	$\chi^2 = 1.7$ d.f. = 1	0.19
Female	42 (65)	32 (70)	10 (53)		
Marital status, <i>n</i> (%)					
In relationship	49 (75)	34 (74)	15 (79)	$\chi^2 = 0.2$ d.f. = 1	0.67
Not in relationship	16 (25)	12 (26)	4 (21)		
Education, <i>n</i> (%)					
Primary/secondary	16 (30)	12 (33)	2 (13)	$\chi^2 = 2.8$ d.f. = 1	0.09
Tertiary	37 (70)	24 (67)	13 (87)		
Household, <i>n</i> (%)					
Living together	37 (57)	23 (50)	14 (74)	$\chi^2 = 3.1$ d.f. = 1	0.08
Living separately	28 (43)	23 (50)	5 (26)		
Relationship, <i>n</i> (%)					
Parent	34 (71)	25 (78)	9 (56)	$\chi^2 = 2.5$ d.f. = 1	0.12
Partner	14 (29)	7 (22)	7 (44)		

IQR, interquartile range.

Caregiver burden

The median level of burden in the sample was 13.00 (IQR 6.00–22.00). The median level of burden in caregivers of involuntarily admitted patients was 11.50 (IQR 6.25–20.75) and in caregivers of those voluntarily admitted it was 18.00 (IQR 5.00–34.00). Caregivers' overall scores of burden did not significantly differ ($U = 328$, $P = 0.18$, $r = 0.17$). However, caregivers of voluntarily admitted patients supervised the person to a greater extent than caregivers of involuntarily admitted patients (median IEQ supervision scores 2 v. 0, $U = 258$, $P < 0.001$, $r = 0.38$). The particular items of the subscale of supervision on which caregivers of voluntarily admitted individuals scored higher were ensuring that the person had enough sleep ($P = 0.02$) and that they did not drink too much alcohol ($P = 0.05$).

Factors associated with caregiver burden

There was no significant association between the level of caregiver burden and the caregiver's gender, patient's gender, diagnosis, level of functioning, relationship to caregiver or living in the same household as the patient (*Table 2*).

Involvement Evaluation Questionnaire (IEQ) and General Health Questionnaire (GHQ-12) scores according to demographic and clinical characteristics

	IEQ					
Ca regiver gender						
Male	9 (5–22)	3 (1–8)	0 (0–2)	2 (0–5)	3 (1–7)	1 (0–2)
Female	14 (8–23)	4 (1–7)	0 (0–1)	3 (2–6)	6 (3–8)	1 (0–3)
Patient gender						
Male	10 (5–23)	4 (1–9)	0 (0–2)	2 (1–4)	5 (2–8)	1 (0–2)
Female	14 (8–22)	3 (1–8)	0 (0–2)	4 (2–7)	5 (3–8)	1 (0–3)
Di agnosis						
Af fective	11 (7–21)	3 (1–6)	0 (0–2)	3 (1–6)	4 (1–7)	1 (0–2)
Ps ychotic	14 (8–21)	5 (1–12)	0 (0–3)	3 (0–6)	6 (3–9)	1 (0–3)
GAF score						
Higher func tioning	12 (5–23)	3 (1–8)	0 (0–2)	4 (0–7)	5 (1–9)	1 (0–2)
Lower func tioning	14 (7–21)	4 (1–9)	0 (0–2)	3 (1–6)	5 (2–8)	1 (0–3)
Relat ionship of ca regiver to patient						
Parent	11 (5–21)	3 (1–6)	0 (0–2)	3 (1–6)	5 (3–8)	1 (0–3)
Partner	21 (7–28)	6 (1–11)	1 (0–2)	4 (2–7)	4 (2–10)	1 (0–2)
Ho usehold						
Living t ogether	15 (6–24)*	2–10)*	0 (0–2)	4 (1–6)	6 (2–9)	1 (0–2)
Living sep arately	9 (6–20)	2 (1–5)	2 (1–6)	2 (1–6)	4 (1–7)	1 (0–3)

GAF, Global Assessment of Functioning; IQR, interquartile range.

P 0.05. On applying a Bonferroni correction, no variable reached significance.

Psychological distress

Nine caregivers (15%) reported high levels of distress (defined as a score of 4 on GHQ-12). The median score of psychological distress was 1.00 (IQR 0.00–2.50): 1.00 (IQR 0.00–3.00) in caregivers of involuntarily admitted patients and 0.00 (IQR 0.00–1.00) in caregivers of voluntarily admitted patients. Caregivers of involuntarily or voluntarily admitted patients did not significantly differ in their levels of psychological distress ($U = 302, P = 0.19$).

Factors associated with psychological distress

No significant association was found between the caregiver's level of psychological distress and the caregiver's gender, patient's gender, diagnosis, level of functioning, relationship to caregiver or whether they lived in the same household as the patient (*Table 2*).

Post hoc analysis

We hypothesised that subsequent admissions from the index admission could affect the burden and psychological distress of caregivers and therefore further analysis examining this was performed. Caregiver burden was higher when the patients had been readmitted (16.0 *v.* 9.5, $U = 281.5, P = 0.04$) and there was a trend for a higher level of distress (1.0 *v.* 0.0, $U = 277, P = 0.06$). Legal status for the index admission was not associated with readmission ($\chi^2 = 0.28, n = 61, P = 0.60$).

Discussion

Summary of findings

The findings indicated that overall levels of burden and psychological distress did not differ between caregivers of involuntarily and voluntarily admitted patients at approximately 18 months after discharge from an acute mental health unit. However, caregivers of voluntarily admitted patients engaged in significantly higher levels of supervision than caregivers of those involuntarily admitted. Such supervision focused on, for example, ensuring that the patient slept sufficiently. *Post hoc* analysis also suggested that caregiver burden is associated with readmission to hospital.

Comparison with previous research

To our knowledge, no study to date has examined whether differences in the patient's legal status at admission accounted for differences in caregiver burden (objective and subjective) at more than 1 year follow-up. Our findings, however, support those of Boydell *et al.*,⁷ who also emphasised that overall burden was not linked to involuntary admission in caregivers of patients with first-episode psychosis. Our scores of burden and psychological distress are substantially lower than those reported by other authors.¹¹ Thus, the similarity in scores between caregivers in this sample may be due to a reduction in overall caregiver burden following the person's admission to hospital regardless of legal status.¹⁵

Implications

The finding that caregivers of voluntarily admitted individuals supervised the person to a greater extent is interesting and warrants discussion. It is possible that this additional supervision is a positive experience and that it results in an earlier detection of warning signs and prevents potential relapses from progressing to an involuntary admission. This finding highlights the need for caregivers of both voluntarily and involuntarily admitted individuals to receive support and psychoeducation. Interestingly, the *post hoc* analysis suggests that it may be the frequency of admissions that results in higher burden, as opposed to the legal status of the admissions. Furthermore, a longitudinal replication of this study assessing burden at various time points may provide us with a clearer picture of the caregiver's experience of burden.

Strengths and limitations

The study encompassed a number of strengths and limitations. Our sample included caregivers of involuntarily and voluntarily admitted individuals from both rural and urban geographical locations. Another strength of the study was that the caregivers did not self-select to the study. Nonetheless, our process of consent may have introduced bias, as those who consented for their caregiver to be interviewed may have had closer family relationships. Additionally, there was a significant gap between the index admission and the caregiver interviews, which introduces a number of potential confounders, such as readmission to hospital.

We thank Alastair Fetherston for designing the database for this study.

1.6.28 Unlocking an acute psychiatric ward: the impact on unauthorised absences, assaults and seclusions

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Abstract

Aims and method The acute psychiatric in-patient service in Christchurch, New Zealand, recently changed from two locked and two unlocked wards to four open wards. This provided the opportunity to evaluate whether shifting to an unlocked environment was associated with higher rates of adverse events, including unauthorised absences, violent incidents and seclusion. We compared long-term adverse event data before and after ward configuration change.

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Results Rates of unauthorised absences increased by 58% after the change in ward configuration ($P = 0.005$), but seclusion hours dropped by 53% ($P = 0.001$). A small increase in violent incidents was recorded but this was not statistically significant.

Clinical implications Although unauthorised absences increased, the absence of statistically significant changes for violent incidents and a reduction in seclusion hours suggest that the change to a less restrictive environment may have some positive effects.

Contents

- *Unlocking an acute psychiatric ward: the impact on unauthorised absences, assaults and seclusions*
 - *Method*
 - *Results*
 - *Discussion*
 - * *Strengths and limitations*
 - * *Final consideration*

The locking of psychiatric institutions is an important topic because detention involves significant restrictions on human rights, enshrined in the Universal Declaration of Human Rights. However, studies that have evaluated the impact of unlocking a psychiatric ward are rare; we were only able to identify four such studies spanning 7-decade-long assessing in this area. Lang *et al*¹ evaluated a policy change that resulted in a ward changing from being largely locked for 6 months to being largely open for 6 months and found that negative outcomes were more common during the closed time period. Other studies are considerably older^{2,3} and were largely positive in their findings, with the exception of the study by Molnar *et al*,⁴ which reported an increase in the frequency of ‘elopement’ (unauthorised absence) from 2.5 to 7% of admissions in the context of changing ward policy to allow a largely unlocked environment.

Any consideration of locked psychiatric wards must be viewed in the context of emerging policy that recommends minimising the use of locked psychiatric wards⁵ and emphasises a duty to provide psychiatric care in the least restrictive environment. A desire to provide least restrictive care created the impetus for our local psychiatric service to shift from an acute in-patient environment consisting of two locked wards and two unlocked wards to four largely unlocked wards. It also provided the opportunity to evaluate the impact of the change through reporting of long-term data detailing adverse events, such as unauthorised absences, ward violence and rates of seclusion, prior to and following the changes in ward environment.

Method

Data for this study were taken from the acute in-patient service in Christchurch, New Zealand. The service is the sole provider of acute in-patient services to adults aged 18–65 in the city of Christchurch, outlying towns and rural areas, with the exception of forensic patients, patients with an intellectual disability and in-patients requiring planned detoxification from substances, who are admitted elsewhere. The acute in-patient service receives admissions from community and emergency psychiatric services when care in the community is no longer feasible, with a typical case mix consisting of patients with affective disorders, psychotic disorders and personality disorders.

The service underwent major architectural change in 2013. Before, the service was configured with two locked wards (totalling 20 beds), two wards (totalling 44 beds) that were predominantly unlocked except overnight, and a seclusion area with 3 seclusion rooms. In response to service development initiatives and the desire to provide less restrictive care, the wards were reconfigured into 4 largely unlocked 16-bed wards (except overnight when the wards remain locked). At the end of each ward is a zone called the ‘high care area’, which is quieter than the general ward and provides care for up to three of the more unwell patients. Each high care area is continuous with its adjacent ward and can be designated ‘high care’ when doors are closed or locked, or be regarded as part of the general ward when extra clinical input is not required. The décor and bedrooms of the high care area are identical to the adjacent ward, but an

additional lounge, bathroom and courtyard are provided in order for the high care area to act as a self-sufficient unit when required. All wards, including the high care areas, are intended to be unlocked as much as possible but each ward or high care area can be locked separately in order to detain a patient if this is deemed necessary. The high care area bedrooms were not outfitted for seclusion but the seclusion area remained unaltered and could still be used if required. *Figure 1* presents details of the ward layout. If the ward or a high care area is locked, it is recorded in the restraint register as an environment restraint, and is therefore available for review.

In addition to these structural changes, nursing staff numbers increased, from 27 nurses routinely rostered on the wards to 34 nurses. However, if a nurse was required to provide one-to-one supervision after the change, this needed to occur within existing staff levels, whereas previously this was not the case. The frequency of one-to-one supervision pre- and post-change was not systematically recorded and is not readily available for review.

The acute in-patient service routinely records data on unauthorised absences, seclusions and violent incidents. Unauthorised absences include patients who are under involuntary mental health legislation and leave the ward without permission or fail to return from authorised leave, and voluntary patients who leave the ward outside of their agreed treatment parameters or fail to return from agreed leave. Nursing staff follow procedures when absences occur, including filling out a form documenting the absence which is then collated in a central database.

Violent incidents are assessed clinically and categorised into a number of subcategories including verbal abuse, threats of violence and assaults; all are recorded and collated centrally.

Seclusion is initiated by nursing staff as an intervention of last resort for managing a situation of imminent or actual violence. In response to international and New Zealand initiatives,⁶ seclusion reduction initiatives became embedded into the routine care environment of the acute in-patient service from 2010 and the goal of reducing seclusion occurred alongside the plan to provide a less restrictive environment through the ward redevelopment. Although seclusion rates are likely to be reduced by the seclusion reduction initiatives, the change in ward environment had the potential to hinder or assist the goal of reducing seclusion. As a consequence, we report seclusion rates which are collated centrally on a database and are therefore available for review.

The AWOL (absent without leave), violent incidents and seclusion databases have all collected data over an extended period. In de-identified form, they provided the opportunity to examine rates of unauthorised absences, seclusions and violent incidents for 18 months prior to the change in ward configuration and compare this to 18 months following the change. The mean rates and standard deviations of the monthly adverse events were calculated for the pre- and post-change 18-month intervals. As the data were non-parametric in nature, the Mann-Whitney *U*-test was used to compare the 18 months prior to the change with the 18 months following the change. The change in ward environment was staggered during June and July 2013; this time period was therefore not included in any data analysis as our goal was to examine a longer-term impact of the policy change as opposed to short-term effects during and following the transition.

We also report frequency and duration of the use of environmental restraint to clarify whether or not the intended change to a largely unlocked environment was successful or resulted in frequent locking of the newly configured wards. The frequency of Safety Assessment Code (SAC) 1 and 2 incidents (adverse events involving serious, major or extreme harm to patients) involving psychiatric in-patients is also provided pre- and post-change and examined for the possibility of a change in more serious adverse events that would not be detected by previous methods.

Ward occupancy data are routinely collected by means of a census taken at midnight every 24 hours. Admission data to the acute in-patient service and the forensic service are also recorded daily. Forensic in-patients are predominantly admitted from forensic out-patient services, courts and prisons, and not from general out-patient services. However, we examined admission and occupancy data for these services to test for the possibility that changes in outcome data were confounded by variations in occupancy or transfer to the more secure environment of the forensic service. The rate of monthly admissions pre- and post-change was compared using the Mann-Whitney *U*-test.

Although this was a study of group data and individual files were not accessed, ethics approval was sought and granted by the local University of Otago ethics committee (reference number HD 14/21).

Results

Longitudinal data on monthly unauthorised absences are presented in *Fig. 2*. The mean rate for the 18 months prior to the new ward configuration (December 2011-May 2013) was 16.9 (s.d. = 7.7) compared with 26.7 (s.d. = 11.2) for 18 months following the change in ward configuration (August 2013-January 2015). This represented a mean increase of 9.7 unauthorised absences per month and a percentage increase of 58% that was statistically significant ($P = 0.005$). As some literature suggests unauthorised absences may be seasonal, means were also calculated for the year pre- and post-change to ensure identical calendar months were compared, and the results were similar (16.6 (s.d. = 9.1) v. 29.6 (s.d. = 7.5), respectively).

Violent incidents were examined through the extraction of data recorded under the category of aggression, which includes verbal abuse, verbal threats, physical threats and physical assaults. Specific data were also extracted on physical assaults to assess for more significant violence. *Figure 3* shows the longitudinal data for all violent incidents and the mean monthly rates for 18 months pre- and 18 months post-ward changes, which were 72.3 (s.d. = 34.5) and 78.2 (s.d. = 43.1), respectively. This represented a mean increase of 5.9 violent incidents/month, or an 8% increase in incidents, which was not statistically significant ($P = 0.696$). With regard to physical assaults, the mean difference of 2.8 assaults/month, from 11.5 (s.d. = 5.9) before to 14.3 (s.d. = 10.1) after, was also not statistically significant ($P = 0.628$) (*Fig. 3*).

Another assessed variable was the longitudinal data on monthly seclusion hours over the study period as well as the mean rates of monthly seclusion (hours/month) (*Fig. 4*). The mean length of seclusion prior to the change was 391.5 (s.d. 203.0) compared with 185.2 (s.d. 135.6) following the change. This represented a mean drop of 206 hours/month or a percentage drop of 53% that was statistically significant ($P = 0.001$).

Occupancy was recorded according to bed nights/month and converted to a percentage of available bed nights. Occupancy varied between 80 and 101%, with a mean occupancy of 91% over the study period. It is likely that the single month that experienced more than 100% occupancy was very busy and included extra persons in rooms (e.g. partners, who do not routinely stay) being entered in the census data. Percentage occupancy data were largely stable over the study period and were without systematic trends that could account for the significant increases in unauthorised absences or significant reduction in seclusion hours. In keeping with the occupancy data, the rate of new admissions to the acute in-patient service was also largely stable over the study period (mean monthly admissions for the 18 months pre-change 100.4 compared with 107.8 for the 18 months post-change, $P=0.071$). The mean number of monthly admissions to the forensic service increased from 3.1 before the new ward configuration to 4.4 after; however, the increase was not caused by in-patients from the acute in-patient service as a total of 3 patients were transferred from the acute in-patient service to the forensic service for the 18 months prior to the ward change compared with 4 patients in the 18 months following the change.

The frequency of environmental restraint (locking of the high care areas or whole wards) revealed that, on average, there were 16 times per month when either a high care area or a whole ward was locked following the change in ward configuration. This meant that on average, each of the four wards had 4 periods each month in which part or the whole of the ward was locked. The frequency of locked periods/month varied from 0 for some wards to a maximum of 19, when the high care area of one ward was locked on multiple occasions in response to a single patient's multiple attempts to leave. In 37% of the environmental restraints, just the high care areas were locked as opposed to whole wards (affecting only 1–3 patients at a time). The mean time an area was locked was 120 minutes, and the range varied from 1 minute to 920 minutes. These results can be compared with the period prior to the new ward configuration, which had two wards (affecting up to 20 patients) constantly locked and occasional periods when the two open wards were locked in response to clinical pressure.

The total number of SAC1 and SAC2 events involving in-patients was 14 over the study period. Of these, 10 occurred before the change in ward configuration, 0 occurred during the transition period, and 4 occurred after the changes were made. For SAC1 incidents resulting in the death of a patient, 7 occurred prior to the ward changes (4 deaths occurred on the ward, 2 while patients were on granted leave, and 1 while on unauthorised absence from the ward) and 4 deaths occurred following the ward changes (3 on the ward and 1 while on granted leave). No SAC2 incidents occurred for patients who were on leave in the community or during an unauthorised absence.

Discussion

This study examined a range of adverse indicators over an extended time period in order to clarify whether or not a change in ward environment from two locked and two unlocked wards to a largely unlocked environment was associated with an increase in adverse events. The principal finding was that a significant increase in unauthorised absences occurred. However, significant decreases in the use of seclusion and non-significant increases in violent outcomes were also observed, although the reduction in seclusion occurred alongside national and local initiatives to minimise the use of seclusion.

The new ward configuration still made provision for the locking of wards. However, this was only done for relatively short periods (mean 120 min) and less often than prior to the ward redevelopment, when 2 wards affecting 20 patients were continuously locked. In addition, in 37% of the occasions when locking occurred, only a high care area was locked, meaning that 3 or fewer patients were affected. These numbers suggest that the unlocking of two wards and the change in ward environment did not result in wide-spread or prolonged locking of the new ward configuration.

The occupancy and admission data were without systematic trends to explain the changes noted. In addition, there was minimal flow of patients from the acute in-patient service to the forensic service, suggesting that more difficult patients who may be over-represented in adverse incident data were not transferred to forensic services after the wards were reconfigured.

Previous studies of unauthorised absences from psychiatric wards have raised concerns about rare but serious adverse events that have occurred while patients are absent.⁷ Although the low base rate of these events makes analysis difficult, it is reassuring for those considering a transition to the provision of a largely unlocked environment that of the 14 SAC1 and SAC2 events occurring over the study period, 10 occurred prior to the ward change and only 4 occurred afterwards. In addition, of the adverse events resulting in the death of a patient, 7 occurred before the ward changes and 4 afterwards. Although total numbers of unauthorised absences increased, there was only one death involving a patient who had left the ward without being granted leave, and it occurred prior to the ward change. All other community deaths over the study period involving in-patients occurred for patients who had been granted leave.

Strengths and limitations

One strength of the study was the routine collection of outcome data by hospital staff who were unaware that the data would later be used for study purposes. As a consequence, changes in reporting behaviour could not arise as a result of study influences because of the retrospective nature of the study conception and design. A further strength is the longitudinal nature of the data-set that allowed us to make before-and-after comparisons and consider longer-term effects, as opposed to solely focusing on the transition period during which staff are adapting to changes. These longer-term effects were thought to be more important in evaluating the impact of the change in environment and can be taken into account by service leaders in other locations considering similar changes. Although the longer-term outcomes were our primary area of interest, it is also reassuring that the transition period did not coincide with any SAC1 or SAC2 events, or a spike in the other adverse events evaluated by the study.

Our main limitation was that the study design was not experimental in nature. As the study was uncontrolled, our methodology allows comments to be made on associations between adverse events and the ward changes, but demonstrating causation is not possible. In particular, there was a service initiative to reduce seclusion that started prior to the study period. There were also increases in the numbers of routinely rostered nursing staff on the acute in-patient service after the ward change. This means that the relative influences of the change in ward configuration, the seclusion-reducing initiatives and the changes in nursing numbers on the adverse event rates are hard to quantify. It is therefore possible that increases in seclusion might have been observed if the changes in ward configuration had occurred in isolation. However, it is also reassuring to note that no such increases were seen in the presence of the seclusion reduction focus and nursing number changes that also occurred over the study period.

Final consideration

Studies such as ours that have evaluated the impact of unlocking psychiatric wards are rare. We were only able to identify 4 previous studies over 7 decades in our literature review. These studies were largely supportive of unlocking psychiatric wards, although the Molnar *et al*⁴ study also identified an increase in unauthorised absences following changing ward policy. However, after the initial increase, the rate subsequently decreased following an intervention to better manage risk and absconding.⁴

As stated, the unlocking of our in-patient ward should not be viewed in isolation. Although the findings were mixed with respect to adverse outcomes, we suggest that clinical attention and adaptations to nursing practice and clinical care have the ability to mitigate adverse outcomes when changes in environment occur. This conjecture is supported by the ability of some psychiatric units to markedly reduce seclusion rates⁸ in the presence of administrative and clinical support, and scrutiny of seclusion practice. It is likely that the reduction of seclusion hours demonstrated in this study occurred largely as a result of nursing and management strategies already in place to reduce seclusion in our service. However, seclusion hours continued to fall despite the change in ward configuration, meaning that the less restrictive environment did not have a negative impact on seclusion rates or supported the continued reduction of seclusion. Further support for the ability of service improvement initiatives to minimise adverse outcomes is given by the studies of Bowers *et al*,^{9,10} who trialled anti-absconding interventions in acute psychiatric wards with positive results, and the study by Nijman,¹¹ who demonstrated a reduction in aggressive incidents through a systematic focus on aggression alongside an intervention to reduce aggression. These studies suggest the importance of nursing practice interventions in addition to any environmental measures for reducing rates of absconding and aggression.

Adverse outcomes varied after the change to a largely unlocked environment, with increases in absconding, reductions in seclusion and non-significant increases in violent incidents. The real-world nature of this study does not allow clear inferences to be made regarding whether or not the unlocking of the ward was causally linked to these changes in adverse outcome rates. However, the longer-term nature of the database, with the ability to scrutinise the adverse outcomes pre- and post-change in ward configuration, strengthened the ability of this study to examine the change. The change to a largely unlocked environment was stimulated by a desire to provide care in the least restrictive way possible. Our findings constitute a cautious endorsement of this approach. Although unauthorised absences increased, other adverse outcomes were stable or improved. Thus, providing acute in-patient psychiatric care in a largely unlocked environment appears feasible, particularly in the presence of other service improvement strategies.

1.6.29 Psychiatry trainees' experiences of cognitive-behavioural therapy training in a UK deanery: a qualitative analysis

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Abstract

Aims and method To explore core psychiatry trainees' experiences of cognitive–behavioural therapy (CBT) training by using interpretative phenomenological analysis of semi-structured interviews conducted with seven core trainee psychiatrists in Yorkshire and the Humber Deanery.

Results Four key themes emerged: (1) barriers to training; (2) guidance, with emphasis on the importance of supervision groups; (3) acquisition of new skills and confidence; (4) personal influence on the training experience.

Clinical implications Many trainees in Yorkshire have a positive experience of CBT training; however, some also experience barriers to acquiring the relevant skills. Further research should build on the positive factors and barriers identified here, with a view to guiding improvements in training nationwide.

Contents

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 - *Discussion*

In 2009 the Royal College of Psychiatrists revised the curriculum for psychiatric training to include specific psychotherapy elements within the core curriculum for all psychiatry trainees.^{1,2} The curriculum outlines general and specific competencies.² To achieve these competencies, trainees must complete a psychotherapy Assessment of Clinical Experience (ACE) as a workplace-based assessment (WPBA), attend case-based discussion (CBD) groups and undertake two psychotherapy cases in two modalities.² This revision was an attempt to ensure that core trainees get sufficient experience of psychological treatments to be able to utilise them accurately, evaluate their effects intelligently and, where appropriate, deliver them competently. Cognitive–behavioural therapy (CBT) is one of the recommended modalities of psychological treatments. Psychiatry trainees are expected to be competent to deliver CBT effectively, and CBT is a valuable skill that enriches and informs their practice.^{3–5}

The current literature suggests that prior recommendations for training in psychotherapies have not been widely implemented,^{6–8} despite trainees expressing an interest in acquiring such skills.⁸ Historically, trainees have been unaware of new curriculum guidelines^{7–9} and barriers to the training have been identified. These include lack of supervision,¹⁰ limited availability of suitable cases for training,⁹ and lack of protected learning time.^{4,11–16} A small study¹⁷ suggested working with low-complexity patients in the primary care setting as a way of overcoming these barriers, with protected time to do so. However, this has not been trialled on a wider scale, and limited data are available about whether this is a preferred route of training.¹⁷ Indeed, little qualitative research exists on the experiential accounts of psychiatric trainees undergoing the current training programme.

Aims

This study aims to explore the experiences of CBT training, delivery and supervision in core trainee psychiatrists who have trained in Yorkshire and the Humber Deanery. This work aims to identify barriers that lead to negative experiences of CBT training and identify the factors that facilitate a positive training experience. We also hope this study will guide improvements to CBT training for core trainee psychiatrists to enable trainees to meet the Royal College of Psychiatrists' objectives and, ultimately, become more competent and psychologically minded psychiatrists.

Method

This was an exploratory, qualitative study. Semi-structured telephone interviews and face-to-face interviews were used for data collection, and interpretative phenomenological analysis (IPA) was employed. IPA is a qualitative tool that enables the exploration of an individual's perception of events and how they 'make sense' of experiences.^{18,19} Approval for the study was granted by the Research and Development Department, Faculty of Medicine and Health, University of Leeds.

Recruitment

Twelve core trainee psychiatrists in Yorkshire who had recently completed CBT cases under supervision were invited to participate in the study via email. One trainee declined participation as they were no longer working in the area and four trainees did not respond to the recruitment emails. Seven participants consented to take part in the study.

Participants

The participants were a small, purposeful sample of seven core trainee psychiatrists (CT2 and CT3). Three participants were male. Two participants had worked in a psychotherapy post and one expressed an interest in specialising in psychotherapy.

Procedure

The semi-structured interviews were guided by a review of the pre-existing literature concerning psychotherapy training experiences. This was piloted and amended as necessary. The questions concerned core trainees' experiences of CBT training and the generalisability of acquired competencies, the feasibility of training, the impact of supervision, the emotional aspects of training, and understanding of the College's curriculum. The interviews lasted between 12 and 24 min and were recorded. The recordings were transcribed verbatim to produce the raw data for the study.

Analysis

The process of IPA¹⁹ was conducted by both interviewers, who listened to interview recordings and read and re-read the transcripts to familiarise themselves with the data. Initial interpretations of the data (descriptive summaries and points of interest) were entered as annotations in the margins of the transcripts. Emergent themes were then drawn and recorded in a table after cross-checking them against the transcript. This process was repeated for each transcript. Initially, the researchers searched for connections between the themes within the transcripts, and then between the transcripts. Thematic connections were identified and emergent themes were clustered, and a list of subordinate themes was compiled. Subordinate themes were clustered into superordinate themes. The superordinate themes and sub-themes were verified against the transcripts to ensure that they were grounded in evidence and then they were organised into a master table (*Table 1*). Last, quotations which best encapsulated each theme were identified.

Themes

Superordinate themes	Subordinate themes
1. Barriers	a. Time b. Cases c. Patients d. Access to learning resources
2. Guidance	a. The role of supervision b. Learning from peers c. Sticking to the curriculum
3. Acquisition	a. Gaining new skills b. Models of mental illness c. Personal influence d. Confidence

Results

Three superordinate themes were identified, with three or four subordinate themes each, and are described below.

Barriers

Barriers to CBT training and the impact that this had on learning was a prominent theme across all of the interviews. Some participants had personally experienced barriers to training and others described the impact that barriers had had on their peers.

Time

The impact of insufficient time for learning was a theme that occurred across all seven interviews. Participants disclosed how shift work caused disruption to their CBT training.

‘if we were on-call that day or on nights or on leave, um, you ended up missing some of the sessions because of that and I think because CBT is quite structured, so you learn one thing in one session and then progress on to the next bit in the next session, so if you miss a bit I think it becomes a bit more difficult to get your head around it’ (participant 2).

One participant described the challenges encountered in maintaining protected learning time amidst other work commitments: “‘Because I was working in the ward [...] it’s quite difficult to get out of that to get supervision and do other things’ (participant 6).”

Conversely, another participant perceived that colleagues respected protected learning time, suggesting that trainees’ experiences varied depending on where they were working: “‘There’s no problem getting time away from your day job to go [to] the CBT training’ (participant 7).”

One participant, who had worked in a psychotherapy job, acknowledged that this job provided more time for training than other jobs: “‘I did a psychotherapy job in my last 6 months, so I was able to spend a lot more time and pick up a

lot more cases than perhaps other people have experienced' (participant 4)."

One participant expressed concern that lack of time may prevent the use of CBT in future practice: "depending on the workload you're not always able to provide the adequate time per patient' (participant 2)."

The time delay between beginning CBT training and being allocated a patient case was identified as a barrier.

Cases

Participants felt that there was a shortage of CBT cases available for trainees and this had a significant impact on their CBT training.

'I think the barrier is there is a big waiting list and that is a problem, like you have to wait to get a case [...] and obviously if there [aren't] enough patients [...] you [won't] get a case and there's loads of trainees and this is kind of a mandatory thing, everybody has to have a case' (participant 3).

Participants felt that it would be beneficial to have more than one case: "I would say if we had at least two cases that might be better but again it is very difficult to get a CBT patient because we have got loads of trainees and, um, not a lot of CBT we do, we get for trainees because [...] if it is not simple for trainees they do not consider it, to give it to us, and there is a long waiting list, I think you know that, there is a big waiting list for CBT, so like I had to wait for nearly ... more than a year actually' (participant 3)."

A participant who had worked in a psychotherapy post observed that one case would not have provided sufficient CBT experience: "I work in psychotherapies so I have had more than one case and [I] have had good exposure to CBT. I just don't know whether if I hadn't had this job, this exposure would be enough' (participant 1)."

Patients

Six of the participants discussed the impact of the patient on their experience of CBT. First, participants felt that completing a CBT case was more challenging if the patient did not engage. Second, they discussed the impact of patients not attending sessions or discontinuing with treatment; this was perceived to be a substantial barrier to training that was not taken into account by the College's curriculum.

'if the patient doesn't engage or doesn't complete therapy – this could potentially be a problem. In fact [the trainee] might not have the time to undertake another case and complete it' (participant 7).

However, participants acknowledged that the impact of the patient on CBT training was a factor that is difficult to control.

'It's totally up to the [patient] whether he or she will continue or not and if she leaves before you complete the full therapy then you have to wait for the next patient so that is a problem but I don't know the way to change it because it's totally up to the patient if they will continue or not' (participant 3).

Conversely, one participant acknowledged that a good doctor-patient relationship could have a positive impact on the experience of CBT training.

'seeing results from patients as well has been really good' (participant 4).

Access to learning resources

Participants expressed concern about keeping skills up to date as time elapsed.

‘I think the Royal College [of Psychiatrists] run a CBT module, but it’s all things that you have to pay for [...] and I think that most people feel like they pay for enough exam material [and] for the Royal College exam, and probably don’t have [a] mountain of spare cash to be spending on more e-learning stuff, so it might be good if the trust wanted to sort of do something with CBT, or if the Royal College will give out [an] e-learning module – I think that would be quite useful, and for people who are not seeing cases that regularly – I think it might kind of just update you with CBT’ (participant 4).

Conversely, others thought that the time and experience was ‘ample’: “‘I’ve been given adequate texts to read and stuff in my spare time. I have ample opportunity to discuss any complications that arise with my case so [...] all in all it’s been really good’ (participant 2).”

Guidance

The participants perceived that supervision was an important feature within their experience of CBT training. The superordinate theme of guidance was identified across all interviews, with the subordinate themes of supervision, peer learning and curriculum.

The role of supervision

There was an overall satisfaction with supervision from all the participants, who felt that they had continued support and advice. Feedback and reassurance from supervision encouraged the trainee to gain confidence and it was highlighted that the participants felt able to ask their supervisor for advice.

‘I would say that the supervision was really good, it was tailored down to trainees’ need [...] the supervisor was approachable’ (participant 5).

‘there were quite a few things that needed improvement and I felt that supervision enabled me to identify these areas and work on improving these sets of things’ (participant 1).

It appeared that the expertise of the supervisor themselves was respected and was useful to the majority of the participants. All of the participants had a consultant psychiatrist as their supervisor.

‘expert opinion on where you are going with your cases, so you feel like you do a good job with the patient’ (participant 4).

‘has a lot of experience on this ground so that was quite helpful’ (participant 3).

In terms of emotional support, there appeared to be a consensus that, if required, emotional support from supervision would be present.

Interviewer: ‘And, do you feel like you had enough emotional support if needed during your training?’

Participant: ‘I suppose I would, yes. It was never an issue, but I would imagine that if I had felt stressed I would have found support’ (participant 1).

Learning from peers

Three of the participants discussed how helpful peer learning was in their training, in particular as regards case supervision conducted in group sessions.

‘Well, I actually used to love and look forward to [...] supervision, because every time – because our supervision was a group sort of supervision – I learn not only from my case, but [I] also learn from other people’s cases. Because people have different aspects they need supervision [for], so I will kind of learn quite generally because it’s quite enjoyable to keep on listening to different cases, including mine – and following it up through week after week. So I really enjoyed it’ (participant 6).

Sticking to the curriculum

In contrast to the optimism surrounding supervision, the participants did not consider the College curriculum to be a sufficient source of guidance.

I: ‘Also, how aware were you of the Royal College guidelines before you started your CBT training?’

P: ‘Um ... not very.’

I: ‘And do you feel that there is any way in which they could be accessed more easily?’

P: ‘I wouldn’t even know how you access them now to be honest.’

I: ‘Okay, that’s okay. Okay.’

P: ‘I’m assuming that you look on the Royal College website but I never have’ (participant 7).

This lack of awareness of the Royal College of Psychiatrists’ curriculum guidelines was found in other participants, who reasoned that the guidelines are too extensive and incomprehensible. However, it transpired that six participants had acquired the competencies outlined in the curriculum despite the fact they were unaware of what these were.

‘The curriculum for core training is huge and extremely vague mostly – so you need to trawl through that document, probably most people haven’t’ (participant 4).

P6: ‘I’ve been able to explain to the patient what CBT is and what it is used for and also, sometimes I’ve been able to use the skills I’ve learnt in CBT, to offer treatment to the patient.’

I: ‘Do you feel like you are able to deliver CBT?’

P6: ‘I think I feel that way’ (participant 6).

One participant relayed that the curriculum needed to be more flexible owing to the nature of the therapy itself being unpredictable and time consuming.

‘I do think they need to be a bit flexible, because say if a patient drops out of therapy and say you have done 10 sessions that now doesn’t count as a case!’ (participant 4).

Acquisition

The participants felt that they acquired a great deal via their CBT training, in terms of gaining specific CBT skills, but also in learning generic skills that could be applied to psychiatric practice and learning which patients would be suitable for CBT. They acquired a new insight into models of mental illness and learnt to conceptualise mental illness in accordance with the CBT model. Trainees also discussed their personal influence on their experience and thus their acquisition of CBT skills. Last, they grew in confidence as they gained experience working with their CBT case.

Gaining new skills

The trainees felt that they gained a great deal from their CBT training, in terms of both specific CBT skills and also broader transferable skills that could be applied to their psychiatric practice.

‘I enjoyed it. I think basically it’s really important [...] for [a] psychiatric trainee or for a psychiatrist to have experience in CBT’ (participant 1).

Most of the participants felt that they gained a greater understanding of what CBT entails and how it works. This enabled them to confidently explain CBT to patients.

‘it gave a clear understanding for me of what exactly CBT involves and how it has a beneficial effect on patients’ (participant 5).

Three participants described how the training helped them to identify which patients would be suitable for CBT. They felt confident in referring patients for CBT. However, others felt that they needed more experience to accurately assess patients for CBT.

‘I mean, now like when I will refer patients for psychotherapy I would now know what are the categories that I need to check before referring and whether the patient is suitable for CBT or not because I have practical experience of doing it and I know that I’ve some idea whether the patient [would benefit] from CBT or not’ (participant 3).

Some of the participants felt confident using CBT techniques. However, they acknowledged that they had limited experience and that they were not fully equipped to deliver formal CBT.

‘And do you feel like you would be able to deliver it as well?’ P: ‘Delivering, to be honest – no. Because, I think, err, having done only one short case of CBT, without any supervision, I won’t be able to take up a case on my own I guess ...’ (participant 5).

Although not all of the participants felt confident in delivering CBT, they felt that they had gained transferable skills that could be used elsewhere in their psychiatric practice.

‘Sometimes in my session now [...] I see people with [...] anxiety and other disorders; I am able to use the very same skills I used in my CBT session to kind of handle the situation around me’ (participant 6).

The participants hoped that they would continue to use the skills that they had gained. However, some expressed concern about losing skills over time, particularly if they did not use CBT regularly in their job.

‘if you’re not in touch then you may lose some skills. That may be a problem in the future because you’re not going, not actually keeping doing it, practising it, yeah, so maybe it can impact on practice in the future’ (participant 3).

Models of mental illness

Six participants talked of the training causing a shift in their understanding of mental illness, moving them away from the diagnosis exclusively, and focusing on the wider problems for their patient, allowing them to reach the criteria of the curriculum and develop their emotional intelligence.

‘what I found out is that [pause] maybe some of these people do not have defined mental illness but they definitely have a problem, and just basically move me away from having to diagnose a patient with something, so [I was able to] focus on the problem rather than the diagnosis, and sometimes the problem did not correspond to an ICD-10 diagnosis, and I think this is really useful because, eh, usually in everyday life, people have problems – rather than psychiatric diagnosis’ (participant 1).

‘Well it has given me the insight into looking at the behaviour and thoughts, in terms of how people are affected, and how to help them – that’s not what I was thinking before, because before I was thinking in terms of the medical model, and now I’m thinking more about other things like their thoughts and their

behaviour, and their emotion – and how all of that is part of their illness, and how to use that to treat their illness’ (participant 6).

The trainees described how this increased awareness affected the management of their patients.

‘it does change your thinking about your practice, and you know – what else is out there, other than, you know, medication and that kind of thing, there are other ways that people can benefit from secondary care’ (participant 4).

‘having done CBT training [pause] it helped me to identify that there are some mental disorders which need both medications and psychotherapy’ (participant 5).

The benefits of having time to reflect as part of psychotherapy training gave trainees a different perspective on the patient that they were treating.

‘and I think when you’re using CBT to make them think differently about their illness and their actions it makes you think differently about it as well [...] and you certainly see patients’ difficulties from a different point of view [...] and it gives you time to figure that out’ (participant 2).

Personal use of this new way of looking at models of mental illness was cited; the participants described how this changed how they see themselves.

‘within myself, it changed me in such a way, the way I am able to kind of evaluate my behaviour, with what I do and what I think – so I use it on myself quite a bit. If I find myself in a difficult situation, even in day-to-day life – I use the same principle on myself to kind of look at how things are done, and change things differently. So I think that’s how personally CBT has influenced me’ (participant 6).

Personal influence

Several of the participants acknowledged that they had a particular interest in CBT. Two had worked in a psychotherapy post and one hoped to specialise in psychotherapy. Furthermore, the participants acknowledged that their personal interest may have affected their experience of CBT training and they may have gained more from the training as a result.

‘Personally, I am interested in psychotherapy anyway, so I wanted – I want to be able to use CBT [pause] later on in my career, so [pause] so that’s one of the reasons why I think it was really useful’ (participant 1).

Confidence

The majority of the participants talked of increased confidence during their training and afterwards. This is in regards to their own skills and understanding, as well as recognition of when to refer a patient for CBT.

‘since my first case, [I] have got a lot more fluent [than] in the beginnings of therapy’ (participant 4) .

One participant expressed a lack of confidence in referring patients for CBT because their CBT supervision was still ongoing at the time of the study: “‘I don’t think I’m confident at the minute because I suppose I’ve been given a patient, I’ve not assessed someone for it as such but, um, I’m continuing to have CBT supervision [...] so I think by the end of it I will be able to, yes, to figure out who would benefit from it’ (participant 2).”

Overall, there was a positive association between experience and confidence.

‘Do you know, I feel much more confident about CBT ... because I know what it is, so I feel much more confident’ (participant 3).

Discussion

A number of barriers that affect trainees' experiences of CBT training have been identified here; chiefly a lack of protected learning time, a shortage of available cases for training purposes and difficulties arising due to problems with patient engagement and therapy completion.

Having protected time for CBT training was high-lighted as crucial for psychiatry trainees, who reasoned that the difficulty in completion and the formulaic structure of CBT require a regularity and dedication to carry it through. The 'inevitability' of work disruptions and shift patterns were the main source for these disruptions recognised in this study. As previous work suggests, there was variability within this, dependent on where one is a trainee and what jobs one is assigned. Trainees in a dedicated psychotherapy post were more positive about their ability to complete and transfer their CBT skills. We propose that this may be due to the trainee having a personal interest in 'talking therapies' in addition to the granted protected time to acquire these skills in a psychotherapy post, a proposition which resonates with previous work in this area.⁴ This variation resulting from chance permeates to the level of patient allocation as well – as each trainee is allocated a different patient, standardisation of experience becomes problematic. One aspect that helped with this was peer-group learning, insofar as the experience of each trainee is shared and hence multiple cases are acquired instead of just the one that each trainee has had. This echoes previous recommendations to utilise novel ways, such as peer-group learning, to assist CBT supervision and skills acquisition.³ Thus, ensuring that protected learning time is provided and that it is a feasible task is likely to improve the trainees' experience.

Concerning the shortage of cases, further enquiry would be beneficial to explore the feasibility of targeting the long waiting lists for both the patients and the trainees by enabling trainees to take on a broader range of patient cases. A larger study would be beneficial in exploring this, continuing with the idea to source cases from primary care.¹⁷ This could help to relieve the pressure for the trainee to complete one 'ideal' CBT case, and thus the patient being a barrier to learning could have less impact. It was also suggested that it could be beneficial to provide a follow-up course that can be accessed freely to ensure that skills are maintained over time. Furthermore, the training experience could be improved if the Royal College of Psychiatrists' curriculum took into account the effect of patients discontinuing with therapy and allowed a degree of flexibility for cases in which almost all sessions had been completed. Moreover, as prior literature suggests, further dissemination and accessibility of the College curriculum is still warranted.

A number of factors that facilitated a positive experience of CBT training in Yorkshire were identified. Supervision was highly valued and deemed to be an important facilitating factor during the training. Further research could be useful in order to elucidate how the benefits of supervision are mediated and thus enable similar supervision to be conducted elsewhere.

In accordance with the College curriculum, this study suggests that psychiatric trainees in Yorkshire report enhancements in their emotional intelligence and being able to refer for CBT accurately and evaluate its effect intelligently after the training. A broad positive association was relayed from the participants between exposure to CBT and confidence in recognition and delivery of skills learned. However, although trainees' overall confidence about psychotherapy increased, further experience is deemed necessary for the trainees to feel able to deliver CBT competently. On the whole, trainees gained a broader perspective of models of mental illness and learned transferable skills, which have now influenced their clinical practice.

Although a robust study design was employed and triangulation of the data was used to increase the validity of the findings, the qualitative nature of the study has inherent limitations.²⁰ Nonetheless, the study provides a valuable insight into the experiences of psychiatry trainees in Yorkshire and paves the way for further research in other deaneries across the UK in order to gain a clearer insight into the experiences of core trainee psychiatrists in general, with the aim of improving CBT training and ultimately enabling psychiatrists to become more emotionally aware, competent and confident.

1.6.30 Antipsychotic prescribing of consultant forensic psychiatrists working in different levels of secure care with patients with schizophrenia

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Abstract

Aims and method To detect any differences in the antipsychotic prescribing practices of consultant forensic psychiatrists working in different levels of secure care with patients diagnosed with schizophrenia, and to identify potential reasons for any differences. Prescribing data were collected from four secure hospitals within one National Health Service trust. A questionnaire was sent to consultant forensic psychiatrists working at those hospitals as well as those working in the trust's community forensic services.

Results Consultants working in high security prescribed more oral antipsychotics than consultants working in medium and low security, who prescribed more depot antipsychotics, as established via the prescribing data. The questionnaire provided insight regarding the reasons for these preferences.

Clinical implications There were differences in the antipsychotic prescribing practices of consultant forensic psychiatrists working in different levels of secure care, and, overall, the rate of depot antipsychotic prescribing was lower than might be expected. Although it was positive that the rate of polypharmacy was low when compared with earlier studies, the lower-than-expected rate of depot antipsychotic prescribing has clinical implications.

Contents

- *Antipsychotic prescribing of consultant forensic psychiatrists working in different levels of secure care with patients with schizophrenia*
 - *Aims*
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 - * *Demographic information*

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Schizophrenia is an enduring mental illness characterised by remissions and relapses. Treatment is available in the form of psychosocial interventions but the mainstay of effective management is antipsychotic medication.^{1–3} Antipsychotic efficacy is reduced by poor adherence and it is estimated that the risk of relapse is 2 to 6 times greater for patients not taking antipsychotic treatment.¹

Forensic psychiatrists working in secure hospitals are likely to have case-loads with high levels of comorbidity, non-adherence and risk;^{4,5} a history of aggression has been found to predict the use of high-dose antipsychotic treatment (total antipsychotic doses totalling greater than 100% maximum *British National Formulary* dose).¹

Paton *et al*⁶ reported on an in-patient census. Most (97%) of the 53.2% diagnosed with psychosis were prescribed an antipsychotic. Polypharmacy (the prescription of more than one antipsychotic agent) was common. Of those prescribed a regular antipsychotic, 51.6% were prescribed a first-generation agent, 11.3% were prescribed clozapine and 33% were prescribed a depot agent (80% of these patients had a psychotic illness). High-dose prescribing was more common when a depot agent was prescribed.

No previous studies have examined the prescribing patterns of forensic psychiatrists working in differing levels of security. It is important to identify such patterns to build on existing knowledge and to identify areas requiring change.

Aims

To detect any differences in the antipsychotic prescribing practices of consultant forensic psychiatrists working in different levels of secure care within a National Health Service (NHS) trust, and to identify potential reasons for any differences. We hypothesised that there would be no significant differences in prescribing patterns in this clinician group.

Method

Settings and sample

Covering a vast geographical area, the NHS trust studied is one of the largest in England and provides services in a variety of settings. Its secure hospitals feature one high secure hospital, two medium secure hospitals and one low secure hospital. Information on antipsychotic prescribing was collected on all in-patients with schizophrenia in these four hospitals in July 2014. A questionnaire was sent to the 34 consultant forensic psychiatrists based at the hospitals and 3 community-based consultant forensic psychiatrists working within the same trust.

Procedure

Prescribing patterns

In July 2014, the electronic healthcare records were used to produce a list of all current in-patients at the trust's four secure hospitals. The clinical records (electronic and paper healthcare records, and pharmacy records) were then used to ascertain which of these patients had schizophrenia. Further information was collected about patients with schizophrenia (gender, age, ethnicity, length of stay, antipsychotic medication prescribed), to produce an anonymised data-set detailing the percentage of patients diagnosed with schizophrenia at each hospital, and the proportion of patients with schizophrenia prescribed different types of antipsychotic medication.

Consultant questionnaires

Owing to the absence of a validated instrument, a semi-structured self-report questionnaire was developed to assess forensic consultants' attitudes to the prescription of oral and depot antipsychotic medications. The questionnaire was designed to take less than 5 min to complete. Consultants were asked in which level of security they worked and then three further questions: Disregarding the special case of clozapine, when treating a patient with schizophrenia do you have a general preference for either oral or depot antipsychotic medications? (Yes/No) Please indicate the strength of any preference on the scale below (0–100 anchored Likert scale: 0 – oral, 100 – depot). What are the reasons behind any stated preference? ((a) Improves adherence, (b) Better clinical outcome, (c) More convenient for the patient, (d) More convenient for the clinical team, (d) The next level of security/community team would expect/prefer it). There was also space for a free-text response. The three community consultants were asked two further questions: How important is the route of antipsychotic administration in your considering whether to accept a patient on to your caseload? (0–100 anchored Likert scale: 0 – very important, 100 – not at all important). How likely are you to accept a patient currently prescribed an oral antipsychotic (not clozapine)? (0–100 anchored Likert scale: 0 – very unlikely, 100 – very likely). The Likert scale is an ordinal psychometric assessment of attitudes or opinions, typically lacking concrete answers to accommodate neutral or undecided feelings. It was selected for this questionnaire owing to the speed and ease of completion, low cost, ease of distribution, and providing results amenable to analysis.

The Likert scale has been criticised for failing to measure the true attitudes of respondents, as it gives only 5 to 7 options of choice, and also for the space between each choice in reality possibly not being equidistant. In view of this, and in an attempt to further maximise freedom on behalf of the responder and to avoid railroading respondents into giving polarised responses, the Likert scale was amended to include some characteristics of an analogue scale.

The questionnaire was sent, with a cover letter, to all forensic consultants working in the four secure hospitals and in community forensic services in the NHS trust. After 3 months, the questionnaire was sent again to encourage non-responders. All data were supplied anonymously.

Ethical considerations

The project proposal was reviewed by the trust's research and innovations department and approved as service evaluation; research ethics approval was therefore not required. Patient anonymity was preserved throughout the study.

Analytic strategy

SPSS version 21 (Windows 10) was used for data analysis. Chi-square and ANOVA were used where appropriate. All tests were two-tailed and $P < 0.05$ was used to determine statistical significance.

Results

Demographic information

In July 2014, there were 556 patients detained at the four secure hospitals; 265 (48%) were diagnosed with schizophrenia. The sample characteristics are summarised in *Table 1*.

Sample characteristics of in-patients at each of the four secure hospitals

	High secure hospital	Medium secure hospital 1	Medium secure hospital 2	Low secure hospital	P	
Total number	339	69	85	63	–	
Schizophrenia, n (%)	139 (41)	53 (77)	33 (39)	40 (63)	** 0.001**	: sup:2 = 38.52, d.f. = 3
Ethnicity, n (%)						
White British	100 (72)	41 (77)	21 (64)	17 (42)	** 0.002**	: sup:2 = 15.23, d.f. = 3
White other	5 (4)	0 (0)	1 (3)	2 (5)	0.500	: sup:2 = 2.34, d.f. = 3
Black/Black British	19 (14)	3 (6)	4 (12)	11 (28)	** 0.026**	: sup:2 = 9.25, d.f. = 3
Asian/Asian British	9 (6)	5 (9)	2 (6)	3 (7)	0.902	: sup:2 = 0.58, d.f. = 3
Mixed/other ethnicity	6 (4)	4 (8)	5 (15)	7 (18)	** 0.024**	: sup:2 = 9.42, d.f. = 3
Age, years						
Mean (s.d.)	40.0 (9.8)	36.9 (8.7)	36.5 (8.8)	38.1 (10.3)	0.100	ANOVA $F_{(3,261)} = 2.10$
Median (range)	38.6 (21.9–66.3)	37.2 (19.6–60.0)	35.2 (21.8–58.2)	35.9 (19.8–62.0)	–	
Length of stay, years						
Mean (s.d.)	6.4 (4.5)	2.1 (1.9)	1.9 (1.4)	3.0 (3.9)	** 0.001**	ANOVA $F_{(3,261)} = 26.86$
Median (range)	5.9 (0.1–21.4)	1.5 (0.1–8.0)	1.4 (0.03–5.6)	1.5 (0.03–18.2)	–	
Female patients, n (%)	5 (3.6)	0 (0)	1 (3.0)	4 (10.0)	0.093	: sup:2 = 0.58, d.f. = 3
Age, years: mean (s.d.)	43.1 (5.9)	–	–	41.7 (13.4)	0.373	ANOVA $F_{:sub: (2,7)} = 1.14$
Age, years: median (range)	41.1 (36.9–54.3)	–	–	39.7 (25.7–62.0)	–	
Length of stay, years: mean (s.d.)	4.9 (2.4)	–	–	1.1 (0.4)	0.053	ANOVA $F_{:sub: (2,7)} = 4.62$
Length of stay, years: median (range)	6.5 (1.3–6.8)	–	–	1.1 (0.5–1.6)	–	

Bold denotes significance ($P < 0.05$).

As medium secure hospital 2 had only 1 female in-patient, means and medians for age and length of stay have not been calculated.

Medium secure hospital 1 provides a male-only service. The high secure hospital and medium secure hospital 2 have wards specialising in the care of patients with personality disorder, whereas medium secure hospital 1 and the low secure hospital do not, hence the differences in the rate of schizophrenia. The proportion of patients from Black and minority ethnic (BME) groups was high when compared with the general population⁷ (29% v. 14% respectively). The rate was highest for the low secure hospital (53%). This significant finding mirrors an earlier study⁸ which found an overrepresentation of BME groups admitted to low secure services across the UK.

There was little difference in mean patient age between the four hospitals, and expected differences in the mean lengths of stay.

Pattern of prescribing

Of all patients with schizophrenia, 3% ($n = 8$) were not prescribed antipsychotic medication and 12% ($n = 33$) were prescribed antipsychotic medication constituting polypharmacy. The most common polypharmacological combination was clozapine augmented with a second-generation oral antipsychotic. Data regarding the prescription of antipsychotic medication are summarised in *Table 2*.

Antipsychotic prescribing for patients with schizophrenia at the four hospitals

	High secure hospital	Medium secure hospitals	Low secure hospital			
Regular first-generation antipsychotic only, n (%)						
Oral	6 (4)	2 (4)	0 (0)	2 (2)	2 (5)	10 (4)
Depot	17 (12)	7 (13)	8 (24)	15 (17)	9 (22)	41 (15)
Regular second-generation antipsychotic only, n (%)						
Oral	59 (42)	8 (15)	10 (30)	18 (21)	11 (27)	88 (33)
Depot	1 (1)	9 (17)	0 (0)	9 (10)	6 (15)	16 (6)
Clonazepam only, n (%)	33 (24)	18 (34)	10 (30)	28 (33)	8 (20)	69 (26)
Total, n	139	53	33	86	40	265

Excluding clozapine.

Clozapine was prescribed to 26% of all patients, with the highest prescription rate observed in medium security hospitals (33%).

Excluding polypharmacy and clozapine use, more patients were prescribed a second-generation oral agent than a first-generation oral agent (33% v. 4%); this was true for all four hospitals. In general, this pattern was reversed for depot agents, with more patients being prescribed a first-generation depot agent than a second-generation depot agent (15% v. 6%). 70% of patients with schizophrenia in high security were prescribed an oral antipsychotic only (including clozapine), compared with 56% of patients in medium security and 52% of patients in low security (*Table 2*). It emerged that 13% of patients with schizophrenia in high security were prescribed a depot antipsychotic only, compared with 28% of patients in medium security and 37% of patients in low security. Owing to the relatively small sample sizes, data from the two medium secure hospitals and one low secure hospital were combined for statistical analysis, as shown in *Table 3*.

Oral and depot antipsychotic prescribing for schizophrenia in high security and the other hospitals

	High secure hospital	Other hospitals <i>a</i>	Total, <i>n</i>
One type of regular oral antipsychotic only, <i>n</i> (%)	98 (70)	69 (55)	167
One type of regular depot antipsychotic only, <i>n</i> (%)	18 (13)	39 (31)	57
Other, <i>b n</i> (%)	23 (17)	18 (14)	41
Total, <i>n</i>	139	126	265

Medium secure hospital 1, medium secure hospital 2, low secure hospital.

More than one type of antipsychotic prescribed regularly, no regular antipsychotic prescribed.

Chi-square testing revealed a significant difference in the rate of prescribing of oral and depot antipsychotic medication between the high secure hospital and the other hospitals ($\chi^2 = 12.78$, d.f. = 2, $P < 0.01$). The data suggest that more oral medication was used in high security and more depot medication was used in the other hospitals. *Table 4* shows the route of medication administration for patients with schizophrenia broken down by ethnicity. When medication was prescribed (i.e. excluding the 'no antipsychotic prescribed' category), chi-square analysis showed a statistically significant difference between the ethnic groups ($\chi^2 = 6.90$, d.f. = 2, $P < 0.05$); depot antipsychotics appear to be used more frequently for patients from BME groups.

Medication administration for patients with schizophrenia by ethnicity

	Regular depot antipsychotic only	Regular oral antipsychotic only	Regular depot and oral antipsychotic	No antipsychotic	Total
BME patients, <i>n</i> (%)	23 (29.5)	48 (61.5)	5 (6.4)	2 (2.6)	78
White patients, <i>n</i> (%)	34 (18.2)	142 (75.9)	5 (2.7)	6 (3.2)	187
Total	57	190	10	8	265

Consultant questionnaires

The questionnaire was sent to the 34 consultant forensic psychiatrists based at the four secure hospitals in the trust (19 at the high secure hospital, 10 at the two medium secure hospitals and 5 at the low secure hospital), as well as to the 3 forensic consultants working in community forensic services within the same trust. The overall response rate was 78% (74% high secure, 80% medium secure, 80% low secure and 100% community). Limitations in the data collected leave us unable to comment on any differences (e.g. gender, age, years of experience) between consultants who did and did not respond.

Of the hospital-based consultants responding to the questionnaire, 35% expressed a preference for oral medication and 42% expressed a preference for depot medication; 23% did not express a preference. The mean score on the 0–100 scale, where 0 indicated a preference for oral and 100 for depot medication, was 37 (s.d. = 20) for respondents from high security and 74 (s.d. = 22) for respondents from other settings (medium security and low security); ANOVA demonstrated a significant difference between the two groups ($F_{(1,24)} = 19.759, P < 0.01$). Thus, those working in high security preferred oral medications and those working in other settings preferred depot medications.

Most (89%) expressing a preference for oral medications worked in high security. The following reasons were given: convenience for patient, adherence, safety, less invasive, improved engagement, increased patient responsibility and improved therapeutic relationship. Most (73%) expressing a preference for depot medications worked in medium or low security, and their reasons were: adherence, clinical outcome, expectation from next level of security, reduced side-effects, reduced tension between patient and team, easier risk management in community, ‘mental health review tribunal’/‘Ministry of Justice’ reassurance, and reduced adverse events.

All of the community-based forensic consultants expressed a preference for depot medication; stated reasons included adherence, clinical outcome and convenience for the patient.

Community-based forensic consultants were asked two further questions (see Method). It emerged that route of administration was important for consultants when considering whether or not to accept a patient (mean rating for question 1, where 0 was ‘very important’ and 100 was ‘not at all important’, was 31 (s.d. = 17)). Considering question 2, consultants were also likely to accept patients currently prescribed an oral antipsychotic (not clozapine) (mean rating 72 (s.d. = 21), where 0 – very unlikely, 100 – very likely).

Discussion

Findings

This study demonstrates a similar rate of antipsychotic prescribing (97%) as a previous study;⁶ 3% of patients were not prescribed antipsychotic medication. Consultant psychiatrists may opt not to prescribe antipsychotic medication in the context of a drug-free trial related to diagnostic uncertainty or severe side-effects, or because a patient has refused to take such medication.

This study reveals significant differences in the antipsychotic prescribing practices of consultants working in different levels of secure care. Consultants in high security were found to prescribe more oral antipsychotics, and those in medium and low security were found to prescribe more depot antipsychotics. It may be that the likelihood of high secure patients having an extended period of supervised care ahead of them reduces the bearing of adherence on antipsychotic selection.

The overall rate of depot antipsychotic prescribing was lower than that found by Paton⁶ and also lower than that quoted in the Maudsley guidelines.⁹ Polypharmacy was less prevalent than in Paton’s study;⁶ this finding was welcome but perhaps unsurprising as over a decade later the risks associated with polypharmacy are better understood and many trusts have guidelines restricting polypharmacy. The Care Quality Commission also actively discourages polypharmacy. The most common combination of clozapine augmented by a second-generation oral antipsychotic is in keeping with usual approaches to treatment-resistant schizophrenia.

BME patients with schizophrenia were significantly more likely than their White counterparts to be prescribed a depot antipsychotic. This finding builds upon existing research.^{10,11}

Significant differences in the opinions expressed by consultants were found: consultants working in high security preferred oral antipsychotics and consultants working in other settings preferred depot antipsychotics. Overall, 31% of all respondents expressed a preference for oral antipsychotics and 89% of these worked in high security, whereas 48% of respondents expressed a preference for depot antipsychotics and 79% of these worked in medium and low security and the community. Comments from community consultants suggest there is no expectation that patients should be prescribed a depot antipsychotic before they are deemed suitable to be managed by community services.

It is noteworthy that the presence of a community forensic team may mean that the area served by the NHS trust in this study is not typical of other areas in England and Wales. Community forensic services are not available countrywide and it may be that general adult psychiatrists accepting patients from secure services hold different views than their forensic colleagues.

Adherence

Both consultants preferring oral antipsychotics and those preferring depot antipsychotics listed 'adherence' as a reason for their preference. For patients with schizophrenia, poor adherence can be related to forgetfulness, disorganisation, complexity of regime, cost, lack of insight, ambivalence, poor relationship with therapist, stigma, side-effects and lack of perceived efficacy.^{3,12} Higher rates of non-adherence have been reported in patients with schizophrenia prescribed oral medication than those prescribed depot medication¹³ and patients treated with depot medication have been found more likely to continue medication, and to continue it for longer, than patients treated with oral medication. It has been suggested that improved adherence is likely to lead to better clinical and functional outcomes.¹⁴

Stone & Niz¹⁵ found that non-adherent patients with schizophrenia were more likely to enter the criminal justice system and suggest that consideration be given to using depot antipsychotics (or clozapine) as a first-line treatment for offenders with schizophrenia. Arango *et al*¹⁶ studied patients with schizophrenia and a history of violence. Of those who were violent again, those prescribed oral antipsychotics were violent sooner, and more frequently, than those prescribed depot antipsychotics. The authors link improved adherence to reductions in violence. It may therefore appear counterintuitive that the forensic population studied were prescribed less depot medication than patients in an earlier, mixed population, study⁶ and the rates quoted in the Maudsley guidelines.⁹

Efficacy

Reviews comparing the efficacy of oral and depot antipsychotics^{12,17} report that mirror-image and some large cohort studies have favoured depot preparations but randomised controlled trials (RCTs) have not.

Lafeuille *et al*¹⁸ compared outcomes in patients who relapsed on an oral medication and were then 'switched' to a depot antipsychotic with those who remained on an oral medication. 'Switched' patients had fewer readmissions and fewer emergency presentations. Johnson¹⁹ found that 33 months after being discharged from hospital, 40% of patients prescribed depot antipsychotics relapsed, in comparison with 60% of patients prescribed oral antipsychotics. David & Adams' review³ of non-forensic patients with schizophrenia identified little difference between oral and depot antipsychotics in terms of relapse rates or side-effects, but depot formulations were found superior in bringing about 'important global change'. Leucht *et al*²⁰ present a systematic review and meta-analysis of 10 RCTs carried out between 1975 and 2010; there were significantly fewer relapses in out-patients prescribed depot medication than in those prescribed oral medication.

Psychiatrist attitude

Haddad *et al*²¹ report that 50% of psychiatrists said that their use of depot antipsychotics had reduced in the previous 5 years, and 23% said that their use had increased (the 5-year time-span included the introduction of second-generation depot agents). Despite 89% opining that depot administration was associated with better adherence, and 98% opining that depot administration was associated with reduced relapse rates, only 4% said that depot was their 'first choice' route of administration for patients requiring long-term treatment. The findings from the current study may go some way in explaining the possible cognitive dissonance demonstrated by Haddad *et al*'s findings, i.e. consultant psychiatrists may consider many things other than adherence when deciding on antipsychotic treatment.

Potkin *et al*²² reviewed prescriber-patient conversations and found that depot antipsychotics were discussed only half of the time when a patient prescribed an oral antipsychotic wished to discuss a change in medication.

Advantages and disadvantages of depot antipsychotic medication

Previous studies have commented on perceived advantages and disadvantages of depot medications.^{1,3,12–14,19,22,23} Advantages have included a more constant plasma level, improved bioavailability, reduced availability of medication for overdose, improved adherence, more time to intervene when non-adherence is identified, reduction in family conflict and reduced treatment costs. Studies assessing patient attitude towards depot medication have revealed generally positive attitudes.^{3,22}

Disadvantages have included concern about side-effects, effect on therapeutic relationship, risk of high-dose prescribing, inappropriateness of use post-neuroleptic malignant syndrome, less flexibility and delayed response (i.e. mental state improvement on initiation, side-effect reduction on discontinuation). Potkin *et al*²² found that the usual reason for a patient declining depot medication was needle phobia.

This study adds to the existing literature by providing a forensic perspective on the advantages and disadvantages of depot medication.

Limitations

This study encountered a number of limitations which restrict the generalisability of the findings to wider forensic and indeed non-forensic settings. These include the small sample size, particularly with regard to the community consultants, the use of a non-validated questionnaire, and not including patients in the private sector (who in 2007 accounted for 35% of patients in England).²⁴

Clinical implications

Community teams caring for forensic patients with schizophrenia do not seem to have an expectation that patients should be prescribed a depot antipsychotic medication before they are deemed suitable for their service. It could be argued that given the relatively low rate of depot antipsychotic prescribing found in this study, and the superiority of depot preparations in terms of adherence, readmission and relapse rates, 'important global change' and, notably, risk of violence revealed through this literature review, consultants working with forensic populations should consider taking steps to increase their use of depot antipsychotic medications.

Directions for future research

Future research could attempt to evaluate the opinions of a more representative sample of consultant forensic psychiatrists, or the opinions of general adult psychiatrists and non-medical practitioners, particularly nurses,³ who may be expected to receive the handover of patients formerly known to forensic services. It would also be interesting to establish whether or not the perceived effectiveness of different types of antipsychotics influences prescribers' choices. Future research could further explore the finding that BME patients are more likely to be prescribed a depot antipsychotic than their White counterparts. It may also be useful to undertake a follow-up study, where patients stepped down from high or medium security are followed up some time after discharge and any changes in antipsychotic prescription are identified and investigated.

We are grateful to Dr Chris Clark, Dr Simon Gibbon, Dr Najat Khalifa and Sarah Brennan for their help and advice.

1.6.31 Niemann–Pick type C disease – the tip of the iceberg? A review of neuropsychiatric presentation, diagnosis and treatment

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Abstract

Niemann–Pick type C (NP-C) disease is a rare neurodegenerative lysosomal storage disorder. It is highly heterogeneous, and there is limited awareness of a substantial subgroup that has an attenuated adolescent/adult-onset disease. In these patients psychiatric features, often a psychosis, may dominate the initial impression, although often there is an associated ataxia and cognitive impairment. Typically, patients experience a substantial diagnostic delay. In this review we highlight the importance of early recognition and discuss the pathophysiology, neuropsychiatric presentation and recent changes in the investigation and work-up of these patients, and treatment options.

Contents

- *Niemann–Pick type C disease – the tip of the iceberg? A review of neuropsychiatric presentation, diagnosis and treatment*
 - *Pathophysiology*
 - *Neuropsychiatric presentation*
 - * *Cognitive decline*
 - * *Psychiatric symptoms*

1

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- * *Neurological features*
- * *Systemic features*
- *Investigation and diagnosis*
- *Treatment options*
 - * *Disease-specific treatments*
 - * *Symptomatic treatments*
- *Prognosis*
- *Summary*

Inborn errors of metabolism (IEM) are a collection of diseases that result from a deficiency in a metabolic pathway (usually an enzyme), leading to altered intracellular synthesis and catabolism.¹ IEMs are individually rare but collectively common. Most are diagnosed during childhood, but there is increasing awareness of later-onset variant forms that may present in adults, often with a mix of both cognitive and psychiatric problems.²

Niemann–Pick type C (NP-C) disease is a neurodegenerative, pan-ethnic, globally occurring lysosomal storage disorder. Lysosomal storage disorders are a subgroup of nearly 60 IEMs that also includes Gaucher’s disease, Tay–Sachs disease and the mucopolysaccharidoses. Although the lysosomal storage disorders are individually rare, their collective prevalence is 1:5000;³ they are usually the consequence of an enzyme deficiency and follow an autosomal pattern of inheritance. NP-C is rare, with a ‘classical’ clinical incidence of approximately 1:100 000.^{4–7} It follows an autosomal inheritance pattern, the result of mutations in one of two genes: *NPC1* (chromosome 18q 11–12) or *NPC2* (chromosome 14q 24.3),⁸ with *NPC1* accounting for 95% of cases.^{4,6} However, unusually, neither of these genes encodes an enzyme; they encode intracellular transporter proteins: *NPC1*, a late endosome/lysosomal transmembrane-bound protein and *NPC2*, a soluble protein.⁹

NP-C, like many other IEMs, has historically been considered a severe neurological and systemic disease of children, but this does not reflect the wide range of its presentations and severities. In a substantial subgroup of patients the illness has an adolescent/adult onset, with cognitive decline and neuropsychiatric symptoms predominating and survival that can extend even into their 7th decade.¹⁰ Most of these patients never receive an accurate diagnosis and for those who do, it is often after many years’ delay with frequent misdiagnoses.^{1,4,10–12}

This is a timely review of adult- and adolescent-onset NP-C. A recent publication suggests that the frequency of this late-onset disease may be far higher than the 1:100 000 ‘classical’ incidence.^{4–7,13} Wassif *et al*⁶ predicted a prevalence as high as 1:19 000–36 000, based on exome sequencing data of known disease-causing mutations. With easier and more readily available diagnostic tests, a disease-specific treatment⁴ and ongoing clinical trials, there has never been a more important time for a heightened awareness of NP-C.

Pathophysiology

The lysosome is an intracellular organelle, often termed the recycling centre of the cell. It has an acidic interior containing hydrolytic enzymes (hydrolases). These hydrolases, together with the integral transporter proteins (such as NPC1 and NPC2), traffic, break down and recycle cellular products. A defect in these results in the accumulation of partially metabolised substrates and a shortage of other lysosomal products. This ‘traffic jam’ leads to a complex chain of events, resulting in cell dysfunction and death and the consequent disease phenotype.

NP-C was described more than 100 years ago by Albert Niemann as an infantile disorder with hepatosplenomegaly and neurodegeneration,⁹ but the exact function of the NPC1 and NPC2 proteins has still to be fully elucidated. We know that a loss of function of either results in an identical clinical phenotype, suggesting a shared pathway for the two proteins. NPC1, a large transmembrane protein of the late endosome/lysosome and NPC2, a soluble lysosomal protein,⁸ work cooperatively to traffic intracellular lipids. Loss of function in either protein leads to the accumulation of cholesterol and a range of sphingolipids in the late endosomal/lysosomal intracellular compartment. This disrupts lysosomal calcium homeostasis, resulting in a host of secondary cellular trafficking defects.¹⁴ The neuropathological sequelae

of these defects include Alzheimer's-like neurofibrillary tangles, neuronal degeneration, neuroaxonal dystrophy and demyelination.⁶⁻¹⁸ Also, as endogenously synthesised cholesterol is necessary for axonal membrane maintenance and repair, white matter tracts are severely affected, with the corpus callosum showing the most striking axonal loss.^{18,19} Purkinje cells of the cerebellum, basal ganglia and thalamus are characteristically vulnerable in NP-C, leading to the often pronounced cerebellar dysfunction and ataxia in NP-C patients.¹⁵

Neuropsychiatric presentation

An organic cause can be found in a sizeable proportion of patients presenting with psychosis. For example, Johnstone *et al*²⁰ showed that a causative organic disease could be found in 6% of patients with a first episode of psychosis. Several IEMs are known to cause both psychoses and cognitive decline in adults. A recent systematic review² highlighted six metabolic disorders that should be considered in adult patients with psychosis: homocysteine metabolism disorders, urea cycle disorders, Wilson's disease, acute porphyrias, cerebrotendinous xanthomatosis and NP-C.

NP-C can vary widely in both age at onset and symptoms. A useful classification system subdivides NP-C into four groups based on the onset of neurological disease: early infantile/late infantile/juvenile/adolescent/adult onset.⁴

Typically, the earlier the onset of neurological disease, the more aggressive the disease process (*Fig. 1*).^{4,21,22}

Patients with adolescent/adult-onset NP-C have a neuropsychiatric disease involving varying degrees of cognitive decline, psychiatric and neurological symptoms.⁴ At presentation, psychiatric symptoms often dominate the clinical impression, and a substantial period may pass before neurological symptoms develop or are recognised by treating clinicians.²² In many patients this delay is confounded by early neurological features, commonly an ataxia misinterpreted as a side-effect of psychotropic medication, and the challenge of eliciting subtle cognitive decline in a depressed or psychotic patient.^{22,24} This diagnostic delay is often measured in years or sometimes even decades,^{10,24} with patients frequently receiving a range of incorrect neurological and psychiatric diagnoses before NP-C is confirmed. Incorrect diagnoses made in patients with NP-C include:¹² psychotic syndromes/Alzheimer's disease and frontotemporal dementia/progressive supranuclear palsy/Parkinson's disease/parkinsonism/spinocerebellar ataxia/Wilson's disease/multiple sclerosis/Creutzfeldt-Jakob disease/Wernicke encephalopathy.

Cognitive decline

The neurodegenerative disease leads to dementia in almost all NP-C patients. NP-C is sometimes referred to as 'childhood Alzheimer's'. Although this is used as an easy identifier rather than for its accuracy, the two diseases share some neuropathological features.

In patients with adult/adolescent onset, cognitive decline features to a greater or lesser extent in almost all cases. If found in combination with other disease features, further investigations should be performed.²⁵ To highlight a possible diagnosis, the three most useful clinical features are: cognitive decline, psychosis and progressive ataxia. Consequently, these have been utilised in a patient group-initiated awareness campaign 'Think again, think NPC' (<http://think-npc.com>). This clustering of symptoms to help identify patients has been further investigated by Wijburg *et al*²⁵ who have developed 'The NP-C Suspicion Index'. This index attributes scores to different clinical features to identify the likelihood of a patient having NP-C, with pre-senile cognitive decline (< 40 years) considered a strong indicator.²⁵

The cognitive profile in adult patients with NP-C usually starts with problems in word fluidity, working memory and executive dysfunction.^{4,8,26} There may also be a frontal lobe syndrome with perseveration and loss of interpersonal distance that manifests as excessive familiarity.²⁶ At this early stage of cognitive impairment, the Mini-Mental State Examination (MMSE) often fails to identify deficiencies in these areas. However, with disease progression, a more global impairment of function develops, meeting the diagnostic criteria for dementia.^{4,5,21,22}

Psychiatric symptoms

Psychiatric symptoms associated with NP-C can vary. In juvenile- and adolescent-onset patients, intellectual disability, behavioural problems and attention-deficit hyperactivity disorder (ADHD) have been reported.^{4,11,22} Many of these patients receive further psychiatric diagnoses at a later stage.⁴ One case report describes a patient with an autism spectrum-like disorder preceding a schizophrenia-like illness before eventually receiving their final diagnosis of NP-C.²⁷

In adult patients both affective disorders and psychoses are reported.^{4,5,22} An NP-C case series describes general psychiatric symptoms in 38% of early adult-onset patients,²² with the literature suggesting that a schizophrenia-like disorder is found in 25–40% of adolescent- and adult-onset NP-C patients.^{4,22} This psychiatric disease may initially be indistinguishable from schizophrenia, with auditory hallucinations, delusions and disorders of thought and behaviour; however, certain features are suggestive of an organic cause: neurological or visceral features, cognitive impairment, treatment resistance or even a paradoxical worsening of psychosis with drug therapy, visual hallucinations, unusual in classical forms of schizophrenia.⁴

Although the psychosis may be resistant to therapy, atypical antipsychotics can be useful, but caution should be taken to avoid worsening of any pre-existing dystonia.^{4,18}

Other major psychiatric illnesses described in NP-C include: depression generally susceptible to selective serotonin reuptake inhibitor (SSRI) therapy,⁴ bipolar disorder, often sensitive to mood stabilisers such as sodium valproate^{4,18} obsessive-compulsive behaviour, catatonia, often in younger patients and sometimes resistant to treatment, although electroconvulsive therapy (ECT) has been used successfully.^{4,18}

Neurological features

Adolescent- and adult-onset NP-C patients almost always have some neurological features at presentation, although these may at first be subtle and eclipsed by psychiatric features. In the more aggressive late infantile/juvenile-onset group, patients are often first described as being clumsy and struggling at school. This then progresses to the development of frank neurological disease that may include limb and gait ataxia, seizures, gelastic cataplexy (the loss of muscle tone with emotional stimuli), dysarthria, dystonia, dysphagia and dementia. Prognosis in these patients is poor, with death from the consequences of their advanced neurological disease typically in their late teenage years or early adulthood.^{4,7}

Adolescent and adult patients share some of these disease features, but in their case the illness is more insidious in its onset and slower in progression. Cerebellar dysfunction, especially ataxia, is the most commonly identified neurological feature, although dysarthria and dystonia are also frequently present.^{4,18,22} Interestingly, epilepsy, common in infantile and juvenile disease, and cataplexy (20% of classical NP-C patients), are both rarely seen.²²

The most important neurological sign in NP-C, as it is both highly prevalent and specific, is a vertical supranuclear gaze palsy (VSGP).^{4,7} VSGP is seen in only a limited number of other neurodegenerative diseases and rarely so early in their disease process. In NP-C it nearly always heralds the onset of the neuropsychiatric disease, regardless of the patient's age.^{4,22}

The gaze palsy, initially in the vertical plane, progresses to also involve horizontal eye movements as the brainstem pathology advances. Initially, the VSGP is subtle and may be missed. It involves vertical voluntary saccadic movements only, especially of downward gaze, and at this stage slow pursuit eye movements are preserved.⁴ If saccadic eye movements are not tested, the initial VSGP will be missed. Saccadic eye movements are easily tested by requesting the patient to look up and then down in quick repetition. (See <http://think-npc.com/could-it-be-np-c> for a video demonstrating saccadic eye movement testing in NP-C.)

Systemic features

NP-C is a neurovisceral disease, but in adolescents and adults the visceral component is rarely of clinical significance, although splenomegaly with or without hepatomegaly is usually present.⁴

In the perinatal and early juvenile forms, systemic manifestations may be pronounced, with severe and sometimes fatal liver and pulmonary disease.⁴ Interestingly, regardless of the patient's age, visceral disease, when present, always precedes neuropsychiatric features, often by years or even decades. The severity of this visceral disease offers little insight into the likely onset or severity of the patient's later neurological disease.^{4,5} There are cases of patients with paediatric liver disease who only develop neuropsychiatric features many decades later in adulthood.¹²

In adolescent- and adult-onset patients, hepatosplenomegaly – although frequently present – is often unrecognised. When present it is usually less pronounced and nearly always asymptomatic.⁴ The proportion of patients with hepatosplenomegaly in one case series was 85%, but within the adolescent/adult cohort it was reported lower, at nearer to 50%.⁵ However, another group reported that splenomegaly (with or without hepatomegaly) was found on abdominal ultrasound in closer to 90% of patients, regardless of the patient's age.^{4,22} Because of this, Bonnot *et al*² incorporate an abdominal ultrasound scan into their diagnostic 'work-up' algorithm for IEMs causing a schizophrenia-like illness.²

A patient with splenomegaly (especially in the absence of liver disease) with a co-existent neurodegenerative or psychiatric disorder is strongly suggestive of NP-C⁴ and should be appropriately investigated. A history of paediatric liver disease in such patients should also raise clinical suspicion.

Investigation and diagnosis

Rapid advancements in gene sequencing and liquid chromatography/tandem mass spectrometry (LC-MS/MS) have led to significant change in the available approaches to diagnosing NP-C, with both easier and more affordable tests available or in development.²⁸

Bonnot *et al*² suggest an algorithm for the work-up of a patient with a schizophrenia-like illness and a possible IEM. They suggest that with initial suspicion, a clinical and ophthalmological assessment and a cerebral magnetic resonance imaging (MRI) scan should be performed. Subsequent investigations should be performed based on these findings, with an abdominal ultrasound scan to identify hepatosplenomegaly if NP-C is considered. If this is positive, then disease-specific NP-C tests can be performed.² However, this pragmatic approach has some limitations: not all patients with NP-C have hepatosplenomegaly,^{4,5,22} and with easier plasma diagnostic tests available these should be performed earlier in the diagnostic process.

Historically, the diagnosis of NP-C was made histopathologically, by both cholesterol esterification studies and filipin staining of cultured skin fibroblasts,⁴ with most patients receiving a combination of different tests performed prior to this good, but costly and difficult, definitive investigation. These tests may have included: chitotriosidase measurements, white cell enzyme studies to exclude other lysosomal storage disorders, and fluorescent and electron microscopy of both bone marrow aspirate and liver biopsy specimens.²⁸ Because of the difficulties with the filipin staining test, the most widely performed and accessible definitive diagnostic test is now the sequencing of the *NPC1* and *NPC2* genes. Next-generation sequencers make this far easier to perform, especially if the genes concerned are included on a multi-gene panel appropriate for patients presenting with a certain disease phenotype – such as neonatal cholestatic jaundice.²⁹ But this approach is not without some limitations either. In 10% of patients only a single pathogenic mutation can be identified, and in some patients new mutations of uncertain clinical significance may be identified.

More recently, highly specific and sensitive oxidative cholesterol metabolites for NP-C have been identified.³⁰ This 'oxysterol test' can be performed on a plasma sample and is now used as the first-line diagnostic test with subsequent genetic confirmation at one of the principal UK reference laboratories for lysosomal storage disorders. Although it has a positive predictive value of > 97% in an NP-C enriched population such as infants with cholestatic jaundice,²⁸ its accuracy as a screen in broader populations is still being clarified. With the recent advances in LC-MS/MS, other candidate metabolites for diagnostic tests are being identified, with several in the pipeline. These are likely to be available in the near future as cheaper and widely accessible plasma or urine diagnostic tests.²⁸

Treatment options

Disease-specific treatments

Miglustat, a small iminosugar molecule, is licensed in the European Union for the treatment of the progressive neurological manifestations of NP-C in both adults and children.⁴ It reduces the accumulation of the downstream toxic metabolites, glycosphingolipids (GSL), by competitively inhibiting the first step in their synthesis.³¹ It has been shown to stabilise certain key neurological manifestations in a randomised controlled trial (RCT), a retrospective cohort study and in clinical experience.^{4,32,33} However, in adults it may take a year or longer to identify a discernible clinical benefit.⁴

Multiple other therapies are currently under clinical investigation for NP-C, of which two studies are at the Phase 2b/3 pivotal trial stage: arimoclomol, a small molecule that induces the heat shock protein response – a normal cellular stress response³⁴ cyclodextrins, ring-like sugar molecules that reduce lipid storage and in animal models have both substantially reduced the burden of disease and greatly prolonged lifespan.^{35,36}

Symptomatic treatments

Complex neuropsychiatric diseases have a profound effect on the patient, their family and carers. Consideration of the patient's nutritional status, swallow safety and toileting/bowel function, as well as their mobility and safety, is important, with a multidisciplinary team involved and access to appropriate agencies as needed. Timely discussions around issues of capacity, care and end-of-life planning are also necessary.

Cognitive impairment

Appropriate support services should be involved. Although miglustat may stabilise the cognitive decline, there is no evidence that cognitive-enhancing drugs such as cholinesterase inhibitors have a beneficial role.⁴

Psychiatric illness

Psychosis usually responds to antipsychotic medications, but some NP-C patients are resistant to treatment or even show (paradoxical) worsening with the initiation of drug therapy (a useful diagnostic red flag in unidentified NP-C). Atypical antipsychotics should be used and frequent neurological assessments performed to identify worsening of any pre-existing dystonia. If it occurs, dose reduction or an alternative antipsychotic may be used, supplemented if necessary with sodium valproate.⁴ Depression typically responds well to SSRIs,³⁷ and in some patients, when effectively treated, this leads to improvements not only in their mood but also their cognition and neurological disease. Bipolar disorder in NP-C has responded to mood stabilisers such as sodium valproate and catatonia has been treated successfully with ECT.^{4,18} Sleep disturbance in NP-C may manifest as sleep inversion, narcolepsy or obstructive sleep apnoea and can be treated with melatonin and continuous positive airway pressure ventilation (CPAP).⁴

Neurological disease

Patterson *et al*⁴ have published recommended treatment strategies for a range of different NP-C neurological complications.

Prognosis

Accurate prognostic predictions in NP-C are difficult. There is poor genotype-phenotype correlation in disease course, with affected siblings not infrequently following different disease trajectories. The extent and severity of visceral disease offers little insight into the severity of later neurological disease, an additional challenge when counselling parents of a newly diagnosed infant with liver disease.

The most useful prognostic indicator is the age at neuropsychiatric disease onset.

Summary

The largest subgroup of NP-C patients is likely to be an undiagnosed/misdiagnosed adult population with a neuropsychiatric disease. Consequently, NP-C highlights the need for continual diagnostic review in patients with psychosis, especially if there is coexistent cognitive decline and/or ataxia.

1.6.32 The mini-PAT as a multi-source feedback tool for trainees in child and adolescent psychiatry: assessing whether it is fit for purpose

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Abstract

This paper discusses the research supporting the use of multi-source feedback (MSF) for doctors and describes the mini-Peer Assessment Tool (mini-PAT), the MSF instrument currently used to assess trainees in child and adolescent psychiatry. The relevance of issues raised in the literature about MSF tools in general is examined in relation to trainees in child and adolescent psychiatry as well as the appropriateness of the mini-PAT for this group. Suggestions for change including modifications to existing MSF tools or the development of a specialty-specific MSF instrument are offered.

Contents

- *The mini-PAT as a multi-source feedback tool for trainees in child and adolescent psychiatry: assessing whether it is fit for purpose*
 - *Research on the use of MSF for doctors*
 - *The mini-PAT as an MSF tool*
 - *Use of the mini-PAT in child and adolescent psychiatry training*

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- *Potential issues with using MSF tools*
- *Does the mini-PAT suit the needs of trainees in child and adolescent psychiatry?*
- *Conclusions*

Multi-source feedback (MSF) can motivate doctors to improve and change their practice.^{1,2} It gives doctors an overview of how others see them and compares this with their own view as well as the results of their peer group.³ MSF evolved in Canada and the USA out of a public demand for accountability to patients as well as an acceptance that assessments examining clinical decision-making and medical expertise do not address other essential competencies, such as interpersonal skills, professionalism and communication.³ MSF tools were originally designed to be formative, that is, to lead to awareness of and improvements in performance through feedback. More recently, however, they are being used for summative purposes, namely to provide information for revalidation and the annual review of competence progression (ARCP) which determines whether a trainee is considered fit to proceed with their training. As such, MSF tools need to be sufficiently reliable and valid. Reliability refers to the reproducibility of assessment measures or scores over repeated tests under identical conditions, and validity refers to the degree of confidence that an assessment measures what it is intended to measure. An associated term, feasibility, is a measure of whether an assessment instrument is practical, realistic and sensible given the circumstances and context.⁴

Research on the use of MSF for doctors

Ramsey *et al*⁵ published a landmark study showing that it was feasible for internal medicine physicians to obtain peer assessments about their humanistic qualities, clinical practice and communication skills. They also came to important conclusions about the reliability of MSF – for example, that 11 peer ratings were needed to ensure a reliability coefficient of 0.7 (the minimum acceptable for workplace-based assessments (WPBAs)) and that the results were not substantially affected by the relationship between the rater and the person being rated nor by the method used to select the raters. The findings of this study also suggested that a doctor's medical knowledge (determined by examination marks) was not predictive of how peers subsequently rated their interpersonal relationships or communication skills.

The finding that reliable and valid MSF questionnaires can be developed and be feasible to use for assessing doctors has been replicated across settings and specialties.^{2,6–9} A number of systematic reviews have also been published, all of which conclude that MSF as a method of assessing communication skills, collegiality, humanism and professionalism in doctors has high reliability, validity and feasibility.^{10–15}

The mini-PAT as an MSF tool

The mini-PAT is used by the Royal College of Psychiatrists as an MSF instrument for trainees. It is well known because of its widespread use in the Foundation Programme.^{16,17} The mini-PAT was derived from the Sheffield Peer Review Assessment Tool (SPRAT) following a mapping exercise against the foundation curriculum,⁶ thus ensuring its content validity. The SPRAT contains 24 questions assessing a doctor's competencies and professional attributes, and it maps directly on to General Medical Council (GMC) standards of good medical practice,¹⁸ again establishing its content validity. These standards include good clinical care, maintaining good medical practice, teaching and training, appraising and assessing, relationships with patients and working with colleagues. The SPRAT was the first MSF tool validated in the UK for use by paediatric consultants as part of their appraisal.¹⁹ It has also been shown to be reliable, needing as few as four raters to determine whether a doctor is in difficulty or not (more in borderline situations), and feasible, taking only 5–6 minutes to use with good return rates (more than 70%).²⁰ It can also discriminate between the more and less experienced trainee.²¹

In developing the mini-PAT, nine questions which did not map on to the curriculum for the Foundation Programme were removed from the SPRAT. These included questions relating to the management of complex patients and leadership. One question about probity and health was added while the free-text element and six-point scale (where 1 indicates 'very poor' and 6 indicates 'very good') remained unchanged.⁶ The resulting mini-PAT was thought to reflect the importance for foundation doctors of developing communication skills, team work and other humanistic qualities in relation to patient care in addition to their medical knowledge.³

In his critical analysis of the mini-PAT, while accepting its content validity and feasibility, Abdulla stated that it 'lacks sufficient field evaluation and has not gone through any stringent criteria that are required for the validation of an assessment tool'.³ Data on the reliability and validity of 693 mini-PAT assessments on 553 foundation year 1 and 2 (F1/F2) doctors have subsequently been published.⁶ The mean scores of the two groups were found to be significantly different when using the same criterion standard (i.e. expectation for F2 completion), with 19.6% of F1s and 5.6% of F2s being assessed as borderline or below the expectations for F2 completion. This was used as evidence of internal standardisation and construct validity, as was the finding that the trainees scored higher in the domains of working with colleagues and relationships with patients compared with the clinical skills domains. Overall, 53% of F1 doctors and 74% of F2 doctors could have been assessed by no more than 8 assessors based on their mean scores. Factor analysis revealed that the two main factors were humanistic qualities and clinical performance. The authors concluded that the mini-PAT was a valid and reliable MSF tool for assessing foundation doctors.

Use of the mini-PAT in child and adolescent psychiatry training

In child and adolescent psychiatry, the process when using the mini-PAT is as follows: twice a year, the trainee provides contact details of between 8 and 12 co-workers who see them on a frequent basis in a range of situations. These people and the trainee then complete the mini-PAT online. Presumably based on the findings of Archer *et al*,⁶ it is suggested that at least 8 forms must be completed to ensure the assessment is reliable. There is, however, no research specifically related to the mini-PAT on the minimum number of assessors required to give a valid result.³ The form uses a 6-point Likert-type rating scale. Trainees are rated according to the standard expected at each stage of training. A score of 4 corresponds to the expected standard, with higher or lower scores suggesting the trainee's performance is better or worse.²² The responses are analysed centrally and a report is then sent to the trainee's educational supervisor who delivers the feedback in person.²³

Potential issues with using MSF tools

Several issues that have been identified in relation to the use of MSF tools for medical practitioners in general are also relevant to their use in child and adolescent psychiatry. One is the trainee's choice of rater. Although several authors have found that MSF assessment is not necessarily biased by allowing the doctor to select their own raters,^{5,24,25} others have found that factors such as the seniority, gender and profession of raters can significantly influence the assessment. For example, Archer *et al*²¹ found that consultant raters using the SPRAT gave significantly lower mean scores to paediatric trainees than more junior doctors did; similarly, Bullock *et al*²⁶ found that consultants and senior nurses were more likely to give 'concern' ratings when assessing junior doctors than were peers or administrators. Thus, there is a trend for assessors to be more critical with increasing seniority. When considering the mini-PAT, Archer *et al*⁶ found that assessors' scores were affected by their occupation, the length of time the trainee had been working with them, and the working environment. They suggested standardising the number of consultants used as raters by each trainee. These findings support the need for more detailed guidance in rater selection from the Royal College of Psychiatrists. Trainees are currently only advised that raters be chosen from a broad range of co-workers.⁴ In addition, Abdulla³ suggests that selection bias can be reduced if the list of raters is discussed and agreed on beforehand with the trainee's supervisor.

Measurement errors, such as the central tendency and halo effect, can also occur and are particularly likely when behaviours which cannot be easily observed are being assessed.²⁷ A particular issue for non-doctor raters is knowing what standards they should expect for a doctor at that stage in their training. In an attempt to reduce measurement errors, Abdulla³ suggests better education for mini-PAT raters. This could be provided by the Royal College of Psychiatrists as part of their online mini-PAT package.

It has been shown that doctors' self-assessments do not correlate well with peer or patient ratings.^{7,28} Violato & Lockyer²⁹ studied psychiatrists, internal medicine physicians and paediatricians, and found that all were inaccurate in assessing their own performance. Those psychiatrists who were rated by peers to be in the bottom quartile saw themselves as 'average', whereas the psychiatrists in the top quartile significantly underrated themselves. This indicates that poorly performing doctors often lack insight, not always accepting negative feedback from others and querying its validity.³⁰ Overeem *et al*³¹ advise that trained facilitators should encourage trainees to reflect on MSF results and help them set concrete goals for improvement. Offering coaching to help trainees identify their strengths and weaknesses

may help facilitate changes in performance.³² Making the feedback highly structured can help trainees acknowledge feedback from all sources rather than just the medical scores which they tend to value more.^{5,33–35} Although taking the mean of the scores may be the most reliable approach,³⁶ attention should also be given to the free-text comments which might highlight specific performance issues and which may also make the feedback more acceptable.³⁵ These findings highlight the importance of the MSF feedback process, which should include the development of a relevant action plan in collaboration with the doctor.

It has been proposed that a single, generic MSF tool be used in the UK.³⁷ Research supporting this includes Violato & Lockyer's^{29,38} study of the use of one MSF tool for internal medicine physicians, paediatricians and psychiatrists. Although they found no specialty differences in response rates or reliability, it is of note that of the items clustered into the same four factors across the specialties, for psychiatry the most discriminating factor was communication whereas for the other two specialties the most important was patient management. By contrast, Mackillop *et al*³⁹ evaluated the use of a generic MSF tool across specialties and concluded that, although the generic content was appropriate for most specialties, some would benefit from specialty-specific content.

Does the mini-PAT suit the needs of trainees in child and adolescent psychiatry?

In child and adolescent psychiatry, the mini-PAT is currently used to assess trainees. Although the mini-PAT has content validity for foundation doctors, having been mapped against their curriculum, this does not necessarily mean it is also a valid tool for other grades or for use across specialties. In the making of the mini-PAT, some questions were removed from the SPRAT, namely those relating to management of complex patients and leadership.⁶ However, these items are highly relevant to trainees in child and adolescent psychiatry. Davies *et al*⁴⁰ modified the SPRAT for trainees in histopathology following a blueprinting exercise against the histopathology curriculum to establish content validity. They concluded that specialty-specific MSF is feasible and achieves satisfactory reliability. A similar approach blueprinting the SPRAT against the child and adolescent psychiatry competency-based curriculum⁴¹ could therefore be considered. The SPRAT also requires fewer raters than the mini-PAT in order for the results to be sufficiently reliable,⁶ thus adding to its potential suitability for child psychiatry trainees who often work in small teams.

Alternatively, a specialty-specific MSF instrument for child and adolescent psychiatry trainees could be developed, to reflect the differences in their practice compared with other specialties and the greater importance placed on communication, interpersonal skills, emotional intelligence and relationship building.⁴ Tools taking these attributes into account have been developed for use with consultant psychiatrists and have been found to be feasible to use as well as being reliable and valid.^{42,43} The child and adolescent psychiatry competency-based curriculum⁴¹ gives details of intended learning outcomes (ILOs), which are either mandatory or selective, some of which tap into these areas. The ILOs range from those that are predominantly clinical (e.g. managing emergencies (mandatory), paediatric psychopharmacology (mandatory) and paediatric liaison (selective)) to those that focus on more humanistic skills (e.g. professionalism (mandatory) and establishing and maintaining therapeutic relationships with children, adolescents and families (mandatory)). The ILO on professionalism includes: 'practicing Child and Adolescent Psychiatry in a professional and ethical manner; child and family centred practice; understanding the impact of stigma and other barriers to accessing mental health services and inter-professional and multi-agency working'.⁴¹ Some of the necessary associated skills which trainees are expected to attain include: supervising junior psychiatric staff, working with colleagues within the team and with other agencies to put the child's needs as central, and acting as an advocate for the child. There is scope to develop this area of the curriculum even further; the American Board of Pediatrics (ABP) published guidelines for the teaching and evaluation of professionalism in paediatric residency programmes⁴⁴ as well as standards of professional behaviour against which paediatricians, including those in training, can be evaluated.⁴⁵ Both are of relevance to child and adolescent psychiatrists.

If developed, a child and adolescent psychiatry specialty-specific MSF instrument would need to map on to the relevant ILOs. It could also include feedback from patients and families (which is not currently routinely collected as part of the WPBAs) to reflect the need to balance the views of the child (who is the patient) with those of their carers.

Conclusions

MSF tools such as the mini-PAT can provide reliable and valid information on areas of a trainee's performance such as communication skills and other humanistic qualities affecting patient care for which other forms of assessment, such as written examinations, are unhelpful. MSF tools have their predominant strength when used for formative assessment and were generally designed for this purpose. They are most appropriately used within a portfolio of other WPBAs and can help in making decisions about a doctor's fitness to practice or to continue training.⁴⁶ Rater bias and measurement error could be reduced by offering more detailed guidance to trainees in their choice of rater as well as to raters in the use of the tool. Measurement error could also be reduced by encouraging trainees to obtain a larger number of returns than the minimum of eight recommended by the Royal College of Psychiatrists.³ The quality of the feedback to the trainee is also important and educational supervisors would benefit from training in this area.

Although the mini-PAT is used widely across specialties, it has only been properly evaluated for use with foundation doctors. Interested researchers, clinicians or educationalists might now want to consider developing a modified version of the SPRAT or a specialty-specific MSF tool that is more appropriate for the needs of trainees in child and adolescent psychiatry. This would reflect the differences in their day-to-day practice compared with that of other trainees but would obviously need to be mapped to the curriculum and evaluated in practice to ensure content validity and reliability.

1.6.33 James Patrick Watson MD, FRCP, FRCPsych

: Formerly Professor of Psychiatry, King's College London and Honorary Consultant Psychiatrist, South London and Maudsley NHS Trust

Tom K. J. Craig Nick Bouras

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James (Jim) Watson, who died after a stroke on 3 August 2016 aged 80, was among a small band of British psychiatrists who trained in the 1960s and 70s to take psychiatry out of the asylums and establish robust services in general hospital and community settings. They were also responsible for developing a wide range of specialist mental health services. Jim was deeply committed to improving the standards of clinical care, from early implementation of behavioural therapy through in-patient group therapies and the understanding and management of behaviour on hospital wards. He championed the relationship between staff and patient as key to recovery in psychiatry, deploring the move to ever fewer acute beds, reductions in staffing levels and organisational changes that resulted in fractured continuity of care and consequent erosion of the essence of good mental healthcare.

His clinical interest was reflected in his research, which included evaluations of community mental health, telemedicine and treatments for psychosexual disorders, for which he established one of the earliest specialist multidisciplinary clinics and training programmes in Britain. With his personal style, he led a vibrant, outward-facing, creative and very happy department, in which a serious commitment to excellence went along with a refreshing lack of pomposity and a keen sense of work being enjoyable. This was in no small part due to Jim's dedication to improving the quality of psychiatric services, not least by ensuring excellence in the education and training of psychiatrists and by making sure that medical students had a varied and stimulating exposure to psychiatry.

Under his leadership, Guy's Hospital Medical School had the enviable reputation of having the highest proportion of medical students opting for a career in psychiatry. In the postgraduate field, he was an inspirational leader of the South East of England training scheme for psychiatry, chairman of the Royal College of Psychiatrists' Specialist Training Committee and chairman of the Association of University Teachers of Psychiatry. In the mid-1990s he launched an MSc in mental health studies – a programme directed at professionals from all disciplines involved in delivering mental health services. This course was extraordinarily successful: consistently oversubscribed, with unprecedented numbers of applicants. Its success spawned further collaborations with university departments overseas, notably in Egypt and the Middle East, where he worked with colleagues to develop a diploma in psychiatric practice for wider dissemination across the region. His determination to improve mental healthcare led him to a lengthy involvement with mental healthcare in Pakistan. From the early 1990s, he collaborated with colleagues there, visiting regularly and helping to train staff for mental health clinics in rural settings that have now expanded to more than 15 centres, some of which are co-located with a mosque and madrasa. Jim was also connected with several other international projects involving, among other countries, Greece and the former Yugoslavia.

Jim was the eldest of three sons. His father was a teacher and his mother a doctor. He attended the Roan School for Boys in Greenwich, where he excelled academically and in sport. He studied medicine at Trinity College, Cambridge, where he was a senior scholar. In 1957 he transferred to King's College Hospital Medical School for clinical studies, qualifying in April 1960. It was there that he met his fellow student and future wife Christine Colley – they were married in April 1962.

After training in psychiatry at the Bethlem Royal and Maudsley Hospitals and Institute of Psychiatry, he was appointed as consultant and senior lecturer in psychiatry at St George's Hospital London in May 1971. He was appointed to the Chair of Psychiatry at Guy's Hospital Medical School in September 1974, steering his department through the union with St Thomas's Hospital in 1982 and onward to the final merger with King's College in 2000. In addition, he served as honorary consultant psychiatrist to the British Army from 1980 to 2000 and was the vice-president of the Royal College of Psychiatrists from 1998 to his retirement.

After retirement, Jim continued to contribute actively to the field, providing teaching and mentorship to psychiatrists in the Sussex Partnership NHS Foundation Trust. He maintained his collaboration with colleagues in Pakistan, advising on setting up a new School of Nursing as well as the development of a service and training resource for children with learning disabilities and autism. He took part in continuing education meetings with colleagues in Cheltenham, chaired a patient support group in a local general practitioner practice and was trustee of the Soundwell Music Therapy Trust which provides music therapy for people suffering from mental ill health.

Jim enjoyed a very happy family life, having four sons whose diverse careers in music, international school teaching, hospital medicine and clinical psychology were a great source of pride and affection. In 2002, he and Christine exchanged London life for a Cotswold home where he could indulge his enthusiasm for vegetable gardening – a throwback to his maternal ancestors who had traded as market gardeners, supplying mustard and cress to Queen Victoria.

Jim's passing will be felt as a great loss to psychiatry and by the many clinical and academic colleagues who had the privilege of knowing and working with him.

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1.6.34 Irving Gottesman

: American psychologist and behaviour geneticist who radically changed traditional views of schizophrenia

Peter McGuffin

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 - : *American psychologist and behaviour geneticist who radically changed traditional views of schizophrenia*

The research and writings of the clinical psychologist and behaviour geneticist Irving Gottesman, who has died aged 85, radically changed the way psychologists and psychiatrists think about schizophrenia and, more generally, about what Irv called the ‘origins of madness’ (which was the subtitle of his 1991 book *Schizophrenia Genesis*).

His path to becoming a dominant figure in psychiatric genetics began at an international conference in 1961 when, as a psychology lecturer at Harvard University, he was introduced to Eliot Slater, director of the Medical Research Council (MRC) psychiatric genetics unit at the Institute of Psychiatry in London, and the doyen of psychiatric genetics of his day.

Slater agreed that Irv might join his unit provided he brought his own funding. Irv duly won a three-year grant from the US National Institutes of Health (NIH) and arrived in London in 1963. Slater was an austere and imposing figure and the building that housed his unit was equally austere, a makeshift postwar prefabricated building, affectionately known by staff as ‘the hut’, on the fringe of the campus of the Maudsley hospital in Camberwell. Although its physical environment was poor, the unit had much intellectual capital, provided by Slater himself, his deputy director Valerie Cowie, a psychiatrist trained in the new techniques of cytogenetics, and a brilliant if self-effacing senior research assistant, Jerry Shields.

The hut also housed another world-class asset, the Maudsley Twin Register. Begun by Slater in 1948, it contained the names of all patients entering the Maudsley and Bethlem Royal hospitals who had been born a twin. Irv’s successful NIH proposal was for a study of schizophrenia using the register and Slater paired him with Shields to carry out the work.

The principle of the classic twin method is straight-forward. Identical or monozygotic (MZ) twins share all their genes, whereas fraternal or dizygotic (DZ) twins share half their genes. MZ and DZ twins usually share the environment in which they are raised. Therefore if a disorder such as schizophrenia shows greater co-occurrence (‘concordance’) in MZ versus DZ twins this is evidence of a genetic effect. Similarly, absence of 100% concordance in MZ twins is evidence of environmental effects. The Gottesman-Shields Twin Study (1967) clearly confirmed the proposition that both genes and environment play a role in schizophrenia (at a time when theorists in the US and Britain were blaming parents, particularly mothers, for ‘causing’ the disorder).

One of Irv and Jerry’s major contributions was to propose a plausible mode of inheritance for schizophrenia. One of the big puzzles about familial common diseases at the time was that none (including physical disorders such as heart disease, diabetes, some cancers) showed the simple ratios of affected:unaffected within families predicted by Mendel’s laws.

The most widely accepted solution for schizophrenia was Slater’s model invoking the idea of a dominant gene with ‘incomplete penetrance’ (some people carry the gene but do not show the disorder). Irv and Jerry boldly proposed an alternative polygenic model, derived from the work of the Edinburgh mathematical geneticist DS (Douglas) Falconer, in which liability to develop schizophrenia has a normal ‘bell-shaped’ distribution in the population (like height or

weight) contributed to by many genes. But, unlike height or weight, there is a threshold effect, so that only the 1% or so of the population with the highest liability show the disorder.

The Gottesman-Shields polygenic model of schizophrenia eventually gained ascendancy, even though the final clinching piece of evidence emerged only in 2014 with the publication of a huge genome-wide molecular study of tens of thousands of subjects showing that more than 100 genes are involved.

Another far-reaching conceptual innovation was their idea of ‘endophenotypes’. Irv and Jerry proposed in their 1972 book, *Schizophrenia and Genetics*, that the genetic basis of psychiatric disorders could be better understood, and specific genes more readily identified, by the discovery of biological characteristics that lie a step closer to DNA than the clinically observable symptoms and signs, the ‘exophenotypes’, by which disorders are defined. Irv continued to elaborate the endophenotype concept over ensuing years and it provoked thousands of papers by others, a sort of Higgs boson for biological psychiatry. Unlike the Higgs particle, the existence of endophenotypes has yet to be proved experimentally for any of the major disorders.

Irv was born in Cleveland, Ohio, to Hungarian-Romanian Jewish emigre parents, Bernard, an insurance agent, and Virginia (nee Weitzner). He was a science enthusiast from an early age and began a physics degree while serving as an officer in the US navy, later switching to psychology. He completed his PhD at the University of Minnesota on the genetics of personality but initially had great difficulty in getting his findings published because of the prevailing orthodoxy in US academia in the late 1950s that behaviour was entirely due to nurture and nothing to do with nature.

After his postdoctoral fellowship in London, Irv returned in 1966 to the biology-friendly department of psychology in Minneapolis and set up one of the first behaviour genetics training programmes in the US. He thereafter held chairs in Washington University in St Louis (1980–85), where I first came under his mentorship as a visiting MRC fellow, and at the University of Virginia (1986–2001), where he set up a clinical psychology doctorate, before returning to Minnesota, where he remained for the rest of his career.

He won many plaudits and prizes worldwide but retained particular affection for and gratitude to the UK, where his recent awards included honorary fellowship of the Royal College of Psychiatrists and King’s College London.

Irv is survived by his wife, Carol (nee Appen), whom he married in 1970, and their sons, Adam and David, and grandchildren, Josh, Ava and Fiona.

Irving Isadore Gottesman, clinical psychologist and geneticist, born 29 December 1930; died 29 June 2016

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1.6.35 The Other Side of Silence: A Psychiatrist's Memoir of Depression

Tom Brown¹

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- *The Other Side of Silence: A Psychiatrist's Memoir of Depression*

Linda Gask is an eminent academic psychiatrist with an outstanding international reputation. I state this upfront because it is none too obvious from this book – owing to her self-effacing style – and in my opinion, it is very relevant. I should also declare an interest as Linda and I were in the same year at Edinburgh University's medical school and I have heard small snippets of this story from her over the ensuing years.

In this excellent book Linda Gask shows what may be achieved despite living with a recurrent depressive illness; hope emerges even from her darkest moments and this work should encourage many. It is striking for its frankness and honesty – no small achievement given that she clearly must have known it would be read not only by colleagues, but by patients past and present, some of whom would have known little about her. She even mentions her failure to pass the MRCPsych exam at the first attempt and describes her – surprising to some! – experience of how sensitive and supportive a very senior academic colleague was at this time.

The book chronicles her life and career and the impact of her illness, including thoughtful reflections on its roots (in her early life). She teaches us about depression through the mirror of her own illness and that of her patients, and brings this to life through the use of clinical vignettes. She emphasises the importance of both biological and psychosocial factors in the origins of this illness and her description of treatments is both fair and accurate. Her accounts of her interactions with patients are particularly helpful and should be of value to any doctor, whether trainee or senior. I especially valued her comments on those whose failure to improve is ascribed to personality disorder, which is, alas, an all too common tactic of many psychiatrists.

This is an exceptional book and should be read by many, both doctors and patients. The high-profile endorsements on the cover are entirely deserved. Some years ago Linda wrote another excellent book entitled *A Short Introduction to Psychiatry*. I gave it to many medical students to read. I will give this to many more.

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1.6.36 Mentalisation-Based Group Therapy (MBT-G): A Theoretical, Clinical, and Research Manual

Gwen Adshead¹

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- *Mentalisation-Based Group Therapy (MBT-G): A Theoretical, Clinical, and Research Manual*

This book presents a challenge for a reviewer because it is both a theoretical text and a technical manual. The technique in question is mentalisation-based group therapy (MBT-G) and one of this book's functions is to assist supervisors of MBT-G in rating therapists on quality of technique and adherence to the MBT-G guidelines. So, at first sight, you might not be drawn to this publication unless you are a group therapist – and trained in MBT-G.

However, I encourage people who are not psychotherapists or trained in MBT to consider this manual as a useful introduction to the concept of mentalising. Mentalisation is an old concept in psychology and refers to our human ability to understand ourselves as agents who make choices and form intentions. This ability includes an understanding and perception of *other* people as having minds that form intentions, which are real and distinct from our own.

All psychiatrists need a valid and reliable model of mind with which to work clinically, and the concept of mentalisation fits the bill. Mentalising capacities are crucial to our social existence, across the lifespan; failure to mentalise successfully is a feature of all mental disorders. The healthy mind is constantly mentalising, with odd lapses in reasoning and dialogue that are neither too severe nor too frequent. When the mind is disordered – through any cause – mentalising fails and immature modes of thinking dominate, often with catastrophic results in terms of social identity and function. The restoration of mentalising then becomes a crucial aspect of all psychiatric treatment.

There are several books on mentalising and mentalisation-based therapy by Karterud's collaborators in the UK (Peter Fonagy and Anthony Bateman) and the USA (Jon Allen). I found this particular book of interest because it approaches mentalising from a philosophical perspective: that of hermeneutics and how we interpret the world. Karterud suggests that the way we interact with and interpret others comes before our experience of our own minds; that the social self is primary in developmental terms. Such a relational approach to mind is a vital complement to models of mind that are either atomistic or mechanical. We have no evidence that the mind works like a machine, but there is growing evidence that the mind is organic and dynamic, responding, developing and evolving in response to the environment – which, for human beings, is the experience of other minds.

MBT is recommended by the National Institute for Health and Care Excellence for the treatment of borderline personality disorder and treatment trials of MBT for antisocial personality disorder are ongoing. But understanding mentalising is a broader objective which all psychiatrists need to achieve. This work is obviously essential reading for trained MBT-G therapists, but it is a useful introduction to mentalising in its own right.

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1.6.37 The Narcissist Next Door. Understanding the Monster in Your Family, in Your Office, in Your Bed – in Your World

Jon Patrick¹

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- *The Narcissist Next Door. Understanding the Monster in Your Family, in Your Office, in Your Bed – in Your World*

I find myself split in my thinking about this book. On the one hand, I can see its appeal as an airport read; requiring little effort to get through, and full of celebrity and political commentary as well as easily digestible chunks of scientific evidence.

At that level, it's enjoyable. Especially so when it allowed me to neatly project all my ugly narcissism into reports about Kanye West and Sarah Palin. Perhaps a first for them to be mentioned in the *Bulletin*, no doubt adding to their narcissistic satisfaction, should they or their agents be subscribers.

At another level – and this is where I'm split – it is an exercise in quite contemptuous character assassination. Kluger's portrayal of his example subjects is cold and sneering at times. Furthermore, he often seems to conflate the concepts of narcissism and psychopathy, leading to a sense that the more narcissistic of us are one step away from becoming serial killers or workplace tyrants.

There are only brief mentions of how the presentation of narcissism might be related to inner vulnerability, and this left me wondering if Kluger might have been looking at the mirror crack'd. Even as I write this I wonder if I too am succumbing to the narcissistic appeal to feel superior to what we read – this is hard to contain when I am a UK reader and the author mentions former prime minister 'Malcolm Browne' (referring to Gordon) and the football team 'Aston Vista'. Such mistakes feel sloppy, arousing my narcissistic contempt; perhaps a response to feeling as though the author does not care enough about the UK to check facts properly.

Coming from a psychoanalytic tradition, where this subject has been a preoccupation of clinicians since Freud's 1914 *On Narcissism: An Introduction*, Kluger's view on the dilemma of the narcissist saddened me. We are all narcissists to some degree; it's what allows us to get out of bed in the morning and feel like we are good people who might be loved. The pathological narcissist is someone who has found their early experiences to be lacking and who has lost their trust in acceptance by others. To manage this insufferable situation, they create an outer self that is contemptuous of need and full of itself, and project away their dependent, vulnerable selves onto others. Sometimes, they are contemptuous and dismissive of needy people. Sometimes, if society is lucky, and the person more creative, they will look after others who are vulnerable – to repair the damage they feel inside themselves.

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1.6.38 The Vegetarian

Ginevra Read¹

date

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- *The Vegetarian*

This short novel, winner of the Man Booker International Prize 2016, is translated from Korean and tells the story of Yeong-hye, a young woman in modern day South Korea. It is a fascinating and thought-provoking narrative that starts with Yeong-hye choosing to become vegetarian. This seemingly unremarkable and straightforward choice turns out to be nothing of the sort – vegetarianism is almost unheard of in Korea but, more importantly, Yeong-hye is on the verge of serious mental illness. Yeong-hye's stance is challenged by all of those around her, but she remains steadfast. It transpires that becoming vegetarian is the prodromal seed of an all-encompassing psychosis which will take Yeong-hye on a journey from being vegetarian to believing that she is vegetal in nature and therefore food is superfluous to her needs.

Clinicians will be acquainted with the somewhat perplexing process by which this intricate and emotive story develops. Information appears not in neat chronological order but in a tangle that needs some work to unpick. Yeong-hye's story is told in three parts. We hear first from her husband, then her brother-in-law and finally her sister, all the while following the unravelling of Yeong-hye's internal and external world, in a tale that deepens in complexity and darkness as it unfolds. Interspersed italicised monologues allow us a brief glimpse of Yeong-hye's muddled (and muddling) mind. By portraying thoughts that mingle with dreams and memories in a way that confuses the reader as to what is real and what is not, Kang elegantly conveys something of Yeong-hye's mental state. We don't hear much about Yeong-hye's premorbid adult life, other than through her husband, who says she was 'ordinary' and functioned to his liking. We can, however, sense the weight of the oppression she is subject to and guess that although becoming vegetarian may have marked an important transition point in her illness, it is unlikely to have been the beginning of it. The husband's account of Yeong-hye's condition reveals, through the lens of his own narcissism, a shocking lack of concern for his wife beyond her role in satisfying his immediate needs. He views Yeong-hye as an object and a possession, and this is most apparent in his remorseless and matter-of-fact description of raping her. A meal with her husband's boss tells us something about society's inflexible expectations and demonstrates that the lack of compassion experienced by Yeong-hye is multifaceted. We see Yeong-hye's father in action and learn a little about her upbringing; as a result, the degree to which she has been repressed and forced to endure throughout her life becomes clearer, and the powerful, subversive resistance enacted through her illness begins to make sense.

The second part of the book is equally disturbing and leads us to the brother-in-law, a less than successful video-artist who becomes obsessed with Yeong-hye's pre-pubertal appearance and whose paraphilic behaviour uncomfortably exposes her vulnerability.

In the final part of the book, several years later, we join Yeong-hye's sister In-hye as she visits her in a psychiatric hospital. In-hye now faces the repercussions of preceding events and the resulting family disintegration. We hear more

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about the sisters' childhood and the abuse which they experienced; we learn that In-hye continues to suffer her own anguish as a corollary and that she in some way envies her sister's position.

This is an astonishing book. Strange, surreal and beautifully written. The idea that people could find themselves surrounded by such brutal inhumanity and lack of connection that they reject their current existence and instead opt for transformation into a life form that does not involve thought or feeling is indescribably sad, but probably not beyond imagination for most psychiatrists. Readers will find that they must piece together the jigsaw of Yeong-hye's life, and as hard as they try, the image is not clear and the final pieces can never be found – an experience to which most of us surely relate.

1.6.39 The Psychedelic Policy Quagmire: Health, Law, Freedom, and Society

Adam G. Van Hagen¹

date

2017-4

Contents

- *The Psychedelic Policy Quagmire: Health, Law, Freedom, and Society*

The resurgence of psychedelic research has opened up a new realm of possibilities in consciousness research. However, public policy surrounding the use of psychedelics has struggled to acknowledge that they may be effective therapeutic treatments or tools for enhancing self-awareness and exploring consciousness. Highlighting the need for redress, this anthology argues that current international public policy is not scientifically or culturally informed and is thus divorced from the empirical evidence that is supposed to inform its construction and implementation.

The book examines the complex policy issues surrounding psychedelic-based healing modalities and calls for an urgent shift in policy regulating the research and application of psychedelic substances. At its core, it is a scathing criticism of legal frameworks and regulatory policies that control the use of and research on psychedelics, and goes so far as to suggest that current structures and mechanisms impose a status quo of consciousness, thereby preventing people from fully enacting their right to freedom of religion, thought and conscience. At the very least, policy makers and ethicists need to give due attention to medical and psychotherapeutic research on psychedelics and the role they have in facilitating direct spiritual experiences. This includes acknowledging the transformative effect that experience may have on the self, as well as the right of all people to freedom of religion, thought and conscience.

Any book that rates these substances highly as a connection between the individual, society and the human race as a whole will find its detractors. That being said, *The Psychedelic Policy Quagmire* presents a strong case for the notion that psychedelics have transcended seemingly outdated legal, academic, cultural and spiritual paradigms. Although – by the editors' own admission – this volume is by no means definitive, it will undoubtedly prove to be a lightning rod in the academic community. With its focus on research and policy that maximise the benefits of the use of psychedelics, reduce the potential dangers of misuse and remove impediments to achieving these ends, it is inevitable that this book will be a catalyst for lively and robust debate. Recommended to academics and researchers in various fields, including

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psychology, psychiatry, anthropology and the arts, this work should challenge many long-held assumptions about these fascinating substances.

1.6.40 Spirituality and Narrative in Psychiatric Practice: Stories of Mind and Soul

Paramabandhu Groves¹

date

2017-4

Contents

- *Spirituality and Narrative in Psychiatric Practice: Stories of Mind and Soul*

Telling stories is probably as old as human culture. Our ancestors used storytelling to entertain, instruct and make sense of their experience. A psychiatric history, when well taken, should be more than a fact-finding mission to provide a diagnosis and treatment plan. To be effective in providing treatment, helping with healing and promoting recovery, we need to know what matters to our patients. This includes the realm of belief and practice encompassed by the broad term spirituality. A book then that explores both spirituality and narrative is welcome.

Spirituality and Narrative in Psychiatric Practice, like the term spirituality, is broad in its scope. On the one hand, we have agnostic atheist Jeremy Holmes describing in his chapter “Meaning without ‘believing’ ” the spiritual nature of mentalising. As he puts it, ‘an intensely practical and loving pathway to spiritual aliveness’. On the other hand, there are writers from a theistic background, such as mental health chaplain Beaumont Stevenson, who considers how God or a higher power may manifest in the everyday stories of patients, providing a greater frame of reference than the story of self that often limits a human’s potential. The early chapters give a range of perspectives on narrative. With characteristic clarity Andrew Sims indicates how through careful psychopathological appraisal from attending to the patient’s story, it is possible to distinguish between spiritual experiences and psychiatric symptoms. Later chapters explore narrative and spirituality in a wide variety of themes such as affective disorders, offending behaviour, psychosis and the end of life.

The subtitle of the book is *Stories of Mind and Soul* and it is the stories that really shine. To preserve anonymity some are composite – made up from several people’s histories or typical examples – and therefore feel somewhat artificial; nevertheless, they engage the reader and serve didactic purposes well. Others are the words of individuals who have been willing to share their stories, and these have a greater ring of authenticity. In particular, the chapter by Jo Barber stands out as an honest and moving account of someone who has struggled with mental health problems and for whom spirituality has been important – at times problematic but often a resource that has supported her ongoing journey of recovery.

As the editors note in their concluding chapter, pressures on service delivery may get in the way of the time and space to listen well to patients’ narratives. However, for good psychiatric practice, not taking a good history is a short-cut we can ill afford. This work is a timely reminder of the importance of the fundamental tool of psychiatry and a welcome enjoiner to attend to what is significant to our patients.

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1.6.41 Big data in mental health research – do the *ns* justify the means? Using large data-sets of electronic health records for mental health research

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2017-6

Abstract

Advances in information technology and data storage, so-called ‘big data’, have the potential to dramatically change the way we do research. We are presented with the possibility of whole-population data, collected over multiple time points and including detailed demographic information usually only available in expensive and labour-intensive surveys, but at a fraction of the cost and effort. Typically, accounts highlight the sheer volume of data available in terms of terabytes (10^{12}) and petabytes (10^{15}) of data while charting the exponential growth in computing power we can use to make sense of this. Presented with resources of such dizzying magnitude it is easy to lose sight of the potential limitations when the amount of data itself appears unlimited. In this short account I look at some recent advances in electronic health data that are relevant for mental health research while highlighting some of the potential pitfalls.

Contents

- *Big data in mental health research – do the ns justify the means? Using large data-sets of electronic health records for mental health research*
 - *Recent advances*
 - *Do big data mean high-quality data?*
 - *Are the data we routinely collect aligned with research agendas?*
 - *How complex is the analysis of big data?*
 - *Do big data mean more or less transparency?*
 - *Complementary methods*

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Recent advances

The most extensive electronic health data available for research in the UK are collected in primary care. For example, the Clinical Practice Research Datalink (CPRD) covers approximately 5 million active patients, with longitudinal records going back to 1987. This in turn is now linked to hospital episode statistics (HES) and mortality data, providing one of the world's largest longitudinal health data-sets.¹ As with any big data project much depends on the quality of the data. This may be enhanced in primary care, as general practitioners (GPs) have a financial incentive to accurately record certain treatments and outcomes under the quality and outcomes framework (QOF).²

While there is no national equivalent for psychiatric care, HES data provide at least some information about psychiatric in-patient stays nationally. There are also examples of local schemes providing comprehensive psychiatric data for research use, often on a very large scale. For example, the Case Register Interactive Search (CRIS) system covers the full clinical record of over 250 000 patients from the South London and Maudsley (SLAM) catchment area.^{3,4} This can be linked with neighbourhood census data, primary care records, HES data and educational data from the National Pupil Database (NPD). A feature of CRIS is that it comprises the entire clinical record so that much of what is available is in the form of free text which, through recent advances in the use of natural language processing (NLP) techniques, is now accessible for large-scale research.⁴ For example, a recent project used free-text-mining algorithms to extract information about cannabis use to investigate the relation with clinical outcomes for just over 2000 patients with first-episode psychosis.⁵ Another recent study supplemented coded diagnostic and treatment data with data extracted from free text to look at delays in treatment and diagnosis for patients presenting with bipolar disorder.⁶

With over 50 publications to date using this data-set, CRIS has proved particularly useful for research into mortality outcomes for people with severe mental illness,^{7,8} hard-to-reach groups such as homeless people^{9,10} and, more recently, services for people in the early stages of psychosis.^{11,12}

These examples are, however, still limited to either specific geographical regions or a relatively small subsample of the population. We have, of course, recently come close to a universal data-set of health records with the, ultimately ill fated, care.data proposal. Originally intended to link primary care data with existing hospital records, this would have provided whole-population data for research use. Arguably, this was unsuccessful because it was presented in a way that failed to reassure the public their data would be safe.¹³ While this has now been scrapped, it is still the government's aim that something similar is implemented.¹⁴

Allowing whole-population health data to be made available for research has, however, long been an accepted part of life in Nordic countries. For example, since 1968 all Danish citizens have had a unique personal identification number allowing data linkage across a range of health, welfare, employment and education data.¹⁵ This arguably represents a gold standard for mental health research, with all psychiatric in-patient admissions (since 1969) and all out-patient contacts (since 1995) providing longitudinal data for the entire population over nearly five decades.¹⁶ Because of the scale of longitudinal data collected, register-based studies using data such as these have proved particularly useful for aetiological research into relatively rare disorders such as schizophrenia. For example, a number of landmark papers have highlighted urban/rural differences in psychosis incidence^{17,18} and also documented the increased risk of psychosis for migrants and refugees.^{19,20}

Do big data mean high-quality data?

All these developments in the resources available for research are to be welcomed. However, simply having the ability to access data on this scale is not enough. What we gain through the sheer volume of data and breadth of coverage could be offset by ill-informed analysis and interpretation that fails to account for the limitations of the data. One fundamental limitation is that almost all examples of what we think of as big data are collected for purposes other than research. Health records, just like any bureaucratic product, are shaped by administrative convenience rather than the search for scientific truth. For example, if we look at the way that depression is recorded in primary care, it would be a mistake to take this at face value.^{21,22} For some time, recording a diagnosis of depression on the electronic record has triggered a series of prompts and demands on the clinician, which many saw as unnecessarily burdensome. This became a disincentive to code a formal diagnosis and instead alternatives, such as 'low mood', would be entered, although treatment itself remained unaffected. This has meant that GP records can show an exceptionally low prevalence of depression compared with what we know from national survey data.^{23,24} In this case, a failure to understand what statisticians term

the data-generating process would lead to a fundamental misinterpretation of what these data represent. Furthermore, the quantity of data collected here makes no difference to the validity of our conclusions. In fact, having more data is likely to help reinforce any erroneous claims.

Looking at health informatics more broadly, a classic example of what can go wrong if we fail to understand the data-generating process is that much cited example of big data, Google flu trends. Here, the frequency and location of a selection of Google search terms, based on health-seeking behaviour, were used to predict where and when the next flu epidemic would occur.²⁵ This was shown to more accurately predict epidemics compared with previous epidemiological studies and was therefore held up as an exemplar of the ascendancy of big data in health research.²⁶ That is, until Google flu trends stopped predicting accurately and eventually proved no better than estimates based on flu prevalence from a few weeks before.²⁷ This was in part a result of changes Google had made to their search engine, including the introduction of the auto-complete feature that meant searches no longer worked in quite the same way as when the algorithm was first devised. This problem was further exacerbated as the original search terms were never actually made public so could not be externally validated. Clearly, electronic health records are not subject to the same technical issues as a search algorithm. However, as we outline above, changes in the data-generating process, such as how diseases are coded, could make an important difference to results. In some ways, Google flu trends is the perfect example of the hubris associated with big data; as one of the early evangelical accounts confidently stated, ‘society needs to shed some of its obsession with causality in exchange for simple correlations: not knowing why but only what’.²⁶ Although this might make sense if we are simply mining data looking for patterns, this approach alone has little to offer in the way of research evidence.

Are the data we routinely collect aligned with research agendas?

A further limitation of research using administrative data is that we rarely have any control over what is collected and therefore risk the research agenda being set by what data are available. One field in which there have been major advances in recent years is ethnicity and mental health, partly due to the availability of electronic health records where patients’ ethnicity is now routinely coded. In particular, large-scale case registers have been used to document the increased incidence of psychosis among Black and minority ethnic groups, as well as exploring possible risk factors to explain these differences.^{28–31} These findings have been validated using other methodologies. However, there is a risk that we now focus research attention on what are often fairly crude categories, while neglecting other forms of minority status or more nuanced definitions of ethnicity simply because of the available data. For example, it is likely that other forms of marginalised status may also be relevant as risk factors where individual characteristics (such as sexuality, social class or marital status) are at variance with what is usual in a locality.^{32,33} However, these are typically not recorded in register data and are therefore unlikely to receive as much research attention. Where relevant risk factors are not being recorded, research has the potential to inform the data collection process to not only benefit research but also enhance clinical care.

How complex is the analysis of big data?

Another inherent danger is in the way we analyse these data. Often, the more data we have to analyse the more likely it is that we miss patterns in the data that could confound the associations we are interested in. For example, there might be temporal patterns in longitudinal data, such as long-term disease trends, that make it difficult to distinguish effects in before-and-after study designs. Short-term events such as the shift from ICD-9 to ICD-10 in the 1990s could confound our results when comparing changes in rates of diagnosed psychiatric disorders. Data might also be spatially patterned, with different environmental risk factors operating in different areas. This might be further patterned by administrative structures where, for example, differences in mental health outcomes in particular areas may reflect the performance, and reporting practices, of different mental health trusts. Considerable advances have been made in recent years in the tools available for analysing data patterned in this way. In particular, multilevel modelling and Bayesian analysis techniques allow us to simultaneously account for effects operating at temporal, individual, spatial and administrative levels. However, these are still not easily accessible to many researchers, or research consumers, although their use and accessibility are increasing. Implicit in these methods is a fundamentally different approach to that of small-scale studies, such as randomised controlled trials, where the aim is to remove complexity from the data through random

allocation. With big data we can no longer rely on random assignment and rely instead on being able to model the complexity inherent in the data to account for possible confounding effects.

Do big data mean more or less transparency?

Admittedly, complex data of this kind can be difficult to analyse, but it also presents an ever-increasing number of choices about how the analysis could be conducted. We might use different diagnostic categories, we could follow our sample over different time periods and look at a variety of different subgroups. We might use different statistical methods for the same analysis and we could also adjust for different sets of covariates. This growing array of possibilities also increases the opportunities to pick and choose our analysis until we find the most impressive-looking *P*-value. This tendency, often termed *P*-hacking or *P*-fishing, can be found in any statistical analysis, unless of course the method is predetermined and published in an advance protocol. However, big data exacerbate this tendency by increasing the possibilities for analysis. Often this means that statistically significant effects, which appear to show something important, cannot then be reproduced and our analysis is ‘over-fitted’ to our data. The US statistician Andrew Gelman describes this potential as the ‘garden of forking paths’.³⁴ He argues that this need not necessarily mean deliberate deception on the part of the analyst, but is often the result of unconscious bias as reasonable analysis decisions are made but they are contingent on the data. The accumulation of these decisions, at different stages in the analysis, ultimately leads to a statistically significant result being more likely. What is required, argues Gelman, is greater transparency so that we are able to retrace the steps made in the analysis to assess for ourselves the significance of findings. A related problem with large data-set analysis is that often very low, highly statistically significant *P*-values can be found for what amount to clinically insignificant effects. It is argued that these tendencies have led to what has been described as a ‘reproducibility crisis’ in science.³⁵ In response, the American Statistical Association recently issued a statement calling for greater transparency in the reporting of results and a move away from simply reporting *P*-values below a certain threshold ($P < 0.05$).³⁶

Complementary methods

Clearly, there are some inherent problems in the analysis of large-scale health records data, both for the unwary and for the unscrupulous. However, there is nothing either inherently good or bad about the use of these kinds of data for mental health research. Ultimately, this comes down to understanding the human story behind how the data were created, having the analytical skills to best interpret the data and being transparent in the way results are reported. What big data can then give us is one version of the truth to complement what we are able to discover using other methods. In fact, one of the best examples of big data that we have in UK mental health, CRIS, also includes a parallel community survey component, the South East London Community Health Study (SELCoH).³⁷ This is intended both to provide a parallel sample of community controls to match the case register and to yield detailed information about individual circumstances and attitudes otherwise absent from medical records.

There are of course a number of well-established national community survey resources, such as the Adult Psychiatric Morbidity Survey and the annual Health Survey for England, that are not dependent on health service use or subject to the diagnostic bias that occurs in health records data.^{38,39} We must also not forget the potential for qualitative research to address many of the questions in mental health research that are beyond the reach of statistical analysis. With the increased emphasis on evidence-based medicine, qualitative methods have increasingly been sidelined. For example, the *BMJ* recently announced that, in future, qualitative studies would have a low priority in the journal.⁴⁰ In response, 76 senior academics from 11 countries wrote an open letter calling for the journal to reconsider.⁴¹ They cite the complementary role that qualitative research can have, particularly where there is a failure to reproduce the results of analyses of large-scale health data-sets.

Last, let us not forget that the research we do is only meaningful in that it relates to the, essentially individual, experience of mental disorder. Whatever volume of data we analyse, whether we look at $n = 100$ or $n = 1\,000\,000$, ultimately we are interested in what this can tell us about the experience of $n = 1$.

The author would like to acknowledge the contribution of Justin Lock, who provided the inspiration for the title of this editorial.

1.6.42 Vitamin D deficiency in adolescents in a tier 4 psychiatric unit

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2017-6

Abstract

Aims and method To review the current clinical practice and guidelines for testing and treating vitamin D deficiency in adolescents admitted to a tier 4 adolescent psychiatric unit in north London. The blood test results of 56 patients admitted between 2012 and 2014 were examined to determine whether vitamin D levels had been tested. For those individuals who were tested for vitamin D, results were analysed by gender and ethnicity.

Results Of 56 patients admitted, 48% were tested for vitamin D deficiency and in 81.5% of cases we uncovered deficiency or severe deficiency; 18.5% had the minimum levels of vitamin D for bone health as per our trust guidelines.

Clinical implications Adolescents within tier 4 adolescent mental health services may be at higher risk of vitamin D deficiency and so assessment of vitamin D levels should be considered as part of a standard physical health review for this group of young people.

Contents

- *Vitamin D deficiency in adolescents in a tier 4 psychiatric unit*
 - *Aim*
 - *Method*
 - *Results*
 - * *Results by ethnicity*
 - * *Results by gender*
 - *Discussion*
 - * *Are adolescents at risk?*
 - * *Which guidelines to use?*
 - * *Prevention and treatment*
 - * *How much sun exposure is recommended?*
 - * *Study recommendations*

¹

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It is well known that vitamin D plays a role in bone health. In addition, vitamin D receptors have been found in several areas of the brain and are reported to be involved in neuroimmuno-modulation, neuroprotection, neuro-plasticity and brain development.¹ Given that some of these receptors are found in brain areas implicated in mental illnesses such as depression,¹ it is plausible that vitamin D and/or vitamin D deficiency have a role in the pathogenesis of mental illness.

Existing guidelines identify risk factors for vitamin D deficiency²⁻⁴ (details available from the authors on request), although there is little that relates specifically to adolescents or individuals within mental health settings. We hypothesised that patients in a tier 4 adolescent psychiatric unit in north London may be at increased risk of vitamin D deficiency, potentially having had reduced exposure to sunlight as a result of their psychiatric presentations. Linked to this, according to data from the UK National Census in 2011,⁵ there is a higher proportion of individuals with increased skin pigmentation (black and minority ethnic (BME)) compared with the national average within inner London schools, which may reflect general population trends in urban areas.

Aim

We examined the blood test results of all patients admitted to Simmons House, a tier 4 adolescent psychiatric unit, to review our management of individuals with vitamin D deficiency, make recommendations for future practice and identify areas where further study is needed.

Method

The blood test results of patients admitted to the unit between 2012 and 2014 were examined after a clinical observation that a number of patients had vitamin D deficiency. Patient notes were checked to determine gender, ethnicity, whether they were tested for vitamin D levels and the result of the test. The results were classified according to local laboratory reference ranges at the Whittington Hospital NHS Trust in London: <25 nmol/L severe deficiency, 25–50 nmol/L deficiency and 50 nmol/L minimal vitamin D levels for bone health. The results were also mapped to other guidelines, such as National Institute for Health and Care Excellence (NICE) guidelines (<25 nmol/L ‘low vitamin D status’) and those outlined by the Endocrine Society and Society for Adolescent Health and Medicine (>75 nmol/L ‘adequate’).^{4,7}

Results

Of 56 patients on the unit between 2012 and 2014, 48% ($n = 27$) were tested for vitamin D deficiency. According to local laboratory reference ranges (Whittington Hospital NHS Trust), 81.5% ($n = 22$) were deficient or severely deficient (40.7% deficient and 40.7% severely deficient) and 18.5% had the minimum levels for bone health. Applying the NICE guidelines, 40.7% of patients had low vitamin D status. No individuals tested had levels of >75 nmol/L (a level recommended in other guidelines).^{4,7} The results are summarised in *Table 1*.

Vitamin D levels in the tested patient sample

	Pa-tients <i>n</i>	Tested for vitamin D levels (%)	D deficient or severely deficient (%)	Minimum level of vitamin D for bone health (%)	Vitamin D at > 75 nmol/L
Male	14	8 (57)	6 (75)	2 (25)	0 (0)
Female	42	19 (45.2)	15 (79)	4 (21)	0 (0)
White	39	18 (46.1)	13 (72.2)	5 (27.8)	0 (0)
BME	17	9 (52.9)	9 (100)	0 (0)	0 (0)
Total	56	27 (48)	22 (81.5)	5 (18.5)	0 (0)

BME, Black and minority ethnic.

<50 nmol/L

>50 nmol/L

Results by ethnicity

Nearly half of adolescents who were White were tested (46.1%, 18/39), and 72.2% ($n = 13$) were deficient or severely deficient in vitamin D. In individuals from BME groups, who were potentially at higher risk of vitamin D deficiency due to increased skin pigmentation, 52.9% (9/17) were tested for vitamin D levels and 100% were deficient or severely deficient. There was no significant statistical association between ethnicity and vitamin D deficiency ($\chi^2 = 3.07$, $P = 0.136$ (Fisher's exact test)).

Results by gender

Three-quarters of the sample were female ($n = 42$); 14 were male. Of the 57% ($n = 8$) males tested, 75% ($n = 6$) were deficient or severely deficient in vitamin D, whereas of the 45.2% ($n = 19$) females tested, 79% ($n = 15$) were deficient or severely deficient in vitamin D. There was no statistical association between gender and vitamin D deficiency ($\chi^2 = 0.05$, $P = 1.000$ (Fisher's exact test)).

Discussion

Are adolescents at risk?

There is emerging evidence that the adolescent population in general is at risk of vitamin D deficiency.⁸ Although risk factors may vary, depending on geographical location, seasonal changes, latitude and variations in ultraviolet light levels, there has also been a suggestion of a worldwide re-emergence of rickets in the paediatric population.⁹ The Royal College of Paediatrics and Child Health identifies adolescents as having an 'increased need' for vitamin D,¹⁰ and the draft NICE guidelines⁶ stated that young people undergoing rapid periods of growth are at an increased risk of vitamin D deficiency, although this did not appear in the final guideline.²

Which guidelines to use?

An update to the NICE guidelines regarding vitamin D deficiency was published in November 2014 with the aim of increasing vitamin D supplement use among at-risk groups.² The guidelines include the findings of the *National Diet and Nutrition Survey* showing that 8–24% of children (depending on age and gender) may have vitamin D deficiency (details available from the authors on request). It is also noted that up to 75% of Asian adults may be deficient in vitamin D. The groups at risk of vitamin D deficiency, including adolescents, are: people who have low or no exposure to the sun, for example those who cover their skin for cultural reasons, those who are housebound or confined indoors for long periods, and people with darker skin, for example people of African, African-Caribbean or South Asian origin.

There appears to be a lack of consensus between various guidelines in defining a biochemical vitamin D deficiency. NICE guidelines² give a level of <25 nmol/L as low vitamin D status, but local laboratory reference ranges and recommendations made in other guidelines vary. For example, the Endocrine Society⁴ and the Society for Adolescent Health and Medicine⁷ provide different recommendations regarding required vitamin D levels, which appear to be higher than those in the NICE guidelines.² *Table 2* summarises the guidelines.

Vitamin D levels by guideline

	Whittington Hospital NHS Trust laboratory interpretation	NICE guidelines	Endocrine Society and SAHM interpretation
< 25 nmol/L	Severe deficiency	Low vitamin D status	Deficiency
25–50 nmol/L	Deficiency	n/i	Deficiency
>50 nmol/L	Minimal levels for bone health	n/i	Recommended or 'adequate' level

SAHM, Society for Adolescent Health and Medicine; n/i, no interpretation offered in the guideline.

Prevention and treatment

Vitamin D deficiency can be treated with oral or intramuscular supplementation, usually in the D₃ form (cholecalciferol), as this may be more effective than vitamin D₂ in raising serum 25(OH)D levels.¹¹ NICE guidelines outline the daily vitamin D intake requirements to minimise the risk of deficiency in various age groups, with 400 IU for 'at risk' adults. Similar requirements have been suggested for adolescents.⁸ Medical causes of vitamin D deficiency, other than reduced sunlight exposure, should also be considered, for example reduced parathyroid hormone levels or malabsorption disorders such as coeliac disease. No single treatment recommendation for vitamin D deficiency is given in national guidelines.

How much sun exposure is recommended?

A recent NICE guideline, published in February 2016, outlines the risks and benefits of sunlight exposure.¹² It recognises that advice on sunlight exposure to date has been available from many sources and that the information has often been 'inconsistent and potentially confusing'.¹² Young people and their parents/carers could be confused, worrying about balancing advice to limit sun exposure, because of the increase in incidence of skin cancer and other skin disorders, with a need to have sun exposure for vitamin D production.^{13,14} The new NICE guideline acknowledges that, with a proviso that 'a simple definitive message telling different groups how often and how long they can be exposed to sunlight to ensure minimum risk but maximum benefit' is not possible because of the multiple biological, social and environmental factors that contribute towards an individual's risk-and-benefit profile.¹² Specific risk factors for skin cancer such as a family history of the disease should always be considered when giving sun exposure advice, and the NICE guideline also mentions groups who should take 'extra care to avoid skin damage and skin cancer'. This includes young people.¹²

It is suggested that skin colour charts may be helpful in making judgements about sun exposure advice. Individuals with naturally very light skin (skin types I and II) are at greater risk of sunburn and skin cancer and require shorter times of sun exposure to synthesise vitamin D compared with those with darker skin types (types V and VI), who are at increased risk of vitamin D deficiency in the UK.¹²

Advice should be tailored for the time of year and the time of day. For example, in the UK between March and October and between 11 am and 3 pm, short periods of sun exposure to the forearms, hands or lower legs are required to synthesise vitamin D, whereas longer times are required between 3 pm and 11 am.¹² Between October and March, there is 'very little of the ultraviolet B wavelength the skin needs to make vitamin D'.¹²

With so many factors to consider, it is perhaps not surprising that the general advice given in the NICE guideline remains equivocal, with an emphasis on providing consistent, balanced messages regarding the risks and benefits of sunlight exposure for each individual. It is suggested that: 'short (less than the time it takes for skin to redden or burn), frequent periods of sunlight exposure are best for vitamin D synthesis. In addition, this type of exposure is less likely

to result in skin cancer'.¹² This advice is broadly similar to advice published in a multiagency consensus document in 2010 (<https://www.cancerresearchuk.org/sites/default/files/vitamins-consensus.pdf>).⁷

Study recommendations

If it were assumed that all of the individuals in our study who were not tested – deliberately or by accidental omission – had 'optimum' vitamin D levels, then 39.3% ($n = 22$) of the total sample had vitamin D deficiency. However, it seems unlikely that all of the non-tested patients had optimal levels given that, for example, 8 BME patients were not tested and 100% of those who were tested were deficient or severely deficient in vitamin D.

Factors influencing whether patients on Simmons House Adolescent Unit were tested for vitamin D before 2015 have not been explored in this project. The apparent idiosyncrasy of testing is beyond the scope of the present study but was one of the reasons for the study and subsequent recommendations detailed in the *Appendix*.

The results could suggest that all individuals within Simmons House at risk of vitamin D deficiency were identified and their levels tested accordingly. Alternatively, it may be that a proportion of the 52% of individuals not tested had an undetected vitamin D deficiency, particularly those from BME backgrounds given that 100% of the BME patients who were tested had deficiency or severe deficiency. As increased skin pigmentation is identified as a specific risk factor for vitamin D deficiency in the NICE guidelines, it could be that all adolescents with increased skin pigmentation admitted to a tier 4 adolescent psychiatric unit should have their vitamin D levels checked. This may be particularly relevant in units with culturally diverse populations. Specific recommendations made for Simmons House are detailed in the *Appendix*.

Perhaps any adolescent with a mental illness of a severity that requires in-patient admission is at risk of reduced sun exposure and consequent vitamin D deficiency, no matter their ethnicity. It could be suggested that all patients within tier 4 adolescent psychiatric units should be considered at high risk of vitamin D deficiency and tested, unless there was clear evidence to the contrary, such as a confirmed history of adequate sun exposure and theoretically sufficient dietary intake.

Choosing a particular treatment regime depends on clinical need and consideration of local guidelines. Recommendations given in various London NHS trusts guidelines (St Bartholomew's and The London NHS Trust, Royal Free Hospital NHS Trust and The Whittington Hospital NHS Trust; details available from the authors on request) range from treating a deficiency with oral cholecalciferol in doses of 2000 to 6000 IU per day, or once-weekly doses of 20 000 IU, all for a minimum of 3 months before rechecking vitamin D levels. Once the serum 25(OH)D level has been normalised, the recommended maintenance doses range from 400 to 1000 IU of cholecalciferol per day, with NICE suggesting 400 IU per day as a prophylactic dose for those at risk of deficiency. Therefore, at the very least, it seems that prophylactic supplementation of 400 IU of vitamin D₃ per day should be considered for adolescents at risk of vitamin D deficiency, or treatment of a confirmed vitamin D deficiency initiated after discussion with the adolescent and/or their family/carers. Treatment regimens should be in line with local guidelines until a sufficient evidence base is established to provide national guidelines.

More research is needed into the prevalence of vitamin D deficiency in all age groups, both in the general population and in hospital settings (general and psychiatric hospitals). The topic is likely to appear in the medical literature frequently in years to come, with hypothesised links between vitamin D deficiency and a multitude of medical conditions ranging from cancer to psychosis,¹⁵ multiple sclerosis¹⁶ and the possibility of a worldwide re-emergence of rickets in the paediatric population.⁹ The relationship between vitamin D and mental illness is not known. A meta-analysis¹⁷ published in the *British Journal of Psychiatry* in 2013 supported an association between low vitamin D concentrations and depression, mostly based on observational studies. However, the nature of the association is not yet known to be causal and the paper also noted that the quality of evidence in this particular area to date is poor; no randomised control trials have been performed.¹⁷

If an association between depression and vitamin D deficiency were to be confirmed through future study, vitamin D supplementation could potentially be a cost-effective treatment adjunct with minimal adverse effects. In the meantime, the beneficial effects of vitamin D on bone health have been clearly demonstrated. Future research might include a nationwide project through the Royal College of Psychiatrists' Quality Network of Inpatient CAMHS Units (QNIC;

qnic.org.uk) to which almost all tier 4 units in the UK are allied for appraisal and accreditation. Additionally, consideration of whether the child and adolescent population attending tier 3 child and adolescent mental health services (CAMHS) should be tested for their vitamin D status requires further thought.

1. All admissions to Simmons House should be considered at high risk of vitamin D deficiency, especially individuals with increased skin pigmentation or with a history suggestive of a lack of sun exposure. Therefore, vitamin D levels should be included as part of the routine physical assessment.
2. If blood tests are refused or clinically inappropriate, prophylactic treatment should be considered with 400 IU cholecalciferol (vitamin D₃) orally once daily, assuming informed consent is gained.
3. If a vitamin D deficiency is detected, baseline corrected calcium levels should be tested, plus a full bone mineral profile and testing of parathyroid hormone levels, along with routine admission blood tests (e.g. full blood count, urea and electrolytes, liver function tests, random blood glucose, thyroid function tests and lipid profile).
4. Treatment of a vitamin D deficiency should consist of high-dose cholecalciferol (vitamin D₃) (5000–6000 IU) orally daily for 3 months. Vitamin D levels and corrected calcium levels should then be checked again and a maintenance dose of cholecalciferol (vitamin D₃) 400 IU commenced once daily when vitamin D levels have normalised. Continuation of treatment should be tailored to each individual, based on severity of the deficiency and ongoing risk factors for vitamin D deficiency. Longer-term management of supplementation should be discussed with primary care colleagues.
5. Patients and/or their families/carers should be made aware of potential side-effects of treatment i.e. vitamin D toxicity or hypercalcaemia, which may present with anorexia, weight loss, vomiting and polyuria.
6. Ongoing examination of blood test results (serum vitamin D levels) should take place and internal audit on clinical practice should continue.

1.6.43 Adherence to NICE guidance on lifestyle advice for people with schizophrenia: a survey

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date

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Abstract

Aims and method The STEPWISE trial (STRUCTURED lifestyle Education for People WITH SchizophrEnia, schizoaffective disorder and first episode psychosis) is currently evaluating a lifestyle

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education programme in addition to usual care. However, it is difficult to define what constitutes 'usual care'. We aimed to define 'usual care' for lifestyle management in people with schizophrenia, schizoaffective disorder and first-episode psychosis in STEPWISE study sites. Ten National Health Service (NHS) mental health trusts participated in a bespoke survey based on the National Institute for Health and Care Excellence (NICE) guidance.

Results Eight trusts reported offering lifestyle education programmes and nine offered smoking cessation support. Reported recording of biomedical measures varied.

Clinical implications Although recommended by NICE, lifestyle education programmes are not consistently offered across UK NHS mental health trusts. This highlights missed opportunities to improve the physical health of people with psychotic illness. Our survey benchmarks 'usual care' for the STEPWISE study, against which changes can be measured. Furthermore, future studies will be able to identify whether any progress in clinical practice has been made towards achieving the NICE recommendations.

Contents

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The prevalence of overweight (body mass index (BMI) >25 kg/m²) and obesity (BMI>30 kg/m²) in adults with schizophrenia is approximately twice that in the general population and while it has increased in both groups in the past 30 years, the rate of increase is greater in people with schizophrenia.¹ Weight gain often occurs after initiation of antipsychotic treatment: over 50% of individuals gain more than 7% of their initial body weight within the first 12 months of treatment, with up to 86% gaining weight with some types of antipsychotic.² Compared with the general population, people with schizophrenia consume more fat and refined carbohydrates and fewer vegetables,³⁻⁵ are less physically active and experience higher levels of deprivation,⁴⁻⁷ all of which are associated with obesity. The National Institute for Health and Care Excellence (NICE) recommends that people with psychosis or schizophrenia, particularly those taking antipsychotics, should be offered access to a combined healthy eating and physical activity programme

to aid in the prevention of weight gain and its related comorbidities, leading to improved quality of life.⁸ They should be supported by clinicians to make choices about antipsychotic medication, informed by discussions of likely benefits, possible side-effects, such as weight gain and metabolic disturbance, and impact on other aspects of their physical health. For those who smoke, help should be offered to stop smoking.⁸

The STEPWISE study (STructured lifestyle Education for People WItch SchizophrEnia, schizoaffective disorder and first episode psychosis; ISRCTN19447796) was commissioned to evaluate the extent to which a structured lifestyle education programme can support weight loss, compared with usual care, when delivered to adults with schizophrenia, including those with schizoaffective disorder or first-episode psychosis, in a community mental health setting. In pragmatic trials, practitioners are often allowed ‘considerable leeway in deciding how to formulate and apply’ the treatment in a control arm defined as ‘usual care’.⁹ While the result may be reflective of the care received by patients outside the trial, there is often variation in care in an active control arm, which may be difficult to document.^{10,11} For this reason, study teams often try to capture the active content of the control arm of their trials.¹² In this paper we describe a survey of ‘usual care’ for the management of weight and other lifestyle factors in people with schizophrenia, schizoaffective disorder and first-episode psychosis in the ten participating study sites.

Method

Research tool

The survey instrument consisted of 14 questions, which were a combination of closed and open design, with the aim of eliciting information about the implementation of the recent NICE guidance on psychosis and schizophrenia at National Health Service (NHS) mental health trusts in the UK, and consequently what is offered as ‘usual care’. The survey was developed for the research study, based on the physical health aspects of the NICE recommendations in clinical guideline 178.⁸ Questions followed the baseline assessment tool published alongside the NICE guidance. The instrument was piloted with one study site investigator (J.M.) on two occasions, and each led to substantial changes to the tool. For instance, the second iteration revised questions to ascertain proportions of patients to whom certain criteria apply, rather than closed questions such as ‘Are patients referred to a healthy eating programme?’ The final version of the tool also clarified which questions related to all patients with schizophrenia, schizoaffective disorder and first-episode psychosis, and which questions related to patients with first-episode psychosis only (the questionnaire is included in the *Appendix*). This is in line with the additional recommendations specified in the NICE guidance for patients with first-episode psychosis who have recently been prescribed antipsychotic medication; these additional questions were not applicable to the management of patients with established mental illnesses.

Survey structure

Trusts were initially asked whether they offered a healthy eating and physical activity programme. Subsequent questions asked for more information about these programmes, including whether they were combined or separate for healthy eating and physical activity; how patients accessed them; and how often patients were referred to such services. Additional information was sought on the availability of smoking cessation services in this population and whether discussions took place between patients and clinicians prior to antipsychotic treatment initiation, including benefits of treatment, interactions with other substances and other possible side-effects.

In addition, NICE recommend that a number of physiological measures should be recorded both prior to the patient starting antipsychotic medication and annually thereafter. Respondents were asked to comment on how likely it was that each measure would be recorded at both of these time points in their trust and how often patients on antipsychotic medication have their weight recorded.

Sample selection

The STEPWISE trial has ten centres in a variety of urban, suburban and rural locations across England: Sheffield Health and Social Care NHS Foundation Trust, Leeds and York Partnership NHS Foundation Trust, Bradford District Care NHS Foundation Trust, Greater Manchester West Mental Health NHS Foundation Trust, South London and Maudsley NHS Foundation Trust, Sussex Partnership NHS Foundation Trust, Southern Health NHS Foundation Trust, Devon Partnership NHS Trust, Somerset Partnership NHS Foundation Trust and Cornwall Partnership NHS Foundation Trust. A representative from each centre was invited to complete the survey.

Respondents

The principal investigators at each of the ten centres for the STEPWISE trial were initially approached. Some of them completed the survey themselves, while others delegated to trust physical health leads or equivalent as they were better placed to answer the questions. Contact was made via email in the first instance, with an invitation to attend a teleconference with the STEPWISE research assistant (L.S.) to complete the survey. Those who did not provide a response to the invitation within 4 weeks were contacted again by reminder emails and/or by telephone. Six of the ten sites' surveys were completed through discussion via teleconference. The remaining four sites' surveys were completed independently by a trust representative and written responses were provided to the STEPWISE research assistant.

No sites required more than one reminder email/telephone call in order to arrange completion of the survey. As the survey information was requested from members of a research team, a favourable ethical opinion from an NHS Research Ethics Committee was not sought and consent was unnecessary. Responses provided organisational data only and did not include any personal data. Responses from all sites were received between 22 May and 28 October 2015.

Analysis

Descriptive statistics in the form of counts were produced for quantitative variables. Supporting information provided by respondents and information yielded from qualitative questions was summarised in narrative form.

Results

Healthy eating and physical activity programmes

Eight respondents reported that their trust offered programmes on healthy eating and physical activity, which were mostly separate programmes. Supplementary information indicated that provision was *ad hoc* and interventions were rarely standardised. Most respondents reported routinely inviting patients to access services such as discounted local gym memberships, cooking groups and activity groups delivered by local authorities and third-sector organisations. Two trusts reported offering one-on-one advice sessions with healthy living advisors or health trainers, but the sessions were usually advice-giving and often more clinically focused rather than looking at the patient's physical well-being.

Those trusts that offered trust-led programmes reported that these were available in principle to all of their patients rather than specific groups based on diagnosis. However, interventions were often accessed only by certain groups of patients, usually through particular clinicians or clinics. One trust estimated that 70% of their eligible patients are referred to such services by mental health professionals, based on recent Commissioning for Quality and Innovation (CQUIN) results; other respondents were unaware of routine data from which they could quantify referrals. Six trusts reported offering lifestyle advice through open-ended group courses, three through courses delivered over a fixed period and four through drop-in sessions.

Smoking cessation advice

Six respondents indicated that patients who smoke were offered help to stop some of the time, three reported help was offered all of the time, and one said this was not offered at all. Respondents who selected 'some of the time' were unable to quantify this, but felt that this occurred most of the time. Although it varied whether smoking cessation services were offered by the trusts or external services, most offered a combination of the two. Seven trusts reported offering trust-led smoking cessation services, while others had trained smoking cessation advisors but had no formal trust-offered service. Most trusts reported signposting outpatients to external services, some of which were managed by primary care, with advice leaflets available within the trust.

Antipsychotic treatment initiation

Table 1 shows the reported levels of discussion about likely benefits of treatment, as well as potential weight gain, diabetes and metabolic side-effects and any other possible side-effects, across all respondents. Most trusts who reported that the recommended discussions took place 'some of the time' felt that this would be most of the time, but there was a lack of evidence to support this. One site reported that discussions would be dependent on the clinician, but that resources were available to clinicians to support the discussions. Another site suggested that such discussions may be part of an ongoing process rather than all happening in one session, depending on the patient's level of capacity.

Discussions with patients when deciding on antipsychotic treatment ($n = 10$ NHS trusts)

	All of the time	Some of the time	Not at all
Topic			
Likely benefits	7	3	0
Weight gain	5	5	0
Diabetes and metabolic side-effects	3	7	0
Other possible side-effects	5	5	0
Other substances			
Alcohol	5	5	0
Tobacco	2	8	0
Other prescribed medications	3	7	0
Non-prescribed medications	0	10	0
Illicit drugs	3	7	0

Table 1 also shows how often respondents reported discussions taking place regarding the use of alcohol, tobacco, prescribed and non-prescribed medications and illicit drugs, at the time of antipsychotic treatment initiation.

Table 2 shows how likely trusts considered that physiological measures would be recorded prior to treatment initiation.

Recording of physiological measures prior to antipsychotic treatment initiation ($n = 10$ NHS trusts)

	Very likely	Likely	Neither likely nor unlikely	Unlikely	Very unlikely
Weight	3	4	1	2	0
Weight plotted on a chart	1	3	1	3	2
Waist circumference	0	2	3	3	2
Pulse	3	4	1	1	1
Blood pressure	4	2	1	2	1
Fasting blood glucose	0	5	1	2	2
Random blood glucose	2	4	0	3	1
HbA1c	2	2	1	2	3
Blood lipid profile	2	4	0	2	2
A ssesment of any movement disorders	2	4	2	0	2
A ssesment of nutritional status, diet and level of physical activity	3	3	1	3	0

Ongoing monitoring of weight and other physiological measures

It was clear from the responses that there were variations in recording patients' weight at the time points recommended by NICE (first at 6 weeks post-treatment initiation, then at 12 weeks, at 1 year and annually thereafter), both between trusts and within trust services. Some confusion exists regarding responsibility for annual patient reviews in the community and whether these should be completed by the general practitioner (GP) or the trust. Half of those surveyed reported that it was neither likely nor unlikely that patients would have their weight recorded weekly for the first 6 weeks, with three other trusts reporting that this was very unlikely. There was an even spread across all response categories as to whether weight was recorded at 12 weeks, but at 1 year four of those surveyed reported that patients were very likely to have their weight recorded. Six respondents reported that weight was likely or very likely to be recorded annually thereafter, although this was where the confusion arose regarding responsibility for these reviews.

Table 3 shows trusts' consideration as to how likely it was that physiological measures would be recorded at least annually in patients taking antipsychotic medication. One site felt they were unable to answer this question, so we present data reflecting responses from nine trusts.

Recording of physiological measures at least annually for patients on antipsychotic medication ($n = 9$ NHS trusts)

	Very likely	Likely	Neither likely or unlikely	Unlikely	Very unlikely
Weight	3	4	0	2	0
Weight plotted on a chart	0	3	3	2	1
Waist circumference	0	2	2	3	2
Pulse	2	4	1	1	1
Blood pressure	3	4	1	1	0
Fasting blood glucose	1	2	5	1	0
HbA1c	2	2	4	1	0
Blood lipid profile	2	1	4	2	0
A assessment of any movement disorders	1	4	3	1	0
A assessment of nutritional status, diet and level of physical activity	3	1	3	2	0

There was no correlation between which of the recommended physiological measures were recorded by trusts prior to antipsychotic treatment initiation or annually thereafter, although generally those trusts who were likely to record particular measures prior to treatment initiation were also likely to record the same measures at least annually thereafter.

Discussion

Principal findings

It was clear from this survey that there was great variation between different NHS mental health trusts in the provision of healthy eating and physical activity interventions routinely offered to patients, as well as variation between clinicians within the same trust, with interventions often accessed only through particular clinicians or clinics. Commonly, trusts reported signposting or referring patients to programmes offered by external services, such as gym memberships and activity classes.

Most patients had access to a smoking cessation service should they require it, and referrals to such services were reported to occur most if not all of the time at nine out of the ten trusts surveyed, regardless of whether the service was offered within the trust or run externally.

When deciding on antipsychotic medication with newly diagnosed patients, there was also variability in the reported discussions that took place across trusts. All trusts reported that the likely benefits, weight gain, diabetes and metabolic and other possible side-effects were discussed with the patient at least some of the time; the possible interference of other substances with prescribed antipsychotic medication was also discussed.

Although at the early stages in the course of antipsychotic treatment it was reported unlikely that trusts would record a patient's weight, as recommended by NICE, by 1 year after treatment initiation a larger proportion of trusts reported weight recording, with an increase for annual reviews thereafter, despite the uncertainties regarding responsibility for undertaking annual reviews in the community.

Study strengths and limitations

A strength of this survey was that its design was based on the NICE guidelines to which mental health trusts should be adhering. This meant that trusts' compliance with these recommendations could be assessed, allowing us to elicit information on what programmes (if any) trusts were offering in usual practice and how these compared with what is recommended by NICE. This also allowed us to try to define 'usual care' in relation to the STEPWISE study, using a standard approach across all trusts.

The survey was, in principle, a suitable method to elicit the same information from all respondents; however, it was clear from the responses that owing to the variability of services offered it was often difficult to provide a succinct account using this survey tool. The narrative information provided by the respondents proved more useful in gaining a fuller picture of their usual care than the descriptive statistics, which in some cases were a best guess, as clear data were not always available.

Furthermore, responses were based on one member of staff's knowledge of usual care in practice, and although this person was usually best placed to answer the questions, from the survey responses received knowledge may have been limited, especially as some interventions offered were particular to a specific clinic or clinician and usual care may vary within and between community mental health teams in any given NHS organisation. In addition, how representative 'usual care' is in comparison with NHS trusts not taking part in the STEPWISE study remains unknown.

The levels of detail regarding the content of available services also varied, perhaps indicating that the respondent had more involvement with some programmes than others. Therefore, it was considered likely that additional interventions may have been offered within trusts of which the survey respondent was unaware.

In relation to implementation, a weakness in the survey was highlighted when some responses were received through telephone discussion while others were completed by the respondent and returned to the researcher. No systematic differences between telephone and paper copy responses were identified, although more supporting information was often provided through telephone responses, as these were elicited through more of a conversational discussion. This difference in response methods may have caused questions to be perceived differently, although all telephone participants had a copy of the questionnaire available to them at the time of completion. Perceptions of appropriate levels of detail can change with different methods of completion, which may lead to variation in results. However, as such variation was evident between practices offered as 'usual care' in the ten trusts surveyed, the impact of these differences in completion method is considered likely to be small.

The variability in the information elicited has not allowed for a common picture across all sites, as although a type of programme is recommended by NICE, a particular standardised programme is not available across all trusts. However, the survey did provide sufficient baseline information to allow any changes in usual practice during the course of the STEPWISE study to be monitored at a trust level, rather than across all study sites as a whole. This will enable assessing at the end of the STEPWISE study the extent of potential contamination between the intervention and control arms of the trial, based on changes in practice reported in the survey.

Context

Although there may be an increased awareness of the potential benefits of some treatments, this does not ensure that such treatments are implemented effectively. Evaluations and methods of improving the implementation of NICE guidelines often have limited attention.¹³ A systematic review undertaken by Berry & Haddock¹³ noted that the research around the implementation of NICE guidelines on schizophrenia is relatively limited, suggesting that these patients have poor access to psychological interventions such as cognitive-behavioural therapy (CBT). Some barriers to implementation of NICE guidelines were reported, such as insufficient support from trust management and the needs of organisations. The paper also highlights that whereas NICE considers randomised controlled trials (RCTs) to be the gold standard when developing an evidence base for its guidelines, RCTs have also been criticised for their poor ability to reflect the 'real world'. The authors suggest that targeting these barriers is key to facilitating successful implementation of the guidelines.¹³

It is therefore important to identify which aspects of the guidance are not currently being followed, in order to target these areas for implementation and improve clinical care. Not only is it important to consider the implementation of

guidance relating to monitoring of biomedical measures, but there is also likely to be a limited effect unless this is combined with sufficient intervention in behaviour or treatment. Similarly, the mere fact of guidance or a trial does not necessarily lead to substantive changes or better outcomes. Repeating the survey annually will allow identification of any substantive, systematic changes within the organisations, both since the introduction of the NICE guidelines and throughout the duration of the STEPWISE trial.

From a research perspective, the reported variation also has implications for our study when defining 'usual care'. If all trusts adhered to all recommendations in the NICE guidelines, we could be sufficiently confident that contamination between trial arms would be minimal. However, as different levels of compliance with different recommendations were evident, this does not allow for standardised 'usual care' across the study. This does mean that usual practice can be compared over time within each trust individually, in order to assess how much 'usual care' has changed throughout the course of their participation in the STEPWISE study.

The Royal College of Psychiatrists' National Audit of Schizophrenia includes standards on the monitoring of physical health in patients with schizophrenia. The audit report in 2014 noted that the provision of interventions is poor when there is evidence of physical health risks.¹⁴ It highlighted barriers to intervention, such as availability of staff time, facilities and equipment, the need for formal systems to conduct annual reviews, and the need for more formal arrangements regarding responsibility for physical health between primary and secondary care.¹⁴ Standard 5 in the audit specifically looks at interventions offered for particular physical health risks. The overall results show that intervention for BMI > 25 kg/m² was evident in 71% of patients, while interventions for smoking were reported in 59% of patients.¹⁴

For the ten trusts surveyed, the audit reported a range of 47–83% of patients receiving intervention for elevated BMI, and 33–67% receiving intervention for smoking. Overall, the audit also showed wide variation in the monitoring of physical health risk factors. For example, the range across all participating trusts for monitoring of BMI was 5–92% of patients and 16–99% for the monitoring of glucose control. This is supportive of the information yielded from the study survey and highlights variability in services offered across trusts.¹⁴

Implications for stakeholders

This survey indicates that the ten sites surveyed are not fully compliant with NICE physical health recommendations on the management of patients with schizophrenia. However, as the guidelines were published in March 2014, this is not surprising, because services require time to commission and set up. In some respects, this alleviates the concerns that the 'usual care' arm of the STEPWISE trial may converge with the intervention arm, as there are no reported standardised programmes offered across any of the trusts surveyed. However, there is such variability observed that it becomes clear that 'usual care' is not the same for all participants in the trial or in the wider population group.

We have not tried to assess the success or potential effect of any one aspect of the physical health programme in comparison with others. Although it may be argued that smoking cessation could have a greater effect on physical health than healthy eating or physical activity programmes, despite the lower compliance with NICE guidance, any discussion is likely to be subjective. Furthermore, NICE does not prioritise any one element, coming from an understanding that all aspects are important and contribute to improved physical health.

As a future direction, it may be useful to try to identify patients at higher risk of cardiovascular events, using recording of cardiovascular disease risk factors in combination with risk engines to calculate risk accurately. This identification process could then drive intervention. This may be of interest to trusts as a method of offering a physical health intervention to those patients who are likely to receive the most benefit clinically. A suitable risk engine to calculate this would be the PRIMROSE cardiovascular disease algorithm,¹⁵ as this has been developed specifically for people with severe mental illness. The PRIMROSE model includes additional variables for psychiatric diagnosis, psychotropic medication, harmful use of alcohol, antidepressants and social deprivation score, unlike similar prediction models used in the general population. This is perhaps why PRIMROSE performed better than some other available published risk models, which may overpredict the risk of cardiovascular disease in this population.¹⁵

Further research

The survey will be repeated with the same ten NHS trust representatives at 12 and 24 months after the first iteration. This will allow the STEPWISE study team to consider how trusts are implementing the NICE guidelines and, consequently, whether convergence has occurred between the two arms of the STEPWISE trial at an individual trust level. As STEPWISE progresses, the participating NHS organisations may become more aware of the need to undertake physical health interventions and so 'usual care' may improve, potentially diminishing the effect of the STEPWISE intervention.

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1.6.44 Are men under-treated and women over-treated with antidepressants? Findings from a cross-sectional survey in Sweden

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Abstract

Aims and method To examine gender differences in self-reported depression and prescribed antidepressants (ADs). The Hospital Anxiety and Depression Scale was used to assess depression, and information on prescribed ADs was obtained from the Swedish Prescribed Drug Register.

Results Depression was reported by 11.7% of the participants (12.3% men and 11.2% women). ADs were prescribed for 7.6% of the participants (5.3% men, 9.8% women). Among men, 1.8% reported

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depression and used ADs, 10.5% reported depression but did not use ADs, and 3.6% used ADs but did not report depression. The corresponding figures for women were 2.6%, 8.6% and 7.2%.

Clinical implications Men report depression to a greater extent than women but are prescribed ADs to a lesser extent, possibly a sign of under-treatment. Women are prescribed ADs without reporting depression more often than men, possibly a sign of over-treatment. Although the causes remain unclear, diagnostic and treatment guidelines should benefit from considering gender differences in these respects.

Contents

- *Are men under-treated and women over-treated with antidepressants? Findings from a cross-sectional survey in Sweden*
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Depression is currently considered one of the largest and fastest growing health hazards.¹ Although only a small percentage of all those with mental health problems contact healthcare professionals and obtain a diagnosis, depression is one of the most common causes of sick leave and disability.^{2–5} Diagnosed depression was relatively unusual 20 years ago, but the incidence has increased remarkably with the introduction of new diagnostic guidelines and antidepressant drugs. What was previously considered psychological distress was then interpreted as a disease, with the risk of over-diagnosis and over-treatment.^{6–10} The point prevalence of depression in the general population is now estimated as 3–9%.^{1,11,12} There is an explicit gender impact on diagnosed depression, with a 2:1 ratio of women/men; about one in four women and one in ten men will develop depression severe enough to require treatment at some time in their lives.^{1,2,11,12} Moreover, depression may present differently in women and men. Women may be more prone to somatic symptoms of depression, whereas men appear to have more melancholic symptoms and to be more susceptible to drug misuse and aggressive behaviour.^{13–17} To date, however, there is no clear understanding of what causes these gender disparities in depression. They are considered likely to be a combination of several factors: biological, social and behavioural.^{18,19}

Depression is a long-lasting and, if left untreated, often chronic condition. Treatment usually lasts at least 6–12 months, and includes pharmacological therapy with antidepressants (ADs).²⁰ The use of ADs has increased dramatically in recent years.²¹ According to the national Swedish Prescribed Drug Register (SPDR), almost 9% of the Swedish population was prescribed ADs in 2014, and 65% of these ADs were prescribed for women.²² Similar patterns have been found in other countries.^{23–25} The explanation for this escalation, especially seen in women, remains unclear, but has sometimes been interpreted as a sign of inappropriate use.^{8,9} Nevertheless, despite the widespread use of ADs, depression has repeatedly been shown to be inadequately treated in the general population. Some studies have found that fewer than one in four patients with depression are prescribed ADs and that the duration of treatment is often shorter than recommended.^{26,27}

The ADs prescribed are primarily selective serotonin reuptake inhibitors (SSRIs), although others, for example serotonin–noradrenaline reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs), are also used depending on illness severity, the patient's age and various adverse drug reactions.^{20,28,29} Gender impact has been observed not only on the number of ADs prescribed but also on their type. For example, women

are prescribed SSRIs more often than men.³⁰

We examined gender differences in the relationship between self-reported depression and prescribed ADs, in the prevalence of self-reported depression, and in the number and type of prescribed ADs.

Method

Participants

A questionnaire was sent to a random sample ($n = 16\,000$, aged 18–84 years) of the Swedish population (totaling 9.5 million); responses were received from 7725 people (48.3%), as presented in *Fig. 1*. The study complies with ethical research requirements, as approved by the Regional Ethical Review Board in Uppsala, Sweden (Dnr 2012/073). Participation in the study was voluntary and information about its purpose was sent out with the questionnaire. Filling in and returning the questionnaire was considered to be equivalent to the respondent giving their agreement to participate in the study.

Assessment of depression and prescribed antidepressants

Self-reported depression was assessed using the Hospital Anxiety and Depression Scale (HADS).³¹ Of the 7725 available participants, 7618 (3435 men, 4183 women) filled in the HADS form (*Fig. 1*) and all analyses were based only on these participants. The HADS was developed to detect patients with high levels of psychological distress and does not include assessment of somatic symptoms. It contains two subscales, one each for anxiety and depression, each consisting of 7 items (score range 0–21) capable of distinguishing between these diagnoses. Higher scores indicate higher levels of psychological distress. Each subscale has three categories based on the score: 0–7 (normal), 8–10 (borderline) and 11–21 (abnormal). In this study, a cut-off level of +8 was used on the depression scale; this level indicates at least mild depression and provides an optimal balance between sensitivity and specificity.³²

Information on depression obtained from the HADS was linked (through the participants' identification number, a unique lifetime personal identifier given to all Swedish citizens) to prescription data. Prescribed ADs were obtained from the SPDR, a national register held by the National Board of Health and Welfare, which gathers data on all dispensed prescriptions for patients in ambulatory care from the entire Swedish population.^{22,33} We collected information on ADs 0–6 months prior to the HADS evaluation. SPDR drugs are classified according to the Anatomical Therapeutic Chemical (ATC) classification system.³⁴ The ADs (N06A) were categorised as TCAs (N06AA, e.g. amitriptyline, imipramine), SSRIs (N06AB, e.g. citalopram, fluoxetine), 'others' (N06AX, including SNRIs (e.g. venlafaxine) and tetracyclic antidepressants (TeCAs, e.g. mirtazapine)), and monoamine oxidase inhibitors (MAOIs; N06AF, N06AG, e.g. moclobemide). The MAOIs were excluded due to few users.

Analyses

The Statistical Analysis System software (SAS9.2, Cary, North Carolina, USA) was used to perform chi-squared tests (χ^2 , P) to examine gender differences in the relationship between self-reported depression and prescribed ADs, and in prevalence of self-reported depression, prescribed ADs, and type of ADs prescribed. Logistic regression analysis (odds ratios (OR) with 95% confidence intervals) was used to examine gender differences in self-reported depression, controlling for age.

Results

In total, 11.7% of the study population (12.3% men, 11.2% women; ², n.s.) was classified as having self-reported depression. Logistic regression analysis showed that the difference between men and women was statistically significant, i.e. men reported depression more often than women (OR 1.226 (CI 1.062–1.414)). According to the SPDR, 7.6% of the study population had been prescribed at least one AD during the 6 months prior to the HADS evaluation. Significantly more women than men were prescribed ADs: 5.3% of the men and 9.8% of the women were prescribed at least one AD ($P < 0.0001$).

Table 1 presents gender differences in the relation between prescribed ADs and self-reported depression in the study population. Among the men, 1.8% reported depression and used ADs, 10.5% reported depression but did not use ADs, and 3.6% used ADs but did not report current depression, while 84.1% were neither depressed nor used ADs. The corresponding figures for women were 2.6%, 8.6%, 7.2% and 81.6%. The gender difference was statistically significant (² $P < 0.001$) in all age groups except the youngest, and was most marked in the groups aged 45–64 and 65–74 years.

Relation between self-reported depression (assessed using the HADS) and prescribed antidepressants (ADs) in the study population ($n = 7618$), Sweden 2012/2013

	Men	Women									
18–34	593	1.7	8.9	2.0	87.4	831	1.8	9.8	3.6	84.8	N.S.
35–44	475	1.9	11.8	2.3	84.0	576	3.1	8.7	6.8	81.4	<0.01
45–64	1277	1.8	10.6	4.6	82.9	1537	3.3	9.0	8.3	79.4	<0.001
65–74	740	1.5	9.9	3.6	85.0	811	2.1	6.8	9.2	81.9	<0.001
75–84	350	2.3	12.6	3.7	81.4	428	1.9	7.9	7.0	83.2	<0.05
Total	3435	1.8	10.5	3.6	84.1	4183	2.6	8.6	7.2	81.6	<0.001

² analyses comparing men and women.

The participants who had received at least one prescribed AD during the 6 months studied ($n = 592$: men $n = 182$, women $n = 410$) were analysed with respect to the type of AD prescribed (Table 2). SSRIs were the most commonly prescribed ADs for both men (62.8%) and women (71.0%), although women were prescribed them more often than men, particularly in the age group 45–64 years (² $P < 0.05$). By contrast, there was no statistically significant gender difference for the TCAs (men 14.8%, women 10.2%), except for in the age group 45–64 years. Further, men were prescribed ‘other’ ADs (e.g. SNRIs and TeCAs) significantly more often than women (men 39.3%, women 28.1%; ² $P < 0.01$).

Types of antidepressant (ATC classification) among participants prescribed at least one antidepressant ($n = 592$), by age and gender, Sweden 2012/2013

	Users, <i>n</i>	SSRIs (N 06AB)	TCAs (N 06AA)	Others (N 06AX) <i>a</i>								
18–44	144	42	102	69.1	73.5	NS	9.5	5.9	NS	38.1	29.4	NS
45–64	260	82	178	58.5	71.3	<0.05	20.7	12.4	<0.05	37.8	25.8	<0.05
65–84	188	58	130	64.4	68.5	NS	10.2	10.8	NS	42.4	30.0	<0.05
Total	592	182	410	62.8	71.0	<0.05	14.8	10.2	NS	39.3	28.1	<0.05

ATC, Anatomical Therapeutic Chemical; NS, not significant; SSRIs, selective serotonin reuptake inhibitors; TCAs, tricyclic antidepressants.

For example, serotonin–noradrenaline reuptake inhibitors, tetracyclic antidepressants.

² analyses comparing men and women.

Discussion

The present study found that the relationship between self-reported depression and prescribed ADs differs by gender. As in several other studies,^{26,27} the majority of those who reported depression in our study did not use ADs, and overall, men used ADs to a lesser extent than did women, although they reported depression to a greater extent. This could have been caused by several factors. Many people, especially men, prefer not to seek healthcare.³⁵ Women are clinically diagnosed with depression far more often than men, probably not only because they are more depressed but also because they are more likely to seek healthcare, thus increasing the chance that their depression will be detected.³⁶ Also, diagnostic criteria for depression originate from a female norm and symptoms provided by women, leading to an increased likelihood that depression in women will be diagnosed.¹⁵ Depression in men has a different presentation than the classic depressive symptoms more often than in women, and this could lead to men's mental health problems not being recognised and therefore being under-treated.^{13,35}

In contrast to diagnosed depression, previous studies using HADS to assess depression have mostly found no gender differences or, like our study, found a higher prevalence of depression in men.^{37,38} Since men experience more melancholic symptoms and women more somatic symptoms (e.g. increased appetite and weight, and hypersomnia),^{13–17} the reversed gender differences in depression assessed with HADS compared with clinically diagnosed depression could be due to the fact that HADS's focus is more on melancholic rather than somatic symptoms. Whether the HADS might be more sensitive than other scales in detecting depression in men is as yet unclear.

Other factors that could explain the relatively low use of ADs in our study among the sample with depression might be that the depressed participants may have been reluctant to accept treatment with ADs, a choice that is possibly more common among men; they may not have needed drug treatment, perhaps because other treatments were used (in mild depression psychotherapy is considered as effective as drugs); or they may not have had the prescribed drug dispensed. Many patients do not adhere to treatment instructions, for example do not even obtain their prescribed drugs (primary non-adherence), and prior studies have suggested that both gender and illness severity affect adherence.^{39–42}

In our study, it was twice as common for women as for men to use ADs when not currently depressed. This could indicate that their depression was in remission, but it could also mean that women are being over-treated with ADs. Several studies have found AD use to be higher among women, and the increased prescription of ADs in recent decades is especially notable among women.^{23–25,30,43} The higher level of AD prescribing to women may in part be attributed to the greater consumption of healthcare among women in general.^{36,44} Apropos of this, there are studies that show that women are more likely than men to receive a prescription during their medical visits.⁴⁵ The lower threshold for prescribing ADs has led to a debate about the possibility of over-prescription or of ADs being sometimes prescribed where alternatives would be better.^{7–9} It seems that even mild symptoms are now considered indicative of disease and treated with medications, although the efficacy is often limited in mild to moderate depression.^{7,46,47} Further, an

expanding number of indications (e.g. neuropathic pain, anxiety disorders, eating disorders and sleep disorders) seen more often in women than in men are contributors to the increasing trend to prescribe ADs, and this could explain some of the AD use without depression seen in our study.^{9,48}

As in other studies, the SSRIs were the main drugs in our study.^{28,30} Because of gender differences in the pharmacokinetics and pharmacodynamics of ADs, and because depression may present differently in women and men, it has been suggested that men and women could differ in their response to treatment and that pharmacological treatments should therefore be chosen by gender.^{49–51} The women in our study used SSRIs more often than the men. It could be that somatic symptoms respond better to SSRIs than to TCAs. Another cause might be gender differences in adverse drug reactions. However, supporting data are limited and sometimes conflicting, and current treatment guidelines do not take gender into account.^{49,50,52} Regardless, it is important to continue to examine any differences between men and women concerning pharmacotherapeutic efficacy and adverse drug reactions.

Limitations

The SPDR offers complete data on all dispensed drugs; however, it does not give information on actual usage. Also, ADs during the 6-month period were analysed without distinguishing whether the drugs had been used for a long or a short time. Moreover, ADs are sometimes prescribed for indications other than depression, which we could not control for. However, previous studies have reported that depression remains the main indication for AD use.⁵³ Participation in the study was voluntary and there may have been selection biases. For example, non-responders were more likely to be men than women. It is also possible that people with current symptoms of depression would be less likely to respond, introducing further bias to participant selection. Depression assessed using the HADS (in the previous week) was not directly linked to prescribed ADs via the SPDR (0–6 months prior to the HADS evaluation). However, depression is often a prolonged state, and problems in this respect that were encountered in the previous week were probably not temporary. Finally, it is important to emphasise that a cross-sectional design does not permit evaluation of causality to be derived from the results.

Summary of findings

The relationship between self-reported depression and use of ADs differed by gender. Overall, men were prescribed ADs to a lesser extent than women, although they reported depression to a greater extent. By contrast, women were prescribed ADs without reporting depression more often than men. This may be a sign for under-treatment among men and over-treatment among women. Further, men and women were prescribed different types of ADs, possibly because of gender differences in treatment outcomes and adverse drug reactions. Although the causes of these findings remain unclear, diagnostic and treatment guidelines should benefit from considering gender in these respects.

1.6.45 An analysis of whether a working-age ward-based liaison psychiatry service requires the input of a liaison psychiatrist

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Abstract

Aims and method This article presents a 12-month case series to determine the fraction of ward referrals of adults of working age who needed a liaison psychiatrist in a busy tertiary referral teaching hospital.

Results The service received 344 referrals resulting in 1259 face-to-face contacts. Depression accounted for the most face-to-face contacts. We deemed the involvement of a liaison psychiatrist necessary in 241 (70.1%) referrals, with medication management as the most common reason.

Clinical implications A substantial amount of liaison ward work involves the treatment and management of severe and complex mental health problems. Our analysis suggests that in the majority of cases the input of a liaison psychiatrist is required.

Contents

- *An analysis of whether a working-age ward-based liaison psychiatry service requires the input of a liaison psychiatrist*
 - *Method*
 - * *Involvement of a liaison psychiatrist*
 - *Results*
 - * *Referrals which required the involvement of a psychiatrist*
 - *Discussion*

Liaison psychiatry services in England have recently seen considerable expansion, following the positive evaluation of the Rapid Assessment Interface and Discharge Team (RAID) service in Birmingham.¹ The independent evaluation suggested that this well-staffed multidisciplinary liaison psychiatry service returned considerable cost savings for people with mental health problems in that general hospital and those attending the emergency department.

The 2015 annual survey of liaison psychiatry in England demonstrated that many services are too poorly resourced to be delivering benefits to patients as envisaged by the RAID study,² while the recent *Guidance on Developing Models for Liaison Psychiatry Services* has shown great variability in service provision.³ The relative lack of consultant psychiatric input suggests that the specialist skills offered by consultant liaison psychiatrists may be poorly understood. To examine the multidisciplinary liaison psychiatry team, we aimed to determine the proportion of referrals to a ward-based liaison service which required the involvement of a psychiatrist in a busy tertiary teaching hospital in England. This project was carried out as part of a registered audit (Audit Project 2125) with Manchester Mental Health and Social Care Trust.

There are many descriptions of the activity of liaison services, but we believe this is the first time the role of a psychiatrist has been addressed in depth. We hope our findings will help inform decisions regarding staffing and the configuration of multidisciplinary liaison psychiatry teams. We focused on a ward-based liaison service for adults of working age.

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Method

We carried out a case series of the electronic records of consecutive referrals to a ward-based liaison service at a large teaching hospital in Manchester, over a 12-month period from 18 June 2013 to 17 June 2014. The hospital has approximately 750 beds, with a large renal and critical care unit. There is also a maternity unit on site, with over 8500 deliveries per annum, and an eye hospital. Our liaison service reviews referrals covering an age range of 16–65 by the next working day. Routine alcohol referrals, covered by two specialist nurses, may also be received by our service.

The following details were recorded for each referral: age, gender, number of face-to-face contacts carried out by the team, amount of time the team had ongoing contact with the patient (days), reason for referral, referrer type, psychiatric diagnosis using clinical judgement according to ICD-10 criteria,⁴ employment of the Mental Health Act 1983, and disposal.

Involvement of a liaison psychiatrist

To determine the proportion of patients who required the input of a psychiatrist, we developed criteria for contacts or interventions that required medical input and could not be undertaken by a non-psychiatrist. We deemed the involvement of a psychiatrist would be necessary in any of the following scenarios: Mental Health Act employed, rescinded or considered; medication management; treatment with psychotropic medications commenced in the general hospital; complex diagnostic matters; behavioural disturbance in physically unwell patients where advice about appropriate sedation is required; complex capacity assessments; and a specific request for a consultant psychiatrist opinion. Each case was reviewed and rated by a member of the team. *Box 1* provides detailed criteria for each of these scenarios. We recognise that there are many other kinds of interventions a psychiatrist may carry out as part of liaison work, but we wished to focus solely on interventions which could not be carried out by someone other than a psychiatrist. Many of the interventions therefore require some kind of expertise involving medical knowledge or prescribing of psychotropic medication in patients who are physically unwell.

Summary scores for normally distributed data are presented as means and standard deviations (s.d.). The activity data were not normally distributed, so summary scores are presented in the form of medians and interquartile ranges (IQR). Comparisons of continuous activity data were carried out using non-parametric statistical tests. Mann-Whitney *U*-tests were used to compare continuous data. As in some cases we had few activity data, with only one or two patients in each group, groups with very small sizes (two patients or fewer) were not included in the statistical analyses.

Results

The service received 344 referrals over the study period and carried out 1259 face-to-face contacts with patients. The average number of ‘face-to-face’ contacts per patient was 3.7 (s.d. = 5, range 1–33). The median age of patients seen was 48 years (IQR 36–59), and 184 (53.4%) were female. At any one time, between 8 and 15 patients were under review by the team. The majority of referrals were from physicians (all medical departments) ($n = 227$, 66.0%), 59 (17.2%) were from surgery, 31 (9%) from the maternity hospital and 23 (6.7%) from the critical care unit. One referral came from the eye hospital and a further 3 were from the liaison service for older adults, but these patients were best managed by the adults of working age team.

Table DS1 in the online supplement provides a snapshot of the patients under the care of the service on one day in May 2014, and is typical of the kind of patients who are under review by the service at any given time. Five patients had severe mental illness (four had schizophrenia and one had bipolar disorder). Two had been treated under the Mental Health Act and there was a possibility that one more person may have needed treatment. One person was on a community treatment order (CTO). Four patients had voiced recent suicidal ideas, two had complex organic mental disorders, and three had psychological reactions to physical illness or difficulties with their behaviour in an acute hospital setting.

Referrals which required the involvement of a psychiatrist

Table 1 illustrates the number of referrals which needed a psychiatrist. Of the 344 referred patients who saw a psychiatrist, we deemed on the basis of our criteria that a psychiatrist was required for 241 patients (70.1%). Patients who required a psychiatrist needed more face-to-face contacts than those who did not require a psychiatrist (median 2 (IQR 1–5) v. median 1 (IQR 1–2)), and were under the liaison service for a greater period of time (median 7 days (IQR 1–14) v. median 1 day (IQR 1–7)).

Referrals and service workload depending on whether patient required a psychiatrist or not

		Face-to-face contacts	Days in contact with service, median (IQR)	
Requires psychiatrist	241 (70.1)	1039 (82.5)	2 (1–5)***	7 (1–14)***
Does not require psychiatrist	103 (29.9)	220 (17.5)	1 (1–2)	1 (1–7)
Total	344	1259	2 (1–5)	4 (1–13)

IQR, interquartile range.

$P < 0.001$ (requires v. does not require a psychiatrist).

According to our criteria, the most common reason for psychiatric input was medication management (Table 2): 77 patients (32.0%) required input regarding their current psychotropic medication use. Of interest, 10 of these patients were referred for clozapine management which required over 100 face-to-face contacts from the team. 56 patients were started on treatment for their mental health problems while they were in hospital (i.e. patient started on psychotropic medication). There were complex diagnostic issues in 38 patients and the Mental Health Act was considered in 23 patients, but only actually implemented in 18. In 14 cases the patient required a complex capacity assessment, 10 patients presented with challenging behaviour requiring advice about sedation, and a specific consultant opinion or involvement was requested in 6 patients. The categories are not mutually exclusive.

The number of patients who required a psychiatrist according to the categories in the study

Clinical categories	<i>n</i>	Percentage of total requiring psychiatrist
Medication management	77	32.0%
Treatment with psychotropic drugs	56	23.2%
Complex diagnostic issues	38	15.8%
Mental Health Act	23	9.5%
Management of severe mental illness	17	7.1%
Complex capacity assessments	14	5.8%
Management of behavioural disturbance	10	4.1%
Specific liaison consultant review	6	2.5%

Box 1 Definitions of categories used to determine whether the involvement of a liaison psychiatrist was required

- **Mental Health Act:** situations where the Mental Health Act has been applied or its potential use has been seriously considered
- **Medication management:** consultation in which there was a specific issue about psychotropic medication the patient was taking due to a change in their physical health. This may involve stopping, switching or another action.
- **Management of behavioural disturbance in the general hospital:** involving advice about medication, where a psychiatrist has provided assessment, advice and guidance about using sedating medication. The psychiatrist will have considered the patient's underlying physical health problems (e.g. renal failure) in making the decision regarding type and dosage of medication. Other non-pharmacological aspects for management of acute behavioural disturbance in physically unwell patients are not considered here, as they are not exclusively carried out by liaison psychiatrists
- **Complex diagnostic matters:** diagnosis or understanding of a clinical problem which required knowledge of specific medical disorders
- **Capacity:** requests for medically complex capacity assessments, where the patient has a history of a psychiatric condition which may be interfering with their judgement to give informed consent to potentially life-saving treatment
- **Treatment with psychotropic medications commenced in the general hospital:** treatment with a psychotropic agent that was commenced in the general hospital by the liaison team, in a patient who had ongoing physical health concerns
- **Specific request for consultant liaison psychiatrist opinion:** the referring consultant specifically requested a consultant psychiatric opinion or involvement

Box 2 Categories of clinical scenarios where we judged a psychiatrist was required (examples)

- **Mental Health Act:** Female (age range 50–60) with diagnosis of schizophrenia. Admitted with a ruptured oesophagus. Clozapine had been stopped prior to admission as she had refused to take it. Her psychosis had relapsed and she was floridly psychotic in hospital. Following repair of her oesophagus she required 6–8 weeks bed rest for the repair to heal. She was treated under Section 3 of the MHA with covert medication (clozapine). Her mental state returned to normal. She had a good physical and mental health recovery. She later agreed to continue to take clozapine on a voluntary basis.
- **Medication management:** Female (age range 30–40) admitted following collapse and found to have very low sodium. Diagnosis of schizophrenia. In discussion with medical team, all psychotropic medication was stopped. Haloperidol started cautiously. Usual medications re-started after physical recovery. Discharged to CMHT.
- **Management of behavioural disturbance:** Male (age range 40–50) who was admitted with delirium, barricaded himself and 3 other patients in a 4-bedded side room. History of hydrocephalus and other abnormal neurological signs. Input required sedation to manage the current situation and to facilitate medical investigations including brain MRI.
- **Diagnosis:** Male (age range 50–60) admitted from nursing home with a history of severe weight loss. History of schizophrenia and extrapyramidal side-effects attributed to neuroleptics. Huntington's chorea diagnosed by consultant psychiatrist.
- **Capacity:** Male (age range 50–60) with history of schizophrenia. Jumped off a bridge when 22 years of age, paraplegic following this. Psychosis treated well for years on clozapine. Developed bowel obstruction, multi-organ failure. Clozapine stopped. On regular haemodialysis. Chronically psychotic. Refusing dialysis. Complicating factors, low mood, chronic psychosis (at times he believes he is Christ and can be resurrected).
- **Treatment with psychotropic drugs commenced in the general hospital:** Male (age 60–70) admitted after stabbing his wife in the back and then stabbing himself 4 times in the abdomen. Diagnosed with depressive disorder. Treatment started with antidepressants while receiving medical treatment on ward. Mood improved.

- **Specific request for consultant liaison psychiatric opinion:** Male (age range 40–50) with a history of gastric problems and feeding difficulties. Had had gastrectomy and had been started on TPN. Had been in hospital for over a year. Staff suspected that reliance on TPN was far more than clinically indicated but all efforts to reduce it failed. Patient was aggressive on occasions with staff, made frequent complaints about staff and at times threatened self-harm. Consultant opinion was specifically sought regarding the risks of moving to home with TPN feeding.

CMHT, community mental health team; MHA, Mental Health Act; MRI, magnetic resonance imaging; TPN, total parenteral nutrition.

Table 2 shows the number of patients who required a psychiatrist according to the categories developed for this study.

Clinical illustrations of actions or interventions which were judged to require the involvement of a psychiatrist, according to each category, are provided in *Box 2*.

Table 3 shows the number and percentage of patients who required input from a liaison psychiatrist according to the most common psychiatric diagnoses. Patients with bipolar affective disorder, schizophrenia, Korsakoff's psychosis, amnesic syndrome and somatoform disorder required the involvement of a psychiatrist in over 80% of all cases, whereas for patients with anxiety/panic disorder, adjustment disorder or dementia the requirement was much lower.

Patients who required input from a liaison psychiatrist according to diagnosis

Psychiatric diagnosis	Required psychiatrist (% of total seen)
Somatoform disorders	9 (100.0%)
Bipolar affective disorder	23 (92.0%)
Amnesic syndrome	11 (91.7%)
Korsakoff's psychosis	11 (91.7%)
Schizophrenia	42 (82.4%)
Depression	100 (74.1%)
Miscellaneous including eating disorders, intellectual disability	5 (71.4%)
Personality disorder	9 (69%)
Substance misuse	11 (68%)
Delirium	15 (65.2%)
Anxiety/panic disorder	6 (50.0%)
Dementia	2 (33.3%)
No diagnosis	8 (32.0%)
Adjustment disorder	2 (20.0%)

Discussion

Our findings suggest that a ward-based liaison psychiatry service for working-age adults in a large teaching hospital requires the input of liaison psychiatrists. We deemed that a psychiatrist was essential in the assessment or management of approximately 70% of all referrals to the service, whereas approximately 30% could be reviewed by other members of a liaison team. We based this judgement on clear, definable actions or aspects of care that necessitated the involvement of a psychiatrist. A consultant liaison psychiatrist would of course have many other roles, but for the purposes of this study we limited our focus to interventions or actions where the role of a psychiatrist was unequivocal.

Many of the patients seen by the service had complex physical and mental health needs. Table DS1 provides a snapshot of the work, and illustrates that it is necessary to involve a psychiatrist in the management of a large proportion of referrals. Out of the 12 patients under the care of the team on one day in May 2014, 9 required the input of a psychiatrist.

Certain patients with diagnoses such as adjustment disorder and dementia were unlikely to require psychiatric input, whereas high rates of psychiatric involvement were required for patients with severe mental illness and somatoform disorders. Psychiatric input was also needed in the management of patients with Korsakoff's psychosis, because locally a formal diagnosis from a psychiatrist is required in order to access particular kinds of Social Services support.

This study has three major limitations. First, data were based on routine clinical entries made using a National Health Service (NHS) electronic record system. It is possible that this may have led to an underestimation of the numbers of patients requiring psychiatric input due to a lack of recording certain data (e.g. details about psychotropic medication). It is very unlikely that it would have led to an overestimate of our findings. Second, this study was undertaken in a teaching hospital, with a large critical care unit, a large renal unit, a very busy maternity hospital and other specialist centres. It may not reflect the work of a liaison service in a district general hospital, but it emphasises the need to take account of local variations in acute hospital services when planning a liaison service. Third, this liaison service is a ward-based service only. Approximately a third of liaison services run out-patient clinics for complex cases requiring psychiatric time. Clinics can take psychiatrists away from acute ward cover and require different planning and staff resources compared with a ward-based liaison service.

The methods we employed, however, can easily be used by other services to estimate the requirement for input from a liaison psychiatrist, and this is likely to vary depending on the setting and age range of patients seen. As this research team consisted entirely of psychiatrists, we may have overestimated the need for the skills of our own discipline when creating the criteria and applying them. However, we have provided clinical examples to illustrate our decision-making process and thus expose it to critical examination.

Our results suggest that liaison psychiatrists have a pivotal role in ward-based liaison services for adults of working age, and this may be particularly important in a teaching hospital setting. Our work also provides support for the recent commissioning guidance for liaison psychiatry services in England developed by the Department of Health, which suggests that liaison psychiatry services in a teaching hospital/inner city setting may require additional consultant psychiatric input.⁷

1.6.46 Civil and forensic patients in secure psychiatric settings: a comparison

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Abstract

Aims and method To evaluate differences between male patients in secure psychiatric settings in the UK based on whether they are detained under civil or forensic sections of the Mental Health Act 1983. A cohort of patients discharged from a secure psychiatric hospital were evaluated for length of stay and frequency of risk-related incidents.

Results Overall, 84 patients were included in the study: 52 in the forensic group and 32 in the civil group. Civil patients had more frequent incidents of aggression, sex offending, fire-setting and vulnerability, whereas forensic patients had more frequent episodes of self-harm.

Clinical implications Secure hospitals should ensure treatment programmes are tailored to each patient's needs. Civil patients require greater emphasis on treatment of their mental illness, whereas forensic patients have additional offence-related treatment needs. Regular liaison between forensic and general adult services is essential to help ensure patients can return to appropriate settings at the earliest opportunity in their recovery.

Contents

- *Civil and forensic patients in secure psychiatric settings: a comparison*
 - *Method*
 - *Results*
 - *Discussion*
 - * *Limitations*
 - * *Practice recommendations*

Further to the closure of the asylums and subsequent rare but high-profile failures in community care, forensic psychiatry in the UK has rapidly expanded, with the development of high, medium and low secure in-patient services across the country as well as specialist forensic mental health teams in the community.¹ Alongside its expansion, an ongoing debate related to its interface with general psychiatry has persisted.² In England and Wales, the forensic v. general psychiatry divide extends to the subdivision of in-patients detained under the Mental Health Act 1983 into those affected by civil and forensic sections. Patients detained under Part II of the Act are termed 'civil patients'. They can be detained under Section 2 for assessment and treatment for up to 28 days where there is suspicion of a mental disorder. Section 2 can be converted to Section 3 for further treatment. Alternatively, patients can be admitted directly under Section 3 when there is a known mental disorder. Patients detained under Part III of the Act are termed 'forensic patients', given their involvement in the criminal justice system through the courts and prisons.

While forensic units have expanded, there has been an overall reduction of in-patient bed numbers in the UK, which have fallen from 155 000 in 1954 to just 18 166 as of 31 March 2014. The number of patients detained in all settings under civil sections during 2013/2014 was 32 781, of which 25 300 were under Section 2 and 7481 were under Section 3. During 2013/2014 there were 1847 detentions under forensic sections: 99 under Section 35 or 36, which is admission for assessment or treatment via the courts; 763 under Section 37 hospital orders, allowing detention in hospital instead of a prison sentence; and 457 under Section 47, which allows transfer of a serving prisoner to hospital.^{2,3}

Secure psychiatric hospitals are generally geared towards providing assessment, treatment and rehabilitation for forensic patients, since they are the majority group in such hospitals. In particular, Coid *et al* found that 69% of patients in

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medium security were detained under forensic sections.⁴ Despite this discrepancy in distribution, research into whether there are differences between these groups is limited. The only study we could identify was that by Reed (2004),⁵ who evaluated the differences between civil and forensic in-patients in a low secure intellectual disability setting and found, surprisingly, that the forensic patients were less likely to be aggressive or use weapons but more likely to harm themselves.⁵ It is not known whether these findings are isolated to intellectual disability settings. Therefore, we present findings from our evaluation of male patients discharged from a secure psychiatric hospital (excluding intellectual disability – the hospital does not cater for such patients) and suggest recommendations on how to meet the differing clinical needs identified in each group.

Method

The study was conducted as part of a service evaluation into length of stay at St Andrew's Healthcare, Birmingham, and registered with the St Andrew's Clinical Audit Team. In keeping with previous similar evaluations, ethical approval was not required as the study evaluated retrospective, non-patient-identifiable data from health records as part of service evaluation.⁵ Data were retrospectively collected for all discharges from the two medium and three low secure wards since the opening of the hospital in March 2009 to the study end point of 30 December 2014. The source of data were patients' electronic health records, including medical reports, Historical Clinical Risk Management-20 (HCR-20) assessments, Care Programme Approach records, electronically recorded risk incident logs and discharge summaries.

Summary statistics were calculated for all patients evaluated. Patients were then grouped by whether they were initially detained under a civil or forensic section at the start of their admission to St Andrew's Birmingham. In order to evaluate illness severity between the two groups, Health of the Nation Outcome Scales for Users of Secure and Forensic Services (HoNOS-secure) assessment scores taken at admission and discharge were noted.⁶ A power calculation was not performed but all available data were used in the analysis. The average length of stay was calculated for each group. SPSS version 16 for Windows was then used to calculate independent *t*-test statistics to examine any between-group associations and frequency of various types of incidents.

Results

In total, 93 male patients were discharged from the hospital during the data collection period; 9 patients were excluded from the study: 7 were excluded as their admission was less than 3 months and unlikely to be representative of the treatment phase being evaluated, and discharge would also have occurred prior to the standard Care Programme Approach meeting held 3 months after admission, where a formal diagnosis would have been made. One patient was excluded as they were informal during the course of their admission and one was excluded due to death from natural causes. Therefore, 84 patients were included in the study, with 32 in the civil group and 52 in the forensic group. In the civil group, 16 patients were admitted from general adult services, 1 from a police station, 7 from low secure services and 8 from medium secure services. The legal status of patients in the civil group remained unchanged during the course of their admission, apart from one patient who became informal in the days prior to discharge. None of the patients in the civil group switched to being forensic patients following convictions in court. Regarding the forensic group, 4 patients were admitted from general adult services, 3 from low secure services, 16 from medium secure services, 28 from prison and 1 from a high secure hospital. In this group, 14 patients changed their legal status prior to discharge; 11 changed from being sentenced prisoners under Section 47/49 to being detained under a notional Section 37, as they had gone past what would have been their automatic release date from prison. Two patients switched from being remanded prisoners under Section 48/49 to being sentenced under a Section 37 hospital order at court and one patient switched from Section 48/49 to a Section 37/41 hospital order with restrictions after sentencing at court.

Table 1 outlines the baseline characteristics of each group, including diagnosis, age, ethnicity and Mental Health Act status on admission. All patients were male, with a mean age of 37 years (range 20 to 63 years). *Table 2* shows the mean length of stay, HoNOS-secure scores on admission and discharge, and frequency of risk-related incidents.

Patient characteristics

	Civil group ^a <i>n</i> (%)	Forensic group ^b <i>n</i> (%)
Primary diagnosis		
Psychosis (schizophrenia, schizoaffective disorder, delusional disorder)	30 (94)	46 (88)
Personality disorder	2 (6)	3 (6)
Affective disorder (depression, bipolar affective disorder)	0 (0)	3 (6)
Secondary diagnosis		
Personality disorder	5 (16)	11 (21)
Substance misuse	18 (56)	33 (63)
Alcohol misuse	1 (3)	7 (13)
Ethnicity		
Black	10 (31)	13 (25)
White	18 (56)	27 (52)
Other	4 (13)	12 (23)
Legal status		
Section 2	1 (3)	
Section 3	31 (97)	
Section 37		8 (15)
Section 47 (notional 37)		5 (10)
Section 37/41		12 (23)
Section 48/49		7 (13)
Section 47/49		20 (39)

n=32.

n=52.

Length of stay in secure care and frequency of risk-related incidents

	Civil group <i>a</i>	Forensic group <i>b</i>	Independent <i>t</i> -test <i>c</i>
Length of stay, days: mean (range)	587 (95–1396)	523 (105–1407)	$t = 0.75, P = 0.96$
Mean HoNOS-secure score:			
admission	25.31	24.62	$t = 0.39, P = 0.07$
discharge	20.16	18.77	$t = 0.81, P = 0.94$
Risk incidents per 30 days, mean			
Violence (includes assaults against staff or peers)	0.92	0.34	$t = 2.01, P = 0.02$
Self-harm (threats or acts)	0.06	0.21	$t = 2.09, P = 0.02$
Unauthorised leave (attempts or episodes of absconding or escape)	0.22	0.05	$t = 1.17, P = 0.44$
Substance misuse (intentions or incidents of illicit drug misuse)	0.06	0.12	$t = 1.14, P = 0.15$
Self-neglect (poor self-care/diet)	0.41	0.25	$t = 1.39, P = 0.17$
Fire-setting (threats or acts)	0.08	0.02	$t = 1.76, P = 0.002$
Sex offending (sexual comments or contact offences)	0.06	0.03	$t = 1.09, P = 0.04$
Vulnerability (being intimidated, bullied or assaulted)	2.10	0.29	$t = 4.88, P = 0.00$
Verbal aggression (abusive comments)	2.10	1.62	$t = 0.87, P = 0.36$
Other unspecified risk incidents	1.85	1.99	$t = 0.33, P = 0.36$

$n=32$.

$n=52$.

d.f=82.

Discussion

The study found no significant difference in length of stay or severity of illness based on HoNOS-secure scores at the start or end of admission between the civil and forensic groups. However, it should be noted that HoNOS-secure is not a specific measure of mental state, since it also evaluates behavioural functioning and a range of security measures. This study identified that civil patients in secure settings have more frequent incidents of aggression, sex offending, fire-setting and vulnerability, whereas forensic patients have more frequent episodes of self-harm. This finding challenges the preconception that forensic patients are more ‘dangerous’ and difficult to manage.² One explanation for this may be that the civil patients in this study represent a cohort of general adult patients that have been placed in forensic services due to their frequency of aggressive and difficult to manage behaviours, whereas the more stable forensic patients have been admitted due to severe but more isolated offences.

The higher frequency of incidents in the civil group may make engaging with specialist treatment programmes practically more difficult for this group, which may in turn become a factor that limits their motivation to engage. Secure hospitals should be aware that civil patients, due to higher frequency of risk incidents, may have differing needs to forensic patients. Therefore, we suggest that civil patients who present with a high frequency of incidents will benefit from a greater emphasis on treatment of their mental illness combined with behavioural interventions, with less of a requirement to engage in specialist treatment programmes or to complete formal psychological therapy programmes that are often required in forensic settings. Further research is needed to explore whether the higher frequency of incidents among civil patients affects the therapeutic milieu on the ward and has an adverse impact on outcomes for forensic patients engaging in specialist treatment interventions. The higher frequency of vulnerability incidents among civil patients highlights the difficulty they experience in forensic settings and suggests a greater need for vigilance and robust safeguarding for this patient group, who may be at risk of reprisal assaults by their forensic peers. The findings of our study must also be considered in light of the Schizophrenia Commission report,⁷ which comments that patients stay too long in secure services, and highlights funding cuts and acute bed closures in general adult services as part of the problem.

We conclude that our study supports the need to focus more on preventive interventions, such as avoiding delays in assessment, ensuring early treatment and supporting alternatives to admission such as crisis and home-based treatment teams, to help avoid admissions. Regular liaison between forensic and general adult services is essential to help ensure patients can return to appropriate settings at the earliest opportunity in their recovery. This may only be possible with careful consideration when commissioning services at all levels of care.

The finding that forensic patients have a greater frequency of self-harm incidents should be treated with caution as the numbers in this study are small and self-harm is a rare outcome. One possibility is that forensic patients may find the criminal justice system and their conviction distressing, leading to a greater risk of self-harm and potentially suicide. We suggest that clinical teams should be aware of this risk in these patients and ensure careful monitoring, risk management and support for patients during criminal proceedings.

Limitations

This study has a number of limitations. Most significantly, it is a comparison of forensic and civil patients conducted in a secure mental health hospital and the findings cannot be used to compare differences between forensic and general adult patients in non-secure settings. In addition, the civil patients in the study are likely to represent patients with greater treatment resistance whose aggressive behaviours have led to them being transferred to secure settings. It remains possible that the section status assigned to the patient on admission may be misleading, as quite often patients who commit offences when unwell are not prosecuted.⁸ The study is reliant on accurate recording of risk incidents in patients’ records. Although some degree of inaccuracy in recording of incidents may have occurred, it is anticipated that this would have occurred evenly between both groups and thus not affected the validity of the results. This study, in line with previous work, evaluates data for a cohort of discharged patients in order to evaluate comparable groups. It is possible that the study may underestimate the severity of risk incidents, since the most challenging patients would not have been included in the analysis as they have not yet been discharged from hospital. It is anticipated that the impact of this factor would be evenly distributed between each group.

Practice recommendations

Secure hospitals should ensure all treatment plans are based around the individual. There should be an emphasis on managing the mental illness of civil patients and tailoring treatments based on this goal, which will help reduce risks and hopefully shorten length of admission. Forensic patients are more likely to have additional offence-related treatment needs which would require specific interventions. Regular liaison between forensic and general adult services is essential to help ensure patients can return to appropriate settings at the earliest opportunity in their recovery. This can only be possible with careful consideration when commissioning services at all levels of care.

We thank Catherine Clarke, Psychology student at the University of Birmingham, for her help in the study.

1.6.47 Known unknowns and unknown unknowns in suicide risk assessment: evidence from meta-analyses of aleatory and epistemic uncertainty

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Abstract

Suicide risk assessment aims to reduce uncertainty in order to focus treatment and supervision on those who are judged to be more likely to die by suicide. In this article we consider recent meta-analytic research that highlights the difference between uncertainty about suicide due to chance factors (aleatory uncertainty) and uncertainty that results from lack of knowledge (epistemic uncertainty). We conclude that much of the uncertainty about suicide is aleatory rather than epistemic, and discuss the implications for clinicians.

Contents

- *Known unknowns and unknown unknowns in suicide risk assessment: evidence from meta-analyses of aleatory and epistemic uncertainty*
 - *Can knowing about suicidality reduce uncertainty about suicide?*
 - *Can knowing about a wider range of risk factors reduce uncertainty about suicide?*
 - *Implications of the limits to epistemic uncertainty*

Uncertainty is the psychological state of being unsure, of having doubt, of not fully knowing. Uncertainty is central to modern medicine, where its recognition drives diagnostic efforts and leads to the pursuit of evidence-based practice.

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All medical decision-making occurs under conditions of varying uncertainty about diagnosis, optimal treatment and prognosis. This is true in the assessment of suicidal patients.

Uncertainty has two underlying components: epistemic uncertainty that results from a lack of knowledge, and aleatory uncertainty that results from random or chance events.¹⁻³ In medical practice, both types of uncertainty are at play. A teenage tobacco user might or might not develop cancer later in life. This is mostly a matter of chance, a chance that will increase with heavier and longer tobacco use. This longitudinal cancer risk is probabilistic, akin to the throw of a die, and further knowledge might not greatly reduce uncertainty about what will eventually happen. In middle age, the same smoker might develop haemoptysis. A chest X-ray would reduce uncertainty about the presence or absence of lung cancer, but it might be more clearly resolved by a biopsy. Uncertainty in this case is not probabilistic – the smoker either has or does not have cancer. This is now a question that can be resolved with more information. Chance is no longer playing a part.

It is generally considered that uncertainty in suicide risk assessment can be greatly reduced by a detailed assessment of the patient's suicidal thoughts, plans and actions, and attention to other demographic and clinical factors. Suicide risk assessment guidelines and relevant peer-reviewed publications often contain long lists of questions to ask and factors to consider.⁴⁻⁷ This approach assumes that more substantial knowledge of the patient, their illness, circumstances and intentions will reduce the epistemic uncertainty in the assessment. Few would doubt that chance also plays a major part in suicide. The course of underlying illness, the vagaries of individual decision-making and impulsivity, and the patient's future circumstances are all sources of aleatory uncertainty.

In this article we consider the uncertainty surrounding suicide using the framework of epistemic and aleatory uncertainty. In order to do this, we use recent meta-analytic research to interrogate the proposition that uncertainty about suicide risk can be reduced by knowing more about suicidal thoughts and behaviours, or by the knowledge of a wider range of suicide risk factors.

Can knowing about suicidality reduce uncertainty about suicide?

No small number of references could begin to do justice to the importance that suicidal ideation and behaviours have assumed in suicide research. Several recent systematic meta-analyses have synthesised the quantitative peer-reviewed literature on the statistical relationship between suicidality and suicide. Each of these meta-analyses has cast doubt on the notion that knowing more about suicide ideas, or suicidality more broadly, reduces uncertainty about suicide.

Two meta-analyses published in 2011, one examining risk factors for suicide by psychiatric in-patients⁸ and the other examining risk factors for suicide by recently discharged patients,⁹ found that the association between suicidal ideation and suicide was statistically weak, with diagnostic odds ratios (OR) of less than 3. In 2015, Chapman *et al*¹⁰ published a meta-analysis finding that suicidal ideation was significantly associated with suicide among patients with schizophrenia spectrum conditions. However, suicidal ideation was not significantly more likely to lead to suicide than no suicidal ideation among patients with mood disorders (OR = 1.49, 95% CI 0.92–2.42).

A 2016 meta-analysis¹¹ examined the broader question of whether self-injurious thoughts and behaviours deserve their status as strong predictors of future suicidal behaviour. This study found that self-injurious thoughts and behaviours are only weakly associated with later suicide attempts (OR = 2.14, 95% CI 2.00–2.30) and death from suicide (OR = 1.54, 95% CI 1.39–1.71). The authors concluded that assessments of suicidality provided an improvement in prognostic accuracy that was only marginally above chance.

Another 2016 meta-analysis examined the psychometric properties of both individual risk factors and suicide risk assessment scales (the Beck Hopelessness Scale, Suicide Intent Scale and Scale for Suicide Ideation) among populations of people who self-harm.¹² The authors found a modest statistical association between previous self-harm and suicidal intent and later suicide, concluding that individual risk factors are 'unlikely to be of much practical use because they are comparatively common in clinical populations'. With respect to use of suicide risk scales they considered that they 'may provide false reassurance and [are], therefore, potentially dangerous'.

Thus, five recent meta-analytic summaries of the peer-reviewed literature have each reached similar conclusions – knowing about suicide thoughts and behaviours can only reduce uncertainty about future suicide to a modest extent.

Can knowing about a wider range of risk factors reduce uncertainty about suicide?

If enquiries about our patients' suicide ideas, plans and actions do not help very much, what else should mental health professionals do to reduce uncertainty? The most common and obvious answer is to consider a comprehensive range of other suicide risk factors. Again it is simply not possible to describe the full range of articles, guidelines and peer-reviewed papers that consider the range of potentially important risk factors for suicide. A weakness of this literature is that although very large numbers of risk factors for suicide have been identified, there is no widely accepted way in which this information can be combined to improve the predictive strength of suicide risk assessment. Further, despite widespread recommendations for a comprehensive consideration of suicide risk factors, there are doubts as to whether combining risk factors can ever produce clinically useful predictive models. More than 30 years ago, Pokorny¹³ concluded his paper describing a landmark prospective suicide prediction study with the statement that it 'is inescapable that we do not possess any item of information or any combination of items that permit us to identify to a useful degree the particular persons who will commit suicide, in spite of the fact that we do have scores of items available, each of which is significantly related to suicide'.

We recently published a meta-analysis that further examined the dilemma posed by Pokorny.¹⁴ We synthesised the results of all the published longitudinal prospective studies that used multiple risk factors to model future suicide among cohorts of psychiatric patients. We included experimental studies that employed multiple regression or survival analysis and studies that validated suicide risk prediction instruments. Our main outcome measure was the odds of suicide in high-risk patients compared with lower-risk patients. One of the aims of the meta-analysis was to determine if the observed between-study variability in this OR could be explained by the number of risk factors used in the predictive modelling. The results were very clear. We found a pooled OR of 4.84 (95% CI 3.79–6.20) derived from 37 studies and 53 samples of patients. This indicates that the rate of suicide among high-risk patients can be expected to be about 5 times the rate of suicide of low-risk patients. While this sounds like it might be a clinically useful finding, these odds do not meaningfully improve on the pooled ORs of about 4 that are associated with some individual suicide risk factors among psychiatric patients – factors such as depression, hopelessness and prior suicide attempts.^{8,9} The meta-analysis also found that 56% of suicides occurred in high-risk groups (sensitivity) and 44% occurred among the lower-risk group. Over an average follow-up of 5 years, 5.5% of high-risk patients, but 1% of low-risk patients, died by suicide. This 5.5% suicide mortality over a period of 5 years means the probability of suicide of high-risk patients over clinically important durations is extremely low. For example, the weekly probability of suicide of a high-risk patient over the 5-year follow-up can be estimated at $0.055/(5 \times 52) = 0.0002115$ or 1 in 4700 people. In practical terms, what this means is that if a patient is deemed at higher risk of suicide because of the presence of one or more risk factors (recall that the number of risk factors seems unimportant), our best estimate of the incidence of suicide in the following week is about 1 in 4700. Even if there was a hypothetical dynamic risk factor that transiently increased the next-week risk of suicide by 10 times, strict supervision of almost 500 high-risk people for 1 week would be needed to prevent one suicide – assuming that such supervision were 100% effective.

Relevant to the present paper, the meta-analysis found that the predictive models that used more suicide risk factors had no more statistical strength, and no better discrimination between high-risk and lower-risk groups, than studies that used fewer factors (slope 0.007, 95% CI 0.016 to 0.03, $P = 0.53$). In fact, studies that employed two factors had a similar predictive strength to studies that employed ten or more factors. *Figure 1* plots the diagnostic odds with 95% confidence intervals effect size of models using 2 or 3 factors (8 samples), 4 or 5 factors (11 samples), 6 or 7 factors (7 samples), 8 or 9 factors (5 samples) and 10 or more factors (22 samples) with obviously overlapping confidence intervals. We concluded that multivariate models offered little advantage over single risk factors and that multivariate models that relied on more suicide risk factors performed no better than those that use fewer risk factors.

Implications of the limits to epistemic uncertainty

The findings of these recent meta-analytic studies undermine one of our profession's main assumptions about suicide risk assessment. Suicidal ideation,¹⁰ suicide behaviour^{11,12} and more complex modelling¹⁴ offer predictive advantages only a little better discrimination than chance. Hence, most of our uncertainty about suicide risk is aleatory; knowing more does not help because epistemic uncertainty plays only a minor part.

So what should clinicians do? First, we believe that this fundamental problem with suicide risk assessment needs to be acknowledged. We need to acknowledge our powerlessness to usefully classify individuals or groups of patients according to future suicide risk. We need to acknowledge this to ourselves, and communicate this to health departments, to the courts, and most importantly, to our patients and their families.

Second, we need to provide a more universal standard of care, involving a complete and sympathetic assessment of every patient, their illness and their circumstances. Such assessment is needed to guide individualised treatment plans, and might also have the intrinsic benefit of reducing suicidality.¹⁵ Where modifiable risk factors are found, we need to try to modify them. For example, patients who present with suicidal ideation when intoxicated should not be summarily discharged when sober and denying suicidal ideation, but should be offered access to addiction services that have some prospect of reducing suicide risk and improving their lives, irrespective of their overall risk category.

Third, we need to be very sparing in our use of involuntary treatment as a reaction to suicide risk. It is likely that very few patients who we admit to hospital would have died by suicide as out-patients over the period of time usually associated with a contemporary length of stay. Patients making ongoing immediate threats might still be admitted to hospital, as such threats are a crucial communication and legitimate focus of care without recourse to notions of probability. However, suicide risk is simply not a sufficient warrant for making paternalistic decisions about involuntary hospital care. Equally, we should be careful not to automatically deny low-risk patients voluntary in-patient treatment when they want it. Many suicides are by low-risk patients and we should not pretend we are able to peer into their future any more than we can discern the future of a higher-risk patient.

1.6.48 Drug information update. Unconventional treatment strategies for schizophrenia: polypharmacy and heroic dosing

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Abstract

The majority of patients respond to antipsychotic monotherapy at standard doses, but a subset of

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patients will require more heroic measures that include antipsychotic polypharmacy and high-dose monotherapy. Indeed, research has shown that roughly 30% of patients with psychosis are prescribed multiple antipsychotic medications. We discuss the potential benefits and challenges of these approaches and provide a rationale for why and when they should be utilised.

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Schizophrenia is one of the most challenging psychiatric disorders faced by clinicians today, affecting roughly 1% of the population.¹ Many out-patient clinics and virtually all in-patient facilities manage these often complex clinical cases. Since the introduction of the first-generation antipsychotics (FGA) and subsequent development of the dopamine hypothesis, blockade of dopamine 2 (D₂) receptors has been the primary goal of pharmacological intervention. Even with the development and proliferation of the second-generation antipsychotics (SGA), D₂ blockade remains central to effective control of positive symptoms whereas serotonin 2A (5-HT_{2A}) plays an important but secondary role in the modulation of dopamine, theoretically improving negative symptoms while reducing the risk of extrapyramidal symptoms.²

The term ‘dopamine hypothesis’ of schizophrenia is slowly being phased out, as more sophisticated imaging studies have identified the nature of the dopamine dysfunction and its locus within the striatum. The striatum is a major component of the basal ganglia, and is divided functionally into the dorsal sensorimotor portion, the central associative striatum, and the ventral limbic striatum. Recently it has been found that the best correlation between positive symptoms of psychosis in schizophrenia and levels of D₂ activity is in the rostral caudate, a portion of the central associative striatum.^{3,4} We thus have *in vivo* confirmation of excessive D₂ neurotransmission and the relationship to the positive

symptoms of schizophrenia. In the limbic striatum low dopamine release is directly related to the severity of negative symptoms; the lower the dopamine levels, the greater the negative symptom severity.³

While the goal of treatment is normalisation of D₂ neurotransmission in the striatum, a subset of patients do not respond to traditional treatment algorithms which include antipsychotic monotherapy at dosing levels defined in registrational trials. Consequently, many patients continue to exhibit uncontrolled positive and negative symptoms as well as manifesting aggressive and impulsive behaviours.⁵ It has been argued that ‘unconventional’ strategies for better management of treatment-resistant psychosis should be employed.^{6–8} The two primary methods we discuss in the following pages include antipsychotic polypharmacy and high-dose monotherapy.

Why do standard treatments sometimes fail?

To effectively treat the positive symptoms of schizophrenia it is important to achieve at least 60% striatal D₂ blockade with antipsychotics.⁹ The exception is clozapine, which has been shown to have some antipsychotic effect at as little as 20% blockade.¹⁰ Beyond 80% D₂ occupancy, risk of extrapyramidal side-effects (EPS) increases, leading to non-adherence and treatment failure. Therefore, the ‘sweet spot’ of D₂ receptor blockade for most patients is between 60 and 80%.⁶ However, in some treatment-resistant cases, particularly when aggression and impulsivity are of concern, moving beyond 80% may be necessary.^{6,8,11–14} Moreover, there is significant evidence from the literature that a substantial portion of patients tolerate plasma antipsychotic levels consistent with >80% D₂ occupancy.

One of the early imaging studies from 1997 noted that a large fraction of patients stabilised on low-dose oral haloperidol had plasma levels associated with >80% D₂ occupancy;¹² however, prior clinical studies found that even at a plasma haloperidol level of 6 ng/ml (predicted 90% D₂ occupancy), only 30% experienced adverse effects.¹³ A similar pattern is seen with risperidone. The pivotal trials studied doses of 10 mg and 16 mg, which correlate with a plasma active moiety level of 70 ng/ml and 112 ng/ml, respectively.¹⁵ The plasma level of 70 ng/ml would correspond to a D₂ occupancy of 85%;¹⁴ however, despite this high level of predicted D₂ occupancy, the proportion of patients on 10 mg who required anti-Parkinsonian treatment was only 31%.¹⁶

Pharmacokinetic failure

Pharmacokinetics is the umbrella term that covers drug absorption, bioavailability, distribution, metabolism and excretion. The role of pharmacokinetics in antipsychotic treatment failure is relatively simple. Through abnormal pharmacokinetic processes such as poor absorption, rapid metabolism and enzymatic polymorphisms, antipsychotic plasma levels do not reach the threshold associated with 60% striatal D₂ occupancy. This leads to continued psychotic symptoms. It also leads to frustration and confusion for clinicians in that the patient does not sufficiently respond to standard treatment algorithms.

Pharmacodynamic failure

Pharmacodynamics encompasses receptor binding and sensitivity, postreceptor effects, and chemical communication. Pharmacodynamic treatment failure with regard to antipsychotics is the inability to provide significant amelioration of psychotic symptoms in spite of achieving plasma levels associated with at least 60–80% D₂ occupancy.¹⁷ Although adequate drug plasma levels are achieved, patients with treatment-resistant psychosis present with continued positive, cognitive and aggressive symptoms. The treatment failure associated with pharmacodynamic influences is hypothesised to be related to lack of D₂ receptor sensitivity or hypersensitivity. When patients manifest a lack of extrapyramidal adverse effects or akathisia, increasing drug doses to achieve plasma levels that are associated with >80% D₂ blockade may be necessary to provide symptom control.^{18–20} The overriding principle is that there are a subset of patients who both tolerate and require high levels of D₂ antagonism for symptomatic relief.

The importance of being patient

While recent studies have demonstrated that minimal response after 2 weeks on a particular antipsychotic dose portends a low likelihood of week 6 response on that dose, the full therapeutic effects of adequate D₂ receptor blockade in schizophrenia may not be apparent until many weeks or months later.⁷ Therefore, patience in pharmacological treatment of psychosis is critical when a patient exhibits partial response.^{7,11} For example, Robinson and colleagues found that in a sample of 118 first-episode patients with schizophrenia or schizoaffective disorder only 20% responded to treatment at 4 weeks. The picture was quite different at 52 weeks; roughly 87% responded to treatment.²¹ Other studies of ziprasidone, risperidone and olanzapine have shown continued improvement over several months of treatment.¹¹

Strategies to use prior to heroic measures

We believe polypharmacy and high dosing should not be the initial approach to treating schizophrenia. However, considering that roughly 30% of patients with psychosis are on multiple antipsychotics, the practice is far from rare.^{22,23} In an effort to address the growing practice of antipsychotic polypharmacy and high dosing of antipsychotics in spite of little support in the literature, Stahl provides 12 case-based recommendations.⁷ We review several below.

Utilise monotherapy first to include clozapine

Sequential trials of at least two SGAs are recommended. If both trials fail, consideration of an FGA is appropriate. Also, it is important to not overlook clozapine as monotherapy. The efficacy of clozapine in treatment-resistant schizophrenia, particularly with regard to aggression and violence, is well documented.²⁴⁻²⁶ However, some clinicians may be hesitant to initiate a trial of clozapine owing to fear of side-effects such as agranulocytosis.

Monitor blood levels

Securing drug plasma levels is the only way to know whether treatment failure is due to a pharmacokinetic issue such as rapid metabolism or a cytochrome P450 polymorphism, or simply poor adherence with oral therapy. Likewise, blood levels can alert you to pharmacodynamic abnormalities which occur when treatment response does not correlate with adequate dosing. Blood level monitoring of both FGAs and SGAs can provide the clinician with important information which can guide the treatment plan for patients with treatment-resistant psychosis. This is supported by the recent work of Lopez & Kane as relevant to haloperidol, fluphenazine, perphenazine, risperidone, olanzapine and clozapine.²⁷

Time may not be on your side

As noted above, it takes some patients longer than others to respond to antipsychotic treatments. Granted, it may not be possible to wait several weeks (and certainly not months) in acute settings or when a patient's behaviour is potentially harmful to self or others, but when possible, allowing adequate time for full response may be all that is needed when a patient has exhibited a partial response. The result of impatience is that a second antipsychotic may be prescribed or a single medication may be dosed in an unnecessarily aggressive manner.

Double-check the diagnosis

It is common practice to rethink the primary diagnosis if the treatment plan appears ineffective. Once pharmacokinetic, pharmacodynamic or time-course failures have been ruled out, the presence of substance misuse or a personality disorder or neurological illness should be considered.

Antipsychotic polypharmacy

Although a number of published treatment guidelines for schizophrenia are available, some of which conflict with each other, it is clear that clinicians should utilise a monotherapy approach to antipsychotic medication use.²⁸ Multiple trials of antipsychotic medications, generally SGAs to include clozapine, are recommended. In fact, divergence from this sequential clinical progression has historically been met with scepticism, caution and outright criticism.^{29–36} It is certainly understandable why this is the case. The literature is replete with evidence supporting the efficacy of monotherapy for schizophrenia. Furthermore, the pitfalls associated with combining antipsychotics are well documented. Increased side-effects, higher medication costs, scant information supporting efficacy, and suboptimal outcomes are all problematic with regard to antipsychotic polypharmacy.^{29–36} So, why the need to even review the topic? The reality is that patients included in research studies are generally those who are able to give consent, exhibit less violence and less impulsivity, have lower rates of chemical dependency, and are less likely to have histories of sequential trials of antipsychotics at documented therapeutic levels.^{7,8} In other words, consistent with much of psychiatry research, they are healthier and not mirror images of the patients seen in clinical practice. Therefore, we believe a strict adherence to a treatment guideline based on highly selective samples does not necessarily translate well to community-based out-patient clinics and in-patient facilities.

We acknowledge that antipsychotic monotherapy is sufficient for the majority of patients with schizophrenia and that adherence to established guidelines should generally occur. Indeed, recent studies support this position. A 2004 study by Suzuki and colleagues revealed that when patients with schizophrenia were switched from multiple antipsychotics to monotherapy, roughly half maintained gains whereas a quarter showed improvements. Another quarter of the sample decompensated.³⁷ In a similar study by Essock and colleagues it was found that patients switched to monotherapy maintained gains, but also showed improvement in metabolic effects assumed to be caused by antipsychotic polypharmacy. It should be noted that approximately a third of patients required multiple antipsychotics.²³ However, some evidence supports the use of antipsychotic polypharmacy. A recent meta-analysis of randomised controlled trials comparing antipsychotic monotherapy and polypharmacy highlighted that polypharmacy may be superior to monotherapy in certain clinical cases.³⁸

In addition to achieving adequate D₂ occupancy, antipsychotic polypharmacy also exploits other receptor-binding properties that could lead to improvement in other schizophrenia symptom clusters. For example, serotonergic, noradrenergic and histaminergic binding theoretically ameliorate depression, anxiety, insomnia, impulsivity and aggression. On the flip side, however, the patient is potentially exposed to adverse side-effects from multiple receptor binding or excessive binding via similar properties shared by antipsychotics (e.g. excessive histaminergic binding leading to daytime sedation or appetite stimulation and weight gain). Consequently, combining antipsychotics should be done rationally based on their binding profiles. One clear example is the need to avoid combining the partial D₂ agonism of aripiprazole with antipsychotics with full D₂ antagonism. The binding interference may lead to a worsening of symptoms due to aripiprazole's high affinity for the D₂ receptor, and the fact that even low doses such as 10 mg achieve 83% D₂ occupancy, and thus may displace full antagonists.⁶

High dosing of antipsychotics

Antipsychotic polypharmacy is not the only means of addressing the more complex and treatment-resistant cases of schizophrenia. High-dose monotherapy is a viable option as well. In fact, it has been argued that if the goal is to occupy a greater degree of D₂ receptors in order to address treatment-resistant positive and aggressive symptoms, high-dose monotherapy is the preferred option when compared with polypharmacy. High-dose monotherapy does, however, come at a greater financial expense and the risk of increased metabolic and other potential treatment-limiting side-effects.¹¹

It is impossible to know what dose of a particular antipsychotic is required to achieve the intended outcome. Therefore, the prudent action is to start low within the US Food and Drug Administration (FDA)- and British National Formulary (BNF)-approved guidelines for the particular medication. The medication can be gradually increased outside the FDA-approved dosing window until therapeutic response occurs or the patient develops intolerable side-effects. It is important that informed consent is obtained and treatment rationale is well documented when this occurs. Below we discuss the typical dosing ranges and special considerations for high dosing of the antipsychotics. A more detailed analysis can be found in Stahl & Morrissette's review of the topic.¹¹

Clozapine

Clozapine is typically only recommended after subsequent trials of other antipsychotics have failed. This is primarily owing to its side-effect profile. At typical dosing of 300–450 mg/day, clozapine binds to less than 50% of D₂ receptors, but as noted earlier, the antipsychotic benefits with this medication can be seen at as low as 20% occupancy.¹⁰ A meta-analysis by Davis & Chen revealed that patients on high levels of clozapine responded more frequently than those on low levels.³⁹ Clozapine can be dosed as high as 900 mg/day, but seizure risk does increase with higher plasma levels, so titration to this dose should be done slowly. Furthermore, due to the diverse binding profile of clozapine, improvement in multiple symptoms clusters is possible.

Quetiapine

Quetiapine has a relatively weak affinity for D₂ receptors and often requires high dosing to achieve intended outcomes. Only at the upper range of 400–800 mg/day are the antipsychotic properties of the medication seen. It is generally believed that a dose of 1200 mg/day is no more effective than the typical dosing range and carries greater incidence of metabolic effects; however, clinical practice has shown that 1800 mg/day may be useful in treating violent patients.^{2,5,39}

Olanzapine

Doses of olanzapine between 10 and 20 mg/day equate to 60–80% D₂ occupancy. Higher doses of 40–60 mg daily appear to be more effective, particularly with aggressive patients and in some forensic settings.^{2,32,40,41} A note of caution is that as plasma levels increase the risks of anticholinergic and metabolic effects also increase.^{5,10}

Risperidone/paliperidone

Risperidone reaches 70–80% of D₂ occupancy at doses between 2 and 6 mg/day. The risk of EPS is positively correlated with dose. Doses above 8 mg/day are generally not considered beneficial for most patients, but in some, the side-effects may not appear until higher dosages.⁵ As noted previously, even at 10 mg/day only 31% of patients required anti-Parkinsonian medication in the pivotal trials, again providing evidence that a subgroup may both require and tolerate higher dosages and plasma levels.¹⁶ Risperidone's active metabolite paliperidone has less chance of drug–drug interactions as it is not metabolised by the liver. Similar to risperidone, paliperidone carries increased risk of EPS as the dose increases.¹¹

Ziprasidone

Data support the use of high doses of ziprasidone, particularly in forensic settings at 360 mg/day.^{2–5,40,41} It can be difficult to achieve adequate plasma levels with ziprasidone in out-patient settings as food is required to increase absorption. It has been reported that ziprasidone has historically been under-dosed due to concern about increased agitation and QTc prolongation.

Aripiprazole

Aripiprazole has a different mechanism of action compared with the ‘first wave’ of SGAs. Contrary to its predecessors, high doses of aripiprazole may not result in increased efficacy in schizophrenia. This is due to its partial agonist properties and high affinity for D₂ receptors.¹¹ Doses of 40 mg/day are associated with 96.8% D₂ occupancy, so further increases will not have an impact on D₂ neurotransmission to any considerable extent.

Asenapine, iloperidone, and lurasidone

Asenapine, iloperidone, and lurasidone are newer atypical antipsychotics. Consequently, there is limited information that supports their use in high doses. Although doses of asenapine of 30–40 mg/day may be effective for some treatment-resistant cases, there are virtually no data supporting use at these higher doses, and the buccal absorption of asenapine declines significantly for each 5 mg increase in the dose. As with asenapine, there are limited to no data supporting the use of iloperidone at high doses. One treatment-limiting issue with iloperidone is orthostatic hypotension. Lurasidone is approved up to 160 mg/day for schizophrenia, but higher dosages have not been studied for efficacy, only for safety (e.g. thorough QT studies up to 600 mg). Similar to ziprasidone, lurasidone should be taken with food to increase absorption.¹¹

Summary

Schizophrenia is a relatively common psychiatric disorder but it is often difficult to treat. Although antipsychotic monotherapy at standard dosing levels is sufficient for the majority of patients, a subset will require ‘unconventional’ approaches such as antipsychotic polypharmacy and higher than normal dosing. If done cautiously and rationally, these approaches can provide much-needed benefit for those most in need of relief.

1.6.49 Should compulsory admission to hospital be part of suicide prevention strategies?

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Abstract

The World Health Organization report *Preventing Suicide: A Global Imperative* provides governments with guidance for comprehensive suicide prevention strategies. However, it does not mention the role that compulsory admission to hospital of psychiatric patients should have in policies for suicide prevention. This was a missed opportunity for international discussion and guidance about a measure that, although widely used, is becoming increasingly controversial in light of the existing evidence and human rights norms.

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- *Should compulsory admission to hospital be part of suicide prevention strategies?*
 - *Compulsory admission to hospital for suicide prevention*
 - *Compulsory admission to hospital: trade-offs and human rights*
 - *The need for guidance*

Legal and policy approaches to suicide have been changing significantly in the past decades. Notably, the decriminalisation of suicide attempts in many countries has been followed by an increasing recognition that the stigma around suicide must be grappled with and that adequate social and healthcare policies can reduce the rate of suicide in the population. In other words, the focus has shifted from criminal punishment and moral condemnation to awareness, support and prevention.¹

The 2014 World Health Organization (WHO) report *Preventing Suicide: A Global Imperative*¹ is an important step in this direction. It draws attention to the discrepancy between the magnitude of suicide as a health problem worldwide and the low priority it is given by national governments. The report also describes the risk and protective factors in suicide prevention based on state of the art research and offers guidance for comprehensive strategies for suicide prevention. The central message in the document is that suicides are preventable but this requires actions such as restricting access to the means of suicide, reducing excessive use of alcohol, collecting and collating good-quality data about suicide and suicide attempts, providing training for gatekeepers, improving the quality of mental healthcare services, and promoting responsible reporting of suicide by the media. The report is also clear that taboo, stigma, shame, guilt and discrimination surrounding suicide hamper effective suicide prevention policies as they discourage vulnerable people from seeking help.

However, despite its emphasis on the need for comprehensive strategies for suicide prevention, the compulsory admission to hospital of people at risk of suicide was not discussed in the WHO report. This should not come completely as a surprise given that compulsory admission to hospital was also ignored in the previous United Nations (UN) and WHO documents on which this report was built.²⁻⁴ Moreover, the literature on suicide prevention rarely lists compulsory admission to hospital among the measures for suicide prevention, and those who do normally do not distinguish between voluntary and compulsory admission.⁵⁻⁷

This gap in international guidelines and in the scholarly literature needs to be addressed. Compulsory admission to hospital is widely used as a measure for suicide prevention, but the trade-offs involved and the human rights implications make it a topic in which guidance and further discussion are urgently needed.

Compulsory admission to hospital for suicide prevention

Compulsory admission to psychiatric hospitals or psychiatric wards is allowed in many countries as a measure to prevent self-harm.⁸ In England and Wales, for instance, the Mental Health Act 1983 (MHA) provides the legal framework for the compulsory admission and treatment of patients with mental disorders of a nature or degree that warrants their detention in a hospital and who ought to be so detained in the interests of their own health or safety or with a view to the protection of other persons. Whether the patient has capacity to decide on their stay in hospital and has objected to it will not affect the legality of a detention under the MHA. A recent publication shows that there were over 63 000 detentions under the MHA in the period from 1 April 2015 to 31 March 2016.⁹ Considering the body of literature associating suicide with mental disorders^{6,10} (see, however, Hjelmeland *et al*¹¹) and that statistically people with mental disorders are at a higher risk to themselves than to others,¹² it is plausible to assume that prevention of self-harm is a common reason for compulsory admission to hospital.

Some would interpret this authorisation to detain as actually a duty to detain when there is a high and immediate risk of a person taking their own life. A failure to do so can be considered medical negligence and may also be a breach of human rights. In the case of *Rabone & Anor v Pennine Care NHS Foundation Trust* [2012],¹³ the Supreme Court unanimously held that the failure of the hospital staff to detain Melanie, a voluntary psychiatric patient who hanged herself from a tree after being allowed to spend the weekend with her family, was a breach of her right to life under Article 2 of the European Convention on Human Rights. According to the Court, given her history of depression and self-harm, including a previous suicide attempt, the hospital staff should have used their powers to detain Melanie under the MHA to protect her from the 'real and immediate risk of suicide' when she demanded to leave the hospital.

Even though this precedent applies to the UK only, it shows that a national strategy for suicide prevention may be incomplete without a policy for compulsory admission to hospital. In hindsight, it is clear that the deaths of people like Melanie could have been avoided were they admitted to hospital and put under close observation, treated, managed and prevented from having access to the means to take their own life.

Compulsory admission to hospital: trade-offs and human rights

When looking at individual cases of suicide and at the data from population-based studies there is evidence that compulsory admission to hospital saves lives.^{14,15} However, this does not answer the question of how, when or whether it should be used to prevent suicide. Compulsory admission to hospital involves trade-offs and has human rights implications that need to be considered in clinical, policy and legal decisions about its role in strategies for the prevention of suicide.

There is now compelling evidence that suicide, being a low-frequency event, is very difficult to predict. The clinical methods for predicting suicide among patients have a very poor predictive capacity.^{16–20} A recent meta-analysis revealed that, over an average follow-up of 5 years, almost half of all suicides are likely to occur in patients considered at low risk, and that 95% of high-risk patients will not die by suicide.²¹ This creates a trade-off between the need to be sensitive to the risk of suicide to reduce the chance of false negatives and the need to be specific to avoid false positives that may lead to unnecessary detentions. Assuming that it is impossible to predict whether a person is going to take their own life and that the best we can do is to estimate that 1 out of X people in a certain cohort will die by suicide, then a society that allows compulsory detention of people at risk of suicide has to admit that to save one person it will have to unnecessarily detain $(X - 1)$ people.

There are also concerns about whether compulsory detention may increase the risk of suicide in some cases. First, some people may not seek treatment because they are fearful of being forced to accept treatments not of their choice or of being detained for prolonged periods.²² This would go against the WHO recommendation that a national effort to prevent suicide should encourage people to seek help. Second, there is an association between suicide and psychiatric admission to hospital, as suicide risk peaks in the period immediately after admission to hospital and shortly after discharge.^{5,6,14,23,24} This association can be explained in part by the fact that individuals with higher risk of suicide are more likely to be admitted to hospital,²⁵ but some argue that admission to psychiatric in-patient care might actually increase the risk of suicide. The stigma, discrimination, impact on employability, trauma, isolation and the feeling of dehumanisation caused or augmented by compulsory admission to hospital may contribute to the extremely high risk of suicide in the first few days of admission and after discharge.^{17,22,26,27} Although further research is necessary,

this hypothesis does not seem farfetched given that people who are detained, disconnected from their social circle and experience trauma, abuse and emotional distress are at a higher risk of suicide.¹ Hence, it is possible that some of the (X1) people unnecessarily detained will in fact die by suicide as a result of compulsory admission.

The trade-offs and tragic choices in compulsory admission to hospital have clear human rights implications. Health systems and professionals who are under pressure to be sensitive to the risk of suicide to avoid breaching a patient's right to life will do so at the expense of specificity. This leads to an increase in unnecessary detentions, which interferes with the right to freedom of movement, autonomy, bodily integrity and private life of those detained. It may also affect the right to life of those whose risk of suicide increased as a result of their stay in hospital. Therefore, the rules and practices regarding the compulsory admission to hospital of people with mental disorders to prevent suicide are always choices between different rights and rights-holders.

There are also concerns about whether compulsory admission to hospital is inherently discriminatory against people with mental disorders as it denies them the right to decide about their own treatment. This concern is reflected in the discussions about whether compulsory admission to hospital is compatible with the UN Convention on the Rights of Persons with Disabilities (CRPD), in particular Article 14, which establishes that 'the existence of a disability shall in no case justify a deprivation of liberty'. The UN Committee on the Rights of Persons with Disabilities,²⁸ for instance, affirms in its guidelines on Article 14 of the CRPD that the 'legislation of several States parties, including mental health laws, still provide instances in which persons may be detained on the grounds of their actual or perceived impairment, provided there are other reasons for their detention, including that they are deemed dangerous to themselves or others. This practice is incompatible with Article 14 [...]'. Others, however, worry about how the prohibition of compulsory detention and treatment for people with mental disorders will affect the protection of other rights of people with disabilities, such as their rights to health and to life.²⁹

The need for guidance

In conclusion, four things can be said about compulsory admission to hospital as a measure for suicide prevention. First, it can save the lives of those who, without the care, treatment and management received in hospital, would have taken their own life. Second, owing to the poor suicide predictive capacity of the existing methods, false positives will occur and this results in unnecessary hospital admissions, which can be aggravated if legal accountability encourages defensive clinical practice. Third, there is the possibility that compulsory admission to hospital is partially responsible for the suicides of those who failed to seek help owing to the fear of involuntary detention or for whom the experience of being admitted to hospital contributed to the decision to take their own life. Fourth, it is still unclear how and if compulsory admission to hospital of people on the basis of their mental impairment and the risk of danger to themselves can be reconciled with the CRPD.

The trade-offs involved and the need for measures for the prevention of suicide to be compliant with human rights make the creation of guidelines concerning their use challenging, but necessary. The WHO is a forum in which an evidence-informed, international, multi-stakeholder discussion can shed light on the role (if any) that compulsory admission to hospital should have in a national policy for the prevention of suicide. It is unfortunate that the otherwise commendable 2014 report missed this opportunity. It may be uncomfortable for those advocating policies to prevent suicide to discuss compulsory admission to hospital as this is a measure in which the line that separates protection and harm can be very thin, and there is controversy about where it lies. However, as those working in the area of suicide prevention already know, avoiding a difficult issue is never the best way to deal with it.

1.6.50 Improving the quality of mental health services using patient outcome data: making the most of HoNOS

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Abstract

Efforts to assess and improve the quality of mental health services are often hampered by a lack of information on patient outcomes. Most mental health services in England have been routinely collecting Health of the Nation Outcome Scales (HoNOS) data for some time. In this article we illustrate how clinical teams have used HoNOS data to identify areas where performance could be improved. HoNOS data have the potential to give clinical teams the information they need to assess the quality of care they deliver, as well as develop and test initiatives aimed at improving the services they provide.

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A commitment to improving the quality of healthcare is central to the aims of the National Health Service (NHS). ¹ This commitment involves developing and evaluating new interventions and treatments, obtaining feedback from patients and learning from mistakes. ² It also involves monitoring and improving patient outcomes. Despite repeated calls for greater use of patient outcome measures in mental health, available evidence suggests that very few services use them to monitor change over time. ³ There are a number of important barriers which make it difficult to implement systems for monitoring patient outcomes, including access to reliable and valid measures, the need to protect patient confidentiality and the time and money needed to collect, analyse and report data. ^{4,5}

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While many initiatives aimed at improving the quality of NHS services have been ‘top-down’, it is widely acknowledged that front-line clinicians have a key role in efforts to improve service quality.^{6,7} However, unless clinical teams have access to information about patient outcomes, they cannot assess their performance or identify areas where performance could be improved.

For the past 20 years the Health of the Nation Outcome Scales (HoNOS) have provided a means of assessing the health and social functioning of people who use mental health services.⁸ HoNOS is a clinician-rated outcome measure comprising 12 scales covering symptoms, functioning, social relationships and environmental issues. Each domain is rated by the treating clinician on the scale of 0 to 4: 0 means no problem, 1 means a problem that probably requires no intervention and 2, 3 and 4 correspond to ‘mild’, ‘moderate’ and ‘severe’ problems. They are rated by staff using all available information – not as a questionnaire or interview – based on the worst state in the reference period, usually 2 weeks. There is a glossary, and training in their use is generally recommended.⁹ Although it is possible to calculate a total HoNOS score for a patient, individual scores on each of the 12 scales provide a better guide to the problems they are experiencing and targets for future interventions and treatments. Originally developed to measure the health and social functioning of working-age adults with severe mental illness, the scales have been modified to assess mental health of older adults (HoNOS65+),¹⁰ children and adolescents (HoNOSCA),¹¹ people with intellectual disability (HoNOS-LD),¹² in secure settings (HoNOS-Secure)¹³ and with acute brain injury (HoNOS-ABI).¹⁴

Use of HoNOS in mental health services in England was patchy until work started on the development of a commissioning tariff based on a Mental Health Clustering Tool, which needed HoNOS scores to be completed on all patients who are in scope of the mental health tariff.¹⁵ While these plans are still in development, this initiative has led to widespread use of HoNOS throughout the country. In recent years clinicians have begun to consider how these data might be used to assess and improve the quality of care they provide. In the next section we present how clinical teams in three trusts have used HoNOS data to identify problems with the care they provide and plan ways to improve it.

HoNOS use – examples of application

Example 1: using HoNOS to examine reasons for admission

Reasons for admission to hospital or to crisis resolution/home treatment (CRHT) teams are poorly understood yet very important in terms of ensuring that available resources are used effectively. As the number of beds decreases, thresholds for admission are becoming increasingly important to assess at a service level.

A team in Southampton used routine HoNOS data to explore mental health problems (such as psychotic symptoms, suicidality and aggression) experienced by adults who were admitted to in-patient units and people referred to CRHT services. They compared the proportion of people who had problems requiring intervention (a score of 2 or more on different HoNOS items) among 3409 people admitted to hospital and 2991 referred to local crisis teams (*Table 1*). The most prevalent problems among people referred to either service were suicidality and agitation, with levels of agitation higher among those admitted to hospital. Nonetheless, clinicians were surprised to see that only around half of patients admitted to hospital and 39% taken on by crisis teams scored as requiring intervention for suicidality and/or agitation. Even when people with significant problems with psychosis or accommodation status were included, a significant minority did not appear to have major problems requiring intervention.

HoNOS scale differences between hospital and crisis team admissions

Scores > 2 on HoNOS items	Hospital <i>n</i> = 3409 %	Crisis team <i>n</i> = 2991 %
1: Agitation	29	16
2: Suicidality	22	27
3: Accommodation	6	5
4: Delusions and hallucinations	13	9
1 or 2	47	39
1 or 2, 3 or 4	66	53

When these findings were discussed within teams, clinicians raised the possibility that people may be being referred to in-patient or CRHT services because of a combination of different problems at less severe level or that staff were under-scoring these items. It also led to discussions about the level of severity at which people were being referred to these services. Discussions based on this information led to a review of in-patient services (numbers of beds in the area were higher than in other comparable catchment areas),¹⁶ and a review of thresholds for access to CHRT services.

Example 2: outcomes of patients treated by assessment and brief treatment teams

Community mental health teams in central London used routine data from HoNOS to examine outcomes of treatment. Changes in mean HoNOS scores were calculated for patients under the care of assessment and brief treatment teams between April 2013 and September 2014 by comparing the mean severity from initial review with that from a follow-up. Scores of 3 (moderate) or 4 (severe) were categorised as 'high' and scores of 0 (absent), 1 (minimal) or 2 (mild) were categorised as 'low', and proportions of people moving between low and high scores were plotted (*Fig. 1*). In *Fig. 1* differences in severity of each subscale of HoNOS are presented for people in clusters 1–5 (single non-psychotic episode), clusters 6–8 (enduring non-psychotic) and clusters 10–15 (psychosis). The data showed that a smaller proportion of people in clusters 6 to 8 had made progress during their time with teams; among people in clusters 6 to 8, fewer who had high scores at baseline had lower levels at follow-up, especially compared with people in clusters 10 to 15. When data were examined from four other sector services in the trust a similar pattern emerged, with a greater proportion of patients in clusters 6 to 8 failing to show evidence of improvement or problems becoming more severe between the two time points compared with people in clusters 10 to 15.

When these data were presented to front-line staff they commented that it can be difficult to help meet the needs of people in clusters 6–8 (predominately people with personality disorder) through the types of interventions available to staff working in assessment and brief treatment teams. Although staff working in these services are able to refer patients to a local specialist personality disorder service, many do not want the group-based psychological treatment offered by this service or are too chaotic and poorly motivated to engage in psychological treatment. Discussions prompted by a review of these data led to the development and piloting of a six-session brief intervention package for people with personality disorder offered by members of the local specialist team (details available from the authors on request). This package of treatment is based on National Institute for Health and Care Excellence (NICE) guidelines¹⁷ and focuses on psychoeducation and skills training. It is hoped that some people who initially reject the offer of longer-term psychological treatment can be engaged through this extended assessment and that others will benefit more from this approach than they do from the care they are currently receiving.

Example 3: comparing outcomes of older adults admitted to in-patient units

Staff working on an in-patient mental health unit for older adults with dementia and other organic conditions used routine HoNOS65+ data to examine outcomes of people admitted to their service. It was noted that over a 3-year period the mean percentage improvement in scores on the depression scale of the HoNOS65+ declined (*Fig. 2*). Outcomes can only be properly understood with reference to context and interventions. These data were therefore compared with those from a similar unit in the same trust with the same operational policy, lengths of stay, diagnostic and demographic characteristics, and initial severity scores. Data from this unit showed that mean percentage improvement on the depression scale over the same period was approximately 50%. The team did not have and still do not have direct data on interventions, but in 2001 there was a pilot study of the systematic recording of care plans, and these data were linked to outcomes data. It transpired that in the unit with the poorer outcomes, all patients with dementia were automatically given night-time benzodiazepine hypnotics. Furthermore, there was a strong association between being given night-time benzodiazepines and poor outcomes. During discussion with the teams it was agreed that routine use of benzodiazepines was a plausible explanation of poor outcomes and this policy was revoked. Over the course of the next year mental health outcomes of patients admitted to the unit improved (*Fig. 2*).

Discussion

The examples given above illustrate how front-line clinical teams have used routinely collected HoNOS data to examine and to try to improve the outcomes of the patients they treat. While changes to mental health services will continue to be made in response to new national policy directives, new research findings and new technologies, we believe that one of the most effective ways to improve service quality is ‘bottom-up’: through local teams using local data to drive change. However, front-line clinicians face a number of significant challenges when trying to assess and improve the quality of the care they provide. Chief among these are limited time and other resources needed to collect data on patient outcomes. We are aware of numerous occasions when clinical teams have made changes to the services they provide but have not had the resources to examine whether these changes led to improvements in patient care. In other instances, baseline audits are conducted that identify problems in a service that teams try to correct, but staff have not had time to assess whether these changes benefited patients. To fulfil the NHS promise to patients to continuously work to improve service quality, clinical teams need to be able to access data on patient outcomes. Yet the experience of participants in the UK Routine Clinical Outcomes Network (www.ukrcom.org) suggests that very few services provide outcomes data to their teams. Embarking on new efforts to collect patient- and staff-rated outcomes is expensive and time consuming. By contrast, routinely collected HoNOS data in England provide an important source of clinician-rated patient outcomes that do not require additional resources to be spent and can be used to assess and improve the quality of care that teams provide.

Challenges to widespread HoNOS use

While the vignettes above illustrate how HoNOS data have been used by front-line clinical teams, a number of obstacles need to be overcome if this approach is to become more widespread.

First, concerns have been raised about the quality of routine HoNOS data.¹⁸ Available evidence suggests that if staff are provided with appropriate support and training, HoNOS can be used to generate reliable information that can be used to compare different services and examine changes in patient outcomes over time.¹⁹ Second, IT systems in trusts need to be able to generate reports on outcome data in a form that clinical teams find useful. Third, data from HoNOS and other routine outcomes scales need to be interpreted cautiously. Random variation and subtle changes in practice and case-mix may have led to changes in patients outcomes over time. Separating real and spurious differences can be difficult.²⁰ Finally, teams need to be given time and space to examine their data, learn from them and use them to evaluate their efforts to improve service quality. If staff are supported to generate reliable data and systems are available to deliver data to front-line clinical teams, then these data have the potential to be used in clinical audit and in alternative models for improving service quality, such as Plan–Do–Study–Act cycles.²¹ The latter approach may have some advantages over traditional audits because it allows the impact of changes in practice to be examined more frequently and provides a more iterative approach to developing changes aimed at improving patient outcomes.^{22,23}

At present, most staff see collecting outcome data as an ‘invisible task’, in which time is spent collecting and entering data for no purpose.²⁴ If systems can be implemented that deliver feedback to staff on service-level patient outcomes, staff are more likely to value collecting these data. For instance, in South London and Maudsley NHS Foundation Trust and Central and North West London NHS Foundation Trust, clinicians have organised meetings for staff in which HoNOS data are presented and discussed. Feedback from staff attending these meetings has shown they value getting this information and their comments have been used to refine the way that data are collated and presented (most staff indicated a preference for the categorical change model presented in *Fig. 1* rather than changes in total HoNOS scores).

While HoNOS scores collected through the current mental health payment initiative¹⁵ provide a rich source of routine data on patient outcomes, the timing of assessments is unlikely to be optimal for evaluating the impact of treatments and services. Further work is needed to establish when outcome assessments are best undertaken in different settings to compare services and assess the impact of quality improvement initiatives.

HoNOS data are not the only form of evidence that mental health services collect. For instance, psychiatric in-patients are asked to complete the ‘friends and family test’ (a two-item short patient-rated experience measure).²⁵ However, there is very little evidence that these data are being fed back to clinicians to allow them to reflect on differences in levels of patient satisfaction over time or between different teams.²⁶ Such data also have the potential to stimulate bottom-up efforts to assess and improve service quality if steps are taken to use them in this way. One of the great strengths of HoNOS data is that they provide a summary of mental health, behavioural problems and social factors. Although this means that HoNOS can be used under circumstances where poor mental health or impaired cognition may limit the value of patient-rated data, there are drawbacks to relying solely on clinician-rated outcomes. The possibility that outcome data could be used to pay services based on patient outcomes could paradoxically reduce their value as a means to assess and improve service quality.²⁷ This is commonly known as Goodhart’s law after the British economist Charles Goodhart: ‘When a measure becomes a target, it ceases to be a good measure’.²⁸

Mental health trusts in England are currently collecting large amounts of outcome data using HoNOS. We believe that efforts by mental health services to use HoNOS data and other routinely collected patient outcomes have the potential to make better use of available resources and engage front-line clinicians in efforts to improve patient outcomes.

1.6.51 Personalisation and social care assessment – the Care Act 2014

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Abstract

The Care Act 2014 represents a significant change in legislation in England. For the first time it brings together various aspects of adult social care into a single statute succeeding earlier acts and policy. Given its importance to the lives of service users and carers, clinicians need to have a clear

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understanding of its implications. We provide an overview of why it was developed, its underlying principles and international comparisons, as well as implications for assessments, interventions and outcomes. The impact on the lives of patients and carers is discussed, as well as dilemmas and challenges the Act presents. While it addresses other important aspects of social care, including safeguarding, Mental Health Act section 117 aftercare and duty of candour, we focus on personalisation because of the opportunities it provides to enhance management plans for people experiencing mental health problems.

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Why was the Care Act 2014 developed?

The Care Act 2014 represents the latest evolution in current attitudes to care. It was asserted by Norman Lamb MP, Care and Support Minister in the UK coalition government, as ‘the most significant reform of care and support in more than 60 years’. ¹ Think Local Act Personal (TLAP, a partnership of more than 50 organisations, including the National Health Service (NHS), ‘committed to transforming health and care through personalisation and community-based support’ (www.thinklocalactpersonal.org.uk/About-us/)) sees it as representing a significant change in legislation, of importance to service users and carers in England and Wales because ‘for the first time it puts them in control of their care and support. It also makes clear what kind of care they should expect’ (www.thinklocalactpersonal.org.uk/Browse/careact2014/).

Social care law can be seen to have begun with the National Assistance Act in 1948 that contained provisions for the basis of the modern welfare state. Direct payments as a method of personalisation were introduced in 1996 by the Community Care Act. More recent updates, such as the Carers and Disabled Children Act 2000 and the Health and Social Care Act 2001, broadened and refreshed these approaches. Separately, safeguarding of adults from abuse was dealt with by the Department of Health in *No Secrets*. ² The Care Act 2014 succeeds earlier acts with a single statute.

The golden thread running through the Act is the promotion of individual well-being (*Box 1*): “‘The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual’s well-being.’ (Care Act 2014 section 1(1)) ‘As a service user who has in the past been a carer to a diverse group of individuals, I feel that had a lot of these changes been made in the past, many people’s lives would have transformed sooner rather than later. That being said, we are now moving forward to enable individual lives to be more fulfilled.’ (Deb Barnes)”

Box 1 Scope: purpose of the Care Act (adapted from the Care Act 2014)

- a. To reform the law relating to care and support for adults
- b. To reform the law relating to support for carers
- c. To make provision about safeguarding adults from abuse or neglect
- d. To make provision about care standards
- e. To establish and make provision about Health Education England
- f. To establish and make provision about the Health Research Authority
- g. To make provision about integrating care and support with health services

Box 2 Care Act specified outcomes

The specified outcomes as defined in the Act are: managing and maintaining nutrition maintaining personal hygiene managing toilet needs being appropriately clothed being able to make use of the adult’s home safely maintaining a habitable home environment developing and maintaining family or other personal relationships accessing and engaging in work, training, education or volunteering making use of necessary facilities or services in the local community including public transport and recreational facilities or services, and carrying out any caring responsibilities the adult has for a child.

What are the international comparisons?

In establishing the Care Act, a cap on spending for long-term social care was originally proposed to be introduced in April 2016. However, this has now been postponed until at least 2020. In 2014, The King’s Fund reviewed international comparisons for health and social care provision.³ It highlights that The Netherlands introduced a ‘universal’ (i.e. available to all) system of insurance for long-term care in 1968. In the 1990s it introduced caps in response to rising costs, but this led to long waiting lists and the caps were abolished. Latterly, they have raised the threshold to access social care and outlined aspects of care that are expected to be delivered by families. Sweden established the right to tax-funded legislation in 1982/1983, whereas countries including Germany, France, Japan and South Korea all have mandatory long-term care insurance schemes.

Assessment under the Care Act

Assessment of needs, both for service users and their carers, is a core aspect of the Care Act. The process is divided into three stages: identifying needs, assessing eligibility and care planning.⁴ Each of these should be viewed not only as a gateway to support but as an intervention in itself.

Stage 1: identifying needs

The Act places a statutory duty on local authorities to provide assessments for any adult, including carers, appearing to have a need for care or support, regardless of the local authority's view of the level of that need or the individual's financial resources (section 9–10). It is important to note that in some areas this responsibility may be delegated by the local authority to partner organisations, such as NHS foundation trusts, and that assessment may be carried out by a range of professionals, including healthcare professionals. This assessment should address the person's needs in relation to the specified outcomes as defined in the Care Act (*Box 2*). It aims to identify the impact of these needs, the person's desired outcomes, and whether the provision of care and support services will be effective in contributing to the achievement of these outcomes (section 9(4), 10(5)). For clarity, we have used the term 'specified outcome' as a technical definition to refer to those outcomes specified in the Care Act (*Box 2*) and 'personal outcome' to describe all possible outcomes individuals may see as important.

It is crucial that the individual, their carer and any other person the individual requests be fully involved in the assessment process. Consideration should also be given to the most appropriate kind of assessment. Options for supported self-assessment, telephone assessment, joint assessment with other agencies or a combined assessment of the needs of, for example, the individual and their carer, may be appropriate (Care Act section 6(3)). In addition, in cases where the individual has significant difficulty in representing themselves at assessment and has no suitable advocate, the local authority is required to provide an independent advocate regardless of the individual's capacity under the Mental Capacity Act 2005.⁵

Stage 2: assessing eligibility

At the eligibility stage, the Care Act replaces previous Fair Access to Care (FACS) guidance on eligibility criteria^{6,7} with a national eligibility threshold based on the causes, extent and impact of the individual's needs (~*Box 3*). It should however be noted that local authorities are able, where considered appropriate, to meet non-eligible needs and may choose to do so, for example, in order to prevent further deterioration.

Well-being, individual personal outcomes and eligibility

In order to judge eligibility, impacts and contexts of needs are relevant: individual needs must be considered against the specified outcomes to determine whether or not they can be met, and reasons for this should be understood. Some social needs are not addressed by the Care Act, for example housing and debt. A homeless person would not be eligible purely by virtue of their homelessness, but the reasons for homelessness may make them eligible. For example, becoming homeless solely through relationship breakdown would not be considered potentially eligible. However, homelessness through an inability to manage a tenancy due to the impact of severe mental illness (i.e. impaired 'ability to maintain a habitable home' as defined in the specified outcomes) may well be eligible.

Furthermore, the impact on well-being is a personalised assessment and an individual perception, so that two people with the same needs in relation to specific outcomes could end up with a different assessment of eligibility. For example, obsessive-compulsive disorder could manifest in repetitive behaviours which affect an individual's ability to maintain family relationships and employment. These two specified outcomes may be fundamental for one person and significantly affect their well-being. Another person may have very different priorities or personal outcomes that they want to achieve; their well-being is not significantly affected and they would not be eligible.

The word 'significant' is not defined in the legislation, rather it is a judgement made by the local authority after considering the person's needs and what is important to them. However, well-being is a broadly defined and holistically assessed concept, relating to areas such as: personal dignity; physical and mental health and emotional well-being; protection from abuse and neglect; control by the individual over day-to-day life; participation in work, education, training or recreation; social and economic well-being; domestic, family and personal relationships; suitability of living accommodation; and the individual's contribution to society.⁵

Box 3 The National Eligibility Threshold (Regulation 2(1)14)¹¹

An adult's needs meet the eligibility criteria if – the adult's needs arise from or are related to a physical or mental impairment or illness; as a result of the adult's needs the adult is unable to achieve two or more of the outcomes [...] and as a consequence there is, or is likely to be, a significant impact on the adult's well-being.

The key to assessment under the Care Act is understanding what personal outcome (personal aim, wish or goal) the individual is looking for and what their needs are, before considering how these needs can be met. Person-centred assessment focuses on the individual and the difficulty they have in achieving personal outcomes, balanced with their strengths and support network; it does not start with service provision. For example, the assessment does not begin with 'the person needs residential care', but rather may find that 'the person is unable to wash, dress and feed themselves. This is having an impact on their personal dignity and their ability to continue to live safely in their own home'.

The local authority must consider what strengths, resources and capabilities the person has themselves and within their support networks and wider community. This strengths-based approach to assessment and care planning can maximise opportunities for utilising assets found within communities and normative support networks, thereby reducing dependence on service provision by meeting people's needs in more innovative and creative ways.

Stage 3: care planning

In developing and delivering preventive approaches to care and support, local authorities should ensure that individuals are not seen as passive recipients of support services, but are actively encouraged and supported to participate and are able to design care and support based around achievement of their goals. All assessments and subsequent care and support plans should be person-centred and genuinely engage the person and people involved in their care throughout.

Support plans should consider the broader needs identified by the assessment as well as the personal outcomes associated with the specified outcomes the individual is looking to achieve to maintain or improve their well-being. The person's own capabilities, assets and strengths and the potential for improving their skills, as well as the role of any support from family, friends or others that could help them to achieve what they wish for, should be incorporated into the plan. A person's independence should be maximised across these networks before any statutory service provision is considered to meet the desired personal outcomes.

Any person who requires ongoing support and has eligible needs is entitled to have these needs met through a personal budget. The Care Act 2014 has given parity to carers, who are now entitled to have their own eligible needs met through a carer's personal budget. A personal budget is an amount of money allocated for a person's support; this can be managed with or on behalf of the individual by the local authority or a broker, or can be paid to the individual as a direct payment. Person-centred care and support planning means that a person can receive part or all of their personal budget as a direct payment. Direct payments aim to enable a person to exercise the maximum possible choice over how they are supported, who they are supported by and where they are supported. The person must understand how much money is likely to be required to meet their eligible needs and have clear and realistic expectations of what is available locally. People who self-fund are entitled to receive necessary information, advice and support with support planning.

The third national TLAP survey⁸ demonstrated that over three-quarters of personal budget holders reported a positive impact of personal budgets on their lives. People with mental health difficulties were more likely than other groups to report a positive impact on relationships with carers, family and friends. However, older people were less likely than other cohorts to report a positive impact on mental health.

Review

Plans may be revised as a scheduled review or in response to changing needs or circumstances. The review should be a positive opportunity to consider whether the plan is enabling the person to meet their needs and achieve their desired personal outcomes. At this point it can be considered whether the support provided is working (be this through a carer, the community, through a direct payment or a commissioned service through a personal budget), whether new personal outcomes need to be defined, or whether any changes need to be made to care and support to achieve improvement.

Responsibilities of professionals

The Care Act places a responsibility on the local authority to inform the individual of their eligibility determination and produce a written record of whether any of their needs meet the eligibility criteria, and the reasons for this decision. Where an individual does not have eligible needs, the local authority must also provide information on what support may be available in the wider community, or what preventive measures might be taken to prevent or delay the condition progressing. This will require professionals responsible for eligibility decision-making to clearly evidence the reasons for their decisions and present these in an accessible format for the person concerned.

Implications for service users and carers

The Care Act 2014 has changed the ability that a service user or carer has to influence assessment of their own needs and eligibility. Whereas the FACS criteria⁷ considered the needs of the individual, they did not consider their whole well-being and how this fits into their everyday lives, meaning that some service users may not have completely fitted into the specified categories. The criteria that the Care Act 2014 looks at focus on the individual in context, so that the impact on their well-being cannot now be overlooked or misjudged.

This holistic approach is mirrored by the TLAP 'I' statements, which make their markers for change much simpler to understand across a diverse range of individuals (*Box 4*). These statements complement the Care Act in allowing the individual service user to take control of everything that supports their specific needs and requirements. 'I' statements are presented in the form of first-person statements, for instance, 'I have the information and support I need in order to remain as independent as possible'.

'A service user or carer can automatically feel comfortable in all the statements as they are very clear and acknowledging. They allow you to take control of everything that supports your needs and requirements. The implications are quite dramatic; you feel worthwhile and not a burden to anyone and it allows you to take greater control of your own personal needs.' (Deb Barnes)

Box 4 Think Local, Act Personal 'I' statements⁹

- Information and advice: having the information I need, when I need it
- active and supportive communities: keeping friends, family and place
- flexible integrated care and support: my support my own way
- workforce: my support staff
- risk enablement: feeling in control and safe
- personal budgets and self-funding: my money.

Dilemmas and challenges

The Care Act 2014 has introduced some major statutory changes to the way social care is delivered nationally, and as such presents a number of dilemmas and challenges to service users, carers and service providers.

Assessment as intervention

Assessment under the Care Act should be an intervention in itself rather than merely a process by which individuals are granted or denied access to funded services. This presents challenges both for local authorities as a whole and for individual professionals in a number of areas, including the necessary provision of reliable and up-to-date information about local services, and management of the time and resources required to ensure that assessments can be completed in a full and holistic manner.

Provision of appropriate and proportionate assessment

Assessment under the Care Act 2014 requires local authorities to become more flexible in administering assessments and to develop assessment processes which allow for this both internally and in collaboration with other organisations.

Measurement of efficacy

Whereas the Care Act 2014 defines specified outcomes for service users and carers, the way in which these are met will be highly specific to each individual service user and may create challenges in the ways local authorities monitor and measure the efficacy of service delivery.

Provision of services

Local authorities are expected under the Care Act to promote and shape the local market so as to achieve diverse provision of care and support in their area. This carries with it budgetary implications with regards to commissioning, funding and fee-setting, which must be considered not only in terms of local authority budgets but also in relation to providers' sustainability.¹⁰

Carer support

The Care Act broadens previous definitions of the carer role and requires assessment of support needs for anyone who feels that they fulfil this role.⁶ The challenge for local authorities is to provide sufficient information to all potential carers on their rights to assessment and possible financial support, while managing the potentially increased demand for these assessments and provisions.

Conclusion

Time will tell whether the aspirations of the Care Act are achieved. The emphasis is clear that care should be holistic and empowering; promotion of well-being is at its core. It is hoped that it will develop services that are inclusive, work in a person-centred way, and achieve specific outcomes. The introduction of the Care Act makes this way of working a statutory duty that public services will be measured by. It will be through individual lives and stories that success will be realised.

1.6.52 Dr Robert George (Rob) Jones FRCPsych

: Formerly Honorary Professor of Old Age Psychiatry, University of Nottingham

Tom Denning Tom Arie

date

2017-6

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- *Dr Robert George (Rob) Jones FRCPsych*
– : *Formerly Honorary Professor of Old Age Psychiatry, University of Nottingham*

For over 30 years Rob Jones, who died recently at the age of 69, was a pillar of old age psychiatry in Nottingham and beyond. Qualifying in Manchester in 1970, he trained there in psychiatry and was particularly impressed with David Jolley's work in old age psychiatry. Following research with David Goldberg, he moved in 1980 to Nottingham as senior lecturer in psychiatry in the department of Health Care of the Elderly that Tom Arie had newly set up. This comprised physicians, psychiatrists and other health professions – Rob worked opposite John Bendall, the senior lecturer in medicine, and was a key figure in the ambitious 1-month combined attachment in old age medicine and psychiatry for all medical students. The novel joint department attracted wide interest, visitors and attached workers coming from home and abroad. Courses in psycho-geriatrics sponsored by the British Council or the World Health Organization brought workers from more than 30 countries to Nottingham and Nottingham staff were often invited abroad. Rob also contributed to a British Council course in Warsaw.

Rob's research included studies of outcomes for care home residents and of community provision; he also participated in major national studies and published widely. He was involved in collaborations that have shaped the practice of old age psychiatry across the UK and internationally. These included the DOMINO-AD clinical trial,¹ which has shown that continuing anti-dementia drugs in people with moderate to severe Alzheimer's disease is worthwhile and does reduce the likelihood of entering a care home at least for a few months.

His most important research was around the care and services for older people with dementia, including, with Ian Rothera and others, a study of life expectancy after entering residential care.² More recently, he provided the psychiatry input into the Medical Crises in Older People programme led by John Gladman. This documented just how many very elderly, frail and vulnerable people are admitted to hospital.³ His later work included studies of care for people with dementia living at home and at the time of his death he was involved in the NIHR Programme Grant PrAISED: Promoting Activity, Independence and Stability in Early Dementia, led by Rowan Harwood.

Rob was a busy clinician and led a district service for older people which served some of the most socially deprived parts of Nottingham, whenever possible taking services to people's own homes. He retired from clinical work in 2013 but continued to be a trustee of the local Radford Care Group, reflecting his passion for the well-being of people living at home, particularly those with dementia. He continued also to work for the university, heading the teaching programme in Health Care of the Elderly until his full retirement in October 2015. Of course, this was not the last we saw of him! He carried on with his research interests, as well as work on public involvement in dementia research – he organised the monthly Centre for Dementia seminars at the Institute of Mental Health. His contributions were recognised by the university with an honorary professorship.

Rob Jones was born in Paignton, Devon, into a family of proud Welsh ancestry. His father edited the local newspaper and this doubtlessly contributed to his insatiable lifelong interest in current affairs. At home he was permanently tuned into BBC Radio 4 and his colleagues were often deeply impressed by his detailed knowledge of world news and politics, to say nothing of lower league football (Torquay United in particular). In Manchester he met Diane and they married in 1971.

Rob was a man of warm and generous personality. He was regarded with respect and affection by all who knew him. His enthusiasm and commitment to the cause of older people was inspiring. For the last 20 years of his career he led academic old age psychiatry in Nottingham, as well as the Trent Dementia Research Network from 2004 until the establishment of the Nottingham Centre for Dementia in 2014. A particular mission was to keep us psychiatrists in close alliance with our colleagues in geriatric medicine, notably through the combined medical student programme. He was especially noted for bundles of papers in carrier bags, festoons of keys and lanyards at his neck, and his characteristic hearty laugh.

Notwithstanding his interest in people, he was quite private. For example, nobody he worked with was aware that Rob had been living with multiple sclerosis for 15 years. Indeed, he completed numerous half marathons during this time. He was definitely not one to complain. After he suffered a myocardial infarction in 2015, we were able to welcome him back to work. It is no surprise, therefore, that his sudden death on 23 May 2016 from a cerebellar haemorrhage came as a blow to all.

He leaves his wife Diane, and his children Haydn, Rhian, David and Siân, along with nine grandchildren.

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1.6.53 Mental Health in the Digital Age: Grave Dangers, Great Promise

Melvyn W. B. Zhang¹

date

2017-6

Contents

- *Mental Health in the Digital Age: Grave Dangers, Great Promise*

Technology has always been a double-edged sword: there are associated risks and benefits. As a practising psychiatrist I increasingly rely on technology at work, using next-generation electronic medical records and at times recommending appropriate smartphone-based applications as additional therapy for my patients.

In contrast to numerous other titles about technology and its impact on healthcare – which have emerged as a result of the massive technical advances in the past decade – *Mental Health in the Digital Age* does not focus only on the benefits

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of the use of technology in mental healthcare. It offers a timely balanced perspective by also providing an in-depth analysis of the risks.

The risks highlighted in the book are not limited to addictive behaviours such as internet or gaming addiction, but also include cyberbullying and the increased risk of suicide due to pro-suicide websites and suicide pacts. Cyberbullying is perhaps one of the most common problems linked with the use of technology to date and it is not unusual for me and my team to see children and adolescents who refuse to go to school as a result of cyberbullying. Unlike conventional forms of bullying, cyberbullying implies the use of social networks and internet-based messaging services to harass an individual. This work examines not only the prevalence of the problem, but also the various prevention strategies available, such as having a specific academic curriculum to deal with the issue.

The authors review the existing literature comprehensively – referring also to current evidence – and look at the potential of technology across several areas of mental healthcare, including the provision of psychotherapy and the integration of patients' health records. They also discuss how recent advances – such as virtual reality – could in principle be a powerful tool in exposure therapy. As a team with an interest in e-health, my colleagues and I have been developing smartphone applications for various mental health disorders. The introduction of virtual reality technology means that we could perhaps tap on games and various other sensors and headset devices to create an interactive environment not just for psychotherapy but for other forms of interventions too.

This is a good guide for novices in e-health but equally a useful tool for the more experienced in this area. It would be helpful if a future edition included more detailed coverage of smartphone applications and their inherent risks and benefits – a topic of concern not only for clinicians, but patients at large.

1.6.54 MCQs in Psychiatry for Medical Students

Suzanne Dash¹

date

2017-6

Contents

- *MCQs in Psychiatry for Medical Students*

Love them or loathe them, most medical student written examinations now take the form of multiple choice questions (MCQs). Some medical educators dislike this assessment style, suggesting it encourages students to learn isolated facts in a superficial way. Yet, undeniably, MCQs provide an objective, time-efficient manner of evaluation.

MCQs in Psychiatry for Medical Students is a valuable resource for medical students undertaking their psychiatry rotations. It includes MCQs and extended matching items grouped into chapters concerned either with a type of disorder – for example, psychotic disorders and alcohol and substance misuse disorders – or another important aspect of psychiatry, such as physical health, pharmacological treatments, psychology and psychotherapy.

Each MCQ is accompanied by a paragraph or two explaining the correct answer. More information is provided than is strictly necessary to understand the answer, but this is illuminating rather than turgid. The 400-plus contemporary

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references encourage the reader to consider issues in more depth than the superficial learning style many associate with MCQs, making the scope of this book potentially greater than is obvious from its title. In contrast, the three extended matching item questions in each chapter are not followed by explanations, making them far less informative.

Writing good MCQ distractor items is a challenge, and in a few places – especially questions on risk factors and protective factors – it is possible to guess the answer by eliminating answers simply based on whether they describe something positive or negative.

This is a must-have title for all medical students; it will pique the interest of many students and may even assist in recruiting future psychiatrists to the profession.

1.6.55 Falls in Scottish homicide: lessons for homicide reduction in mental health patients

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date

2017-8

Abstract

The sustained fall in Scottish homicide rates follows crime reduction measures informed by the epidemiology of suicide. The violence reduction unit targeted young men carrying knives in public. The restriction of weapons immediately to hand appears to have caused an absolute fall in homicide just as suicide reduction was observed following changes to domestic gas supply. Further homicide reduction may be accomplished in the domestic setting with targeted changes in kitchen knife design in home safety planning for high-risk households. Most commonly homicides involving those in recent contact with mental health services in the UK have domestic characteristics and similar safety planning may be targeted at those with mental disorder and a history of violence.

Contents

- *Falls in Scottish homicide: lessons for homicide reduction in mental health patients*

The sustained fall in Scottish homicide rates to 10.65 per million in 2015–2016 marks a 60% fall in the homicide rate since the peak of 26.3 per million in 2005.^{1,2} The greatest fall in homicide involves encounters between young men in public places. The Violence Reduction Unit, formed in 2005, utilised a public health approach to target young men with educational programmes and stiff penalties aimed at achieving reduction in knife carrying outside the home.³ From 2005 to 2016 police in Scotland recorded a 69% fall in cases of offensive weapon carrying.⁴ From 2008 to 2015, Scottish hospitals saw a 63% fall in admissions and a 50% reduction in deaths arising from assaults with a sharp object.⁵

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Limiting the availability of a lethal weapon immediately to hand outside the home has been associated with a dramatic decline in homicide and serious injury.

The targeting of knife carrying in Scotland is an example of situational crime reduction, a highly successful approach inspired by the fall in suicide following changes to domestic gas supply.⁶ The model, aimed at increasing the difficulty of accomplishing a criminal act, arose from observing the marked decline in the UK suicide rate associated with the change from coal gas to natural gas.⁷ A major means of suicide – placing one’s head in an unlit oven and breathing in the gas – abruptly disappeared. Not only was there a dramatic fall in carbon monoxide suicides but a fall in the number of suicides overall. It can be inferred then that there are a group of individuals who, while apparently committed to dying by suicide, can be deviated from a life-ending course of action by a seemingly trivial inconvenience.

Despite the fall in overall Scottish homicides, this has not been observed in homicides associated with those in recent contact with mental health services.⁸ The stereotype of homicides associated with mental disorder involving stranger victims and unusual weapons in public places is false. In a 10-year review of 870 UK homicides carried out by current or recent users of mental health services, the homicide victim was a spouse or ex-spouse in 21% of cases, another family member in 18% and other acquaintances 46%; 15% were stranger victims, as opposed to 24% stranger victims for all homicides.⁸ Similar findings were observed in a 15-year series of 271 homicides carried out by mental health patients in England, where 42% occurred in the shared home of the victim and perpetrator, 25% at the victim’s home and 4% in the perpetrator’s home.⁹ To test the hypothesis that ordinary objects were used in such homicides, this cohort was re-examined: 45% overall involved a knife and of those knives that could be identified 85% were kitchen knives.¹⁰ Homicides associated with mental disorder typically have domestic characteristics, involving family or acquaintances in a domestic setting, not the homicide type targeted in the Scottish campaign.

The evidence would suggest that limiting weapon carrying in public reduces homicides outside the domestic setting, but how can this be achieved within the home where kitchen knives are required? Long sharp-tipped knives have limited specific culinary utility and alternative designs are available.¹¹ One design has an ‘r’ shaped tip and has been demonstrated as being as effective as wearing an anti-stab vest in a thrust to the torso (details available from the author on request), although similar benefits to safety may be achieved with a rounded or square tips.

Perhaps murder mythology in fiction and in the news media, with its emphasis on the exceptional and planned murder, obscures the possible benefits to changes to knife design, which may reduce the injury of unplanned acts of impulsive violence within the home.¹² Yet there is media bias for reporting the unusual, stranger homicide involving those with mental disorder.¹³ This obscures the role of promoting home safety measures utilised in domestic violence reduction for those with mental disorder and a history of violence and weapon use. Such a public health approach could be criticised for restricting freedom and would not stop a planned act of violence. Conversely, this may provide a way of generalising the benefits observed in Scotland to a domestic situation. The role of simple barriers to immediate weapon use in homicide reduction may also indicate strategies for violence reduction in other contexts.

The author gratefully acknowledges colleagues at The Orchard Clinic, Edinburgh, for their constructive comments and support.

1.6.56 Evaluation of the 13-item Hypomania Checklist and a brief 3-item manic features questionnaire in primary care

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Abstract

Aims and method The mean delay for bipolar disorder diagnosis is 10 years. Identification of patients with previous hypomania is challenging, sometimes resulting in misdiagnosis. The aims of this study were: (a) to estimate the proportion of primary care patients with depression currently taking antidepressants who have undiagnosed bipolar disorder and (b) to compare a brief 3-item manic features questionnaire with the Hypomania Checklist (HCL-13). The sample comprised patients with a recorded diagnosis of depression, either on long-term antidepressant therapy or with previous multiple courses of antidepressants.

Results Of 149 participants assessed, 24 (16.1%) satisfied criteria for bipolar disorder. Areas under the curve (AUC) for the 3-item questionnaire and the HCL-13 were similar (0.79 and 0.72, respectively) but positive predictive values (PPV) were low.

Clinical implications Bipolar disorder may be underdiagnosed in primary care. A 3-item questionnaire could be used by general practitioners to screen for bipolar disorder in their patients with depression.

Contents

- *Evaluation of the 13-item Hypomania Checklist and a brief 3-item manic features questionnaire in primary care*
 - *Method*
 - * *Sample*
 - * *Assessment measures*
 - * *Analyses*
 - *Results*
 - * *ROC analyses*
 - *Discussion*
 - * *Strengths and limitations*
 - * *Clinical implications*

Bipolar disorder affects at least 1–2% of the population and is associated with considerable psychosocial impairment.^{1–4} Accurate diagnosis can be difficult because patients tend initially to present in primary care for help with depression rather than with manic features, and many primary care practitioners do not systematically assess for a history of bipolar disorder.^{5–7} Recently the National Institute for Health and Care Excellence (NICE) recommended that all patients in the UK presenting to primary care with depression should be assessed for a history of manic features, specifically ‘previous periods of overactivity or disinhibited behaviour’.⁸

Recent screening studies of bipolar disorder in UK primary care have identified that between 7 and 10% of individuals with depression may have undiagnosed bipolar disorder, usually bipolar disorder type II.^{9,10} It is also the case that individuals with difficult to treat depression and those with poor response to antidepressants are more likely to have unrecognised bipolar disorder.¹¹

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In this context, we aimed to estimate unrecognised bipolar disorder within a sample of primary care patients with depression who were taking antidepressant medications, as well as to evaluate the potential clinical utility of two short screening questionnaires for bipolar disorder: the 13-item Hypomania Checklist (HCL-13)¹² and a brief 3-item manic features questionnaire. Our focus on these brief assessment instruments was stimulated by the need for questionnaires that could be used easily in primary care consultations, which are usually no longer than 10–15 min.

Method

Sample

Practice managers of 9 primary care practices in the west of Scotland identified from their databases 2633 patients who (a) had a recorded diagnosis of depression and (b) were either currently taking long-term antidepressants (more than 12 months) or had had 3 or more courses of antidepressants in the past 5 years. Then, 1860 potentially eligible patients were reviewed by their general practitioner (GP) for eligibility and 1833 written invitations were sent by post, with participant information sheets, on behalf of the research team. There were 204 people who responded to this invitation and 151 were interviewed, giving a response rate of 8.23%. The study was approved by the West of Scotland Research Ethics Committee (reference: 13/WS/0071 18th, approval letter dated April 2013).

Assessment measures

A research nurse completed the Structured Clinical Interview for DSM-IV (SCID-1)¹³ in person in order to obtain a gold-standard diagnosis. An assessment of practice notes was also conducted to corroborate findings from the SCID-1 assessment and to clarify medication regimens. Participants completed the HCL-13 and a brief 3-item bipolar screening questionnaire. This 3-item questionnaire (with a maximum score of 6) was based on the three core diagnostic features for bipolar disorder taken from DSM-5: elevated mood, severe irritability and overactivity.¹⁴ The questions and scoring were as follows: Have you ever had a period of time when you were feeling so good, 'high', excited or 'hyper' that other people thought you were not your normal self or you were so 'hyper' that you got into trouble? (Definitely no (score 0), perhaps yes (score 1), definitely yes (score 2).) What about a period of time when you were so irritable that you found yourself shouting at people or starting fights or arguments? (Definitely no (score 0), perhaps yes (score 1), definitely yes (score 2).) What about a period of time when you were physically much more active than usual, for example, when you had lots of different projects on the go at the same time? (Definitely no (score 0), perhaps yes (score 1), definitely yes (score 2).)

Analyses

Analyses included the Student's *t*-test, chi-squared test and chi-squared test for association, and were conducted using SPSS version 21 for Windows. To assess the likely clinical usefulness of the HCL-13 and 3-item questionnaires, in terms of differentiating between bipolar disorder and major depressive disorder (MDD), we calculated sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) using MedCalc and verified these manually. Positive and negative clinical utility measures were calculated using an online calculator constructed by the developer of the MedCalc test (www.psycho-oncology.info/cui.html).¹⁵

Results

Of those who had a full diagnostic assessment, two participants were excluded because their SCID results suggested a primary diagnosis of alcohol-related mood problems. In total, 24 participants from our final sample of $n = 149$ had a DMS-IV diagnosis of bipolar disorder (16.1%; 95% CI 10.8–23.2%) and the remainder had a diagnosis of MDD ($n = 125$, 83.9%).

There were no significant differences between the bipolar disorder group and the MDD group in terms of age, gender distribution and socioeconomic status (assessed using the Scottish Index of Multiple Deprivation, SIMD) (*Table 1*). However, as expected, the bipolar disorder group had higher mean scores on the HCL-13 (9.21 *v.* 6.61, $P = 0.001$) and on the 3-item questionnaire (4.79 *v.* 2.88, $P < 0.001$).

Characteristics of participants with major depressive disorder (MDD) and bipolar disorder

	MDD (<i>n</i> = 125)	Bipolar disorder (<i>n</i> = 24)	<i>P</i>
Age, years: mean (s.d.)	47.50 (10.50)	47.58 (8.79)	0.972 <i>a</i>
Females: <i>n</i> (%)	77 (62.6)	15 (62.5)	0.992 <i>b</i>
SIMD 1: <i>n</i> (%) <i>d</i> (most deprived quintile)	56 (45.5)	14 (58.3)	0.705 <i>c</i>
SIMD 2: <i>n</i> (%)	20 (16.3)	2 (8.3)	
SIMD 3: <i>n</i> (%)	15(12.2)	4(16.7)	
SIMD 4: <i>n</i> (%)	13 (10.6)	1 (4.2)	
SIMD 5: <i>n</i> (%) (most af- fluent quintile)	18 (14.6)	3 (12.5)	
HCL-13: mean (s.d.)	6.61 (3.36)	9.21 (2.77)	0.001 <i>a</i>
3-item questionnaire: mean (s.d.)	2.88 (1.84)	4.79 (1.56)	<0.001 <i>a</i>

HCL-13, Hypomania Checklist 13; SIMD, Scottish Index of Multiple Deprivation.

Student *t*-test.

Chi-squared test.

Chi-squared test for association.

No SIMD data for 1 participant with MDD.

ROC analyses

The receiver operating characteristics (ROC) curves in *Fig. 1* demonstrate that both the HCL-13 and the 3-item questionnaire performed well in terms of differentiating between MDD (*n* = 125) and bipolar disorder (*n* = 24). For the HCL-13, an area under the curve (AUC) of 0.72 (95% CI 0.61–0.84) demonstrates a ‘fair’ overall ability of the questionnaire to discriminate effectively between the two groups. Similarly, an AUC of 0.79 (95% CI 0.69–0.89) for the 3-item questionnaire also demonstrates a ‘fair’ overall ability. An AUC of over 0.80 is considered to demonstrate a ‘good’ overall ability to discriminate.¹⁶

Table 2 presents the sensitivity, specificity, PPV, NPV and likelihood ratio analyses. For the HCL-13, a threshold score of 8 points had a sensitivity of 75.0% and specificity of 55.28% but PPV was low at 24.66%. At a higher threshold of

9 points, the sensitivity was 70.83%, specificity was 63.41%, PPV was 27.42% and NPV was 91.76%. At the lower threshold of 7 points, the sensitivity was 79.17%, specificity was 52.03%, PPV was 24.36% and NPV was 92.75%. Therefore, a threshold of 4 points was chosen to give the best balance between different statistical parameters.

HCL-13 and 3-item questionnaire screening for bipolar disorder

Questionnaire	Threshold	Sensitivity (%) (95% CI)	Specificity (%) (95% CI)	PPV (95% CI)
HCL-13	13 points	4.17 (0.11–21.12)	99.19 (95.55–99.98)	50.00 (1.26–98.7)
12 points	12.50 (2.66–32.36)	95.12 (89.68–98.19)	33.33 (7.49–70.07)	84.78 (77.68–90.0)
11 points	45.83 (25.55–67.18)	87.80 (80.68–93.01)	42.31 (23.35–63.08)	89.26 (82.33–94.0)
10 points	60.50 (40.59–81.20)	78.05 (69.69–85.01)	35.71 (21.55–51.97)	91.43 (84.35–96.0)
9 points	70.83 (48.91–87.38)	63.41 (54.25–71.91)	27.42 (16.85–40.23)	91.76 (83.77–96.0)
8 points	75.00 (53.39–90.23)	55.28 (46.06–64.25)	24.66 (15.32–36.14)	91.89 (83.18–96.0)
7 points	79.17 (57.85–92.87)	52.03 (42.84–61.12)	24.36 (15.35–35.40)	92.75 (83.89–97.0)
6 points	83.33 (62.62–95.26)	36.59 (28.09–45.75)	20.41 (12.93–29.74)	91.84 (80.40–97.0)
5 points	91.67 (73.00–98.97)	24.39 (17.10–32.95)	19.13 (12.39–27.52)	93.75 (79.19–99.0)
4 points	95.83 (78.88–99.89)	16.26 (10.22–23.99)	18.25 (11.94–26.12)	95.75 (79.19–99.0)
3 points	100.00 (87.75–100.00)	15.45 (9.56–23.07)	18.75 (12.40–26.60)	100.00 (82.35–100.0)
2 points	100.00 (85.75–100.00)	15.45 (9.56–23.07)	18.75 (12.40–26.60)	100.00 (82.35–100.0)
1 point	100.00 (85.75–100.00)	11.11 (6.05–18.25)	18.75 (12.40–26.60)	100.00 (75.29–100.0)
3-item questionnaire	6 points	45.83 (25.55–67.18)	88.62 (81.64–93.64)	44.00 (24.40–65.0)
5 points	66.67 (44.68–84.37)	78.05 (69.69–85.01)	37.21 (22.98–53.27)	92.31 (85.40–96.0)
4 points	83.33 (62.62–95.26)	64.23 (55.09–72.67)	31.25 (20.24–44.06)	95.18 (88.12–98.0)
3 points	91.67 (73.00–98.97)	43.09 (34.20–52.32)	23.91 (15.63–33.94)	96.36 (87.47–99.0)
2 points	95.83 (78.88–99.89)	28.45 (20.69–37.29)	20.72 (13.61–29.45)	97.22 (85.47–99.0)
1 point	95.83 (78.88–99.89)	9.76 (5.14–16.42)	17.16 (11.20–24.63)	92.31 (63.97–99.0)

HCL-13, 13-item Hypomania Checklist; NPV, negative predictive value; PPV, positive predictive value.

Similarly, a threshold score of 4 on the 3-item questionnaire had a sensitivity of 83.33%, specificity of 64.23% and PPV of only 31.25%. At a higher threshold of 5 points, the sensitivity was 66.67%, specificity was 78.05%, PPV was 37.21% and NPV was 92.31%. At a lower threshold of 3 points, sensitivity was 91.67%, specificity was 43.09%, PPV was 23.91% and NPV was 93.36%. Therefore, a threshold of 4 points was chosen to give the best balance between these different parameters.

The positive clinical utility – the ability of the test to confirm cases of bipolar disorder – was poor for both tests. The

negative clinical utility a measure of screening and excluding bipolar disorder, was slightly better for the 3-item questionnaire than the HCL-13 at our threshold values: 0.611 (95% CI 0.541–0.682) compared with 0.582 (0.509–0.655). These thresholds were chosen to give the best balance between sensitivity, specificity, PPV, NPV and positive and negative clinical utility

Discussion

One of the goals of this study was to estimate how common DMS-IV bipolar disorders might be in a sample of primary care patients taking antidepressant medication, specifically those patients who were either taking antidepressant therapy for more than 12 months or who had had multiple courses of antidepressants over the preceding 5 years. We found that 16.1% of our sample had bipolar disorder. This rate is higher than in previous literature from the UK. In samples of primary care patients, Hughes *et al*¹⁰ found a prevalence of 7.3% whereas Smith *et al* found a prevalence of 9.6%. Both studies assessed patients with depressive disorder who had been prescribed antidepressant medication. It is possible that the addition in our study of participants who had previously been prescribed multiple courses of antidepressants led to a higher prevalence estimate for bipolar disorder, because unrecognised bipolar disorder is more common in patients with more severe and enduring depression.¹⁷

We also aimed to compare the HCL-13 and a brief 3-item questionnaire in terms of their ability to differentiate between patients with MDD and bipolar disorder. We found that the AUC for HCL-13 was 0.72, while for the 3-item questionnaire it was slightly higher, at 0.79. For both tests the ability to discriminate between MDD and bipolar disorder in terms of sensitivity and specificity was reasonable, but PPVs were low. This is a function of the low prevalence of bipolar disorder in primary care setting, but represents a potential limitation in terms of the usefulness of these instruments to GPs in everyday clinical practice.¹⁸ In a review of brief screening instruments for depressive disorder in a low-income country, Hanlon *et al*¹⁹ concluded that the low PPV at acceptable sensitivity levels may preclude their use in clinical settings.

Nevertheless, we would argue that there may be some use in primary care for these brief screening instruments alongside additional assessments, for example whether patients have a strong family history of mood disorder. The 3-item questionnaire in particular may be useful to GPs in terms of fulfilling the NICE requirement to assess all patients with depression for a history of manic features. The high NPV of 95% means that clinicians may find this useful for excluding a diagnosis of bipolar disorder in their patients with depression. The NICE guidance states that the ideal instrument should be brief, easy to administer and to score, and should be able to be interpreted without extensive and specialist training.⁸

Strengths and limitations

This was a reasonably large study that took a systematic approach to screening patients in primary care settings. We used definitions of bipolar disorder and MDD based on formal diagnostic classifications by using SCID assessment. The study included a range of people from different social backgrounds, with the majority living in some of the most deprived areas of Scotland. However, it may have been helpful to have more baseline demographic information on patients, such as ethnicity, family history of bipolar disorder and age at onset of depression, and the study may be subject to recall bias because it relied on the patient's recall of prior episodes of manic symptoms rather than a corroborative history. There may also be an issue of selection bias, because GPs were able to exclude certain participants if they felt that they were not suitable for this study. As a result of this, and the fact that only one method of recruitment was used in this study, there was a relatively small final sample given the number of invitations sent, which may have led to ascertainment bias. Moreover, the SCID interviewer was not masked to HCL-13 and 3-item scores, which may also have been a source of bias.

Another potential limitation is that the 3-item questionnaire had no requirement for a minimum duration of symptoms. It is possible that individuals with brief periods of affective instability, such as those with borderline personality disorder, would be inclined to respond positively to these questions. Similarly, we did not take a history of alcohol or drug use, and while we did exclude alcohol or substance-induced mood disorders, the use of psychoactive substances could have led to false positives with the 3-item questionnaire.

Clinical implications

A brief 3-item questionnaire may be clinically useful for GPs who wish to screen for manic features in patients with MDD. This could prompt more detailed assessment, such as an appointment with a relative or friend to obtain a collateral history before assessing the need for a referral to secondary care. Further studies are required in larger samples to assess the clinical usefulness of this test in screening, ideally without the issues of recruitment faced in this study. It may also be helpful to develop the 3-item questionnaire further, perhaps with the addition of other items such as the duration of symptoms. While the addition of items would lead to a more statistically sound test, it would also take longer to administer such a test, which may make it less clinically useful.

A proportion of primary care patients with MDD, perhaps as many as 1 in 5, may have undiagnosed bipolar disorder. For busy clinicians working in a time-restricted environment, we suggest that a brief 3-item questionnaire may be a useful screening tool for bipolar disorder and a first step towards a more comprehensive assessment.

1.6.57 Flexible assertive community treatment (FACT) model in specialist psychosis teams: an evaluation

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2017-8

Abstract

Aims and method The impact of flexible assertive community treatment (FACT) has been observed in people previously supported by assertive community treatment (ACT) teams, but its effect on those previously with a community mental health team (CMHT) has not been studied in the UK. An observational study was conducted of 380 people from 3 CMHTs and 95 people from an ACT team, all with a history of psychosis, following service reconfiguration to 3 FACT teams.

Results People previously with a CMHT required less time in hospital when the FACT model was introduced. A smaller reduction was observed in people coming from the ACT team. Both groups required less crisis resolution home treatment (CRHT) team input.

Clinical implications FACT may be a better model than standard CMHT care for people with a history of psychosis, as a result of reduced need for acute (CRHT and in-patient) services.

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Recent years have seen a widespread disinvestment from assertive community treatment (ACT), with many teams being merged into generic community mental health teams (CMHTs).^{1,2} Such changes have been criticised for moving away from evidence-based systems, instead adopting untested models of service delivery, with poorer quality care, described in a King's Fund report as 'a leap in the dark'.³ In some cases new services have adopted a flexible ACT (FACT) model, with people able to access intensive support delivered in the community using a team case-load and ACT principles, as and when they require it.^{4,5} In this model, care coordinators manage individual case-loads, but also work together to provide shared care for people at times of increased need, enabling seamless transition between high- and low-intensity care.

An observational study in the UK has not shown negative effects in people previously supported by ACT teams in terms of hospital admissions or need for crisis resolution home treatment team (CRHT) interventions.^{6,7} However, there have been no UK studies assessing whether there could be advantages for people previously supported by a CMHT but now receiving FACT. It might be expected that some people who have not previously had access to periods of more intensive support within the CMHT could benefit from the FACT approach, perhaps with a reduced need to have interventions from a CRHT or hospital admission.

Method

In South Warwickshire there had previously been a single, well-established ACT team, with outcome data over a 10-year period showing a reduced need for time in hospital.⁸ The area was also served by three generic CMHTs and a single early intervention team. The early intervention services were maintained, whereas each of the three CMHTs was divided into a team for people with a history of psychosis (recovery teams) and a team for people with other non-organic mental disorders. At the same time they became 'age-independent', with no upper age limit. The previous ACT team was disbanded and merged into the new recovery teams, which were configured to deliver services using the FACT model. A few months prior to the changes, the ACT team had absorbed a community rehabilitation team and therefore fidelity to the original ACT model had reduced. Characteristics of the ACT, CMHT and FACT teams are shown in *Table 1*.

Characteristics of the different teams

	CMHT	ACT	FACT
Case mix	People with psychotic or non-psychotic disorders	People with history of severe psychosis who have difficulty engaging with traditional services and often with comorbid problems	People with a history of psychosis
Age range, years	17–65 for new referrals, no upper age limit for existing users of the service	17–65 for new referrals, no upper age limit for existing users of the service	17 and upwards for new and existing users of the service
Care planning	Individual case management	Shared care	Individual case management with periods of shared care as needed
Interface with mental health professionals	Referrals made between professionals when needed	All professionals involved in delivery of care without referrals, on a needs-led basis	All professionals involved in delivery of care without referrals, on a needs-led basis
Care coordinator: patient ratio	30	12–15	25

ACT, assertive community treatment; CMHT, community mental health team; FACT, flexible assertive community treatment.

There was no change in acute hospital bed availability during the study period. However, a long-stay rehabilitation ward was closed at about the same time as the other changes took place, with most residents being discharged either to nursing homes or to intensive community placements with 24-hour live-in staff support. This group had been care-coordinated by the ACT team both prior to and following discharge.

The current study was a service evaluation of the new FACT-based recovery teams. It assessed their impact in enabling people to avoid time in hospital, to reduce the use of crisis home treatment support, and to examine how much face-to-face support people received from the new service. There were multiple changes associated with setting up the teams, all of which took place in June 2014. Many people experienced a change in care coordinator and/or consultant, and there were various teething problems with the transition. In order to avoid these becoming confounding variables, we chose to study a 13-month period starting 6 months after the creation of the new services: December 2014 until January 2016. We compared this with a 13-month period in the old services a year earlier (December 2012 until January 2014).

The trust uses a computerised notes system for all staff in the community, which constitutes the sole record of any contacts with clients. It can generate detailed reports on clinical contacts between specified time periods, broken down by team or staff member, and is routinely used for gathering trust performance data. Because people are constantly moving in and out of services, we decided to study only those people who were open to the new FACT service during the 13-month study period, and who had also been in one of the 3 CMHTs or the ACT team during the comparison 13-month period. Because of the closure of the rehabilitation ward, there was potential for a considerable impact on bed use data in the ACT arm of the study – the patients, having spent several years in hospital, were moving to nursing care or 24-hour live-in support. For this reason, we excluded from the bed use analysis those who were being discharged from hospital after several years into nursing or live-in community care.

Results

A total of 475 people who had also been with one of the previous legacy teams the year before were identified as being open to the new service. Of these, 95 had previously been with the ACT team and 380 with one of the CMHTs. Results were analysed separately for these two groups. Tests of significance between the old systems and the new FACT service were carried out using 2-tailed paired *t*-tests or, when data were skewed, using the Wilcoxon signed rank test. A Monte Carlo permutation test, as described by Good⁹ and derived from Fisher,¹⁰ was used when there was no standard statistical method available, such as to compare partially paired data. This type of testing gives a *P*-value directly (much like Fisher's exact test) without an intermediary test statistic such as a *t*-value. To keep the false detection rate (i.e. the overall type 1 error) low at 0.05 on account of multiple testing, we used the Benjamini-Hochberg¹¹ correction, which gave a significance level alpha of 0.0288. This means that *P*-values of less than 0.0288 are significant. Where a significant difference was observed in one group but not in the other, *post hoc* power calculations were carried out in order to check for any potential type 2 errors. Demographic and clinical characteristics of people from the two legacy teams are shown in *Table 2*.

Demographic and clinical characteristics of the cohorts

Previous team	ACT (<i>n</i> = 95)	CMHT (<i>n</i> = 380)
Gender, male: %	66.0	54.2
Age, years: mean	45.3	47.7
Time in services, years: mean	13.7	11.0
ICD-10 diagnosis, %		
Schizophrenia	78.3	53.4
Schizoaffective disorder	16.3	4.7
Bipolar affective disorder	4.3	28.2
Other	1.1	13.8

ACT, assertive community treatment; CMHT, community mental health team.

Face-to-face contacts with the FACT teams

For people previously with the ACT team, the number of face-to-face contacts with a member of the new FACT team reduced from 1.16 to 0.69 per week, with a corresponding reduction in mean duration of contacts from 65 to 38 minutes per person. These differences were statistically significant and are of similar magnitude to the changes observed in the other UK study of FACT.^{6,7} The number of contacts by support workers was not significantly different (0.25 compared with 0.29), but the proportion increased from 22 to 43%. In other words, the reduction of face-to-face contacts in the new FACT system for people previously in the ACT team was a result of less involvement of qualified staff. The number of community-based contacts reduced significantly in the new service, but the proportion was greater, indicating that, overall, more contacts had been lost in clinic settings compared with those in the community. For people previously with a CMHT there was very little difference in number and duration of contacts when the service adopted the FACT model. However, there was greater use of support workers and more contacts were in community settings, consistent with the principles of the FACT model (*Table 3*).

Contacts with FACT team compared with previous service (ACT or CMHT)

Previous team	ACT (<i>n</i> = 95)	CMHT (<i>n</i> = 380)				
Face-to-face contacts per week: mean	1.16	0.69	<0.0001 _a	0.47	0.45	0.6018 _a
Duration, minutes: mean	64.80	38.13	<0.0001 _a	26.38	25.33	0.5544 _a
By support worker: mean	0.25	0.29	0.3941 _a	0.07	0.15	<0.0001 _a
By support worker: %	21.45	42.60	<0.0001 _b	14.18	33.86	<0.0001 _b
In the community: mean	0.74	0.51	0.0001 _a	0.25	0.29	0.0314 _a
In the community: %	63.81	73.73	0.0001 _b	52.42	63.85	<0.0001 _b
CRHT use						
People with any face-to-face contact: <i>n</i> (mean)	28 (0.29)	16 (0.17)	0.0023 _a	128 (0.34)	88 (0.23)	<0.0001 _a
Face-to-face contacts: mean	5.83	1.94	0.0237 _a	7.14	2.83	<0.0001 _a
Duration of face-to-face contacts per person, minutes: mean	151.87	51.03	0.0455 _a	250.98	97.15	<0.0001 _a
People with any telephone or face-to-face contact: <i>n</i> (mean)	29 (0.31)	23 (0.24)	0.1584 _a	134 (0.35)	119 (0.31)	0.0190 _a
Hospital use						
Days in hospital: mean	31.76	25.86	0.7413 _c	19.34	12.35	0.0006 _c
Admissions: mean	0.20	0.12	0.0776 _c	0.25	0.18	0.0535 _c
People with any admission: <i>n</i>	15	11	0.3458 _b	71	52	0.0388 _b

ACT, assertive community treatment; CMHT, community mental health team; FACT, flexible assertive community treatment.

2-tailed paired *t*-test.

Monte Carlo permutation test.

2-tailed Wilcoxon.

$P > 0.0288$ not significant (after Benjamini–Hochberg correction).

Contact with the CRHT and hospital use

The number of face-to-face contacts with the CRHT was compared before and after the changes, and significant reductions were seen in both groups. Similarly, the number of people who required any face-to-face support from the CRHT was significantly lower following the changes.

For people who had previously been with the ACT team there was a 19% reduction in number of days spent in hospital, which failed to reach statistical significance. However, the power calculated *post hoc* was only 4%, which indicates that the numbers were insufficient to conclude there was no difference following the change of model. There was also a reduction in mean number of admissions in this group but numbers were too low for a meaningful comparison to be made. In the CMHT group, reductions in bed use were much greater, with a 36% reduction following the introduction of the FACT model, which reached statistical significance. There was also a non-significant reduction in admissions in this group.

Discussion

People previously with a CMHT

There have been no other UK studies exploring the effect of the FACT model on people who had previously been with a CMHT. We observed that these people experienced less than half the number of face-to-face interventions with the CRHT than when they were with a CMHT, which was statistically significant. This is consistent with the FACT philosophy of enabling people to seamlessly move to a high-intensity team approach at times of increased need.¹² Hence, it is possible that during periods of crisis, people were able to receive intensive community support within the FACT team, reducing the need for transfer to the CRHT. Similarly, the reductions in bed use would be consistent with the ability of the FACT model to support people at times of crisis with less need for admission. There were no changes in background bed availability in the services that would provide an alternative explanation for these reductions.

People previously with the ACT team

The other UK evaluation of FACT considered 112 people who had previously been with an ACT service, comparing their hospital and CRHT use before and after the change,^{6,7} but without an appraisal of the impact of people going to FACT from a CMHT. Our findings for people who had previously been supported by the ACT team were similar, with no evidence of adverse consequences in terms of increased need for admission or increased crisis home treatment team contact in the first year. This was despite a considerable reduction in face-to-face support from mental health services. In fact, bed use was reduced, but not significantly, although this has to be interpreted with caution and may not be clinically meaningful as the number of people admitted during the study period was very low.

A possible explanation for this is that a FACT approach could be a more efficient model than ACT because people only receive high-intensity team-based interventions at times of need, freeing up resources for those who most need them. However, our previous follow-up study of the ACT population in South Warwickshire⁸ showed that most people, once they had been with the service for 5 years, reverted to a relatively low level of bed use. The average time with the ACT team had been over 6 years, and by the time the services changed most of these people were relatively stable. Hence, it might be expected that they would cope well with a move to a less intensive service. Any conclusion that there was no evidence of harm when moving from ACT to FACT would therefore be limited to the context of people who have already received a period of several years of intensive ACT interventions.

Limitations

Because there were a number of changes to services, including moving to an ‘age-independent’ model, caution needs to be exercised in interpreting the findings as being solely attributable to the FACT model. One of the limitations of the observational design is the possibility of regression to the mean or background variations which could contribute to reduced hospital use or less contact with the CRHT. Change point analysis can mitigate against this,^{13–15} particularly if combined with start points staggered in time in order to reduce the effect of wider system changes which might influence results. However, because the time period under study was relatively short and the changes in team structure occurred on the same date it was not possible to use this technique. The most robust method for addressing confounding factors would be a randomised controlled trial, but this was beyond the scope of our pragmatic evaluation. The pragmatic method was limited to routinely collected contact data and did not capture more personally meaningful information about satisfaction, social functioning and engagement with services, which are known benefits of ACT.¹⁶

ACT teams have had varying levels of success in terms of achieving fidelity to the model.¹⁷ Without the use of an objective measure, such as the Dartmouth Assertive Community Treatment Scale (DACTS),¹⁸ it is not possible to know with certainty the degree to which the South Warwickshire team was practising according to the ACT principles. Although previous DACTS measures taken several years earlier had shown high fidelity, this had been eroded with less use of shared case-loads and lower staff to patient ratios. Hence, the observations about the outcome for people who had been with the ACT team cannot be extrapolated with certainty to other ACT teams with higher fidelity. This argument also applies to the Firn studies^{6,7} of dismantling ACT teams, which failed to measure ACT fidelity. Although a FACT fidelity scale is available (from The Netherlands),¹² this has never been validated in a UK setting. As Dutch FACT teams also undertake the role of a 24-hour crisis home treatment service, it would not be meaningful to use this scale with a service in the UK, where this function is provided by separate teams.

Conclusions

This is the first study in the UK which has examined the impact of adopting the FACT model on people previously supported by a CMHT within a generic community psychosis service. Although limited by the observational design, the results are consistent with the hypothesis that FACT may be of benefit to this group, who previously did not have access to ACT. People who had been with the CMHT were able to receive increased support delivered with a team case-load at times of increased need, a key component of the FACT approach, thereby reducing their need for the help of the CRHT. We would argue that there is still a case for maintaining ACT teams, which have been much more rigorously assessed than FACT, and that the benefits to patients justify the investment in these services. However, where mental health providers are planning to disband ACT services, there would be value in configuring new teams according to the FACT model, which appears to be a safe alternative in the short term for people who have been with an ACT team for several years.

1.6.58 Burnout and psychiatric morbidity among doctors in the UK: a systematic literature review of prevalence and associated factors

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Abstract

Aims and method To systematically review the prevalence and associated factors of burnout and stress-related psychiatric disorders among UK doctors. An extensive search was conducted of PubMed, EBSCOhost and British medical journals for studies published over a 20-year span measuring the prevalence of psychiatric morbidity (using the General Health Questionnaire) and burnout (using the Maslach Burnout Inventory).

Results Prevalence of psychiatric morbidity ranged from 17 to 52%. Burnout scores for emotional exhaustion ranged from 31 to 54.3%, depersonalisation 17.4 to 44.5% and low personal accomplishment 6 to 39.6%. General practitioners and consultants had the highest scores. Factors significantly associated with increase in the prevalence of burnout and psychiatric morbidity include low job satisfaction, overload, increased hours worked and neuroticism.

Clinical implications The results indicate a worryingly high rate of burnout and psychiatric morbidity among UK doctors, which could have a huge negative impact on healthcare provision in general. Factors at personal and organisational levels contribute to burnout and psychiatric morbidity, and so efforts made to counter these problems should target both levels.

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Doctors have a legal duty broader than that of any other health professional and therefore a responsibility to contribute to the effective running of the organisation in which they work, and to its future direction.¹ In an environment where their health and well-being is not prioritised doctors sometimes become ill, manifesting features of burnout and/or stress-related psychiatric disorders. Such psychiatric morbidity, or ‘caseness’, is detected using self-reported instruments such as the General Health Questionnaire (GHQ).² Doctors also experience ‘burnout’, which is defined as a syndrome of exhaustion, cynicism and low professional efficacy.³ Maslach *et al* described burnout as a prolonged response to chronic emotional and interpersonal stressors on the job, and stated: ‘What started out as important, meaningful, and challenging work becomes unpleasant, unfulfilling, and meaningless. Energy turns into exhaustion, involvement turns into cynicism, and efficacy turns into ineffectiveness’.

Increased prevalence of psychiatric morbidity and burnout has been established in studies from different parts of the

world. A study of Italian physicians found an estimated prevalence of psychiatric morbidity to be 25%, and prevalence of burnout on the emotional exhaustion scale of the Maslach Burnout Inventory (MBI) to be 38.7%.⁵ Other studies have reviewed the factors associated with the development and maintenance of psychiatric illness and burnout among doctors. A survey of Australian doctors found that having medico-legal issues, not taking a holiday in the previous year and working long hours were all significantly associated with psychiatric morbidity.⁶ Self-criticism as a medical student was significantly correlated with psychological stress as a doctor in a cohort followed over 10 years by Firth-Cozens.⁷

Burnout among doctors can lead to self-reported suboptimal patient care,⁸ and to major medical errors.⁹ Psychiatric morbidity increases the likelihood of retirement thoughts and retirement preference.¹⁰ Behavioural responses to burnout established in the literature also include alcohol and drug misuse, physical withdrawal from co-workers, increased absenteeism, arriving for work late and leaving early, and employee turnover.¹¹ An extreme reaction to stress can be suicide, even though the pathway to this is complex and multifactorial. A UK survey of suicides between 1979 and 1983 ranked the medical profession as 10th in the list of high-risk professions.¹²

Mental ill health can be found within every workplace in every country. In the UK the total cost to employers of mental health problems among their staff is estimated at nearly £26 billion each year: £8.4 billion from sickness absences and £15.1 billion from reduced productivity at work.¹³ The National Institute for Health and Care Excellence (NICE) found that promoting the mental well-being of employees can yield economic benefits for the business or organisation, in terms of increased commitment and job satisfaction, staff retention, improved productivity and performance, and reduced staff absenteeism.¹⁴ For the National Health Service (NHS) to reap the benefits described by NICE, priority should be given to employee mental health. However, the constant structural changes to the NHS in England have created instability and lack of job security within the public health workforce.¹⁵ The Health and Social Care Act of 2012 has placed doctors at the centre of clinical commissioning groups in charge of shaping services and made them responsible for £65 billion of the £95 billion NHS commissioning budget.¹⁶ This imposes on doctors, especially general practitioners (GPs), a responsibility unlike any before,¹⁷ one which their training has not prepared them for. The ability to cope with the challenges of working in the NHS and the possibility of stress and burnout were highlighted in the annual meeting of the British Medical Association in 2013,¹⁸ and are the focus of this review.

Numerous research papers document burnout and stress-related psychiatric disorders in doctors worldwide, but none has presented the results in the form of a systematic review showing the prevalence and associated factors among UK doctors. The overall aim of this review was to redress this by assessing the prevalence of burnout and psychiatric morbidity among UK doctors working in different specialties, and to explore the associated identified factors. The objectives were to review the prevalence of the syndrome of burnout and psychiatric morbidity, to explore the nature of the relationship between burnout and psychiatric morbidity, and to identify other factors associated with the development and/or perpetuation of those conditions.

Method

Search strategies

The words ‘burnout’ and ‘doctors’ were put into the search field of the EBSCOhost website specifying the following databases: Academic Search Complete, CINAHL Plus, PsycINFO and PsycARTICLES. Limiters activated were: English language, human, apply related words, and a time limit of January 1993 to December 2013. A total of 562 articles resulted from this, reduced to 489 automatically after duplicates were removed; 28 articles were selected for further analysis, and out of these 9 remained based on the study inclusion and exclusion criteria. Using the same parameters but with the words ‘psychiatric morbidity’ AND ‘doctors’, a total of 97 articles were generated, reduced to 77 after the removal of duplicates, and from these only 1 was selected as new and appropriate. Again using the same parameters but with the words ‘stress’ AND ‘doctors’ NOT ‘nurses’, 3560 articles came up, reduced to 2259 after duplicates were removed; 23 new articles were reviewed in greater detail, and from these 5 new and appropriate articles were selected.

An advanced search on PubMed with the words ‘doctors’ OR ‘physicians’ AND ‘stress’, with a time limit of 1 January 1980 to 15 December 2013 and other limits (human, English language, clinical trial, journal article, reviews, lectures) generated 5973 articles. After careful analysis of the abstracts 28 new articles were identified for more detailed review, and from these 10 were selected as new and appropriate.

Two searches within the group of British medical journals with the phrases ‘burnout and doctors’ and ‘doctors and stress’ with the time limit of January 1993 to December 2013 yielded two new and appropriate papers.

A review of the reference lists of already-identified papers yielded three relevant papers.

Altogether, this extensive search yielded 30 relevant papers which were included in the units of analysis for this review (*Fig. 1*).

Fig. 3: Flowchart of the study selection process.

Inclusion criteria

Certain criteria had to be met before a study was included in the units of analysis: it had to answer any of the research questions for the measurement of the prevalence of psychiatric morbidity the study had to have used any version of the GHQ, and for the prevalence of burnout syndrome only the MBI was considered population group – only medical doctors in the UK irrespective of which organisation they work in minimum sample size of 50 published between January 1993 and December 2013 published in the English language.

The questionnaires

The GHQ is a well-validated and widely used screening tool for the detection of minor psychiatric disorders (psychiatric morbidity) in the general population.¹⁹ The GHQ-12 is self-administered and only takes about 5 min to complete. It enquires about the experience of psychosocial and somatic symptoms in recent weeks. Each of the 12 items is measured on a 4-point Likert scale. Studies validating the GHQ-12 against standardised psychiatric interviews indicate that a cut-off score of 4 or above indicates a high probability that the individual suffers from a clinically significant level of distress (‘caseness’ or psychiatric morbidity).

The MBI is a 22-item self-report questionnaire, which is well recognised and widely used to measure burnout in relation to occupational stress.²⁰ It has three subscales: personal accomplishment (measured by 8 items), depersonalisation (measured by 9 items) and emotional exhaustion (measured by 5 items). Responses are rated for each item according to frequency on a 7-point scale from ‘never’ to ‘every day’. The total score for each subscale is categorised ‘low’, ‘average’ or ‘high’ according to predetermined cut-off scores, based on normative data from a sample of American health professionals. A high degree of burnout is indicated by high scores on the emotional exhaustion and depersonalisation subscales and low scores on the personal accomplishment subscale.

Data extraction

A simple paper data extraction tool was created in Microsoft Word, and the tables from this have been used to portray the results in the results section. Data were extracted by the author over the months of November and December 2013.

Results

A total of 30 papers considered relevant and appropriate based on the study inclusion and exclusion criteria were included in this review. *Table 1* summarises these papers.

Units of analysis included in this review

Study	Journal	Running head	Subs pecialty/grade
Sharma <i>et al</i> (20 08) ²¹	<i>Ps ycho-Oncology</i>	Stress and burnout in colorectal and vascular surgical consultants	Surge ry/consultants
Ramirez <i>et al</i> (19 96) ²²	<i>Lancet</i>	Mental health of hospital consultants: the effects of stress and	Surgery, gastro, oncology, radiology consultants
Wall <i>et al</i> (19 97) ²³	<i>British Journal of Psychiatry</i>	Minor psychiatric disorder in NHS trust staff: occupational	Non-specific
Ramirez <i>et al</i> (19 95) ²⁴	<i>British Journal of Cancer</i>	Burnout and psychiatric disorder among cancer clinicians	Oncology/consultants
Sharma <i>et al</i> (20 07) ²⁵	<i>Colorectal Disease</i>	Stress and burnout among colorectal surgeons and	Surge ry/consultants
Kapur <i>et al</i> (19 99) ²⁶	<i>Family Practice</i>	Sources of job satisfaction and psychological distress in	GP, medical house officer
Guthrie <i>et al</i> (19 99) ²⁷	<i>BJPsych Bulletin</i>	Sources of stress, psychological distress and burnout	Psychiatry/non-specific
Benbow & Jolley (20 02) ²⁸	• <i>International* Journal of Geriatric Psychiatry</i>	Burnout and stress amongst old age psychiatrists	Psychiatry/consultants
Orton <i>et al</i> (20 12) ²⁹	<i>BMJ Open</i>	Depersonalised doctors: a cross-sectional study of 564 doctors	GP
McManus <i>et al</i> (20 02) ³⁰	<i>Lancet</i>	The causal links between stress and burnout in a longitudinal study of UK	Non-specific
Kirwan & Armstrong (19 95) ³¹	<i>British Journal of General Practice</i>	Investigation of burnout in a sample of British general practitioners	GP
Kapur <i>et al</i> (19 98) ³²	<i>BMJ</i>	Psychological morbidity and job satisfaction in hospital consultants	Consultants/junior HO
Coomber <i>et al</i> (20 02) ³³	<i>British Journal of Anaesthesia</i>	Stress in UK intensive care unit doctors	Intensive care/consultants

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Table 3 – continued from previous page

Study	Journal	Running head	Subs pecialty/grade
Appleton <i>et al</i> (19 98) ³⁴	<i>British Journal of General Practice</i>	A survey of job satisfaction, sources of stress and psychological	GP
Newbury-Birch & Kamali (20 01) ³⁵	<i>Postgraduate Medical Journal</i>	Psychological stress, anxiety, depression, job satisfaction	Junior HO
Cartwright <i>et al</i> (20 02) ³⁶	<i>Journal of Clinical Pathology</i>	Workload and stress in consultant medical microbiologists	Microbiology/virology consultants
Caplan (19 94) ³⁷	<i>BMJ</i>	Stress, anxiety, and depression in hospital consultants, general	Consultants (non-specific), GP
Burbeck <i>et al</i> (20 02) ³⁸	<i>Emergency Medicine Journal</i>	Occupational stress in consultants in accident and emergency	Emergency medicine/ consultants
Soler <i>et al</i> (20 08) ³⁹	<i>Family Practice</i>	Burnout in European family doctors: the EGPRN study	GP
Bogg <i>et al</i> (20 01) ⁴⁰	<i>Medical Education</i>	Training, job demands and mental health of pre-registration	Pre-registration HO
Upton <i>et al</i> (20 12) ⁴¹	<i>Surgery</i>	The experience of burnout across different surgical specialties	Surge ry/consultants
Sochos & Bowers (20 12) ⁴²	<i>The European Journal of Psychiatry</i>	Burnout, occupational stressors, and social support in psychiatric	Psychiatry, medicine/ senior HO
McManus <i>et al</i> (20 04) ⁴³	<i>BMC Medicine</i>	Stress, burnout and doctors' attitudes to work are determined	Non-specific
Paice <i>et al</i> (20 02) ⁴⁴	<i>Medical Education</i>	Stressful incidents, stress and coping strategies in the pre-registration	Pre-registration HO
Tattersall <i>et al</i> (19 99) ⁴⁵	<i>Stress Medicine</i>	Stress and coping in hospital doctors	Non-specific
McManus <i>et al</i> (20 11) ⁴⁶	<i>BMC Medicine</i>	Vocation and avocation: leisure activities correlate with professional	Non-specific

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Table 3 – continued from previous page

Study	Journal	Running head	Subs pecialty/grade
Deary <i>et al</i> (19 96) ⁴⁷	<i>British Journal of Psychology</i>	Models of job-related stress and personal achievement among	Consultants
Thompson <i>et al</i> (20 09) ⁴⁸	<i>The Clinical Teacher</i>	Contemporary experience of stress in UK foundation doctors	Foundation doctors
Berman <i>et al</i> (20 07) ⁴⁹	<i>Clinical Medicine</i>	Occupational stress in palliative medicine, medical oncology	Oncology and palliative medicine registrars
Taylor <i>et al</i> (20 05) ⁵⁰	<i>Lancet</i>	Changes in mental health of UK hospital consultants	Consultants

GP, general practitioner; HO, house officer.

Findings on prevalence

Seven studies^{21,22,24,25,27,30,50} had quantifiable data on the prevalence of both psychiatric morbidity and burnout (an in-depth analysis of studies reviewed in this paper is included in an online data supplement to this article). Altogether 22 studies reported on prevalence of psychiatric morbidity, and the range was 17–52% (average 31%). GPs and consultants had the highest scores. Fourteen studies had burnout scores, with nine reporting scores as percentages and five as mean scores; one study²⁸ had both percentage and mean burnout scores. For emotional exhaustion the scores ranged from 31 to 54.3% and mean scores ranged from 2.90 to 31.26; for depersonalisation the scores ranged from 17.4 to 44.5% (1.95–15.68) and for low personal accomplishment the range was 6–39.6% (4.36–34.21). GPs, consultants and pre-registration house officers had the highest levels of burnout in the studies.

McManus *et al*,⁴⁶ in a UK-wide study carried out in 2009, had the largest sample size at 2845 doctors and reported prevalence of psychiatric morbidity at 19.2%. The other two UK-wide studies with samples of over 1000 cutting across specialties and grades^{23,43} reported psychiatric morbidity prevalence rates of 27.8% and 21.3%, respectively. Taylor *et al*⁵⁰ reviewed 1308 consultants from different specialties and found the prevalence of psychiatric morbidity to be 32%.

One longitudinal study³⁰ found no significant increase in the prevalence of psychiatric morbidity over 3 years in a non-specific group of doctors. Another longitudinal study⁵⁰ found a significant increase in psychiatric morbidity and emotional exhaustion among consultants over 8 years.

The only European Union (EU) study looking at the prevalence of burnout in GPs from 12 EU countries³⁹ found lower average scores on all burnout scales compared with those of English GPs.

Findings on associated factors

Job satisfaction was found to be protective against the effect of stress on emotional exhaustion. The number of hours worked, job stress and overload were associated with increased psychiatric morbidity in eight studies. Two studies^{22,38} found that women had significantly higher psychiatric morbidity than men, but three studies^{27,34,45} did not find any association with gender. The personality trait of neuroticism was significantly associated with increase in psychiatric morbidity in three studies,^{35,43,47} while conscientiousness was a protective factor. Psychiatric morbidity was also positively associated with taking work home and with the effect of stress on family life.

Job satisfaction was negatively correlated with burnout in three studies.^{21,22,25} Age was an interesting factor; increased depersonalisation was found in younger doctors in five studies,^{21,22,27,29,31} whereas emotional exhaustion increased with

age in two studies.^{22,41} Being single was associated with increased burnout scores, and neuroticism increased burnout significantly in two studies.^{43,47} Increased job stress and workload increased burnout in three studies, with significantly lower emotional exhaustion scores in part-time GPs.

Findings on the direct relationship between burnout and psychiatric morbidity

Three studies^{25,30,46} found significant positive correlations between psychiatric morbidity as measured by the GHQ, and burnout syndrome. Using the process of casual modelling, McManus *et al*³⁰ found that when scores were considered in 1997 and later in 2000, emotional exhaustion increased psychiatric morbidity, and *vice versa*. Personal accomplishment increased emotional exhaustion directly, and increased psychiatric morbidity directly but also indirectly through increasing emotional exhaustion. When other mental health problems were considered, anxiety and depression were found to increase psychiatric morbidity in three studies,^{35,37,38} and depression increased depersonalisation.⁴¹

Discussion

The findings indicate that the prevalence of psychiatric morbidity among UK doctors is quite high, ranging from 17 to 52%. This compares unfavourably with the results from a longitudinal survey of people living in private households within the UK, which found an 18-month period prevalence of common mental disorders to be 21%.⁵¹ Only 4 of the 22 studies that reported on psychiatric morbidity found prevalence of less than 21%,^{26,30,32,46} which is slightly better than 27% found in a study of palliative care physicians in Western Australia.⁵² An earlier study of junior house officers in the UK found psychiatric morbidity in 50% of doctors,⁵³ but this was in a period when the working pattern of junior doctors was relatively unregulated. More recent studies of junior doctors contained in this review found the prevalence of psychiatric morbidity to be around 19%.^{26,32} Concern over increasing prevalence of common psychiatric illnesses was borne out by the results from the study which found a 5% increase in morbidity among a cohort of consultants over an 8-year period.⁵⁰

This review also found a high prevalence of burnout among UK doctors measured using the MBI. It lends further support to the growing body of evidence which has found the syndrome of burnout to be prevalent all over the world among health professionals. In a sample of Australian doctors, 24% suffered burnout;⁵² in a New Zealand sample of medical consultants one in five did;⁵⁴ and in a cross-section of Japanese doctors 19% were affected.⁵⁵ This review found even higher rates of burnout, with the prevalence of emotional exhaustion ranging from 31 to 54.3%, which would suggest UK doctors are comparatively more prone to burnout. GPs generally had higher scores for burnout,²⁹ particularly in the study of European family doctors,³⁹ which found that the only countries in which GPs had higher burnout scores than England were Turkey, Italy, Bulgaria and Greece. Emotional exhaustion among a cohort of consultants was shown to have increased over an 8-year period,⁵⁰ with a prevalence of 41% in 2002.

This review has been able to pool together different studies which report on factors associated with the development and perpetuation of psychiatric morbidity and burnout. Neuroticism was positively and significantly correlated with psychological distress and burnout in three studies.^{35,43,47} Neuroticism refers to a lack of psychological adjustment and instability leading to a tendency to be stress-prone, anxious, depressed and insecure, and it has been shown to negatively predict extrinsic career success.⁵⁶ McManus *et al*,⁴³ in a 12-year longitudinal study on a cohort of students who started studying medicine in 1990, found that doctors who are more stressed and emotionally exhausted showed higher levels of neuroticism all through their careers. Neuroticism was also positively associated with perceived high workload. The researchers concluded that neuroticism was not only a correlate but a cause of work-related stress and burnout. Similar findings were noted by Clarke & Singh⁵⁷ in a study looking at the pessimistic explanatory style of processing information, which is a manifestation of neuroticism. In that study neuroticism was shown to positively predict psychological distress in doctors, and the authors recommended that susceptible doctors should be offered cognitive-behavioural therapy (CBT) to alter their explanatory style.

In an editorial titled 'Why are doctors so unhappy?' Richard Smith stated that the most obvious cause of doctors' unhappiness was that they feel overworked and under-supported.⁵⁸ Job stress, feeling overloaded and the number of hours worked were positively linked to psychiatric 'caseness' and burnout in many of the studies in the present review, and this cut across specialties and grades. A General Medical Council (GMQ survey⁵⁹ of doctors in training found that 22% felt their working pattern leaves them short of sleep at work, and 59% said they regularly worked beyond

their rostered hours. Increasing job stress without a commensurate increase in job satisfaction was associated with the presence of psychiatric morbidity, and job satisfaction was also positively correlated with illness in six of the reviewed studies^{21,22,25,34–36}. Another significant finding was the correlation between psychiatric disorders and burnout, with the two feeding off each other, leading to worsening outcomes.

The public health importance of these findings cannot be overemphasised. GPs are at the frontline of healthcare delivery in the UK, and around 90% of all NHS contacts take place in primary care, with nearly 300 million GP consultations a year.⁶⁰ The estimated total number of GP consultations in England rose from 217.3 million in 1995 to 300.4 million in 2008, with a trebling of telephone consultations, and with the highest consultation rates among the growing population of elderly individuals.⁶¹ Increased live births of over 110 000 over the past 10 years,⁶² and an ageing population⁶³ have contributed to the pressure felt by services in general. However, in spite of the increased demand on primary care services, the proportion of the NHS budget that is spent on general practice has slumped to record levels, and GPs report that this has compromised the quality of care they can provide.⁶⁴ Under these circumstances, the added expectation from the UK Department of Health that GP surgeries should open for longer hours and should expand patient choice will undoubtedly lead to even more psychological distress and burnout among GPs.

A government-driven emphasis in the NHS on performance management and targets increases job demands and stress among managers,⁶⁵ and increases psychiatric morbidity among doctors. The current climate of austerity in the UK, and the expectation that doctors should continue to provide high-quality care to patients within an NHS intending to make £20 billion worth of savings,⁶⁶ further expose doctors to burnout and stress. Psychiatrists are already having to deal with the expected increase in demand for mental health services stemming from the economic downturn,⁶⁷ and the increase in suicide rates⁶⁸ among the working-age population. Psychiatrists are particularly vulnerable to burnout, and patient suicide is a factor significantly associated with stress and burnout in this group.⁶⁹

Burnout among doctors can affect the entire public health workforce because as a syndrome it is considered ‘contagious’.⁴ With the push for doctors to take up leadership positions at every level within the NHS a burnt-out doctor can negatively affect the entire healthcare delivery system. Unhealthy coping strategies in response to burnout and stress were identified in this review: these include retiring early, taking work home, taking it out on family, mixing less with friends, and avoidance, all of which work against the development of a healthy work-life balance.

Limitations

Some key limitations are worth highlighting. First, all the studies were cross-sectional surveys using questionnaires sent to the participants online or by post. Response rates varied, with some as low as 17%, and only in half of the studies was effort made to increase the response rate by sending reminders or repeat questionnaires. Non-response bias could have affected the results. Second, although the MBI was used in all the studies examining burnout, different versions of the MBI were utilised. With the GHQ some studies used the 28-item version but most used the 12-item version. The cut-off for ‘caseness’ using the GHQ also differed between studies and ranged between 3 and 5. However, these differences may not have significantly affected the overall findings given that a study to validate the two versions of the GHQ found no difference between them, and also established that the different cut-off for ‘caseness’ did not affect the questionnaire’s validity.²

The cross-sectional method used for the surveys makes it difficult to draw a firm conclusion on the outcomes from a cause and effect perspective. Also, the number of potential confounders for the presence of burnout and common psychiatric disorders is vast and cannot be controlled for in surveys alone.

The fact that this literature review ends in 2013 may be considered a limitation, but the hope is that this paper will trigger more research in this area, and the author’s intention is to update the literature review by 2023.

Recommendations

Doctors are ultimately responsible for the quality of care they provide at any time, and they need to be aware of their own vulnerability to burnout and psychiatric illness, and of their impact on patient care. Traditionally, doctors take pride in working a lot of hours,⁷⁰ and are 3 to 4 times less likely to take days off sick compared with other health professionals;⁷¹ this combination is a recipe for burnout. A whole list of support networks is available on the GMC website,⁷² and doctors should be encouraged to utilise these. However, there is a 'culture of fear' among doctors regarding the GMC, and 96 doctors, a lot of whom had mental health problems, have died by suicide since 2004 while being investigated by the GMC.⁷³ A lot more work is therefore needed to make the most vulnerable doctors feel supported.

At an organisational level, approaches designed to reduce the workload of doctors should be prioritised. Changes to doctors' contract of service should reflect an understanding of the impact of work-related factors on the health and well-being of doctors, and any such contract should contain the necessary protections to reduce the experience of psychiatric illness and burnout. The benefits of a healthy workforce on the quality of care provided in the NHS cannot be overstated.

1.6.59 The impact of transforming care on the care and safety of patients with intellectual disabilities and forensic needs

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Abstract

NHS England recently published a national plan to develop community services for people with intellectual disabilities and autism who display challenging behaviour by using resources from the closure of a large number of hospital beds. An ambitious timescale has been set to implement this plan. The bed closure programme is moving ahead rapidly, but there has been little progress in developing community services to support it. This paper discusses the impact of the gap between policy and practice on the care and safety of patients with intellectual disabilities and forensic needs who form a distinct subgroup of the target population and are being disproportionately affected by this government policy.

Contents

- *The impact of transforming care on the care and safety of patients with intellectual disabilities and forensic needs*

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- *The policy context*
- *Lack of investment in community services*
- *The effects of Transforming Care*
- *Discussion and conclusions*

The policy context

Building the Right Support, a national plan to develop community services and close hospital beds for people with intellectual disabilities and autism who ‘display behaviour that challenges’ (p. 4), was published last October by NHS England and its local authority partners. ¹ The genesis of this plan was the Winterbourne View scandal in 2011, which involved the systematic abuse of people with intellectual disabilities in an independent sector hospital unit run by Castlebeck Care in Bristol, England. ² This led to a concordat that committed the Department of Health to a rapid reduction in the number of people with intellectual disabilities and challenging behaviour in hospital beds by mid-2014. ³ Under pressure from politicians and stakeholder groups, who claimed that the government had failed to deliver on its concordat promises and that the situation had worsened, ⁴ the chief executive of the National Health Service (NHS) committed to a 2-year intellectual disability hospital closure programme during a parliamentary select committee hearing on services for people with intellectual disabilities and challenging behaviour in early 2015. ⁵

The ensuing national plan includes the closure of 45–65% of local clinical commissioning group (CCG)-commissioned and 25–40% of NHS England national specialist-commissioned in-patient beds by 2018. This is a ‘starting point’ and commissioners are encouraged to be ‘ambitious in thinking about how much further they can go’ (p. 6; unless stated otherwise, all quotations in this commentary are from *Building the Right Support* document ¹). The rationale for these numbers and timescale is unclear beyond what NHS commissioners and local authorities have told the plan’s authors ‘they believe is possible’, which was then ‘sense-checked’ against geographical variations in current in-patient service usage (p. 27). The money saved from these bed closures is to be reinvested in the development of community services (p. 6). The national plan is clear that this transition will involve significant costs. It is stated that commissioners ‘will need to invest in new community support *before* closing inpatient provision’ (p. 7, italics added). Also required is the ‘temporary double running of services as inpatient facilities continue to be funded whilst new community services are established’ (p. 44). Local Transforming Care partnerships were tasked with drawing up implementation plans to support a new model of care and to start delivering against these plans by 1 April 2016.

Lack of investment in community services

Unfortunately, little progress appears to have been made in agreeing, let alone implementing, new community service models to support the bed closure plans as envisaged in the national plan. The current authors work clinically with patients with intellectual and developmental disabilities who display offending and offending-type behaviours in in-patient and community services across six CCG areas in the north-east of England. As a group we have been closely involved in initiatives to increase hospital discharge rates and reduce readmissions, bed numbers and lengths of stay as well as to support and strengthen community services for people with intellectual disabilities who are at risk of offending. These innovations pre-date the Transforming Care programme and have already led to the closure of two in-patient units and a number of satellite beds in our services (40 beds in total). Despite our engagement and commitment to this transformation process we are concerned about the impact of the national plan, and the manner in which it is being implemented locally on patient care, patient safety and the safety of others.

The North East and Cumbria is one of six ‘fast-track areas’ in the national plan, set up with £2.06 million support from the NHS England Transforming Care programme to ‘help fund transitional costs and speed up implementation’ (p. 12). Fast-track areas aim to reduce in-patient bed usage by around 50% within 3 years, thereby ‘freeing up tens of millions of pounds which will be invested in community-based support to prevent hospital admissions’ (p. 13). The North East and Cumbria service model, which aims to deliver a 50% reduction in in-patient admissions, is currently in draft form and the ‘new community model’ embedded within the overall service model is not due to be considered by the North East and Cumbria Transforming Care Board until September 2016 at the earliest. Once the model is agreed,

implementation plans will need to be developed, and resources including people and funds will need to be identified to enable it to be initiated. Judging by the pace of progress to date, this is likely to take considerable time. In the meantime, plans for in-patient bed closures are progressing rapidly, with 31 out of 112 beds (35%) across our medium- and low-secure and locked rehabilitation services currently empty as part of the closure programme.

The effects of Transforming Care

The impact on patient care and safety of the drive to close in-patient beds without first having developed or strengthened community services is already beginning to show locally. The population served by these in-patient services, in contrast to the intended target population, is relatively high functioning intellectually (that is, mild/borderline in intellectual disability terms),⁶ shows high levels of psychiatric comorbidity⁷ and personality disorder characteristics,⁸ and generally does not display 'behaviour that challenges', but outwardly directed high-impact offending behaviour that has resulted in criminal convictions and/or detention under the Mental Health Act 1983 on the basis of 'abnormally aggressive' and/or 'seriously irresponsible' behaviour. Chief among the behaviours that bring these patients into these services are serious violence and aggression, sex offences, damage to property and firesetting.⁹ The most recent national census data reflect this offending behaviour profile, in that 33% of patients with intellectual disabilities detained under the Mental Health Act in England are subject to Part III criminal sections, and 21% of that group are subject to Ministry of Justice restrictions, meaning that they cannot be discharged without the approval of the Secretary of State or a mental health tribunal.¹⁰ Just 17% of in-patients with intellectual disabilities in the census were informal – that is, not detained under the Act.

The imperative to empty and then close in-patient beds has resulted in pressure being applied on clinical teams through commissioner-led 'care and treatment reviews'¹¹ to provide discharge dates for some forensic patients who continue to present levels of risk that local service providers and community teams are not adequately resourced to manage, or to consider transfers from NHS to independent hospital beds. Some evidence for the movement of patients around the in-patient system – possibly to create the illusion of progress – comes from a recent update from the NHS England Director of Transformation – Learning Disabilities,¹² who reported that in April 2016, 20 of the net 100 recorded discharges were in fact transfers to other hospitals, and the destination of a further 20 discharged patients was unknown.

There is also concern that owing to the pressure to discharge as quickly as possible to meet the national plan targets, patients' rehabilitation is being hurried and/or truncated, resulting in some people being discharged before they are ready to take on the challenges of living in the wider community, or without the receiving community services being properly prepared to manage the risks these patients continue to present. The high level of clinical complexity and associated forensic risk in this population can require a significant period of assessment, formulation and specialist treatment to help patients develop thinking styles and attitudes, emotional control strategies and lifestyles less compatible with offending behaviour. A carefully considered and planned period of pre-discharge preparation is an important component of the treatment pathway and is essential to facilitating a successful transition from hospital to community care.

Another consequence of the current rapid bed closure policy is that people with intellectual disabilities and forensic needs who require urgent hospital treatment are being admitted to generic psychiatric services. This includes patients who have been previously detained in hospital under the Mental Health Act 1983 and discharged on community treatment orders, and who have been subsequently formally recalled to hospital owing to escalating risks of harm to themselves or others. Admission to acute psychiatry units can result in these patients being targeted and exploited by more able patients. In addition, they are unable to access appropriate assessment and treatment as the staff teams in these services have little or no experience of working with this population and lack the specialist skills required.¹³ This will result in longer periods of in-patient admission for these patients as access to suitable interventions aimed at reducing forensic risks is delayed.

One aim of the Transforming Care programme is to prevent people with intellectual disabilities and challenging behaviours from undergoing unnecessary admissions to intellectual disability and mental health in-patient services. Whether an admission is necessary or not is inevitably a matter of judgement. With the requirement for commissioner agreement to admission, there is a real risk of the judgement of clinicians being circumvented. Efforts to prevent admission to hospital by increasing supervision and support to people in community settings to manage emerging risks have paradoxically resulted in situations amounting to *de facto* deprivation of liberty in some cases, where a short informal

hospital admission to allow the risks to be assessed and required amendments made to care plans would have been a less restrictive and more clinically effective option.

Discussion and conclusions

People with intellectual disabilities who require treatment in hospital for behavioural, psychiatric and forensic problems should have access to the best evidence-based interventions available, delivered by caring staff with positive attitudes and person-centred values, in good-quality, safe environments. It is clear that a disproportionate number of people with intellectual disabilities are detained in hospital under the Mental Health Act¹⁴ and, once detained, they have on average longer lengths of stay than detained patients who do not have intellectual disability.¹⁵ The *Building the Right Support* national plan aims to address these inequities, albeit based on uncertain evidence and questionable assumptions.

There is no credible evidence or analysis presented to support the proposed bed reduction numbers. Between 1988 and 2015 the number of intellectual disability beds in the NHS reduced dramatically, from approximately 33 000 to about 2500.¹ It is debatable whether this 90%-plus reduction over the past 30 years has been caused by centrally driven government policy initiatives, for example *Valuing People*,¹⁶ or the impact of human services theories, such as social role valorisation,¹⁷ on the deinstitutionalisation and community care movements in the 1980s and 90s.¹⁸ Either way, looking at the most recent census of in-patient services for people with intellectual disabilities in England,¹⁰ 83% were legally detained under the Mental Health Act 1983, with all of the scrutiny and protections this affords via mental health tribunals, hospital managers' hearings and Care Quality Commission inspections. It could be argued therefore that the majority of the remaining intellectual disability in-patient beds represent equipoise in the system and, as such, the current huge diversion of resources into forcing the closure of these remaining beds is unlikely to be successful in the long term.

The national plan starts from the supposition that all people with intellectual disabilities 'should have a home within their community' (p. 4). Seemingly underpinning this position is a belief that families and the community are always better for people with intellectual disabilities and that hospital services do not provide safety and sanctuary for some people. For many of our patients with forensic needs, their histories indicate that families and the community can be part of the problem rather than the solution. Putting to one side the fact that communities are generally not keen to embrace people who might have violently or sexually assaulted people in their midst, or set fire to their buildings, people with disabilities frequently experience abuse, aggression and violence in and by the community.¹⁹ There are many examples of people like Brent Martin, who was brutally murdered in 2007 by his more able 'friends' in Sunderland 3 months after being discharged from hospital.²⁰

A further assumption underpinning the national plan is that hospital admissions should be as short as possible. There is an apparent lack of understanding that the population managed and treated by in-patient forensic intellectual disability services is distinct from the population envisaged within the Transforming Care programme. Patients with significant forensic histories have frequently experienced high levels of abuse, neglect and deprivation. They require time to develop insight into their difficulties in relating to others, acquire skills in regulating their emotions and acknowledge their future support needs. The application of a bed closure policy and as yet unclear community service model that is designed for a very different population carries significant risks of harm for patients with intellectual disabilities and forensic needs, as well as for others. The implementation of that policy without the required and promised investment in and development of community services is especially concerning. Some of the unintended consequences of this approach might include more vulnerable offenders with intellectual disabilities being sent to prison rather than diverted to hospital for appropriate treatment as recommended in the Bradley Report²¹ While imprisoned, such offenders will likely be targeted by other prisoners because of their disabilities and will remain at risk of re-offending, as they will be unable to access prison offending behaviour programmes²² Finally, it is perhaps ironic that this policy will possibly lead to an increase in the use of independent sector hospital beds for people with intellectual disabilities – exactly where this all started.

1.6.60 Prevent: what is pre-criminal space?

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Abstract

Prevent is a UK-wide programme within the government's anti-terrorism strategy aimed at stopping individuals from supporting or taking part in terrorist activities. NHS England's Prevent Training and Competencies Framework requires health professionals to understand the concept of pre-criminal space. This article examines pre-criminal space, a new term which refers to a period of time during which a person is referred to a specific Prevent-related safeguarding panel, Channel. It is unclear what the concept of pre-criminal space adds to the Prevent programme. The term should be either clarified or removed from the Framework.

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- *Prevent: what is pre-criminal space?*
 - *Pre-criminal space in the NHS England Framework*
 - *Coining of 'pre-criminal space'*
 - *Denotation and connotation*
 - *The derivation of pre-criminal space*
 - *Rhetoric*
 - *Opinion*

The Prevent Training and Competencies Framework¹ begins thus: “Prevent is part of the Government's counter-terrorism strategy CONTEST and aims to stop people becoming terrorists or supporting terrorism; as such it is described as the only long term solution to the threat we face from terrorism. Prevent focuses on all forms of terrorism and operates in a pre-criminal space, providing support and redirection to vulnerable individuals at risk of being groomed in to terrorist activity before any crimes are committed. Radicalisation is comparable to other forms of exploitation; it is therefore a safeguarding issue staff working in the health sector must be aware of. [...] Staff must be able to recognise signs of radicalisation and be confident in referring individuals who can then receive support in the pre-criminal space.” (p. 5) The Framework is cascaded down the National Health Service (NHS) hierarchies in England to ensure that all front-line staff in the NHS receive mandatory training in the Prevent process. NHS staff refer patients considered vulnerable to radicalisation to local Prevent leads and onward to Prevent case managers and the Channel panel. The Channel acts as a multi-agency panel along the lines of other safeguarding panels in England.

¹

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This Training and Competency Framework follows from the *Prevent Duty Guidance*,² the *Channel Duty Guidance*³ and the *Channel: Vulnerability Assessment Framework*⁴ produced by the government following *CONTEST: The United Kingdom's Strategy for Countering Terrorism*⁵ and the Counter-Terrorism and Security Act 2015. The Framework does not name these documents but mentions two other documents which focus on multi-agency working. The first, *Safeguarding Children and Young People*,⁶ details the roles and competencies for healthcare staff when working with other professionals to safeguard children and young people. The second, *Building Partnerships, Staying Safe*,⁷ stresses the importance of effective interprofessional working.

The focus of the Framework is on training. Among the competencies listed within is to understand the concept of pre-criminal space. This article examines this term using publicly accessible government documents and internet searches performed on Google and Google Scholar. It is a textual analysis, read in the context of other government documents,⁸ which presumes that what is read may not necessarily be what the authors initially intended. Meanings applied to words, particularly new compound words, gain significance over time and use.⁹ One of the presumptions of this method is that textual analysis may not relate directly to what is happening in practice.

Pre-criminal space in the NHS England Framework

'Pre-criminal space' appears four times in the Framework document, including twice in the introduction: 'Prevent focuses on all forms of terrorism and operates in a pre-criminal space' (p. 5) '... individuals [...] can then receive support in the pre-criminal space' (p. 5) '... aware[ness that] [...] the health sector contribution operates in pre-criminal space' (p. 8) 'Understand [...] the concept of pre-criminal space' (p. 10). The meaning of 'pre-criminal space' can be deduced from these quotes. 'Prevent focuses on all forms of terrorism and operates in a pre-criminal space' suggests that pre-criminal space may relate to specific physical spaces and times where professionals 'operate' or act within the aims of the Prevent programme. The statement that 'individuals [...] can then receive support in the pre-criminal space' suggests that the professional activity involved is 'support'. What constitutes 'support' is detailed in the *Channel Duty Guidance*.³ The fact that 'the health sector contribution operates in pre-criminal space' implies that other health sector activities may not operate in the pre-criminal space. In what way NHS activity in this 'space' is different from that in other space is not stated anywhere. The need for health professionals to understand 'the concept of pre-criminal space' suggests that there is an important difference between what pre-criminal space is and what it is not. Read in the context of Prevent² and *Channel Duty Guidance*,³ pre-criminal space is likely to start on acceptance of a referral of a person within the Channel panel, or perhaps on referral or discussion of the possibility of referral by NHS staff to Channel personnel. Thus, pre-criminal space has temporal and spatial aspects. As the time and space is decided by negotiation with and between professionals, the term also has inter-professional dimensions. This is supported by Framework naming documents that focus on effective multidisciplinary work rather than the Prevent and Channel Duty guidelines.^{6,7}

The Framework document views the Prevent programme as part of the wider safeguarding agenda. However, there is one important difference compared with other safeguarding panels: the coordinator of the Channel process, the Channel Police Practitioner (CPP), is a police officer or is employed by the police (ref. 3, para. 30). Thus, unlike other safeguarding procedures, the police have a central coordinating function.

Coining of 'pre-criminal space'

The term pre-criminal space is new. It was introduced by this Framework and cascaded to all trusts by NHS England. The term does not occur in non-NHS Prevent documents or in CONTEST. References to pre-criminal space since the term was introduced are largely found in trust documentation and NHS PowerPoint presentations, together with some journalist reports and blogs. For instance, the *Telegraph* comments on the police use of the term and possible repercussions on state-Muslim relations.¹⁰

All NHS trusts in England are mandated to enact the Framework document and produce policy or guidance documents. None of these documents define pre-criminal space any further. Many use pre-criminal space with quotation marks, a few prefacing the term with 'so-called'. The usual statement is a reiteration of 'Prevent operates in the pre-criminal space'. Occasionally the hyphen is replaced by a space between 'pre' and 'criminal' but the words are never placed directly together. The most detailed definition we have found comes from a glossary in a Prevent document from

Mersey Care NHS Trust, beginning with a precautionary note: ‘These definitions relate to PREVENT and are not always authoritative in any wider context.’ ‘Pre-Criminal Activity/Space’ is explained by focusing on ‘multi-agency working to ensure that individuals are diverted away before any crime is committed’.¹¹ This definition merges ‘space’ with multi-agency activity.

Denotation and connotation

So far we have argued that pre-criminal space refers to the time when a person is engaged by the Channel panel and related professionals. It denotes the time, space and interprofessional activity involved in planning, coordinating support and possibly monitoring in the NHS England Prevent programme. What is unclear is whether the Channel process and panel meetings are in any way different from other multi-agency activities. This may be deduced by examining possible connotations of the term based on participants’ understanding of language use in its social context.

Pre-criminal space consists of three terms: ‘pre’ meaning before, ‘criminal’ as a person who has committed a crime or repeated crimes, and ‘space’ as a continuous physical area. ‘Pre’ appears to modify the second term, ‘criminal’, rather than space. Hyphens are not usually used after prefixes such as ‘pre’, unless the resulting meaning becomes ambiguous, for example ‘pre-order’ rather than ‘preorder’. Thus, the use of the hyphen both gives a separation between pre-crime and crime and creates the link. The term implies that the ‘space’ is pre-criminal, not the individual. While the use of the term ‘space’ suggests a physical space, such as a meeting room, there are no references to where the vulnerable person is to be supported. ‘Space’ in this context is used as a relational concept, common in expressions such as ‘I need space to think’, meaning ‘I need a place for myself, away from certain social relationships’.

The derivation of pre-criminal space

The etymology of the term is significant to the discussion. ‘Pre-crime’ and ‘space’, as separate words, suggest they are potentially independent concepts. The term ‘precrime’ was said to be coined by science fiction writer Philip K. Dick in his short story *Minority Report*.¹² The drama is based on the concept that crime has not occurred yet but will occur in future unless measures are taken. The belief that crime can be prevented by identification and intervention has a long history. In the 19th century, Lombroso’s theory of criminal atavism famously purported to identify future criminals by their abnormal physical appearance. In recent years, criminologists use the term pre-crime to criticise the move to criminalise people prior to the committing of crime.¹³ More recently, the term ‘pre-criminal space’ has been used in the US security industry in relation to Islamic fundamentalist terrorism.¹⁴ We find no evidence that the concept of ‘space’ in pre-criminal space derives from academic theorising about space. Depending on context, however, space connotes elements of time as well as physical or abstract forms of space. Space in pre-criminal space can thus gain different metaphoric associations depending on the immediate social context. Pre-criminal space may describe the physical space where ‘support’ is planned, ‘operated’ or monitored. It may also relate to the time that the person is subject to the Channel panel process, or to differences in the social rules of interprofessional interaction, as compared with different safeguarding panel discussions. Finally, it may refer to differing social identities of the person referred to the Channel panel and the professionals involved.

Rhetoric

The Framework provides an abbreviated and reasoned argument in support of the Prevent programme and the involvement of health professionals. Like all arguments, it persuades through the use of the metaphoric qualities which words gain in use. There are two sets of metaphors within the Framework, one pertinent to NHS professionals and the other to the police. The health metaphors are borrowed from structural engineering, with vulnerability and support suggesting the diathesis-stress model. The person is weakened from external assault or internal deficiency; structural support is provided from outside so the individual can withstand potential assaults or threats. Even the WRAP acronym (Workshops to Raise Awareness of Prevent) suggests physical bodily protection against external threat. The criminal justice terms (i.e. radicalisation, extremism, CONTEST, counter-terrorism, strategy) suggest a heightened spatial metaphor, polarisation and direction of movement. The creation of the term pre-criminal space may be an attempt to bridge the health and police use of metaphor: the health metaphor aiming for stability and predictability, while the criminal justice

metaphor focuses on adaptability. The lack of effective definition of pre-criminal space allows for evolving inter-agency norms during the Channel process to vary with context.

If new concepts emerge by visual analogy,¹⁵ pre-criminal space can be seen as an extension of crime prevention. It can be visualised as a system of continuous and contained passages. Prior to the vent (derived from the Latin root, as in *prevent*), professionals direct radicals, people who have an attractive or repulsive charge or energy, past the vent and into the channel. As the radicals pass along the vent their charge or energy becomes less strong and the radical no longer moves towards the extreme.

If the term pre-criminal space mobilises healthcare professionals and Channel partners towards a crime prevention role of health intervention, pre-criminal space has the potential to act as a form of ‘excitable speech’ to alert listeners to the threat of terrorism.¹⁶ The rhetorical use of the term pre-criminal space during the Channel process could be perceived as an attempt to persuade professionals to disclose information or make decisions they would otherwise not make in other safeguarding forums and in comparable circumstances.

Opinion

The Training and Competency Framework is an action plan, laying out who does what, when and with whom. For the implementation of Prevent, terms need to be defined to such a degree that the participants can understand the concepts involved. Indeed, the Framework itself asks NHS staff to understand the concept of pre-criminal space (p. 10). Pre-criminal space clearly denotes a period of time in the Prevent process without adding further meaning and keeping open the opportunity for the term’s possible rhetorical use in Channel meetings.

One synonym for pre-criminal space is crime prevention. This raises the possibility of changing the wording of the Framework to replace this obscure and newly coined term with ‘crime prevention’. Alternatively, discussion and clarification of the concept of pre-criminal space would allow it to define the participants’ relationships as the crime prevention activity proceeds. Further multidisciplinary research linking NHS documents to practice may enable the Prevent guidance and framework to be linked with practice. When the time comes for the Prevent framework to be updated (although no such date is given in the document), we recommend that the term should be clarified or removed.

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1.6.61 Drug information update. Atypical antipsychotics and neuroleptic malignant syndrome: nuances and pragmatics of the association

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Abstract

Neuroleptic malignant syndrome (NMS) is a rare but potentially fatal adverse event associated with the use of antipsychotics. Although atypical antipsychotics were initially considered to carry no risk of NMS, reports have accumulated over time implicating them in NMS causation. Almost all atypical antipsychotics have been reported to be associated with NMS. The clinical profile of NMS caused by certain atypical antipsychotics such as clozapine has been reported to be considerably different from the NMS produced by typical antipsychotics, with diaphoresis encountered more commonly, and rigidity and tremor encountered less frequently. This article briefly discusses the evidence relating to the occurrence, presentation and management of NMS induced by atypical antipsychotics.

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Neuroleptic malignant syndrome (NMS) refers to an idiosyncratic severe adverse reaction associated with the use of antipsychotics. It is a rare and unpredictable side-effect that has been associated with both first- and second-generation antipsychotics.^{1,2} It occurs in about 0.02–3% of individuals who are prescribed antipsychotics.³ NMS is generally characterised by rigidity fever, autonomic dysregulation, tremor, elevated creatine phosphokinase (CPK) levels and leucocytosis (*Box 1*).⁴ NMS is a potentially fatal adverse event. It can lead to permanent neurological impairment in survivors in the form of parkinsonian symptoms and cognitive deficits, which could be primarily ascribed to the raised core body temperature and ischaemia following rhabdomyolysis.^{5–7}

Atypical (second-generation) antipsychotics were initially considered to have negligible risk of inducing NMS due to their distinctive pharmacodynamic characteristics.⁸ In fact, side-effect profile has been one of the important distinguishing features between typical (first-generation) and atypical antipsychotics. However, considerable research evidence has accumulated to suggest that atypical antipsychotics are also associated with NMS.^{9,10} Clozapine was one of the earliest atypical antipsychotics implicated in the causation of NMS.¹¹ Subsequently, almost all of the atypical

antipsychotics have been associated with the occurrence of NMS. The clinical features of NMS induced by atypical antipsychotics have been reported to be somewhat different from those induced by typical antipsychotics.¹⁰

Atypical antipsychotics are among the most commonly prescribed antipsychotics.^{12,13} They are utilised for the treatment of a range of psychiatric disorders including schizophrenia, mania, depression with psychotic symptoms and personality disorders, and for behavioural symptoms in dementia and intellectual disability.^{14,15} Hence, understanding the clinical presentation and occurrence of NMS associated with atypical antipsychotics is of clinical relevance. This article discusses the evidence relating to the occurrence of NMS with atypical antipsychotics and various aspects of management for this condition. The authors reckon that the definition of ‘atypical’ antipsychotics itself may not have clear margins,¹⁶ yet the term ‘atypical’ remains in clinical usage to refer to those medications that have comparably smaller chances of causing extrapyramidal symptoms. We do not aim to present a systematic review of the topic, but rather a pragmatic review of the literature on NMS with atypical antipsychotics.

Reports of atypical antipsychotics causing NMS

Risperidone

Risperidone has been associated with probably the largest number of cases of atypical antipsychotic-induced NMS.^{9,17} It has been noted more frequently in the younger age group who had been antipsychotic naive. A severe clinical picture of typical NMS has been encountered, marked by rigidity, extrapyramidal symptoms, fever and highly elevated CPK levels. Tachycardia was more common than diaphoresis and autonomic dysregulation occurred frequently.⁹

Clozapine

Cases of clozapine-induced NMS, reported since the 1980s, typically occurred with rapid dose increases. Also, many patients who developed clozapine-induced NMS had a history of NMS with other antipsychotics. Tachycardia, tachypnoea, diaphoresis and autonomic lability were encountered frequently, possibly due to clozapine acting on adrenergic and muscarinic receptors.¹⁸ Rigidity and extrapyramidal symptoms were rare, possibly due to the lower affinity of clozapine to the D₂ receptor. The increases in CPK were lower and delayed when compared with other antipsychotics. The occurrence of fever and autonomic instability in patients receiving clozapine in the absence of rigidity may necessitate ruling out the diagnosis of clozapine-related agranulocytosis before a diagnosis of NMS.¹⁹ The clinical severity of clozapine-induced NMS has been described to be lower than with other antipsychotics, and hence such cases have infrequently required intensive care unit admissions. The infrequent occurrence of rigidity and extrapyramidal symptoms in patients with clozapine-induced NMS require a high degree of suspicion for this diagnosis. However, certain researchers have suggested that clozapine-induced NMS should not be considered as a diagnosis in the absence of typical features of NMS.²⁰

Box 1 Symptoms and signs commonly encountered in neuroleptic malignant syndrome

- Fever
- Rigidity
- Elevated creatine phosphokinase (CPK) levels
- Tachycardia
- Tachypnoea
- Altered mental state
- Fluctuating blood pressure
- Diaphoresis
- Leukocytosis

Olanzapine

Although olanzapine has been reported to present with the typical features of NMS, extrapyramidal symptoms and fever were absent in a small proportion of patients. Autonomic imbalances and diaphoresis are frequent, and are often the first signs to appear in patients with olanzapine-induced NMS. Nausea was infrequent, probably due to the antiemetic purported properties of olanzapine,²¹ but neurological impairments such as hemiplegia, ataxia and seizures have been reported.⁹ Several cases have been reported in patients receiving other medications apart from antipsychotics, for example mood stabilisers and antidepressants, and the clinical picture of NMS has been more severe in such patients.⁹

Amisulpride

Several cases of amisulpride-induced NMS have been described in the literature,^{22,23} many reported in elderly males. The clinical profile primarily involves an altered mental state, frequent rigidity and high levels of CPK, whereas high fever, tremor and other autonomic symptoms have been reported less frequently. The lower propensity to cause autonomic symptoms is probably due to low affinity in amisulpride for muscarinic, adrenergic, serotonergic and histamine receptors than in other antipsychotics.²⁴

Quetiapine

Quetiapine-induced NMS has been primarily reported in the elderly, although it has also been described in children.²⁵ Clinically, it presents with extrapyramidal symptoms and prominent autonomic symptoms such as tachycardia, blood pressure fluctuations, tachypnoea and diaphoresis. These prominent autonomic symptoms may be consequent to norepinephrine reuptake inhibition, histaminergic antagonism and serotonin toxicity associated with the use of quetiapine.²³ The outcome of quetiapine-induced NMS has been relatively poor, probably due to the older age of patients in whom it has been reported.⁹

Aripiprazole

Several case reports and case series have accumulated on the occurrence of NMS in patients receiving aripiprazole.^{26,27} Rigidity and altered mental state seem to be present frequently in such patients, while fever, diaphoresis and tachypnoea are less frequent. NMS has been reported to occur more commonly with fast upward titration of dosages of aripiprazole. The severity and duration of NMS seem lower than in other antipsychotic medications, probably due to the partial dopamine agonist activity of aripiprazole. Aripiprazole has also been implicated in combination antipsychotic regimens, when used alongside other atypical antipsychotics such as clozapine.²⁷

Ziprasidone

Few cases of ziprasidone-induced NMS have been described.^{28,29} The onset of NMS in these patients has been generally abrupt, with most displaying typical features such as alterations of mental state, fever, diaphoresis, tachycardia, blood pressure alterations, leukocytosis, tremor, and other extrapyramidal symptoms with high CPK. No fatality has been reported with ziprasidone to date, and recovery is usually achieved in about 10 days.

Paliperidone

Paliperidone has a similar pharmacodynamic profile to risperidone, but it has a lower affinity for dopamine receptors and higher serotonin antagonist activity. Paliperidone-induced NMS has been described mainly in patients who have been previously treated with other atypical antipsychotics and have had a recent dose increase or cross-titrations.^{30,31} Paliperidone-induced NMS presents with a typical clinical profile with mental state alteration, rigidity, diaphoresis, hyperpyrexia, tremor and other extrapyramidal symptoms, and the outcome is favourable, with resolution achieved in all cases.

Zotepine

Several cases of zotepine-induced NMS have been described in the literature.^{22,32} Rapid dose escalation was reported in one case, although NMS has also developed with the usual titration pattern. Zotepine-associated NMS presents with alterations of mental state, rigidity, diaphoresis, fever, tachycardia and leukocytosis, with less frequent occurrence of tremor, tachypnoea and alterations in blood pressure.

Other atypical antipsychotics and summary

At present, there is a single case report of iloperidone being considered as a cause of NMS.³³ The patient, who had schizophrenia, developed mutism, diaphoresis, diffuse lead pipe rigidity and tachycardia without fever or marked increase in CPK levels. The outcome was favourable, but the patient also required anticoagulation therapy for the management of comorbid pulmonary embolism.

Blonanserin was reported as a cause of NMS in a 30-year-old female with intellectual impairment.³⁴ The patient presented with fever, tachycardia, rigidity, extrapyramidal symptoms and leukocytosis after the initiation of blonanserin. Symptomatic improvement was seen after discontinuation.

Although different atypical antipsychotics have different NMS clinical symptom profiles, rigidity, tremor and fever are encountered less frequently with atypical antipsychotics, whereas diaphoresis is quite common. Clozapine is particularly associated with atypical presentations of NMS with infrequent CPK level elevations. Risperidone, on the other hand, produces a clinical picture more similar to the NMS induced by typical antipsychotics. Some of the atypical antipsychotics have also been associated with serious features such as myoglobinuria and acute renal failure.^{35,36}

Risk factors for atypical antipsychotic-induced NMS

A few significant risk factors for atypical antipsychotic-induced NMS have been identified. They have been reported in one study as male gender, confusion, dehydration and delirium.²⁵ Another study reported Black and minority ethnic background, antipsychotic polypharmacy, use of aripiprazole, and increasing dosing patterns.³⁷ More recently, it has been suggested that rapid dose escalation of the antipsychotic may be a risk factor for NMS.² The demographic profile of patients who developed NMS with atypical antipsychotics does not seem to differ substantially from that of patients with NMS induced by typical antipsychotics.

Management

Diagnostic uncertainty

The clinical picture and features of NMS with atypical antipsychotics seem to be different from those of typical antipsychotics. This had led to uncertainty over the diagnosis of NMS in patients on atypical antipsychotics who manifest only few of the NMS symptoms.³⁸ Among the core symptoms of NMS, fever is often encountered less frequently in patients with atypical antipsychotic-induced NMS.³⁸ The issue is further complicated by the various operational definitions of NMS.³⁸ The DSM-IV-TR defines NMS as the presence of severe muscle rigidity and elevated temperature after antipsychotic initiation along with two or more of: diaphoresis, dysphagia, tremor, incontinence, changes in level of consciousness, mutism, tachycardia, elevated or labile blood pressure, leukocytosis, or laboratory evidence of muscle injury (elevated CPK level). Various other criteria for NMS have been postulated, each with varying emphasis on the individual symptoms and signs.³⁹ Another set of criteria defines NMS in patients with either three major symptoms (hyperthermia, rigidity, elevated CPK level) or two major and four minor symptoms (diaphoresis, tachycardia, tachypnoea, abnormal blood pressure, leukocytosis, altered consciousness).⁴⁰ Yet another diagnostic system defines NMS through the presence of extrapyramidal symptoms and fever (37°C) alongside three minor symptoms within a 48-hour period.⁴¹ This may potentially mean that a case fulfilling the diagnosis of NMS according to one set of criteria may not do so with another set. The DSM-5 has taken a pragmatic approach of not explicitly stating the number of criteria required for the diagnosis of NMS.

It has been proposed that with the growing awareness of NMS, those in the early course of its development may benefit from early identification and immediate treatment. This may lead to an abortive course of NMS development, with an incomplete picture and only few of the criteria being met. Hence, some authors have proposed a dimensional concept of NMS, which takes into consideration the minor and subthreshold forms of NMS.^{38,42} This is likely to further our knowledge about NMS pathophysiology, clinical profile subtypes and appropriate management strategies.

Furthermore, various other medical and neurological conditions may present with a clinical picture similar to NMS (briefly mentioned in *Box 2*). Patient condition may require expedient decisions so that a rational line of management can be instituted. Hence, the clinician may need to take a brief and focused history for being reasonably sure about the diagnosis. Neuroimaging and electroencephalogram may be helpful for ruling out neurological pathologies mimicking NMS. For example, in patients with psychosis, catatonia may be considered as a differential diagnosis, especially when the patient is mute and exhibits staring. It may not be possible to exhaustively rule out all differential diagnoses, and at times management may need to be started on an empirical basis.

Treatment strategies for NMS

The management of NMS caused by atypical antipsychotics would not be substantially different from the management of NMS induced by typical antipsychotics (*Box 3*). NMS is a medical emergency and requires immediate attention for clinical management. Clinical diagnosis should be supplemented by laboratory tests, particularly CPK levels and total leukocyte counts. Once the diagnosis is suspected, the offending antipsychotic agent must be immediately stopped. Regular monitoring of the vitals should be carried out. The patient should be moved to the intensive care unit based on the severity of their medical condition. Intensive care would typically focus on monitoring of cardiorespiratory and renal status. Serial monitoring of serum electrolytes should be performed and corrected as required. In extreme hyperthermia, physical cooling measures may be instituted.

Several pharmacological options are available for the treatment of NMS.^{43,44} Dopaminergic agents such as amantadine and bromocriptine have been demonstrated to decrease the duration of and mortality associated with NMS. Amantadine 200 mg to 400 mg per day in divided doses is administered either through a nasogastric tube or orally. Bromocriptine is started at the dose of 2.5 mg three times a day and can be titrated upwards to 45 mg per day. Benzodiazepines, particularly lorazepam, can be given when underlying catatonia is suspected and where agitation is encountered in the patient. Lorazepam challenge can be done with 1 to 2 mg lorazepam administered parenterally, and may be continued in cases which show some response. Dantrolene is a muscle relaxant that can be applied in cases presenting with severe rigidity and hyperthermia. It is initiated at doses of 1–2.5 mg/kg body weight and can be repeated 6 hourly if improvement is seen. It can be administered orally after improvement with the parenteral preparation.

Box 2 Differential diagnosis of neuroleptic malignant syndrome

- Amphetamine toxicity
- Anticholinergic delirium
- Benign extrapyramidal side-effects
- Brain abscess
- Catatonia
- Heat stroke
- Malignant catatonia
- Malignant hyperthermia
- Meningitis or encephalitis
- Mid-brain structural lesions
- Non-convulsive status epilepticus
- Sepsis
- Serotonin syndrome
- Thyrotoxicosis

The altered mental state encountered during NMS also needs attention. If sedation is required, benzodiazepines may be a preferred choice. The medical management of the patient takes precedence over the underlying psychiatric disorder. As the patient's condition improves, discussion about further treatment options may be initiated.

Re-challenge with antipsychotics after NMS

One of the important considerations for a clinician is to whether to start another antipsychotic after a patient develops NMS. If the antipsychotic had been started for the control of psychotic symptoms, then the risk of psychosis without the cover of antipsychotics is high. The clinician may have to weigh the pros and cons of re-starting antipsychotic medication: the advantage of making the patient more manageable against the risk of inducing NMS.

Box 3 Treatment of neuroleptic malignant syndrome

- Consider shifting to intensive care unit
- Regular monitoring of vitals
- Monitoring of electrolytes and correction if required
- Management of medical comorbidity
- Physical cooling measures if required
- Dopaminergic medications: amantadine and bromocriptine
- Muscle relaxant: dantrolene
- Benzodiazepines: for management of agitation, when clinical suspicion of catatonia is present

Several reports of post-NMS antipsychotic re-challenge have been published.^{45–48} Indications for a re-challenge need to be clearly documented and other options of management (including electroconvulsive therapy) should be explored. Taking informed consent from the patient and/or family members/carers becomes necessary in such circumstances. Re-challenge should be done with an atypical antipsychotic with low propensity to cause NMS and dose titration should be gradual. Careful monitoring should be instituted, watching the evolution of symptoms of NMS. The re-challenge strategies thus adopted are in no way different from those post-NMS due to typical antipsychotics.

Conclusions

As psychiatrists, we are likely to encounter NMS induced by atypical antipsychotics during clinical practice. Although it is an uncommon adverse event of antipsychotic use, the potential fatality requires the clinician to take cognisance of this, and institute treatment immediately. The presentation of NMS induced by atypical antipsychotics, especially clozapine, may be quite different from NMS induced by typical antipsychotics – rigidity and tremor are encountered less frequently, while diaphoresis is probably encountered more frequently. Hence, a high degree of clinical suspicion may be required. Overall, the management of NMS induced by atypical antipsychotics is not broadly different to the management of that induced by typical antipsychotics. Additionally, an episode of resolved NMS does not preclude the subsequent initiation of antipsychotics, although due caution needs to be exercised while re-challenging antipsychotics in patients with a history of NMS induced by atypical antipsychotics.

1.6.62 Drug information update. Lithium and chronic kidney disease: debates and dilemmas

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Abstract

Lithium is an established treatment for bipolar disorder and an augmenting agent for treatment-resistant depression. Despite awareness of renal adverse effects, including chronic kidney disease, for the past five decades, there has been a lack of research evidence. This has led to debates around the existence and magnitude of the risk. This article discusses the current evidence base regarding the link between lithium and chronic kidney disease, monitoring of renal functions and its clinical implications.

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 - *Debate 1: does lithium cause CKD?*
 - *Debate 2: is there any relationship between the tubular and glomerular adverse effects of lithium?*
 - *Debate 3: is it possible to identify patients at high risk of developing CKD/ESRD and to predict the prognosis of these adverse effects?*
 - *Debate 4: how can we effectively monitor glomerular adverse effects?*
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 - *Dilemma 2: should we consider lithium therapy for patients already diagnosed with CKD?*

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– Conclusions

Lithium is one of the oldest psychotropic medications. It remains the gold standard treatment for bipolar disorder and an augmenting agent for treating depression. Over the past few decades, additional benefits of lithium have also come to light, most importantly its role in preventing suicide and Alzheimer's disease.^{1,2} As it is often used as a maintenance treatment for lifelong disorders, concerns have been raised about its potential long-term organ toxicity, mainly the effect on glomerular function leading to chronic kidney disease (CKD).^{3–5}

Debate 1: does lithium cause CKD?

The association between CKD and lithium has been known for a long time, and monitoring renal function in patients receiving lithium therapy has been the norm for many decades. Despite this, there has been little research into the renal adverse effects of lithium so far. A link between lithium therapy and CKD has received increasing recognition, and there are several explanations for this. First, glomerular function decreases gradually as a normal part of the ageing process; increased life expectancy has led to increasing numbers of lithium patients being diagnosed with CKD. Second, there has been a resurgence of interest in lithium and its safe use, owing to its proven effectiveness in bipolar disorder in comparison with other mood stabiliser drugs and its anti-suicide effect. Last, more effective monitoring of renal function and the use of more sensitive measures to diagnose CKD, such as the estimated glomerular filtration rate (eGFR) rather than serum urea and creatinine levels, have led to the early identification of affected patients.

Despite significant progress over the past two decades, doubts still remain about the existence and magnitude of the risk.^{3–5} Unlike its tubular adverse effects, which more commonly present with polyuria and polydipsia, the glomerular adverse effects of lithium therapy appear after long-term use and might not normalise or improve after its discontinuation. It has therefore been difficult to attribute causality for this adverse effect.

The debate about lithium nephrotoxicity started in 1977, with reported abnormalities in renal biopsies from a small group of patients treated with lithium.⁶ Initial cross-sectional, case-control and small cohort studies with short-term follow-ups reported contradictory findings on the toxicity risk.^{7–10} In 1994, Bendz *et al* published a study of 142 patients who had been taking lithium for more than 15 years. The authors measured the glomerular filtration rate (GFR) by chromium-51-labelled ethylene diamine tetra-acetic acid (⁵¹Cr]EDTA) clearance and found that in 21% of patients the GFR was lower than in the demographic-matched population control group.¹¹ Two meta-analyses of these diverse studies failed to produce conclusive evidence for or against lithium nephrotoxicity. Although they showed that patients on lithium therapy had worse renal function than controls (as measured by serum creatinine levels or the eGFR), they reported that the clinical significance was questionable. Both meta-analyses highlighted poor quality data and significant heterogeneity among studies.^{12,13}

Recent epidemiological studies utilising large databases have consistently shown that CKD (defined as an eGFR of < 60 ml/min/1.73 m²) is common among lithium patients but that lithium therapy increases the risk of CKD. In addition, renal failure in patients with end-stage renal disease (ESRD) is not as rare as previously thought.^{14–17} In a retrospective cohort study using the General Practice Research Database, Close *et al* reported that patients taking lithium for bipolar disorder had a twofold increased risk of developing renal failure and a two-and-a-half-fold increased risk of developing CKD of any stage compared with lithium-naïve patients.¹⁴

The relationship between lithium therapy and renal failure or ESRD has been investigated in many other studies that mainly use data from databases of patients undergoing renal replacement therapy (dialysis or renal transplant). A Swedish study found that 0.81% of renal replacement therapy patients had kidney disease attributable to lithium-induced nephropathy. Moreover, the risk of ESRD in lithium-treated patients was nearly sixfold greater than in the general population.¹⁷ Another recent retrospective cohort study, of renal replacement therapy patients in Australia, reported that the incidence rate of ESRD due to lithium therapy had increased significantly from 0.14 cases per million population per year (95% CI 0.06–0.22) in 1992–1996 to 0.78 cases per million population per year (95% CI 0.67–0.90) in 2007–2011. This report emphasised that lithium-induced nephropathy is not a rare cause of ESRD, and is becoming more common.¹⁸ However, the debate is far from over and contradictory findings continue to be published. For example, in a review of patients with ESRD in Sweden, Aiff *et al* found 32 cases of ESRD in patients who had started taking lithium before 1980 but none in those who had started taking lithium after 1980. Hence, the authors suggested that the opposite was true: renal failure might not be a problem with the current practice of maintaining lower serum

lithium levels along with better monitoring of renal function.¹⁹ In a recent population-based retrospective cohort study in Denmark, Kessing *et al* also failed to identify any patients with lithium-induced ESRD. However, their findings indicated that bipolar disorder is independently associated with CKD.²⁰ Therefore, uncertainties about the magnitude of the CKD risk are yet to be resolved.

It is clear that not all patients taking lithium experience glomerular adverse effects. Most likely, only a select group of patients develop CKD and only a small proportion of these progress to ESRD.²¹ Moreover, the association between lithium therapy and CKD is unlikely to be entirely explained by coincidence or confounding variables (such as age, other psychotropic drugs or comorbid medical/psychiatric illnesses). Discrepancies among studies were largely due to methodological differences such as varied parameters to assess renal function and definitions of renal impairment, short-term follow-up, a lack of patients on long-term lithium therapy, combining high-risk and low-risk groups, choice of control group (healthy *v.* psychiatric patients), and an inability to control the confounding variables. Definitive data on the magnitude of the risk are still lacking. Moreover, in the absence of any pathognomonic histological or biochemical changes, lithium-associated CKD remains a diagnosis of exclusion.

Debate 2: is there any relationship between the tubular and glomerular adverse effects of lithium?

It was previously assumed that CKD is preceded by tubular adverse effects of lithium. However, differences in the prevalence of tubular and glomerular adverse effects and a lack of correlation between reduced glomerular function and tubular abnormalities on renal biopsy (in the form of tubular dilation and microcysts) argue against this assumption.^{22,23} Despite this, the presence of tubular adverse effects is suggested to increase the risk of CKD, hence the suggestion that treating or preventing tubular adverse effects might help to prevent deterioration of glomerular function.²¹

Debate 3: is it possible to identify patients at high risk of developing CKD/ESRD and to predict the prognosis of these adverse effects?

As only a small proportion of patients on lithium therapy experience CKD, early identification of these high-risk patients might help to prevent and manage this adverse effect. Over the years, researchers have tried to identify both susceptibility and treatment-related factors such as associations with ageing, comorbid physical/psychiatric health problems, cumulative lithium dose or treatment duration, dosing frequency, and number of toxicity episodes.

Acute lithium toxicity is known to cause acute renal failure, and many patients suffer renal impairment even after recovering from an acute episode. There is consistent evidence that acute nephrotoxicity episodes can lead to CKD.^{6,9,24} Recently, Clos *et al* suggested that lithium-associated CKD is primarily mediated by acute lithium toxicity, and that avoiding lithium toxicity can prevent renal impairment.²⁵ Studies suggest a relationship between impaired renal function and either persistent high serum lithium levels (>0.6mmol/L *v.* <0.6mmol/L) or a single serum lithium measure of > 1.0 mmol/L. As these were not prospective studies, it is difficult to establish a causal relationship, especially as reduced renal function can also increase serum lithium levels.^{26,27} On the other hand, a recent randomised placebo controlled trial of low-dose lithium therapy (serum lithium levels of 0.25–0.50 mmol/L) in elderly patients with mild cognitive impairment did not show a significant difference in eGFR over a 4-year follow-up period.²⁸ The study suggests that lower therapeutic levels of lithium might not impair renal function.²⁸ In contrast, other studies have failed to show a relationship between CKD risk and lithium dose or serum lithium levels.^{17,24} It is well established that higher serum lithium levels provide better protection against another affective episode (especially a manic episode). Therefore, the debate about what serum lithium level represents a balance between safety and effectiveness is likely to continue until more definitive data become available.

Once-daily dose is thought to be associated with less renal impairment than multiple daily doses.²¹ Although a few studies do not support this, none have so far reported disadvantages for once-daily dosing.²⁹ Therefore, although a definitive answer is lacking, it makes sense to adopt a once-daily dosing strategy. Comorbid physical health conditions such as diabetes or hypertension can independently cause CKD, but CKD is also commonly seen in lithium-treated patients, even in the absence of a comorbid physical illness. Therefore, comorbidity is unlikely to entirely explain the association between lithium and CKD.

So far, evidence about CKD risk factors is limited and somewhat contradictory. However, it indicates that lower therapeutic lithium doses might have a reduced detrimental effect on renal function and that acute lithium toxicity should

be avoided to prevent renal dysfunction. Furthermore, once-daily dosing might be safer than multiple daily doses.

Debate 4: how can we effectively monitor glomerular adverse effects?

Monitoring renal function in patients on lithium therapy has been the norm for many years, but there are significant discrepancies among the different guidelines on the parameters that should be used and the frequency of monitoring.^{30–32} The UK National Institute for Health and Care Excellence (NICE) recommends 6-monthly monitoring; the British Association for Psychopharmacology recommends annual monitoring; and the American Psychiatric Association recommends monitoring every 2–3 months for the first 6 months, followed by 6-monthly to annual measurements.^{30–32} However, they do not give specific guidance about the parameters for measuring renal function and continue to recommend measuring serum urea and creatinine levels, although recent guidelines have started to recommend measuring the eGFR. In other medical areas, measuring serum urea and creatinine levels is no longer a preferred option for monitoring renal function: standard practice is to monitor the eGFR. Many equations can be used to calculate the eGFR from serum creatinine concentration, with differing accuracies. Recent NICE guidelines on managing CKD suggest using the CKD Epidemiology Collaboration (CKD-EPI) equation. They also suggest using the CKD-EPI equation based on cystatin C levels if accurate GFR estimates are necessary.³³ Psychiatry guidelines do not recommend any particular method for calculating the eGFR.

The importance of measuring proteinuria to monitor renal function in CKD patients is now firmly established. Proteinuria is an independent predictor of CKD progression, cardiovascular disorders and all-cause mortality.³³ However, a role for estimating and monitoring proteinuria in lithium-related renal impairment is yet to be established. The evidence so far is sparse and contradictory: some reports suggest that proteinuria is linked to lithium-associated CKD and indicates a poor prognosis, while others suggest that lithium-associated CKD is not associated with proteinuria and that in the presence of proteinuria one should rule out other causes.^{5,10,21} However, recent publications have highlighted the importance of monitoring proteinuria in patients with lithium-associated CKD.^{21,34}

Unfortunately, psychiatric guidelines have not kept up with advances in nephrology, and we need guidelines for evidence-based monitoring of renal function. Recent publications suggest that renal function should be monitored regularly via the eGFR and that the degree of proteinuria should be measured in patients with a declining eGFR or an eGFR of <60 ml/min/1.73 m.^{2,21,34} However, these recommendations are developed for CKD associated with other aetiological factors, and more specific evidence-based monitoring guidelines need to be developed to screen and monitor lithium-associated CKD.

Dilemma 1: should lithium be stopped if a patient develops CKD?

The most common dilemma clinicians face is what to do if a patient on lithium therapy develops CKD. In this scenario, the clinician must decide whether to continue or discontinue lithium. Advice in the literature is contradictory, ranging from discontinuing lithium as soon as renal function starts to deteriorate (as evidenced by two consecutive tests) to continuing lithium even in the presence of CKD.^{18,35} The decision to discontinue lithium is based on the assumption that lithium is a causative factor for CKD and that its discontinuation would improve renal function or at least slow down deterioration. However, neither of these assumptions is completely supported by current evidence.^{4,5,36} Moreover, we still do not know whether lithium-associated CKD is reversible or irreversible. It has been suggested that this adverse effect might be reversible at the initial stages, only becoming irreversible after a certain threshold is reached.^{4,21} Presne *et al* suggested that the threshold might be somewhere between a GFR of 25 and 40 ml/min/1.73 m².²² Thus, the advantages of discontinuing lithium are uncertain.^{4,5,35,36} On the other hand, there is enough evidence to suggest that lithium discontinuation is associated with high risk of relapse for patients with mood disorders, especially those with bipolar disorder. Moreover, the illness might become treatment refractory.²¹ One of the advantages of lithium is its anti-suicide effect: the risk of suicide is known to increase after lithium discontinuation.³⁷ The decision to continue or discontinue lithium treatment should thus only be taken after careful assessment of the benefits and risks, and because of uncertainties surrounding these, it is essential that the decision-making process should include patients and all of the professionals involved, including nephrologists. Our experience agrees with a documented report that many psychiatric patients prefer to maintain their mental stability against the unknown risk of further deterioration in renal function.³⁸ In clinical practice, it is not unusual to request that a nephrologist makes this treatment decision. However, it is important that psychiatrists should not abdicate responsibility, because nephrologists might not be fully aware of

the risks associated with the psychiatric illness.^{5,21,34,35} Another option would be to continue lithium treatment while closely monitoring renal function. Many authors have suggested trying to keep the lithium level at the lower end of the therapeutic range, although there is not much evidence that this prevents further deterioration in renal function. However, as CKD patients are particularly prone to lithium toxicity, this strategy appears prudent.

Dilemma 2: should we consider lithium therapy for patients already diagnosed with CKD?

There is not much research evidence to support or dispute this decision. Lithium treatment may lead to further deterioration in renal function, which could be clinically important because the renal reserve is already low in patients with CKD. A study of elderly patients suggested that individuals with pre-existing CKD were more susceptible to a lithium-associated decline in renal function³⁶ On the other hand, we should not deprive such patients of an effective therapy because of unproven adverse consequences. In 2012, Werneke *et al* designed a mathematical model based on the existing, but limited, evidence to analyse the risks and benefits of continuing or discontinuing lithium therapy for CKD patients. They concluded that most patients should continue lithium treatment even if long-term renal adverse effects develop. They also recommended prescribing lithium to CKD patients because treatment benefits outweighed the risks.³⁵ However, at present there is not enough evidence to support any decision.

Conclusions

Limited knowledge of its renal (especially glomerular) adverse effects has led clinicians to either avoid or prematurely discontinue lithium therapy because of the perceived risk of a negative renal outcome. Over the past decade, a few large database studies have confirmed the existence of lithium-associated CKD, but uncertainty remains about the magnitude and determinants of the risks. Lithium therapy is here to stay and we should learn to optimise its efficacy and safety. There is a need for large-scale prospective studies focused on the early identification of high-risk patients and for developing evidence-based guidelines to monitor renal function in patients treated with lithium.

1.6.63 Shared decision-making in medication management: development of a training intervention

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Abstract

Shared decision-making is a collaborative process in which clinicians and patients make treatment decisions together. Although it is considered essential to patient-centred care, the adoption of shared decision-making into routine clinical practice has been slow, and there is a need to increase implementation. This paper describes the development and delivery of a training intervention to promote

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shared decision-making in medication management in mental health as part of the Shared Involvement in Medication Management Education (ShIMME) project. Three stakeholder groups (service users, care coordinators and psychiatrists) received training in shared decision-making, and their feedback was evaluated. The programme was mostly well received, with all groups rating interaction with peers as the best aspect of the training. This small-scale pilot shows that it is feasible to deliver training in shared decision-making to several key stakeholders. Larger studies will be required to assess the effectiveness of such training.

Contents

- *Shared decision-making in medication management: development of a training intervention*
 - *Method*
 - * *Consultation phase*
 - * *Training intervention: design*
 - * *Training intervention: delivery*
 - * *Evaluation*
 - *Results*
 - *Discussion*

Shared decision-making is a collaborative process in which clinicians and patients make treatment decisions in partnership. Both partners bring valuable contributions to this process: patients share their experiences, values and preferences, and clinicians support patients in clarifying these, as well as providing clinical expertise and evidence-based information about treatment options. Jointly, they aim to reach an agreement on the best way to proceed.¹⁻³

Shared decision-making is considered particularly relevant for preference-sensitive decisions, where there are several reasonable treatment options and evidence does not support a clear best choice. Different options require the balancing of possible benefits against potentially significant adverse or as yet unknown effects.³⁻⁵ Most medication decisions in mental health fall into this category, which makes psychiatric medication management an important area for shared decision-making.⁶

There are good reasons for encouraging adoption of shared decision-making in mental health. Many patients wish for greater participation in treatment decisions.⁷ In chronic conditions, where long-term healthcare decisions are required, studies have shown that shared decision-making improves satisfaction, adherence and well-being.⁸ Shared decision-making is at the core of recovery principles which promote autonomy and self-management skills, as well as being considered essential for delivering patient-centred care.⁹ National and international government initiatives,^{1,10-13} such as the UK Health and Social Care Act 2012 and the US Patient Protection and Affordable Care Act 2010, endorse shared decision-making, as do professional bodies¹⁴⁻¹⁶ and practice guidelines.¹⁷⁻²¹ Shared decision-making is an expected element of all NHS care (Health and Social Care Act 2012, s. 23, 26). Although there is evidence of its benefits, and many patients want greater involvement,⁷ the adoption of shared decision-making into routine clinical practice continues to be slow,^{22,23} especially in mental health.²⁴

A range of interventions has been developed to promote implementation of shared decision-making, predominantly in physical health.²⁵⁻²⁸ Although this is an evolving area, relatively few interventions focus specifically on treatment decisions in mental health.^{6,29-33} Evidence is sparse regarding the effectiveness of such interventions in general,^{23,25} and in mental health settings in particular,³³ although some promising results have been reported. These include a study of in-patients with schizophrenia or schizoaffective disorder who received five sessions of shared decision-making training;²⁹ a multifaceted programme based on shared decision-making concepts for primary care physicians treating patients with depression;³⁰ a peer-run Decision Support Centre in the waiting area of a psychiatric medication clinic;³¹ and online resources supporting shared decision-making.³² The limited evidence available points towards interventions being more effective when involving healthcare professionals and patients together, rather than only targeting one group.²³

The Shared Involvement in Medication Management Education (ShIMME) project was set up to promote shared decision-making of service users (the term ‘service users’ was used in the ShIMME project and has been retained here) in medication decisions by delivering a specially developed training programme to three key stakeholder groups: service users, care coordinators and psychiatrists. (In the context of the ShIMME project ‘care coordinator’ refers to psychiatric nurses, social workers, occupational therapists, psychologists, support workers, peer workers and students training in these disciplines.) To our knowledge this is the first UK-based project to deliver and evaluate such an intervention that targets multiple stakeholders simultaneously.

The project was a partnership between Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and Anglia Ruskin University. Reflecting the strong collaborative ethos, service users were active team members jointly with academic researchers, mental health practitioners and other professionals working within CPFT.

This paper describes the stages of the ShIMME project: consultations about shared decision-making, development and implementation of a pilot intervention, and evaluation of feedback. It is one of several articles relating to the project.

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Method

Consultation phase

The initial phase of the project involved a literature review and consultation with local stakeholders about the process of shared decision-making. Data were collected via focus groups with practitioners and users of adult mental health services in CPFT. Four focus groups were conducted with service users ($n = 27$), two with psychiatrists ($n = 4$), one with community psychiatric nurses (CPNs, $n = 10$), and one with care coordinators other than CPNs ($n = 8$). Four individual telephone interviews were also conducted with psychiatrists. Discussion was generated in response to open questions about current practice in medication management, how decisions should ideally be made, perceived barriers to and facilitators of shared decision-making, and how shared decision-making training should be conducted. Consultation groups lasted around 90 min and were audio recorded. The anonymised transcripts were analysed using thematic analysis,³⁷ conducted with NVivo software (www.qsrinternational.com). This involved a detailed exploration of transcript texts by two team members who worked in collaboration to iteratively develop themes.

The following themes about shared decision-making in medication management, which are presented in more detail elsewhere,³⁴ emerged from this analysis and fed into the development of the training programmes.

1. Ongoing respectful, trusting, open and honest relationships are paramount – service users’ concerns and experiences need to be heard and taken seriously.
2. Differences of power in the consultation can be complex and a barrier to shared decision-making – clinicians can underestimate the effect this has.
3. Access to reliable, user-friendly information is essential, including information about reducing or coming off medication and adverse effects of medication.
4. All available treatment options should be considered, including non-pharmacological treatments.
5. The process of shared decision-making needs to be flexible, taking into account preferences and situations which may change over time. Acute stages of illness or crisis situations were identified as times when shared decision-making would be likely to be more problematic.
6. Broader stakeholders (beyond service user and prescribe! ¹) have important roles in the shared decision-making process (e.g. other professionals, carers).
7. There is currently significant variation in medication management and the extent to which this involves shared decision-making.

Training intervention: design

A multidisciplinary working group including service users, academic researchers, psychiatrists, a mental health nurse and a pharmacist met regularly to develop the training intervention. The results of the consultations, literature review and examples of existing practice fed into the development.

Training was designed to be delivered to service users, care coordinators and psychiatrists in parallel but separate groups. The aim was to optimise the impact of the intervention by delivering it simultaneously to key stakeholders who are actively involved in medication management, while addressing the specific training needs and concerns of each group. Each group was facilitated by a service user trainer, and either a psychiatrist (for service user and psychiatrist groups) or a mental health nurse (for care coordinator groups), allowing participants to learn from two relevant perspectives.

The programme employed a range of interactive learning methods. These included specially commissioned video material showing different clinical scenarios, small group exercises, general group discussions, use of testimonials and role plays. The resource materials and hand-outs covered a diverse range of views and approaches, to raise awareness and stimulate discussion. All participants had access to the public section of the project website (www.shimme.arcusglobal.com) as well as a secure discussion forum for their group.

The training programmes for the three stakeholder groups covered the same core content: background to the project key components of shared decision-making in the clinical encounter and rationale for promoting shared decision-making barriers to and facilitators of shared decision-making awareness of the effects of power imbalances in psychiatric consultations developing collaborative relationships importance of clarifying personal preferences, values and experiences in shared decision-making the concept of a ‘meeting of two experts’ in the clinical encounter, with personal experience and clinical expertise complementing each other³⁸ accessing and appraising information about medication, including examples of decision aids raising awareness of adjuncts or alternatives to medication addressing issues around coming off or reducing medication trialling of versions of three paper-based tools developed for supporting and recording the shared decision-making process information about useful websites.

In addition to the core content, the service user groups focused on: practising setting personal goals and identifying preferences making use of a personal well-being plan and self-help resources looking beyond medication to enhance well-being, drawing on Deegan’s work on ‘personal medicine’³⁹ introduction to assertiveness how to access information about medication, including a talk by a National Health Service (NHS) trust mental health pharmacist, who was available for further discussion afterwards supported ‘hands-on’ experience exploring relevant websites.

Besides the core content, the care coordinator training focused on adopting the role of a ‘shared decision-making coach’, supporting service users to play a more active part in the shared decision-making process³⁵ The programme for psychiatrists focused on competencies and resources that support embedding shared decision-making into routine clinical practice while acknowledging real-life challenges.

Training intervention: delivery

All training group participants were recruited from CPFT community mental health services: service users from the rehabilitation and recovery pathways; and professionals from these services and from assertive outreach teams. Service users were invited to participate by their care coordinators and psychiatrists and care coordinators were approached by team managers. In total, 47 service users, 12 psychiatrists and 35 care coordinators took part in the training.

Training was held in three different locations to reduce travelling for participants. Service users were reimbursed for travelling costs and received a fee (£40) for completing an evaluation before and after the programme.

The training was delivered in small group settings (2–12 participants), with each cohort completing their course of training together. An atmosphere of trust, acceptance and respect was encouraged. Participants had the opportunity for informal interaction before and after sessions as well as during breaks. Facilitators and project team members could be contacted between sessions for additional support.

Service user training groups were structured into four 2h sessions, meeting fortnightly After the training, two follow-up sessions were offered for ongoing support. Care coordinators met three times, at monthly intervals, for 1.5 h.

Psychiatrists had two 2 h sessions, one month apart, with an online self-study component. For organisational reasons one multidisciplinary team of clinicians received their training together in a single day.

Evaluation

The experience and impact of the training intervention was evaluated by collecting quantitative and qualitative data anonymously from participants at different stages of the project.

After providing baseline data, participants and facilitators completed a short questionnaire after each session, and participants completed a longer one immediately after the final training session. The questionnaires explored what the participants had hoped to learn from the programme, their views on its content and impact, and feedback on particular sessions, practical aspects, teaching methods and support materials.

Analysis of quantitative and qualitative data examining the impact of the intervention at a 12-month follow-up, as well as an economic analysis, will be reported on separately.

Results

Although care coordinators and psychiatrists were mostly trained in separate groups, their demographic and feedback data are reported as one group of clinicians. Demographic and attendance data for service users and clinicians are shown in *Table 1* and *Table 2*.

Demographic characteristics of participants

	Service users (<i>n</i> = 47) <i>n</i> (%)	Clinicians (<i>n</i> = 47) <i>n</i> (%)
Female	22 (47)	33 (70)
Male	25 (53)	14 (30)
Mean age, years	48	45
Ethnicity		
White	42 (89)	37 (79)
Black	1 (2)	1 (2)
Asian	0	4(9)
Other	3 (6)	2 (4)
No data	1 (2)	3 (6)
Education		
Tertiary/further	30 (64)	
Secondary	14 (30)	
Primary or less	1 (2)	
No data	2 (4)	
Employment <i>a</i>		
Paid/self-employed	3 (6)	
Voluntary employment	7 (14)	
Unemployed	25 (50)	
Student (including part-time)	4 (8)	
Age-related retirement	4 (8)	
Other	7 (14)	

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Table 4 – continued from previous page

	Service users (<i>n</i> = 47) <i>n</i> (%)	Clinicians (<i>n</i> = 47) <i>n</i> (%)
Professional background of clinicians		
CPN/nurse		11 (23)
Occupational therapist		9 (19)
Clinical psychologist		2 (4)
Social worker		2 (4)
Support time and recovery worker		6 (13)
Peer support worker		2 (4)
Team leader/deputy manager		3 (6)
Psychiatrist		12 (26)

CPN, community psychiatric nurse.

More than one answer possible.

Session attendance

	Patients	Care coordinators	Psychiatrists
Sessions offered	4 × 2 h	3 × 1.5 h	2 × 2 h
Cohorts training delivered to	6	2 + 1 (team training day)	2 + 1 (team training day)
Attendance	37 (79%) attended at least 3 sessions of 4	20 of 21 (95%) attended at least 2 sessions of 3 14 attended team training day	6 of 10 (60%) attended both training sessions 2 attended team training day

The mean length of contact with mental health services for service users was 17 years. The most common reported diagnoses were schizophrenia, schizoaffective disorder or psychosis (*n* = 28, 60%), followed by depression (*n* = 12, 26%), bipolar affective disorder (*n* = 9, 19%), personality disorder (*n* = 5, 11%), anxiety (*n* = 4, 9%) and post-traumatic stress disorder (*n* = 4, 9%). Some participants reported multiple diagnoses. The majority of service users received state benefits (*n* = 43, 92%), with *n* = 39 (83%) on a disability living allowance.

Immediate post-programme feedback was given by 61 (65%) participants: 33 (70%) service users and 28 (60%) clinicians, including 22 (63%) care coordinators and 6 (50%) psychiatrists. Before starting the programme, service users mostly hoped to learn about ways to cope with their symptoms not solely focused on medication, to understand their medication better and to negotiate decisions. Clinicians were particularly interested in improving their practice, learning about the model and process of shared decision-making, availability of support materials, and sharing experiences with colleagues.

Expectations of the programme were largely met in both groups, with the majority of participants expressing a positive view about its content. In all groups, the opportunity for discussion and exchange of views with peers was highlighted as the best aspect of the programme. In addition, service users valued the clarity of the information conveyed, access to resources and the prospect of greater collaboration in consultations. Clinicians also appreciated access to resources and the information given, as well as the opportunity to reflect on their own practice, particularly in the case of psychiatrists.

There was little negative feedback. Just over half of service users (*n* = 17, 52%) and the majority of clinicians (*n* = 20, 71%) did not identify any aspects of the programme as being 'least satisfactory'. Some service users mentioned dissatisfaction with practical aspects or teaching methods, and a few referred to difficulties reading all the paperwork/understanding everything. A small number of psychiatrists expressed concerns about a perceived bias against their profession. Most participants felt the training was pitched at the right level. Use of the project website was variable, with about half of service users visiting it outside sessions. Most psychiatrists visited the website, but only a few

care coordinators did. The online forum was not used by any of the groups.

Most clinicians rated the training programme as relevant to their clinical practice, but fewer expected that what they had learned would shape their future practice. Over half of service users expected or were at least hopeful that the programme would affect future practice.

A summary of the post-programme feedback is given in *Table 3*.

Summary of feedback

	Service users (<i>n</i> = 33)	Clinicians (<i>n</i> = 28)
Most important things participants hoped to learn <i>a</i>	Lifestyle changes/coping with symptoms/alternatives to medication Understanding medication Management/SDM/negotiating decisions Sharing experiences Understanding side-effects of medication Assertiveness/confidence with professionals Info about project/research Reducing/coming off medication	Improving practice Learning about SDM model and process Support materials/tools for SDM Sharing ideas and practice Information about medication, including side-effects and coming off Learning about the project Gaining confidence in discussions with service users Understanding service user perspective
Views on content of the programme	Positive views 28 (85%): interesting, helpful, informative, empowering, encouraging, learned a lot Other comments 4 (12%): SDM needs to be implemented from consultant psychiatrist downwards/did not learn that much concrete	Positive views 21 (75%) 18 (82%) care coordinators, 3 (50%) psychiatrists: very good, good, interesting, informative, well-balanced Other comments 4 (14%): repetitive, some prejudice against psychiatrists
Best aspects of programme <i>a</i>	Meeting others, exchanging views and experiences, supportive environment Information conveyed, new ideas and access to resources Learning to be involved in my medication management, feeling confident my views will be listened to	Interaction with others, chance to discuss implementation of SDM Direction regarding resources/tools to support SDM, information Concept of SDM Gaining confidence in promoting SDM/putting SDM into practice Reflecting on own practice Getting service user perspective
Least satisfactory aspects <i>a</i>	Practical aspects, teaching methods Not understanding everything, not able to read all paperwork Parts boring, same	Practical aspects, teaching methods Perceived bias against psychiatrists Did not improve personal knowledge of medication Content
Training pitch at right level	32 (97%)	20 (71%): 17 (77%) care coordinators, 3 (50%) psychiatrists
Use of project website	17 (52%)	11 (39%): 6 (27%) care coordinators, 5 (83%) psychiatrists
Relevance of training programme and impact on future practice	Expecting impact: 12 (36%) Hopeful of impact: 7 (21%) Doubtful/unsure: 5 (15%) Relevant for others: 2 (6%)	Relevant: 23 (82%) Impact on own practice in future: yes 16 (57%), no 1 (4%), hopeful/probably 2 (7%)

SDM, shared decision-making.

Listed in order of frequency.

Discussion

The ShIMME project was a small-scale exploratory project with an emphasis on service users co-leading in all aspects, while aiming to ensure the views of all key stakeholders were integrated into the development and delivery of the training intervention.

The training programme was well received overall, demonstrating the feasibility of providing group-based training in shared decision-making to service users and practitioners in NHS community settings. In this case, service user participants were drawn from the rehabilitation and recovery pathways which serve people with chronic and often severe mental health problems. Demographic data from participants indicated high levels of chronicity and disability. The positive feedback, good attendance and engagement from this group suggest that taking part in shared decision-making training is possible and worthwhile for people experiencing a range of mental health challenges.

Feedback indicated that service user participants were interested in being actively involved in managing their mental health, including gaining a better understanding of medication and exploring a range of other strategies to foster well-being. Clinicians showed an interest in improving their practice by learning about shared decision-making.

Members of all the stakeholder groups gave positive feedback about the group-based training, allowing for the exchange of ideas and experiences with peers. This was also reflected in facilitator comments about the supportive atmosphere and participants' enjoyment of meeting with each other in the service user groups. Interaction with peers seemed to be an important aspect of the whole programme.

There may also be advantages in service users and clinicians attending joint training groups, allowing participants from different backgrounds to work together on an equal basis and to gain a better understanding of others' perspectives without the pressures and structures of the clinical encounter. The involvement of carers and important others might bring further benefits.

The feedback about the content, approach and pitch of the teaching within the group of psychiatrists was not quite as positive as in the other groups. The reasons for this are likely to be multifaceted and would warrant further exploration, with possible adjustments of the programme. Away to enhance acceptability and engagement would be to encourage more psychiatrists to become involved in shared decision-making training and development of tools.²⁸ Use of the project website was limited, in particular by care coordinators and service users. Technical difficulties with the website might have contributed to this, but comments during sessions indicated that some participants, particularly service users, had low IT confidence and limited internet access outside the training sessions. Future training programmes will need to provide non-digital resources, as well as supporting access and use of IT resources.

The project team developed three paper-based tools to support the process of shared decision-making, which were trialled in training groups and repeatedly revised. Although useful, these would need to be integrated into the existing electronic records system to be truly effective in promoting, supporting and documenting the process of shared decision-making without significantly affecting consultation time. At present this remains a challenge, but there have been some promising recent developments.⁴⁰

Both groups of clinicians considered the training relevant to their clinical practice, although they appeared uncertain whether the programme would influence their future practice. This might be due to concerns about additional barriers to implementation or aspects of the training itself. Despite their positive feedback about the programme, service users were also cautious about its impact. This might reflect the perception that they have little influence in making significant changes to their healthcare delivery or doubts about positive initiatives being translated into clinical practice.

While this pilot programme had the limitations of a modest number of participants, not all of whom provided feedback, the consultation data from local stakeholders, the development of the training programme and the feedback from participants were all encouraging. Drawing on experiences from this project, CPFT has been working towards implementing shared decision-making across the trust by embedding shared decision-making into its procedures, raising awareness and offering training to practitioners across the trust (www.promise.global/sdm.html). The associated Recovery College (www.cpft.nhs.uk/about-us/recovery-college-east.htm), which is open to service users, family, friends and staff,

also included training in shared decision-making. The pilot project benefitted from a supportive environment within the trust, and the success of implementation in other organisations would depend on their own local conditions.

The complexity and difficulty of implementing shared decision-making in a mental health setting should not be underestimated.^{36,41} For it to truly become a routine part of clinical practice, changes in attitudes and behaviours are necessary among all parties involved, as well as the wider society.^{36,42} Psychiatrists are well placed to take on a leadership role in promoting shared decision-making within health services and should also be pivotal in explaining the benefits of increased patient autonomy and responsibility to the general community.

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1.6.64 Trainee experiences of intellectual disability psychiatry and an innovative leaderless support group: a qualitative study

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Abstract

Aims and method There is very little research into the challenges of training in intellectual disability psychiatry or into interventions which may address these challenges. Using focus groups, we explored the experiences of intellectual disability psychiatry trainees, and evaluated a leaderless trainee support group developed in Bristol.

Results Five distinct themes were identified via framework analysis: that trainees felt unprepared for the difference from previous posts; the need for support; the value of the group; that trainees were concerned about judgement in supervision; that the group structure was valued.

Clinical implications Our findings highlight the support needs specific to intellectual disability psychiatry trainees. Leaderless peer support groups may be a valued resource to address such issues, and may be a useful model to be considered by other training schemes.

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- *Trainee experiences of intellectual disability psychiatry and an innovative leaderless support group: a qualitative study*

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Intellectual disability psychiatry (also known as learning disability psychiatry particularly in UK healthcare services) is a specialty in the UK involving the assessment and management of mental health problems in individuals with intellectual disability and other developmental disabilities. Trainees in intellectual disability psychiatry face specific challenges, including the need to acquire enhanced communication skills, understand a range of genetic, neuropsychiatric and neurodevelopmental conditions, and utilise knowledge of complex psychopharmacology.¹ They may also have to confront substantial existential and societal issues associated with caring for vulnerable individuals who face exclusion and disadvantage in many aspects of their lives.²

Although there is little published literature, one study exploring the experiences of intellectual disability psychiatry trainees described strong feelings of isolation, alienation, lack of skills and impotence, not unlike the feelings experienced by the patient groups the trainees worked with.² Prompted by these findings, trainees on the Bristol intellectual disability psychiatry training scheme developed an innovative, leaderless trainee support group (*Box 1*) after taking advice from a consultant psychotherapist. The group aimed to provide a forum for reflective peer support for core and advanced intellectual disability psychiatry trainees (doctors specialising in psychiatry, previously termed senior house officers and specialist registrars). It has continued since 2005, with individual membership varying from 6 months (core trainees) to 3 years (advanced trainees).

Here we report the findings of a qualitative study exploring the experiences of trainees in intellectual disability psychiatry who participated in this support group. The aims were to explore doctors' experiences of training in intellectual disability psychiatry, in particular the positive and negative aspects of working in this specialty, and the role of support and supervision; and to evaluate the model of a leaderless peer support group from the perspective of its participants.

Box 1 Trainee support group

- **Who:** All core and advanced trainees in intellectual disability psychiatry placements are invited. Typical attendance is 3–6 participants, dependent on need, leave or competing priorities. The group does not have a facilitator or leader, and was set up with an egalitarian structure.
- **When:** Fortnightly before the academic programme.
- **Where:** On the site of the academic meeting, central in the area between the different placements.
- **How long:** 90 min.
- **Structure:** 10 min of chat as people arrive, 70 min of focused support group. No fixed agenda, time used between trainees depending on needs that day.
- **Boundaries:** start and end time, confidentiality, respect.

Method

We approached this project using a qualitative design, as we were interested in exploring a variety of individuals' interpretations of their experiences.³ Although one-on-one interviews were an alternative, focus groups provided a time-efficient way to gather data, allowed discussion of the issues raised, and enabled researchers to gain a sense of whether the individuals identified with each other's experiences.⁴

Procedure

Two focus groups were held, one for each cohort, each lasting 90 min. Focus groups were facilitated by two of the researchers (J.N. and J.K. for the first cohort, and J.K. and D.R. for the second), who used a topic guide and encouraged free-floating discussion. The facilitators sought clarification when needed, and prompted the participants to move on to new areas when they started to repeat previously discussed issues, or after periods of prolonged silence. They also encouraged participants to share examples from their own work wherever possible. Recordings were transcribed, including spoken words, speech fillers and dysfluencies, by a medical secretary.⁵

The topic guide comprised four sections: experiences of working with people with intellectual disability; the role of support and supervision in training in intellectual disability psychiatry; reflections on the value and usefulness of the trainee support groups; specific consideration of the leaderless, egalitarian model of the trainee support group. The list was generated from data gathered via a previous semi-quantitative survey investigating perceptions of the trainee support group held by trainees and trainers in 2007.

Participants

All doctors who had been members of the trainee support group during the preceding year were invited to participate in each of the study's two focus groups. This process was performed twice, 4 years apart, sampling two non-overlapping cohorts. This was to allow exploration of whether experiences were cohort specific. Each focus group comprised five participants. The first included three core and two advanced trainees and the second two core and three advanced trainees. Each group was mixed gender and had trainees from different community learning disability teams (CLDTs) in the scheme. The ages of the participants were between 25 and 40 years.

Participation was voluntary, without incentive and occurred during work time. All participants consented to their comments being recorded and transcribed for analysis, with individual identities removed.

Ethical considerations

The regional training programme director reviewed the proposal, considered relevant ethical issues and gave approval for the study.

Analysis

Framework analysis was the most appropriate analytic method, given its relative simplicity and ease of use, and served the intended aims of seeking themes rather than generating explanations or new theories or concepts. A process similar to the framework analysis described in detail in Rabiee was followed.⁵

Stage 1

Two authors (J.K. and D.R. in the first and R.S. and H.T. in the second focus group) independently immersed themselves in the focus group transcript as a whole. The transcript was manually coded on paper, thus developing a 'thematic framework'.

Stage 2

Following this, quotes were highlighted, pasted into a separate document and arranged by broad themes.

Stage 3

The interpretation stage of the analysis was done jointly between each pair of authors and involved refining and condensing the themed quotations using suggested criteria of: attention to frequency; emotion/intensity; specificity (attention to actual personal experience over hypotheticals); and extensiveness. Internal consistency (reduced attention to views subsequently contradicted or changed) could not be reviewed as suggested by Rabiee,⁵ as individuals could not be consistently tracked throughout the transcript.

Stage 4

The final stage involved a review of the analysed and interpreted data to see whether they had resulted in significantly overlapping themes suggestive of an overarching or superordinate theme. Themes were named by a process of abstraction as described by Fade.⁶ A requirement for reflexivity was acknowledged from the outset. Thus, researchers' influence was viewed as a necessity for making sense of the richness of the data generated by group participants rather than as bias to be eliminated.⁷

Results

Results of thematic analysis

Five distinct themes evident in both focus groups were identified. Owing to the anonymisation of participants during transcription, it was not possible to attribute quotes to specific participants. However, the quoted contributions incorporated a broad range of views arising in themes evident in both focus groups. Furthermore, it was evident in the transcript that they did not represent any one dominant voice.

Theme 1: unprepared for difference

Both groups perceived placements in intellectual disability psychiatry as being quite different to other psychiatry posts. This was viewed as having both positive and negative facets. Positive aspects included having more time allocated to conduct detailed assessments, and the potential to work jointly with colleagues from other professional groups. These were seen as enabling the doctor to assess the patient in a holistic manner and the overall experience was described as 'rewarding' by several trainees: "You don't just see the person in one dimension; you are seeing a holistic view. Working with people with disabilities ... can be very rewarding." A variety of negative issues were discussed, including problems associated with reliance on suboptimal collateral histories and doctors questioning their own abilities to provide adequate care to this patient group, particularly with respect to specialist skills such as epilepsy management: 'Suddenly you are asked to treat something you've probably not had a great deal of training for [epilepsy]... suddenly you are expected to already know about it.' Some trainees appeared to be aware of such differences prior to starting posts, which was sometimes a source of apprehension. However, for others it was more of a surprise: 'I think it is very

different to what one gets in general psychiatry and I think that is not clear at the outset and sometimes can come as a surprise.’

A sense of isolation while working in these posts was part of the discourse in both groups. The change from being in large mental health teams to smaller CLDTs, where the other professionals have limited psychiatry training, was noted. The low number of medical colleagues in the CLDTs also generated feelings of isolation, as did the geographical spread of posts: “The posts can be quite isolating ... there might be you and another doctor within the team. We are quite isolated, we are far and few. There is that huge geographical spread which means that you don’t tend to see people informally.”

Theme 2: need for support

The trainees described the need for help and support in coping with aspects of their work. For example, there were accounts of doctors struggling with the emotions evoked by working with a patient group with disabilities: “I think it is quite difficult to work with people with [intellectual disabilities]; especially people who are severely ... physically and mentally disabled, it can make [you] feel quite low if you see those people who are completely dependent on carers. If you work with someone who has so much pain and trouble, if you work with them and you don’t get any support, I think I would personally get depressed, just thinking about it. If you don’t actually discuss your feelings with someone else who understands where you are coming from, I think that can pile on and on and can actually start affecting you in your personal life too.” Some trainees also described being overwhelmed by the additive effect of numerous emotionally challenging encounters: ‘In a week you collect things in your head. If there were deaths you would have a formal debrief, but these things are not deaths. They are things that keep on happening, small things.’

Many of the participants also expressed feelings of impotence to ‘fix’ the underlying conditions of their patients with intellectual disability: ‘I’ve always been taught to diagnose a disorder and treat it... I felt powerless.’

The trainees described the trainee support group and consultant supervision as addressing different support needs: “I think they are quite separate things... they do quite different things. I think... supervision is about supporting your work and this [trainee support group] is a place that supports you.”

The trainee support group was also highlighted by several trainees as a useful place to talk about difficulties related to training and difficulties experienced within CLDTs.

Being a doctor who is newly working in learning disability and the emotions that generates and the challenges of training, I think you get more out of discussing that with a group of people who are going through the same thing.

Theme 3: value of the group

The trainees described finding the group a source of: “Genuine support and encouragement and reassurance. We talk, and when you talk it comes out, and you are able to share, and it is not so ... painful anymore.” Some participants also recalled specific clinical and nonclinical issues where the group had been helpful to them: ‘I was struggling ... the support was phenomenal.’ Trainees also stated that the group had a positive impact on their clinical work: ‘I think it does help us to become better clinicians in terms of how to deal with our emotions ... we do learn from each other a lot.’

Positive aspects to the structure of the group included: permission to discuss anything, the group being confidential, and the opportunity to be with peers who are experiencing similar challenges: “The openness and the fact that you feel a bit equal ... you can pretty much bring anything there. I can speak and no one will judge me.” Sessions that had been of most value were reported to be those that were best attended, and setting ground rules was considered helpful to the group. If the group discussion was solely focused on an informal chat or issues such as rota swaps, it then lost its supportive benefits: ‘Incredibly valuable [sessions] have been the ones where people, lots of people, have come and come on time, and other times they definitely have felt like a missed opportunity.’

Theme 4: judgement in supervision

Participants described finding it easier to talk about their feelings with peers in the group than in consultant supervision. In particular, worries were expressed regarding looking incompetent during supervision, as the consultant would need to sign off the trainee at the end of the placement.

I don't want to say something [in consultant supervision] that will make me look bad, that will go on my file.

I would probably be worried in supervision that I don't want to say that I felt unsure about myself.

I find the trainee support group is more about me and about how I am coping, whereas clinical supervision is everything about the client and getting my assessments and appraisal.

Part of the issue might be your unhappiness with your interaction with other members of the team or with your consultant, which ... you would find difficult to discuss in supervision.

However, consultant supervision sessions were deemed more appropriate for some other issues, which trainees said they would not discuss in a group setting: 'Certain personal and professional issues that you may want to discuss in a supervision environment I wouldn't do in a Balint group or here.'

Theme 5: group structure

The egalitarian model was described as enabling core and advanced trainees to express their opinions knowing trainees were viewed as of equal value to the group: 'My views were valued and ... I could also give advice to my senior colleagues, which is not always respected everywhere, so this was a major strength.'

It also allowed all members to talk about what they felt was important to them rather than to a facilitator. However, some noted a downside that a less confident member might not highlight their desire to bring a new topic to a session, and the group could be dominated by particular individuals: "There is a freedom in the group that comes from the fact that it's unstructured and doesn't particularly have an agenda. I think a chairman would be useful [...] in asking if particular quiet members would [...] like to say anything because there are some people who have attended and I haven't heard speak in 6 months." The lack of a leader was thought to promote a more lax view on attendance and punctuality, and some trainees and consultants were reported as giving the group a lower priority than other aspects of the trainees' work. Group members arriving late or leaving early was disruptive and disturbing: 'We value the group, we see it as valuable or we wouldn't come at all, but we don't value it as highly as other things in our timetable so it tends to be the first thing that gets bumped.'

Discussion

This study adds substantially to the very limited literature detailing the peculiarities and challenges of training in intellectual disability psychiatry.^{1,2} One strong theme that emerged from our results was how trainees considered training in intellectual disability to be different from other psychiatric posts and the degree to which they were prepared for this. The reasons cited were related to both the specifics of the work and the structure of teams. It is well known that psychiatric disorders in intellectual disability may be more complex to diagnose, particularly owing to difficulties in effective communication. A further contrast with many other areas of psychiatry is the degree to which healing or restoration to full function or participation is possible. In intellectual disability psychiatry, the primary disability is often the intellectual impairment or associated developmental disorder, thus treatment of any mental illness may restore the patient's previous level of functioning and quality of life, but no further. Despite epilepsy management being a common role for the intellectual disability psychiatrist,⁸ our findings suggest that many trainees felt apprehensive about their skills and confidence in this area.

Feelings of isolation were also highlighted. CLDTs in the area of the study are geographically spread out and based away from their mainstream psychiatric colleagues. Separation from peers has been noted as off-putting to foundation doctors,⁹ but few studies explore feelings of isolation among psychiatry trainees² It has been noted previously that

individuals who work with people with disabilities can feel stigmatised and isolated.^{10–12} Stigma by association is the process by which relatives, support staff, friends and associates feel stigmatised owing to their contact with a stigmatised group.^{13,14} This may also affect trainees working in this area and contribute to their feelings of isolation. We think that one reason the group was valued could be its ability both to reduce the feeling of isolation by bringing trainees together, and to mitigate some of the stigma felt by enabling the trainees to share difficult experiences. One could speculate that the group may have not just attenuated some potential negatives of the subspecialty training, but also contributed to the enjoyment and reward of it. If this were to be true, it would be interesting to study whether training schemes in areas with specialty-specific support or educational groups do better in relation to trainee retention or satisfaction than those without such structures.

It should be noted that despite the challenges, there was also a strong and pervasive feeling of positivity about training and working in intellectual disability psychiatry. Such experiences were startlingly absent in previous work,² but are important to note to reassure future recruits in the specialty. In particular, the trainees mentioned the term ‘rewarding’, a varied and complex concept.¹⁵ The view that community-based intellectual disability psychiatry would be rewarding was predicted some 30 years ago,¹⁶ although this is the first study as far as we are aware that affirms this view. Intellectual disability requires a particularly holistic approach, often not dissimilar to the approach of general practitioners (GPs). While there is an absence of published surveys or qualitative studies on what psychiatrists find rewarding, interpersonal relationships between doctor and patient have been found to be particularly satisfying for GPs.¹⁷ However, we are unaware of similar studies among psychiatrists.¹⁸

Both focus groups discussed how consultant supervision and the support group were different, but mutually supportive and compatible. When surveyed, UK trainees report they are mostly happy with supervision and find it useful.¹⁹ The Royal College of Psychiatrists recommends that supervision should enable ‘the development and assessment of clinical and personal skills under direct one-to-one supervision by an expert’ and should be ‘focused on discussion of individual training matters’.²⁰ The hierarchical nature of consultant supervision is both valued by trainees²¹ and necessary for valid competency assessments, but this can be a potential barrier to seeking support in some areas, particularly revealing vulnerabilities to a supervisor who is also an assessor. Personal upset and secondary grief relating to patients is considered by some supervisors and supervisees to be a boundary breach in supervision.²² The trainee support group is set up without hierarchy and this may have contributed to reducing boundaries around discussing vulnerabilities. Honest discussion about how trainees were ‘coping’ was easier in the trainee support group than supervision, despite the College suggesting consultant supervision should include this.²⁰ This study adds to previous work suggesting some mismatch between intent and what trainees feel comfortable discussing.²³ This space for honesty is a value of the group but it would be a concern if the availability of the trainee support group and its support acted as a colluder or barrier to honesty in consultant supervision.

Group peer support may be more beneficial than alternatives such as paired peer support. Several of the benefits described in both focus groups suggested similarities to Yalom’s therapeutic factors: universality, altruism, guidance, imparting of information, cohesion, and existential factors.²⁴ That senior trainees stayed in the group for up to 3 years may reinforce some of these factors, and their relative maturity and existing trust following a longer involvement in the group may provide additional support.²⁵ It also provides senior opinions, which have been found to be supportive when shared in other contexts.²⁶ A common concern when leaderless groups are used for supervision is a loss of focus on the task and drifting into support and advice-giving.^{27,28} As the model presented here is primarily for support, and advice is part of that, the lack of leader is not a concern in this context, although the results did suggest that some participants would have liked a facilitator role in encouraging quieter members to contribute.

As this is an analysis of a single group and the findings have not been replicated elsewhere, it is difficult to generalise the utility of such groups to other areas. However, we think similar models of egalitarian peer support that require limited resources for setting up may have the potential to benefit trainees in other, smaller or more challenging, specialties.

Strengths and limitations

The qualitative design and use of focus groups is appropriate to investigate attitudes and experiences of trainees. The training rotation is relatively small, with 7–9 core and advanced trainees available to attend the trainee support group in each 6-month period. ‘Group think and the articulation of group norms may have introduced a positive bias. However, the anonymity of participants in the transcript is likely to have mitigated self-censorship and there was evidence of a diversity of opinion, particularly illustrated by both praise and criticism of the trainee support group and highlighting a range of experiences in training. The anonymisation happened at transcription rather than at analysis stage. This precluded the ability of the authors analysing the data from tracking individuals’ comments or reviewing whether they were linked to particular posts or trainers. Generalisability is a concern in qualitative studies, and was also a concern in this particular training scheme. First, at the time of the focus groups, the Bristol scheme was performing above average on trainee satisfaction in GMC surveys.²⁹ Second, many of the CLDTs may be unusually isolating for trainees compared with elsewhere in the country by virtue of their geographic spread and relatively rural setting. Finally, in several CLDTs within the scheme, most team members, except psychiatrists, are employed by a different organisation and may have few psychiatric skills.

In conclusion, we have highlighted some of the challenges and rewards of training in intellectual disability psychiatry. Our evaluation of an egalitarian, trainee-led peer support group suggests that the model could be useful for other intellectual disability psychiatry training schemes. Whether this could be a support structure suitable for other specialties remains to be studied.

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1.6.65 Scottish independence: the view of psychiatry from Edinburgh

Julia Bland¹

date

2017-8

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- *Scottish independence: the view of psychiatry from Edinburgh*
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As a southerner and medical psychotherapist, it was with some trepidation that I ‘Ubered’ to Professor Eve Johnstone’s house in Edinburgh, which boasts over a hundred roses in her immaculate garden. After all, I was going to meet the

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woman whose research work had wrenched the pendulum radically in the direction of biological psychiatry, with her landmark *Lancet* paper ¹ showing anatomical differences on CT scans between the brains of those with and without schizophrenia. I feared that she ate psychotherapists for breakfast, although she had sounded kind and friendly on the telephone. My anxiety was misplaced, since the person who emerged was a woman of fierce intelligence, with rigorous, idealistic, uncompromising and wholly admirable moral standards; compassionate and committed to patients and science, without any personal vanity, unless you include intellectual certainty.

Professor Johnstone is not a postmodern relativist: her life has indeed been a life scientific. For her this is seamless: the scientific truth is what leads to effective and therefore optimal treatment. She has never given interviews before, owing to a self-deprecating Scottish horror of self-publicity, but agreed to speak now as a retired professor.

Eve Cordelia Johnstone, ‘Scottish neuroscientist’, is the eighth generation of Glaswegian Presbyterian doctors, but the first woman doctor in her family. She laughed gently at my southern ignorance in asking about Catholicism in Glasgow: of course the Catholics were often of Irish origin, poor, poorly educated and discriminated against. No chance of eight generations of doctors then. (In fact, her father was a dentist because his serious deafness made medicine impossible.)

She remembered vividly the poverty and overcrowding in Glasgow, the worst in the UK at the time. One of her first patients on medical take was an exhausted woman presenting with open tuberculosis, a urinary tract infection and a haemoglobin of 8, who arrived late at night, after three jobs that day: scrubbing steps, cleaning offices, then washing dishes. ‘Had she ever been to the hospital before?’ I ask. ‘Yes, to be sterilised after having 13 children.’ The woman was 35 and looked 20 years older. Infant mortality was 28/1000 in Glasgow at this time, compared with about 6/1000 now.

Born in 1944, the young Eve was sent to an academic private Presbyterian girls’ school and was an obvious high flyer. This remained the case: she qualified in medicine in Glasgow in 1967. As a woman medical student, she was one of a 20% maximum quota. Most of her female contemporaries ended up doing a bit of part-time practice rather than working ‘in a serious capacity’, as she put it.

As a clinical researcher who looked after patients with scrupulous care, she is proud of having been supported by the Medical Research Council (MRC) continuously for 33 years, which is almost unprecedented. She did research at Northwick Park in Harrow from 1974 until 1989, and was Professor and Head of Department of Psychiatry at the University of Edinburgh from 1989 until 2010. She has a reputation in Edinburgh for supporting younger psychiatrists, although she has no time for slacking (or striking, as a doctor): ‘I worked 12 hours a day, it was what I expected’.

The struggle for schizophrenia

In 2016 it may be hard to remember the climate in which the 1976 *Lancet* paper landed. ¹ Debate on the origin and meaning of mental illness was in the international public domain. The flamboyant R. D. Laing, a fellow Scot, was describing psychosis as a sane response to an insane society, chiming perfectly with the other social and sexual revolutions in progress. ² Thomas Szasz published *The Myth of Mental Illness* in the same year, depicting psychiatrists (and all other doctors) as agents of social control. ³ In 1975 Miloš Forman’s *One Flew over the Cuckoo’s Nest* portrayed the excesses of medicalisation, incarceration and psychosurgery. ⁴ A famous study emerged in the USA in 1973, showing how journalists going to the emergency room complaining of ‘hearing’ three words in their heads attracted the diagnosis of schizophrenia. ⁵ This massively discredited conventional psychiatric diagnosis. In the UK, David Cooper published *The Death of the Family* (1971), describing the family as the crucible of mental illness, and coined the term ‘anti-psychiatry’. ⁶ The now discredited and mother-blaming notion of the ‘schizophrenogenic mother’ was widely held.

So just imagine the hostile reaction that a paper showing anatomical changes in schizophrenia would receive. As Professor Johnstone remembers: ‘There was all this anti-psychiatry stuff [...] People were saying schizophrenia didn’t exist [...] I had to prove my opponents wrong.’ As she reminisces today, it is not difficult to detect her contrarian relish for the battle: Professor Johnstone had no time for these theories. ‘There were 200 000 people in hospital with schizophrenia [...] what did they think they were there for?’ she asks incredulously. It was also the time that John Wing had written about the phenomenon of institutionalisation, ^{7,8} although she points out ‘he never claimed that the institutions were the cause of the illness’.

In her own mind, Professor Johnstone was crystal clear: “‘I felt it had to be that this was a disease, but I couldn’t prove it [...] and then the non-invasive method of CT scanning came in. I was lucky. Before that people had to do pneumoencephalography (injecting air into the ventricles and X-raying them, resulting in terrible headaches and worse), so there were no controls because of the dangers of the technique. The papers were all in Japanese or German.’” This is a chilling moment: we are talking the Third Reich. ‘It sounds awful to admit’, she says ‘but the best papers [in support of the notion of schizophrenia as a disease originated in] the Third Reich. The Nazis wanted proof that schizophrenia was an inherited degenerative condition.’ When the 1976 study was published, even other neuroscientists objected, suggesting that the anatomical change could be secondary to drug treatment or encephalitis. ‘But I knew something was wrong with these people [...] When I was 21, I saw a 21-year-old woman, terribly distressed by paranoid delusions, who had been working in a bank 3 weeks earlier. It was ridiculous to say this was due to imperfect interpersonal reactions at home [...] just stupid.’

With iron determination, she then went on to refute all the challenges to the original paper with a study of 600 people with schizophrenia in Shenley hospital.⁹ They were followed up until death, and their brains at autopsy showed larger ventricles and smaller brains. However, there was no gliosis, suggesting that the pathology may be neurodevelopmental. Professor Johnstone, for all her modesty, cannot suppress an element of glee in having pipped to the post her American research competitors. Daniel Weinberger, backed by the enormous funds of the National Institute for Mental Health, confirmed her findings 2.5 years later.¹⁰ Not shirking controversy, she then ran a placebo-controlled trial of electroconvulsive therapy (ECT), which demonstrated ECT to be effective, albeit only for about 8 weeks, particularly in those depressed patients who experienced delusions and had intellectual disability.

Her next project, the Edinburgh High Risk Study,¹¹ was a prospective study of 16- to 22-year-olds, carefully comparing the incidence of developing schizophrenia in a cohort of people whose relatives had schizophrenia, the controls having no family history. Twenty-one of the high-risk group who then developed schizophrenia in fact had some anatomical differences in the brain when they were still well. The changes include smaller amygdala and hippocampus and hyperfolded gyration. Of course, this finding raises a host of ethical issues in relation to premorbid diagnosis and its implications.

I asked Professor Johnstone what she thought of the recovery model, and she was sceptical: “‘Seems to me a bit of a semantic issue [...] if it’s a dreadful illness, very hard for families, specially if you knew the people before they became ill [...] and people don’t want to say how bad it’s going to be. I don’t think the [Royal College of Psychiatrists] has emphasised psychopharmacology enough. We need much more individually tailored treatments, taking account of distinct side-effect profiles, not general algorithms. Unfortunately, it’s not true that the drugs we have now are vastly better, although it is better to have a wider range.’” She sees non-pharmacological treatment as ‘a bit better than nothing, if [the patient] will engage’, but her scrupulous honesty demands that we acknowledge that ‘a terrible thing has happened to them.’ Talking to her it was clear that she personally provided intensive clinical care to her patients and their families, and we could easily agree that continuity of care is crucial and dangerously eroded in many overstretched contemporary psychiatric services. She is unconvinced of the benefits of the newer antipsychotics: ‘It’s true the side-effects are different, but they hammer weight on to you, which is very distressing for young people.’ As for clozapine, the benefits have been ‘greatly exaggerated’.

Her academic success has been recognised. She received a CBE in 2002 for services to medicine, and a Lifetime Achievement Award of the European Psychiatric Association in 2009. She also had many senior roles in the MRC, including the chairing of the highly publicised inquiry into the disastrous linking of the MMR (measles, mumps and rubella) vaccine and autism. With the distressed parents of autistic children leading a class action against the government on the basis of the Wakefield paper,¹² she was truly in the eye of the storm. ‘I had to carry the parents with me.’ The disgraced Wakefield ‘got what he deserved’, she says.

In retirement Professor Johnstone has remained actively interested in the link between schizophrenia and cognitive impairment. She reminds me that there is a 3% point prevalence of schizophrenia in people with mild intellectual disability, three times higher than in the general population. The focus of understanding is in the area of overlap of schizotypal cognitions, molecular genetics and anomalies of brain structure, where ‘we are seeing a final common pathway that leads to schizophrenia.’ The large data-sets she has in this area fit well with the work of the Patrick Dick Wild Centre, a charitable trust in Edinburgh set up for research into autism, fragile X syndrome and intellectual disability. Politically savvy and persuasive, she raised the funds for the centre, named after a person with severe autism.

Future hopes

In terms of the future, she told me about some hopeful developments in Edinburgh, which have potential for a personalised preventive psychiatry. Starting with a simple skin biopsy fibroblast, stem cells and then neurones can be grown, giving an opportunity to ‘develop drug treatments which basically work on an individual patient’s brain which has been developed in a dish’, as Professor Stephen Lawrie, her successor at the University of Edinburgh, put it. Roll on the day.

1.6.66 Handbook on Obsessive-Compulsive and Related Disorders

Lynne M. Drummond¹

date

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- *Handbook on Obsessive-Compulsive and Related Disorders*

This multi-author book examines the disorders categorised in DSM-5 as obsessive-compulsive and related disorders (OCaRDs) and also covers two other related disorders: illness anxiety and obsessive-compulsive personality disorders. The text is written by experts in the field, many of whom were instrumental in developing the concept of OCaRDs in DSM-5. Unlike many multi-author publications, this is brief and to the point. Each of the chapters is arranged in a structured format which includes a general introduction; diagnostic criteria and symptomatology; epidemiology; comorbidity; course and prognosis; psychosocial impairment; developmental considerations; gender-related issues; cultural aspects of phenomenology; assessment and differential diagnosis; aetiology and pathophysiology; treatment (somatic as well as cognitive and behavioural) and a summary of key points at the end. Most chapters also contain illustrative case vignettes which demonstrate the disorders and their potential severity.

This excellent title should be on the bookshelf of every psychiatrist, whether working with adults or children. Mental health workers, managers and commissioners often overlook common conditions such as obsessive-compulsive disorder and body dysmorphic disorder, regarding them as less severe and important than conditions such as schizophrenia. This work describes the hugely detrimental effects these conditions can have on the individual’s mortality, morbidity and social functioning. It also considers newly defined disorders, such as hoarding and skin-picking disorders. These conditions are poorly understood and have generally not been researched extensively. They do, however, appear to be widespread and often have extreme consequences on the individual’s mental and physical well-being. For example, hoarding disorder, which was previously often classified as obsessive-compulsive disorder or else obsessive-compulsive personality disorder, may affect up to 6% of the adult population. Excessive hoarding can lead to death due to fire risk or the falling of large numbers of possessions resulting in an avalanche. It also frequently coexists with self-neglect and – owing to the extreme shame – social isolation. Nevertheless, few community mental health teams in the UK offer comprehensive treatment for hoarding disorders. Some enlightened councils have developed hoarding protocols incorporating housing agencies, social services, and mental and physical health services but overall these are patchy and rare.

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Hopefully, heightened awareness will lead to systematic research and a better understanding of the disorders and their treatment, as well as the development of effective services. This handbook would be a perfect introduction to these areas for a busy practitioner seeking brief but authoritative information.

1.6.67 Shrink Wrapped: Tales from Psychiatrists

Gary Cooney¹

date

2017-8

Contents

- *Shrink Wrapped: Tales from Psychiatrists*

There is something that feels a little otherworldly about *Shrink Wrapped*. As readers, we are invited to find our way into the psychiatrist's mind, to take our bearings from this anonymous collection of short anecdotes and reflections, written by psychiatrists, as a point of departure into understanding what it might mean to be a modern-day 'shrink'. We find warm, affectionate and humorous musings that are abruptly punctured by sharper observations, memories painful to revisit, self-doubt, recrimination and a sense of ever-questioned legitimacy. It is an honest, undiluted look into the experiences of eight psychiatrists, the whispered, confessional moments that blurred the boundaries of their personal and professional lives.

There is a strength of variety to the collection and, at its best, it draws us into questioning ourselves: what kind of a psychiatrist have I become and how did I get here? Does the voice I'm reading remind me of my own thoughts or my own journey? There are, however, one or two weaker moments alongside: in its editorial efforts to be snapshot-succinct, it can sometimes feel frustratingly whimsical and underdeveloped, like a string of highly promising film trailers. There are also passages that veer a little close to what might be found in the reflective practice section of an online portfolio.

Shrink Wrapped is as intimate and conversational as a cup of tea with a close colleague. It considers our own professional self-consciousness, 'the navel-gazing and self-doubt' that besiege our specialty, and takes a frank, unabashed look at the inevitable cross-pollination of our work and life experiences. The collection provides the reader with moments of piercing honesty, such as this summation from one particularly candid contributor, reflecting on what she, as a psychiatrist, might represent: 'I am very clearly a middle class professional White woman who is sitting here telling [the patient] what is happening.'

But who was this woman? Indeed, who were any of these interviewees? Their names are listed in the acknowledgements but not alongside any of their own contributions, an editorial device which purports to leave us free to explore the book in our own way. I found this troubling, untethering, as if I were experiencing these voices in an alternative space. It felt more in service to the interviewees, in defining the boundaries of the reader-writer relationship. It reminded me a little of the dynamic in clinic: you might be able to learn something about a psychiatrist, but not on your own terms. A lot will also be held back.

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1.6.68 Service user perspectives on coercion and restraint in mental health

Diana Rose Emma Perry Sarah Rae Naomi Good

date

2017-8-01

Abstract

Coercion remains a central aspect of many people's mental healthcare. It can include the use of legislation to restrict freedoms, the use of physical restraint, the restriction of freedom of movement and/or association, and the forced or covert administration of medication. There is good evidence that the use of such measures can traumatise service users. This article reports the findings of a survey of service users regarding their experiences of coercion and restraint and embeds this in the wider international and institutional environment.

Contents

- *Service user perspectives on coercion and restraint in mental health*
 - *The CRPD*
 - *Global South*
 - *Industrialised West*
 - *Conclusion: minimising coercion and restraint*

Most jurisdictions in the industrialised West promulgate mental health legislation which permits infringement of liberty and treatment against the will of the person detained. Increasingly, coercion in the community is also allowed. Partly at the behest of the World Health Organization, other countries are developing similar legislation. This ability to compel and coerce is unique in medicine and, from within psychiatry, has been called discriminatory (Dawson & Szmukler, 2006) and criticised for the focus on risk.

Dealing first with the United Nations' 2006 Convention on the Rights of Persons with Disabilities (CRPD) and its implications for coercion and compulsion globally, this article summarises what is known about service users' responses to coercion and compulsion, which includes chemical, physical and mechanical restraint. Responding to the paucity of studies focusing specifically on physical restraint (which is commonly followed by chemical restraint), this article reports on recent experiences of people subject to this practice in the UK while situating this in more general concerns.

The CRPD

The CRPD appears to be top of the agenda for service user movements everywhere except the UK. The European Network for (ex) Users and Survivors of Psychiatry (ENUSP) has provided a point-by-point explanation of how European human rights legislation is in breach of the CRPD and the World Network (WNUSP) was involved in drawing up the Convention itself. It is important as it is the first time that people 'with psychosocial disabilities' have been recognised as equal in law to other citizens in terms of rights.

But the Convention is controversial, particularly since the publication of the General Comment on Article 12, which states that all persons with disabilities must be deemed to have legal capacity all of the time. This intensifies the commitment in Article 14 to abolish compulsory detention and treatment by doing away with the last criterion on which it could be justified. The General Comment has drawn the ire of leading Western psychiatrists (Freeman *et al*, 2015). The debate is also not settled within service user circles, as shown by the different positions of Tina Minkowitz and Anne Plumb (see Spandler *et al*, 2015).

Global South

The CRPD language of ‘persons with psychosocial disabilities’ has also had important implications in the Global South. There is a move from the terms ‘user/survivor’ to ‘persons with psychosocial disabilities’. For example, the Pan African Network of Users and Survivors of Psychiatry is now the Pan African Network of Persons with Psychosocial Disabilities. A similar move has been counselled in India (Davar, 2013). This is not simply a change in language but a political position that states ‘we don’t have psychiatry and don’t want it’.

An Indonesian government programme, Aceh Free Pasung, intends to protect the human rights of people with severe mental illness by eliminating the practice of *pasung* from the province. *Pasung* means restraint by shackles, rope, wooden stocks and cages, and can cause death. Since the alternative was the building of a mental health hospital, the initiative has enabled access to free hospital treatment (Minas *et al*, 2011). Its replacement with neuroleptics, restraint and hospital confinement is nevertheless problematic.

Industrialised West

Decisions about coercion often hinge on the concept of risk. Recent evidence suggests that risk assessments exclude service users from the discussion and render invisible the fact that the assessments are more or less fictions in actuarial terms (Coffey *et al*, 2017).

How risk of harm within mental health settings is perceived and managed has received attention. However, harm in the context of restraint is mostly not recognised. Nonetheless, restraint-related deaths have been reported throughout the Western world, including in the UK, where 38 deaths have been recorded since 1988, 15 of people from Black and Minority Ethnic (BME) communities (Aiken *et al*, 2011). A qualitative study of in-patients showed that nurses and patients had very different accounts of both the determinants of and appropriate responses to violence and aggression (Rose *et al*, 2015).

Reviewing evidence of the effects of restraint, Cusack *et al* (2016) concluded that ‘restraint can be a form of abuse, its inappropriate use often being a consequence of fear, neglect and lack of using de-escalation techniques’.

A small pilot study by the National Survivor User Network (NSUN), as yet unpublished, surveyed 65 people about their experiences of restraint and recruited respondents mainly through the weekly e-bulletin. The findings align with Strout’s (2010) integrative review of the international qualitative literature on patient perspectives on the use of restraint. Strout identifies four categories: negative psychological impact, re-traumatisation, perceptions of unethical practices, and the broken spirit. Of the respondents surveyed in the NSUN study, 43% ($n = 28$) stated that their most recent experience of restraint had felt like an act of aggression ‘a great deal’, 12% ($n = 8$) ‘a lot’ and 15% ($n = 10$) ‘somewhat’. Although the number was small, all respondents from BME communities ($n = 5$) stated that their experience had felt like an act of aggression ‘a great deal’ or ‘a lot’. Respondents frequently cited the unnecessary use of physical force and the number of staff members who were involved in each incident of restraint. The most frequent reason for restraint given by respondents was the refusal to take medication, and physical restraint was routinely followed by a rapid tranquillising injection. This was often experienced as shaming and humiliating:

When I become agitated it is very obviously extreme fear and terror. On each occasion it is ALWAYS male staff pinning me down – always face down so [I] can’t breathe or move and who pull my underwear off/down to inject. They know the abuse history – it has been a police case. They never have talked to me afterwards. It is like being raped again.

One clear theme was the link between instances of physical restraint and tranquillisation with re-traumatisation. Consistent with studies of women’s experience of restraint representing an event that re-enacts the experience of trauma and sexual abuse, Gallop *et al* (1999) found that restraint and associated feelings of humiliation, punishment and powerlessness engendered traumatic emotional reactions such as fear, anxiety and rage.

Half of the respondents stated that experiencing physical restraint had affected their engagement with services ‘a great deal’. The majority reported a loss of trust in staff, and increased fear, suspicion and wariness. Others reported that they avoided services because of their experiences.

The Promise study (Wilson *et al.*, 2015), which informs the development of a proactive care framework to reduce the need for physical intervention, involved interviews with both staff and patients. The most dominant theme to emerge centred on staff–patient communication and relationships, with 11 patients and 19 staff members providing suggestions:

if you wish to reduce the number of restraints a high level of communication is needed whatever the issues of a particular patient, whatever their predisposition to violence or hatred of psychiatric staff, or factions within the resident group, or dislikes of a particular patient. In an ideal world there must be more verbal communication ... the culture is to encourage what Winston Churchill used to say was a 'jaw jaw rather than war war', to counsel and support a person onto a different state of thinking. (Wilson *et al.*, 2015)

Conclusion: minimising coercion and restraint

In the NSUN study, 94% ($n = 50$) of respondents reported that restraint could have been managed very differently, emphasising that if staff had taken the time to listen and to speak to them addressing fears, frustrations and concerns, the situation could have been avoided. Respondents said that staff needed better training and that service users should be involved in this.

No differences were found in the experiences of restraint occurring within the past 10 years compared with the past 2 years. Of the NSUN respondents, 40% ($n = 23$) reported incidents of restraint that occurred within the past 2 years, suggesting no recent improvement in experiences of restraint. These findings signal that the 2-year UK government programme 'Positive and Safe', launched in 2014 with the goal of reducing the need for physical restraint (Department of Health, 2014), has had no impact to date and that a fundamental culture change is needed. This directive was followed by an investigation involving the facedown restraint of a woman eight and a half months pregnant in July 2016 (*Mental Health Today*, 2016).

There are various arguments for reducing coercion and restraint and many different approaches that service users say they find more beneficial. Since 2007 the Mental Health Act in England has made it mandatory for advocacy to be practised by professionals alone, although the service user voice is not completely absent (Newbigging *et al.*, 2015). It will be important to regain and strengthen the user voice within peer and self-advocacy, as has happened in Africa (Kleintjes *et al.*, 2013).

Joint crisis plans or advance directives are counselled by many as a means of reducing incidents of restraint and of listening to the needs of service users (Papageorgiou *et al.*, 2002; Amering *et al.*, 2005). Approaches that include peer facilitators and improvements to the frequency and quality of communications are crucial. Some existing institutional systems make good communication a practical impossibility.

From the perspective of service users, coercion and restraint are mostly harmful and must stop being legitimised. There is an urgent need to challenge and address these practices as they represent gross human rights violations according to the stipulations of the CRPD. UK compliance with the legislation is due to be monitored in the next 2 years.

Conflict of interest. No authors have any conflicts of interest to declare.

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1.6.69 Patient safety and quality of care in mental health: a world of its own?

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2017-10

Abstract

Quality and safety in healthcare, as an academic discipline, has made significant progress over recent decades, and there is now an active and established community of researchers and practitioners. However, work has predominantly focused on physical health, despite broader controversy regarding the attention paid to, and significance attributed to, mental health. Work from both communities is required in order to ensure that quality and safety is actively embedded within mental health research and practice and that the academic discipline of quality and safety accurately represents the scientific knowledge that has been accumulated within the mental health community.

Contents

- *Patient safety and quality of care in mental health: a world of its own?*

With repeated examples of failure across the healthcare system,^{1,2} there has long been a need to understand how we can better uphold and improve on the quality and safety of care that is being provided to our patients. There is a gap between the policy and guidelines generated from research evidence and the practice of medical, nursing and allied health professionals. This gap is at risk of increasing, owing to an under-appreciation of heterogeneity in local context³⁻⁵ and the ever-growing demands on the healthcare system, with fewer resources provided to manage them. As a result, quality and safety in healthcare, a discipline which aims to integrate scientific understanding with applied practice, has made significant progress over recent decades and is now regarded as an active and established community of researchers and practitioners alongside the fields of improvement and implementation science.⁶⁻⁸

Such growth has been reflected in the establishment of discipline-specific journals. For example, the BMJ launched *BMJ Quality and Safety* in 1992, and in 2006 a journal devoted purely to implementation science was introduced – *Implementation Science*. The evolution of the discipline has also included the development and refinement of a number of methodological tools, such as Plan, Do, Study, Act (PDSA) cycles and Driver Diagrams, which draw on the manufacturing industry to support individuals in applying continuous quality improvement (CQI) principles in healthcare practice.⁹

Despite the growing international interest in quality and safety in healthcare, its application to a mental health context has not been explored.¹⁰ It cannot be assumed that findings based on physical health in acute care hospitals can be automatically applied to mental health. This is because of the different challenges presented by patients and settings in this specialised area of care, including a greater emphasis on community-based care, greater use of Mental Health Act legislation and increased risk of self-harm.¹⁰ Mental health in general has been viewed as a neglected area and one in which patients may be less likely to have a voice when it comes to their care and safety.¹¹ It has also been suggested that

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the stigma surrounding mental health issues has the potential in itself to contribute to staff neglecting patient safety and quality of care.¹⁰ In order to deliver high-quality care to patients, it is essential that a firmer understanding of patient safety and quality of care in mental health is not only developed, but also disseminated appropriately to ensure that it has the greatest impact.

Key literature searches of high-profile quality and safety journals reveal that there is a lack of published literature under the umbrella term of mental health. For example, a high-level search conducted in *BMJ Quality and Safety* in July 2016 based on the search term 'mental health' appearing in the title or abstract returns just 56 hits across all archives. When restricted to 'mental health' appearing in the title only (and therefore indicating that it is the primary focus of the article), the search returns just 17 results. This is disappointing, especially when compared with similar searches on key search terms for other medical specialties, for example paediatrics (94 hits for title and abstract) and surgery (237 hits for title and abstract). These findings are also reflected in other notable quality and safety journals such as *Implementation Science* (30 hits for 'mental health' in a title-only search) and the *International Journal for Quality in Health Care* (15 hits for 'mental health' in a title-only search). We recognise that there are inherent challenges in these comparisons, including selection of terminology and disciplines; however, these searches are intended to be illustrative rather than exhaustive.

Even the small number of studies that are returned from these searches do not consistently focus on mental health as the primary setting of interest. Instead, mental health tends to form one component of a system-level study often associated with high-level quality improvement and quality of care structures in the healthcare system.¹²⁻¹⁴ In other instances, mental health is positioned as just one example or context alongside physical health settings and is therefore not the sole focus of the article or its key messages.¹⁵⁻¹⁷ Generally, the work being published in these quality and safety journals does not focus on aspects of safe care that may be of specific importance to a mental health setting or explore how established quality and safety metrics apply and translate to this unique context. However, searches do identify a systematic review on medication errors in mental health¹⁸ and some work around continuity of care and communication between in-patient and out-patient mental health settings, for example.¹⁹

Contrary to these findings, searches run across the broader medical and social science literature reveal that much has been published on the topic of quality and safety in mental health in other, more specialty-specific areas (e.g. psychiatric nursing journals). For example, academic teams in mental health led by Louis Appleby, Len Bowers and Joy Duxbury contributed a significant amount of work. Therefore, it seems that the issue is not necessarily a lack of work on quality and safety within a mental health context, but instead a lack of its representation as part of the stand-alone quality and safety discipline.

The specialty-specific literature succeeds at providing a significant amount of research into patient safety incidents that are more precisely related to a mental health setting. These include violence and aggression, patient victimisation, suicide and self-harm, seclusion and restraint, and absconding and missing patients.¹⁰ Other key areas that apply more broadly across all settings are falls and other patient accidents, adverse medication events and adverse diagnostic events such as misdiagnosis. This literature is not without its faults, however, as there is a tendency for it to focus on areas of safety that may be of greatest concern to the public rather than areas of quality that may contribute most to patient experience and clinical outcome effectiveness. It may also not be fully reflective of the vast developments that have been made in understanding quality and safety in healthcare more broadly.

There is a clear disparity between the two bodies of literature (i.e. work around mental health within the established quality and safety discipline and work around quality and safety of care within the broader and less defined mental health discipline). In recent years there has been a call for 'parity of esteem' between physical and mental health (i.e. recognition of mental health as an equally important discipline within medicine).^{20,21} The data that we have presented certainly suggest that there is no parity in the attention being paid to quality and safety, and this is an area that requires attention. The structure of the National Health Service (NHS) is guilty of fostering this separation, to some extent, through commissioning different organisations to provide physical and mental healthcare.²² However, Academic Health Science Networks are aiming to help break down historical barriers between acute care and mental health trusts.

Furthermore, the two bodies of literature appear to exist in silos and do not explicitly refer to or build on one another as a matter of course. Therefore, the core integration of the quality and safety discipline with the mental health setting is currently lacking and not fully reflective of the scientific understanding that has been incrementally built up via the specialty-specific journals. The opportunity has also been missed for the two bodies of work to effectively communicate, learn from each other's limitations and strengthen one another. For example, a more thorough integration could ensure

that quality and safety is explored across the board within the mental health setting in a way that is appropriately sensitive to the local context without being restrictive. This approach is likely to have the greatest direct benefit to mental health patients when such research translates into clinical practice.

It is important to discuss and reflect on the potential reasons for this disparity in order to understand how it might be rectified in the future. It is possible that academics focusing specifically on quality and safety as a research area (i.e. not wedded to any particular specialty) are not conducting a sufficient amount of research in a mental health context. Assuming that academics of this type are more likely to submit to quality and safety rather than specialty-specific journals, it is possible that the issue centres on a lack of work being completed in these settings by patient safety and quality improvement researchers.

A recent independent report into the quality of in-patient mental health services highlighted the need for further training and use of quality improvement in mental health services.²³ The Royal College of Psychiatrists also recognise this issue and have set up a working group to steer progress. The Institute for Healthcare Improvement (IHI) is working with a number of mental health trusts in the UK to build capacity and capability to implement quality improvement programming at scale. It is important to recognise the challenges in applying improvement science in different healthcare delivery models, targeting different health conditions that follow very different courses. For example, the challenge of adapting quality improvement methodology for long-term conditions (which is often the case in a mental health setting) as opposed to interventional healthcare where it is simpler to measure impact and change pre- and post-implementation.

We must also consider what drives authors to publish in specialty-specific rather than quality and safety journals. It may be the case that mental health professionals and academics are more motivated to do so. For example, they may have concerns about ensuring that their work has the greatest impact or be unaware of the alternative journals that are appropriate. If this is the case, then raising awareness across the scientific community will be vital for ensuring that authors submit their work to the most suitable outlet in terms of target audience and opportunities for translation. On a separate note, it is possible that work is already being submitted to quality and safety journals but is not being accepted. There may be factors around quality of work and acceptance processes that need to be considered. This could be due to differences in academic approach and levels of rigour across the disciplines.

These dilemmas have a number of potential implications for both research and practice, and recommendations for the future are required in order to increase and support integration between the two bodies of work. Both the quality and safety and mental health disciplines should be concerned by the clear disparities between their bodies of work. Existing in silos automatically forms a barrier to effective quality improvement and safer patient care. Mental health should form a core part of the quality and safety agenda and influence the ways in which it grows and develops as a discipline over time. The disparity may also prevent the academic expansion of the discipline as a science owing to a lack of incremental growth that is fully reflective of all relevant research on this complex topic area. It is also likely that the mental health community will miss out on full access to the knowledge that has been accumulated within the quality and safety discipline, which will therefore prevent optimal patient care.

Quality and safety journals should explicitly invite submissions from the mental health community in order to demonstrate their openness to work based in this setting. Simultaneously, mental health professionals and academics should be made aware of the different disciplines with which they could be integrating their work, and should not be penalised for publishing their work in quality and safety rather than specialty-specific journals. The long-term goal should be to normalise that quality and safety journals are a viable option for mental health professionals' academic work. This would involve incorporating and building on the present understanding of quality and safety that has already been developed more broadly, rather than scoping out a separate area of quality and safety that applies solely to the mental health setting. Patient safety and quality of care in mental health should not be existing in a world of its own but instead be a fully integrated component of the broader scientific discipline. It is the responsibility of members of both communities to ensure that this happens.

1.6.70 A Devil's dictionary for mental health

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Abstract

Clinical psychiatry, for all its emphasis on scientific rigour, is mediated mainly by words rather than by numbers. As with other professional areas, it has developed its own set of jargon words and phrases. Many of these are not the technical terms traditionally seen as jargon, but standard English words and phrases used in an idiosyncratic way. They therefore go unnoticed as jargon, while enfeebling our communications. I have used the template of Ambrose Bierce's *The Devil's Dictionary* to highlight some examples, with the aim of helping us all to talk, write and, perhaps, think more clearly.

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- *A Devil's dictionary for mental health*
 - *What is jargon?*
 - *My Devil's Dictionary*
 - *Casting out demons*

A review of health literacy suggests that patients often do not understand what doctors are trying to tell them – and, rather obviously, tells us that we should be more straightforward.¹ But it is not just us. The US boss of Pfizer has exasperated a British parliamentary committee with his obscure business jargon.² Farrington has highlighted the chasm between clinical and managerial language.³ Brian Lask pilloried the 'infestation' of family therapy publications with jargon, pomposity and impenetrability.⁴ And, although they were mainly addressing technical obfuscation, a pair of psychologists have trenchantly characterised much of the research communication in their field as 'bullshit'.⁵ They recommend translating 'others' procedures and outcomes in(to) ordinary language' to separate out any discernible content from the chaff of jargon.

But I am not here going to consider how we talk to patients or managers – or even researchers and academics. I have been thinking about how we talk to each other. It can be said that technical jargon does not matter inside a profession because each participant understands the words involved. It only becomes a problem when a professional tries to communicate with outsiders.⁶ But I think we may have a problem in day-to-day communication between those of us involved in mental health services. Over the past few years I have noticed the appearance of words and phrases which, because of their novelty and lack of definition, create real problems with communication. Many of these can be seen as 'weasel' words or phrases. They carry a covert meaning or overtones of meaning – or, sometimes, no meaning at all. They can be defined as 'something that someone says either to avoid answering a question clearly or to make someone believe something that is not true' (<http://dictionary.cambridge.org/dictionary/english/weasel-words>). Some are more technical, but all can be seen as forms of jargon owing to their characteristic use in medicine and psychiatry.

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What is jargon?

But what is jargon? The current version of the online Oxford Dictionary defines it as ‘Special words or expressions used by a profession or group that are difficult for others to understand’. It also tells us that it been with us for nearly 400 years, being derived from Late Middle English, originally in the sense of ‘twittering, chattering’, later ‘gibberish’ (www.oxforddictionaries.com/definition/english/jargon). Earlier dictionaries are more robust: ‘Barbarous or debased language: gibberish: speech full of technical terms etc’.⁷ Synonyms include slang, cant, idiom, argot, patter and gobbledegook (www.thesaurus.com/browse/jargon). Nobody much likes jargon, even though we all seem driven to use it.

At first hearing, such language may not sound at all technical. The words or phrases are drawn from day-to-day English, but, as we use them, their meaning starts to dissolve. They become the aforementioned weasel words because they are either novel or of broad, inclusive meaning. Those inside a profession find that they can use such language in an idiosyncratic way to preserve professional authority and power.⁸ If you cannot understand a discussion, you cannot participate. The young may feel that they have to use this language to be an authentic part of professional life. The old, consciously or unconsciously, realise that it can be used to conceal, confuse, stonewall and neuter objections or criticism. Moreover, jargon is mostly categorical and conceptual, not concrete and specific. It can present an intimidating facade behind which, if one takes the trouble to look, there is little of substance. Although unsavoury, is it not a victimless crime? Not according to the House of Commons Public Administration Select Committee. They felt that ‘the use of inaccurate, confusing or misleading official language which results in tangible harm, such as preventing individuals from receiving benefits or public services, should be regarded as maladministration’ (p. 16).⁶ Perhaps, then, we should take this issue more seriously.

One might, in an uncharitable moment, single out managers as the main offenders. However, I have heard colleagues from our sister professions talking impenetrably, as well as my fellow psychiatrists and, regrettably, myself. We are all guilty. So, I decided to round up some words and phrases that seem, to me, to be misused in this way. Some of these are specific to psychiatry and mental health, some are used across medicine. Some remain a local coinage, others have attained a more universal currency. We hear some in the front line, in wards and community teams, and others in committee rooms and consultation papers. Ambrose Bierce was a 19th-century journalist who was similarly intrigued by the ways in which language can be misused. I have used the template of his *The Devil’s Dictionary*⁹ to produce my own, somewhat scattershot, rogue’s gallery.

My Devil’s Dictionary

Acting out: an analytical term provoked by extravagant behaviour. Example: ‘the patient acted out by shouting in the lounge’. We are thereby relieved from the burden of considering the matter further.

Adherence (to medication, advice, etc.): a delusion, held by all doctors, most strongly by enthusiastic pharmacologists. For us, a mainstay of treatment. For our patients, an irritation best neglected. They are reluctant to reveal their disinterest, not wishing to distress their psychiatrist.

Acuity: a snappy euphemism which removes to arms-length the stress and risk of our under-resourced and risky services. Essential to reduce the anxiety felt in higher echelons of management.

Behavioural: a term used by those of us with no behavioural training, to describe behaviour of which we disapprove (*see* ‘Acting out’). Commonly combined with ‘just’ – ‘It’s just behavioural’. Usually paired with the helpful conclusion: ‘he/she is not for our service’.

Best evidence: the cracked and misty lens with which the one-eyed man navigates the country of the blind.

Care pathway: a sequence of ideal interventions (*see* ‘Best evidence’) for a model patient. Lengthy and complicated, so best illustrated on a sheet of A3 paper. The dogged patient may be said to trudge, march or run the gauntlet on such a trek.

Challenge: the presentation of the impossible and implausible as a bold plan. Example: the NHS Challenge – save £20 billion in the next 3 years while improving quality. You can then, subsequent to the inevitable failure of the plan, pillory those involved as being old-fashioned, inflexible, not trying hard enough ... according to taste.

Clinician: a drone, a harmless drudge who sees patients. They can apparently perform audit, supervision and research simultaneously (*see* ‘Job description’). Their ability to be in two places at once (*see* ‘Job description’) suggests that they would have been burned as witches in less scrupulously rational times.

Consultation: the practice of gathering views about a proposed change in a service. To complain that such views are subsequently ignored would be both harsh and naive (*see* ‘Listening event’ and ‘Efficiency saving’).

Cover: an illusion of doubles. It suggests that an overworked colleague will also do your work in your absence. Essential to maintain the appearance of an adequately staffed service.

Cut: the Voldemort word that must never, ever, be uttered (*see* ‘Efficiency saving’). Sometimes linked with ‘Transformation’.

Distress: a catch-all for every experience from mild anxiety to raging psychosis. As one gently minimises the more extreme and intractable varieties of experience, one can slyly insinuate that psychiatry is just a way to medicalise normal experience.

Efficiency saving: as the wolf to Red Riding Hood’s grandmother. Cloaked in two benign words with which none can take issue, it stalks our services – and suddenly they disappear. *See also* ‘Challenge’ and ‘Cut’.

Evidence: the single academic paper that supports one’s proposed course of action.

Holistic: a synonym for comprehensive, originating from the word ‘whole’. But where did the ‘W’ go? The spelling generates a spurious overtone of spirituality. Clearly not intentional; evidence of unconscious processes at work.

Hypothesis: a simple idea that leaves port to the sound of marching bands, but then founders on the rocks of bureaucracy or upon the craggy island of sober reflection.

Integration: the unicorn of service provision. Often spoken of but rarely seen. Some say they have seen it in Birmingham. Others say it is a mirage, glimpsed by the desperate.

Innovation: a novelty that attracts money.

Inappropriate (behaviour): rational behaviour of which we disapprove. Studiously neutral, it is commonly used in close proximity to an emphatic font. Example: ‘patients must *not* use our accident and emergency department inappropriately’.

Job description: a work of fantasy that masquerades as a workaday agenda. As nectar to the bee, it attracts naive applicants to your service while obscuring the inquisitive gaze of our College. Any subsequent disaffection can be met with the phrase ‘caveat emptor’.

Just: an excellent way to deny complexity. One can avoid the trouble of biopsychosocial formulation without admitting to idleness, ignorance or indifference. Example: ‘It’s just... behavioural/social/drug-induced...’.

Liaison: the assurance that someone will, at some time, communicate something to someone. Example: ‘Community mental health team to liaise with primary care’. A common parasite of care plans and strategy documents. The phrase ‘liaison psychiatry’ can be honourably exempted.

Listening event: a talking shop.

Metric: a swaggering and self-confident synonym for ‘number’, ‘figure’ or ‘statistic’. It ballasts with false weight the inadequate and corrupted data that leak out of our struggling services.

Medical model: a synonym for the crudely biological. Essential if one has a sketchy acquaintance with medicine but a sincere desire to damn psychiatry. Best bolstered by a quote from an antique textbook which few have ever read – or even heard of.

Mission statement: a haiku of the obvious. A way for those remote from the front line to sincerely avow the commitments of an organisation. Only misfits and malcontents could assert that such statements are banal and platitudinous.

New ways of working: the promise that clinical drones (see above) can become queen bees. The admirable and novel element is that psychiatrists should, as far as possible, steer well clear of patients.

Ongoing: a way to communicate to the naive reader an impression of dogged and ceaseless activity.

Paradigm shift: a bit of a change. It proclaims how different (and how much better) your pet idea (*see* ‘Hypothesis’) is from everything that has gone before. Such shifts promise seismic change but most, mysteriously, register zero on the Richter scale of life.

Prioritisation: cutting one service to provide another. One service dies and another is born. Disney’s circle of life.

Quality indicator: an easily measurable irrelevance.

Quality improvement: an unarguable good. It marvellously exempts management from any responsibility for the lack of armaments or ammunition and ‘empowers’ frontline platoons to sort out the subsequent carnage.

Research: the selection of an unrepresentative group of people, the provision of an unsustainable intervention and the careful selection of a rating cut-off point to show your intervention to its best advantage.

Recovery: a two-edged sword. To Tweedledum, an essential reorientation of services to patient priorities. To Tweedledee, a pretext for culling rehabilitation services.

Reconfiguration: another attempt to rearrange the chairs on the deck of the Titanic (*see* ‘Transformation’).

Significance (statistical) (*see also* ‘Research’): a simple number that lends colossal weight to negligible differences.

Signposting: a respectable way to rebuff those seeking help from our service. We direct the patient towards another step on their therapeutic pilgrimage (*see* ‘Care pathway’), braced by the pious assurance that another will meet their need. Much loved by hard-pressed commissioners for whom distance from our services is by far the best medicine.

Target: a worthy aim, applauded by all. The resources marshalled to meet it hyperperfuse privileged parts of the organisation but induce gangrene and necrosis elsewhere.

Triage: a battlefield technique to sift the doomed from the salvageable. Applied to civilians in peacetime when the money runs out.

Transformation: an ‘abracadabra’ word, the promise to turn an ugly duckling into a swan. This powerful spell can reduce resistance to modish technology or to shedding staff. Memories mysteriously fail when the new swan proves to be just another maladroit fowl.

Vision(s): in a patient, evidence of brain dysfunction. In ourselves, evidence of foresight, imagination and understanding.

Work-life balance (*see* ‘Job description’): an excellent way to communicate an uncomfortable truth. Example: ‘We know you need to work X+1 sessions to do the job, but we will only pay you for X sessions’. Dissimulation is charmingly paired with an expression of concern for one’s welfare.

Casting out demons

The American edition of the online Oxford Dictionary, somewhat uncharitably, states that weasel words are ‘intentionally ambiguous or misleading’.⁷ I am less judgemental and would suggest that they have a less deceitful function. They help us to feel more at ease with difficult truths we have both to confront ourselves and to present to others. However, although we may feel more comfortable, we will not be communicating as well as we could – and not thinking as clearly as we should. I would not go as far as the Local Government Association which was widely reported to have published, for its members, a list of banned words and phrases.¹⁰ After all, context is everything and, in spite of my accusations, some of these words may be used quite helpfully from time to time. But an awareness of them can serve us as the canary once served the coal miner: as a sign that something may not be quite right, and that we need to keep our wits about us. To the charge that I am a cynic, I confess that I do not have the stomach for it. I still shrink from the uncomfortable and cling to desperate and unreasonable hopes. I have been unable to yet become that paragon described inimitably by Bierce⁹ (p. 34) as ‘A blackguard whose faulty vision sees things as they are, not as they ought to be’.

This list is not comprehensive and is certainly not static. New weasel words will emerge as others wither and perish. Each of us can identify our own offenders. To pay attention to how we talk (and write) is not self-indulgent. It can help us to think more clearly, to communicate more meaningfully and to engage with reality rather than self-serving fantasy.

1.6.71 Personality disorder services in England: findings from a national survey

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Abstract

Aims and method We aimed to evaluate the availability and nature of services for people affected by personality disorder in England by conducting a survey of English National Health Service (NHS) mental health trusts and independent organisations.

Results In England, 84% of organisations reported having at least one dedicated personality disorder service. This represents a fivefold increase compared with a 2002 survey. However, only 55% of organisations reported that patients had equal access across localities to these dedicated services. Dedicated services commonly had good levels of service use and carer involvement, and engagement in education, research and training. However, a wider multidisciplinary team and a greater number of biopsychosocial interventions were available through generic services.

Clinical implications There has been a substantial increase in service provision for people affected by personality disorder, but continued variability in the availability of services is apparent and it remains unclear whether quality of care has improved.

Contents

- *Personality disorder services in England: findings from a national survey*
 - *Aims*
 - *Method*
 - * *Survey design*
 - * *Sample*
 - * *Procedure*
 - * *Survey questionnaire*

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- * *Data analysis*
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Personality disorder is a serious mental health condition affecting up to 52% of psychiatric out-patients and 70% of in-patients and forensic patients.¹⁻⁴ Given the significant public health implications associated with the disorder – including extensive use of healthcare resources, high rates of suicide and reduced life expectancy – effective treatment is a priority.⁵⁻⁸

In 2003, the National Institute for Mental Health England (NIMHE) published *Personality Disorder: No Longer a Diagnosis of Exclusion*, challenging the healthcare community to address shortcomings in the treatment of people with personality disorders.⁹ Citing a survey of English mental health trusts conducted in 2002, the paper brought to attention the variability in practice and highlighted institutionalised stigmatisation which explicitly barred patients with personality disorder from mainstream services. At that time, only 17% of trusts had a dedicated personality disorder service, 40% provided some level of service, 28% had no identified service, and 25% did not respond.⁹

The 2003 NIMHE publication⁹ set out broad principles for how personality disorder services should be developed, stipulating that they should be multidisciplinary, follow a hub-and-spoke model, accept the management of risk, use the care programme approach (CPA),¹⁰ offer specialist biopsychosocial interventions, deliver training and consultation, and support the development of patient networks. Similarly, the 2009 guidance on borderline personality disorder from the National Institute for Health and Care Excellence (NICE) specified that mental health trusts should develop specialist multidisciplinary teams and/or services for people with personality disorders.^{11,12} In 2011, a preliminary investigation at a regional level found that specialist service capacity for those with personality disorder was inadequate.¹³ There have been no systematic attempts at a national scale aimed at understanding how the evidence for the management of personality disorder is being applied or whether service availability has become more uniform.

In 2014, the National Personality Disorder Service Review Group was formed to evaluate the extent to which variable service availability affects those with personality disorder. The group used the vision of *Personality Disorder: No Longer a Diagnosis of Exclusion* as its benchmark. Through this lens, we sought to map the availability and nature of dedicated personality disorder services, and to compare these to the care for clients with personality disorder available through generic services. The group drew on a wide range of evidence to define the concept of a ‘dedicated personality disorder service’. This included the Delphi study of the 11 pilot personality disorder projects within the National Personality Disorder Programme.¹⁴ We considered a dedicated service as one which is explicitly designed to manage the care of individuals affected by personality disorder, as opposed to a generic service which might be considered a typical community mental health service. *Table 1* displays the characteristics hypothesised by the group to distinguish dedicated from generic services.

Summary of service characteristics

Dedicated personality disorder services	Generic services
Personality disorder inclusion	No diagnostic inclusion/exclusion criteria
Variable service availability	Ubiquitous
Personality disorder-specific interventions	Offer range of biopsychosocial interventions
Specialist team	Mainstream multidisciplinary team
Local, regional and national catchment	Local catchment
Variable tiers (T1 to T6)	Locally focused tiers (T2 to T3)
Target complexity	Range of complexity
Treatment, consultation and training	Treatment orientation
Variable framework (includes CPA)	Operate under CPA framework

CPA, care programme approach.

Aims

The primary aim of this study was to describe a number of organisations which provided care for those affected by personality disorder and whether this care was delivered through dedicated personality disorder services, generic services or both.

The secondary aim was to evaluate the provision of services for personality disorder along key quality indicators outlined by NICE and NIMHE,^{9,11,12} and explore any differences between dedicated and generic services. The quality indicators evaluated were: Is there a multidisciplinary team available? Is care managed under the CPA process? Are patients offered specific interventions for personality disorder within a biopsychosocial approach? Are services involved in education, training and research? What level of patient and carer involvement do services employ? What exclusion criteria, if any, are applied by services?

Method

Survey design

We conducted a cross-sectional survey of mental health organisations in England using a questionnaire designed for this study. Data were collected between January and June 2015 using an online survey tool (www.surveymonkey.com).

Sample

The sample included any English mental health National Health Service (NHS) trust or independent provider of mental healthcare to adults or young people. In 2015 there were 57 relevant English mental health NHS trusts and 10 independent service providers, all of whom were approached to participate in the survey.

Procedure

Letters were sent to the medical directors of each NHS mental health trust and the CEOs of the independent providers informing them of the survey and requesting the name of the individual who they considered to have the requisite knowledge to complete the survey. Once details of these individuals were obtained, letters were sent inviting them to take part. Non-responders were followed up at least twice where necessary, offering further information or support to complete the survey questionnaire.

Survey questionnaire

Following an analysis of available literature, the electronic survey was structured to address the primary and secondary aims of the project. Participants were asked to briefly describe their organisation (e.g. NHS or independent provider, geographical remit) and their own professional role. They were then given a brief definition of a dedicated personality disorder service and of a generic service and asked to indicate whether their organisation had services of each type and detailed questions about its characteristics. We requested details of a maximum of five dedicated personality disorder services per organisation.

Questions relating to service characteristics included service leadership, team make-up, service access, inclusion and exclusion criteria, care management framework, intervention availability, patient and carer involvement, and training, education and research activity. The survey took up to 45 minutes to complete and could be conducted electronically or with telephone support.

Data analysis

Data were downloaded from Survey Monkey and entered initially into Excel for checking and data cleaning, and transferred to STATA (version 11) for statistical analysis. To address the primary aim of the survey, the characteristics of services were summarised descriptively in order to build a picture of service availability and characteristics. The availability of biopsychosocial interventions was assessed by generating a score ranging from 0 to 100 based on the number of available interventions of each type, weighted to give equal consideration to each of the three domains. The availability of personality disorder-specific interventions was assessed by determining whether services offered psychological therapies developed specifically for personality disorder.¹⁵ The level of perceived patient and carer involvement was similarly analysed and scored from 0 to 100 based on the number of involvement activities for each service, with paid involvement double weighted.

To address the secondary aims of the survey, logistic and linear regression was used to evaluate the effect of service type (dedicated or generic) on professional diversity, exclusion criteria, CPA usage, biopsychosocial provision, patient and carer involvement, and training, education and research activity. Multilevel models, with a random effect for organisation, were used to adjust for the potential higher similarity between services within the same organisation than between services from different organisations. Robust standard errors were used for linear variables that did not conform to a normal distribution. Where significant differences between dedicated and generic services were found, multivariate models were used to adjust for the influence of potentially confounding service characteristics.

Results

Respondents

Of the 57 relevant English mental health NHS trusts, 52 responded (response rate 91%) and of the 10 independent service providers approached 4 responded (response rate 40%).

Primary study aim: availability of services for people with personality disorder

Of the 56 organisations that responded to the survey, 47 (84%) reported having at least one dedicated personality disorder service and 43 (77%) reported having both generic and dedicated services. The remaining 4 organisations (7%) stated that they did not have any generic services and that all services were specialist; all offered dedicated personality disorder services. Nine organisations (16%) did not have any dedicated personality disorder services, and all of these stated that their generic services catered to personality disorder. Patients were reported to have equal access to dedicated personality disorder services in 31 (55%) of the organisations surveyed.

The number of dedicated personality disorder services per organisation ranged from 1 to 5 (mean 1.7, s.d. = 1.1). Across the 52 English mental health NHS trusts, 71 dedicated personality disorder services and 48 generic services were described, a mean of 1.37 dedicated service per organisation (range 0–5). The four independent service providers described ten dedicated personality disorder services; a mean of 2.50 dedicated service per organisation (range 1–5). *Figure 1* compares the findings with the survey of 2002. To aid comparison, the independent sector organisations have been removed from the 2015 results so that only English NHS mental health trusts are referred to. Tables 2, 3, 4, 5 and 6 summarise the characteristics of the dedicated and generic services across all domains surveyed.

Summary of service and team characteristics

	Dedicated <i>n</i> (%)	Generic <i>n</i> (%)
Tier 1	9 (11)	
Tier 2	43 (53)	
Tier 3	45 (56)	
Tier 4	17 (21)	
Tier 5	11 (14)	
Tier 6	1 (1)	
Service level leadership		
Consultant clinical psychologist	26 (32)	6 (12)
Consultant medical psychotherapist	21 (26)	2 (4)
Consultant psychiatrist	13 (16)	25 (49)
Consultant nurse	8 (10)	0 (0)
Clinical psychologist	4 (5)	1 (2)
Consultant adult psychotherapist	3 (4)	0 (0)
Non-medical psychotherapist	1 (1)	0 (0)
Undisclosed	3 (4)	16 (31)
Other	2 (2)	2 (4)
Team constitution		

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Table 5 – continued from previous page

	Dedicated <i>n</i> (%)	Generic <i>n</i> (%)
Nurse	56 (69)	45 (88)
Consultant clinical psychologist	41 (51)	29 (57)
Trainee psychologist	37 (46)	40 (78)
Consultant medical psychotherapist	36 (44)	18 (35)
Clinical psychologist	32 (40)	44 (86)
Occupational therapist	32 (40)	42 (82)
Social worker	31 (38)	38 (75)
Non-medical psychotherapist	30 (37)	25 (49)
Peer worker	26 (32)	26 (51)
Consultant adult psychiatrist	25 (31)	45 (88)
Trainee psychiatrist	24 (30)	37 (73)
Consultant nurse	20 (25)	21 (41)
Advocate	13 (16)	16 (31)
Consultant forensic psychiatrist	10 (12)	14 (27)
Pharmacist	10 (12)	25 (49)
Forensic psychologist	6 (7)	14 (27)
Trainee medical psychotherapist	4 (5)	13 (25)
Probation professional	4 (5)	5 (10)
Consultant forensic psychologist	3 (4)	11 (22)
Dual diagnosis professional	2 (2)	17 (33)
Clinical management framework		
Under CPA	64 (79)	47 (92)
Not under CPA	9 (11)	2 (4)
Not applicable	8 (10)	6 (12)

CPA, care programme approach.

Summary of interventions offered

	Dedicated service	Generic service
Biological interventions, <i>n</i> (%)		
Medication management	42 (52)	46 (90)
Organic investigations	28 (35)	42 (82)
Physical healthcare interventions	27 (33)	44 (86)
MUS management	23 (28)	27 (53)
Psychological interventions, <i>n</i> (%)		
Psychoeducation	44 (54)	40 (78)
DBT	40 (49)	29 (57)
MBT	35 (43)	21 (41)
Psychodynamic	30 (37)	27 (53)
CBT	27 (33)	42 (82)
CAT	26 (32)	35 (69)
Art therapies	22 (27)	25 (49)
Therapeutic community	19 (23)	9 (18)
Family therapy	14 (17)	26 (51)
Motivational interviewing	14 (17)	22 (43)
SFT	10 (12)	23 (45)
STEPPS	8 (10)	8 (16)

continues on next page

Table 6 – continued from previous page

	Dedicated service	Generic service
Social interventions, <i>n</i> (%)		
Peer support	39 (48)	26 (51)
Vocational support	37 (46)	34 (67)
Occupational therapy	35 (43)	41 (80)
Social work	32 (40)	36 (71)
Housing support	31 (38)	37 (73)
Benefits advisory	28 (35)	28 (55)
Advocacy	25 (31)	31 (61)
Bio-psychosocial interventions rating, mean (s.d.)	3.4 (2.5)	6.3 (2.0)

CAT, cognitive–analytic therapy; CBT, cognitive–behavioural therapy; DBT, dialectical behaviour therapy; MBT, mentalisation-based therapy; MUS, medically unexplained symptoms; SFT, schema-focused therapy; STEPPS, systems training for emotional predictability and problem solving.

Summary of development activities

Integrated development activities	Dedicated <i>n</i> (%)	Generic <i>n</i> (%)
Training	75 (93)	27 (53)
Education	66 (81)	22 (43)
Research	56 (69)	18 (35)
Training + education + research	48 (59)	13 (25)

Summary of patient and carer involvement

	Paid, <i>n</i> (%)	Voluntary, <i>n</i> (%)		
Patient				
Service development	25 (31)	24 (47)	33 (41)	23 (45)
Education and training	25 (31)	19 (37)	26 (32)	20 (39)
Treatment	14 (17)	11 (19)	16 (20)	13 (25)
Service delivery	14 (17)	5 (10)	20 (25)	16 (31)
Leadership	11 (14)	11 (22)	14 (17)	10 (20)
Care planning	7 (9)	8 (16)	19 (23)	13 (25)
None	18 (22)	19 (37)	9 (11)	20 (39)
Carer				
Service development	1 (1)	1 (2)	11 (14)	11 (22)
Education and training	3 (4)	4 (8)	5 (6)	7 (14)
Service delivery	2 (2)	3 (6)	3 (4)	7 (14)
Care planning	0 (0)	3 (6)	10 (12)	9 (18)
Treatment	0 (0)	2 (4)	2 (2)	5 (10)
Leadership	3 (4)	2 (4)	2 (2)	3 (6)
None	14 (17)	39 (76)	9 (11)	32 (63)
	Dedicated	Generic		
Patient and carer involvement rating, mean (s.d.)	12.4 (12.3)	6.3 (5.6)		

Service level exclusion

Criteria	Dedicated <i>n</i> (%)	Generic <i>n</i> (%)
Uncontrolled substance misuse	43 (53)	10 (20)
Active risk to others	19 (23)	2 (4)
Ability to engage	16 (20)	4 (8)
Comorbid psychotic disorder	14 (17)	1 (2)
Developmental disorder	12 (15)	1 (2)
Gender	11 (14)	1 (2)
Forensic history	6 (7)	1 (2)
Comorbid affective disorder	6 (7)	1 (2)
Active risk to self	4 (5)	2 (4)
Past risk to others	2 (2)	0 (0)
Past risk to self	0 (0)	0 (0)
Prescribed medication	0 (0)	0 (0)
None	18 (22)	35 (69)
Others or not applicable	7 (9)	6 (12)

Secondary study aims: quality indicators of available services

1. Is there a multidisciplinary team available?

Across services, teams varied widely in their multi-disciplinary composition (*Table 2*). Within services, team make-up was significantly less diverse in dedicated than in generic services, with the latter utilising almost twice as many different types of professional on average (dedicated personality disorder services mean 5.7, s.d. = 3.0; generic services mean 10.5, s.d. = 5.1 ($= 4.85$, 95% CI 6.37 to 3.32, $P < 0.01$)). Dedicated services remained less professionally diverse than generic services after adjusting for the range of biopsychosocial interventions available, the provision of personality disorder-specific interventions, and the profession of the service lead ($= 3.14$, 95% CI 4.46 to 1.82, $P < 0.01$). This suggests that the less diverse workforce in dedicated services was not simply due to providing a more focused range of interventions.

2. Is care managed under the CPA process?

Almost all services used the CPA as their management framework. There was no difference between dedicated and generic services in CPA usage (odds ratio (OR) = 0.22, 95% CI 0.04 to 1.47, $P = 0.12$).

3. Are patients offered specific interventions for personality disorder within a biopsychosocial approach?

Across services, there was a fairly wide availability of a number of different biological, psychological and social interventions. *Table 3* includes the mean biopsychosocial ratings stratified by service type. Generic services had significantly higher biopsychosocial ratings than dedicated ones, indicating a greater availability and diversity of interventions ($= 3.02$, 95% CI 2.32 to 3.73, $P < 0.01$). However, services led by medics offered a greater range of interventions than those led by other professionals ($= 1.09$, 95% CI 0.97 to 2.84, $P < 0.01$), as did services with a more diverse professional make-up ($= 0.38$, 95% CI 0.32 to 0.45, $P < 0.01$). Biopsychosocial intervention provision did not differ between dedicated and generic services after adjusting for these factors ($= 0.69$, 95% CI 0.29 to 1.68, $P = 0.17$). Contrary to hypothesis, the availability of interventions developed specifically for personality disorder (such as dialectical behaviour therapy (DBT), mentalisation-based therapy (MBT), schema-focused therapy (SFT) and systems training for emotional predictability and problem solving (STEPPS)) did not differ significantly between dedicated and generic services (OR = 0.91, 95% CI 0.37 to 2.21, $P = 0.83$).

4. Are services involved in education, training and research?

Most services were involved in at least one of these activities (*Table 4*). The rates of participation in these activities for dedicated services were approximately twice those of generic services, and dedicated services were significantly more likely than generic services to be involved in all three of these activities (i.e. education, training and research) (OR = 6.18, 95% CI 2.29 to 16.69, $P < 0.01$). This difference remained significant after adjusting for the profession of the service lead and for the professional diversity of the team (OR = 31.67, 95% CI 4.26 to 235.5, $P < 0.01$).

5. What level of patient and carer involvement do services employ?

Table 5 contains the mean patient and carer ratings stratified by service type. Very few services had no patient or carer involvement, and the odds of having any involvement activity did not differ between dedicated and generic services (OR = 1.17, 95% CI 0.42 to 3.22, $P = 0.77$). However, dedicated services had significantly higher patient and carer involvement ratings than generic ones, indicating involvement in a greater number of service development, care planning, service delivery, training and leadership activities (= 6.29, 95% CI 3.03 to 9.55, $P < 0.01$). This difference remained significant after adjusting for the profession of the service lead and for the professional diversity of the team (= 9.76, 95% CI 3.90 to 15.62, $P < 0.01$).

6. What exclusion criteria, if any, are applied by services?

No services excluded individuals on the basis of a diagnosis of personality disorder. Across both dedicated and generic services, the most common exclusion criterion was uncontrolled substance misuse, followed by active risk to others (*Table 6*). Almost half of services (43%) had no exclusion criteria. Dedicated services were significantly more likely than generic ones to have exclusion criteria (OR = 10.95, 95% CI 3.31 to 36.19, $P < 0.01$). This difference remained significant after adjusting for the profession of the service lead and for the professional diversity of the team (OR = 5.02, 95% CI 1.24 to 20.35, $P = 0.02$).

Discussion

This national survey was the first of its kind and captured data provided by 56 relevant mental health organisations in England. With a response rate of 91% for English mental health NHS trusts, and a sample of independent service providers, we can be confident the survey is representative of personality disorder provision in England.

The majority of organisations described both dedicated personality disorder services (84%) and generic services (91%), and in organisations with no dedicated services all provision for personality disorder was through a generic service. This quantifies the progress made in this area since 2002 and points to a fivefold increase in organisations providing dedicated personality disorder services.⁹

This represents substantial progress in a decade in which the economic landscape has been challenging. Yet, while on this measure we can see substantial progress at an organisational level, the survey indicates a worrying level of variability at a local level, with only 55% ($n = 31$) of organisations indicating equal access to the dedicated services they provide.

The 2003 NIMHE publication formally introduced the concept of dedicated personality disorder service as distinguished from generic service, and this distinction has been further developed in the current paper.⁹ We had *a priori* assumptions about the nature of dedicated and generic services (*Table 1*), and this survey allows a more detailed conceptual analysis. The survey methodology steered respondents to consider the concept of dedicated *v.* generic services. Analysis of the descriptive and statistical differences between the 81 dedicated and 51 generic services allows us to draw some conclusions about these two types of service provision. For instance, we found that generic services draw from a wide range of professional disciplines, which is in line with their broader remit. Seemingly, dedicated services draw from a more restricted range of professional disciplines; this supports the notion that they are specialist, niche services.

Contrary to our *a priori* hypothesis, dedicated services were no more likely to provide personality disorder-specific interventions when compared with generic services. Furthermore, generic services provide a significantly wider range of biopsychosocial interventions than dedicated ones, although there was some suggestion that this was influenced by their employment of a significantly more diverse workforce and by their higher rates of medical professional leadership. The accessibility of these interventions and the quality of their delivery are unknown; however, NICE guidance stipulates that specialist interventions are best delivered by specialist services.¹¹

The delivery of developmental activities is a clear priority for dedicated services, with almost all involved in training, and significantly more dedicated than generic services involved, indicating that they deliver both training and education and research. This is in keeping with both the 2003 NIMHE publication and NICE guidance.^{9,11,12} Patient and carer involvement is also prioritised by dedicated services, with patients and carers involved in significantly more service development, management and delivery activities than those in generic services. Dedicated services appear to show greater selectivity in patient choice than generic ones, as significantly more operate with exclusion criteria. Given that impulsivity is a diagnostic criterion for borderline and dissocial personality disorder, it is noteworthy that active risk to others (23%) and substance misuse (53%) were so widely quoted as exclusion criteria for dedicated personality disorder services.

Limitations

The response rate for the independent providers should be treated with caution as it is subject to selection bias. Responses were self-reported and there may have been variation in the interpretation of what constituted a dedicated personality disorder service.

In the comparisons made with generic services, the respondents were asked to provide an overview of all of the generic services within their organisation. Although this was pragmatically necessary, given the large numbers of generic services within any organisation, this approach requires the reader to consider the comparisons with appropriate caution. In particular, the findings which relate to the personality disorder-specific interventions and range of staff within the multidisciplinary team will be skewed by this methodology.

While this survey is able to give a good organisational-level description of service availability, mapping the local provision is achieved to a limited degree. Perhaps the most important consideration is that the indicators used in this survey to consider the quality can only provide a broad brush-stroke indication, owing to necessary methodological trade-offs for pragmatic purposes.

Understanding the consistency with which individual patients and carers can expect adherence to best practice and the timeliness of the interventions offered is beyond the scope of this survey. We believe this body of work begins to elucidate the questions which need to be considered, but it is a long way from achieving that. Indeed, the largest limitation of this work is that at best it provides a broad overview of provision. To properly understand what is actually delivered to those in need will require a more systematic and sustained effort to describe quality standards and ensure, perhaps through accreditation, that best practice is being followed.

Further developments

This paper charts the most systematic attempt to date at mapping the provision of care across England for those affected by personality disorder. What is clear is that the past decade or so has seen considerable progress in providing a service for this range of disorders. Despite this progress, data presented here provide evidence that there remains continued exclusion, variability of practice and inconsistencies in the availability of services.

The current NICE guidance, in step with the evidence base, supports the provision of a range of cost-effective interventions and the establishment of specialist services from which to deliver them. The initial offering presented here lends weight to the call for the establishment of authoritative commissioning guidance and service standards to ensure that patients and carers have access to the care that they need.

The National Personality Disorder Service Review Group work stream was seeded by a small project funding initiative through the Royal College of Psychiatrists' Faculty of General Adult Psychiatry in 2014 and West London Mental

Health Trust Research and Development. A multidisciplinary group was formed with representations from psychiatry, psychology, psychotherapy and expertise through lived experience of personality disorder. At various stages through the project the affiliates included: the Faculty of General Adult Psychiatry, West London Mental Health Trust Research and Development, Informed Thinking, The Medway Engagement Group and Network (MEGAN) and the Imperial College Centre for Mental Health. The project was granted approval as a service evaluation through the audit department of West London Mental Health Trust.

1.6.72 Perceptions and knowledge of antipsychotics among mental health professionals and patients

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Abstract

Aims and method To assess the patients' most influential concerns regarding long-acting injectable antipsychotics (LAIs) and mental health professionals' preconceptions about these concerns. For both groups, to assess the level of knowledge about LAIs. This cross-sectional study used semi-structured interviews of patients with schizophrenia or schizoaffective disorder ($n = 164$), nurses ($n = 43$) and physicians ($n = 20$).

Results The mental health professionals overestimated many of the patients' fears of LAIs, and the expressed fears exceeded the actual experiences of patients already on LAIs. Acceptance to switch to LAIs was associated with shorter time from diagnosis. Nurses and patients disclosed limited knowledge of antipsychotics.

Clinical implications Physicians and nurses should aim to identify the individual patient's concerns about LAIs in the discussion about choice of antipsychotic treatment early in the course of illness.

Contents

- *Perceptions and knowledge of antipsychotics among mental health professionals and patients*
 - *Method*
 - * *Design*
 - * *Participants and setting*
 - * *Questionnaires*
 - * *Statistical analysis*

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 - * *Inclusion and exclusion of study participants*
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Adherence to antipsychotic treatment is a major challenge and an important predictor of the outcome in patients with schizophrenia and schizoaffective disorder.¹ The risks of relapse and admission to hospital increase immediately after discontinuation, even with small treatment gaps.^{2–5} With oral antipsychotics, such gaps often go undetected until relapse – an issue that can be overcome by use of long-acting injectable antipsychotics (LAIs).⁵ There is growing evidence that, compared with oral treatment, LAIs reduce the risk of discontinuation, relapse and hospital admission.⁶ Furthermore, owing to superior pharmacokinetics, the use of LAIs is considered to increase the likelihood of finding the lowest effective dose, which subsequently reduces the risk of side-effects.^{7,8}

Despite the identified advantages, LAIs are not used as widely as might be expected. The prescription frequency varies greatly between countries,⁹ indicating that factors other than the patient's attitude influence the utilisation rate. While patients' attitudes towards LAIs become more positive with increased knowledge and experience of the treatment,¹⁰ clinicians often overestimate patients' resistance against LAIs, anticipating that they will be concerned about the injection procedure.^{10–12} This impedes so-called shared decision-making, an approach with the potential to increase adherence.¹³ Patients are frequently excluded from the discussion about the choice of antipsychotic formulation,¹⁴ and one reason may be resistance arising from mental health professionals' preconceptions.

We aimed to investigate the specific concerns that affect patients' perceptions of LAIs, and to what extent mental health professionals' preconceptions agree with these perceptions. Furthermore, we aimed to identify knowledge gaps about antipsychotic formulations among both patients and mental health professionals.

Method

Design

We conducted a cross-sectional study of mental health professionals' and patients' perceptions and knowledge regarding antipsychotic treatment in a psychiatry catchment area in Stockholm, Sweden, operated by PRIMA Adult Psychiatry. Data were collected in semi-structured interviews performed by a research nurse (L.C.) at the participant's home clinic between January and October 2015. The participants were enrolled upon giving written informed consent. The study was approved by the regional ethical review board in Stockholm (ref. 2015/47-31).

Participants and setting

We studied three categories of participants: (a) patients on LAIs; (b) patients on oral treatment; (c) mental health professionals, including physicians and nurses.

We identified all patients with schizophrenia or schizoaffective disorder. Patients with no medical treatment or with previous but discontinued LAIs, as well as patients who had been on LAIs >5 years were excluded. Other exclusion criteria were language barriers (i.e. need of interpreter in consultations), cognitive impairment and severe autism spectrum disorders. We collected information on patients' age, gender, years with diagnosis, marital status, number of children, highest achieved academic degree and occupation. The patients on oral medication were block randomised on diagnosis (schizophrenia/schizoaffective disorder), gender and age to two separate arms. The first group was included in this study to represent those on oral medication, while the second group did not participate and will act as controls in a future intervention study.

All physicians and nurses working in the psychosis sector of PRIMA were asked to participate. We recorded age, gender and extent of experience within the psychiatric field.

Questionnaires

We conducted semi-structured interviews based on different questionnaires specific to each participant category and designed for the present study. Participants graded their potential concerns with a mark on a continuous 100 mm scale ranging from 0 ('Does not affect at all') to 100 ('Decisive to decline LAIs'). Potential concerns included in the questionnaire were pain at administration, possible observation time of 3h, embarrassment at administration, restricted autonomy, feeling of being controlled, being obliged to show up at the clinic regularly, lack of ability to decide when medication is administered, and stigmatisation. The questions were designed to address the participant appropriately, for example, mental health professionals: 'To what extent do you think fear of pain affects the patients' perception?'; patients on oral medication: 'To what extent does fear of pain affect your perception?'; and patients on LAIs: 'To what extent does pain affect your perception?'. The investigated concerns were predefined based on a literature review and clinical experience.^{10,15,16}

Questions about knowledge of the differences between LAIs and oral treatment regarding achieved plasma concentration, side-effects and risk of readmission to hospital were identical for all participants and included pre-specified nominal options. In questions regarding clinical approach among mental health professionals, participants were asked to state items freely. Physicians stated their most common reasons for prescribing LAIs, and their strategies to encourage patients to consider LAIs. Furthermore, they were asked to speculate what the patients' key reasons for accepting LAIs are. These answers were assessed using thematic analysis after the study was complete.

Nurses were asked whether they tried to influence patients' and physicians' choice of formulation (yes/no). Patients on oral medication were asked whether they had previously been offered LAIs and whether they knew of the features of being on LAIs. Finally, at the end of the interview, all patients were asked about their perspective on switching formulation (positive/negative).

Statistical analysis

Anonymised data were analysed using Prism 5.03 for Windows. Sample comparisons were made using Fisher's exact test for categorical variables (gender, positive/negative towards switching to LAI). The Mann-Whitney [*U*-test or Wilcoxon matched-pairs test was used for continuous variables (age, illness duration, mental health professionals' experience and questionnaire responses on a 100 mm scale), where appropriate.

Results

Inclusion and exclusion of study participants

We identified 875 patients in the catchment area with a diagnosis of either schizophrenia or schizoaffective disorder; 341 patients were currently being treated with LAIs (39%). Of the 875 patients, 302 met our inclusion criteria. Finally, 101 patients on oral treatment and 63 on LAIs participated in the study. The reasons for not participating are presented in *Fig. 1*. All 21 physicians and 46 nurses working in the psychosis sector of PRIMA were asked to participate; 1 physician and 3 nurses declined owing to lack of time.

Participant characteristics

There were no statistical differences regarding characteristics between patients on LAIs and patients on oral medication, except that patients on oral medication were more likely to have achieved a higher academic degree (*Table 1*). The median age of the 20 physicians was 47 years (range 34–69) and 45% were women. The median number of completed years in the psychiatric field was 6.5 years (range 0–20). The 43 nurses had a median age of 51 years (range 27–67) and 81% were women. The median length of experience in the psychiatric field was 12 years (range 0–36), and 51% were specialists in psychiatric care.

Characteristics of interviewed patients

Characteristics	Patients on oral treatment (<i>n</i> = 101)	Patients on LAIs (<i>n</i> = 63)	<i>P</i>
Females, <i>n</i> (%)	46 (46)	26 (41)	n.s.
Age, years: median (range)	50 (21–84)	51 (24–74)	n.s.
Diagnosis, <i>n</i> (%)			
Schizophrenia	71 (70)	41 (65)	n.s.
Schizoaffective disorder	30 (30)	22 (35)	n.s.
Duration of illness, years: median (range)	21 (1–55)	18 (1–45)	n.s.
Highest education, <i>n</i> (%)			
Elementary school	21 (21)	24 (38)	0.020
High school	49 (49)	31 (49)	n.s.
University	31 (31)	8 (13)	0.0086
Employed, <i>n</i> (%)	19 (19)	7 (11)	n.s.
Marital status, <i>n</i> (%)			
Single	71 (70)	53 (84)	n.s.
Living independently	8 (8)	2 (3)	n.s.
Married/cohabiting	22 (22)	8 (13)	n.s.
Underage children living at home, <i>n</i> (%)	8 (8)	3 (5)	n.s.

LAIs, long-acting injectable antipsychotics; n.s., not significant.

Perceptions of LAI antipsychotics

Comparing patients on oral antipsychotics *v.* patients on LAIs, fears exceeded the actual experiences for all factors examined (Table 2, online Fig. DS1), but fear was only statistically significant for the concerns of being tied to the clinic (62 *v.* 28, $P = 0.018$) and loss of decision-making regarding when to take the medicine (45 *v.* 8, $P = 0.001$). Overall, patients' results tended to be polarised to either end of the 100 mm scale whereas the mental health professionals' results were more centred in their distribution.

Estimated and actual fears as well as experienced factors affecting the decision to decline long-acting injectable antipsychotics (LAIs)

Factors	Mental health professionals ($n = 63$)	Patients on oral treatment ($n = 101$)	P	Patients on LAIs ($n = 63$)	* P * a
Pain at the injection site	50.5 (11–95)	28 (0–100)	0.001	12 (0–100)	0.21
Being regularly tied to a clinic	49 (5–98)	62 (0–100)	0.24	28 (0–99)	0.018
Observation time at the clinic after one certain type of LAI	64 (4–98)	89 (0–100)	<0.0001	67 (3–98)	0.23
Embarrassment of having an injection	41 (1–93)	12 (0–98)	<0.0001	17 (0–100)	0.11
Reduction in autonomy	62 (5–93)	30 (0–98)	0.0025	10 (0–100)	0.18
Loss of ability to decide when to take the medication	56 (4–95)	45 (0–100)	0.13	8 (0–98)	0.001
Feeling of being controlled	56 (3–94)	25 (0–100)	0.013	13 (0–100)	0.58
Perceptions of stigma of being on LAI	51 (4–88)	17 (0–100)	0.0004	11 (0–100)	0.63

The questions were presented orally and adapted based on the participant category, *i.e.* mental health professionals, patients on oral treatment and patients on LAIs.

Patients on oral treatment *v.* patients on LAIs.

Only the 7 patients on long-acting injectable olanzapine who had experienced a 3 h observation time were included.

Patients on LAIs were asked to recall their fears before switching from oral treatment. They graded their recalled fears higher than the actual experiences regarding all factors except for observation time (online Table DS1). The differences were small, but reached statistical significance for pain (24 *v.* 12, $P < 0.0001$), embarrassment (9 *v.* 7, $P = 0.0006$), reduction in autonomy (13 *v.* 10, $P = 0.0027$) and loss of ability to decide when to take the medicine (14 *v.* 8, $P = 0.019$). Finally, there were no statistically significant differences between the graded fears of patients on oral treatment *v.* recalled fears in patients on LAIs (data not shown).

Mental health professionals overestimated the concerns of orally treated patients regarding feared pain (51 *v.* 28, $P = 0.001$), embarrassment (41 *v.* 12, $P < 0.0001$), reduction in autonomy (62 *v.* 30, $P = 0.0025$), feeling of being controlled (56 *v.* 25, $P = 0.013$), and stigma (51 *v.* 17, $P = 0.0004$; Table 2, online Fig. DS1). Conversely, they underestimated the patients' concerns regarding the 3h observation time required after injection of LAI olanzapine (64 *v.* 89, $P < 0.0001$).

Knowledge of oral and LAI antipsychotics

All physicians (100%) claimed that LAIs are associated with a more stable plasma concentration than oral treatment (Table 3). For nurses, patients on oral treatment and patients on LAIs, the corresponding proportions were 56%, 16% and 22%, respectively.

Mental health professionals' and patients' knowledge about oral v. long-acting injectable antipsychotics (LAIs) regarding plasma concentration, side-effects and frequency of readmission to hospital

Topic	Physicians (n = 20)	Nurses (n = 43)	Patients on oral treatment (n = 101)	Patients on LAIs (n = 63)
Plasma concentration, n (%)				
Lower/more stable with LAIs	20 (100)	24 (56)	16 (16)	14 (22)
Equal	0 (0)	11 (26)	23 (23)	20 (32)
Lower/more stable with oral	0 (0)	4 (9)	41 (41)	20 (32)
Don't know	0 (0)	4 (9)	21 (21)	9 (14)
Side-effects, n (%)				
Less with LAIs	15 (75)	12 (28)	18 (18)	27 (43)
Equal	3 (15)	17 (40)	25 (25)	19 (30)
Less with oral	1 (5)	11 (26)	45 (45)	11 (17)
Don't know	1 (5)	3 (7)	13 (13)	6 (10)
Risk of rehospitalisation, n (%)				
Less with LAIs	19 (95)	37 (86)	21 (21)	23 (36)
Equal	0 (0)	3 (7)	40 (40)	20 (32)
Less with oral	1 (5)	2 (5)	15 (15)	5 (8)
Don't know	0 (0)	1 (2)	25 (25)	15 (24)

Eligible answers were presented as pre-specified nominal options.

Of physicians, 90% stated that LAIs are superior or equal to oral treatment concerning side-effects. For nurses, patients on oral treatment and patients on LAIs, the corresponding proportions were 68%, 43% and 73%, respectively.

All physicians but one (95%) and 86% of nurses claimed that LAIs reduce the risk of readmission to hospital, while 21% of patients with oral treatment and 36% of patients on LAIs claimed LAIs to be superior in this matter.

Clinical approach to LAIs among mental health professionals

Poor adherence, limited insight and multiple relapses were the most common reasons for prescribing LAIs, mentioned by 80% of physicians. However, one-fourth considered LAIs an option even early in the disease course. Their strategies to encourage patients to consider LAIs were to inform them about the advantages of the formulation (65%) and about the risks and consequences of treatment discontinuation (40%). Exploring patients' fears was a strategy mentioned by 20% of physicians.

Half of physicians believed that not having to remember to take pills was the key reason for patients to accept LAIs. Other factors mentioned were good insight (40%) and that LAIs are associated with lower frequency of relapse (20%).

Of nurses, 31 (72%) replied that they actively tried to influence the patients' attitude towards one or the other formulation, and 29 (67%) actively tried to influence the physician's decision.

Patients' perspective on switching

Almost half of the patients on oral treatment (41%) declared that they had little or no knowledge of LAIs. At the end of the interview, they were asked whether they would switch to LAIs if offered by their treating physician. While 78 (77%) said no and three (3%) could not decide, 20 (20%) declared that they would agree to switch if offered such an option. The patients willing to switch had fewer years since diagnosis than those who were reluctant (12 v. 24, $P = 0.0013$; online Fig. DS2). Furthermore, the proportion of women was higher in the positive group (75% v. 44%, odds ratio (OR) = 3.9, $P = 0.023$). They considered pain (7 v. 40, $P = 0.020$), being tied to the clinic (26 v. 70, $P = 0.017$), reduction in autonomy (9 v. 30, $P = 0.034$) and stigma (6 v. 27, $P = 0.035$) to be less important issues than did the patients who were reluctant to switch to LAIs.

A total of 21 (33%) patients on LAIs would switch to oral treatment if they were offered it, 1 (1.6%) could not decide and 41 (65%) preferred to continue with LAIs. There were no statistically significant differences between patients who were positive v. patients who were negative about switching formulation with regard to age, number of years with diagnosis or gender. Those who opted to stay on LAIs were less concerned with the lack of autonomy (7 v. 40, $P = 0.015$) and the feeling of being controlled (9 v. 50, $P = 0.0011$). They also gave more correct answers regarding differences in side-effects between oral formulations and LAIs (85% v. 52%, OR = 5.3, $P = 0.012$).

Discussion

In this study, we found that patients' concerns with LAIs were minor except when considering observation time and being tied to the clinic, and that there was a mismatch in the assessment of specific concerns between the patients and the mental health professionals. We identified important knowledge gaps among patients and nurses. As many as one-fifth of the patients on oral medications were willing to switch to LAIs; these potential switchers were more recently diagnosed than those who were reluctant.

The patients on oral treatment were most concerned about observation time post-injection and about being tied to the clinic when asked about LAIs. This indicates that they valued their time and that practical issues surpassed in significance emotional ones such as stigma, a feeling of being controlled and embarrassment. All fears expressed by patients on oral treatment exceeded the actual experiences of patients on LAIs. This could be a result of selection bias, in that patients on LAIs were less concerned even before accepting LAI treatment. However, since patients on LAIs were speaking from experience, this difference may also reflect that these issues had a lower impact than expected once the patients had been started on LAIs. That the recalled concerns pre-LAIs were similar to the levels of concern among those still on oral treatment also supports this hypothesis.

Mental health professionals tended to answer questions by placing the indicator centrally on the 100 mm scale, which may reflect uncertainty as they were just estimating the patients' experiences. The patients' answers, on the other hand, were polarised, indicating that their opinions were more set. Patients also graded some factors distinctly low and others distinctly high. In light of this, physicians should be encouraged to learn more about the individual patient's concerns. Only 20% of physicians reported that they used this strategy when discussing treatment regimens.

According to previous studies, physicians' knowledge regarding antipsychotic formulations varies.^{16,17} Physicians in the current study showed very good knowledge. However, a significant proportion of the interviewed nurses had knowledge gaps concerning some of the advantages of LAIs. This could have a negative impact on the patient's attitude towards LAIs, especially as the majority of nurses claimed that they actively tried to influence both doctors and patients in the discussion on treatment choices. Patients already on LAIs had significantly better knowledge about the reduced side-effects with LAIs than patients on oral treatment. This most likely reflects their own experiences. It could also be an effect of information provided by mental health professionals – information many patients on oral treatment reported as lacking. This is of concern, as we know that patients' attitudes towards LAIs are likely to become more positive with increased knowledge and experience of the treatment.¹⁰ The physicians' observed reluctance to bring up the topic may be due to their anticipation that the patients are unlikely to accept the offered LAI. However, keeping the patients uninformed makes shared decision-making impossible.¹⁵

The majority of the patients on LAIs chose to keep this formulation and as many as 20% of the patients on oral treatment were willing to use LAIs. This is in line with a previous study in which 16% were positive towards a formulation

switch.¹⁴ This also supports the hypothesis that the use of LAIs could be limited by factors other than rejection by the patients.¹² Some physicians claimed that they offered LAIs early in the disease course, but their most common reasons for prescribing LAIs were poor adherence to oral medication and recurring relapses. Previous studies also report non-adherence^{16,17} and multiple relapses¹⁷ as key criteria for prescribing LAIs. This may be unfortunate as longer illness duration was associated with being reluctant to switch. Instead, this motivates a discussion of LAIs early on in the course of illness, especially as there is cumulative evidence that the use of LAIs as early as after the first admission to hospital decreases the risk of treatment discontinuation, relapse and readmission.^{4,5,18}

Limitations

Our study has several limitations. Not all patients in the targeted study population were included, and some patients could not be reached or were not present to complete the questionnaire. Some were only scheduled for visits once per calendar year, while the study was limited to 10 months. It is possible that patients were either too ill to present themselves or were stable enough to postpone yearly visits. The patients on LAIs were asked to declare their perceptions prior to starting on LAIs, which introduced recall bias. However, we excluded all patients on LAIs 5 years, reducing the effect of this bias. Finally, patients on LAIs are indisputably a selection of patients who have once accepted that formulation. However, the lack of significant differences between the graded fears of patients on oral treatment compared with recalled fears in patients with LAIs may indicate that this selection bias is of minor concern. A strength of this study was that all interviews were performed by the same person (L.C.), securing consistency across interviews.

Clinical implications

In conclusion, physicians should aim to set aside their own preconceptions and instead make time to identify the individual's specific fears regarding LAIs, preferably early in the course of the illness. In addition, there is room for improvement regarding patients' knowledge of antipsychotic formulations. Adequate education would be of value to strengthen nurses' knowledge about LAIs. Finally, there is room for improvement regarding patients' knowledge of antipsychotic formulations.

1.6.73 Mental capacity legislation in the UK: systematic review of the experiences of adults lacking capacity and their carers

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Abstract

Aims and method Capacity legislation in the UK allows substitute decision-making for adults lacking capacity. Research has explored the experiences of such adults and their carers in relation to the Adults with Incapacity (Scotland) Act 2000, and the Mental Capacity Act 2005 in England and Wales. A systematic review of the relevant research was performed using a framework method.

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Results The legislation provided mechanisms for substitute decision-making which were seen as useful, but there were negative experiences. Decision-making did not always seem to follow the legislative principles. Awareness of the legislation was limited. Most research was qualitative and some was of low methodological quality. Data were too heterogeneous to allow comparisons between English and Scottish law.

Clinical implications Capacity legislation was generally viewed positively. However, some experiences were perceived negatively, and the potential benefits of the legislation were not always utilised.

Contents

- *Mental capacity legislation in the UK: systematic review of the experiences of adults lacking capacity and their carers*
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In law, mental capacity is the ability to make decisions, and it relies on a number of attributes such as comprehension and reasoning.¹ Capacity legislation exists to allow legally valid decisions to be made about finances, welfare or medical treatment where the individual lacks mental capacity. In Scotland this legislation exists as the Adults with Incapacity (Scotland) Act 2000 (AWIA) and in England and Wales as the Mental Capacity Act 2005 (MCA). Northern Ireland has recently adopted the Mental Capacity Act (Northern Ireland) 2016.

Prior to the introduction of legislation, English capacity law was criticised by the Law Commission as being unsystematic and out of step with disability rights.² The Scottish Law Commission described Scottish capacity law as fragmented and archaic.³ The AWIA and the MCA were introduced to reform capacity law, and are similar in many respects. They set out principles which aim to promote the rights of adults who lack capacity, and create mechanisms to allow substitute decision-making, a process whereby another individual has the legal power to make decisions on the disabled adult's behalf. The MCA has a specific 'best interests' process, which allows some decisions to be made without court proceedings, whereas there is no equivalent process in the AWIA. The Northern Irish legislation mirrors the MCA in many regards. The terminology varies between jurisdictions, for example, guardianship in the AWIA is similar to deputyship in the MCA.

A number of studies have explored the experiences of adults lacking capacity and their carers in relation to the legislation, and this systematic review draws together findings from this area of research.

Method

This review systematically appraised the research evidence exploring how adults lacking capacity and their carers experienced capacity legislation. It followed the Centre for Reviews and Dissemination guideline.⁴ The process is summarised in *Fig. 1*. All experiences related to the AWIA and the MCA were considered of interest, from everyday decision-making to perceptions of court proceedings and their outcomes. There was no research relating to the Northern Irish legislation, because the review was undertaken prior to its adoption. In this review, ‘carers’ included family and professional carers who made substitute decisions in a day-to-day caring role.

Fig. 4: Flow chart of study selection process.

The primary research question was ‘What are the experiences and perceptions of adults lacking capacity, their carers and the general public in relation to capacity legislation in the UK?’ The secondary research question was whether such experiences varied between jurisdictions.

The published literature consisted of both quantitative and qualitative research. Studies were included if they were published after the year 2000 (the year of introduction of the AWIA) and consisted of quantitative or qualitative research about the experiences or perceptions of adults lacking capacity, their carers or members of the general public in relation to the MCA or AWIA. There was no restriction placed on diagnosis. Exclusion criteria included studies where the individuals were minors, studies of capacity to participate in research, and studies carried out prior to the implementation of whichever Act was relevant. Papers such as accounts of service development activities, assessments of educational interventions and legal commentaries were also excluded. Research publications from sources other than peer-reviewed journals were included, because it seemed likely that there would be a paucity of evidence in the peer-reviewed literature. Although this strategy increased the likelihood of low-quality evidence entering the review, this was addressed by consideration of quality in the synthesis of the results.

A literature search was performed during June 2015. The databases were Medline, PsycINFO, EMBASE, Web of Science, ESRC, Social Care Online, BAILII, HeinOnline and LexisLibrary. The search terms were the keywords ‘Mental Capacity Act’, ‘Adults with Incapacity Act’, and ‘Adults with Incapacity Scotland Act’. Each abstract was screened. Duplicate papers and papers originating outside the UK were not included. Additional papers were sought from reference lists, conference proceedings and contact with authors. The abstracts of the papers were compared with the exclusion criteria. The complete paper was read if it was unclear from the abstract whether the paper should be included. The remaining papers were read once to exclude irrelevant papers from the final sample.

Quality assessment was carried out using the Multi-Methods Appraisal Tool (MMAT),⁵ which was selected because it offered the ability to assess the quality of all the various types of studies in the sample. It consisted of screening questions followed by questions for quantitative, qualitative and mixed-methods studies. No studies were excluded from the final sample because of low quality.

This review followed guidance that items should be regarded as data for secondary research only if they were described as results or findings in the primary research.⁶ A data extraction form was developed during a reading of the final sample papers. The data extraction form consisted of headings taken from the results sections of the final sample papers. Results from each study were then extracted if they were relevant to any heading on the data extraction form. Analysis used a framework method⁷ with a matrix consisting of each study along the x-axis and each heading from the data extraction form along the y-axis.

Results

There were 11 papers in the final sample, containing 12 distinct studies. The type and quality of studies are summarised in *Table 1*. Most of the studies used qualitative or mixed methods. There was variation in the quality of studies; only 4 of the 12 studies were rated as having the highest methodological quality and had been published in peer-reviewed journals. The other eight studies presented their results clearly but failed to report important information.

Type and quality of studies in the final sample

Study	Act	Type	Peer-reviewed journal?	MMAT score
Badger (2009) ⁸	MCA	Multiple qualitative methods	No	3/4
Badger & Parnell (2009) ⁹	MCA	Multiple qualitative methods	No	2/4
Jevon (2014) ¹⁰	AWIA	Quantitative survey	No	2/4
Jingree (2015) ¹¹	MCA	Qualitative interviews	Yes	4/4
Killeen & Myers (2004) Ch. 4 ¹²	AWIA	Mixed-methods – quantitative survey and qualitative interviews	No	2/4
Killeen & Myers (2004) Ch. 5 ¹³	AWIA	Qualitative interviews	No	2/4
Manthorpe <i>et al</i> (2012) ¹⁴	MCA	Qualitative interviews	Yes	4/4
Mental Welfare Commission (2011) ¹⁵	AWIA	Qualitative interviews	No	2/4
Myron <i>et al</i> (2008) ¹⁶	MCA	Mixed-methods – questionnaires and qualitative interviews	No	1/4
Samsi & Manthorpe (2011) ¹⁷	MCA	Qualitative interviews	Yes	4/4
Samsi & Manthorpe (2013) ¹⁸	MCA	Qualitative interviews	Yes	4/4
Williams <i>et al</i> (2012) ¹⁹	MCA	Mixed-methods – quantitative survey and qualitative interviews	No	2/4

AWIA, Adults with Incapacity (Scotland) Act 2000; MCA, Mental Capacity Act 2005; MMAT, Multi-Methods Appraisal Tool.

Research aims and participants are summarised in *Table 2*. Although there were data related to experiences in courts in Scotland, there were no data related to the Court of Protection in England and Wales. The data about the AWIA related mainly to guardianship, and the data about the MCA related mainly to decision-making practices. Therefore, no direct comparison between specific elements of the AWIA and MCA could be made.

Aims and participants in studies in the final sample

Study	Act	Research aim	Population context	Participants
Badger (2009) ⁸	MCA	Explore decision-making	Intellectual disability	27 participants: 2 staff and 1 family member for each of 9 disabled adults in 3 settings (none of the 9 disabled adults directly involved)
Badger & Parnell (2009) ⁹	MCA	Explore decision-making	Not described	24 participants: 6 disabled adults with 2 staff and 1 family member for each
Jevon (2014) ¹⁰	AWIA	Assess experiences of guardians	Not described	193 welfare guardians (27% response rate)
Jingree (2015) ¹¹	MCA	Explore decision-making	Intellectual disability	15 support workers from a single service
Killeen & Myers (2004) Ch. 4 ¹²	AWIA	Explore power of attorney and intromission with funds	General public	3 individuals who had made a power of attorney and 5 individuals who had applied for intromission with funds (8% response rate)
Killeen & Myers (2004) Ch. 5 ¹³	AWIA	Understand the operation of guardianship	Mixed	58 professionals, carers, and adults with incapacity involved in 13 guardianship cases – exact composition not reported
Manthorpe <i>et al</i> (2012) ¹⁴	MCA	Assess links between personal and professional experiences of dementia	Dementia	123 professionals (70 of whom had experience as carers)
Mental Welfare Commission (2011) ¹⁵	AWIA	Assess experiences of guardians and supervisors	Not described	58 welfare guardians (family or carer)
Myron <i>et al</i> (2008) ¹⁶	MCA	Assess staff, family and patient knowledge of capacity	Mixed	73 staff, 20 disabled adults, and 6 carers
Samsi & Manthorpe (2011) ¹⁷	MCA	Understand how older people planned for their future	General public	37 self-identified ‘well’ people aged over 50 years
Samsi & Manthorpe (2013) ¹⁸	MCA	Explore decision-making	Dementia	12 dementia dyads (person with dementia plus their carer)
Williams <i>et al</i> (2012) ¹⁹	MCA	Explore decision-making	Mixed	385 participants, mostly professionals – 5 interviews from the perspective of carers

AWIA, Adults with Incapacity (Scotland) Act 2000; MCA, Mental Capacity Act 2005.

None of the four studies from Scotland had been published in peer-reviewed journals and none received the highest rating of methodological quality. Two of these studies were separate pieces of research in a single publication.^{12,13}

The findings are summarised in *Table 3*. For reasons of parsimony, the 15 items from the data extraction form were collapsed into four headings in the results, but all data were retained.

Summary of findings

Theme	Finding
Positive experiences	Having a legal basis for decision-making was recognised as useful Benefits such as increased safety and quality of life were sometimes described The ability to use the mechanisms of the Acts to plan for the future was seen as beneficial, although only a minority did this The legislation was sometimes perceived as empowering
Negative experiences	Court and other legal processes were seen as challenging and cumbersome, and costs may be off-putting Some participants had extremely negative experiences The legislation was sometimes perceived as disempowering
Decision making	Decisions were sometimes but not always made with the disabled adult's participation Carers sometimes struggled to make decisions in the best interests of the adult lacking capacity There could be conflicts of interest between the adult lacking capacity and the decision maker
Other issues	There were variable findings related to support and supervision There was a lack of understanding of the legislation on the part of the general public and carers A need for carers to be assertive was described The most common reason for applying for powers was because of a wish for a formal role in decision-making There were no findings about carers' abilities to assess capacity There were no findings about deprivation of liberty Data were mainly derived from carers

Positive experiences

One study from Scotland reported that family carers saw guardianship as positive because it offered them the ability to manage their relative's welfare and finances. Improved safety and quality of life were described in several cases. Half of the six adults with incapacity interviewed in this study described improvements in their quality of life.¹³ In a telephone survey, most guardians stated that guardianship was useful, but a minority reported that it made little difference, or found it a negative experience.¹⁵ In a postal survey of guardians, most of the participants described welfare guardianship as being useful, but the response rate (26.7%) in this study was low and the result may not represent the experience of carers.¹⁰ Those who had made a power of attorney or who had made a successful application for intromission with funds saw the process as a positive experience. However, there were only a total of eight participants in this mixed-methods study.¹²

Some older members of the general public in England saw potential benefits from making a power of attorney, but most described a disinclination to plan for the future. Any plans that were made were usually of a financial nature. Individuals living alone with no family described difficulty in appointing someone to look after their affairs.¹⁷ The finding of participants failing to make powers of attorney or advance decisions, despite believing in their utility, was repeated in a group of professionals who had personal experience as carers.¹⁴ Only a minority of elderly people made a power of attorney in another study by the same researchers.¹⁸

Negative experiences

One study involved 58 professionals, carers and adults with incapacity who had been involved in court proceedings for 13 guardianship cases in Scotland. The process was described as perplexing and inhibiting for carers, and confusing and stressful for adults who lacked capacity. The process made some carers feel ‘isolated and under pressure’ and was described in negative terms such as ‘a nightmare’ and ‘an enormous waste of time’.¹³ By contrast, the instruments of the AWIA which did not require court proceedings were viewed generally positively.¹²

However, negative experiences were not just restricted to experiences in court. A minority of participants in the telephone survey of guardians found being a guardian to be a negative experience in general.¹⁵ One study of the MCA included five cases of best interests decision-making from the point of view of family carers, and the experience in each case was described as disempowering and distressing for the carers. No further details were given because the carers were not directly interviewed, but this finding contrasted markedly with the largely positive views of the MCA expressed by professional respondents in the same study.¹⁹

As well as the cases of carers appearing disempowered, some adults who lacked capacity were observed to resent the powers that others held over them.¹³ However, some carers in Scotland who had gone through processes to be formally appointed with decision-making powers saw themselves as empowered.^{12,13} In this review, the legislation was perceived as empowering’ for some and disempowering for others.

Decision-making

A qualitative study of support workers found decision-making to be inconsistent with the MCA; there was no assumption of capacity, and decisions were rarely oriented towards best interests.¹¹ Other support workers described struggling to balance their duties under the MCA with duty of care and safeguarding obligations, and stated that limited resources restricted their ability to support decision-making in practice.⁹ Another group felt that organisational policies, the influences of others such as family and professionals, and their duty of care restricted their ability to engage the adults in best interests decision-making.⁸

Some decision-making was clearly compliant with the general principles of the legislation. All 12 carers for individuals with dementia described the importance of best interests decision-making. They stated that they attempted to maintain the autonomy of the adult who lacked capacity and took a decision-specific approach to each question. They described the use of strategies to enhance the disabled adult’s participation in decision-making, and used their knowledge of the person’s previous wishes. However, even these carers described conflicts of interest between their needs and those of the adult with incapacity, and admitted struggling to decide what constituted best interests.¹⁸ The situation was similar in Scotland, with carers reporting difficulties assessing the most beneficial course of action and understanding the views of the adult with incapacity.¹³

Overall, it appeared to be the case that immediate carers (whether family carers or support workers) sometimes found difficulty in making decisions which adhered to the principles of the legislation, and that there could be conflicts between the wishes of the adult lacking capacity and the priorities of the decision maker. Although the degree of engagement with the principles varied between studies, this finding was consistent in all the studies which examined this theme, including in two of the four highest-quality studies.^{11,18}

Other findings

Practical support

Older members of the public in England were generally unaware of potential resources to support making powers of attorney or advance decisions, and some suggested that this might be helpful.¹⁷ Carers described a lack of practical support for decision-making for the adult lacking capacity, and some would have liked more.¹⁸ In one study, carers could identify potential sources of support, but these were generic supports such as friends, relatives, general practitioners and social services.¹⁶ In Scotland, around 75% of guardians were satisfied with the level of supervision and support they had from their local authorities.¹⁵ Guardians in another study perceived that they received insufficient support but were subject to excessive scrutiny.¹³ The perception of excessive scrutiny was shared by holders of intromission with funds.¹²

Lack of knowledge of the legislation

There was a lack of awareness on the part of the general public about the legislation. None of the respondents in a study of older members of the public in England were aware of the MCA, or that it could potentially support their choices for the future, but a few understood the nature of a power of attorney.¹⁷ Only 3 of 12 ‘dementia dyads’ (consisting of a person with dementia and their carer) had heard of a power of attorney, and only a single pair had utilised one.¹⁸ This lack of understanding of the legislation was apparent even where carers had been trained or where they held specific powers. Support workers thought that they needed more training in using the MCA^{8,16} and were observed to be unclear about some of their duties under the MCA.⁹ Guardians in Scotland were ignorant of their responsibilities to document the use of powers, and were unaware that they could delegate them.¹⁵ Some respondents felt that improved sources of information were necessary.¹³ Organisations caring for disabled adults had policies about risk which needed to be revised to comply with the principles of the legislation, and education about the MCA was suggested not just for professionals, but for adults lacking capacity and family carers as well.⁸

Assertiveness of carers

Those professionals with personal experience of being family carers described a necessity for carers to be ‘assertive’ in using the MCA to compel health and social services to act in the best interests of the adult who lacked capacity.¹⁴ The need for guardians to be ‘assertive and articulate’ was also described in Scotland.¹³

Application for financial/welfare powers

Data about the reasons for making applications for formal financial or welfare powers were only found in studies from Scotland. In a survey of guardians, the most common reason described for applying for guardianship was a wish for a formal role in the care of the adult with incapacity.¹⁵ Carers applied for intromission with funds because they believed that they had no other means of managing the person's finances.¹²

Absent or limited data

There were no findings in relation to carers' abilities to assess capacity. No data in the sample related to experiences of formal legal proceedings under English law in the Court of Protection. There was no information about experiences of Deprivation of Liberty Safeguards. Although many adults lacking capacity participated in the studies in this review (*Table 1*), the experiences of carers dominated the findings (*Table 2*).

Discussion

Methods and limitations

This review offers a systematic appraisal of the empirical research literature exploring how adults lacking capacity and their carers experience capacity legislation in the UK. Both quantitative and qualitative data were sought in the process of this review, but most of the studies in the final sample used qualitative or mixed methods. The lack of quantitative studies presented difficulty in data synthesis, because methods for the systematic review of qualitative research are not well established.^{4,6} However, there were benefits from utilising qualitative data to answer this review's research questions. Qualitative methods were appropriate to answer the primary researchers' questions because they are concerned with experiences and perceptions,⁴ are not reliant on random sampling²⁰ and can draw conclusions from small sample sizes.²¹ However, this systematic review cannot make claims of generalisability because it is based mainly on qualitative data, and the prevalence of the experiences described in this review cannot be determined.

There are other limitations which mean that the findings of this review must be treated with caution. This review relied on a single researcher and therefore sampling of papers and quality assessment were carried out without independent checks to ensure consistency. Two-thirds of the studies had not been published in peer-reviewed journals and some were of low quality. Most of the data from England and Wales related to decision-making, and none related to aspects of English capacity law such as experiences in court. Some of the data from Scotland were more than 10 years old, and may not reflect current practices. Data were heterogeneous and the secondary research question could not be answered because direct comparisons between specific components of English and Scottish law were not possible. However, the data were not so heterogeneous as to prevent the use of framework analysis.

Findings

What does this systematic review say about the AWIA and the MCA from the perspectives of the people who are subject to these laws? This review found that the legislation provided family carers with the ability to manage decisions for adults lacking capacity on a legally valid basis, and the mechanisms to allow this were generally seen as satisfactory. There were reports of improved safety and quality of life in some cases, including from some adults who lacked capacity. The ability to make plans for future incapacity was seen as useful. These positive consequences of the AWIA and MCA suggest that the legislation has achieved its goals, at least judging by the standards set by the law reformers of the 1990s.^{2,3} However, although a detailed discussion of human rights is beyond the scope of this paper, it must be acknowledged that the paradigm of disability rights has changed since the drafting of these laws; for example, there is pressure from the United Nations' Committee on the Rights of Persons with Disabilities to replace existing capacity laws with alternative approaches which do not utilise substitute decision-making and which would allow legal capacity regardless of the level of mental impairment.²² These proposals are based on an interpretation of Article 12 of the UN Convention on the Rights of Person with Disabilities²³ which has excited controversy²⁴ and been criticised

as undermining rather than promoting the rights of people with mental illnesses.²⁵ However, if that interpretation of Article 12 is accepted as authoritative, then key areas of UK capacity legislation are incompatible with international law.²⁶

In this review, some positive consequences of the AWIA and the MCA were mitigated by other findings. Perhaps not unexpectedly, adults lacking capacity sometimes resented the powers held over them. There were experiences of both empowerment and disempowerment. Potential benefits such as advance planning were not always realised; for example, planning for the future was seen as potentially beneficial, but despite this few people made powers of attorney or advance decisions. This is an area of concern given the relative simplicity of such instruments compared with the cost and complexity of the legal proceedings which can become necessary when someone loses capacity. Awareness of the legislation seems to be lacking, and public education might increase the utilisation of advance planning. However, not everyone will have the desire or ability to nominate a suitable power of attorney.

Education about the legislation may also be beneficial. As well as a lack of knowledge about the legislation on the part of the general public, support workers and family carers who held specific powers were sometimes unaware of their responsibilities. Decision-making was not always fully compliant with the legislative principles. Although some of the studies with these findings were conducted shortly after the introduction of the legislation when knowledge might be expected to be limited,^{8,9,16} other studies continued to demonstrate this finding several years later.^{11,15}

Legislation could be experienced as either empowering or disempowering by carers. Although some adults lacking capacity described positive outcomes, others described concepts similar to disempowerment. The AWIA and the MCA have been lauded as progressive and empowering instruments.^{27,28} It is true that both are grounded in principles such as enablement, least restriction, and the participation of the adult who lacks capacity in decision-making. Nevertheless, these principles are only empowering in the sense that they return disabled people to the legal status of any other citizen, and do not give them any additional rights to allow them to overcome their impairments. Series²⁹ has observed that most of the mechanisms of the MCA have the effect of transferring power away from disabled adults, and for this reason disputes the claim that the MCA is empowering. The AWIA may be viewed as disempowering for the same reason.

In this review, negative experiences of the legislation related mainly to court proceedings, although data were lacking about the Court of Protection in England and Wales. The transfer of significant decision-making powers between individuals is always likely to require formal proceedings, which will often be perceived as challenging and costly by the applicants. What other options are there? Moving to a tribunal system could potentially decrease costs and reduce distress because the proceedings take place outside the courts. However, tribunals might prove more expensive because of the addition of an extra judicial tier,²⁷ and may not necessarily be experienced more positively than court proceedings.

The initial legislation did not deal with the provision of due legal process for adults without capacity who require restrictive care regimes but lack the ability to challenge their *de facto* detention (so-called 'Bournewood patients').³⁰ This gap in the law still exists in Scotland.³¹ In England and Wales, provisions to deal with this issue were made in the form of the Deprivation of Liberty Safeguards, but these were criticised by the House of Lords, which recommended the process be replaced.²⁷ Both the AWIA and the MCA are undergoing reform to deal with this issue. This review found no data about deprivation of liberty, and it is unfortunate that there are no perspectives from patients or their carers to inform the changes to this area of law.

Finally, the participation of disabled adults in research about capacity legislation needs to be improved. Most of the findings in this review were drawn from carers, despite many adults who lacked capacity having been recruited into the studies. It is disappointing if researchers have made efforts to include such participants, only for those voices to be lost, and future research should take care to avoid this.

This study formed part of an MSc in Mental Health and Law from Queen Mary University of London. Dr Erminia Colucci, Dr Ruth Fletcher and Dr Yasmin Khatib commented on the design of this study and drafts of the manuscript. Dr Lucy Series suggested additional papers for this review.

1.6.74 Does the cognitive therapy of depression rest on a mistake?

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Abstract

Cognitive therapy for depression is common practice in today's National Health Service, yet it does not work well. Aaron Beck developed it after becoming disillusioned with the psychoanalytic theory and therapy he espoused and practised. But Beck's understanding of psychoanalysis appears to have been seriously flawed. Understood rightly, the psychoanalytic approach offers a cogent theory and therapy for depression which, unlike the cognitive approach, takes us to its emotional-motivational roots. A clinically successful therapy can afford to eschew theory and rest on its pragmatic laurels. This is not the case for cognitive therapy. The time is right to re-examine the psychoanalytic theory and treatment of depression.

Contents

- *Does the cognitive therapy of depression rest on a mistake?*
 - *Psychopathological theory*
 - *Therapeutic practice*
 - *Implications*

Cognitive-behavioural therapy (CBT) is, alongside antidepressant medication and counselling, today's mainstay treatment for depression in the UK. Such treatments tend to work better than nothing at all,¹ yet in general fare little better than placebo,^{2,3} suffer relatively high relapse rates, and often struggle to provide a complete remission.^{4,5}

CBT treatments for anxiety disorders, by comparison, appear more successful.⁶ They work by helping the patient articulate, then transcend, their underlying inchoate fears, the transformative learning happening directly within action and experience. This bottom-up experiential focus contrasts with the cognitive treatment of depression, where the patient is more typically trained in an arduous top-down task of managing unhealthy habits of mind through attentional and behavioural training and rational self-management.⁷

One reason for the rather low remission and high relapse rates for CBT-treated depression may be that the treatment does not reach to the emotional roots of the problem. That CBT principally theorises and treats the maintaining, rather than identifies underlying, causes of depression was acknowledged by Aaron Beck, the American psychiatrist who developed the cognitive aspect of this pragmatic depression treatment in the 1950s.⁷

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The psychoanalytic psychology Beck displaced had a theory of the root cause of depression: avoidance of intolerable emotion blocks healthy emotional functioning, depletes uncontrived self-possession, and lowers self-esteem.⁸ But his clinical experience (as a psychoanalytic psychotherapist) and scientific research (on depression, anger and dreaming) led Beck to discount the significance of such unconscious emotion. Ever the pragmatist, he focused instead on treating the conscious assumptions and ruminations of the patient which, he proposed, were maintaining their depressive state.

This article argues that the versions of psychoanalytic theory and therapy Beck espoused, practised and then rejected were recondite and implausible. The claim is that Beck mistakenly threw out the psychoanalytic baby of a significant psychological understanding and treatment of depression with the bathwater of a rather idiosyncratic understanding of psychoanalytic theory and practice. The thesis offered is theoretical rather than scientific: it considers the fundamental conceptual matter of how that theory is itself to be understood, rather than the secondary empirical matter of evidence for or against hypotheses derived from particular interpretations of it. But given the availability of far more plausible versions of psychoanalytic theory and practice that outline and treat depression at its emotional roots, and given the relatively poor success of CBT for depression, the time is now right to put the psychoanalytic theory back on the table and test hypotheses and therapies derived from it.

Psychopathological theory

An important theme in psychoanalytic psychopathology has depression resulting from the avoidance of feelings of loss. When the acute sadness of letting go of a beloved or an aspiration is too painful, the patient may avoid it by shutting down and instead become flat and morose. This, however, prevents adaptation to loss, since sadness is simply the most fundamental form that our recognition of loss takes. Another especially significant theme has depression resulting from the unconscious avoidance of anger towards those to whom we are attached. Rather than risk the feared relational fallout from expressing anger, the patient unconsciously depletes herself, trading that sense of self-worth that would be provided by an angrily assertive sense of injustice for the stability of her relationship. A third theme has depression resulting from the unconscious avoidance of fear. Rather than face the vicissitudes of uncontrollable fate in one's love and work, the patient instead constructs and lives in a dismal and diminished version of himself, his situation and his future. Even if life thereby becomes grim, at least now it will not take him by surprise.

Such ideas form but three strands of a more complex psychoanalytic conceptualisation of depression,⁸⁻¹⁰ but are fairly widespread in both popular and clinical culture for good reason. For clinically what we discover, again and again in straightforward cases, is a depressed person who avoids sadness, fear and in particular anger by going flat, downgrading her sense of her own value, shutting down self-assertion, not allowing herself to get even reasonable hopes up, falsely characterising herself as perpetrator rather than victim of relational injustices, characterising herself as deserving of treatment which reasonable others would consider unjust, denying the significance of her unmet emotional needs, and envisaging a world in which the exercise of agency appears foolhardy. In more complex cases, however, we find masochistic self-abasement added to an anger-avoiding dynamic: unconscious hatred towards another breaks through the attempts at self-suppression and gives rise to intolerable guilt, and this in turn inspires self-punishment where the anger towards the other is 'retroflected' (taken out on oneself), leading to further and darker melancholic misery.⁹

It was by way of a reaction against such psychoanalytic theory that a young, psychoanalytically minded American psychiatrist and dream researcher developed the theory and practice of cognitive therapy. Following a helpful personal experience of psychoanalysis, Aaron Beck treated several depressed patients using psychoanalytical methods, applied (albeit unsuccessfully) for membership of the American Institute of Psychoanalysis, and published a few papers on psychoanalytic psychotherapy and on the themes of his depressed patients' dreams.^{11,12} Reading these today we learn in particular of his scientific interest in the increased prevalence of thwarted, deprived, excluded, rejected, injured and ashamed themes in his patients' dreams, and of his clinical interpretation of these along psychoanalytic lines.

Already in these early papers, however, we find a curious feature which presages his later rejection of psychoanalysis: although most of the themes Beck describes (e.g. 'I was in a restaurant but the waiters would not serve me'; 'Everyone was invited to the party but me'; 'My fiancée married someone else') appear interpretable in terms of the simple hypothesis of motivated self-depletion, surprisingly he interprets them all in terms of the more complex dynamic of self-hatred: the depressed patient's misery is always seen as deliberately rather than incidentally self-inflicted, reflecting his 'need to suffer'.¹³ Dreams such as not getting food that is requested, or being rejected – which in themselves appear at most to indicate a need to safely anticipate setbacks or protect cherished others from one's resentment by portraying

life as hopeless and oneself as worthless – are instead counterintuitively read as ‘the representation of self-punitive tendencies ... the depressed person feels guilt about his ego-alien drives and punishes himself for them.’¹¹

The question naturally arises as to why Beck was so drawn to the masochism hypothesis. And this is particularly significant because it was when his later experimental and clinical investigations – including his patients’ appropriately negative reactions to interpretations overly organised by this hypothesis – rightly led him to doubt whether he really was meeting everywhere with self-hatred, that he threw out the entirety of the baby of the general psychoanalytic theory of depression along with the specific counterintuitive bathwater of an over-reaching application of the masochism hypothesis. Which is to say that the entire project of explaining why a patient may be unconsciously motivated to think and feel and act in depressive ways was abandoned; in Beck’s hands their condition now collapsed into a habitual rut of self-maintaining negative thought, feeling and behaviour.

One answer to why Beck was so compelled by the masochism hypothesis that it overrode his recognition of the frequent sufficiency of the simpler theory of motivated self-depletion is apparent in the early papers themselves. Beck somehow entirely forgets about the psychoanalytic ideas of depression as due either to thwarted mourning or to avoided fear, becoming solely preoccupied by the idea of it as due to suppressed anger. Such depression as did not appear to evince anger (since, one imagines, it was really due to suppressed sadness or fear) could then only be brought into line with the suppressed anger hypothesis by positing that such a patient was masochistically contriving to make herself depressed.

Another answer only becomes apparent in Beck’s later writings; it concerns the nature of dreaming. (Grasping this takes a little patience, but it is worth the effort.) In these later writings he tells us that what he was actually trying to do in his early research was to set the clinical psychoanalytic theory of depression as a function of suppressed anger on a firmer scientific basis by providing quantitative psychological evidence of unconscious anger in the dreams of his depressed patients.^{14,15} Although he did not report it at the time, what he later tells us he found is what has also been established since:¹⁶ that as a group people with depression have fewer themes of anger in their dreams than people who do not have depression. This puzzled him, as somehow he had understood the Freudian idea of dreams being the ‘royal road to the unconscious’¹⁷ to mean that feelings unacceptable to the waking patient ought to show up straightforwardly in their dreams.¹⁴ The finding of fewer angry themes in the dreams of patients with depression therefore appeared to contradict the psychoanalytic hypothesis of depression as resulting from suppressed anger. This troubled Beck, but – at least until he found independent evidence of the implausibility of this interpretation – he realised he could save the psychoanalytic theory by interpreting the very dreaming of such miserabilist dreams as masochistically motivated (‘he makes himself dream such miserable dreams because he hates himself’).

What is deeply unclear in all of this is why Beck thought that Freud’s theory posited that unconscious emotions ought to be directly manifest and countable in dreams. After all, Freud’s theory was that dreams serve to protect sleep by helping prevent the dreamer’s anxious recognition of emotions they find unacceptable, such as anger towards loved ones. In that theory dream construction involves the disguise – through displacement, condensation, reversal, negation and projection – of such impulses and emotions as threaten a comfortable sense of self–other relations. (Freud’s ‘royal road’ refers not to a direct, undisguised revelation of the unconscious, but rather to dreams offering particularly rich sites for interpreting the products of defences against intolerable feelings and motivations – by contrast with the myriad, emotionally irrelevant concerns of waking life.) In retrospect it seems at least possible that Beck’s enthusiasm to formulate and test a psychoanalytic hypothesis using the quantitative methods of empirical psychology ended up getting the better of his grasp of the psychoanalytic theory itself.

To sum up so far: a central plank of cognitive therapy’s origin myth has it that it developed out of an apparent scientific disconfirmation of the clinical psychoanalytic theory of depression as a motivationally explicable state.¹⁴ But in retrospect what seems more likely to have happened is that an inappropriate quantitative methodology deployed to provide support for an unlikely theory of depressive dreaming actually found against it; that an implausibly general theory of depressive masochism was developed to save the floundering analytic theory; and that when this overly general masochism theory was dropped for good reason, the whole idea of symptoms as motivated by the avoidance of intolerable feelings – i.e. the whole idea of a depth psychology – was jettisoned for no good reason at all.

Therapeutic practice

As described above, the development of cognitive therapy's psychopathological theory rests on its unwarranted rejection of the psychoanalytic notion of depression as unconsciously motivated. The development of cognitive therapy's psychotherapeutic technique, however, depends on its rejection of the centrality for psychotherapeutic practice of what psychoanalysis terms the 'transference relationship'.⁷ A curious aspect, then, of Beck's development of cognitive therapy is that it was actually inspired by his encounter with, and dawning realisation of the clinical significance of, what are clearly recognisable as his patients' transferences to him.

First, a note on 'transference'. A defining preoccupation of psychoanalysis is with how immersion in relationships which inspire concern and attachment – such as those with psychotherapists, partners, parents, employers, etc. – so readily elicits unrealistic fearful and idealising expectations concerning others' views of us. These relentlessly maintained, emotionally charged expectations are seen by psychoanalysis as being at the root of much psychopathology, and their manifestations inside and outside of therapy are known as negative and positive transferences. They can be easy to attend from, as it were, but powerfully difficult to attend to – i.e. they are often unconscious – and their patterns are typically transferred from one significant other to another over time.^{18,19} The task of psychoanalytic therapy is the patient's emancipation from distorting transference patterns, a task prosecuted by first facilitating the flourishing and then the subsequent experiential emancipation from the transferences between patient and psychotherapist, an experience that can then generalise to the transferences in the rest of the patient's life. Much of a psychoanalytical psychotherapist's training has to do with developing his ability to make room for and be emotionally touched, yet not inexorably swept along, by the patient's transference so he can think about, experience, describe, and help liberate the patient from her unconscious depressogenic emotional habits.

To return to cognitive therapy. As Beck¹⁵ tells the story, he had a patient who would lie on the couch each session and regale him with lurid tales of her sexual exploits, while he sat back and offered somewhat by-the-book psychoanalytic interpretations regarding the content of whatever it had occurred to her to say. At the end of one session, however, Beck asked his patient how she was feeling; she replied 'anxious'. Beck first suggested to her, in an interpretation focusing only on intra-psychic issues, that conflicts about sex were making her anxious. She cautiously responded, however, to the effect that her real worry was interpersonal: her worry was that he was bored by her. Beck then began to see 'that there's a whole stream of pre-conscious thinking that goes on that the patient doesn't normally communicate to the analyst'¹⁵ – especially pessimistic, biased, black-and-white, over-general irrational expectations concerning what the therapist thinks and feels about the patient. Beck came to call these transference expectations the patient's 'negative automatic thoughts' (NATs) and, drawing on the 'rational therapy' of Albert Ellis,²⁰ went on to develop a significant range of procedures to help the patient attend to and challenge their NATs.

There are several curious things about this and related narratives Beck offers.²¹ The first is that Beck the novice psychoanalyst started out (as one does) by naively listening to and interpreting the explicit content of what the patient freely said, rather than listening in with an analytic ear to what she was not saying, to the unconscious dimension of the transference (i.e. listening to how he featured latently in her mind), or listening in to his own countertransference (i.e. to the feelings provoked in him by, in particular, the performative rather than declarative aspect of her discourse). Thus, despite the patient's manifest lack of inhibition in talking about sex, Beck still interprets her anxiety as due to sexual conflict.

The second is that when Beck shows a real interest in his patient, asking her how she feels, she is able to acknowledge her transference to him, and they can understand it together to beneficial effect. We go on to hear that these worries (which, despite, or perhaps because of, being so very omnipresent in her mind she never discussed before) are actually common for her in other settings too. As the therapeutic relationship is strengthened (by Beck's concerned question about her actual feelings), the emotionally alive experience of the transference (her worries about Beck being bored by her) also begins to be acknowledged and worked through, and interpretative speculation about intra-psychic conflict is foregone.

The most striking thing about Beck's narrative, however, is that this therapy-potentiating emotional experience of the transference is set aside almost as soon as it is encountered. Anyone who has been in psychotherapy will know how replete it is with holding back acknowledgement, both to oneself and to the therapist, of one's thoughts and impulses for fear of encountering one's own or the therapist's disapproval, despite such fears speaking right to the heart of such emotional difficulties as brought one to therapy in the first place. Notwithstanding the simplicity of the 'fundamental

rule' of psychoanalysis – to 'free associate', i.e. say whatever is actually on your mind (which is not the same as saying whatever you feel like saying!) – the fact is that no one can truly follow it,^{21,22} since we naturally associate away from rather than towards conflictual emotional preoccupations.²³ This is why the therapist's job is often to listen not so much to the content of what is said as to performative matters of style, timing and omission. Beck, however, construes NATs as merely incidentally hard for the patient to articulate and challenge – due to a lack of training in attending to and reporting on them²¹ – rather than because of their emotional valence. This, I submit, is intuitively implausible. More consonant with everyday clinical and personal experience is the notion that his patient did not elaborate her actual worries because she feared they might not be disconfirmed – and chose instead to distract herself and please him with endless talk about sex, presumably since, as we all know, Freudians do have rather a reputation for being interested in such matters!

Cognitive therapists are often accused of ignoring the importance of the therapeutic relationship, but as Beck's daughter Judith Beck explains, this is false – cognitive therapy 'requires a good therapeutic relationship. Therapists do many things to build a strong alliance. For example, they work collaboratively with clients ... ask for feedback... and conduct themselves as genuine, warm, empathic, interested, caring human beings.'²⁴ However, as psychoanalytical psychotherapist Jonathan Shedler responds, 'This is the kind of relationship I would expect from my hair stylist or real estate broker. From a psychotherapist, I expect something else. [Beck appears] to have no concept that the therapy relationship provides a special window into the patient's inner world, or a relationship laboratory and sanctuary in which lifelong patterns can be recognized and understood, and new ones created.'²⁵ Shedler's optimism regarding his hair stylist and estate agent perhaps warrants some cognitive restructuring, but his point about the therapeutic relationship stands.

A relationship which is not merely instrumentally useful (as intended by cognitive therapy), but itself intended as the unique locus of change (as in psychoanalytic therapy), is one which both activates the patient's latent transference fears (that the therapist is untrustworthy, angry etc.) and simultaneously provides enough of a working alliance to enable such prototypical fears to be experienced, understood and worked through in real time. With a merely collaborative and empathic focus the opportunity is lost for the real-time eliciting and challenging of the patient's underlying emotional preoccupations. The result is somewhat like trying to conduct exposure therapy for a phobia without physically encountering the fearful stimulus, or like a chat between two adults about the difficulties of a child left waiting in the next room.

A popular canard has it that psychoanalytic psychotherapy is unhelpfully preoccupied with the past, whereas CBT is practically focused on the present. This ignores the way both therapies tend to formulate current disturbance in terms of childhood-acquired pathogenic beliefs. More importantly, it ignores the fact that, at the level of technique, CBT tends to focus on matters arising in the patient's past week, whereas a transference-focused psychotherapist hones in on uncomfortable transference feelings alive right now between patient and therapist. Rather than providing merely intellectual insight to further an ongoing project of dreary self-management, itself supplementing an already exhausting project of defensively managing intolerable feelings, psychoanalytic psychotherapy instead offers an intrinsically mutative emotional exchange which already constitutes a growth in self-possession and a change of heart, obviating the need for such self-management.

Implications

Work in the transference is designed to facilitate a patient's living exposure to their real underlying fears about how they would be seen if they were to allow themselves their own true feelings. The opportunity is thereby provided for a true change of heart – i.e. for emancipation from depressive cognition through an experiential recovery, acceptance and integration of hitherto unconscious emotional experience. Ideally, this would reduce the need to manage the dismal distal products of this emotional evasion with therapeutic techniques of behavioural activation, cognitive challenge or mindfulness. The result of such an effective therapy for depression would be akin to that sometimes achieved by CBT for anxiety conditions: a transformative learning, from the experiential ground up, that reinstates true self-possession.

The time is past for studies comparing outcomes of self-professed cognitive therapy/CBT and psychoanalytic practitioners. The apparent success of particular therapies in such trials is better predicted and explained not by therapeutic model²⁶ but by the theoretical orientation of the lead experimenter,²⁷ the personal qualities of the therapists,²⁸ or by theory drawn from quite different models.²⁹ Beck himself expressed the wish that cognitive therapy as a school die out,³⁰

the apt thought here being that what matters is not the treatment model but rather the particular treatment qualities which are individually worthy of study.

CBT treatments for depression often suffer high drop-out rates.³¹ One possible explanation for this is a lack of attention to transference. Sometimes this may be because negative transference undermines the therapeutic collaboration, although ideally CBT therapists are trained in recognising and managing this.⁷ At other times it may be because psychotherapeutic relationships that are merely collaborative, rather than offering experiential work in the transference, do not hit the therapeutic spot. Recently, however, there has been a resurgence in the general theory of,⁸ clinical practice and treatment manual for,³² and outcome studies supporting a transference-involving psychoanalytic approach to depression. With regard to outcome, outstanding results in helping patients with treatment-resistant depression which is not readily resolved by CBT have been obtained by particular practitioners of psychoanalytic psychotherapy³³ and somewhat optimistic results have been obtained with similar patients in the multi-practitioner Tavistock Adult Depression Study.³⁴

The present article has not been concerned to argue for a psychoanalytic approach to depression on the basis of empirical evidence. Instead, it noted that Beck's development of a cognitive approach to depression was predicated on his rejection of a psychoanalytic understanding of depression in particular, of the dynamic unconscious in general, and of psychoanalytic psychotherapeutic methods – and that his rationale for all this was flawed. What he developed in its stead does not stand or fall on this basis, and there are several benefits (especially clinical pragmatism and a strong research tradition) to the therapy he developed. But, given both the flawed rationale for rejecting a psychoanalytic approach which, rightly understood, possesses considerable clinical plausibility, and given the relatively poor results obtained by CBT for depression in much clinical practice, the time is surely right to revisit the psychoanalytic model.

1.6.75 The cognitive therapy of depression rests on substantial theoretical, empirical and clinical foundations: a reply to Dr Gipps

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Abstract

Dr Gipps claims that the cognitive therapy for depression rests on a mistake. But his anachronistic analysis of Beck's early research from the perspective of current psychoanalytic theory misses the point. The value of the research was not that it disproved psychoanalytic theory, but that it generated a model of depression that has revolutionised psychotherapy research. Psychoanalysts are belatedly adopting research methods that Beck pioneered half a century ago. The cognitive model of depression has explanatory power for both maintenance and vulnerability and has substantial research underpinning it. Cognitive therapy for depression has a larger body of evidence for its efficacy and relapse prevention effect than any other psychotherapy. Transference-focused approaches to depression have yet to establish themselves in the same way.

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 - *Psychopathological theory*
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Dr Gipps's polemic against Beck's cognitive therapy for depression rests on two assumptions. First, that cognitive therapy 'doesn't work very well' for the condition, and second, that the cognitive model is invalid because it is based on a flawed understanding of psychoanalysis. The first statement is misleading – cognitive-behavioural therapy (CBT) has the most comprehensive evidence base of all the psychological therapies. The second statement is largely irrelevant – the cognitive model of depression rests on a substantial body of research that is independent of the experiences that led to its original formulation. This reply will review the evidence for the effectiveness of psychological treatments for depression, highlighting the selectiveness of Dr Gipps's interpretation of the literature. It will then examine the cognitive model, demonstrating that it is far richer than he suggests, and has developed and changed in the light of extensive research. Finally, Gipps's caricature of CBT practice will be challenged: contemporary CBT does have something to say about experiential avoidance and interpersonal processes. It has the flexibility to address these as and when necessary without making them the sole vehicle for change. Gipps seems to believe that by denigrating Beck's psychoanalytic credentials and claiming his theory is based on a misunderstanding he can somehow erase nearly 60 years of research supporting the cognitive model. This is merely opinion, not reasoned scientific discourse.

Dr Gipps argues that current treatments for depression 'fare little better than placebo' so we should turn to psychoanalysis. He claims poor results for medication, counselling and CBT, but neglects to mention that trials of psychodynamic psychotherapy have not demonstrated it does better than CBT (the reverse may actually be the case).¹ If we take a non-partisan approach, the conclusion is that a number of treatments work for depression. For instance, a recent meta-analysis of randomised controlled trials (RCTs) reported effect sizes for CBT, counselling and short-term psychodynamic psychotherapy at 0.67, 0.57 and 0.69, respectively.² Dr Gipps, however, disingenuously selects a small uncontrolled trial of intensive short-term dynamic psychotherapy ($n = 10$) as his argument for the potential superiority of the psychodynamic approach.³ All these psychological treatments are as effective as antidepressants, but the superiority of all treatments over placebo may, as he suggests, be less than was once assumed.⁴ There is indeed a powerful placebo effect in mild depression, but this seems to lessen as severity of depression increases.⁵⁻⁹ It is also important to note that although placebo may do well in the short term, patients are more likely to relapse.¹⁰ Cognitive therapy still has the largest evidence base of all the psychotherapies for depression; not only is it effective in the acute phase, but it also reduces relapse.^{11,12} Its effects are not restricted to RCTs: in naturalistic settings 40% of patients recover and 64% show reliable improvement.¹³ The empirical data give us no reason to abandon CBT for depression.

Psychopathological theory

The implication of Dr Gipps's rather condescending analysis is that cognitive therapy would not have been created if Aaron Beck had been a better psychoanalyst (we are pointedly told that Beck failed entry to the American Institute of Psychoanalysis). According to Gipps, Beck got the wrong end of the stick, and his misunderstanding of theory led him to devise a set of experiments that set psychopathology off on the wrong track for the next half century. The problem here is that Beck's early work is scrutinised from the perspective of current psychoanalytic theory rather than seen in its historical context. It appears the 'mistake' Beck made was to be unaware of British psychoanalysis when he carried out his ground-breaking research in the late 1950s. Gipps's main reference is Trevor Lubbe's 2011 book written from the perspective of the British object relations school, which Beck is unlikely to have encountered in his analytic training in the USA – a training inclined towards instinctual and ego theories. Should we then abandon all Freud's work because his theories, originally framed in biological terms, were based on a misunderstanding of modern neurology?¹⁴ Gipps describes clearly what he sees as the current consensus of psychoanalytic thinking on depression which has unconscious avoidance of emotion at its centre: avoidance of feelings of loss, avoidance of anger towards those to whom we are

attached, and avoidance of fear. Rather than face these feelings the patient retreats into depression, preferring to live 'in a dismal and diminished version of himself, his situation and his future.' Beck's investigations tested one aspect of the anger-avoidance theory of depression: the masochism hypothesis. Anger towards another is repressed because it is unacceptable, but it breaks through and is then turned on the self. This internalised hostility leads to self-punishment, manifested in the self-criticism and self-abasement found in depression. Gipps wonders why Beck was drawn to the masochism hypothesis to the exclusion of others. The simple answer is that the introjected anger hypothesis was the prevailing theory of depression in American psychoanalysis at the time. Even in 1988 David Milrod could still write that 'the essential elements in a depression are the self-directed aggression and the mood state to which it leads'.¹⁵ In this context Beck's investigation of internalised hostility is very reasonable, and his research design perfectly acceptable for its time. But the significance of this research is not that it disproved psychoanalytic theory, but that it stimulated a powerful new theory. Whether one accepts the cognitive model or not, it has made an enormous contribution to the development of empirically based research in depression. Beck showed that it was possible to construct a theory that was refutable, and his steadfast focus on testing his theories has led to changes and modifications on the basis of research evidence. This is in contrast to psychoanalysis, which tends to change on the basis of new theoretical or clinical trends, but rarely in response to new research evidence. The first outcome study of cognitive therapy for depression, for instance, demonstrated that psychological therapy could be as effective as pharmacotherapy and showed that therapy could be operationalised and manualised.¹⁶ Even psychoanalysts now admit the value of treatment manuals!¹⁷ Any studies demonstrating the efficacy of psychoanalytic psychotherapy therefore owe a considerable methodological debt to Beck's pioneering work in outcome research.

So what is this mistaken cognitive model of depression? According to Beck, pervasive negative thinking is at the centre of depression: negative views of the self, the world and the future. These thoughts result from an information processing bias that selectively attends to negative events, negatively interprets situations, and encodes them as negative memories. These processes result from the activation of underlying cognitive structures or schemas, in the form of dysfunctional beliefs.^{18–20}

There is considerable evidence for this cross-sectional model: for a shift in information processing, for the reciprocal interaction between low mood and negative thinking, and for the presence of dysfunctional beliefs in depression.^{21,22} Beck also formulated a developmental model to explain vulnerability to depression. Negative events in childhood, for example loss of a parent, lead to negative beliefs which become activated when specific events impinge on these schemas. Beck revised this theory in the light of findings that severe life events are not always necessary to precipitate depression. An accumulation of milder stressful events can contribute, and with each successive episode the severity of event needed to trigger depression becomes lower (the kindling effect).²³ A further refinement of the model came with the discovery that when a depressed mood was evoked people prone to depression exhibited negative cognitive biases (cognitive reactivity).²⁴ These new findings were integrated into the theory using the concept of the depressive mode – a network of cognitive affective, motivational, behavioural and physiological schemas activated in depression. The mode is 'a complex neural network, including multiple relevant brain regions that are activated or deactivated during depression' (p. 971).¹⁹ With repeated depressive episodes the network of beliefs becomes stronger and relatively autonomous, so that minor stressors trigger the depressive mode. The cognitive model provides a comprehensive account of both vulnerability to and maintenance of depressive episodes. It does focus on unconscious processes, i.e. schemas and information processing biases, but these are unconscious because they are automatic, not because they are repressed. Regardless of its origins, the cognitive model stands on its own merits as an account of significant phenomena in depression.

Therapeutic practice

Dr Gipps's main criticism of CBT practice seems to be that it is not psychoanalysis. The collaborative, problem-solving relationship which is at the heart of good CBT is ridiculed as superficial because it apparently misses the opportunity to work with the transference. CBT, unlike psychoanalysis, is a problem-focused therapy, and one of its strengths lies in the way the problem is placed on the table and the therapist and patient work together to solve it. In depression this allows for a partnership in solving realistic problems and the identification of blocks to problem-solving arising from the patient's negative thought processes. For instance, negative predictions about being rejected may lead a patient to be socially avoidant, further reinforcing their depression. The therapist helps the patient test their beliefs by attending a social event and noting the outcome. This 'collaborative empiricism', together with the structure and focus

of therapy, engages the healthy adult functioning mode and minimises regressive transference so that the patient can learn strategies to help them out of their depression.²⁵ When negative interpretations of the therapist's behaviour arise these can be worked on together, for instance by noting how the patient's fear that the therapist may be cross with them is an example of a pattern of depressive misinterpretation that occurs outside the session with others. As the developmental conceptualisation is deepened over the course of therapy, the underlying assumptions that drive this reaction might be identified (e.g. 'If I make a mistake I'll be rejected'), their origins in parental criticism discussed, and the schemas modified. This is work with the transference but in the service of learning how to manage negative reactions activated when the person is depressed. With patients with personality disturbance the focus on the interpersonal relationship becomes more important and changing interpersonal schemas becomes one of the key goals of therapy. This is what Gipps calls the 'real-time eliciting and challenging of the patient's underlying emotional preoccupations.' However, CBT has the flexibility to work with the therapeutic process when necessary, but is not shackled to it as the only vehicle for change.

A second, more interesting, point made by Gipps concerns the role of experiential avoidance in depression. This is central to CBT for anxiety, where much of therapy focuses on identifying negative predictions and setting up behavioural experiments to test the fear. This is indeed often done in real time, through experiments in the session such as panic induction. This is of course very effective without any reference to transference. Recent developments in 'third-wave' CBT explicitly address emotional avoidance, and there is room for more attention to this within the standard cognitive model of depression. In mindfulness-based cognitive therapy, for instance, mindfulness meditation is taught as a skill to help patients practise moving from the ruminative depressive mode into a mode where they are present for whatever they are experiencing, approaching difficult feelings rather than moving away from them.²⁶ Although this concept of avoidance of emotions is similar to that in the psychoanalytic model, the significant differences are that it is not conceptualised as a motivated avoidance arising from a dynamic unconscious, and that it is perfectly possible to work with it outside the transference.

Dr Gipps's final criticism of CBT practice regards its project of 'dreary self-management'. Psychoanalytic psychotherapy, by contrast, 'offers an intrinsically mutative emotional exchange which . . . constitutes a growth in self-possession and a change of heart, obviating the need for such self-management.' This is wonderful news. Many of us would love to engage in a therapy that magically transforms us so that we do not have to pay attention to our habitual patterns that so frustratingly trip us up, but this is not what good psychodynamic psychotherapy is actually about. It involves noticing reactions outside the session as well as within, and considerable repetitive work on the self. Depression is a relapsing condition and it is patronising and misleading to imply that learning ways to manage it is unnecessary. Patients who successfully negotiate the vicissitudes of recurrent depression learn to identify risk factors that make them vulnerable, recognise how structuring their week helps to maintain positive mood, and how they can easily fall into negative thought patterns. Cognitive therapy gives them tools for doing this, but also changes underlying beliefs, to reduce vulnerability to depression.

Conclusions

Cognitive therapy is a tried and tested therapy for depression. It has a proven relapse prevention effect, but is not a panacea and is not the only effective treatment for depression. Most of these therapies do not work with the transference, and there is nothing to suggest that a transference-focused therapy will be hugely more effective or reduce dropout rates. The results from the two reported trials of psychoanalytic therapy are promising, but much more research is needed before they can be compared with the accumulated evidence for the effectiveness of CBT. Dr Gipps's article is based on a mistaken reading of the research into CBT as a therapy, and an anachronistic approach which judges Beck's evaluation of psychoanalytic theory in 1959 by the standards of 2016. What Beck developed stands not on this, but on almost 60 years of research. This has not only generated a robust theoretical model of depression, but has given psychoanalysts methodologies they now use to evaluate their own theories and therapies. The cognitive model of depression is likely to be around for another 60 years, but it will evolve and change on the basis of empirical research rather than theoretical whimsy.

1.6.76 Suicide patterns on the London Underground railway system, 2000–2010

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Abstract

Aims and Method Suicidal acts on underground railway networks are an area of public health concern. Our aim was to review recent epidemiological patterns of suicidal acts on the London Underground to inform future preventive interventions. Data from 2000 to 2010 were obtained from the British Transport Police via a Freedom of Information request.

Results The mean annual rate of suicidal acts from 2000 to 2010 was 5.8 per 100 million passenger journey stages. Of those who died by suicide, 77.3% were of White Northern European ethnicity. A fifth had a history of mental illness.

Clinical implications The widening gap between the number of recorded suicide attempts and completed suicides is encouraging. Further research is required regarding the role of drug and alcohol use, psychiatric history and area of residence. Installation of platform screen doors should be considered in future railway network expansion.

Contents

- *Suicide patterns on the London Underground railway system, 2000–2010*
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 - * *Strengths and limitations*
 - * *Conclusions*

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The London Underground was built in 1863 and was the world's first underground railway system.¹ Today it comprises 11 train lines serving a total of 270 stations across 402 km.¹ In 2015/16 it saw the completion of 1.34 billion journeys across its network.¹ Suicide on underground railway systems is a major cause for public health concern. Railway suicide can have a traumatic impact on both train drivers² and witnesses, and can lead to significant train delays, with substantial economic consequences.³

Between 1940–49 and 1980–89 the mean number of suicidal acts per year on the London Underground rose from 36.1 to 94.1.⁴ Previous studies have suggested an association between the rising number of suicidal acts across the national railway and increasing volumes of passengers across railway networks;^{5,6} however, this finding has been inconsistent across studies.⁷ Use of preventive measures to stop suicidal acts on railways has been the focus of several studies, for example, concentrating on changes to the immediate environment, media reporting and interagency collaborations.⁸

Our aim was to review recent epidemiological patterns of suicidal acts on the London Underground to better inform future preventive interventions.

Method

Data covering deaths by suicide between 2004 and 2010 and 'person under train' incidents between 2000 and 2010 were obtained by one of the authors (M.R.) on 7 October 2011 through a Freedom of Information request to the British Transport Police. Data covering completed suicides between 2000 and 2003 could not be provided owing to changes in coding. No further information in relation to this was provided by the British Transport Police.

The data provided by the British Transport Police included demographic information (age, gender, ethnicity) of suicide victims between 2004 and 2010. Age was categorised as: <15 years, 15–44 years, 45–74 years and > 75 years. The authors also received figures pertaining to all suicide attempts (which included incidents where individuals were prevented from jumping in front of a train or accessing the tracks) and all 'person under train' incidents (intentional and accidental) between 2000 and 2010.

Information regarding the total number of journeys completed on the London Underground was obtained from the publicly accessible Transport for London (TfL) 2011 *Travel in London* report.⁹ Passenger journeys were recorded as 'journey stages', where a journey stage represents a segment of a trip made on a particular mode of transport. For example, a journey made up of two stages could include a walking stage to the Underground station followed by a second stage on the Underground network.¹⁰

Results

Between 2000 and 2010 there were 644 recorded suicide attempts on the London Underground. The mean annual rate of suicide attempts during this period was 5.8 per 100 million journey stages (95% CI 5.0–6.5). Between 2004 and 2010 there were 132 deaths by suicide. The mean annual rate of individuals who died by suicide during this period was 1.8 per 100 million journey stages (95% CI 1.4–2.2). In addition, there were 38 deaths in which the coroner recorded an open verdict and 9 deaths in which the inquest had not yet taken place or in which the British Transport Police did not have access to the outcome of the verdict. The total number of 'person under train' incidents between 2000 and 2010, which included both intentional and accidental acts, was 433. The mean annual rate of 'person under train' incidents during this period was 3.9 per 100 million journey stages (95% CI 3.6–4.2).

Figure 1 shows an increase in the number of suicide attempts from 2004 to 2009, which is more marked than the increase in the number of incidents of death by suicide. The number of 'person under train' incidents, however, remained relatively constant. Our data revealed a small increase in the number of suicide attempts and 'person under train' incidents during May–August, with a peak in June, as illustrated in *Fig. 2*.

Fig. 5: Suicide attempts v. deaths by suicide, 2000–2010.

Tables 1 and 2 display the age and ethnicity distribution for males and females in incidents of deaths by suicide 2004–2010. Age at death was not available for two male individuals, and ethnicity data were not available for one

male individual. Of the deaths by suicide, two-thirds ($n = 88$) were male and a third ($n = 44$) were female. The average age at death was 40.7 years in males and 45.5 years in females.

Age and ethnicity in incidents of death by suicide in males, 2004–2010^a

	Age, y ears: n (%)		Ethni city, n (%)								
2004	0 (0.0)	66.7)	33.3)	0 (0.0)	12	50.0)	0 (0.0)	25.0)	25.0)	0 (0.0)	12
2005	0 (0.0)	66.7)	16.7)	16.7)	6	71.4)	0 (0.0)	0 (0.0)	28.6)	0 (0.0)	7
2006	0 (0.0)	69.2)	30.8)	0 (0.0)	13	11 (84.6)	0 (0.0)	1 (7.7)	0 (0.0)	1 (7.7)	13
2007	0 (0.0)	10 (76.9)	15.4)	1 (7.7)	13	12 (92.3)	0 (0.0)	1 (7.7)	0 (0.0)	0 (0.0)	13
2008	0 (0.0)	10 (76.9)	23.1)	0 (0.0)	13	69.2)	0 (0.0)	1 (7.7)	23.1)	0 (0.0)	13
2009	0 (0.0)	10 (62.5)	31.3)	1 (6.3)	16	12 (75.0)	0 (0.0)	18.8)	1 (6.3)	0 (0.0)	16
2010	0 (0.0)	46.2)	53.8)	0 (0.0)	13	10 (76.9)	0 (0.0)	0 (0.0)	23.1)	0 (0.0)	13
To- tal	0 (0.0)	57 (66.3)	26 (30.2)	3 (3.5)	86	65 (74.7)	0 (0.0)	10.3)	12 (13.8)	1 (1.1)	87

Age not available for one individual; ethnicity data not available for two individuals.

Age and ethnicity in incidents of death by suicide in females, 2004–2010

	Age, years: <i>n</i> (%)		Ethnicity, <i>n</i> (%)									
2004	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	1	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1
2005	0 (0.0)	54.5	45.5	0 (0.0)	11	10 (90.9)	0 (0.0)	0 (0.0)	1 (0.1)	0 (0.0)	0 (0.0)	11
2006	0 (0.0)	25.0	50.0	25.0	4	4 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	4
2007	0 (0.0)	33.3	66.7	0 (0.0)	3	3 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	3
2008	0 (0.0)	80.0	20.0	0 (0.0)	5	60.0	0 (0.0)	20.0	20.0	0 (0.0)	0 (0.0)	5
2009	0 (0.0)	41.7	58.3	0 (0.0)	12	75.0	0 (0.0)	1 (8.3)	16.7	0 (0.0)	0 (0.0)	12
2010	0 (0.0)	62.5	25.0	12.5	8	87.5	12.5	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	8
Total	0 (0.0)	20 (50.0)	19 (43.2)	3 (6.8)	44	37 (84.1)	1 (2.3)	2 (4.5)	4 (9.1)	0 (0.0)	0 (0.0)	44

Of the 132 individuals who completed suicide on the London Underground, 110 (83.3%) were resident in London at the time of the event. Information was unavailable for one individual. A history of mental illness was confirmed in 20.5% of individuals ($n = 27$).

The Northern Line had the greatest number of recorded suicide attempts ($n = 145$) between 2000 and 2010, followed by the Central Line ($n = 99$) and Piccadilly Line ($n = 92$). The lowest numbers of suicide attempts during that period were recorded on the Jubilee Line ($n = 27$) and Bakerloo Line ($n = 33$).

King's Cross St Pancras station saw the highest number of suicide attempts between 2000 and 2010 ($n = 18$), followed by Mile End ($n = 17$), Victoria ($n = 16$), Camden Town ($n = 15$), Archway ($n = 13$), Liverpool Street ($n = 13$), Oxford Circus ($n = 12$), Green Park ($n = 12$) and Earl's Court ($n = 11$). Suicide attempts led to delays in underground railway services; between 2000 and 2010 the Northern Line and Piccadilly Line experienced the greatest total delays (8484 min and 5521 min, respectively). The Jubilee Line recorded total delays of 2396 min and the Bakerloo Line 1911 min over the same period (*Fig. 3*).

Discussion

Suicide patterns over time

There was a marked increase in the number of suicide attempts across the London Underground from 2004 onwards, although this trend was beginning to reverse in 2009. Although there was also a rise in deaths by suicide during that period, this was of a lesser degree. In their 2016 paper looking at suicide trends across the entire England and Wales railway system, Taylor *et al* found that male suicide rates had increased from 6 to 8.4 per million from 2000 to 2013, with the greatest increase observed between 2010 and 2013, from 6.4 to 8.4 per million.¹¹ By contrast, female suicide rates remained relatively constant. Although previous studies looking at suicide attempts on underground railway systems have suggested a case fatality rate of 43 to 55%^{4,12,13} (compared with 90% on overground railways¹⁴), this does not fully

explain the extent of the difference observed. Increased reporting of suicide attempts by London Underground staff may be a factor, as well as the introduction of preventive interventions allowing for the early identification of persons at risk.

TfL has worked towards suicide prevention since the 1990s.¹⁵ This has included strategically placed Samaritans campaign posters and telephones within stations. More recently there has been further collaborative work with the Samaritans to train staff in identifying persons at risk, and giving them the confidence to intervene.¹⁶ Additional interventions have included platform-edge barriers on the Jubilee Line and gates to prevent passengers from entering tunnels at existing stations, as well as use of video surveillance and markings/warning signs to prevent individuals from approaching the platform edge.¹⁵ Presence of staff on platforms during rush-hour periods may also be helpful. The increase in the number of suicide attempts and deaths by suicide in 2008 and 2009 may in part be explained by the financial crisis of 2008.¹⁷

The number of journey stages made on the London Underground increased from 0.976 million in 2004 to 1.065 million in 2009.⁹ There have been several studies exploring a potential link between higher numbers of passenger journeys and the incidence of suicide, with variable findings. Sonneck *et al* found no such association on the Viennese subway,⁷ whereas in Stockholm, Sweden, and The Netherlands, authors noted a positive association.^{5,6} Although Waterloo station is the busiest in terms of passenger flow,¹⁸ it does not feature in the top 20 stations for suicide attempts on the London Underground in 2000–2010.

Our data did not reveal any marked variation in suicide attempts across the year, although there was a small increase in events during May to August, with a peak in June. Findings in other studies have been variable. Although Dinkel *et al* found no association between seasons of the year and suicide events,¹⁹ others have noted a small increase in suicide events during the summer months⁴ or during the months of April and September.²⁰ Even though summer months are associated with higher numbers of tourists in London, it is unclear whether this has had an effect on the number of suicide attempts during those months. Although a majority of those who died by suicide on the London Underground were mostly resident in the city, the time of year of their death was not available, nor was the proportion of London residents represented among those individuals who attempted suicide.

Demographics

The stark overrepresentation of men in the 15- to 44-year age group (61.4%, $n = 57$) among those who died by suicide was in keeping with national figures (England), where the proportion of males is approximately two-thirds.²¹ The overall gender distribution of suicide victims on the London Underground was very similar to that recorded nationally during the same period (2004–2010), with 66.9% of cases being male and 33.1% female. By contrast, the proportion of females aged over 75 years was almost double that of males (6.8% and 3.5% respectively), although the numbers were very small and therefore need to be interpreted with caution.

This is the first study looking at the ethnic distribution of suicide victims on the London Underground. The predominance of individuals of White Northern European background (>75%) is significant in a place like London where people of White ethnic background make up less than 60% of the total population,²² in particular since 83.3% of individuals who died by suicide on the London Underground were resident in the city. Moreover, use of the London Underground is evenly distributed across different ethnicities.²³ There are currently no data available on the ethnicity of individuals who die by suicide nationally, hence we do not know whether individuals of White Northern European ethnicity are also overrepresented relative to other ethnic groups. Similarly, we do not know whether individuals of White Northern European ethnicity are overrepresented in suicide incidents occurring across the rest of the national railway network or involving violent suicide methods.

In our sample a fifth of individuals had a history of mental illness. Unfortunately, no further data were available regarding their diagnosis, level of psychiatric care at the time of suicide or whether they were current or recent in-patients of a psychiatric unit. Proximity of stations or railway suicide ‘hot spots’ to psychiatric hospitals has been highlighted as a risk factor for suicide in several studies,^{4,5,12,24,25} although the result was not found to be significant across the Stockholm railway system.⁵ In their 1987 study of 100 individuals who had attempted suicide on the London Underground, Cocks found that 13 were current psychiatric in-patients, and 2 had been discharged within 48 h of the event.²⁶ Fifteen individuals had expressed suicidal ideation in the 24 h preceding the event. Although proximity to a

psychiatric hospital was not taken into account in this paper, the presence of a history of mental illness in a fifth of those who died by suicide highlights the need for staff working in psychiatric hospitals to be aware of the proximity of any nearby Underground stations in their assessment of risk in patients.

Additional risk factors

In Stockholm, authors found that the stations with the highest suicide rates were associated with higher levels of surrounding drug-related crime.²⁷ Previous studies have shown that consumption of alcohol or drugs was a characteristic of about 10 to 20% of individuals who had attempted or died by suicide on an underground railway system.^{12,28,29} In the UK National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, the authors noted that 54% of those who died by suicide and had been in contact with mental health services over the past year had a history of alcohol and/or drug misuse.³⁰ Intoxication with drugs or alcohol can increase the risk of impulsive and risk-taking behaviour and may have been a contributing factor in the incidents observed on the London Underground, including ‘person under train’ incidents of accidental cause. Unfortunately, the British Transport Police do not currently collect this information. Consumption of alcohol on the London Underground is forbidden; however, consideration must be given as to how to manage the risk of suicidal behaviour or accidental injury in intoxicated individuals.

Use of preventive measures

Several recent studies looking at suicide attempts on underground and overground railway systems have focused on the use of preventive measures. Diminishing ease of access to the track through barrier methods is suggested as an effective intervention, although Cox *et al* noted a lack of studies demonstrating this.³¹ In Seoul, the presence of platform screen doors (PSDs) reduced suicides on the underground network by 89%.³² PSDs are continuous panels that separate the platform from the train, only opening when the train is in the station. Half-length PSDs (1.6 m) were less effective than full-length PSDs; however, full-length PSDs were 120–150% more expensive to install.³² The effectiveness of PSDs was also noted in Hong Kong.³³ Portions of the Jubilee Line include the presence of PSDs, which may be a contributory factor to the lower number of suicide attempts observed on this line relative to the rest of the network. The presence of PSDs would also reduce the risk of accidental falls on to the railway tracks, thus reducing the number of ‘person under train’ incidents. Although the cost of installing these doors makes their presence across the railway network unlikely in the near future, their potential for significantly reducing the number of injuries or deaths on the tracks should be considered when planning future network renovation or expansion.

Other proposed interventions include increasing the presence of drainage pits, as mortality at London Underground stations that have a drainage pit was 44% *v.* 76% at those stations without, in incidents of individuals falling or jumping in front of trains.³⁴ These drainage pits were originally constructed to drain water between the tracks in deep-tunnel stations. Installation of blue lights at platforms was put forward as an effective measure by Matsubayashi *et al* in 2013³⁵ but this benefit was minimised by Ichikawa *et al* the following year.³⁶ Another suggested measure is reducing the average speed of trains entering the station at peak times.²⁹ In Vienna, changing the way in which media reported suicides on the underground by making it less dramatic was followed by a reduction in suicide.⁷

Strengths and limitations

This is the most recent study looking at patterns of suicide on the London Underground since 1994. It is also the first study looking at ethnicity within incidents of death by suicide on the Underground, and the findings raise new and important dimensions when seeking to introduce preventive measures.

There were several limitations to the study: no data were available for deaths by suicide between 2000 and 2003 owing to changes in coding, and death by suicide could not be confirmed in 47 cases owing to the recording of an open verdict or the outcome of the inquest not being available. Because of the relatively rare occurrence of deaths by suicide on the London Underground the numbers used in the study were small, leading to possible sample size bias. The limited breadth of information collected by the British Transport Police meant that certain risk factors (e.g. use of drugs/alcohol

or whether individuals were psychiatric in-patients at the time of the event) could not be adequately explored in our sample. The study is further limited by the absence of data beyond 2010.

Conclusions

Suicide on the London Underground railway system continues to be an important public health issue. The widening gap between the number of recorded suicide attempts and deaths by suicide is encouraging and may reflect the introduction of preventive measures. Use of PSDs has been proven to be effective for both suicidal acts and accidental ‘person under train’ incidents and needs to be considered when planning railway renovation or construction projects. The overrepresentation of people of White Northern European ethnicity among those who attempted suicide requires further exploration, as does the proportion of non-residents involved in suicide attempts on the London Underground across the year to better target preventive interventions. Finally, the collection of data on alcohol and drug use, as well as a more detailed psychiatric history, would help to inform further research and implementation of preventive measures for suicidal acts on the London Underground.

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1.6.77 Psychiatric neurosurgery in the 21st century: overview and the growth of deep brain stimulation

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Abstract

Ambulatory deep brain stimulation (DBS) became possible in the late 1980s and was initially used to treat people with movement disorders. Trials of DBS in people with treatment-resistant psychiatric disorder began in the late 1990s, initially focusing on obsessive–compulsive disorder, major depressive disorder and Tourette syndrome. Despite methodological issues, including small participant numbers and lack of consensus over brain targets, DBS is now being trialled in a wide range of psychiatric conditions. There has also been more modest increase in ablative procedures. This paper reviews these developments in the light of contemporary brain science, considers future directions and discusses why the approach has not been adopted more widely within psychiatry.

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In 2014 the Mayo Clinic posted an online video in which a musician plays the violin while a neurosurgeon operates on his brain. Electrodes are being directed to an area of his thalamus with the aim of suppressing an essential tremor by electrical stimulation. Playing the violin during surgery was the best way to test whether the electrodes were in the right place. They were, and the operation was a success.¹

Deep brain stimulation (DBS) was first used to treat severe tremor in people with Parkinson's disease in 1987 and was subsequently found effective in severe dystonia.² Since then, tens of thousands of people have undergone the procedure for movement disorders and the technique has largely replaced earlier lesion-based methods. The most recent application, to 'benign' essential tremor, perhaps highlights its relatively low side-effect profile and patient acceptance. In 1999 a Belgian team used DBS in three people with treatment-resistant obsessive-compulsive disorder (OCD), with favourable results. There have since been DBS trials in a wide range of psychiatric conditions, and a more modest increase in ablative procedures.³ 2014 saw the publication of *Psychosurgery: New Techniques for Brain Disorders* by French neurosurgeon Marc Lévêque, the first 'state of the art' textbook to use that term in 40 years.⁴ It was a translation from the French; Anglophone practitioners in the field prefer a word with less toxic associations: neuromodulation.⁵

Whatever you call it, the use of DBS – and to a lesser extent lesion-based psychiatric neurosurgery – is on the rise, and this paper will review these developments. The aim is to inform rather than tilt opinion in a particular direction, but given the polarising nature of the subject it seems relevant to state the perspective from which it is written. The author is a retired neuropsychiatrist who formerly worked in a comprehensive service for working-age adults, within which the most frequent neurological diagnosis was acquired brain injury. While in training, he obtained a doctorate in electroencephalogram-based psychophysiology. A history project on psychiatric neurosurgery in the mid-20th century led to several outcomes, including an essay that prompted the Editor to commission this review.⁶

Background

Renewed interest in psychiatric neurosurgery has occurred against a background of major revisions in the way we think about the brain. At the beginning of the 20th century, anatomist Santiago y Cajal wrote: "Once brain development has ended the fount of growth and regeneration of axons and dendrites dries up irrevocably. In adult centres the nerve paths are something fixed, ended and immutable."⁷ That 'immutable' view of neurons held sway within brain science for much of the past century, although there were dissenting voices, particularly between the World Wars.⁸ The brain's capacity to structurally adapt and even regenerate was eventually demonstrated at the end of the century, by magnetic resonance imaging (MRI), functional MRI (fMRI) and other techniques. In addition, simplistic notions of functional localisation are being replaced by task-related and 'default' systems and networks.⁹ The past 25 years have also witnessed a transformation in our understanding of glial cells. Once viewed simply as the brain's scaffolding and housekeepers, they are now known to guide brain development, shape response to injury, modulate synaptic transmission, and operate an independent chemically based communication system.¹⁰ How all this produces mind remains a topic rich in speculation, with recent theories encompassing 'embodied' cognition and quantum biology.^{11,12} The implication of all this for psychiatry remains to be determined.

In the 1930s neurologist Egas Moniz speculated that in the brains of some people with chronic mental illness, 'the cellular bodies remain altogether normal ... but their multiple liaisons, very variable in normal people ... have arrangements that are more or less fixed'.¹³ He believed the most likely location for such an aberration was the pathway

between the prefrontal cortex and the thalamus. In 1935/6 he tested his theory by directing a surgeon to produce small lesions in that area, in 20 patients with mental illness – the first ‘prefrontal leucotomy’ series. Moniz’s targeted and theory-based approach was soon eclipsed by Freeman & Watts’ more destructive and indiscriminate procedure.¹⁴ The extensive damage that it produced often rendered behaviourally disturbed hospital patients with psychosis docile and, in some cases, dischargeable. The potential economic benefits of that were not lost on the architects of the UK’s National Health Service (NHS): in its first 5 years, there were more than 7000 leucotomies.¹⁵

Chlorpromazine rendered such destructive procedures in people with psychosis unnecessary and over the following 20 years psychosurgery teams – focusing on a narrower range of disorders – sought maximum benefit from minimum damage. Nonetheless, public distrust and dissenting voices increased, particularly in the USA, a trend fuelled by experiments on behaviourally disturbed children and aggressive prisoners.¹⁶ Beginning in 1974 a US Congressional Committee held hearings on psychosurgery, with a view to a possible ban. In the end, they recommended better regulation and, in any event, the number of operations fell dramatically over the next 30 years.¹⁴

Ambulatory DBS became possible in the 1980s because of technical developments (MRI, microprocessors, batteries, etc.) but also because the brain structures and pathways that produce movement had been mapped. Although the structures underlying emotion and behaviour, and the paths between them, have also been mapped, exactly how they produce the complexities of emotional life is much less clear. For that reason, a wide variety of brain areas have been targeted in this new wave of psychiatric neurosurgery. Despite the many theories as to how and why DBS and ablative procedures improve some psychiatric conditions, we do not actually know.

Technicalities: electrodes and procedures

All but two of the procedures in current use involve insertion of electrodes into the brain. The exceptions are vagus nerve stimulation (VNS) and gamma knife capsulotomy. Such surgery usually involves attaching a stereotactic cage to the head as a means of directing electrodes to brain locations mapped by MRI. VNS involves isolating the left vagus nerve in the carotid sheath in the neck and looping two electrodes around it. Electrodes in both cases are wired to a programmable stimulator placed subcutaneously in the upper chest wall (*Fig. 1*).¹⁷

Fig. 6: Illustration of an implanted deep brain stimulation system.

Each electrode includes an anode and a cathode. When an electrical current is applied the brain tissue between them joins the circuit. Three to five volts are usually applied in DBS at pulse frequencies above 100/s. At such frequencies brain tissue immediately surrounding the electrodes is deactivated/depolarised. However, just outside that area, volume conduction leads to electrical stimulation of axons, propagated upstream to cell bodies and downstream to synapses, interrupting local brain function while also producing effects more remotely. At frequencies below 100 – 15 pulses/s, for example, in VNS – stimulation is also produced in the tissue immediately surrounding the electrodes. Electrodes have been used experimentally to stimulate brain tissue in humans since the late 1940s.¹⁸ They have also been used to produce lesions, through thermocoagulation. In anterior cingulotomy, for example, a 10 mm exposed portion of the electrode is heated to 85°C for 60 s.

In gamma knife surgery, multiple narrow beams of gamma radiation intersect at a pre-mapped point in the brain, hence the skull is not opened.¹⁷

Brain targets and treatment rationales

Box 1 summarises the brain targets used in most psychiatric neurosurgery over the past 20 years, and the conditions treated in each case. The targets for current lesion surgery are those that have been found to produce the most benefit with the fewest adverse effects. The targets used for psychiatric DBS were chosen in four ways.

1. The first trial, in 1999, targeted the anterior limb of the internal capsule because lesion surgery to that area has been found in some cases to reduce the symptoms of severe OCD.³ The anterior cingulate and subcaudate areas, and the combination of the two, were chosen for similar reasons, in relation to major depressive disorder (MDD).
2. The subthalamic nucleus (STN) is the favoured target in Parkinson's disease. Following DBS, some patients with comorbid OCD experienced a reduction in the severity of those symptoms, hence its selection for trials in OCD.
3. fMRI has revealed increased metabolic activity in the subgenual cortex and habenula in some patients with MDD. Hence, those areas were targeted based on the hypothesis that such hyperactivity may be causal, rather than simply a manifestation of depression.
4. Tourette syndrome sits on the boundary between movement and compulsive disorder, which has contributed to the wide range of brain targets available, including the thalamus, STN, globus pallidum, nucleus accumbens and internal capsule.

Box 1 Brain targets used in psychiatric neurosurgery

Stimulation procedures

Deep brain

- Anterior limb internal capsule (obsessive-compulsive disorder (OCD), depression, anorexia nervosa)
- Nucleus accumbens (OCD, depression, anorexia nervosa, addictions)
- Subgenual cortex (depression)
- Globus pallidus (Tourette syndrome)
- Habenula (depression)
- Posterior hypothalamus (aggressive behaviour)
- Thalamus centromedian nucleus (Tourette syndrome)
- Subthalamic nucleus (OCD)
- Inferior thalamic peduncle (depression)
- Nucleus basalis (Alzheimer's disease)
- Fornix (Alzheimer's disease)
- Basolateral amygdala (post-traumatic stress disorder)

Cortical surface (epidural)

- Dorsolateral frontal (depression)
- Orbitofrontal (depression)

Vagus nerve (depression)**Ablative procedures****Thermocoagulation**

- Anterior capsulotomy (OCD, depression)
- Cingulotomy (OCD, depression, addiction)
- Limbic leucotomy (OCD)
- Subcaudate tractotomy (depression, OCD)
- Nucleus accumbens (addiction)

Radiosurgery ('gamma knife')

- Capsulotomy (OCD)

VNS was first used in the 1990s to treat some forms of refractory epilepsy. Improvement in the mood of some individuals was noticed, an effect that was independent of seizure response. Trials in treatment-resistant depression yielded positive outcomes, but a later study including a 'sham' surgery group suggested a significant placebo effect.¹⁹

Several authors have sought to explain the beneficial effects of stimulation-based procedures and lesion surgery on depressed mood and anxiety by reference to two cortico-striato-thalamocortical (CSTQ 'loops'.²⁰ Similar loops were previously identified in relation to movement, prior to the introduction of DBS, including inhibitory (GABA-based) and excitatory (glutamate-based) pathways.²¹ The CSTC loops, by contrast, involve a wider range of neurotransmitters, with complex interactions that are yet to be defined. Such 'circuits' may, however, explain the variety of targets that seem to produce at least some benefit in psychiatric DBS studies. It seems reasonable to speculate that tapping into and stimulating the loop at many points could influence and modify the whole network.

Protocols, conditions and outcomes

Lesion-based, ablative surgery continues to be available, including at two centres in the UK, but in most countries it is confined to a very small number of cases each year.^{22,23} The exceptions are Russia and China where it is now frequently used in the treatment of addiction.^{24,25} Radiosurgery has made lesion surgery possible without opening the skull and one report confirmed efficacy in OCD comparable to older techniques.²⁶ At the Editor's direction, the remainder of this review will focus on DBS.

The investigators who first applied DBS to the treatment of psychiatric disorders were aware of the legacy of past psychosurgical excesses and the ethical issues it raised. With that in mind a collaborative group drew up a list of research guidelines, published in 2002.²⁷ They include independent evaluation of potential participants according to strict diagnostic, severity and duration criteria; the need to ensure that individuals are able to give informed consent at the outset and for as long as the treatment continues; and ensuring DBS is never used for 'political, law enforcement or social purposes'.²⁷ Most investigators also use established severity ratings and response criteria based on them (such as a 35% or more reduction on the Yale-Brown Obsessive Compulsive Scale²⁸).

In the early years the focus of DBS studies was on people with treatment-resistant OCD, Tourette syndrome and MDD. The textbook cited at the beginning of this paper tabulates all such studies up to 2013 for each of these diagnoses, including patient numbers, brain targets, follow-up times and reported outcomes.²⁹ In summary: OCD: 11 studies involving 9 targets in a total of 86 patients followed up from 3 to 31 months; positive outcomes in 33–100% Tourette syndrome: 10 studies involving 7 targets in 40 patients followed up from 3 to 36 months; positive outcomes in 23–82% MDD: 6 studies involving 5 targets in 55 patients followed up from 12 to 36 months; positive outcomes in 30–75%.

The longer the duration of the follow-up overall, the better outcomes tended to be, but no one target appeared markedly superior. Whereas in movement disorder, and to an extent in Tourette syndrome, improvement occurred soon after stimulation commenced, in OCD and MDD improvement took many weeks to begin, symptoms diminishing further as time progressed. This perhaps indicates that rather than simply turning off ‘malfunctioning’ neurons, stimulation causes gradual beneficial change in the networks and systems it taps into. One exception to this delayed response was a study in which seven people with MDD received DBS to the medial forebrain bundle. The pulse frequency was lower than usual (see ‘Technicalities’ section) and at 1 year positive responses were reported in six people; all began to improve within a week of stimulation commencing.³⁰

Despite these apparently favourable outcomes, the small patient numbers, bewildering array of brain targets, variable follow-up times, and the impossibility of the double-blind placebo control methods, may lead many to conclude that the efficacy of this approach is far from proven. Although Lévêque considers the efficacy of DBS in OCD to be established, in relation to MDD he concedes that ‘although the benign nature of these techniques is in the process of being established, their efficacy remains difficult to demonstrate’.²⁹ Nonetheless, he and others offer several reasons why these outcomes should be taken seriously.

1. The patients treated have severe conditions that have failed to respond to all other treatments over a prolonged period.
2. Some studies target structures that had proved effective in lesion-based surgery (stimulation being used to simulate a lesion).
3. DBS allows for a form of ‘double blind’ methodology as the stimulating device may be turned on and off, the status at any point being kept from patient and assessor.
4. In some clinically improved cases temporary deterioration followed battery failure or inadvertent disconnection.^{30,31}

Although the reversible nature of DBS makes it more acceptable than lesion surgery, is it as effective in psychiatric applications, and does it result in fewer side-effects? The technique may only simulate a lesion, but if the patient requires that simulation to be in place for the rest of their life, what is the difference, apart from indefinite maintenance costs? A recent paper addressed that question by reviewing outcomes in 20 studies of treatment-resistant OCD.³² 108 patients who underwent capsulotomy were compared with 62 patients who received stimulation to the internal capsule or the nucleus accumbens. Of those undergoing capsulotomy 62% responded favourably, compared with 52% of those undergoing stimulation, but the difference was not statistically significant. Weight gain, which was common after lesion surgery, did not occur with stimulation. Apathy and disinhibition were also experienced by a small number of patients after lesion surgery but not during DBS.

Adverse effects reported after DBS include postoperative problems such as wound infection, haemorrhage (asymptomatic or resulting in transient motor signs), single seizures and syncopal episodes.³³ Additional undesirable effects develop when the stimulator is turned on but seem generally to disappear once the stimulation parameters are altered (voltage, frequency, etc.). These include physical symptoms such as paraesthesia, muscle contractions, dysarthria, diplopia and strabismus, and psychiatric features, particularly excitement, irritability and occasionally hypomania. Cognitive function is usually assessed before and during treatment and a recent review concluded that no adverse cognitive effects had occurred. In fact, as time progressed improvements in scores tended to occur, mirroring improvements in mental state.³⁴ The most common longer-term problems in psychiatric and movement disorder applications seem to be device-based. For example, one study of 84 patients with Parkinson’s disease recorded hardware-related complications in 8.4% of patients each year, including lead fractures, migrations and disconnections.³⁵ Technical improvements have doubtless occurred since that report, but the consequences of such mishaps in patients with severe psychiatric disorders may be grave, and are among the reasons that regular ongoing follow-up is deemed important.

A further stimulation technique that does not involve penetrating the brain has recently been tried in people with MDD.³⁶ Electrodes were placed in the epidural space over the dorsolateral frontal cortex in a single-blind study of 12 patients who were followed up for 2 years, with results comparable to the best DBS studies. A later paper discussed the combination of this technique with psychotherapy, a fascinating subject, sadly beyond the scope of this review.³⁷

The major advantage of DBS over lesion-based surgery is that if it does not work the hardware can be turned off and removed. In the longer term, stimulation could be stopped temporarily to assess whether it is still necessary. But as we now know, the brain is not 'immutable' and unresponsive to such challenge. It adjusts and adapts, chemically and structurally to changing circumstances and, in fact, the delayed onset of improvement in some of these applications seems to depend on such adaptation. The long-term implications of such changes are not clear.

In light of the relatively low side-effect profile of DBS in these early trials and apparently favourable outcomes, the technique has been extended to a number of other conditions including addiction,³⁸ eating disorder,³⁹ posttraumatic stress disorder (PTSD),⁴⁰ early Alzheimer's disease⁴¹ and, most controversially, aggressive behaviour disorder.⁴² Each of these has a defining clinical feature that suggests a particular brain target (in turn, nucleus accumbens, hypothalamus, amygdala, mammillary-fornix-hippocampal complex/nucleus basalis, hypothalamus). Although it is probably too early to comment on the outcome of this work, the target selections in two of these conditions are illustrative of the current approach and will be described briefly. The amygdala is being targeted in PTSD as a result of post brain-injury MRI and fMRI evidence (amygdala damage protecting against developing the condition and evidence of increased metabolic activity), and a positive response to amygdala stimulation in an animal model. The fornix is being targeted in early Alzheimer's disease as a way into the mammillary-fornix-hippocampal complex. This follows the serendipitous finding of improved memory and increased hippocampal volume following stimulation of the anterior hypothalamus undertaken for an unrelated condition, and animal studies showing stimulation-related neural growth.⁴³

The future

In 2013 President Obama launched a US\$100 million research programme with the acronym B.R.A.I.N (Brain Research through Advancing Innovative Neurotechnologies).⁴⁴ 'Emerging technologies' would be applied to the investigation of brain function and the treatment of disorders. This would include nanotechnology and, in relation to treatments, 'wireless fully implantable neural interface medical devices for human use ... closed loop systems able to deliver targeted neural stimulation'.⁴⁵ A patient group singled out for such innovative treatments was injured war-fighters, particularly those with treatment-resistant PTSD and memory problems due to acquired brain injury. This was a remarkable proposal, not least because at that point no 'wired' device-based treatments had been found useful or even trialled in either condition, and closed loop technology had only been used in cardiac dysrhythmia and epilepsy.⁴⁶

Closed loop technology has been more widely identified as important for the future of this work. In the context of epilepsy, implanted closed loop devices monitor an area where seizure originates, detect electrical activity that indicate a seizure is due, and respond with electrical stimulation or cooling to interrupt it.⁴⁶ In the psychiatric context, the possibilities of such devices include using nanotechnology to measure neurotransmitter levels and trigger therapeutic outputs.⁴⁷

Another development of possible importance is optogenetics. Light-sensitive ion channels that respond to different colours are delivered to and incorporated into individual neurons via a virus. Light channelled into the brain via fiberoptics can then be used to turn on and off such channels. Although this sounds the stuff of science fiction, a similar procedure has apparently succeeded in animal studies and trials in humans are expected in due course.^{48,49}

Conclusions

Given the torment of severe treatment-resistant depression, OCD and other psychiatric conditions, and the enthusiasm for DBS in relation to movement disorder, it is reasonable to ask why the technique has not been more widely adopted in psychiatry? A neurosurgeon recently addressed this question and identified a number of reasons: the legacy of ‘old-fashioned’ psychiatric surgery, the complexity and heterogeneity of psychiatric symptoms, and the multitude of brain circuits likely to be involved in them, ‘tricky ethical questions related to potential manipulation of the mind’, difficulty in conducting large trials in these conditions, and inconsistent results.⁵⁰ He might have added lack of consensus over targets in the conditions most often treated and the limited number of ‘placebo’ (sham treatment) controlled trials. Nonetheless, the US Food and Drug Administration gave approval for DBS in treatment-resistant OCD in 2009, albeit through a ‘humanitarian device exemption’.³³

In the UK, new medical procedures tend to be adopted and funded following pressure from patients and their interest groups, clinicians, medical Royal Colleges and the media. It is difficult to envisage such pressure for psychiatric DBS at the moment. The legacy of mid-20th century psychosurgery includes not only public and professional distrust (the charity OCD-UK ‘do not recommend DBS as a treatment for OCD *and remain concerned that the dangers associated with the procedure continue to be overlooked by the medical community*’⁵¹ – my italics) but also ethical and methodological rules that require complex, expensive, multiprofessional teams. In 2013 the NHS Commissioning Board published DBS guidelines for the treatment of movement disorders. They included an estimated cost of £26 070 for each procedure, but acknowledge that savings resulting from clinical and quality-of-life improvements offset ongoing maintenance costs.⁵²

In an afterword to the psychosurgery text mentioned at the beginning of this paper, and a related article, Marwan Hariz, a particularly cautious and thoughtful ‘functional’ neurosurgeon, warns that ‘hying’ DBS in psychiatry at this stage could lead to its demise.⁵⁰ He also expresses concern at recent suggestions that the technique could be used to enhance ‘normal’ functioning or even control antisocial behaviour. ‘Neuromodulation’ he concludes, ‘should not be allowed to become neuromanipulation’.⁵³ It remains to be seen whether a new generation of ‘millennial’ psychiatrists and neurosurgeons armed with these emerging technologies will follow his advice.

1.6.78 Teaching provision for old age psychiatry in medical schools in the UK and Ireland: a survey

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Abstract

Aims and method This work builds on a survey first done in 1999 to understand how old age psychiatry teaching is embedded in undergraduate medical schools in the UK and Ireland and the influence of academic old age psychiatrists on teaching processes. We invited deans of 31 medical schools in the UK and Ireland in 2015 to complete an online survey to reassess the situation 16 years later.

Results Response rate was 74%. As found in the original survey, there was variation across medical schools in how old age psychiatry is taught. Half of schools stated there was not enough space in the curriculum dedicated to old age psychiatry, and not all medical school curricula offered a clinical attachment. Medical schools that involved academic old age psychiatrists in teaching (59%) showed a greater diversity of teaching methods.

Clinical implications There is a need to recognise the importance of old age psychiatry teaching, with the consensus of opinion continuing to be that more curriculum space needs to be given to old age psychiatry. To achieve this we advocate increasing the number of old age psychiatrists with teaching roles, as relying on academics to teach and lead on curriculum development is challenging given their greater research pressures.

Contents

- *Teaching provision for old age psychiatry in medical schools in the UK and Ireland: a survey*
 - *Method*
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 - * *Content and assessment of old age psychiatry teaching*
 - *Discussion*
 - * *Implications for recruitment*
 - * *Strengths and limitations*
 - * *Recommendations*

With the ageing population and high prevalence of mental health burden in the UK, it is becoming increasingly important that medical school undergraduate curricula for old age psychiatry advance in line with future demographic needs. This has been recognised by the General Medical Council (GMC) in *Tomorrow's Doctors*,¹ which stresses the importance of students learning about the special problems associated with older people's health. The Royal College of Psychiatrists has subsequently mapped the core undergraduate psychiatry curriculum outcomes² on to the competencies listed in *Tomorrow's Doctors*. Other UK national drivers, including the National Health Service (NHS) Outcomes Framework³ and the prime minister's dementia strategy,⁴ have highlighted the need for the future workforce to be competent in caring for the needs of the older person.

More broadly, there is also an increasing recognition that there is a shortage of old age psychiatrists, and recruitment of trainees is less than for other specialties (fill rate is 67% for training posts compared with 80% in psychiatry as a whole). The Centre for Workforce Intelligence (CfWI) in their in-depth review of the psychiatry workforce⁵ highlighted old age psychiatry as a particular concern, with the strongest risk of a larger demand–supply shortfall due to weak workforce growth. Currently, there are 1.1 full-time old age psychiatry certificate of completion of training (CCT) post holders per 100 000 population, but the workforce growth is not proportional to the growth in the older population, and baseline demand and supply projections anticipate a shortage of around 315 CCT holders in old age psychiatry by 2033.

In 2012, the Royal College of Psychiatrists published its recruitment strategy,⁶ with the primary aim of increasing recruitment into core psychiatry training, but the recommendations can be extended to old age psychiatry specialty training. Arguably, the concept of increased exposure to old age psychiatry and looking at the undergraduate experience

could be key to understanding why medical school graduates may or may not consider this specialty as an appealing career choice.

This study builds on a previous survey, carried out in 1999, which found that schools with established old age psychiatry academic departments devoted more time to undergraduate teaching of old age psychiatry, covered more topics and used a wider range of teaching methods.⁷ The aim of the current study was to determine how old age psychiatry teaching is embedded in undergraduate medical schools in the UK and Ireland. More than 15 years on from the original survey, we sought to demonstrate how undergraduate provision of old age psychiatry teaching has changed nationally and identify any ongoing gaps. Similar surveys have been carried out by other non-psychiatric specialties facing similar recruitment concerns, in particular geriatric medicine.^{8,9}

Method

The study took place between January and November 2015. A questionnaire (available in the *appendix*) was developed and published in electronic format using the Survey Monkey software (www.surveymonkey.com). It enquired about the teaching provision of undergraduate old age psychiatry, covering whether or not the curriculum included teaching of old age psychiatry; where in the curriculum this teaching took place; whether academic old age psychiatrists (i.e. person(s) working in old age psychiatry but with a significant aspect of their job plan including research and/or medical education) were involved in the organisation of teaching; the duration of attachment to the specialty; the form and content of the teaching; and the nature of the student assessment. There were free-text spaces for respondents to qualify their answers if necessary. The questionnaire was reviewed and the study endorsed by the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists.

The deans of all 31 UK medical schools were contacted by email and letter, asking them to identify a respondent with sufficient awareness of the undergraduate curriculum to allow completion of the survey, and requesting that the letter or email be forwarded to them. Where initial approaches and reminders were unsuccessful, members of the undergraduate leads forum were contacted through the Faculty of Old Age Psychiatry and invited to identify a respondent. As this was a survey requesting information already in the public domain, no formal consent procedure was undertaken and implied consent was assumed through participation.

The project met the Newcastle University preliminary ethical assessment guidelines, indicating that a full university ethics committee review was not required.

Results

Responses were received from 23 (74%) medical schools. No schools responded that they did not wish to participate but 8 did not respond to any form of communication (written, electronic and/or telephone). One (4%) response was from a dean, 9 (40%) from a senior lecturer, 5 (22%) from a consultant psychiatrist or programme director, 3 (13%) from a reader in old age psychiatry, 4 (17%) from a professor and 1 (4%) from a consultant physician.

Overall, 50% of respondents felt that there was not sufficient curriculum space designated to old age psychiatry; however, many appreciated the overlap with other specialties, including adult psychiatry, neurology and care of the elderly.

Staffing establishment of academic old age psychiatry

Figure 1 shows the current staffing establishment of academic old age psychiatry. More than half of schools (59%) reported that academic old age psychiatrists were involved in the organisation and delivery of undergraduate teaching, compared with 40% in the original survey. We found that 41% of schools have an academic old age psychiatrist represented on the board of studies or equivalent.

Fig. 7: Staffing establishment of academic old age psychiatrists.

Organisation and delivery of teaching

A designated clinical attachment in old age psychiatry was present in 86% of schools. Of those, in 13% the duration of the clinical attachment was dependent on individual student choice and in 41% there was the opportunity to spend more time in old age psychiatry. All respondents indicated that the majority of the teaching on cognitive assessment and dementia was delivered by an old age psychiatrist. There was no consistency between schools on when these topics were first covered, with 14% covering them in the first year, 23% in the second year, 36% in the third year, 23% in the fourth year and 5% in the fifth year.

With regard to time spent teaching old age psychiatry in the undergraduate curriculum, again there was no consistent standard, and reports ranged from a 1 h formal lecture to 25 days if the teaching on dementia/delirium covered by other specialties was included. This amount of time overlaps with that found in the original survey, in which time ranged from 1 to 40 days. Both the present and previous survey⁷ found that other, more informal/unstructured teaching was also given, but there was difficulty in quantifying the amount as this tends to depend on the clinical attachment. Some schools also offered self-directed teaching through podcasts or e-lectures (lectures delivered online), which depended on student interest and motivation.

A variety of teaching methods were used (*Table 1*), but with a large proportion primarily using lectures and tutorials as the main format of teaching (82% and 86%, respectively, v. 73% and 55% in the original survey). As with the original survey, schools where academic old age psychiatrists were involved in the organisation and delivery of teaching showed greater teaching method diversity and more use of innovative methods of teaching, such as interprofessional learning, e-learning and simulation, than those schools where there was no academic involvement. However, the overall figures were low (*Table 1*) and significance was only reached for simulation ($P = 0.03$) and home visits ($P = 0.02$). Of all schools, 50% responded that they involved carers or patients when delivering organised teaching sessions.

Method of teaching delivery

	<i>n</i> (%)		
Lectures	12 (92)	6 (60)	0.13
Tutorials	11 (85)	8 (80)	0.57
Bedside teaching	10 (77)	7 (70)	1.00
Problem-based learning	5 (38)	4 (40)	1.00
Interprofessional education	7 (54)	3 (30)	0.40
e-learning	8 (62)	2 (20)	0.09
Simulation	5 (38)	0 (0)	0.03*
Home visits	13 (100)	6 (60)	0.02*
Joint teaching	6 (46)	2 (20)	0.38
Other	0 (0)	1 (10)	0.43

Binomial probability $P = 0.03$ for all the teaching methods where there is academic involvement.

$P < 0.05$.

Content and assessment of old age psychiatry teaching

In 95% of schools the undergraduate curriculum contained specific old age psychiatry outcomes, compared with 100% of schools in the original survey, where the undergraduate curriculum contained some theoretical or clinical teaching of old age psychiatry. All schools were teaching cognitive assessment and dementia (95% in the original survey) but, as found in the original survey, fewer indicated that they covered affective disorders (82% v. 91%) or psychotic disorders (77% v. 82%). Even fewer covered service organisation (36% v. 59%) (*Table 2*). A variety of assessment methods are used (*Table 3*), with the most common (82%) being the observed structured clinical examination (OSCE). In the original survey, student assessment was most commonly by 'formal examination' (68%) and assessment of performance during the clinical attachment (64%).

Teaching content

Topic	Schools with academic old age psychiatrist involvement (<i>N</i> = 13)	Schools without academic old age psychiatrist involvement (<i>N</i> = 10)	χ^2 (<i>P</i>)
Cognitive assessment	13 (100)	10 (100)	1.00
Dementia	13 (100)	10 (100)	1.00
Delirium	10 (77)	10 (100)	0.23
Affective disorders	10 (77)	8 (80)	1.00
Psychotic disorders	9 (69)	8 (80)	0.66
Service organisation	4 (31)	4 (40)	0.69
Mental Health Act	11 (85)	7 (78)	0.62
Cultural issues	7 (54)	4 (44)	0.68
Other	2 (15)	0 (0)	0.49

Teaching and assessment methods in old age psychiatry

Assessment	Schools (<i>N</i> = 23) <i>n</i> (%)
Formal examination	11 (49)
OSCE	18 (82)
Long case	4 (18)
MCQ	14 (63)
Coursework	6 (27)
e-portfolio	3 (13)
Logbook	10 (45)
Essay	4 (18)

MCQ, multiple-choice questions; OSCE, observed structured clinical examination.

Table 2 also shows the content of teaching according to whether there is academic involvement which did not reach significance for any topic.

Discussion

Arguably, the most powerful message from this survey is that 50% of respondents did not feel that sufficient curriculum space is designated to old age psychiatry. This had been a concern in the original survey, in which 57% of schools had reported that there were significant obstacles to introducing and maintaining old age psychiatry teaching in the undergraduate curriculum. This raises the question of how much progress has been made over the past 15 years. Similar surveys done in elderly care medicine, a specialty facing a similar recruitment problem, have also found that inadequate time (<2 weeks) is spent teaching about subjects related to ageing, including dementia, which does not reflect the predominance of older patients in most doctors' workload.^{8,9,10}

The main finding in the original survey undertaken in 1999 had been that those medical schools with established academic old age psychiatry departments provided more teaching of old age psychiatry and are more likely to embrace new teaching methods.⁷ Our survey showed that 59% of schools have academic old age psychiatrists involved in the organisation and delivery of undergraduate teaching and 41% have an academic old age psychiatrist represented on the board of studies or equivalent. Similar to the original survey the main finding from the current survey is that schools where academic old age psychiatrists are involved in the organisation and delivery of teaching are more likely to use a greater diversity of teaching methods; however, only the use of simulation and home visits were found to be significant.

These results should be interpreted in the context that academics now may be less engaged in organising teaching (unless they are specifically medical educators) as they have predominantly research roles and greater research pressures. This highlights a need to drive up the number of other old age psychiatrists with teaching roles.

In the original survey all of the schools reported that the undergraduate curriculum contained some theoretical and/or clinical teaching of old age psychiatry and in our survey 95% of schools reported that their undergraduate curriculum contains specific old age psychiatry outcomes. Worryingly not all schools offer a clinical attachment in old age psychiatry (86%, slightly higher than in the original survey (82%)), and in those that did, the organisation of this is variable. As with the original survey, the amount of time offered varies considerably, and in some schools student exposure to old age psychiatry depends on individual clinical attachments. A wide range of teaching formats are reported, with the commonest methods being lectures and tutorials. Other methods, such as interprofessional teaching, e-learning and simulation, are less common (*Table 1*). Similarly, there was relatively low patient and carer involvement in teaching (50%).

Low use of interprofessional teaching and involvement of patients and carers in particular are missed opportunities, as evidence has shown that interprofessional education (IPE) can be used to significantly improve confidence and change attitudes in staff managing older patients with dementia or delirium.¹¹ This style of teaching delivery could therefore also be applied to undergraduates, especially at a time when the expectation from the GMC is for greater IPE within curricula to improve team-working skills.^{1,11} As such, teaching on topics relevant to old age psychiatry could be the hook through which it is possible to drive up the amount of IPE, and hence development of team-working skills within the broader medical curricula, as well as fostering more positive attitudes towards the older patient and improving recruitment into this specialty.

As regards the content of teaching, all schools are delivering teaching on dementia and cognitive assessment and the majority (91%) are teaching on delirium. It is concerning that not all schools cover affective and psychotic disorders (82% and 77%, respectively) in this age group as, unlike dementia and delirium, these topics are less likely to be covered by other specialties, and their presentation and management differ considerably compared with general adult psychiatry. As with the original survey,⁷ cultural issues were covered less (50%). Academic involvement in teaching did not lead to any significant difference in the content of teaching, which should be expected if medical schools are using a standard curriculum and is perhaps reassuring given that not all medical schools will have academic old age psychiatrists involved in the organisation of teaching.

In contrast to the original survey, where student assessment was most commonly by a 'formal examination', this survey showed that an OSCE was the most commonly used method of assessment, with other techniques, such as assessed

coursework and portfolios or logbooks, less frequently reported (*Table 3*). The need to ensure that teaching and assessment in medical schools is done to a high standard is crucial as assessment drives learning. However, we do not advocate a standardised assessment process as there are contextual variations in teaching nationally. What is important for educators is to understand what is being assessed and thereby select the correct assessment format as per the Millers Pyramid,¹² i.e. multiple choice questions to test knowledge, OSCEs to assess performance. This would enable assessment processes to be undertaken in an appropriate manner and for schools to demonstrate that learning outcomes have been achieved by students.

Implications for recruitment

Given the concerns about recruitment into old age psychiatry, it is important to consider the influence of the undergraduate curriculum experience of old age psychiatry on postgraduate career choice. A survey of graduates from Liverpool University 5 years post-qualification¹³ found that the majority felt their career choice was primarily dictated by their postgraduate experience rather than their undergraduate clinical attachments. However, in another survey of graduates, Goldacre *et al*^{14,15} found that factors during undergraduate experience significantly outweighed any inclinations before entry to medical school concerning the influence on career choice. They also found that career choices were greatly influenced by a particular teacher or department. The importance of a good role model has also been identified by surveys in other specialties,^{16–18} highlighting the importance of individuals in fostering enthusiasm and interest in a specialty.

Specialties with similar recruitment problems to old age psychiatry have found that the most significant factors influencing final-year medical students in their career choice were clinical mentors and specialty-themed, problem-based learning cases.¹⁸ However, for psychiatry as a whole, other studies have found that attitude changes towards considering a career in this specialty were similar whether students were taught with problem-based learning or with a more traditional curriculum.^{19,20}

In elderly care medicine, a study done at the University of Aberdeen²¹ found that an intensive 8-day programme increased the likelihood of fourth-year medical students considering this specialty as a career. Several US studies have shown that a positive attitude towards older people increases the likelihood of pursuing a career in care of the elderly and that increased exposure to this specialty during medical school has a positive influence on attitudes.^{22–24} This supports the view that the most effective interventions to increase recruitment of elderly care physicians should focus on positively influencing medical students' attitudes during medical school through meaningful experiences during clinical attachments, findings which could be extrapolated to include old age psychiatry. Indeed, US and Canadian surveys looking at factors that influence medical students choosing old age psychiatry as a career have found that one of the key factors is completing an old age psychiatry rotation alongside specific teacher attributes and training experiences.^{25,26} These findings support our key recommendations (*Box 1*).

Strengths and limitations

The response rate to this survey was good (74%), although it must be acknowledged that there may still have been a response bias, with a poorer return from the schools without a strong academic old age psychiatry department or representative for undergraduate teaching provision in old age psychiatry. Consequently, we may have underestimated the poorest end of the spectrum.

Box 1 Key recommendations

1. Old age psychiatry should be offered as a clinical attachment in all medical schools.
2. All schools should deliver specific old age psychiatry outcomes in the undergraduate curriculum including affective and psychotic disorders, legal and cultural issues.
3. A minimum time delivering formal teaching and time spent on clinical attachment should be agreed by the College with medical schools to ensure adequate exposure in old age psychiatry.
4. Schools should strive to drive up the number of old age psychiatrists with teaching roles and ensure they are supported in delivering a greater diversity of teaching methods and acting as positive role models.

5. There should be greater use of patients and carers in teaching to help foster positive attitudes.
6. The use of interprofessional learning should be recognised in driving up the status of old age psychiatry and ability to practise effectively in collaboration with other professions.
7. There is a need to ensure that schools teach and assess to a similar high standard in order to demonstrate that old age psychiatry outcomes have been addressed.
8. Future surveys should look at surveying medical students on their opinion and experience of old age psychiatry as well as career intentions.

Of the responding schools, data were collected from only one representative, with the hope that the respondent identified from each school would be whoever had suitable knowledge of the undergraduate curriculum. There is a possibility, however, that some of these representatives may have had an inadequate or biased overview of the undergraduate curriculum and that not all information was reported or accurate.

It was apparent through some of the free-text responses that some schools found it difficult to quantify the length of time spent teaching curriculum outcomes specific to old age psychiatry. For medical schools with an integrated curriculum, it may have been difficult to extract this information, as there is an overlap with other specialties who may have delivered this teaching.

It must be acknowledged that a limitation in the comparisons of academic old age psychiatrist involvement is that results reported were uncorrected and it is likely that there may have been no significant difference due to the overall numbers being low, and the number of comparisons being made. A further limitation was that the survey explores the taught curriculum and does not cover student-selected topics or the fact that some medical students may choose to do a research period in old age psychiatry. There are also no data regarding the opinion of medical students, and subsequently the influence of individual schools' undergraduate experience on career intention. Consequently, the assumption could not be made that medical schools with a mandatory clinical attachment in old age psychiatry and embracing more innovative methods of teaching delivery had a positive effect on intention to pursue old age psychiatry as a career. Further research is needed to explore the experience of the curriculum on paper and the 'hidden curriculum' experienced by the students by means of surveys and focus groups of undergraduate students as well as following up cohorts of students into their chosen career.

Recommendations

With the ageing population and increasing complexity of their needs, it is imperative that the future generations of doctors are suitably equipped with the knowledge, skills and attitudes for dealing with future challenges. It is especially important that the undergraduate experience fosters positive attitudes about old age psychiatry as a specialty and potential future career to try to address the workforce crisis we currently face. This survey of teacher practice has highlighted that there is still variation across medical schools in how old age psychiatry is taught, and made recommendations in how undergraduate experience of old age psychiatry can be enhanced. The value of interprofessional learning, as well as more involvement of patients and carers, should be recognised in improving the attractiveness and status of old age psychiatry. Although there may have been progress over the past 15 years in embedding old age-specific outcomes in the undergraduate curriculum, the consensus of opinion does continue to be that more curriculum space needs to be given to old age psychiatry.

1. Which medical school are you responding on behalf of? _____
2. What is your job title? _____
3. What is the current staffing establishment in academic old age psychiatry?
(number of posts 0 1 2 3 4 5 >5) (professor/reader/senior lecturer/lecturer/research fellow/research assistant)
4. Which of the following best describes the style of teaching at your medical school? (traditional (i.e. lectures and tutorials during years 2–3 followed by the clinical years), integrated (i.e. clinical attachments from year 1), problem-based (i.e. student-centred teaching), other.)
5. Does the undergraduate curriculum contain specific old age psychiatry outcomes? (yes/no/don't know)

6. Which topics are covered? Tick all that apply (cognitive assessment/dementia/delirium/affective disorders/psychotic disorders/depression/service organisation/Mental Health Act/cultural issues/other/none of the above)
7. How much time is spent teaching old age psychiatry in the undergraduate curriculum? (e.g. approximate number of days) _____
8. When is dementia and cognitive assessment first covered? (first year/second year/third year/fourth year/fifth year)
9. Are there plans to incorporate the recent Health Education England dementia curriculum into the teaching program? (yes/no/don't know)
10. Who delivers the majority of the teaching on cognitive assessment and dementia? (old age psychiatrist/other (please specify))
11. Is there a clinical attachment in old age psychiatry? (yes/no)
12. Is the duration of a clinical attachment in old age psychiatry dependent on individual student choice? (yes/no/compulsory attachment with opportunity to spend more time on old age psychiatry/compulsory attachment with no further opportunity to spend more time on old age psychiatry)
13. Which teaching methods are used for old age psychiatry teaching? Tick all that apply (lectures/tutorials/bedside teaching/problem-based learning/inter-professional/e-learning/simulation/home visits/joint teaching/other)
14. Are carers or patients involved in the delivery of teaching? (yes/no)
15. Which methods are used to examine students on old age psychiatry? (formal examination/OSCE/long case/MCQ/coursework/e-portfolio/logbook/essay/other)
16. Are academic old age psychiatrists involved in the organisation and delivery of undergraduate teaching of old age psychiatry? (yes/no/don't know)
17. Are academic old age psychiatrists represented on your board of studies or equivalent? (yes/no/don't know)
18. Do you think that there is sufficient curriculum space given to old age psychiatry? (yes/no)
19. Any other comments re: teaching of old age psychiatry? _____
20. Would you like a copy of the results? (yes/no)

1.6.79 Profile: Derek Summerfield – politics and psychiatry

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date

2017-10

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Preparing for this interview, I was aware of Dr Summerfield's political commitment. After all, he was the principal psychiatrist for Freedom from Torture (Medical Foundation for the Care of Victims of Torture) from 1991 until 2000. He is an outspoken critic of what he describes as the complicity of the Israeli Medical Association (IMA) and Israeli doctors posted to interrogation units in relation to the torture of Palestinian refugees, which has led to him receiving many accusations of anti-Semitism and becoming the subject of a libel suit by the President of the IMA. He is a member of the Critical Psychiatry Network. Before training in psychiatry, he worked as a government medical officer in Zimbabwe to 'repay his debt' to Africa. This was clearly going to be an encounter with a man of the left, passionate about social justice.

The personal and the political

I was curious about how Dr Summerfield sees the personal and the political. Can they ever be separated? What exactly is the role of the psychiatrist in relation to social justice? Should what I will call 'ethico-political awareness' be part of psychiatric training, given the huge relevance to mental health of the context in which our patients live?

If senior psychiatrists should be leading the profession, can this ethico-political thinking be encouraged by example only, or more explicitly within the syllabus? And how does Derek Summerfield see his role within the profession? Is he an individual firebrand, grit in the oyster, provocateur, thinking iconoclast, leading by example and seeking influence via publication, or does he have a more intergenerational mission? (It emerges that he has recently canvassed the juniors at the Maudsley Hospital and recommended they should not comply with trust training in relation to the controversial government Prevent strategy of 2015, intended to detect early radicalisation in pupils, students or patients, which he regards as outrageous state intrusion into clinical confidentiality and a form of McCarthyism.)

More widely, in the recent climate of junior doctor strikes, dire warnings from the British Medical Association, hot controversy over the National Health Service as a public service, what, if any, are the political obligations of (a) doctors in general and (b) psychiatrists in particular? I got my answer loud and clear in a note he sent me a few days after the interview: "There is the doctor as doctor, but also (ethically imperative) the doctor as sentient citizen . . . To do with a fundamental duty to attend not just to the particulars of the patient sitting in front of us, but also to the political and socioeconomic factors that produce distress and disease. Doctors have largely not done this. End of sermon . . ." Dr Summerfield is actually not preachy: he is amusing, not pompous, but self-deprecating – yet utterly (and perhaps unfashionably) serious. Of course he knows that not all doctors or psychiatrists share his views. Indeed, he is realistic: "With exceptions, doctors are not politically engaged. The average doctor doesn't have a social activist bone in his body. . . as a profession we are closer to those in power than those without it. . . medicine is basically an entrenched profession, and we behave like one . . . after the revolutions in places like Cuba, Mozambique, the vast majority of doctors left the country . . ." I wonder how he was viewed by the international and non-homogeneous group of South London and Maudsley NHS Foundation Trust (SLAM) junior psychiatrists when they received his open letter about the Prevent strategy training. Is he admired as a model of the thinking critical psychiatrist, or dismissed as eccentric or even dangerously insurrectionist?

Derek Summerfield was born 68 years ago in Cape Town, South Africa, into a non-medical family, but grew up in Bulawayo, the second city, after Harare, of Zimbabwe (then Rhodesia). He studied physics initially ('the headmaster persuaded bright White boys to do science'), then worked in a shipping company in Cape Town, and did some teaching. He always wanted to be a journalist (and now thinks he'd do law and anthropology if he was starting out again), but nevertheless began medicine, aged 24, at St Mary's Medical School in Paddington, London.

'I failed everything, and nearly left in the first year. I had no interest or feel for science in the preclinical years, but when I got onto the wards I felt an intellectual thrill at last.'

He did house jobs (i.e. FY1) in Oxford and Cambridge, and went on to become a medical registrar with MRCP Part 1. During this period he did several stints in Zimbabwe during and after the civil war, no walk in the park. In Chiredzi, in the war-ravaged rural south-east, there were 200 beds and 2 doctors. He was the paediatrician, 'with 50 desperately sick kids at any one time ... 5 of whom died each day'. He saw up close and personal the effect of poverty on health: 'even measles was 80–100 times more fatal in these malnourished kids'.

He finally decided on psychiatry in 1982, now aged 34, and went to St George's Hospital. While working there he met a beautiful and much younger woman, now a consultant clinical psychologist and psychoanalyst at the Tavistock, Francesca Huhne. They have a 20-year-old daughter, who is reading History at university. He and Francesca subsequently studied war-wounded men from both sides of the civil war in Nicaragua together. He has been a consultant to Oxfam, and for many years was a research associate at the Refugee Studies Centre, University of Oxford.

He joined Freedom from Torture (Medical Foundation for the Care of Victims of Torture) full-time in 1991, where he treated around 800 patients, often seeking asylum in the UK: Bosnians, Sri Lankans, Iraqis, Turkish Kurds, Africans and Palestinians, with 95% of consultations requiring interpreters. But with his lifetime history of independent thinking and acting on principle, this appointment did not end amicably: he was 'asked to leave' Freedom from Torture in 2000 because the organisation was concerned that his widely published questioning of the category of posttraumatic stress disorder (PTSD) might deter funders.¹ He sees the diagnosis of PTSD in the context of refugees as the 'pseudo-scientific pathologising of people affected by war ... the medicalisation of their situation diminishes the importance of work and the rebuilding of social networks ... the broken social world is the lot of the asylum seeker'.²

After leaving Freedom from Torture, he contacted Dr Maurice Lipsedge, who suggested that he should consider applying for his job in SLAM, from which he was retiring. This was in the HIV mental health team, initially part time, then full time.

The HIV team at its zenith had four psychologists and acted as a community mental health team with an HIV focus. He enjoyed the interest of the 'two different groups of patients ... African women and British gay men'. The service was greatly reduced in 2016, owing to both financial constraints and the mainstreaming of HIV. He accepts this process as reasonable, given the changes in HIV treatment and prognosis, with life expectancy being almost normal now, if the medicines are taken reliably. (And many African women don't always do this, and he would like to understand why.)

He has no immediate plans to retire and is busy with a variety of work outside the 'day job'. He's involved with the new medical school in Bulawayo, his home town, helping with the undergraduate curriculum, and will teach there: 'I still feel a debt to Africa'. He advises Oxfam: In the 80s they suddenly got very interested in the mental health of victims of war'. Derek Summerfield helped evaluate their projects in Bosnia, and steered Oxfam away from a PTSD-centred approach to victims of that war: 'I persuaded them not to go down the counselling route ... if you ask Muslim adolescents in Tuzla what they want, they want a bit of normality. They actually requested some fabric so they could put on a fashion show'.

Problem with the concept of global mental health

He has published widely from the standpoint of a fundamental opposition to the medicalisation of human distress and the assumption that Western psychiatry is universally valid, which he sees as a kind of cultural imperialism.^{3,4}

He offers a critique and deconstruction of international attitudes to the mental health of victims of war.² He stresses how the global effects of wars are largely experienced by people living in poverty, and he sees the danger of the PTSD diagnosis as pathologising of the individual rather than attending to the effects of poverty and the need for reconstruction of the social fabric.²

He makes a more general critique of the concept of 'global mental health', highly critical of 'taking depression into a country which has no such concept, followed by the marketing of antidepressants ... Western cultural values parading as medical facts'.^{3,4} His critique extends to the cultural relativism of psychiatric diagnoses in general: as if disease had an objective existence, independent of the gaze of the diagnostician.

The origin of PTSD as a diagnosis was for disturbed Vietnam war veterans in the USA with the benign intention of lobbying to get decent care for them by emphasising the traumatogenic nature of war, thus legitimising a position of victimhood, moral exculpation and receipt of disability pensions. In Summerfield's view, the development of this concept of PTSD needs to be understood in the wider social context of the 'rise of expressive psychologically minded individualism, personal rights, entitlement and grievance,' as opposed to the previously socially sanctioned stiff upper lip self-management of trauma. Now PTSD has become a 'certificate of impairment'. It is the only diagnosis which contains its aetiology within itself, while in fact, he claims, premorbid factors such as psychiatric history or a negative thinking style are more important than the actual event itself in the aetiology of symptoms.¹

Conflating normality and pathology 'devalues the currency of true illness'.

He is an old fighter, brave and almost proud of his battle scars: 'No-one has been called an anti-Semite in the medical press more than me'. He feels the campaign he convened against medical complicity with torture in Israel is the 'best thing I've done in my career'. So the life and views of Derek Summerfield are a challenge to all doctors, even those with different political views: is it acceptable for doctors to absent themselves from political engagement as being outside their remit, or are we ethically obliged to be properly aware of the sociopolitical context of our work? People with unflinching integrity have always made others uncomfortable: consider the unpopularity of Jesus overturning stalls in the temple market.

If we take our ethical obligations as doctors seriously, we need intellectually rigorous and dogged colleagues like Derek Summerfield to point up our innate conservatism and political passivity.

1.6.80 Paul Haydon Rogers FRCP FRCPsych

: Formerly Consultant Psychiatrist and Medical Director, St Crispin Hospital, Northampton

Don Williams

date

2017-10

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- *Paul Haydon Rogers FRCP FRCPsych*

– : *Formerly Consultant Psychiatrist and Medical Director, St Crispin Hospital, Northampton*

Paul Rogers died on 11 February 2016, aged 96, after a short illness. For the last 10 years of his life he lived independently and happily in a support and care complex in the grounds of St Crispin hospital (now converted into apartments) where he had worked from 1955 to 1979. During his time at St Crispin, where he established community-based services, he was responsible for the introduction of new treatments, particularly the newly developed psychotropic drugs. He developed child guidance clinics in the area and was also involved in the planning of Princess Marina Hospital for people with learning difficulties. After retirement from the National Health Service (NHS) he worked with the Health Advisory Service and as a member of the Mental Health Review Tribunal dealing with difficult issues at Broadmoor and Rampton high-security hospitals. In Northampton, he pioneered the recognition of stress at work and helped to create a local charity to advise employers and provide counselling for employees.

A son of the manse, he was born in Cardiff in 1919 and from an early age wanted to be a doctor. After attending Caterham School and Christ's College Cambridge, he qualified in 1943 at the London Hospital, now The Royal London Hospital. Shortly afterwards, he served as captain in the Royal Army Medical Corps in Normandy, Egypt and Palestine. On demobilisation in 1947 he returned to the London Hospital to pursue his ambition to become a consultant physician. Unfortunately, at this time, there was ferocious competition for promotion because of the high number of doctors returning from the forces after the Second World War. So, instead, he retrained at the Maudsley Hospital to become a psychiatrist. Nevertheless, he remained a physician at heart, adopting a medical approach and placing great emphasis

on diagnosis and the use of physical methods of treatment. Although he was insistent that he did not do psychotherapy, he had all the personal qualities of an excellent psychotherapist: empathy, non-possessive warmth, genuineness and a supportive non-judgemental approach.

Paul was a consummate professional dedicated to his work and the NHS, and as a role model he influenced several younger colleagues to take up psychiatry. He had no time for private practice or medical politics. His focus was the care and management of his patients. They loved him and on the rare occasions I took his clinic their disappointment was palpable. Modest, unassuming, understated and unassertive, he combined the qualities of an English gentleman with attributes of Welsh nonconformity and liberalism, reflecting his deep roots in west Wales. Basic Christian values guided his life and he had no regard for social class – a good example of this was his lifelong friendship with his batman, the only link he maintained with his time in the army. The Guardian was his newspaper and he espoused its core values.

He was devoted to his family and only looked for the good in everyone. He supported many charities and was pre-occupied with people, who, as he put it, were ‘less fortunate than I am through no fault of their own’. In retirement, activities linked to psychiatry gradually declined and were replaced by his only hobby – gardening. He enjoyed growing food for the house and his garden was always a pleasure to see. Over the years and into advanced old age he enjoyed excellent health; so much so that his close relatives were lulled into thinking that he would always be around and that his support, consideration and wise advice would always be available. He grew old gracefully in every way, retaining his core liberal values to the end.

Marjorie, his wife, and his younger daughter, Helen, predeceased him. He is survived by his sister, daughter and son.

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1.6.81 Costas Stefanis MD

: Formerly Professor of Psychiatry and Head, Department of Psychiatry, University of Athens Medical School; Director, Eginition University Psychiatric Hospital, Athens

Nick Bouras

date

2017-10

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- *Costas Stefanis MD*
 - : *Formerly Professor of Psychiatry and Head, Department of Psychiatry, University of Athens Medical School; Director, Eginition University Psychiatric Hospital, Athens*

Costas Stefanis, who died recently at the age of 88, was the leading figure in psychiatry in Greece for 30 years, from the time of his appointment as professor of psychiatry in 1970. In collaboration with British-trained colleagues he transformed Greek psychiatry and mental health services, steering away from a previously narrow traditional psychoanalytic approach towards a much broader biopsychosocial direction. He expanded the provision of generic and

specialist mental health services and was quick to adopt the new emerging trends of community care by developing the first community mental health centre in Greece. He developed a strong research programme, having himself – early in his career, while in the USA and Canada – carried out pioneering work on the functional role of pyramidal neurons in the sensorimotor cortex. He had an international reputation as an expert on the mode of action of neurotransmitters functioning on central nervous system synapses.

Several generations of Greek psychiatrists and allied professionals were trained by him, including me. Many became his associates and were inspired to go on to acquire international recognition and reputation. In 1989, in Athens, he founded the University Mental Health Research Institute – which undertook much neurobiological and psychosocial research into mental disorders – and remained president and director until his death.

He also played a major part in international psychiatry. As president of the World Psychiatric Association (WPA) from 1983 to 1990, he was responsible for an organisation in crisis. The political use of psychiatry in the Soviet Union to incarcerate political dissidents on the grounds of mental illness led to an explosive climate within the WPA. In 1983, after major criticism from societies in other countries – which made it likely that it was facing expulsion – the All-Union Society of Psychiatrists and Neuropathologists of the USSR withdrew from the WPA. Years later, at the WPA congress held in Athens in 1989, the general secretary of that Society publicly acknowledged that political abuse of psychiatry had indeed taken place and the organisation was reinstated as a member. This by no means ended the unhappy situation in the Soviet Union, which to some extent continues to this day, but a greater degree of openness was achieved. Costas Stefanis was among those responsible for reaching a conciliatory approach on issues with significant ethical and political dimensions.

Costas Stefanis became active in the political life of his country. Between 1996 and 2000 he served as honorary member of the Greek Parliament in the reformist social-democratic government and was Minister of Health and Welfare from 2002 to 2004. During his ministerial tenure, he was president of the Council of Ministers of Health of the European Union and succeeded in achieving approval for anti-stigma legislation regarding mental illness. On behalf of the EU member states, he signed the World Health Organization's International Treaty on Tobacco Advertising. In Greece, he was responsible for four major bills passed by Parliament – on public health; reform and decentralisation of health services; the organisation of primary health care and provisions for prevention and social reintegration. Unfortunately, most of them are still awaiting implementation.

He received numerous distinctions and awards. In 1994 he was elected life member of the Athens Academy of Sciences and Arts – the highest level of scientific recognition in Greece – and served as its president in 2006. He was awarded the Medal of the Cross of the President of the Hellenic Republic in recognition of his distinguished service to the country. In acknowledgement of his contribution to psychiatry, the World Federation of Societies of Biological Psychiatry and International Neuropsychiatric Association established an international prize: the Costas Stefanis Award for Excellence in Psychiatry and the Neurosciences. He was elected honorary member and fellow of several scientific associations and he authored numerous peer-reviewed articles as well as books and articles in the lay press.

Costas Stefanis was born in Greece in 1928 and graduated from the Medical School of Athens University in 1953. He trained in neurology and psychiatry in Athens and subsequently served as a fellow in basic neurophysiology at McGill University, Montreal, and as a research scientist at the National Institute of Mental Health and Saint Elizabeth Mental Hospital (Bethesda, Maryland and Washington, DC).

He was a highly intelligent, conscientious professional who, during difficult times, strove to improve psychiatric and mental health service provision not only in Greece but worldwide, thus improving the lives of thousands of people. He died on 29 October 2016 after a long illness stoically borne, remaining active in offering advice and ideas to the end. He was devoted to his family and is survived by his wife Adela, two sons – Nicos, professor of psychiatry, and Leonidas, professor of neurology – his daughter Evanthia, a film maker, and four grandchildren.

The death of Costas Stefanis will be felt as a great loss to psychiatry by many clinical, academic and international colleagues who had the privilege of knowing and working with him.

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1.6.82 Kurt Schapira MD FRCP FRCPsych DPM

: Formerly Consultant Psychiatrist, Newcastle Health Authority, Honorary Lecturer in Psychiatry, University of Newcastle

Kenneth Davison Hamish McClelland Alan Kerr Martin Schapira

date

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- *Kurt Schapira MD FRCP FRCPsych DPM*
 - : *Formerly Consultant Psychiatrist, Newcastle Health Authority, Honorary Lecturer in Psychiatry, University of Newcastle*

Shortly after completing his house officer posts and national service in the Royal Army Medical Corps, Kurt Schapira, who died recently aged 87, was appointed a research fellow to the eminent neurologist Henry Miller. More than 1150 patients with multiple sclerosis resident in Northumberland and Durham on 1 January 1958 were reviewed by Dr Schapira. Using this material, he jointly wrote 16 scientific articles on various aspects of multiple sclerosis – including its epidemiology and clinical features – many of which are still cited today. The study made a major contribution to knowledge of this condition.¹ Subsequently, fascinated by the emotional effects of multiple sclerosis on the patients, Dr Schapira decided to switch to psychiatry. He participated in Martin Roth's landmark studies on anxiety and depression and undertook his own research into suicide and attempted suicide, as well as on the treatment of anorexia nervosa. His longitudinal studies relating suicide rates to social factors and the availability of lethal methods were influential in demonstrating the importance of a public health preventive approach to suicide.² He published several articles on these and other topics, including, with others, a much-quoted paper on the influence of tablet colour in the treatment of anxiety and depressive states.³

Born in Vienna to orthodox Jewish parents, Kurt's childhood was disrupted by the death of his mother when he was aged 7 years. This was followed by the incarceration of his father by the Nazis in Dachau and then Buchenwald concentration camps. Fortunately, his father was released from Buchenwald and allowed to travel to England before the Second World War. Kurt lived in Berlin with a maternal aunt until the age of 10, when he obtained a place on a Kindertransport train to England. Having successfully negotiated a path through the British educational system, Kurt was admitted to medical school in Newcastle – then part of the University of Durham – and qualified as a doctor in 1952.

He trained in psychiatry in the university department of psychiatry in Newcastle, headed at that time by Martin Roth and James Gibbons. Within the department he was promoted to first assistant and then senior lecturer. In 1974 he became consultant psychiatrist to the Newcastle Health Authority while retaining his university connection as an honorary lecturer. He continued in this position until his retirement from the NHS in 1989.

He lectured widely both in the UK and abroad, as far afield as Brisbane, Minnesota, Montreal and Jerusalem. During his retirement he remained active in research, especially into factors influencing the incidence of suicide in Newcastle over three decades. His last published article on the subject⁴ – in collaboration with others, including his son Martin – appeared as recently as June 2016.

He undertook many responsibilities in both National Health Service and university administration and was a member of several university committees. Within the Royal College of Psychiatrists, he was a member of Council (1979–82), the Education Committee (1979–82) and the Board of Assessors of the *British Journal of Psychiatry* (1970–75), as well as examiner for the membership and various other psychiatry-related degrees at home and abroad. He was also elected President of the Section of Psychiatry, Royal Society of Medicine (1980) and President of the North of England Medico-Legal Society (1982).

Kurt enjoyed teaching and regularly topped the students' ratings for the quality of his lectures, which were notable for their combination of wit and erudition. These attributes rendered him a popular speaker to non-medical audiences, especially on the art of Chagall, Salvador Dali and Van Gogh, and the artistic portrayal of doctors and lawyers. He was a connoisseur of opera and classical music, particularly Verdi and Mozart.

He was generous with his time in acceding to invitations to speak about his childhood experiences to a variety of audiences, from schoolchildren to prisoners, and was proud to meet Prince Charles recently at a reception for Kindertransport survivors. A genial extrovert and renowned raconteur, whose personality raised the spirits of his friends and colleagues, he had a fund of humorous anecdotes, enhanced in the telling by a trace of a Viennese accent. He often expressed his indebtedness to England for accepting him as a refugee. Considering his many contributions to the sum of human health and happiness, any debt has been more than repaid.

He leaves Eva, his wife of 51 years, 3 children, 5 grandchildren, 4 great grandchildren and an older sister.

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1.6.83 Women in Academic Psychiatry: A Mind to Succeed

Linda Gask¹

date

2017-10

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- *Women in Academic Psychiatry: A Mind to Succeed*

As a female academic psychiatrist I asked two questions of myself about this book. Did I identify with the problems described here? And second, would I have found it valuable to read at an earlier stage in my career? The answer to both of these is a (qualified) yes.

¹

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The book is in two parts. The first consists of 16 interviews with eminent female psychiatrists and psychologists, which were almost certainly conducted by email. The questions are standardised, the responses polished and there is no in-depth probing of replies – which as a qualitative researcher I would have found more revealing. The second part of the book is a series of rather brief chapters which provide a helpful template for recognising the barriers and considering how to overcome them. These include putting yourself first, projecting confidence even if you don't feel it, being memorable, persistent and something I've found to be particularly important – networking.

The problems described are all too familiar – I've been subjected to mansplaining, '*a man compelled to explain, especially to a woman, something that she already knows better than him.*' I've held back in conversation, fearful of asking questions. I've been the only woman in a committee room except for the person taking the minutes. Yet, all of these very talented women demonstrate how a combination of real passion for what you are interested in and the ambition to push yourself forwards, even when times are challenging, has resulted in outstanding academic success.

Almost all the interviewees are now at the pinnacle of their careers. Many came from similar professional families and more than a few acknowledge the role played by a supportive partner with the kind of job that made it easier to be both an academic clinician and a mother. There is no one still 'finding their way' that a younger me might have identified with and the majority work in biological psychiatry – the editors' own field – in the USA. I might have found it helpful to read their stories when I was younger, but on the other hand, I might have been more than a little intimidated too.

1.6.84 Mental health law across the UK†

Tony Zigmond

Correspondence

Tony Zigmond (aszigmond@me.com)¹

date

2017-12

Abstract

The criteria governing medical treatment without consent in the three legal jurisdictions of the UK – England and Wales, Scotland and Northern Ireland – is discussed.

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- *Mental health law across the UK†*

'A doctor is not that sinister figure which in former times he was represented to be, anxious simply to confine a man in a dungeon for life. He is treating mental disorder in exactly the same way as he treats any other disease.'

Lord Russell 1928¹

Nearly 20 years ago I wrote an editorial in this journal that there should be a medical incapacity act to 'provide for the medical treatment, both mental and physical, of those who lack capacity from whatever cause. It would establish a statutory framework offering the same protections to all patients who are unable to consent to medical intervention, from both physical and psychiatric conditions, and permit investigation and treatment of both the physical and mental

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Tony Zigmond, retired consultant psychiatrist, UK.

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illnesses of such patients'.² Szmuckler & Holloway have not just argued for a single piece of legislation for all nonconsensual care and treatment saying that a mental health act is harmful,³ they have written a draft act under the heading of 'Fusion Law'.⁴ We may soon know whether we were right.

There are three distinct legal jurisdictions within the UK: England and Wales, Northern Ireland and Scotland. Until recently all had a mental health act to regulate the care and treatment of people with a mental illness while relying on common law to do the same for the physically ill. The powers given to doctors and other healthcare professionals by the two regimes was very different.

Within a year or two either side of the turn of this century, all the jurisdictions started to review their relevant legislation, not only their mental health law but also the necessity for replacing common law with statutory provision for the non-consensual treatment of physical illness, not least to ensure compliance with the European Convention on Human Rights as required by the Human Rights Act 1998. Scotland passed its Adults with Incapacity (Scotland) Act 2000, England and Wales its Mental Capacity Act 2005, Northern Ireland its Mental Capacity Act (Northern Ireland) 2016. For their mental health acts, each started with a review: Richardson for England and Wales published in 1999,⁵ Millan for Scotland in 2001⁶ and Bamford for Northern Ireland in 2007.⁷ Each considered whether or not their mental health act should include a 'capacity' criterion for medical treatment without consent.

The courts have been consistent about the role of capacity when adults make a decision about medical treatment. Lord Reid in 1972 said: "There is no doubt that a person of full age and capacity cannot be ordered to undergo a blood test against his will. ... the real reason is that English law goes to great lengths to protect a person of full age and capacity from interference with his personal liberty. We have too often seen freedom disappear in other countries not only by coups d'état but by gradual erosion: and often it is the first step that counts. So it would be unwise to make even minor concessions".⁸ Lord Donaldson, then Master of the Rolls, in 1992 said: "Prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death".⁹ Ten years later Dame Butler-Sloss said the same: "A competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even when that decision may lead to his or her death".¹⁰ They all emphasised the importance of autonomy. Although common law has now been replaced by statute law, the provisions of capacity legislation fully reflect these sentiments. I note that all the Judges were, of course, incorrect. A competent person with a mental illness may have no right to refuse treatment.

To return to the reviews. The first principle of Recommendation 3.3 in the Millan report is 'Non discrimination – People with mental disorder should whenever possible retain the same rights and entitlements as those with other health needs' (p. 23).⁶ So, should capacity be a criterion as it is for those with other health needs? The report sets out the arguments against the capacity criterion including that there were difficulties assessing capacity, particularly in patients with mood disorders, obsessive-compulsive disorders and eating disorders; 'Such patients might retain legal capacity but be at such risk as to justify intervention' (p.55).⁶ The committee was also told by some psychiatrists that "incapacity was a concept which they would find difficult to measure and apply. The British Medical Association (BMA) suggested that a capacity test would make it harder for GPs and doctors in, for example, Accident and Emergency Departments to come to a decision, and might lead to a reluctance to use the Act. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), while in favour of making the justification for non-consensual interventions more explicit, suggested that professionals were not equipped to apply sophisticated tests of capacity fairly' (p.55).⁶ These comments about difficulties assessing capacity are noteworthy because no individual or organisation said they could not operate or abide by the provisions of that country's incapacity act which, of course, requires assessment of capacity.

The Millan committee advised "that it should not be possible for a compulsory intervention to be made under mental health law unless there is evidence that the person's judgement is significantly impaired, as a result of mental disorder, so as to justify the intervention. This expresses a broadly similar concept to incapacity, but is felt to be a less legalistic formulation, and one which may be easier to apply in practice' (p. 57).⁶ Significantly impaired decision-making as a result of the mental disorder (SIDMA) is a criterion for compulsion in the Mental Health (Care and Treatment) (Scotland) Act 2005. Millan had asked the question as to whether a mental health act was necessary and decided it was. Richardson also considered the question of capacity. Similar to Millan, 'The principles governing mental health care should be the same as those which govern physical health' (p. 21)⁵ wherever possible. Although deciding that incapacity should not be a criterion because 'Mental disorder unlike most physical health problems may occasionally

have wider consequences for the individual's family and carer, and very occasionally for unconnected members of the public' (p. 19),⁵ the report suggested a form of words which would require the assessment of, and taking into account, the patient's capacity. Patients with capacity could only be detained if they presented a higher degree of risk compared with patients who lacked capacity. The government rejected this proposal. That a distinct mental health act was required was not questioned. There is no 'capacity' or 'SIDMA' criterion, nor a distinction between patients who retain capacity and those who do not, in the Mental Health Act 1983 (amended in 2007). To have such a criterion would have meant, according to Lord Hunt during the debate on the 2007 Bill, 'abandoning one of the most fundamental objectives of the Act, namely that compulsory intervention should be based on need and risk'.¹¹ To spell it out, in England and Wales a person can be forced to accept treatment for their mental illness if there is a health risk to themselves or others despite retaining full decision-making capacity. The equivalent law for physical illness, the Mental Capacity Act 2005, only applies if the person cannot consent because they lack capacity to do so. Patients with capacity who refuse consent cannot be forced to accept treatment no matter what the risks.

Northern Ireland has taken rather longer to determine their way forward. The outcome of the Bamford review and the provisions of their new act are detailed by Lynch *et al.*¹² There is to be no mental health act. The Mental Capacity Act (Northern Ireland) 2016 gives exactly the same legal framework for the non-consensual medical treatment of all citizens no matter what their illness.

Parity of esteem, a flagship policy of the Royal College of Psychiatrists, is best described, according to the College, as: 'Valuing mental health equally with physical health' (p. 3).¹³ The College has described a range of equalities which need to be achieved although, perhaps surprisingly, there is no mention of equality under the law. Northern Ireland now has equality under the law. The day after the judgment in the case of Ms B,¹⁰ *The Independent* newspaper wrote 'Never again may a clinician administer treatment against the will of a mentally competent patient'.¹⁴ In Northern Ireland that will soon be true.

Earl Howe, in his closing statement during the passage of the Mental Health Bill 2007 (England and Wales), quoted the Millan committee, 'It should not be the function of mental health law to impose treatment on those who are clearly able to make decisions for themselves' and then continued, 'As it is we are, in a real sense, back in the world of Enoch Powell and 1959. Patient empowerment and respect for the wishes of the patient are acknowledged features of good clinical practice in all other areas of healthcare – but not, it seems, in mental health'.¹⁵ The Mental Health (Northern Ireland) Act 2016 gives psychiatrists the same legal powers as all other doctors, and psychiatric patients the same autonomy and respect as all other patients. Where Northern Ireland has led surely other UK jurisdictions, and countries across the world, will follow.

1.6.85 Newspaper depictions of mental and physical health

Marian Chen Stephen Lawrie

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date

2017-12

Abstract

Aims and method Media portrayals of mental illness have long been recognised as being misleading and stigmatising. Following the campaigns of several advocacy groups to address this issue, we aimed

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to evaluate the impact on mental health reporting over time. We repeated a survey we did 15 years ago using the same methods. Nine UK daily newspapers were surveyed over a 4-week period and coded with a schema to analyse the reporting of mental health compared with physical health.

Results In total, 963 articles – 200 on mental health and 763 on physical health – were identified. Over half of the articles on mental health were negative in tone: 18.5% indicated an association with violence compared with 0.3% of articles on physical health. However, there were more quotes from patients with mental disorders than physical disorders (22.5% v. 19.7%) and an equal mention of treatment and rehabilitation.

Clinical implications Mental health in print media remains tainted by themes of violence, however some improvement in reporting in recent years is evident, in particular by providing a voice for people with mental illness.

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- *Newspaper depictions of mental and physical health*
 - *Method*
 - * *Inclusion and exclusion criteria*
 - *Results*
 - * *Physical health*
 - * *Mental health*
 - *Discussion*
 - * *Mental illness and violence*
 - * *Strengths and limitations*
 - * *Conclusions*

Newspapers and other forms of mass media are influential in transmitting key information and ideas, including social commentary.^{1,2} Consequently, their role in reporting on mental illness is seen as one of the main conduits through which the public, especially those without personal exposure to mental illness, learn and come into contact with issues surrounding mental health.^{3,4}

For many years it has been recognised that media reporting of mental illness is heavily biased in representing a misleading link between mental illness and violence, with preferential reporting for sensationalist stories depicting individuals with mental disorders as being aggressive, dangerous and unpredictable.^{1,4-7} Such widespread negative portrayals have reinforced the continued stigmatisation and lack of acceptance among those with psychiatric diagnoses, possibly increasing social distance and contributing to morbidity and distress. Of particular concern is the potential ‘internalisation’ of prejudices portrayed by the media, such that people with mental illnesses also begin to take on the view that they are dangerous and unstable.⁸ Furthermore, there is a corresponding lack of voice for people of mental illness,^{6,8} with few personal accounts of their burden of disease and similarly little representation from qualified healthcare professionals.^{6,9} All of this contributes to creating a stereotyped, isolated group without social status and acceptance.¹⁰

In a similar vein, there is a disappointing lack of coverage of stories on recovery and rehabilitation following mental illness.^{5,6} This potentially leads both the public and policy makers to erroneously believe that recovery is rare. We highlighted this in a newspaper survey 15 years ago in which we found that the reporting of mental illness and people with mental illness tended to be negative, whereas that of physical illness was much more likely to be positive in tone.¹¹ This may even influence health resource allocations to conditions that have a higher perceived chance of cure.⁴

As far back as the 1960s, Nunally noted that mental health representations in media were few and distorted, limited to ‘neurotic behaviour’ in evening dramas where ‘the afflicted person often enters the scene staring glassy-eyed, with his mouth widely agape, mumbling incoherent phrases or laughing uncontrollably’.¹² Steadman & Coccozza¹³ also showed

that media depictions are often skewed towards extremes. Their findings on public perception of the ‘criminally insane’ (mentally disordered offenders) are salient, with 61% of the public surveyed responding that they feared former mentally disordered offenders ‘a lot’.¹³ However, as the authors noted, the mentally disordered offenders named by the public following intensive coverage tend not to have any legal claim to be ‘criminally insane’, and are merely assumed to be as such by the media.

Although those with mental illness are reportedly 2–6 times more likely to commit violence than matched controls,^{5,14} the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness¹⁵ found that only 5% of the homicides carried out in the general population between 2001 and 2011 were by those with an abnormal mental state ($n = 52$). However, an additional 14% had been in contact with mental health services in the preceding 12 months. Therefore, the vast majority of perpetrators of homicide do not have a mental illness at the time of the offence ($n = 951$). Contrast this with the statistics for suicide in the same report: 30% of all completed suicides in the 10-year period analysed were by patients already known to mental health services ($n = 2678$). The figures identified are 14 times higher than for homicide. From this, it is reasonable to infer that an individual with a mental health disorder is far more likely to self-harm than harm others. This important point is also often missing from media reports seeking to capitalise on the sensationalist angle and, by doing so, dehumanise the patient to the extent that they are defined by their illness. Similarly, it is clear that people with mental illness are much more likely to be ‘victims’ of crime than perpetrators.^{16,17} This discrepancy in public perception between perpetrator and victim among those with mental illness has also been highlighted in other studies,^{18,19} acknowledging the need to shift attention away from the perceived threat to the public, to providing support and protection for the truly vulnerable. In this regard, the media has been counterproductive in reinforcing misleading stereotypes about public safety while simultaneously underreporting key statistics on mental health.

Although viral campaigns such as Rethink Mental Illness’ ‘Find Mike’²⁰ have been highly successful in bringing mental illness to some public attention, it is difficult to assess their impact. Based on our previous survey,¹¹ we hypothesised that: mental health reporting would still be consistently more negative in tone compared with reporting of physical health issues, and patients would be consistently underrepresented in media depictions compared with physical health reports. Additionally, regarding the link with violence and criminality, we further hypothesised that the association between mental illness and violence would continue to pervade mental health reporting.

Method

The method followed that of Lawrie.¹¹ Nine weekday UK daily newspapers (Scottish editions) were surveyed over a period of 4 weeks between 4 March and 4 April 2014. The papers chosen represent a selection of popular broadsheet (*The Times*, *The Telegraph*, *The Independent*, *The Guardian*, *The Scotsman*, *The Herald*) and tabloid (*Daily Mail*, *The Sun*, *Daily Record*) publications in the UK, with a reported range in circulation of between 64 279 (*The Independent*) and 2 048 977 (*The Sun*) in February 2014.²¹ Only national newspapers were included in this analysis, as they have the widest distribution.

Print copies of the newspapers were obtained from the Reference Library of Edinburgh on the day of publication and manually screened for headlines relating to mental health or psychiatry and general health issues. Two tabloids, *The Sun* and *Daily Record*, were purchased each day, as they were not subscribed to by library services, yet have the highest circulation figures in the UK.

Articles relating to mental health and physical health were identified initially through headline screening. The main body of text was then read and coded as positive, negative or neutral, if the article was mainly stating facts or had mixed elements. As such, it is possible to have a disparity between tone of headline and article. Each article was then analysed and coded to a schema with eight variables, which noted key themes (*Table 1*).

Coding schema for newspaper articles

Variable	Description
Quote from patient, relative or charity	Direct or paraphrased quote from a patient with the illness in question, relative or advocacy organisation
Quote from professional	Quote from a healthcare professional in charge of the patient's care or spokesperson for government organisations, etc.
Association with violence	Any article where a person portrayed as having a mental illness or under the influence of drugs/alcohol engages in criminal or dangerous activity where others are put at risk or harmed. Suicide or self-harm is not included in this category
Mention of treatment/rehabilitation	Either specific (e.g. Prozac), general (anti-depressants, cognitive-behavioural therapy), alternative (mindfulness, yoga) or relating to the Mental Health Act 1983 where treatment is noted under a compulsory treatment order
Substance misuse	Articles relating to addiction, overdose or psychiatric effects of substance misuse were classified as relating to mental health. Physical effects of drug usage, including side-effects, were classified under physical health
System failure/negligence	Any article where substandard care is delivered by a single person or on an organisational level, resulting in adverse outcomes. Shortcomings range from IT failures and changes in social policy to deliberate mistreatment
Innovations in research	Articles where a new diagnostic method, treatment or better understanding of a named disease is reached
Medical advocacy/raising awareness	Where the primary purpose of the article is to transmit information about a particular disease profile or set of symptoms or charity efforts. For example Autism Awareness Week, United Nations World Down Syndrome Day, 'Check 'Em Tuesday' – a campaign run by <i>The Sun</i> to increase uptake of self-screening for breast cancer

Inclusion and exclusion criteria

The sports and business sections were surveyed, however property and automobile inserts were excluded due to likely lack of relevance. Primary newspaper articles, editorials and opinion pieces were included in the data collection. Advertisements, letters to the editor, film and entertainment reviews and obituaries were omitted. Articles with only a passing or chance reference to mental or physical health were also omitted.

All articles concerning mental disorders recognised by the DSM-5,²² psychiatry or psychiatrists were included, as well as generic, undefined mental conditions with the exception of paedophilia and the paraphilias, as their classification as a mental illness in DSM-5 is controversial. For physical health, all articles relating to other general medical issues were collected. Articles concerning the National Health Service (NHS) or other organisational bodies were included only if there was a demonstrable mention of impact on patient health and safety.

Results

In total, 963 health-related articles were collected during the 4-week period. Of these, 763 (79.2%) concerned physical health, whereas 200 (20.8%) were about mental health. Although there was a slight preponderance towards neutral pieces (38.0%) in the physical health category, compared with positive (28.6%) and negative (32.9%) reporting, the majority of articles concerning mental health were negative in tone (50.5%), with only a small number of positive (22.0%) or neutral articles (27.5%) (*Box 1*). This striking disparity between mental and physical health reporting underscores a key finding that mental health reporting remains consistently more negative than physical health, which is in line with the results from Lawrie's¹¹ study over a decade previously (ratio of positive to negative articles for physical health: 218/251; and for mental health: 44/101; odds ratio (OR) 1.99, 95% confidence interval (CI) 1.34–2.97). In addition, we found a prominent and stigmatising association between mental illness and violence as 18.5% of mental health articles featured violence as a major theme, compared with 0.3% of physical health articles (OR = 86.37, 95% CI 20.60–362.1) (*Table 2*).

Comparison of variables between physical and mental health reporting

Variable	Physical health, <i>n</i> (%)	Mental health, <i>n</i> (%)
Total number of articles	763	200
Positive	218 (28.6)	44 (22.0)
Negative	251 (32.9)	101 (50.5)
Neutral	290 (38.0)	55 (27.5)
Quote from patient/charity	150 (19.7)	45 (22.5)
Quote from professional	285 (37.4)	58 (29.0)
Association with violence	2 (0.3)	37 (18.5)
Mention of treatment/rehabilitation	217 (28.4)	48 (24.0)
Substance misuse	31 (4.1)	22 (11.0)
Medical advocacy/raising awareness	131 (17.2)	26 (13.0)
System failure/negligence	118 (15.5)	25 (12.5)
Innovations in research	184 (24.1)	22 (11.0)

Although previous studies have shown that patients with mental illness are underrepresented in newspaper articles,^{6,8} we found this not to be the case, with a higher proportion of quotes from patients with mental illness, their relatives or mental health charities (22.5%) compared with physical health (19.7%) (ratio of quotes in physical health: 150/613; mental health: 45/155; OR=0.84, 95% CI 0.58–1.23). There appears to be comparatively fewer quotes from professionals in relation to mental health however, highlighting the need of the psychiatric profession to make a conscious effort to engage with the media, and vice versa.²³ Interestingly, whereas previous studies have highlighted a lack of reporting on treatment and rehabilitation for mental health,^{4–6} here we found the rates to be comparable to that of physical health articles (24.0% v. 28.4% respectively) and previous reports.⁶

Box 1 Examples of positive, negative and neutral headlines for mental and physical health

Physical health

Positive

‘US Aids baby may be cured’

‘Cholesterol drugs may slow MS, study shows’

Negative

‘Three-year old died after hospital delay’

‘“Sickness culture” claim as 1 in 3 has long-term illness’

Neutral

‘Statins have no side-effects, study finds’

‘Smoking link to breast cancer in older women’

Mental health

Positive

‘Depression and self-harming are taboo ... that’s why I’m determined to speak out’

‘Ketamine trial provides fresh hope for long-term depressed’

Negative

‘Mentally ill man in bus knife attack’

‘School accused of excluding girl with anorexia to avoid copycats’

Neutral

‘Give dementia patients trial drugs en masse’

‘Depression must be seen as a societal disorder’

The disorders most commonly associated with violence were personality disorders as well as undefined ‘mental illnesses’ and post-traumatic stress disorder, which make up 13.5% of all articles pertaining to mental health. Surprisingly, sensationalist stories about schizophrenia were minimal and comparable to reporting on other mental disorders, whereas dementia and eating disorders were least likely to be reported as associated with violence (*Table 3*).

A breakdown of newspaper articles according to diagnosis and association with violence

Diagnosis	Articles <i>n</i> (%)	Association with violence, <i>n</i> (%)
Suicide	31 (15.5)	0
Mood disorder	26 (13)	2 (1.0)
Dementia	32 (16)	0
Eating disorder	12 (6)	0
Developmental disorder	17 (8.5)	3 (1.5)
Substance misuse	13 (6.5)	2 (1.0)
Personality disorder	11 (5.5)	14 (7.0)
Schizophrenia/psychosis	10 (5)	3 (1.5)
Other ^a	49 (24.5)	13 (6.5)

Includes multiple disorders, undefined and post-traumatic stress disorder.

Based on the previous data that show people with mental illnesses are more likely to be victims of crime rather than perpetrators, we were interested to see whether this correlated with media reports. We found that people with mental illness are twice as likely to be portrayed as a perpetrator (34/200) compared with a victim (17/200), in direct contrast to the available data.^{16,18,19,24}

Given that 18.5% of articles on mental health concern violent acts and are seen as a threat to the public, we asked what made up the rest of the negative reporting. On further analysis, it appears that a significant proportion of the negative articles pertain to the stigmatisation and abuse of people with mental health within society, as well as lack of funding and adequate care provision. Examples include headlines such as: ‘The great mental health betrayal’ (*The Independent*, 13 March 2014), an article about the unlawful detaining of people with mental health illnesses in care homes and hospitals, and ‘Mental health and race – the blight of dual discrimination’ (*The Guardian*, 26 March 2014), which highlights the additional burden of being an ethnic minority with mental illness. The remainder of the negative articles are reports on suicide (15.5%).

Overall, there was no significant difference between mental health reporting in broadsheets compared with tabloids.

Discussion

We found that mental health reporting makes up a fifth of all articles concerning health in a selection of UK print media over the course of a month. This is lower than found in a similar study by Pieters *et al*²⁵ in Belgium but comparable to the figures obtained by Lawrie in the UK¹¹ over a decade ago, reflecting little change in the frequency of reporting on mental health. Half of all articles on mental health are negative in tone, which is a much greater proportion than for physical health, but nonetheless represents a small reduction compared with Lawrie's study. On the other hand, the association with violence remains prominent, with 18.5% of articles carrying a theme of danger or criminality.

In the intervening 15 years, several campaigns by mental health charities both in the UK and abroad have sought to lessen the stigma attached to mental illness and encourage open dialogue about mental health. Media coverage is important to the success of such campaigns in influencing public opinion and increasing exposure. In light of this, we asked whether there is any evidence that media reporting on mental illness is improving (see below). Although previous studies have commented on the lack of voice for people with mental illness, we have found this not to be the case with a higher proportion of quotes from patients with mental illnesses compared with physical health. Although there are fewer representations of healthcare professionals in psychiatry, this may reflect reluctance among the profession as a whole to engage with the media, as psychiatrists too are affected by stigma.^{26,27}

Mental illness and violence

The link between mental illness and violence is unfortunately still pervasively reported – being part of about a fifth of all articles on mental health. The figure obtained in this study (18.5%) is lower than previous reports of association with violence.⁶ However, other studies have utilised more restricted search criteria, only using specific keywords such as 'schizo', 'mental', 'deranged' and 'psycho', which does not encompass the whole spectrum of mental illnesses.^{5,6,28,29} As most studies also used a computerised database programme (such as the LexisNexis) to generate articles, limiting the search criteria to only the above keywords will bias the results to find articles on schizophrenia or those that include derogatory terms such as 'psycho' or 'deranged', which are inherently stigmatic and more likely to be associated with violence.²⁹ In contrast, mental illnesses not usually considered violent, such as eating and mood disorders, would be excluded from the analysis.

In our study we found that schizophrenia and psychotic disorders make up a minority (5%) of reporting on mental illness and only 1.5% of these articles featured violence. Although there is little contention that mental disorders are disproportionately associated with violence in the media, one possible explanation for the strength of the association between the two is that it is an artefact created by selective searching among newspaper databases. We suggest the effect would be diluted if all articles on psychiatry, including conditions such as mood and anxiety disorders, were incorporated in the analysis.^{30,31}

In this study, we also found that people with mental disorders are twice as likely to be portrayed as a perpetrator of crime compared with a victim. This is another illustration of how the media can be misleading on key facts. Education for journalists and guidance on the reporting of mental health issues is central to bringing about a change in reporting trends. However, this may be easier said than done. One study attempted to correct journalists' erroneous views about mental illness with a short presentation on schizophrenia prior to a press conference regarding a high-profile assault carried out by a man with a serious mental illness. Although they found that journalists had a good recall for the details several weeks later, the presentation did not ultimately affect the writing of the article.³² This suggests that collaborations with the media will have a greater chance of success and change in reporting if they are mutually beneficial and desired. One example of this is UK mental health charity, Mind, which has set up a series of media awards for responsible and ethical reporting of mental health issues (www.mind.org.uk/news-campaigns/mind-media-awards), as well as reporting guidelines for different conditions.^{33,34}

Strengths and limitations

The main strength of the study is that all papers were hand-searched according to the criteria set out in the Method. This abolishes the need to search based on keywords, potentially increasing the yield of articles. Similarly, the scope and definition of 'mental illness' is wider than in previous studies, allowing for a greater overview of the subject in media. In the current study, the use of one investigator to locate and rate the articles, is both a potential advantage – in reducing interrater variability – but also a disadvantage in that no interrater reliability could be established (although we did discuss and resolve any uncertainties between the authors). The main limitation is that the coding schema used is a relatively blunt tool and cannot convey the complexity or depth of a newspaper story. Second, the categorisation of articles into mental and physical health does not allow for overlap in coverage, although that only occurred in a small minority of articles. Furthermore, the short time frame of the study means it can only provide a snapshot of mental health reporting in the UK. Last, there were two mental health stories that garnered a considerable amount of media attention in this time period and subsequently have the ability to bias the data. One was the suicide of a famous fashion designer and another, the death of a woman who had murdered her three children and was subsequently labelled as having a personality disorder. Both stories were extensively reported on over multiple days. However, they were included in the analysis as this study was designed to encompass all the news on mental health over 4 consecutive weeks, rather than the sampling of random time points, and different reports had different foci as new information about the cases came to light.

Conclusions

Despite several prominent government-led and charity campaigns, mental illness and individuals with mental illness continue to experience stigmatisation and stereotyping. Although it is encouraging that people with mental disorders are being increasingly represented in print media, and there appears to be an overall increase in non-stigmatising articles,³⁵ much remains to be done to address the inaccurate and stigmatising association with violence, and raise the profile of mental illness as a whole.

The particular reasons for the ongoing negative headlines about mental illness, and what could or should be done about them, are beyond the scope of this study. Our results do however indicate that there is a clear need for more reporting about mental health in general, and for more accurate reporting about violence and for more accounts of innovative research developments in particular. We therefore suggest that there is much to be gained from further ongoing engagement between patients and psychiatrists and the media, with an emphasis on realistic depictions of the lives patients lead and of recent research advances.

Many thanks to the staff at the Reference Library of Edinburgh for meticulously collating the newspapers used each day.

1.6.86 Implementation of a novel primary care pathway for patients with severe and enduring mental illness

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Abstract

Aims and method New collaborative care models with an emphasis on primary care are required for long-term management of patients with severe and enduring mental illness (SMI). We conducted a descriptive evaluation of clinical outcomes of the first 3 years of a novel enhanced primary care (EPC) service. Data from 2818 patients and staff survey results were analysed.

Results 2310 patients were discharged to EPC (508 not assessed as clinically suitable or patients/general practitioners declined the transfer); mean length of stay with secondary care service of the cohort was 9.8 years (range 0–24). 717 patients (31%) have been discharged to primary care only out of the EPC services and 233 patients (10%) have been transferred back to secondary care. Patient and staff satisfaction with the new EPC model was high. No severe untoward incidents were recorded.

Clinical implications The data suggest that EPC can be safely provided for a significant proportion of patients with SMI, who traditionally received long-term secondary care support. The novel EPC model can be utilised as a template for the provision of cost-effective, recovery-oriented and non-stigmatising care in the community.

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 - *Discussion*

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* *Limitations and outlook*

Mental healthcare for the majority of patients with severe and enduring mental illness (SMI) was historically provided predominantly by specialist secondary care services in the UK. Hereby, most patients with long-term chronic conditions received open-ended health and social care support and relatively few were discharged back to primary care for ongoing case management. More recently, patients with SMI are increasingly considered for clinical management by less specialised, generic primary healthcare services and in collaborative care models.¹⁻³ Most of these schemes have not been robustly evaluated through clinical and controlled trials. There is however good evidence to suggest that collaborative chronic care models foster patient self-management and can improve mental and physical outcomes for patients with mental health problems.³

In England, the introduction of clinical commissioning groups (CCGs) in 2013⁴ and the significant public spending savings plan with annual targets for all National Health Service (NHS) provider organisations⁵ resulted in a nationwide review of mental healthcare provisions and piloting of novel care pathways. Secondary mental healthcare providers have started to reduce the number of cases held by specialist community mental health teams, including assertive outreach and community rehabilitation teams. The NHS policy paper *No Health Without Mental Health*⁶ emphasised the need for integration of care for physical and mental health needs; provider and commissioner organisations therefore started to engage in various local service redesign projects. In East London, enhanced primary care (EPC) services for patients with SMI were developed and implemented in 2012, following a whole system review which attempted to address the issue of plateauing resources. The overall aim of the EPC service is to foster recovery of patients with SMI, to safely discharge them to primary care settings that attend to their mental healthcare needs. Three years after its launch, clinical outcomes of the novel care pathway for patients with SMI, patient/staff satisfaction were evaluated and are reported in this paper.

Method

Data collection and analysis

This evaluation is based on a retrospective data analysis of routinely collected data on all the patients referred to and/or fully discharged from secondary care to the EPC service since its inception (reporting period from 1 August 2012 to 31 July 2015). Electronic clinical data-sets included: total number of identified/discharged patients; number of patients who refused to be transferred to the new service and where either general practitioners (GPs) or consultant psychiatrists assessed patients as not suitable; diagnoses and ICD-10⁷ codes, gender, ethnicity, duration of service provided by secondary care, number of admissions to hospital; number of patients re-referred to secondary care or readmitted/relapsed analysis of main characteristics of this subgroup of patients.

In addition we conducted an analysis of available information collected regarding staff satisfaction (semi-structured interviews and questionnaires) and summarised data from a patient satisfaction survey (Client's Assessment of Treatment Scale⁸) for the new service from one of the three localities (Newham).

Description of the new EPC service

The model was developed in partnership between East London NHS Foundation Trust and the three East London CCGs (Newham, City & Hackney, Tower Hamlets) across primary/secondary care teams by interdisciplinary working groups; those involved were people participation leads, GPs, consultant psychiatrists, senior community psychiatry nurses, psychologists and social work leads. The initial target was defined as 300 patients per year per locality. The EPC care pathway allows providing mental healthcare flexibly according to patients' needs and to step up (secondary mental health services) or step down (generic primary care) in a seamless way without administrative hurdles.

EPC care pathway elements

Elements of the EPC care pathway were as follows: Regular GP reviews (in addition to quality and outcome requirements), the development of a recovery care plan, practice nurse administration of depot medication, and specific assessment of risk factors for physical illness, signposting into healthy lifestyle services. Enhanced support to primary care from consultant psychiatrists with regular practice-based mental health multidisciplinary review meetings. Training and education to GPs on managing SMI in primary care, and for practice nurses on psychopharmacology and therapeutic depot administration. EPC mental health teams consisting of registered mental nurses, employed by East London NHS Foundation Trust but working within general practice, to support discharge into the EPC and provide recovery-oriented support to patients on an ongoing basis.

The philosophy of the service operationally distinguishes clearly between: specialist acute and rehabilitation treatment for patients with severe or complex needs and/or those identified as presenting with significant risks to self or others associated with their illness (continued to be provided by secondary care services); and long-term condition management aiming to provide monitoring and maintenance support for patients with stable chronic SMI (provided by the new EPC teams). Inclusion criteria for the EPC transfer were defined as follows: Aged 18 years or older, resident in one of the three East London boroughs and currently under the care of secondary care services. Established diagnosis of an SMI that would warrant their inclusion on the practice severe and enduring mental illness (SEMI) register. Identified care needs above those that would ordinarily be provided for under normal primary care, either medical or social needs, that require additional support. Patient agrees to the support offered via the EPC clinic. Sustained clinical progress with less frequent support from secondary care and no identified need for specialist interventions and treatments. Last acute psychiatric hospital admission more than 12 months ago, no current risks to self or others identified; patient is well-established on a medication regime and requires minimal assistance with concordance, but does require regular monitoring and review. Patient has settled accommodation, is able to meet their own basic living needs. Patients requiring lithium prescribing or depot injections in primary care are included.

Teaching, training and supervision

Primary care liaison nurses (PCLNs) of the EPC teams were recruited from secondary care services and all had experience in providing mental healthcare to patients with SMI. A list of essential competencies, skills and experiences were identified as significant requirements for the recruitment of the EPC workforce and included the following areas: history taking/mental state examination, engagement skills and basic knowledge of principles pertaining to a positive therapeutic relationship, risk assessment and management, recovery care and social psychiatry, and psychiatric emergencies. Additional training was offered to PCLNs.

The provision of the EPC service is supported through weekly team meetings, monthly supervision sessions, and six monthly appraisal/reviews, aiming to maintain and update knowledge and skills.

The three localities agreed on mandatory training requirements for primary care staff as part of the EPC contract with their primary care practices and the EPC team provided training for staff in GP practices including mental health awareness training for practice reception staff and depot training for nurses.

Subsequently, in 2015 a website with a wide range of teaching and self-learning materials for all primary care staff was developed with funding from Health Education England North Central and East London, launched into public domain in 2016 (<http://primary-mentalhealth-care.elft.nhs.uk>).

Service aims and expected outcomes

- To support patients to achieve their recovery goals through a process of joint planning that places patients at the centre.
- To empower people to self-manage their own recovery journey and reach a position where they can reduce their contact with mental health services.
- To mark the recovery journey by recognising achievements while being transferred to receive care in EPC and at the point of discharge from EPC.
- To improve the patient experience and outcomes through enhanced multidisciplinary team working that addresses mental health, physical health and social need as part of an integrated approach.
- To improve patient experience and outcomes through the provision of care in a normalised setting, close to home and to assist the navigation of patients towards resources that supports their recovery.
- To enable the development of capacity, confidence and competence in relation to mental health treatment and care in the primary care workforce.

The service elements were developed accordingly, centred on a 'My Recovery Plan' and associated 'My Safety Plan' documents for time-limited EPC interventions according to recovery goals set by the patient (with a recommended duration of up to a year after which the patient is supposed to be discharged into generic primary care services). The time-limited nature of the service was to be made clear to the patients at the outset and the service provides a fast-track option back to secondary care services if needs change.

Team composition

The service is predominantly delivered by psychiatric PCLNs. The three localities agreed on different staffing compositions according to local variations of service needs and/or perceived requirements in respect of multidisciplinary inputs from health professionals.

In Newham, psychiatrist input is provided by one consultant with protected time in the job plan and by catchment area consultants as required based on a sectorised/practice-aligned service model; in Tower Hamlets consultants with a primary base in general practice deliver psychiatric expertise; and in City & Hackney a model with a dedicated EPC service consultant was established.

Following a 12-month review the team of healthcare professionals was complemented by a group of peer support workers, who provide patients with emotional and practical support as they approach discharge from secondary care services. All the peer supporters have personal experience of in-patient and community mental healthcare and support patients flexibly based on their own experiences of recovery. A summary of the current team structures and allocated posts is provided in *Table 1*.

Staffing composition in enhanced primary care (EPC) teams in each locality

Directorate	Total WTE per team	Admin Band 4	Occupational therapist	Clinical psychologist	Nurse Band 6	Nurse Band 7	Consultant	Peer/supervisor Band 3/4	Service manager Band 8a	Team case-load capacity
CH original	10.6					8.0	1.6		1.0	300
CH current	16.3	1.0	0.2	0.2		6.0	1.0 <i>b</i>	7.0	1.0	720
NH original	9.1				4.0		0.1	4.0	1.0	300
NH current	14.0				4.0		0.5 <i>c</i>	8.0	1.0	600
TH original	6.4				6.0		0.4			250
TH current	18.0	1.0			6.0	4.0	1.5 <i>d</i>	4.0	1.0	700
Trust total current	48.3	2.0	0.2	0.2	10	10	3.0	19.0	3.0	2020

CH, City & Hackney; NH, Newham; TH, Tower Hamlets; WTE, whole time equivalent.

Original and current from 2016. Phased increase in size of service with new investment following a service review in 2014–2015.

Consisting of each of the four current primary care consultants devoting 2.5 sessions a week to the EPC service and primary care liaison.

Consisting of time dedicated to EPC and primary care liaison by the four assessment and brief treatment consultants providing support to practices and one consultant with 0.1 WTE leading on EPC.

Consisting of a dedicated consultant providing two sessions a week to provide clinical support to the EPC team and the Compass Primary Care Psychology service, and each of the community mental health team consultants providing one session a fortnight to supporting the primary care practices to which they are aligned.

EPC provides an open general advice service to GPs to assist in the treatment of patients that have been discharged from EPC and secondary care. The arrangements vary between the three East London boroughs but all include case-based discussions between GPs and consultant psychiatrists during regular multidisciplinary clinical meetings at primary care level.

Results

Service activity summary

As per 31 July 2015, the three East London EPC teams provided care for 1370 patients. Since August 2012 the services considered in total 2810 patients, of which 480 were not proceeded with because the patients declined transfer ($n = 149$), the GP declined the transfer ($n = 90$) or the secondary care eventually decided the transfer was not clinically appropriate ($n = 241$). Therefore, 2330 patients have received an active service from EPC services since their inception. In total, 717 patients were transferred to primary care only from EPC with variations across teams. The total number of patients discharged from EPC to primary care alone has significantly increased beyond the reporting period of this service evaluation due to changes in operational policy and as a result of the teaching and training efforts to upskill GPs, resulting in increased throughput.

All referral and case-load data with developments to 30 October 2016 are summarised in *Table 2*.

Total referral and case-load activity for enhanced primary care (EPC)

	At 31 July 2015	At 29 February 2016	At 30 October 2016
Active case-load, <i>n</i>			
City & Hackney	510	547	633
Newham	485	557	610
Tower Hamlets	375	473	618
Total <i>n</i>	1370	1577	1861
Referrals considered, total <i>n</i>			
EPC – Trust wide	2810	4082	5286
Refused/not suitable, <i>n</i>			
EPC – Trust wide	480	576	633
Received EPC service, <i>n</i>			
City & Hackney	955	1317	1635
Newham	787	1186	1448
Tower Hamlets	588	1003	1570
Total <i>n</i>	2330	3506	4653
EPC transfer to primary care, <i>n</i>			
City & Hackney	384	675	939
Newham	184	465	705
Tower Hamlets	149	385	594
Total <i>n</i>	717	1525	2238
Transfer back to secondary care, <i>n</i>			
City & Hackney	65	95	177
Newham	124	164	227
Tower Hamlets	48	94	160
Total <i>n</i>	233	353	564

Patient characteristics

The majority of patients referred to EPC had a significant history of SMI with an average (mean) duration of care provided under care programme approach (CPA) standards by secondary care services (community mental health teams) of 9.7 years (range 0–24). The mean age of patients was 45.7 years (range 18–65; 12.1% 18–30 years and 77.3% 30–60 years); 54% of patients were female and 46% were male. Overall, 47.4% were single/living alone, 26.3% were married/civil partner and 11.6% were separated/divorced/widowed/surviving civil partner. Given the high percentage of Black and ethnic minorities living in East London, the distribution of ethnicity across the sample reflects the diversity: Asian or Asian British 24%, Black or Black British/African–Caribbean 19.8%, White British or other White 38.5%, other ethnic groups 17.8%.

The main diagnoses of patients were: schizophreniform or other psychotic disorders (ICD-10 codes F20–29) 37.2%, mood (affective) disorders (F30–39) 32.1%, anxiety/stress-related/somatoform and other non-psychotic mental disorders (F40–48) 11% and disorders of adult personality and behaviour (F60–69) 4.1%.

According to Department of Health guidance⁹ the main cluster codes on transfer to EPC were: cluster 10–13: 48.9% (11: 19.4%; 12: 21.5%; 13: 7.1%); cluster 4–7: 26.1%. The number of patients referred back to secondary care due to clinical issues (relapse concerns) was 237 (City & Hackney $n = 65$, Newham $n = 124$, Tower Hamlets $n = 48$).

Feedback from patients

Both EPC staff reports and results from questionnaire surveys suggest that the vast majority of patients regarded the new service arrangements as both helpful and adequate according to their needs. We conducted a more detailed survey in one of the three localities (Newham), using the structured Client's Assessment of Treatment Scale. Results from 126 patients who completed the survey (mean age 49.2 years, range 26–71; 66 female, 60 male) are indicative of comparatively high levels of patient satisfaction (most scores across the group rated with a mean of 8–9 out of 10) (*Table 3*).

Results from 126 patients who completed the Client's Assessment of Treatment Scale

	Mean	Range	s.d.
Do you believe you are receiving the right treatment/care for you here?	8.8	4–10	1.6
Does your general practitioner understand you and is she/he engaged in your treatment/care?	8.4	1–10	1.9
Does your named nurse understand you and is she/he engaged in your treatment/care?	9.0	2–10	1.5
Are relations with other staff members here pleasant or unpleasant for you?	8.5	0–10	2.0
Do you believe you are receiving the right medication for you?	8.9	0–10	1.7
Do you believe the other elements of treatment/care here are right for you?	9.4	4–10	1.3
Do you feel respected and regarded well here?	9.0	4–10	1.5
Has treatment/care here been helpful for you?	9.0	4–10	1.4

Feedback from GPs

GPs across all three localities engaged very well with the three EPC teams and expressed high levels of satisfaction; they acknowledged that the EPC service improved care for their patients. A brief survey questionnaire distributed to 61 GP surgeries in Newham was returned by 52 GPs. All but two GPs stated that the EPC helped to change their perception of/and relationship with mental health services.

Another GP survey was conducted in Tower Hamlets and revealed the following feedback (first figure 6 months after service implementation based on 61 responses (from 36 surgeries), second figure 1 year later based on 23 responses); this survey indicates that the EPC model contributed to developing GP's skills and knowledge of psychotropic prescribing (Very confident 3.3/13%, Confident 44.3/47.8%, Neutral 33.4/34.8%, Not confident 18.0/4.4%). In addition, satisfaction rates with practice-based multi-disciplinary meetings as well as the network-linked PCLNs was largely positive and increased over time.

We conducted a subgroup analysis of patients from Newham EPC who were re-referred to secondary care from EPC due to a relapse (significant increase in symptoms) of their mental disorder or other reasons; $n = 124$ out of 787, 15.8%.

Relapse due to a range of stressors (iatrogenic, non-adherence, etc.) was $n = 69$; relapse with acute admission to hospital, $n = 8$; and non-engagement and requests to be discharged from GP, $n = 9$. Requests for medication review by secondary services/GP referred back: $n = 26$; social circumstances: $n = 4$; and patient demanding to be referred back to consultant: $n = 3$.

Only for 3 out of 124 re-referred patients with a change in prescribed dose of medication were identified, all others had been on stable medication as per discharge plan from secondary care. The number of EPC face-to-face contacts for this group varied from 0 to 8, most patients had been seen on 1–3 occasions by their PCLN. The diagnostic codes, PCLN clinics and GP surgeries were equally distributed across this group.

Discussion

The data-set considered for this service evaluation comprised of a large sample of over 2000 patients with predominantly chronic severe mental illness (schizophreniform, psychotic or severe affective disorder, care clusters 10–13 and 4–7) and the observation period of 3 years seems adequate to allow for a critical appraisal of performance data. The overall results from this service evaluation suggest that a significant proportion of patients with SMI, who were traditionally seen long term with open-ended care plans in secondary care, can be successfully discharged to enhanced primary mental healthcare services. This is even more so significant given the fact that prior to transfer of care, patients had been receiving specialist mental health services for on average of nearly 10 years. The number of relapses and referrals to secondary care services has been low, even though the overall referral rate to EPC has risen. A significant number of patients who received EPC services are now supported by primary care alone.

The success of this novel care pathway is based on very close collaboration between primary and secondary care health professionals and service characteristics that provide seamless care across boundaries: all PCLNs were employed through secondary mental health services and mostly recruited from existing mental health teams, which enabled them to provide clinical expertise into the new service – quick access to secondary care for crisis management was built into the service structure.

Only about 14% of patients were not taken into EPC clinic care following the initial referral and this is indicative of a carefully conducted and initially conservative selection process, also taking patient preferences into account. Patient feedback was very positive and no severe untoward incidents occurred during the observational period.

Although mental healthcare services for patients with SMI have traditionally been regarded as too specialised for primary care, most patients regard primary care provisions as a significant milestone in their recovery journey.¹⁰ The care pathway development was conducted based on a much clearer distinction between elements focusing on supporting people to maintain stability and monitor symptoms versus elements providing active recovery-oriented treatment. This allowed refocusing of specialist services and deconstructing the 'shifted out-patient clinic' model,¹¹ essentially a replacement model, which does not provide opportunities for enhanced linkage and face-to-face consultations between

the primary care physician and the psychiatrist.¹² By contrast, the consultation-liaison collaboration model provides regular face-to-face contact between the psychiatrist or mental health worker and the GP.¹³

The survey results suggest that the support primary care doctors receive from consultant psychiatrists is a vital part of the scheme. The precise arrangements vary across the three boroughs but each primary care practice has an aligned consultant who visits the surgery regularly, is available for advice especially on potential referrals to secondary care and who assists the surgeries to become more mental health sensitive and informed.

The main difficulties with the new care pathway identified in the context of this service evaluation are related to the wider context of recovery-focused care with an emphasis on integration with mainstream community services, such as employment, training and leisure activities. Depending on pre-existing skill and knowledge base within each of the participating GP surgeries, the quality of mental state monitoring and therapeutic engagement is likely to vary significantly. More emphasis must therefore be given towards developing robust and ongoing teaching and training curricula for primary care practitioners. Another significant challenge is the variation in access to psychological therapy services and social care from locality to locality depending on the level and specification of integrated care pathways. This is a crucially important issue for the success of EPC services, safeguarding against compromising the quality of care.

A further significant increase of the number of people who experience a mental health problem in England has been predicted (i.e. 14.2%, from 8.65 million in 2007 to 9.88 million in 2026) as a result of population growth.¹⁴ More research of innovative and collaborative schemes for high-quality cost-effective mental healthcare is required, assessing the impact of working across primary and secondary care.¹⁵

The promotion of psychological resources and capabilities at a family and community level to support people experiencing mental ill health appears to be a promising complementary strategy for both primary and secondary prevention. Last but not least there seems to be a real case to extend the role of district nurses, to strengthen the role of GP champions in mental healthcare¹⁶ and to involve patients as teachers in interprofessional learning as already pointed out by Lester *et al*¹⁷ in their discussion paper on integrated primary mental healthcare more than 10 years ago.

Limitations and outlook

This is a retrospective analysis of routinely collected data for service evaluation, not a formal research study. Patients were identified by their secondary care clinicians as potentially suitable for transfer to the EPC clinic and there was no control condition. The Client's Assessment of Treatment Scale satisfaction scores and relapse indicator analysis was only available for one of the three localities and only a subgroup of about 25% of patients open to the EPC service completed the survey.

Empirical research is needed to establish detailed patient characteristics as predictors for successful transfer of care. Longer-term and controlled follow-up studies are required to establish care quality and effectiveness issues across various components of the health and social care pathway (e.g. social inclusion, subjective quality of life, psychopathological symptom levels) following discharge from secondary care services, compared with continuing specialist treatment. It will be important to assess differences between inner-city and more rural areas to establish as to whether the claim, that the delivery of mental healthcare in primary settings is 'more accessible, affordable and acceptable for the population'¹⁸ can be substantiated.

1.6.87 National survey of training of psychiatrists on advance directives to refuse treatment in bipolar disorder

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Abstract

Aims and method To determine features associated with better perceived quality of training for psychiatrists on advance decision-making in the Mental Capacity Act 2005 (MCA), and whether the quality or amount of training were associated with positive attitudes or use of advance decisions to refuse treatment (ADRTs) by psychiatrists in people with bipolar disorder. An anonymised national survey of 650 trainee and consultant psychiatrists in England and Wales was performed.

Results Good or better quality of training was associated with use of case summaries, role-play, ADRTs, assessment of mental capacity and its fluctuation. Good or better quality and two or more sessions of MCA training were associated with more positive attitudes and reported use of ADRTs, although many psychiatrists would never discuss them clinically with people with bipolar disorder.

Clinical implications Consistent delivery of better-quality training is required for all psychiatrists to increase use of ADRTs in people with bipolar disorder.

Contents

- *National survey of training of psychiatrists on advance directives to refuse treatment in bipolar disorder*
 - *Method*
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The Mental Capacity Act 2005 (MCA) in England and Wales provides a legal framework for personal welfare and financial decisions to be made in advance by individuals, who later due to an impairment or disturbance of functioning in the mind or brain, may be unable to make these decisions for themselves. If capacity is not present, a decision can be made on behalf of the person based on what is in their best interests taking consideration of their wishes using three specific provisions of the MCA for advance decision-making: advance decision to refuse treatment (ADRT), a legally binding provision preventing specific treatment; advance statement of wishes and feelings, a non-legally binding statement of preferences for treatment, and/or personal and financial affairs; lasting power of attorney, a legally binding direction identifying who will look after the person's personal and financial affairs. Clinicians and their employers, especially psychiatrists, are legally required to 'have regard to' MCA guidance and, if later asked, prove that they did.¹

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Therefore there is an expectation that psychiatrists receive training in the MCA. However, the methods and amount of training that psychiatrists should receive are not specified, nor has the quality or amount of training been related to attitudes or use of ADRTs in practice. We chose to examine the attitudes to and use of ADRTs by psychiatrists as these may be seen as restrictive in terms of treatment offered by psychiatrists to people with bipolar disorder. In a national survey of general adult and old age psychiatrists in England and Wales, we wished to explore how the quality and amount of training they have received may be associated with their implementation of ADRTs in people where capacity is lost (e.g. mania, severe depression) and regained (e.g. bipolar disorder) to complement a survey of patient experience in bipolar disorder.²

Method

Objectives and design

Our objectives were: to determine what aspects of training in the MCA were associated with higher or lower perceived quality of training in the view of psychiatrists; and to examine whether the quality and amount of training were associated with reported attitudes or use of ADRT in people with bipolar disorder. We anticipated that high-quality training may be required to overcome professional resistance to the use of ADRTs should any be present.

Participants

Inclusion/exclusion criteria were: participants practice within England and Wales, i.e. the jurisdiction of the MCA specialise in either general adult or old age psychiatry they were consultant psychiatrists or in training grades (CT1-CT3, ST4-ST6).

Procedure

We aimed to recruit a national sample of 500 psychiatrists in a 12-month period for the survey. No data were available for a formal power calculation. The study was advertised with the help of the National Institute of Health Research-funded Mental Health Research Network (MHRN) and the Royal College of Psychiatrists. The College agreed to publicise the study by tweeting the link to the survey and the study team also attended a national conference organised by the College to publicise the study. Consultants, senior and junior trainees in general adult and old age psychiatry were selected from different regions to ensure maximum variance of practical clinical experience. To maximise the participation rate of psychiatrists and the frankness of their responses, we anonymised the survey, not asking for personal information such as age, gender or workplace, and placed it online or if they preferred we administered it face to face, by telephone or posted it.

Measures

The survey was divided into nine sections that addressed the following topics: Section A: Preliminary information – position, years since qualification, place of work (e.g. in-patient, crisis team), geographic location. Section B: MCA training – how many sessions attended, whether mandatory, how recent, whether training considered advance decision-making that included ADRTs, nature of training, quality of training (e.g. in your opinion how much of the training focused on advance decision-making (including ADRTs) – a significant amount, a reasonable amount, a minimal amount, none?). Section C: ADRTs and bipolar disorder – whether psychiatrists had experience of patients making ADRTs, whether they had advised on making ADRTs, content of ADRTs, factors influencing their decision to advise regarding ADRTs. Section D: ADRTs and other conditions – content of ADRTs. Section E: ADRTs and the Mental Health Act 1983 – whether psychiatrists had encountered ADRTs in context of patients admitted to psychiatric units or sectioned under the Mental Health Act. Section F: ADRTs in clinical practice – how often should they be discussed (e.g. in your opinion how often do you feel that discussion of ADRTs should take place – at every consultation, every 6 months, at care programme approach meetings, only when I think I might be relevant, only when another health or social care

professional raises the topic, only if the patient or carer raises the topic or never?).Section G: Advance statement of wishes and feelings – whether psychiatrists had experience of patients using these; what was contained, whether the frequency was changing among people with bipolar disorder.Section H: ADRTs and implementation of the MCA – whether psychiatrists had experience of patients using ADRTs and their contents.Section I: Lasting power of attorney – whether psychiatrists had experience of patients making lasting powers of attorney, who advised on these.

Analysis

Descriptive statistics were employed in the survey to explore the professional characteristics of psychiatrists and their experience of training. Univariate analysis indicated that several demographic or service provision factors may be associated with the use of the MCA. Binary logistic regression was applied to three separate analyses: the quality of training (dependent variable) perceived by psychiatrists was explored in relation to the methods, site and content of training the quality of training (dependent variable) was then related to attitudes and experiences of psychiatrists to implementing ADRTs in their clinical practice the amount of training (dependent variable) was related to their attitudes and experiences of implementing ADRTs. Checks for collinearity were applied by exploring the Spearman correlations between the independent variables that might enter the logistic regression. None of the independent variables were excluded because of collinearity. Odds ratios (ORs) and 95% confidence intervals (CIs) are presented for any significant variables.

Results

A total of 650 psychiatrists were recruited for the survey. *Table 1* shows the grade, work setting, country of medical training and duration of time since medical qualification of this sample. Within the sample, there were 374 (57.5%) consultants in general adult or old age psychiatry, and the remainder were trainees, with a slight majority qualified in medicine outside the UK. Psychiatrists were recruited for the study between May 2011 and June 2012. Of 607 respondents who identified the geographic location of their work, 133 (21.9%) were from the West Midlands, 116 (19.1%) from the East Midlands, 80 (13.2%) from the South West, 116 (19.1%) from the South East, 74 (12.2%) from the East of England, 46 (7.6%) from London and 10 (1.6%) from the North West of England.

Professional characteristics and nature of Mental Capacity Act 2005 training of psychiatrists ($n = 650$)

Work characteristic	<i>n</i>	%
Grade		
Consultant general adult psychiatry	283	43.5
Consultant old age psychiatry	91	14.0
ST4–6 trainee	111	17.1
CT1–3 trainee	130	20.0
Missing	35	5.4
Main work setting		
Community mental health team	349	53.7
In-patient	216	33.3
Crisis team/EIP/ACT	77	11.9
Missing	8	1.2
Years since medical qualification		
0–10	210	32.3
11–20	241	37.1
21–30	146	22.5
30+	51	7.8
Missing	2	0.3

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Table 7 – continued from previous page

Work characteristic	<i>n</i>	%
Country of medical qualification		
UK	306	47.1
European Union	51	7.8
Outside European Union	288	44.3
Missing	5	0.8
Number of training sessions		
0	55	8.5
1	128	19.7
2	183	28.2
3	113	17.4
>3	169	26.0
Trained but missing data	2	0.3
Method of training ^a		
Case examples	491	75.5
Role-play	82	12.6
Watch video	44	6.8
None of these	86	13.2
Source of training ^a		
Local NHS trust	489	75.2
Royal College of Psychiatrists	133	20.5
Legal or solicitor	48	7.4
Pharmaceutical company	35	5.4
Other	89	13.7
Perceived quality of training		
Excellent	24	4.0
Very good	153	25.7
Good	269	45.2
Average	134	22.5
Below average	12	2.0
Missing	58	8.9
Primary reason for attending		
Mandatory NHS trust training	172	28.9
Approved clinician training	194	32.6
Educational event	128	21.5
Personal interest	79	13.3
Other	22	3.7
Missing	55	8.4

ACT, assertive community treatment; EIP, early intervention in psychosis; NHS, National Health Service.

Categories are not mutually exclusive.

Table 1 shows the number of training sessions, methods used for training, source of the training, quality of training and reasons for attending the training: 595 (91.5%) had attended at least one training session on the MCA; 465 (71.5%) had attended two or more sessions; and 326 (50.1%) had been to a training session in the previous year. Of the 595

psychiatrists trained in the MCA 489 (75.2%) had been trained by their local National Health Service (NHS) trust. The quality of the training was perceived to be high, with 446 (75.0% receiving training) rating it as good, very good or excellent (Table 1). However, 209 (35.1% receiving training) psychiatrists stated that either minimal or no attention was paid to ADRTs in the training sessions.

Table 2 examines the binary multiple logistic regression associations between the quality of training and the methods of training, the site of training, the number of training sessions and topics covered in the training. Compared with average or poor training, good or better (very good or excellent) training was associated positively with the use of case summaries, role play, coverage of advance decision-making (including ADRTs) and assessment of capacity. Video feedback was only carried out in good or better quality of training (44 or 9.9%, Fisher's exact 2-tailed test $P < 0.001$). Average or poor training was associated with training in their own NHS trust compared with good or better training (Table 2). In relation to the specific use of advance decision-making including ADRTs and the need to be able to assess fluctuating capacity in conditions such as bipolar disorder with highly variable severity and therefore capacity, it is notable that even good or better-quality training covered these issues in only just over 45% and 37% of cases respectively.

Content and method of training related to perceived quality of training in the Mental Capacity Act 2005a ($n=588$)

	Q uality of tr aining						
Used rol e-play	76	17.1	26 6	4.1	3.32	1.3 7–8.07	0.008
Tr aining in a dvance decisi on-mak ing` b <#TF N5>`__	203	45.6	26	17.8	2.58	1.5 4–4.31	<0.001
Ca pacity asse sment	410	92.3	107	74.3	2.80	1.5 6–5.02	0.001
Tr aining in their NHS trust	355	80.0	132	91.7	0.39	0.2 0–0.77	0.007

NHS, National Health Service.

55 psychiatrists received no Mental Capacity Act training, 7 missing responses.

Including advance decision to refuse treatment.

Only 94 (14.5%) of surveyed psychiatrists had encountered a patient with bipolar disorder who had made an ADRT; 136 (20.9%) had encountered a patient with bipolar disorder who had made an oral or written statement of wishes and feelings; and 91 (14.0%) had encountered a patient with bipolar disorder who had made a lasting power of attorney relating to health or personal welfare. Of the 259 psychiatrists expressing an opinion, 208 (80.3%) considered that the number of people with bipolar disorder making ADRTs had remained the same since the implementation of the MCA in 2007, and 41 (15.8%) considered that it had increased by less than 10%. Of the 252 psychiatrists expressing a view regarding statements of wishes and feelings by people with bipolar disorder, 187 (74.2%) thought that the frequency remained the same since the MCA came into force, and 46 (18.3%) that it had increased by less than 10%.

Table 3 displays the binary multiple logistic regression associations between the quality of training and the discussion of ADRT with patients with bipolar disorder or other patients who may lose mental capacity but then regain it. Compared with average or poor training, good or better training was associated with fewer psychiatrists who never discuss ADRTs with patients, and fewer psychiatrists who believed that they had insufficient time to discuss ADRTs with patients. Table 4 shows that compared with only receiving one training session on the MCA receiving two or more training sessions was associated with more psychiatrists discussing ADRTs at care programme approach meetings and fewer psychiatrists who believed that they had insufficient training to discuss ADRTs with patients. There were no other associations between the quality of MCA training or number of MCA training sessions and reported practice or beliefs about implementing ADRTs.

Relationship between quality of training in the Mental Capacity Act 2005 and barriers to implementing ADRTs^a

	Q uality of tr aining						
Never d iscuss ADRTs	96	21.5	48	32.9	0.53	0.3 5–0.79	0.010
Insuff icient time to do ADRTs	177	39.7	79	54.1	0.57	0.3 7–0.88	0.002

ADRTs, advance decisions to refuse treatment.

55 psychiatrists received no Mental Capacity Act training, 7 missing responses on quality of training and 3 missing responses on amount of training.

Relationship between amount of training in the Mental Capacity Act 2005 and barriers to implementing ADRTs^a

	A mount of tra ining	Mu ltiva riate stati stics					
Di scuss ADRTs rout inely at care prog ramme app roach mee tings	77	16.6	11	8.7	2.372	1.17 –4.83	0.017
In suff icient tra ining to do ADRTs	178	38.3	80	63.8	0.41	0.27 –0.63	< 0.001

ADRTs, advance decisions to refuse treatment.

55 psychiatrists received no Mental Capacity Act training, 7 missing responses on quality of training and 3 missing responses on amount of training.

However, 206 (46.3%) psychiatrists would not discuss ADRTs even if the person with bipolar disorder or carer raised it, and even after good or better training 96 (21.5%) would never discuss ADRTs. Furthermore, 177 (39.7%) and 178 (38.3%) of psychiatrists still believed they had insufficient training and time to discuss ADRTs in clinical practice despite good or better training and two or more training sessions respectively.

Discussion

Although the need for training of psychiatrists and other clinical health staff in the MCA is often recommended or even required,^{1,3,4} and clinical guidelines also support the importance of considering the MCA in people with bipolar disorder,⁵ there is an assumption that all training is likely to help clinicians become more familiar with the MCA and that such training will improve attitudes and use in practice of the MCA by psychiatrists. We found that there was plenty of training in the MCA being offered to and taken up by psychiatrists at trainee and consultant level; 92% of trainee and consultant psychiatrists had received at least one training session on the MCA, with 50% receiving the training in the past year. Although 75% of psychiatrists rated their training in the MCA as good or better, ADRTs were only covered in 65% of the MCA training.

Psychiatrists preferred MCA training that was not didactic and merely information giving, rating training as good or better that utilised discussion of the MCA in relation to case summaries, used role-play, and covered topics such as ADRT, the assessment of capacity and the assessment of fluctuating capacity. Although the assessment of mental capacity was usually covered in MCA training, the topic of fluctuating capacity was rarely discussed, whereas the potentially challenging issue of ADRTs was discussed in only 39% of MCA training attended by psychiatrists. Therefore in the view of the authors, training of psychiatrists was rarely of sufficient quality to meet the needs of people with bipolar disorder under the MCA Training arranged by NHS trust was not perceived to be as good as training provided by the Royal College of Psychiatrists, law firms or other external agencies. The reasons for this view are unclear.

There was some evidence that good- or better-quality MCA training received by psychiatrists was associated with fewer psychiatrists reporting that they would never discuss ADRTs under any circumstances. Receipt of two or more sessions of MCA training was associated with an increased likelihood that ADRTs would be discussed routinely in

multidisciplinary care programme approach meetings. Both better quality and more training sessions were associated with a reduced likelihood that psychiatrists had insufficient time to address ADRTs. Although these data are associations and not a comparison of interventions delivered in a randomised controlled trial, there was some evidence that higher-quality training and more than one training session may be helpful in both improving the attitudes to and use in clinical practice of ADRTs by psychiatrists in patients with bipolar disorder or other patients who lose and then regain mental capacity. Another alternative explanation is that psychiatrists who are interested in helping people with bipolar disorder through the MCA attend more than one session of training and find better-quality training.

Nevertheless offering training in the MCA that psychiatrists perceive as good or better quality seems insufficient to improving their attitudes to ADRTs and their use in practice in people with bipolar disorder. Even after good or better training, 22% of psychiatrists would never discuss ADRTs under any circumstances, 46% would not discuss ADRTs even if the person with bipolar disorder or carer raised it, and 39% believed they had insufficient training and time to discuss ADRTs in clinical practice. These findings chime with the experience of people with bipolar disorder in a national survey we carried out² where neither knowledge nor use of ADRTs were associated with seeing a psychiatrist, although knowledge and use of ADRTs were associated with seeing other mental health professionals and attendance at peer support groups.

A strength of the survey was that to our knowledge it is the first of its sort inquiring into quality of training of psychiatrists and relating it to their attitudes and use of ADRTs with people with bipolar disorder. The survey was large, national and deliberately anonymised so that psychiatrists would feel able to comment frankly without any possible constraint. We judged that this advantage of the methodology outweighed the disadvantage that we do not know how many psychiatrists had the opportunity to take part in the survey but decided not to. We also do not know much about the characteristics of psychiatrists in terms of the demographic characteristics of who did or did not take part in the survey. A further limitation was that this survey was completed 4 years ago so the quality of training and use of ADRTs in clinical practice may have improved. Furthermore, by concentrating on MCA training in relation to ADRTs in bipolar disorder, we cannot comment on other aspects of MCA training on other forms of advance decision-making, application of ADRTs in people who are less likely to regain mental capacity and deprivation of liberty.

The findings confirm those of a 4-year re-audit study where increases in MCA training and improved documentation had a minimal impact on the recording of the MCA by psychiatrists in patient records.⁶ There seems to be some consistency in studies of advance planning that the therapeutic relationship between mental health professionals, including psychiatrists, and their patients is improved with advance planning.^{7,8} The House of Lords heard much evidence that the implementation of the MCA had failed to make much of an impact on clinical practice in the way that was intended, and made 39 recommendations to improve the implementation of the MCA³ We have not had the opportunity to study the effects of these recommendations but note that none of these relate to the quality or amount of training that psychiatrists or other health professionals receive in relation to the MCA. The Academy of Royal Medical Colleges were asked to report on measures to improve the uptake of the MCA^{3,4} So far it has organised educational events on the MCA but has not made recommendations on the content, form or amount or frequency of training that psychiatrists or other health professionals should receive in relation to the MCA.⁹

Therefore we conclude that there is a need to improve the quality of training that psychiatrists receive on the MCA so that fluctuating capacity and ADRTs are covered, and that techniques such as case summaries and role-play are employed to improve confidence and competencies of psychiatrists in its use. There may be a case for adding training in the MCA to mandatory training under the Mental Health Act section 22 training regulations. There is a need for further implementation research on ways to improve the knowledge and use of the MCA including ADRTs, by people with bipolar disorder or other conditions where capacity is lost and then regained, and also on how to improve the attitudes of psychiatrists and assist them further to discuss ADRTs with people who have bipolar disorder or similar conditions.

1.6.88 Assessing the second-hand effects of a new no-smoking policy in an acute mental health trust

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Abstract

Aims and method To examine whether a new no-smoking policy in an in-patient mental health setting had any effects outside of smoking cessation. Our hypothesis stated that a forced smoking ban for in-patients may result in an increased susceptibility for clinical incidents, aggression and lower admission rates. All patients admitted to adult in-patient mental health services in Coventry and Warwickshire Partnership NHS Trust were included in the analysis. Data 6 months post-implementation of the smoking policy (1 July 2015 to 1 January 2016) were compared with the same period 1 year prior (1 July 2014 to 1 January 2015). Patient demographics, admission rates, ward occupancy, average lengths of stay, numbers of reported incidents and use of the Mental Health Act 1983 (MHA) were compared.

Results We analysed 4223 admissions. We found a significantly increased number of admissions under the MHA ($P = 0.007$), a significantly greater number of reported smoking-related incidents ($P < 0.001$) and aggression-related incidents in the psychiatric intensive care unit ($P < 0.001$). However, we found no significant difference in capacity of in-patient wards ($P = 0.39$), admission length ($P = 0.34$) or total aggression-related incidents ($P = 0.86$).

Clinical implications Although further comparisons over longer time periods are necessary, our results suggest that enforced smoking cessation on acutely unwell psychiatric patients admitted to the most restricted environments may have some negative effects. Nicotine replacement therapy should be offered to all patients to minimise the risk of clinical incident.

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 - * *Inclusion and exclusion criteria*

1

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Smoking rates among those with a mental illness are 70% higher than in the general population.¹ In fact, although the prevalence of smoking in the general population has decreased, this has not occurred for those with a mental illness.² In particular, the highest smoking rates are found in those acutely unwell with a psychiatric illness, in in-patient units.³⁻⁶

Multiple explanations for such high smoking rates within the mental health sector have been put forward, including symptom control and amelioration,⁷ boredom or loneliness,^{8,9} an increased propensity to experience more severe nicotine withdrawal symptoms than the general population,^{10,11} for relaxation in a stressful environment,^{9,12} a common genetic vulnerability⁵ or that people with a mental illness are less susceptible to anti-smoking messages.¹³

As a result of relatively higher smoking rates, people with a mental illness also have higher mortality rates than the general population. Tobacco use contributes significantly to causes of ill health and mortality in those with mental health disorders.¹¹ Individuals at particular risk are patients with schizophrenia, who have a life expectancy 20% shorter than the general population.^{14,15} Tobacco use can also affect the effectiveness of some psychiatric medication, necessitating increased dosages and therefore purporting a higher chance of side-effects.¹⁶

The UK government implemented its smoke-free policy in July 2007, which extended to all ‘substantially enclosed’ public and work places. This included hospitals, with the aim of reducing the impact of second-hand smoke on patients and staff¹⁷ This was extended to all types of in-patient units from 2008.

Guidance from the National Institute for Health and Care Excellence (NICE), published in 2013, aims to support smoking cessation, temporary abstinence from smoking and smoke-free policies in all secondary care settings.¹⁸ In this guidance, ‘secondary care’ refers to all publicly funded secondary and tertiary care facilities, including buildings, grounds and vehicles. It covers in-patient, residential and long-term care for severe mental illness in hospitals, psychiatric settings, specialist and secure units.

Prior to the introduction of the legislation, a relatively large survey of National Health Service (NHS) staff found that a third of psychiatric staff disagreed with smoke-free legislation compared with only one in ten of general staff.¹⁹ A survey of mental health units in England in January 2007 found that the vast majority (91%) believed mental health premises faced particular challenges due to the high smoking prevalence among patients, associated safety risks, and potential interactions with antipsychotic medication.²⁰ However, despite the challenges, the smoke-free policy has been rated positive overall. Cited advantages include a reduced exposure of patients and staff to second-hand smoke, an enhancement and support in patients’ motivation to stop smoking, improved sleeping patterns among patients, and the conversion of former smoking rooms into new recreational spaces.²⁰

Since the development of non-smoking policies within the NHS, debate has evolved around any potential infringement

this might have on a patient's human rights. A patient at one of Scotland's high-security forensic hospitals recently won a court ruling that a blanket ban on smoking breached his human rights.²¹ According to Article 8 of the Human Rights Act 1998, everyone has the right to respect for his private life and his home. With regard to mental health units, lengthy hospital admissions may qualify as breach of one's private and home life.

The introduction of a non-smoking policy to mental health services remains a relatively novel practice. We are yet to fully appreciate its impact on in-patient services. Coventry and Warwickshire Partnership NHS Trust in the UK introduced a no-smoking policy within its mental health units on 1 July 2015. The Trust is one of the first to implement this policy following the growing evidence of high smoking rates and adverse health implications within the mental health population. Although the benefits of smoking cessation are widely acknowledged, there exists an assumption that enforcing smoking cessation on unwilling patients results in increased stress levels and therefore higher rates of aggression-related incidents.

Voluntary admission to an in-patient mental health ward requires the patient to agree to certain ward policies and procedures explained by the clinician. Within the Trust it is standard procedure to explain the non-smoking policy for both voluntary and involuntary admissions. The impacts outside of smoking cessation caused by a forced no-smoking policy has previously been analysed in a medium secure unit, finding no significant difficulties and that the widely anticipated problems did not materialise.²² We have been unable to find another study analysing similar changes in a typical psychiatric unit (mixed voluntary and involuntary patients).

Aims and objectives

The aim of the study was to examine whether a newly implemented no-smoking policy for patients in a typical in-patient mental health setting had any effects outside of smoking cessation. The objectives were first to compare admission rates and bed occupancy/capacity levels at comparable time periods pre- and post-implementation of the new no-smoking policy in a specified mental health trust. We also sought to compare the numbers of reported incidents occurring on the wards at comparable time periods pre- and post-implementation, focusing particularly on aggression-related and smoking-related incidents. In addition, we wanted to ascertain whether there was any significant difference in the use of the Mental Health Act 1983 at comparable time periods pre- and post-implementation of the new policy, and whether this was related to the change in smoking policy.

Method

Study location and Trust smoking policy

Data were collected from all patients admitted to mental health beds in Coventry and Warwickshire Partnership NHS Trust during the 12 months before and 6 months after implementation of the smoking ban. The change in policy was implemented on 1 July 2015, therefore data were collected between 1 July 2014 and 1 January 2016. The Trust smoking ban states that 'all staff, patients and visitors are not able to smoke tobacco products in Trust buildings or on Trust land.'²³ The Trust maintains a policy of offering nicotine replacement therapy to admitted patients, comprising of either an e-cigarette or nicotine transdermal patch.

Adult in-patient mental health services in the Trust comprise of three acute psychiatric units: the Caludon Centre in Coventry (112 beds), St Michael's Hospital in Warwick (41 beds) and the Pembleton Unit in Nuneaton (12 beds), with adult rehabilitation services provided at multiple sites (40 beds), for a catchment area of around 850 000 people.

Inclusion and exclusion criteria

All patients admitted to adult in-patient mental health services, both acute and rehabilitation, in Coventry and Warwickshire Partnership NHS Trust were included in analysis. To account for seasonal variation, data 6 months post-implementation of the smoking policy (1 July 2015 to 1 January 2016) were compared with the same 6 months the year prior to implementation of the smoking policy (1 July 2014 to 1 January 2015). There were no specific inclusion criteria for diagnosis or length of admission to help prevent selection bias. All sites within the Trust were included in the analysis.

Ethics

The study was approved by Coventry and Warwickshire Partnership NHS Trust as a service evaluation and as such did not need formal ethical approval from an NHS research ethics committee. Data were collated in an anonymised format from routine clinical records, by the authors.

Data collection

First, basic demographic data such as mean age and gender were obtained. Second, monthly admission rates and ward occupancy levels between the dates were collected. Third, monthly total numbers of reported incidents were obtained. All data were collected by data analysts within the Trust.

Statistical analysis

For the count data (number of admissions under the MELA, total incidents, aggression-related incidents, psychiatric intensive care unit (PICU) incidents and smoking incidents), Poisson regression was used to generate a significance value. Where data were provided as percentages (i.e. capacity), we converted to mean n based on the total Trust capacity ($n = 205$). The Shapiro-Wilk test for normality allowed a decision as to whether to use parametric or non-parametric statistical comparisons. All statistical comparisons were made using IBM SPSS Statistics 24.

Since we were measuring six outcomes in our analysis, a Bonferroni correction was applied. The α -value (0.05) was therefore adjusted to a significance value of $P = 0.008$.

Results

Demographic data

Table 1 outlines the demographic data comparisons during our two selected periods of analysis. *Table 2* outlines the findings from our other objectives.

Demographic differences

	Pre-implementation	Post-implementation
n	2124	2099
Male, %	60.2	59.9
Age, years: mean	29.56	29.39

Data outlining differences before/after implementation of no-smoking policy

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
Number of admissions under Mental Health Act 1983, <i>n</i>							
Before	143	144	145	171	169	173	157.5
After	207	184	141	174	188	169	177.2
In-patient ward capacity, %							
Before	101	102	100	101	104	104	102.0
After	104	101	102	104	98	101	101.7
In-patient ward capacity, mean <i>n</i>							
Before	207.5	209.1	205	207.5	213.2	213.2	209.3
After	217.2	207.5	209.1	213.2	200.9	207.5	209.2
Mean duration of stay, days							
Before	38.1	38.8	40.6	44.3	55.7	36.6	42.4
After	44.7	37.0	37.2	37.8	41.9	36.3	45.4
Total aggression-related incidents, <i>n</i>							
Before	105	87	59	48	82	88	78.2
After	76	92	51	93	79	90	80.2
Aggression-related incidents on PICU, <i>n</i>							
Before	24	16	16	22	21	13	18.6
After	32	20	35	25	37	29	29.6
Smoking-related incidents, <i>n</i>							
Before	9	7	9	7	2	5	6.5
After	38	19	17	12	9	26	20.2

PICU, psychiatric intensive care unit.

Number of patients admitted under the Mental Health Act 1983

Poisson regression found that the number of admissions under the MHA increased (1.13, 95% CI 1.03–1.23) at the boundary of our corrected α -value, $P = 0.007$, in the same 6 months the year following the introduction of the new smoking policy.

In-patient ward capacity

Our findings show that the bed capacity was at maximum or over-maximum at each month studied. Using the data adjusted into mean capacity, the Shapiro-Wilk test for normality ($P = 0.306$) allowed us to proceed with an unpaired t -test, which showed no significant difference ($P = 0.99$).

Average duration of in-patient admission in days

The Shapiro-Wilk test for normality ($P = 0.068$) allowed us to proceed with an unpaired t -test, which showed no significant difference ($P = 0.34$).

Total number of in-patient aggression-related incidents

Poisson regression revealed no significant difference in total aggression-related incidents following the introduction of the new smoking policy (1.02, 95% CI 0.90–1.12; $P = 0.70$).

Aggression-related incidents (PICU only)

Poisson regression revealed a significant increase in aggression-related incidents in PICU following the introduction of the new smoking policy (1.59, 95% CI 1.26–2.01; $P < 0.001$).

Smoking-related incidents

Poisson regression revealed a significant increase in smoking-related incidents following the introduction of the new smoking policy (3.10, 95% CI 2.55–4.46; $P < 0.001$).

Discussion

Main findings

We aimed to ascertain whether a new no-smoking policy for in-patients at a specified mental health trust might result in any less favourable effects outside of smoking cessation. We found a statistically significant increase in the number of admissions under the MHA, total number of reported aggression-related incidents on PICU, and a statistically significant increase in the number of reported smoking-related incidents. The majority of these findings may be expected. In consideration with our finding that in-patient bed capacity was at or over 100% for each of the months studied (potentially due to patients being ‘on leave’ from hospital but still named in beds), one might argue that the acutely stressed state necessary to be granted an admission into bedspace at a premium would have been of considerable severity. Such patients may also have been admitted against their will, further heightening stress levels. One may therefore consider that immediately and forcefully removing the right to smoking, a past-time that can bring comfort, reduce stress, ameliorate psychiatric symptoms and help to fight boredom, may be poorly timed.

Perhaps a more surprising finding is the statistically significant increase in patients admitted under the MHA. This was included as an outcome measure as it was hypothesised that patients may refuse informal admission based on the no-smoking policy. Although patient refusal for informal admission may have contributed to the effect, it is likely not the whole story, as that hypothesis relies on the provision of adequate information to patients, i.e. the new smoking policy is explained prior to admission. Other work²⁴ has shown that this is not always the case. It is also well known that detentions under the MHA have been on the rise across the UK over the past 10 years,²⁵ due to a multitude of factors (not smoking related) which we were unable to analyse in this study. In-depth case-note analysis may have allowed us to qualitatively ascertain whether the smoking policy played a part in this significant finding, and future research analysing this perhaps legitimate question could take this into account.

We found no significant difference in the total number of reported aggression-related incidents. At face value, this finding suggests that in an open-ward environment, the new smoking policy did not cause an increase in agitation or aggression, which contradicts the finding we obtained from PICU only. There are several possible explanations for this. First, the patients that are admitted to PICU are likely to be more acutely stressed than those admitted to an open ward and therefore the potential to cause an ‘incident’ might be increased. Second, the more strictly controlled environment in PICU may lend itself to better adherence of the smoking policy than for informal patients on an open ward (who may

be allowed out for 'grounds leave' each hour, or more), thus the new smoking policy may be felt more among patients on PICU. Third, there is the very likely possibility that not all incidents are reported. Incident reporting can sometimes be viewed as an arduous process, especially for staff with busy in-patient ward roles. Although this could affect the results both in the open-ward environment and on PICU, one could suggest that staff on PICU might be more familiar with and better trained to deal with incidents, thus incident reporting might be better adhered to.

We also found no significant difference in patients' length of admission, suggesting that the new no-smoking policy did not positively or negatively affect the patient journey through mental health services. This might be an expected finding as the benefits of smoking cessation are known for long-term rather than short-term health. However, it is useful to address this result in light of our findings of increased smoking-related and aggression-related incidents, as it suggests that the new policy's potential to predispose to aggression or agitation does not necessarily result in prolonged in-patient stay. We also found no significant difference in in-patient ward capacity, which could be expected considering capacity was at maximum or above maximum for each month studied.

Strategies and limitations

We believe this study is one of the first to assess the effects of a new no-smoking policy of psychiatric in-patients in the UK, in an age where the importance of physical health in psychiatric patients is becoming increasingly recognised, such that many more healthcare trusts may in future choose to adopt a similar policy. In using the entire sampling frame over a 6-month period, we have ensured a large sample size which may help to reduce the potential for type I or II statistical errors. We have reduced the impact of seasonal variation by comparing the same 6 months both in the year of introduction of the new no-smoking policy and the year preceding it. In comparing data across time, we can demonstrate a temporal association with the positive findings. Furthermore, regarding the new no-smoking policy being more strictly enforced on PICU, a dose-response relationship may be observed when comparing the non-significant open ward aggression-related findings with those obtained from PICU. In addition, we have included a range of measures that were chosen prior to commencing data collection.

There are however a number of limiting factors that should be taken into consideration. First and most importantly, we cannot show that the new no-smoking policy is causal to the positive findings. There could be many other causes for increased aggression-related incidents on PICU and it is therefore not clear how much (if at all) the change in smoking policy contributed. It is however less probable to consider reverse causality as a factor in this study, as it is unlikely that the no-smoking policy was enacted because of significant aggression-related incidents.

In addition, we are unable to determine the effect of any poor reporting practice on our findings. We have mentioned that reporting might be better in certain areas of in-patient psychiatric care than others which may skew our results and invalidate comparisons. Despite our efforts, we were unable to obtain a comparison of total number of reported incidents between the two time periods. This would have better highlighted the reporting practices in the Trust across the two time periods and may be useful for future work.

It may also be possible that the timing of our data collection may have affected the validity of our results. We chose to measure the 6 months immediately following the introduction of the new no-smoking policy. It is likely that group practice takes time to adapt and this may be an explanation for some of the negative findings in our results. It may have been more appropriate to choose a length of inclusion greater than 6 months to better visualise this, however we were limited by time and resources. Both adherence to the Trust smoking policy and the reporting of incidents (if common) may improve over time, and it therefore may be useful to repeat this study in the future to compare the results.

Finally, since our study only measured outcomes during in-patient stay, we were unable to ascertain any longer-term effects of the new smoking policy, such as the increased achievement of smoking cessation among patients admitted under the new no-smoking policy. Further work might seek to establish the longer-term effects of such a policy.

Other research has been carried out on this topic internationally, which correlates partially with our results. A 2002 systematic review²⁶ including studies from several countries found no significant behavioural effects when smoking bans were enacted in psychiatric units, although the review also notes that in the included studies, smoking bans were not associated with long-term smoking cessation among patients. More recently, a 2005 study²⁷ from the USA found no significant increase in aggression with the introduction of a new smoking ban. Furthermore, a survey²⁸ of mental health staff working at an Australian healthcare trust in 2013 found that although most staff preferred to work in a

smoke-free environment, around half of survey respondents found the smoking ban to be detrimental to acute patient care, which may give the impression of increased agitation or behavioural problems among patients involved.

Our results are therefore broadly in line with the findings of others. However, it is notable that we have shown a potential difference in the effects of a smoking ban on different patient groups across different settings. Further work might seek to clarify and further examine the reasons behind this finding.

Overall, the reasoning behind a smoke-free hospital environment is clear. The long-term health benefits of smoking cessation are numerous and well documented, and other work has shown staff to prefer a smoke-free working environment. However, there is the legitimate debate as to whether the acutely stressed state is the right time to impose this lifestyle change, and whether it is even ethical to do so. Our results show that, in general, a new smoke-free policy did not result in significant changes of reported aggressive behaviour or incidents, and did not affect the patient journey through mental health services. However, we found significantly increased smoking- and aggression-related incidents in more restricted environments. It is possible that the most highly agitated psychiatric patients are most susceptible to cause incidents with this enforced lifestyle change. Our finding of significantly increased use of the MHA may be explained by other factors, but also may warrant further research. Therefore, to reduce the impact this may have on both patients and staff tasked with dealing with any resultant incident, nicotine replacement therapy should be considered for all relevant patients.

The authors would like to extend their thanks to the data analysts of Coventry and Warwickshire Partnership NHS Trust for their support in obtaining the data used in this study, and to Pascal Perry-Cheung for his kind assistance.

1.6.89 A service evaluation of outcomes in two in-patient recovery units

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date

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Abstract

Aims and method To evaluate outcomes for patients during their admission or in the first year of treatment in two in-patient recovery units. Changes in health and social functioning, service use and need (rated by patients and staff) were evaluated.

Results In 43 patients treated, there was a large (30%) increase in patients discharged to their own tenancies, rather than supported accommodation. There was minimal change in Health of the Nation Outcome Scales (HoNOS) scores in the course of the admission but staff- and patient-rated unmet needs reduced and met needs increased. Needs changed mainly in domains relating to social functioning. Reductions in risk to self and others were rated by staff but not patients. There were no cases of patients being readmitted to acute hospital during the study period.

Clinical implications Although these results offer some support to the treatment approach described in these in-patient recovery units, further research in larger samples is needed to identify how these

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services can best be deployed to help individuals with severe mental illness and complex needs.

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From the start of 2011 it was decided to develop greater understanding of the outcomes of the work of our two Together Foundation National Health Service (NHS) Trust recovery in-patient units, by evaluating outcomes assessed by staff and patients at admission, mid-point and discharge from the units. These services have in the past decade adopted a strong recovery-based model of practice, in line with the UK government policy *No Health Without Mental Health*.¹ A major strategic aim in this policy is for more people with mental health problems to recover, defined as: ‘a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live’.¹ The literature on personal recovery emphasises the individual journey in recovery, in which regaining hope, taking back control and finding new opportunities are key processes.² It has been argued that a transformation of mental health services is required for this to occur;³ mental health professionals recognising patients’ strengths and expertise as experts in their own health and acknowledging the importance of personal narratives, alongside other forms of evidence. The increasing focus in UK and international healthcare policy on recovery has occurred at a time of generally increasing personal autonomy in wider society while health services have shifted their focus towards helping every individual to make the most of their health, rather than relating mainly to those with illness.⁴

The recovery units studied provide active rehabilitation for 10 and 13 residents respectively. The units are remote from the main psychiatric hospital services but provide full in-patient support and are registered to take detained patients. The focus of the work in the units is with patients who have complex, severe mental illness, predominantly psychosis, characterised by treatment resistance and other complications. Treatment is provided through a full multi-disciplinary team and includes approaches to optimise health through use of medication, talking therapies including family work, guidance on healthy living, and treatment and support for substance use problems. A wide range of social approaches include help with daily living skills including budgeting, self-care, shopping and cooking, help with finances, benefits and accommodation, and support to develop interests and activity such as sport, leisure activities and work. The work in these units differs from acute in-patient work in focusing more on treating long-term, disabling mental health problems and impaired social functioning over longer time periods, rather than dealing with brief, episodic illness. Typical admissions last approximately 9 months, rather than just over 1 month in acute units (based on November 2016 Together Foundation NHS Trust data).

The original model of the recovery units described was developed to help patients in their rehabilitation from long-stay hospitals,⁵ aiming to support patients with complex illness to reintegrate into the community. They have subsequently evolved to work mainly with patients who need longer-term rehabilitation after acute psychiatric admission or any

patients who have developed disability due to severe mental illness. Over the past 20 years in the UK, in association with NHS and local authority funding changes, there has been a disinvestment in these services,⁶ despite recognition in recent commissioning guidance⁷ that this form of treatment is needed as part of a spectrum of care provision in each district.

The evidence from research in this field has previously been reviewed,⁸ showing that in-patient recovery units can effectively support most patients accepted by them, the majority of whom can be resettled to less dependent community placements over a period of months or years. The research indicates that treatment in recovery units is associated with improvement in social functioning and social networks and reduced levels of negative symptoms in schizophrenia. Placements are associated with relatively few long-term readmissions. These findings have been replicated in other countries such as Australia, the USA Northern Ireland, Norway and Italy.⁹ The quality of the research evidence is however variable and there has been very little formal research carried out in this area.⁵ A recent study of outcomes 5 years after in-patient rehabilitation¹⁰ found that around 40% of patients had remained in stable accommodation or moved to independent placement and sustained this.

Although UK commissioning frameworks have consistently argued the need for services of this type to help patients with complex needs in their pathway from acute or secure hospital to the community, there still seems to be a shortage of appropriate residential places in some areas, particularly for those with the most severe and enduring mental health problems. A study of hospital services in Birmingham, UK,¹¹ showed that long-stay (more than 6 months) patients were consistently found to occupy 20% of acute beds. The authors noted that where staff made recommendations for community placements, 'by far the majority' required 24-hour residential care, suggesting a need to improve access to this sort of provision. A recent paper¹² noted that problems may arise from the fragmentation due to use of private sector psychiatry and made a strong case for local, well-organised, NHS rehabilitation services. A survey¹³ of English rehabilitation services showed that despite closures of nearly all NHS long-stay hospital beds, most areas still had active rehabilitation units available to help people with complex, treatment-resistant illness. In 93 local authority regions, most (77%) had short-term (up to 12 months) rehabilitation units, with an average of 13 beds. It appears that although services are available in most areas, the level of provision is variable and patchy. Hospital services in the UK continue to be under pressure and there are often suggestions of a need for more beds. However, it has been argued¹⁴ that alternatives to acute in-patient admission could reduce this pressure and that around one in four cases in acute units could be managed in a unit run by nurses or care workers.

Aims of the evaluation

This service evaluation aimed to describe, prospectively, aggregated outcomes for new residents over the duration of their admission or in the first year of treatment. The evaluation considered changes in health and social circumstances from admission to the units, to discharge or 1 year after admission. Utilisation of acute hospital treatment was monitored before and during treatment in the recovery units.

Method

This project was carried out as a service evaluation with a formal protocol and a project steering group which met regularly during the project's work. The County Research and Development Support Unit assessed and gave written agreement for the project, prior to commencement. The use of aggregated data was preferred to other methods, such as the use of within-participant findings. This was a pragmatic decision, as the introduction of routine outcome monitoring was hoped to improve and make more systematic individual care planning, as well as to enable individual and service-level evaluation of outcome. The measures used in the project were selected to support the new way of working.

Participants

At the point of admission to the unit, demographic and health-related data were collected for all patients, on a specially designed form. The patient's key worker rated the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS)¹⁵ and Health of the Nation Outcome Scales (HoNOS)¹⁶ scores at the time of admission. CANSAS forms were given by key workers to patients for self-completion, with an explanation about how to complete them. Key workers were instructed to ensure that patient rating of need was independent of their own rating and access to support from local advocacy services was offered if this was considered helpful. Where a carer had a significant role with the patient, this individual was also approached to assess the needs of the patient (with consent, following the usual clinical permissions pathway).

To be included in the evaluation, patients were required to have continuous treatment for a minimum of 3 months in one of the units. This was to ensure that patients who were occasionally admitted briefly from the acute ward, due largely to problems such as homelessness leading to delays in discharge, but were not assessed to require the therapeutic approach of the recovery unit, did not bias the sample. It was also felt that patients discharged before 3 months would not have had time to engage meaningfully with the therapeutic work of these services.

The same ratings were repeated 6 months after admission and at discharge, or at the end of the first year of treatment. Demographic and health-related data were collected at the point of discharge from the unit or at the end of the first year of admission.

Measures

The CANSAS¹⁵ rates need as 'absent' (no problem), 'met' (problem addressed by services) or 'unmet' (significant, ongoing problem) across 22 social and healthcare domains. The HoNOS¹⁶ is a 12-item scale that rates various aspects of health and social functioning on a 5-point Likert scale to measure levels of problem severity.

Data management

At admission, patients were allocated a number for identification purposes and from this time all data were held anonymously, with the identification number only used on forms, held securely by the unit administration lead, who managed the data collection processes. Data sheets were held in a locked office in secure filing cabinets or on a password-protected Trust PC.

Statistical analysis

C.F. advised on the use of descriptive, demographic and illness-related information and the analysis of change scores from admission to discharge using aggregated HoNOS scores and CANSAS total, met and unmet need total scores. Data were entered into SPSS for analysis (SPSS version 18 for Windows). Non-parametric Wilcoxon matched pairs signed ranks tests were used to assess changes in mean HoNOS and CANSAS ratings.

Ethical consideration

This work was an attempt to evaluate whether the recovery units were effective in their intended work. It was a service evaluation and did not have a randomised controlled design. Information was collected as part of the work of the units and it was used at an individual level to more systematically understand patient need and plan treatment. There was no intention to use experimental tools or to compare units or employ a control group. As a result of the design it was noted that results would not be generalisable, although it was hoped that they may be of value at a time of greater attention to treatment outcomes and considering issues of service quality and innovation. Patient consent was not formally taken but was considered to be given by participation, where patients gave individual ratings of need and this was always explained to be optional and unrelated to the rest of the patient's treatment. Prior to starting the project, the need for

formal ethics committee submission was considered by our County Research Support Unit, which advised that this was not required and gave written approval for the project.

Results

Data collection was carried out in the two units from April 2011 to June 2014. During that time a total of 43 patients were admitted for a period of at least 3 months. Data were collected on the patients over this period, the gaps in data being largely due to the challenges of managing data collection within a standard clinical setting, rather than (with the infrastructure permitted by research funding) as a research project. Gaps in the data-set are reported within the results presented below. These related often to patient choice and willingness to participate in routine data collection. Although access to advocacy was freely available and advocates were working regularly in both units through the project, we do not know how often they provided specific support to patients in completing outcome measures. We believe this was rare and in the great majority of cases patients completed forms independently or with minor support from staff.

The study group of 43 patients included 28 (65%) male patients, aged 18–62 years (mean 36.5, s.d. = 10.3); 39 (91%) were single, 2 (5%) married and 2 (5%) divorced. Most patients ($n = 23$, 53%) were admitted from an acute psychiatric ward, the remainder ($n = 20$, 47%) direct from the community. In the year prior to the recovery unit admission, patients had spent a mean of 20.7 weeks (range 0–52, s.d. = 24.5) in a psychiatric hospital. Patients had experienced a mean of 1.0 admissions in the year before entering the recovery unit (range 0–4, s.d. = 0.55).

At the time of admission all patients were unemployed, and 23 (53%) lived in supported accommodation, 19 (44%) in their own tenancy and 1 (2%) with family. Overall, 27 (63%) were under an assertive outreach team, 11 (26%) under a community recovery team (community mental health team) and 5 (12%) under early intervention services.

Patients spent a mean of 380 days (s.d. = 177) in the recovery units; there were no recorded episodes of acute psychiatric readmission during this time. In total, 38 of discharges (74%) were planned and 5 patients (12%) were discharged for other reasons.

At the time of discharge, 42 (98%) were unemployed, 1 patient being a part-time student. Overall, 32 (74%) had their own tenancy, 4 (9%) were living in supported accommodation and 2 (5%) were living with family. In total, 29 (67%) were under an assertive outreach team, 11 (26%) under a community recovery team and 3 (7%) were under early intervention services.

The main changes over the course of this evaluation were: there was a small increase in employment following treatment in the units; there was a 30% increase in patients living in their own tenancy; and some patients were taken over by assertive outreach teams during their admission, mostly moving from early intervention teams.

No individuals were readmitted to acute in-patient care during their recovery in-patient admission.

Baseline and final mean HoNOS and CANSAS met/unmet need scores are presented in *Table 1*.

Mean HoNOS and CANSAS ratings at baseline and discharge/12-month follow-up

	Baseline rating Mean (s.d.)	Discharge/12-month rating Mean (s.d.)	Wilcoxon signed ranks 2-tailed test
HoNOS	19.9 (8.2)	18.5 (9.0)	Z= 1.46, P>0.05
Staff-rated CANSAS met need	7.2 (4.3)	7.3 (3.9)	Z= 0.41, P>0.05
Staff-rated CANSAS unmet need	3.7 (3.6)	3.4 (3.0)	Z= 0.76, P>0.05
Patient-rated CANSAS met need	3.9 (4.5)	4.8 (4.4)	Z= 1.39, P>0.05
Patient-rated CANSAS unmet need	2.8 (3.3)	2.2 (2.5)	Z= 1.32, P>0.05

HoNOS, Health of the Nation Outcome Scales; CANSAS, Camberwell Assessment of Need Short Appraisal Schedule. CANSAS scores by domain at baseline and discharge/12 months are represented in *Table 2* for patient ratings and *Table 3* for staff ratings.

Patient CANSAS ratings of met, unmet and no needs by domain at baseline and discharge/12 months

	Met need	Unmet need	No need	Total completed CANSAS ratings			
Social life	5	13	8 (28)	13	10	3 (10)	11
Psychological distress	7	12	5 (17)	10	6	4 (13)	13
Physical health	10	12	2 (7)	6	5	1 (3)	15
Intimate relationships	5	3	2 (7)	9	14	5 (17)	16
Daytime activities	10	16	6 (21)	10	4	6 (21)	9
Sexual expression	3	4	1 (3)	10	10	0 (0)	16
Accommodation	9	19	10 (33)	8	1	7 (23)	13
Psychotic symptoms	11	14	3 (10)	11	7	4 (13)	9
Safety to self	9	6	3 (10)	4	2	2 (7)	18
Information on treatment	18	23	5 (16)	2	2	0 (0)	11
Enough food	14	18	4 (13)	2	3	1 (3)	15
Use of public transport	7	3	4 (13)	4	7	3 (10)	19
Basic education	2	8	6 (19)	2	0	2 (7)	27
Budgeting	8	8	0 (0)	5	10	5 (16)	18

contin

Table 8 – continued from previous page

	Met need	Unmet need	No need	Total completed CANSAS ratings			
Safety to others	3	1	2 (7)	0	1	1 (3)	27
Care of home	8	15	7 (23)	3	3	0 (0)	12
Self-care	11	10	1 (3)	3	2	1 (3)	17
Non-prescribed drugs	4	2	2 (7)	2	1	1 (3)	25
Benefits taken up	9	10	1 (4)	1	4	3 (12)	16
Use of telephone	4	5	1 (3)	0	0	0 (0)	27
Alcohol problems	2	4	2 (7)	4	1	3 (10)	25
Childcare	2	1	1 (3)	1	0	1 (3)	27

CANSAS, Camberwell Assessment of Need Short Appraisal Schedule.

Staff CANSAS ratings of met, unmet and no needs by domain at baseline and discharge/12 months

	Met need	Unmet need	No need	Total completed CANSAS ratings			
Social life	12	18	6 (15)	18	16	2 (5)	10
Psychological distress	19	21	2 (5)	11	8	3 (8)	8
Physical health	18	20	2 (5)	7	7	0 (0)	14
Intimate relationships	7	3	4 (13)	13	16	3 (9)	12
Daytime activities	22	23	1 (3)	16	13	3 (8)	2
Sexual expression	8	3	5 (18)	10	13	3 (11)	10
Accommodation	12	21	9 (23)	13	9	4 (10)	15
Psychotic symptoms	20	23	3 (8)	18	14	4 (10)	1
Safety to self	19	10	9 (23)	4	4	0 (0)	16
Information on treatment	27	33	6 (15)	2	0	2 (5)	12
Enough food	20	22	2 (5)	3	2	1 (3)	17
Use of public transport	7	4	3 (8)	6	7	1 (3)	24
Basic education	7	11	4 (10)	1	0	1 (2)	33
Budgeting	17	13	4 (10)	9	13	4 (10)	13

conti

Table 9 – continued from previous page

	Met need	Unmet need	No need	Total completed CANSAS ratings			
Safety to others	17	7	10 (25)	2	2	0 (0)	21
Care of home	11	15	4 (11)	12	10	2 (6)	13
Self-care	19	17	2 (5)	6	7	1 (2)	16
Non-prescribed drugs	14	5	9 (23)	2	3	1 (3)	24
Benefits taken up	20	22	2 (6)	1	0	1 (3)	13
Use of telephone	5	7	2 (5)	0	0	0 (0)	36
Alcohol problems	15	13	2 (5)	6	4	2 (5)	20
Childcare	3	4	1 (3)	1	1	0 (0)	35

CANSAS, Camberwell Assessment of Need Short Appraisal Schedule.

There were improvements in patient-rated met needs in domains relating to accommodation, social life, care of the home and daytime activity, most other domains showing no change or minor increases and decreases. There were reductions in patient-rated unmet needs in accommodation, daytime activity budgeting and intimate relationships, with about half the domains showing minimal change. It can be seen that the main changes in patient-rated need were in domains relating to social functioning.

There were increases in staff-rated met needs in domains relating to accommodation, social life and information about treatment. Apparent reductions in staff-rated met need in the domains safety to others, safety to self and use of non-prescribed drugs appeared to be explained by comparable increases in levels of 'no need' in these domains. Staff-rated unmet needs showed smaller levels of change, the domains which reduced most being accommodation, daytime activities and psychotic symptoms.

Discussion

We have shown that it is possible as part of routine clinical outcome measurement to assess longitudinal outcomes in a standard recovery in-patient setting, using staff- and patient-rated measures. The results included some gaps in data which were due largely to patients declining to complete CANSAS ratings of need or incomplete participation by staff members. However, the results seem likely to be reasonably representative of the patients admitted to the units over this time, other than those patients who were admitted and then discharged or readmitted to the acute ward within a short time (these patients were excluded from the study population).

Results and limitations of research

We found minimal change in HoNOS scores in the course of the recovery unit admission but overall staff and patient assessed unmet needs tended to reduce and met needs tended to increase, although not at a statistically significant level. This may have related to the relatively small sample size. The main changes in need found over the study period rated by staff and patients related to improved social functioning, a finding which accords with the primary clinical aims of these services; to help individuals to regain life skills lost through periods of severe illness and ideally to try to achieve the most independent living situation possible. Our evaluation included patient and staff evaluations of need, both being included as the research indicates that they differ, and that the patient's perspective may be particularly important.¹⁷ The reduction in staff-assessed risk to self and others was encouraging and may have linked to reduced substance misuse, as these units have a strict drug-free policy and during admission patients are supported to remain drug free. A recent survey¹⁸ of in-patient rehabilitation units in Birmingham, UK, found chronically high levels of

problematic and socially inappropriate behaviours and suggested that new approaches, focusing on engagement and the management of challenging behaviour, may be helpful.

A number of limitations result from the method of this service evaluation. There was no control group and, as a result, the findings cannot be generalised. We are only aware of the existence of one, small, randomised controlled trial in this area,¹⁹ and arguably this type of research is not really feasible in this setting,⁵ although it remains vital to learn more about outcomes in these important and relatively expensive services. The numbers in our study group were small and it would be helpful to compare our results with studies using similar outcome measures in other settings, ideally with larger patient groups. Further limitations arise from the lack of data relating to progress at different time points during the treatment in the recovery units: it is possible that greater benefits occur early or later in the treatment process, which we were unable to evaluate. The scales used allow limited understanding of the patient experience, which could be more fully accessed through the use of qualitative studies and a number of tools assessing aspects of patient-rated recovery are now available.²⁰ Qualitative studies in this area have emphasised the importance of choice and autonomy for many patients²¹ and have shown the potential for personal recovery to be facilitated through appropriate supported living accommodation.²²

Of interest, poorer outcomes were associated with non-adherence to medication and our finding that most patients were discharged to assertive outreach teams suggests that many patients will continue to need a high level of support following treatment in recovery units. A recent study using retrospective care records⁹ found significantly reduced hospital admission 2 years after in-patient rehabilitation and that a substantial proportion of the sample went into more independent living. We found a large increase (30%) in the number of patients discharged to their own tenancies, rather than supported accommodation.

Consideration of findings against previous research

At a time of increasing pressure on in-patient services, our findings accord with previous research²³ suggesting that alternatives to acute in-patient care could reduce this pressure and that many cases could be managed in facilities such as recovery units. More than half the admissions to our in-patient recovery units were from acute wards and their ability to manage cases effectively without return to hospital and, most importantly, achieve clinical improvements, emphasises the importance of having these services available in each region/district where acute units operate. Our findings were in line with previous research¹⁴ showing improved outcomes in terms of accommodation and stable social functioning following treatment in recovery units. It is important to have a long-term perspective due to the ongoing, high levels of chronic morbidity in this population.¹⁰ There is a continuing need for different types of supported accommodation, although in our study a substantial number progressed to fully independent living.

Research in supported accommodation has been classified⁵ into three domains: quality of care; external evaluation and quality of life; and subjective satisfaction by the resident. In terms of quality of care, the most important factors appear to be the effectiveness of an individually centred, targeted programme of care and the quality of the physical environment. A systematic review of the quality of care in longer-term mental healthcare settings²³ found eight domains of institutional care that were key to recovery: living conditions, interventions for schizophrenia, physical health, restraint and seclusion, staff training and support, therapeutic relationship, autonomy and patient involvement. The two units investigated have both embraced the recovery approach, working alongside patients in pursuit of their goals and promoting autonomy and empowerment of the individual. Previous research²⁴ has shown that quality of care is heavily determined by the personality and orientation of project leaders and staff working in these units drew on extensive experience of local rehabilitation/recovery work, which has resulted in three major reviews and redevelopment of services and extensive staff training in recovery methods. The units were both accredited as 'excellent' in 2016 within the rehab-AIMS national benchmarking of rehabilitation units.²⁵ However, the results in our study show that the patient population is highly disabled with high levels of need and high usage of hospital care. Our results, showing clinical stability alongside progress in personal and social domains, was encouraging and hopeful. These units support many patients who due to their illness have difficulty creating their own structure, with consequent loss of internal security and often associated fears of losing control. The provision of support, treatment and therapeutic approaches available 24 hours provides an important support²⁶ which enables patients to feel stable, secure and then able to progress with rebuilding their lives. It is however important to consider differences between professional and patient preferences. When asked their view, patients have tended to prefer the option of their own, independent accommodation²⁷ over

rehabilitation or supported accommodation. Family members tend to align with the professional view and prefer their relatives being cared for in staffed environments.²⁸ An important criticism of staffed settings is the potential for institutional regimes and a poor rehabilitative culture, which could impede independence and autonomy.²⁹ Conversely, some patients and family members have reported that independent tenancies can be socially isolating²⁷ and it seems that many patients benefit from treatment in these units, particularly if they maintain a collaborative approach and provide a wide range of therapeutic options.

We would like to thank the recovery units' staff and patients for their support with this project and for completing the necessary rating scales required. We thank Natasha Wallace for her administration and support more widely for the project.

1.6.90 Weekend new patient reviews in psychiatry: evaluation of activity over 3 months

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Abstract

Aims and method South West London and St George's Mental Health NHS Trust developed a system of weekend new patient reviews by higher trainees to provide senior medical input 7 days a week. To evaluate the effectiveness of these reviews, the notes for all patients admitted over 3 months were examined. The mean length of stay for patients before and after the introduction of the weekend new patient reviews were compared via unpaired *t*-test.

Results A total of 88 patients were seen: 84.4% of patients were seen within 24 h of admission. Higher trainees instituted some changes in 78.9% of patients. The most frequent action was to modify medication, in 47.8%. The average length of stay after the introduction of weekend reviews was not significantly different.

Clinical implications Weekend reviews of newly admitted patients by higher trainees is a feasible method for providing senior input to patients admitted out of hours.

Contents

- *Weekend new patient reviews in psychiatry: evaluation of activity over 3 months*
 - *Method*
 - *Results*

1

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– Discussion

* Conclusions

Medical specialties of various types are increasingly being requested to deliver senior-led care throughout weekends and bank holidays. This 7-day working is felt to be potentially beneficial for patient care and has been started by many acute specialties. The Academy of Medical Royal Colleges released a report in 2013 outlining how this could be achieved for different specialties, including psychiatry.¹ They recommended that 21–30% of psychiatric in-patients would benefit from a daily consultant-led review; mainly those who have been newly admitted or are clinically unstable. They stated that all new admissions, especially those under the Mental Health Act 1983, should receive a review the following day to initiate a treatment plan, including medication, observation levels, physical and psychosocial investigations and referrals.

The Academy of Medical Royal Colleges also advised that their recommendations were considered in light of the requirements of the local organisation as practice is likely to vary depending on geographic location, organisation size, on-call staffing and number of in-patient units. They also acknowledged that to achieve these outcomes, certain interventions and investigations would need to be available, such as pathology access.

Method

South West London and St George's Mental Health NHS Trust developed a system of weekend ward reviews led by higher trainees with consultant advice. The higher trainees in the Trust were on a full-shift on-call rota with 09:00 h to 21:00 h shifts on weekends and bank holidays. Patients admitted out of hours on Fridays, Saturdays or up to 09:00 h on Sunday morning are reviewed by the on-call higher trainee the next day. Patients admitted after 09:00 h on Sunday are reviewed on Monday by the ward team, unless it is a bank holiday, in which case they are reviewed by the higher trainee on call that day. After the higher trainee has completed their reviews for a given site, they contact the on-call consultant to discuss the cases and ensure the management plans instituted are appropriate. This occasionally led to changes in treatment plan. This provides an opportunity for supervision and training and ensures consultant input. The role of the reviews was to ensure that the patients received prompt assessment by a senior clinician and a comprehensive management plan could be instituted. They were not intended to facilitate immediate discharge, although it was hoped that earlier treatment would reduce the time patients had to spend on the ward.

To evaluate the activity involved in the weekend new patient reviews, the notes for all patients admitted between 17:00 h on Friday and 09:00 h on Sunday between 1 January 2016 and 31 March 2016 were identified via the RiO system used by the Trust. This provided information regarding the timing of their admission. The clinical notes of each of these patients were examined to determine the reason for their admission, when they were seen by the on-call higher trainee, the diagnosis made and any actions taken as a result of the weekend review. The mean length of stay for patients admitted between 17:00 h on Friday and 09:00 h on Sunday and 1 January 2015 to 31 March 2015 were also compared via unpaired *t*-test. The number of serious untoward incidents in each time period was also compared via Mann–Whitney *U*-test.

Results

A total of 88 patients were seen over the 3-month period. This equates to 6.8 patients appropriate for senior review each weekend.

Of those admitted, 46 (52.3%) were male. The average age was 41.9 years (range 18–84, s.d. = 17.8). For males the average age was 41.4 years (range 18–84, s.d. = 19.6) and for females it was 42.5 years (range 19–83, s.d. = 15.9). These differences were not significant on *t*-test.

The time from admission to senior review is indicated in *Table 1*. A total of 11 patients were not seen at all. Of these, 4 were admitted via the 136 Suite in the Trust.

Time from admission to senior review

Review within	Number of patients	Cumulative number	Cumulative percentage of patients seen
12 hours	17	17	22.1
24 hours	48	65	84.4
36 hours	8	73	94.8
48 hours	4	77	100

Diagnoses were made by the higher trainee in 73 patients. The other 15 patients were diagnosed during later assessments. These diagnoses are shown in *Table 2*. There were no significant differences between patients diagnosed by the higher trainee or at a later point on two-tailed *z*-tests.

Diagnoses made by higher trainees, the diagnoses of patients not seen or not diagnosed by the higher trainee

	Diagnosed by higher trainee	Diagnosed subsequently	Total diagnoses			
Psychosis	31	42.5	8	53.3	39	44.3
Depression	17	23.3	7	46.7	24	27.2
Mania/ hypomania	7	9.6	1	6.7	8	9.1
Alcohol or substance misuse	7	15.6	1	6.7	8	9.1
Personality disorder	12	2.6	3	20	15	17
Anxiety and stress-related disorders	2	1.3	2	13.3	4	4.5
Eating disorder	1	5.2	1	6.7	2	2.3
Developmental disorders	4	1	2	13.3	6	6.8
Physical illness	1	1.3	0	0	1	1.1
Unclear	1	1.3	1	6.7	2	2.3

The interventions made or recommended by higher trainees for the 77 patients reviewed during weekends are shown in *Table 3*. This does not include them indicating their agreement with actions made by clinicians who saw the patients before them. Again, the number of interventions shown exceeds the number of patients.

Interventions made or recommended by higher trainees as a result of weekend new patient reviews

Intervention	Total, <i>n</i>	%
Start medication		

continues on next page

Table 10 – continued from previous page

Intervention	Total, <i>n</i>	%
Regular antipsychotic	8	10.4
As required antipsychotic	2	2.6
Mood stabiliser	1	1.3
Antidepressant	8	10.4
Sedation	5	6.5
Hypnotic	3	3.9
Physical medication	3	3.9
Nicotine replacement	1	1.3
Total in which medication started	24	31.2
Increase medication		
Regular antipsychotic	1	1.3
Antidepressant	2	2.6
Sedation	3	3.9
Other psychotropics	1	1.3
Stop medication		
Antipsychotic	1	1.3
Sedation	1	1.3
Opiate replacement	1	1.3
All	2	2.6
Total medication changes	37	47.8
Recommended interventions		
Regular antipsychotic	2	2.6
Psychotherapy	3	3.9
Electroconvulsive therapy	1	1.3
Social interventions	1	1.3
Leave	1	1.3
Transfer	1	1.3
Other specific assessments	3	3.9
Discharge	2	2.6
Recommendation for Mental Health Act assessment	2	2.6
Physical investigations	8	10.4
Physical monitoring or treatments	8	10.4
Total physical health interventions	11	14.3
Transfer to psychiatric intensive care unit	3	3.9
Change in observations	3	3.9
Urine drug screen	3	3.9

continues on next page

Table 10 – continued from previous page

Intervention	Total, <i>n</i>	%
Specific advice or information	3	3.9
Obtained collateral information	2	2.6
No action	17	22.1

The length of stay for patients admitted between Friday 17:00 h and Sunday 09:00 h between 1 January and 31 March in 2015 was 26 days (s.d. = 37) and for the same period of time in 2016 the length of stay was 28 days (s.d. = 43). This was not significant.

The number of serious untoward incidents between January and March 2015 was 13, and during the same period in 2016 it was 28; this was significant ($P = 0.0652$). However, when serious untoward incidents were limited to those occurring in acute services and out of hours, there was 1 incident between January and March 2015 and 3 incidents in the same time period in 2016; these numbers were too low to be analysed and so did not reach significance.

Discussion

A substantial number of patients, 88 in total, were eligible for weekend review over the 3 months covered by the service evaluation and 77 of these were actually seen. A substantial minority of those not seen were admitted through the Trust's dedicated 136 Suite. This mode of admission may be a weak point in the current system, possibly as a patient detained to the suite could be viewed as having been admitted at that point, despite still awaiting formal assessment and possible admission. Patients admitted via the 136 Suite should still have been reviewed the following day.

Of those patients seen by the higher trainees, the vast majority (84.4%) were seen within 24 h and most of the rest, up to 94.8%, were seen within 36 h. Many of those seen between 24 and 36 h had been admitted during the morning on a Saturday and the higher trainee was unable to see them until the afternoon on Sunday. A small number (5.2%) were seen after 36 h had elapsed. The reasons for this are unclear but could be as a result of temporary limited provision of higher trainee cover due to illness.

The characteristics of the patients admitted do not appear to be remarkable, although it would have been useful to have a comparison group of patients admitted during the week to determine whether there were significant differences between the two, in terms of demographics, admission reason and diagnosis. It is unclear why some higher trainees did not formulate diagnoses for the patients they reviewed, but there appears to be no significant differences between those diagnosed during the weekend or following later assessments.

Higher trainees performed or recommended a wide variety of interventions for patients, instituting some changes in 78.9% of cases. The most frequent action was to start some form of medication; this was done for 31.2% of patients. If increasing and stopping medication is also considered, then medication changes were performed in 47.8% of cases seen by the higher trainees. These were in addition to prescriptions made by admitting core trainees.

The next largest group of interventions were recommended physical investigations and interventions, again, which had not been instituted on admission. This occurred in 14.3% of patients reviewed. These varied from instituting monitoring of fluid and food intake to obtaining specific investigations, such as lithium levels.

A variety of other interventions were performed. It is reassuring that only 2 patients needed to have a recommendation for detention under the Mental Health Act completed. The others appear to be appropriately informally or already detained under the Mental Health Act. The limited number of discharges would be at least partially explained by this not being the proposed aim of the weekend reviews.

In 22.1% of patients seen over the weekends no action was taken by the higher trainee. This could be due to all reasonable interventions already having been performed by an experienced core trainee or patients requiring a period of observation before any definitive management plans are made.

Despite these interventions being initiated earlier than expected, there was no change in the average length of stay for patients who were eligible for new patient reviews. This could be explained by the interventions only being delivered

24–48 h earlier than they otherwise would have been. The reviews were also not intended to facilitate immediate discharge. A greater focus on expediting discharge over the weekend may have led to a reduced length of stay.

Although the overall number of serious untoward incidents was significantly higher in 2016 than 2015, there was no significant difference when they were restricted to those associated with acute out-of-hours services which would appear most clearly related to the introduction of weekend new patient reviews. The overall increase in incidents may be due to a continuing Trust drive to improve reporting with a view to improving services, rather than a true increase and so the figures are difficult to interpret accurately in this context.

This system did not require any changes in rota patterns for higher trainees. The system was such that the reviews were carried out during the scheduled 09:00 h to 21:00 h shift, with reviews ceasing at 21:00 h so that patients could rest adequately without their evening or night being disrupted. On rare occasions when all the planned reviews could not be completed, they were postponed until the next day. Furthermore, as mentioned above, the focus of the reviews was not discharge; this prevented difficulties in coordinating with social care and other agencies during the weekend. The system used by the Trust enabled it to provide senior medical input 7 days a week in acute services without disrupting weekday working or leading to any of the other concerns raised by some authors.²

Conclusions

There has been increasing emphasis on providing more senior weekend medical input across all specialties.¹ In psychiatry, the recommendations were mainly in terms of newly admitted patients.

Weekend reviews of newly admitted patients by higher trainees, with consultant support, is a feasible and appropriate method for providing senior input to these patients who could potentially remain on a ward for more than 48 h without being seen by any clinician more senior than a core trainee. This would not be considered appropriate in any other medical specialty. If we are to be committed to parity of esteem in healthcare, then it is reasonable for patients admitted to psychiatric wards to be reviewed by a senior clinician within 24 h, as they would in any other hospital.³ This is particularly pertinent as the higher trainees provided some intervention in most patients, modifying medications in just under half of those admitted. It may be valuable to determine how this compares with patients reviewed during medical or surgical post-take rounds.

1.6.91 New models of care: a liaison psychiatry service for medically unexplained symptoms and frequent attenders in primary care

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date

2017-12

Abstract

Aims and method This paper describes the process of setting up and the early results from a new liaison psychiatry service in primary care for people identified as frequent general practice attenders with long-term conditions or medically unexplained symptoms. Using a rapid evidence synthesis, we identified existing service models, mechanisms to identify and refer patients, and outcomes for the service. Considering this evidence, with local contingencies we defined options and resources. We agreed a model to set up a service in three diverse general practices. An evaluation explored the feasibility of the service and of collecting data for clinical, service and economic outcomes.

Results High levels of patient and staff satisfaction, and reductions in the utilisation of primary and secondary healthcare, with associated cost savings are reported.

Clinical implications A multidisciplinary liaison psychiatry service integrated in primary care is feasible and may be evaluated using routinely collected data.

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Medically unexplained symptoms (MUS) and comorbid physical and mental health conditions place a significant burden on individuals and the economy.^{1,2} Annual costs of MUS have been estimated at £3.1 billion³ and of comorbid conditions at £18 billion.⁴ Policy makers suggest innovative approaches be deployed to improve care for patients and make savings across the system.⁵

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These patients frequently return to general practitioners (GPs) with unresolved and new complaints. Despite being referred to specialist services their problems remain, which is demoralising for all. Current primary care configurations do not adequately provide for this population. Standard secondary care mental health services rarely have staff with relevant expertise and are insufficiently close to primary care services to influence presentations. Improving Access to Psychological Therapies (IAPT) services are unsuitable due to these patients' high level of medical complexity. Access problems are further compounded by patients not meeting the referral criteria for specialist mental health services.

The skill base in liaison psychiatry services renders them an ideal source of expertise. Until recently such services were hospital-based but they can be integrated within primary care services.⁶⁻⁸ We report a novel pilot primary care liaison psychiatry service – the Primary Care Wellbeing Service (PCWS) in Bradford and Airedale, West Yorkshire. The service was targeted to frequent attenders with MUS or psychological difficulties associated with their underlying long-term conditions. This report is a description of the planning, set up and evaluation and feasibility of the preliminary project.

Method

A partnership board of clinical experts, academics and commissioners met monthly to develop and have oversight of the service; the original impetus came from local Clinical Commissioning Groups (CCGs).

A rapid evidence review helped identify service models, staffing and skill mix, patient selection and outcome measures for the service. Review findings in the context of local practitioner preferences and resources were used to agree the service configuration. The Project Board secured 15 months' funding for the preliminary project. An evaluation by the Commissioning Support Unit (CSU) assessed the feasibility of service design, implementation, collecting the data and effectiveness.

Data collection

Electronic patient health records (primary and secondary care and mental health) and measures of patient-reported outcomes, experience, and staff experience, were collected as follows: Healthcare utilisation: defined as any patient event recorded in the electronic record system; a specific Read code for the service was applied to the patient record at each practice and anonymised data extracted for 12 months prior to and 9 months following referral for secondary care data, and 11 months following referral for primary care and mental health data, providing healthcare activity and costs. Clinical effectiveness: at referral and then every 2 months during follow-up using the 9-item Patient Health Questionnaire (PHQ-9),⁹ 15-item Patient Health Questionnaire (PHQ-15),¹⁰ 7-item Generalised Anxiety Disorder scale (GAD-7)¹¹ and the EuroQol 5-dimension, 5-level health status measure (EQ-5D-5L).¹² A clinician-reported outcome measure assessed perceived improvement in the patient's condition by referring clinician. Staff experience: a referrer satisfaction scale, 6 months after the referral or at patient's discharge from the PCWS; and a survey administered at the end of the pilot. Patient experience: a brief patient-reported measure at discharge comprising (a) patient satisfaction with the service; (b) two questions asking what was good about the service and what could be improved; and (c) would they recommend the service? Case studies were used to illustrate individual formulations and negotiations that took place.

Data analysis

Feasibility of data collection was judged by the completeness of measures, using summary descriptive statistics. For healthcare utilisation and costs, a before-and-after 'time series' approach provided an indication of service effectiveness. Data points were taken from the 12-month period prior to the start of the PCWS and were truncated at 9 months post intervention for secondary care data, giving data points for months 1–21 and 11 months post intervention for primary care and mental health service data at months 1–23. Qualitative data were collated and themes reported.

The service

The literature review confirmed there was no ‘off the peg’ solution, providing information about key issues to consider when designing the service.

Service model and setting

An integrated service with specialist mental health professionals based in and collaborating with three GP practices was established. Practices were selected on the basis of expressions of interest, willingness to commit time and resources. Practices were of average size and served areas of high socioeconomic deprivation. One practice also had a high minority ethnic population.

Staffing

The team comprised a team manager, mental health occupational therapist, physiotherapist, psychology assistant, consultant psychiatrist, consultant psychologist, psychologist and administrator. Specialist advice was provided by the consultants. GP practices contributed both GP and practice nurse time.

Patient selection and referral

Most studies in the published literature used some combination of case-finding measures for mental disorder alongside frequency or cost of healthcare to identify the target population. A preliminary study in a local practice used the PHQ-9 and a search of GP electronic databases to identify distressed patients and frequent attenders. Of the 100 patients assessed with the PHQ-9, only 6 were identified who were not already in contact with services and who also had significant mood symptoms. They all declined referral. Using standardised case-finding measures failed to identify relevant candidates for this service.

Instead, GPs identified patients using a combination of their own knowledge of patients alongside a risk stratification tool. They focused on those who had a presumed diagnosis of MUS or patients with long-term conditions experiencing significant psychological difficulties, and who were also frequent attenders in primary and secondary care. Attendance was considered to be frequent when a patient had more than the average number of primary care consultations or hospital admissions and when patients’ problems remained unresolved and were escalating in cost. A discussion of potential candidates helped achieve consensus about appropriate referrals and practices were then asked to refer ten patients each, providing information on goals for referral and a summary of the patient’s health record.

Outcomes

Organisational level outcomes (health service use, healthcare costs, medication use) and patient-level outcomes (mental and physical health, physical functioning, and quality of life).

Results

In total, 28 patients were referred, with 27 appropriate referrals. One was unsuitable due to alcohol dependency and substance misuse. There was a delay of 6 months in receiving referrals from one practice, as the GP lead for the pilot left the practice. Complete data for healthcare utilisation and cost were available for 19/21 patients in 2 practices.

Health issues

A range of difficulties were identified including neuro-developmental problems; undiagnosed autism; significant health anxieties or preoccupation with illness; chronic pain and overuse of opioids; non-epileptic attacks and medically unexplained loss of movement and pain; and other maladaptive behaviours (e.g. misuse of insulin). Most patients had significant psychosocial difficulties including relationship problems, recent and past life adversity. High levels of physical morbidity such as ischaemic heart disease, chronic obstructive pulmonary disease, arthritis and head injury were also found.

Patient engagement

Patients were offered an initial joint assessment by two team members; the choice of health professionals took account of referral information about the presentation and degree of readiness to engage. For example, patients reluctant to see a mental health specialist were contacted first by the physiotherapist or occupational therapist. A flexible approach to timing and location of appointments was taken. We were able to engage with 22 of 27 patients either fully or partly with the service.

Interventions

Initial formulation developed for each patient was reviewed iteratively as alternative interventions were trialed, focused on referral goals. There were four components to interventions as follows: Taking stock and formulating the problem: review of medical notes to reconsider evidence for established diagnoses and medication reviews. Developing a function-based approach, occupationally oriented and focused on improving activities of daily living by accessing community resources; adaptations to home and mobility; introducing non-medical ways of managing pain. Psychological approaches included negotiation of a shared formulation and approach to management, with basic stress and anxiety management. Where indicated, specific therapies such as mindfulness, eye movement desensitisation and reprocessing (EMDR), trauma-focused work and acceptance commitment therapy (ACT). Service-level approaches included non-contingent access to practice staff to manage escalating demands and avoid unscheduled hospital and Accident and Emergency attendance; liaison with GPs and other specialists to agree a consistent approach.

Feasibility of data collection

Of the 19 patients for whom data could be collected there were only 8 complete data-sets for EQ-5D-5L, GAD-7 and PHQ-9, and 7 complete data-sets for PHQ-15 and EQ-5D-5L.

Healthcare utilisation data from the clinical system were readily available, although it was not possible to collect out-of-hours data. However, gathering information on prescriptions and costs of medication was prohibitively resource intensive.

Feasibility and effectiveness of the service

Across the whole patient cohort, secondary care activity reduced by an average of nine events per month. In the 9 months after the implementation of the PCWS, 177 fewer events occurred in secondary care (*Fig. 1*).

Nine months after implementation the total cost of activity was £63 950 less than the previous year (*Fig. 1*). The cost of secondary care activity reduced by an average of £3702 per month after the implementation of the PCWS (*Fig. 2*). Primary care activity had also reduced across the whole patient cohort by an average of 11 events per month.

Primary care

Time spent delivering care reduced by an average of 7 min per month. A substitution effect was observed in primary care with GPs delivering an average of 12 appointments and 127 min less to the patient cohort since the implementation of the PCWS. In contrast, other clinical staff delivered one additional appointment and 120 min more to the patient cohort.

Primary care costs were reduced across the whole scheme by an average of £171 per month for the cohort of 19 patients. In some cases, interventions led to significant changes in symptoms and health-seeking behaviours (*Box 1*). In others, work is still ongoing and longer-term intervention will be needed.

Discussion

What works in a research study does not easily translate into routine clinical practice in the National Health Service (NHS). In this study, academics and GP commissioners worked with specialist mental health providers to consider the evidence and identify local resources to design the best service configuration for patients with MUS, long-term conditions and frequent attenders in primary care. There is no short-term solution for these complex patients but a liaison psychiatry service based within primary care and as part of a long-term care plan shows great promise.

Identifying the patient group for the service and managing complexity

The service presented here addresses a common problem for GPs, which traditional diagnostic categories do not describe well and standard mental health services do not currently manage well. This is not the first attempt at establishing primary care-based liaison services. The service described, however, is unique because it eschews traditional collaborative care approaches¹³ and screening for anxiety and depression widely described in the research literature.^{13,14} In clinical practice that type of screening does not identify the right candidates to work with. The GPs and practice staff identified patients for this study by focusing on those patients with MUS or long-term conditions who were struggling to cope and that were returning with unresolved physical and emotional problems with rising healthcare costs. This was facilitated by a discussion of the case and the development of the vignette prior to referral to the PCWS. There was a level of detail in identifying this type of patient that required consideration and scrutiny by practice staff which could not be picked up by electronic systems or case-finding measures alone.

Patients with such complex conditions cannot be managed in standard ways following a protocol. They require a creative approach to person-centred care that supports their identification and management. In almost all cases the GPs were correct in identifying the right patients for the service via their clinical presentation, the exception being someone who required support from specialist addiction services.

Box 1 Case study

Patient A was a frequent attender at Accident and Emergency, the GP practice and mental health services, with a range of physical and non-psychotic mental health symptoms. She had a suprapubic catheter due to incomplete bladder emptying and detrusor overactivity; she found it too distressing to self-catheterise using a urethral catheter because of a history of sexual abuse. As she was struggling with the suprapubic catheter, an operation was planned to create a conduit between the skin and bladder to make catheterisation easier. However, there was concern that this would not address the underlying reasons for her frequent presentations, and would in fact increase her physical health problems, for example,

increasing her risk of urinary infection. Following referral to the Primary Care Wellbeing Service (PCWS), a review of her case notes revealed that her urodynamic studies had been normal. The team liaised with the surgeon, who agreed to a trial of bladder retraining. The team worked to engage patient A and to develop a shared formulation with her about the reasons for her urological difficulties and accept that her physical health difficulties could be managed in a non-operative way. We recognised the importance that all staff conveyed the same message to the patient and that care did not suddenly decrease while other changes in care took place. With input from the practice nurse and the PCWS team, she was able to start passing urine again without the catheter.

Challenges to service delivery and data collection

Our findings suggest that such services are feasible to deliver but that practices can struggle without sufficient staff to deliver the service. This accords with the literature¹⁵ which suggests an assessment of practice readiness be performed but this might not account for unexpected changes in practice staffing and infrastructure. Patients and staff that completed satisfaction measures were satisfied with the service, although it is possible that those that did not complete measures did not have such a positive experience. Further, it was not possible to routinely collect self-reported outcome measures in routine practice for this service. Given that these practices were highly motivated to take part, it is unlikely that collecting self-report measures, as part of an evaluation package, would be feasible in less motivated practices. Feedback from staff suggested that they were not able to collect this additional data. Any additional work to use self-report measures in practice needs to consider the burden of additional work for practice staff against the need to collect this information. However, routinely collected data on service use and cost proved to be feasible to collect as this is already part of the existing monitoring systems. Again, out-of-hours information was not collected as part of this. Case studies enabled practitioners to consider how well the patient progressed helping to sustain the service in its early phases using cases as a feedback loop as proposed in the literature.¹⁵

Implementing new service models requires a long-term view

There are challenges in setting up and maintaining such services, however. We cannot be sure that they will be cost-effective in the longer term, as the full costs of the service were not examined here only salary costs. This type of analysis would need to be evaluated in a larger study of effectiveness taking account of the commissioning cycle and utilising an economic evaluation. This pilot was only conducted in one metropolitan district in England. Population demographics, health service configurations and commissioning arrangements vary across the UK, and our findings and experience may not be generalisable. Moreover, GP practices taking part were selected for their willingness to engage with the pilot, with one out of the three being unable to launch the proposed service within the project time frame.

Findings from the evaluation are not definitive, but rather provide important data to inform the next stages of service development and evaluation. This pilot demonstrates that service developments can be implemented using NHS resources and commissioning processes, and evaluated using routinely collected data. However, including patient self-report and staff measures, which are not part of usual care, requires additional resources. Administering and collecting paper-based measures for patients and staff proved onerous, with incomplete data collection from all practices despite concerted efforts to collect these by the team.

Questions of sustainability and scaling up need to be considered. In this feasibility study, there were significant reductions in secondary care activity and cost. If such a service could be extended then a further study including full economic costs would be of interest. Such transformation requires commissioners to take a long-term view and to accept that cost savings may be negative or neutral in the first year or more.

Future proposals

To maintain the momentum and build on this project and other innovative pilots in the UK,^{6,7} we propose setting up a network of interested colleagues to critically consider the future development of primary care liaison psychiatry services. The purpose would be to share experience and to inform further implementation projects and design approaches to the particular problems of scaling up and managing the needs of patients with complex problems who are prone to relapse and likely to require repeated specialist help or longer-term care plans.

The Clinical Commissioning Groups of NHS Airedale, Wharfedale & Craven and NHS Bradford Districts commissioned the Health Economics, Evidence and Evaluation Service (HEEES) of Yorkshire and Humber Commissioning Support to evaluate the Primary Care Wellbeing Service pilot.

1.6.92 Systematic review into factors associated with the recruitment crisis in psychiatry in the UK: students', trainees' and consultants' views

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Abstract

Aims and method To review the literature to examine the factors that may be affecting recruitment into psychiatry in the UK. We systematically searched four databases to identify studies from 1974 to 2016 and identified 27 papers that met the specified inclusion criteria.

Results Most papers ($n = 24$) were based on questionnaire surveys. The population in all studies comprised of 1879 psychiatrists, 6733 students and 220 746 trainees. About 4–7% of students opt for a career in psychiatry. Enrichment activities helped to attract students more towards psychiatry than just total time spent in the specialty. Job content in terms of the lack of scientific basis, poor prognosis and stigma towards psychiatry, work-related stress and problems with training jobs were common barriers highlighted among students and trainees, affecting recruitment. Job satisfaction and family-friendly status of psychiatry was rated highly by students, with lifestyle factors appearing to be important for trainees who tend to choose psychiatry.

Clinical implications Negative attitudes and stigma towards psychiatry continue to persist. Teaching and training in psychiatry needs rethinking to improve student experience and recruitment into the specialty.

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Psychiatry as a career has been negatively regarded and unpopular among medical students. About 3.6% of British graduates decide on a career in psychiatry whereas about 6% are needed.¹ From 2000 to 2011, the absolute number of consultant psychiatrists in England rose from 2904 to 4394 (an increase of 51%), with similar increases in Scotland and Wales, in line with the expansion of the consultant workforce in most secondary care specialties.¹ A need for more psychiatric consultant posts has been predicted based on projections of increasing workloads due to the increased population needs.² A perceived fall in the proportion of UK medical school graduates choosing a postgraduate career in psychiatry, and low competition ratios for first-year core specialist training (CT1) posts in psychiatry,^{3–5} has led to many questions about the way in which psychiatry is taught at medical school and how psychiatry could be made as an attractive career option.^{6–8}

Low recruitment in psychiatry is a global issue, highlighted in a number of publications.^{9,10} However, the problem also has country-specific dimensions, as each country has different factors such as the pay scale for the specialty, medical education system and training programmes, which may attract or dissuade medical students from a career in psychiatry. The subject has not been reviewed systematically especially in the context of recruitment in the UK. The review question was: what are the factors that influence recruitment to psychiatry as a career choice and how can this be improved? The aim of this paper is to systematically review the literature from the UK on psychiatry as a career choice. We are specifically interested in identifying the factors that influence the recruitment into psychiatry with emphasis on barriers and facilitators affecting recruitment. A greater understanding of the views ranging from medical students to trainees and consultants working in the UK may enable curriculum developers and recruitment leads to design programmes that attract students and trainees to psychiatry as a career and improve students' attitudes towards psychiatry in the long term.

Method

We followed the PRISMA statement¹¹ as a guide for conducting the systematic review. The following electronic databases were searched from 1974 onwards: Medline, EMBASE, CINAHL, PsycINFO. These databases were selected in view of the fact that almost all the literature published from the UK would be covered in these databases. Keywords used in the searches included: medical students, trainees, doctors, consultant, attitudes, psychiatry, career, undergraduate psychiatry. Boolean operations and truncations were added to allow for alternative endings in the keyword searches. The search was last updated in August 2016.

We included studies that described a UK sample, were published in English in a peer-reviewed journal and provided original data on careers in psychiatry or factors affecting recruitment in psychiatry. We excluded studies that had the primary objective of addressing other issues that were not directly relevant to recruitment in psychiatry but only mentioned their effects on career choice as a secondary effect. Studies which provided data on medical careers in general were included if these provided data relevant to psychiatric careers or recruitment.

The electronic search returned 601 relevant abstracts and titles. We screened the titles and abstracts and excluded the studies that were not directly relevant to the objectives of the review. Therefore we excluded the studies that did not describe a UK sample or did not provide the original data. We also excluded the studies that described the recruitment to certain subspecialties and therefore not relevant to the recruitment to psychiatry in general. After screening these titles and abstracts we decided to examine 56 full text papers. Finally, we included 27 papers in the review. Further details are provided in *Fig. 1*. The studies were conducted in a number of different populations, settings and periods, and also used diverse methodologies varying from surveys to statistics derived from databases. The 30-item Attitudes Towards Psychiatry (ATP-30),¹² a validated tool used to assess attitudes of students towards psychiatry, was used in four papers; other papers used different questionnaires to assess attitudes. Due to the diverse methodologies it was inappropriate to pool the data to produce a statistical summary. We therefore describe the main findings and produce a narrative summary of results.

Results

Characteristics of included studies

Table 1 shows the characteristics of the 27 studies included in the review. The majority of studies ($n = 24$) were surveys and questionnaire-based studies. The other studies included one database study of doctors entering training posts and two retrospective cohort studies, which looked at which medical school psychiatrists had attended. These reported on medical students ($n = 12$), trainees ($n = 10$), medical students and trainees ($n = 1$), trainees and consultants ($n = 1$) and consultants ($n = 3$). One of these studies looked at data from postgraduate departments in different medical schools, and one study reported on the database of applicants to MMC (Modernising Medical Careers) for training posts.

Study characteristics

Author/year	Population	Method/design	T
Brook, 1976 ¹⁹	Medical school of origin for psychiatrists	Retrospective cohort	5
Brook, 1983 ²¹	Medical school of origin for psychiatrists	Retrospective cohort	1
Levine <i>et al</i> , 1983 ²⁴	Medical students	Survey	3
Brook <i>et al</i> , 1986 ²⁰	Medical students	Survey	4
Calvert <i>et al</i> , 1999 ³³	Medical students	Survey	3
Mcparland <i>et al</i> , 2003 ³⁰	Medical students	Cohort study – survey	3

Table 11 – continued from pre

Author/year	Population	Method/design	T
Maidment <i>et al</i> , 2003 ³¹	Medical students	Survey	8
Petrides & McManus, 2004 ²³	Medical students	Cohort study – survey	8
Rajagopal <i>et al</i> , 2004 ³⁵	Medical students	Survey	3
Curtis-Barton & Eagles, 2011 ²⁵	Medical students	Survey	4
Budd <i>et al</i> , 2011 ²⁶	Medical students at 4 different medical schools	Survey	9
Archdall <i>et al</i> , 2013 ³⁴	Medical students	Survey	1
Halder <i>et al</i> , 2013 ²⁸	Medical students – 18 UK medical schools	Survey	4
Farooq <i>et al</i> , 2014 ²⁷	Medical students (only UK data used)	Survey	2
Maidment <i>et al</i> , 2004 ³¹	Trainee doctors	Survey	2
Goldacre <i>et al</i> , 2005 ¹⁴	Trainee doctors (graduates from 1974 to 2000, UK medical schools)	Survey	2
Lambert <i>et al</i> , 2006 ¹⁵	Trainee doctors	Survey	5
Fazel <i>et al</i> , 2009 ¹³	Trainee doctors (all applicants to MMC for training posts)	Database analysis	3
Barras & Harris, 2012 ³⁸	Trainee doctors	Survey	3
Goldacre <i>et al</i> , 2012 ¹⁶	Trainee doctors who had qualified in 2002, 2005, 2008	Survey	9
Goldacre <i>et al</i> , 2013 ¹⁷	Trainee doctors who qualified between 1974 and 2009	Survey	3
Svirko <i>et al</i> , 2013 ¹⁸	Trainee doctors who qualified 2005, 2008, 2009	Survey	9
Collier & Moreton, 2013 ²²	Hospital postgraduate departments of 19 medical schools	Survey	1
Woolf <i>et al</i> , 2015 ³⁷	Medical students and trainee doctors	Cohort study – survey	1
Korszun <i>et al</i> , 2011 ³⁶	Trainee doctors, academics, trust clinicians	Survey	3
Dein <i>et al</i> , 2007 ³⁹	Consultants	Survey	7
Denman <i>et al</i> , 2016 ³²	Consultants and trainees	Survey	C

M, male; F, female; MMC, Modernising Medical Careers.

Data not used from this paper just broad findings in review.

In survey-based studies response rates varied from 16% to 100%. Mean response rate from the papers which had figures available ($n = 20$) was 63.3%. The population in all studies comprised of 1879 psychiatrists, 6733 students and 220 746 trainees. One database study¹³ looked at 31 434 trainee doctors, and studies by Goldacre *et al* were aimed at all doctors in training, accounting for large numbers of respondents in the trainee subcategory.^{14–18}

The influence of the medical school and teaching practices

Most of the research addressing the influence of the medical school and teaching practices on selecting psychiatry as a career was carried out in the 1970's and 1980's. Two studies by Brook *et al*^{19,20} looked at the medical school of origin for 531 psychiatrists between 1961 and 1970 and reported no significant relationship between schools that had a professional unit or specific teaching programme and students pursuing psychiatry in the long term. However, it was noted that those schools that produced fewer psychiatrists tended to have either a recently established professional unit or none.¹⁹

No clear pattern emerged in terms of the type of teaching offered at each university and the impact this had on choice of psychiatry as a career in the long term.¹⁹ All four Scottish schools, and Cambridge and Oxford were noted to be higher in terms of producing psychiatrists, attributed possibly to the well-established professional units such as the Maudsley and Bethlem Royal hospitals.¹⁹ The personality, charisma and enthusiasm of teachers were associated with an increase in the uptake of psychiatry in the long term.^{19,21}

Brook *et al*²¹ found that the effectiveness of teaching rather than the amount of teaching had an effect on student attitudes and recruitment into psychiatry. The attitude of non-psychiatric teachers appeared to be influential with doctors experiencing negative attitudes of other doctors towards psychiatry.²¹ The two hospitals which ranked top in terms of producing psychiatrists had changed their teaching model. One stressed the importance of psychiatry as being part of general medicine, emphasising the effectiveness of physical therapy, whereas the other placed emphasis on liaison psychiatry and psychotherapy.²¹

More recent work by Collier *et al*²² looked into the teaching time allocated for psychiatry in foundation programmes across the country. They found that only 2.3% of teaching was dedicated to psychiatry compared with 44.1% to medical and surgical topics.²² Exposure to psychiatry remained limited with 4 out of 17 hospitals in the survey not having any teaching on psychiatry for medical students.²² Doctors generally led a higher proportion of medicine and surgery teaching sessions (63%) compared with psychiatry (48%).²²

Medical students' views of psychiatry and factors affecting career choice

Twelve studies examined the factors affecting medical students' career choice and one study looked at both medical students and trainees. Petrides *et al*²³ studied the theoretical understanding of how different medical specialties are perceived and how choices are made. Psychiatrists were found to have a more artistic approach to medicine, seeing interpreting and responding imaginatively to a range of medical, social, ethical and other problems. This is in keeping with early work by Levine *et al*²⁴ who also found that there was a group of students who were 'psychologically minded' and they could be identified and encouraged to make psychiatry as career choice.

Budd *et al*²⁶ found that job satisfaction (98%, $n = 128$) and family-friendly status of psychiatry (79%, $n = 103$) were important for students who rated psychiatry as one of their top three choices.²⁶ The academic status was significantly less important (48%) for students who placed psychiatry as their top three specialty schools *v.* 63% for those who did not place psychiatry in their top three choice.²⁶

Choice of psychiatry as a career among medical and sixth form students

The number of students choosing psychiatry has remained fairly stable at around 4–7%.^{25–27} Three per cent of students from six medical schools placed psychiatry as their first choice, with 18% seriously considering it.²⁰ Halder *et al*²⁸ found similar results in 18 medical schools; 16% chose psychiatry as a future career on entering medical school but by the final year only 3% had decided to pursue a career in the subject. These results were replicated by Farooq *et al*²⁷ In a survey of sixth form students, Maidment *et al*²⁹ reported that 60.9% ($n = 363$) indicated that it would be very likely or they would definitely want to pursue psychiatry as a career. In terms of overall intentions to pursue a career in a specialty, the ratings for psychiatry was similar to general medicine at 12.4% ($n = 72$) *v.* 12.2% ($n = 69$) respectively.²⁹

Effect of undergraduate attachment and education on choosing psychiatry as a career

Positive attitudes towards psychiatry and the influence by a teacher during the attachment correlated with an intention to pursue psychiatry as a career in the long term.^{29–31} Three studies highlighted the importance of psychiatric attachment. Student attitudes improved as the attachment progressed.^{26,30,31} Maidment *et al*²⁹ found 1.4% of fourth-year medical students expressed a definite intention to pursue which rose to 4.7% after their attachment.²⁹ McParland *et al*³⁰ reported that 19% ($n = 58/309$) of students were very attracted to psychiatry or had a definite intention to pursue psychiatry at the start of the placement, which increased to 27% ($n = 101/373$) of students at the end of the attachment. The importance of the undergraduate experience was highlighted by a recent study showing 50% of consultants and 37% of trainees surveyed decided on a career in psychiatry while still at medical school.³²

Calvert *et al*³³ looked into the attitudes of medical students towards psychiatry and psychiatric patients at year 1, 3 and 5 in medical school. First-year medical students were more likely to have stereotypical views compared with third- and fifth-year students, and were more likely to agree with statements such as 'Psychiatry deals with imaginary illness' (mean 1.4, s.d. = 0.9, $P < 0.5$).³³ Fifth-year students (mean 3.2, s.d. = 1.4) showed lower agreement than third-year medical students (mean 3.6, s.d. = 1.2, $P < 0.5$) with the statement 'Psychiatry is as a challenging career'.³³ As they progressed through medical school, students recognised that mental illness has serious morbidity and that people do recover from mental illness,³³ showing that attitudes towards psychiatric patients improved with greater clinical experience but possibly became more negative towards psychiatry as a career.

Other factors that appeared to affect students positively included enrichment activities, i.e. activities beyond standard teaching and clinical placements led to a significantly increased interest in psychiatry.²⁸ These included research experience in psychiatry (13% v. 4% in those not interested in psychiatry, $P = 0.001$), university psychiatry clubs (38% v. 11%, $P < 0.001$), psychiatry electives (14% v. 1%, $P < 0.001$) and psychiatry special study modules (38% v. 16%, $P < 0.001$).²⁸

McParland *et al*³⁰ identified factors which increased interest in psychiatry, including: influence or encouragement by someone during the attachment (74%, $n = 282$), particularly the influence by consultants (43%, $n = 163$), exposure to interesting and stimulating ideas (29%, $n = 110$), liking someone's approach (27%, $n = 103$), feeling someone believed in their ability (11%, $n = 41$) and having formed close working relationships (9%, $n = 33$).³⁰ Other factors that had a significant impact were: receiving encouragement from the consultants ($n = 374$, $P < 0.001$, $r = 0.26$), seeing patients respond to treatment ($n = 374$, $P < 0.001$, $r = 0.20$) and having a direct role in the involvement of patient care ($n = 374$, $P < 0.001$, $r = 0.26$).³⁰

Factors which did not affect career choice of medical students

Seeing patients in different settings or different phases of the illness had no effect on career choice of medical students when deciding their career intentions.²⁸ Interestingly, one study found that the earning potential and status of psychiatry had no effect on selecting psychiatry as a career choice.²⁶ Other factors related to teaching such as quality of rating of small group teaching and lectures,²⁸ the curriculum type used^{30,31} and performance at viva examinations and multiple choice questions also had no effect on the career choice.³¹

Factors discouraging medical students to choose psychiatry as a career

Curtis-Barton *et al*²⁵ in their survey ($n = 467$) found that the factors discouraging students to pursue a career in psychiatry included: prognosis of patients (62%), perception that there is a lack of evidence in diagnosis (51%), lack of scientific basis (53%) and the amount of bureaucracy and paperwork in the specialty (48%). Other discouraging factors included the stigma towards psychiatry (30%), the standing of the profession among medical colleagues (31%) and comments by other specialists (26%).^{25,34} Psychiatry scored the lowest among the specialties as a career choice. Students described psychiatry as boring, unscientific, depressing, stressful, frustrating and 'not enjoying the rotation'.³⁵

Many students experienced psychiatry as being different to other specialties. For some this was a reason not to pursue psychiatry as a career but for others it was a positive aspect of the specialty. Students felt ward rounds focused on 'social

issues' rather than medical conditions. Some found it an 'emotional burden' and others felt that psychiatry could not 'fix' people and no one is being cured.³⁴

A survey by Korszun *et al*³⁶ examined the views of trainee, academics and clinicians on students not taking up psychiatry. The following factors were identified as deterring the students from psychiatry: negative attitudes towards psychiatrists from other doctors and health professionals (57%), stigmatisation of psychiatry (40%), stigma associated with mental health disorders (39%), poor teaching and role modelling from psychiatrists (37%), psychiatry not seen as medical or scientific enough (26%) and poor morale among psychiatrists (26%).³⁶

Factors affecting trainees' and consultants' choice of psychiatry

Fazel *et al*¹³ found that psychiatry was the sixth most popular specialty out of ten specialty groups for trainees applying for training places. A higher proportion of female graduates were shown to choose psychiatry between 1974 (32%) and 1999 (59%).¹³ However, a more recent survey showed a slight decline in the number of women choosing psychiatry over the last decade, 4.9% (1999) v. 4.6% (2009).¹⁷

Goldacre *et al*¹⁴ examined career choices for medical students over the past 40 years. The number of doctors choosing psychiatry as a career has hardly changed and remains around 4–5%, which is similar to figures from 1975.¹⁴ It was noted that students who went on to work in psychiatry 10 years after graduation, 52% (224 out of 428) had chosen psychiatry in the first year after graduation and 71% (308 out of 434) had chosen it in year 3.¹⁴

In common with the factors attracting students towards psychiatry, numerous studies identified factors that appear to attract trainees towards psychiatry. The major attractions for choosing psychiatry are listed in *Box 1*. Denman *et al*³² found that the most common factor influencing core trainees' (60%) and consultants' (70%) decisions to specialise in psychiatry was emphasis on the patient as a whole.³² Trainees highlighted that mental health was an area of need (53%) and empathy and concerns for people with mental illness (53%) were important reasons for choosing psychiatry.³²

Box 1 Factors attracting medical students and trainees in pursuing psychiatry as a career

Medical students

- Encouragement by colleagues^{24,26,30,31}
- Influence by someone during the placement^{24,30}
- Females are more likely to favour a career in psychiatry^{24,27,30}
- Family history of mental illness was associated with choosing psychiatry²⁴
- Quality of experience^{26,27,30,33}
- Role models can have a positive impact on students pursuing a career in psychiatry^{28,30,33}
- Enrichment activities^{27,28}

Trainees

- Hours and conditions of work^{17,31,32}
- The doctor's personal assessment of their aptitudes and skills,^{17,31,32} for example recognising factors such as using one's intellect to help others³⁷
- Experience of the subject as a student^{17,31}
- Inclinations before medical school and a positive student experience^{17,37}
- Attitudes and inclination to psychiatry as a medical student^{24,31,37}

- Lifestyle factors^{32,37}
- Encouragement from consultants and senior doctors³¹
- Emphasis on the patient as a whole person and empathy/concern for mentally ill people³²

Barriers associated with not choosing psychiatry as a long-term career choice for trainees

Barras & Harris³⁸ explored trainee's experiences ($n = 359$) within psychiatry. Trainee attitudes were grouped into different categories. The attitudes towards psychiatry (12.6%), professional role (12%) and day-to-day working (11.3%) were identified as the main negative factors. Trainees raised concerns with the training programmes in psychiatry, such as problems with the rota and not having enough time with patients.³⁸ Many trainees felt frustrated with the Annual Review of Competence Progression (ARCP) process and workplace-based assessments, as well as the duplication of paperwork being a constant frustration.³⁸

The studies identified a number of barriers against choosing psychiatry as a career (*Box 2*).

Trainees felt improvements were needed in terms of training opportunities and felt this could be enhanced by providing a variety of jobs, increasing research opportunities and increasing medical aspects of training.³⁸

Work looking into consultant psychiatrists' views into why they chose psychiatry was limited to two papers.^{32,39} Dein *et al*³⁹ found that the majority of consultants (46%) chose psychiatry as a career soon after leaving medical school, and a recent study surveying consultants in the West Midlands found that 50% had made their choice by graduation from medical school.³² The main reasons cited by consultants for choosing psychiatry as a career included: empathy for those with a mental disorder (36.1%), interface with neuroscience (25%), expectation of better working conditions in psychiatry (20%) and influence of teaching at medical school (19.4%).³⁹ Denman *et al*³² highlighted several 'very important' reasons for consultants choosing psychiatry including: career in psychiatry would be intellectually challenging (60%), sense of fulfilment expected from seeing patients improve (47%) and enjoyment of problem-solving (47%). Lifestyle factors such as salary, better working conditions and quality of life were shown to be more important reasons for choosing psychiatry for trainees compared with consultants.³²

Box 2 Barriers associated with not choosing psychiatry as a career

- Job content (71.7%) ($n = 71$) (including the lack of scientific basis, job not being clinical, poor prognosis)^{15,17,25,35,36,38}
- Poor public image of psychiatry^{15,25,36}
- Lack of respect towards psychiatry as a specialty by other specialties^{15,25,36}
- Work-related stress cited by (49%)¹⁵ trainees in psychiatry³⁸
- 25–50% of trainees leaving psychiatry as a specialty cited lack of resources as one of the main reasons which was significantly more than those rejecting general practice and trauma and orthopaedics^{15,38}
- 25–50% of trainees leaving psychiatry^{15,16,38} highlighted:
 - a. lack of adequately supervised training
 - b. lack of evidence base to diagnosis and treatment
 - c. lack of improvement in patients
 - d. work-life balance
 - e. work not clinical enough
- Physical risks involved in the job¹⁵
- Sense of eroded professionalism^{36,38}
- Too much paperwork and duplication^{25,36,38}

- Problems with rota and not enough time with patients³⁸
- Trainees leaving the scheme felt frustrated with workplace-based assessments³⁸
- Low morale among workforce³³
- Future role of psychiatrists being eroded³³

Discussion

This is the first systematic review of literature which examined factors that influence the choice of psychiatry as a career in the UK. The main findings are that enrichment activities help to attract students more towards psychiatry than just total time spent in the specialty. Job satisfaction and family-friendly status of psychiatry was rated highly by students who tend to choose psychiatry. Role models and encouragement from consultants may increase the number of students who want to pursue psychiatry as a career. The major factors that appeared to dissuade medical students/trainees from pursuing psychiatry as a career included: an apparent lack of scientific basis of psychiatry and work not being clinical enough, perception that psychiatry is more concerned about social issues, the bureaucracy, paperwork, apparent poor prognosis of patients, stigma towards psychiatry as a specialty, low morale, and onerous workloads as a consultant.

We are aware of one previous systematic review that examined medical students' attitudes towards psychiatry internationally.⁴⁰ In common with our study this systematic review alongside another survey of psychiatrists³⁶ highlighted the stigma towards mental illness as a major barrier influencing negative medical views towards psychiatry.⁴⁰ Stigma towards psychiatry as a specialty arises from a variety of sources, notably from medical students themselves. In addition, this stigma could arise from ward staff attitudes towards patients and from other doctors in other specialties, which detract students.^{13,25,34}

Other reviews have looked at one aspect such as the effect of clinical experience of psychiatry on medical students' attitudes towards the specialty.⁴¹ Lyons⁴⁰ highlighted the impact of poor-quality teaching leading to negative attitudes towards psychiatry and highlighted the need to address psychiatry curricula and introduce novel teaching strategies.⁴⁰ El-Sayeh *et al*⁴² have previously highlighted the importance of teaching and the various methods which could be utilised to try to improve the student experience and in turn help attract students towards psychiatry. The recent survey by Korszun *et al*³⁶ highlighted that the number of clinicians compared with academics and trainees agreed that they did not have time to teach medical students ($P < 0.001$). Both clinicians (42%) and academics (47%) felt that teaching medical students did not contribute to their future career prospects compared with 21% of trainees ($P < 0.001$).³⁶ Fewer clinicians considered teaching to be a significant component of their appraisal compared with trainees and academics.³⁶ The combination of poor teaching practices due to lack of resources or commitment and the stigma reinforce the poor image of psychiatry.

We feel that the findings of our study support the recommendations made by Mukherjee *et al*⁴³ which identify a number of steps to address the crisis in psychiatry recruitment at different nodal points in a medical career, i.e. prior to entry to medical school, during medical education and after graduation.

Improving recruitment

This study highlights the need to change the experience of psychiatry at undergraduate and postgraduate level in keeping with work by Shah *et al*⁴⁴ who highlighted early medical experience, influence of seniors and the aspects related to working environment as areas that could be affected positively which in turn could have a positive effect on choosing psychiatry as a career. Kelley *et al*⁴⁵ highlighted the impact of foundation programme experience in psychiatry, with a significantly higher proportion of trainees pursuing a career in psychiatry compared with those without any exposure to psychiatry (14.9% v. 1.8%). This correlates with earlier findings by Shah *et al*⁴⁴ that found a significant correlation between those Scottish students considering psychiatry as a career and having held a psychiatry post.⁴³ A recent survey by Denman *et al*³² showed that 43% of psychiatry trainees made their decision to specialise in psychiatry during the foundation years, correlating with increased exposure to psychiatry during the foundation years with 80% of trainees in this survey completing a post in psychiatry during the foundation years. Specific enrichment activities beyond standard teaching and clinical placements such as research experience in psychiatry, university psychiatry clubs, summer

schools,⁴⁶ psychiatry electives and psychiatry special study modules appear to be a way in which medical students will gain invaluable experiences and improve their attitudes to psychiatry. These need to be adopted and evaluated in future programmes to enhance recruitment in psychiatry Collier *et al*²² found that only 2.3% of teaching was dedicated to psychiatry compared with 44.1% to medical and surgical topics, which does not help the poor image of psychiatry. This and similar issues need to be addressed at institutional level.

A number of studies found that psychiatry has a perception that it is not a 'scientific' or 'medical' discipline.^{15,36,38} Medical students and trainees expressed the views about the weakened medical identity of psychiatry. The erosion of the role of the psychiatrist was cited by some psychiatry trainees as a potential factor that would make them consider leaving psychiatry training.³⁸ This unfortunately is not helped by negative comments or 'bad-mouthing' of psychiatry.^{36,47}

Interventions such as anti-stigma films and Medfest⁴⁸ have been shown to improve medical students' attitudes to psychiatrists, serious mental illness and psychiatry, at least in the short term.^{48,49} However, it appears that there is need to reconsider the content of psychiatric training and the undergraduate curriculum. It has been suggested that moving undergraduate teaching from in-patient to general hospital settings such as liaison psychiatry will allow students to see patients with problems that are relevant to medical practice.⁴⁷ Setting up and evaluating such programmes that have the potential to offer a different and enjoyable experience for medical students and foundation doctors should be a priority to improve the image of and recruitment into psychiatry.

Limitations

A limitation of the study is that almost all data are based on surveys and databases. This represents a cross-sectional view on the subject. The lack of any comparisons with other specialties, which may have similar recruitment rates, is particularly concerning. The focus on UK studies is also a limitation but was necessary to understand the factors affecting recruitment in this country. We noted with some concern that there are only a few studies that address the positive aspects of psychiatry,^{26–28,30–33} which may attract students and trainees towards psychiatry, and how these can be used for improving the recruitment. Future studies need to address this gap in the literature. Finally, we feel that the problems underlying the recruitment in psychiatry perhaps also reflect the lack of parity of esteem. Unless mental health is valued equally with physical health, the misconceptions and distorted perceptions about psychiatry as a discipline in which a medical career can be fruitfully pursued will linger on and will hinder aspiring physicians from considering psychiatry as a career option.

1.6.93 Mental Capacity Act (Northern Ireland) 2016†

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Abstract

Mental health legislation in Northern Ireland has always been separate from legislation in the rest of the UK; the Mental Health (Northern Ireland) Order (MHO) had been in place since 1986. In common with other jurisdictions, this legislation utilises the presence of mental disorder and risk as criteria for detention and involuntary treatment. The MHO has been replaced by the Mental Capacity Act (Northern Ireland) 2016 (MCA), an example of ‘fusion’ legislation in which impairment of decision-making capacity and best interests are the only criteria to be used when making decisions across health and social care. In this paper, we outline the development of the MCA to date, and discuss its potential to improve mental healthcare by placing the treatment of mental illness within the same legislative framework as physical illnesses.

Contents

- *Mental Capacity Act (Northern Ireland) 2016†*
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The Mental Capacity Act (Northern Ireland) 2016 (MCA) is an example of a ‘fusion’ legislation – a generic law applicable across all medical specialties and social care where an intervention is proposed and the person has impaired decision-making capacity.

The MCA was enacted in May 2016. Since then, the Department of Health has completed phase 1 of the implementation work; creating a first working draft of a code of practice, and working on forms and draft regulations associated with the Act. This work has been shared with a ‘virtual’ MCA Reference Group, composed of a wide range of stakeholders. The first full draft of the code of practice, forms and regulations have recently been circulated to the MCA Reference Group and the second phase, a pre-consultation phase on the full draft, has just begun.

Background

The Bamford review of mental health and learning disability, established in 2002, was a wide-ranging examination of the delivery of mental health and learning disability services in Northern Ireland.

In addition to the examination of service delivery, the review also undertook a review of the mental health legislation, the Mental Health (Northern Ireland) Order (MHO), which had been on the statute books since 1986. Criteria for involuntary treatment of mental illness under the MHO were based on diagnosis and risk; the presence of mental illness or severe mental impairment, and failure to detain leading to a substantial risk of serious physical harm to self or others. In addition, certain conditions were specifically excluded – no person could be detained solely on the grounds of personality disorder, dependence on alcohol or other drugs, or sexual deviancy.

There was no specific or separate mental capacity legislation in Northern Ireland. Decisions on the treatment of incapacitous patients are taken under common law, with decisions based on a presumption of capacity and the doctrine of necessity (best interests).

The Bamford review decided that the legislation was not compliant with essential principles (autonomy, justice, benefit and least harm). In 2007, it recommended that:¹ There should be a single comprehensive legislative framework for the reform of mental health legislation and the introduction of capacity. The framework should be based on agreed principles. These principles should apply to all healthcare decisions, as well as welfare and financial needs. Impairment of decision-making capacity should be a mandatory prerequisite for any interference with a person's autonomy without their consent. Individuals who are subject to the criminal justice system should have access to assessment, treatment and care which is equivalent to that available to other people.

A public consultation was held in 2011. There was strong support for the proposal of a single legislative framework. It was therefore decided to fuse mental capacity and mental health law into a single bill. The resulting draft bill was the subject of another consultation in 2014, followed by its introduction to the Stormont Assembly. There, it underwent further consideration and amendment, and was passed as the Mental Capacity Act (Northern Ireland), receiving Royal Assent in May 2016.

Aims and principles

Fusion legislation provides equally for all circumstances in which a person's autonomy might be compromised on health grounds. It puts impaired decision-making capacity at the heart of all non-consensual interventions. By treating mental and physical illnesses equally under the law, it reduces stigma associated with separate mental health legislation, and is respectful of a person's autonomy and decision-making capacity whether they have a mental or a physical illness.

Compatibility with international statements on human rights, particularly the European Convention on Human Rights (ECHR)² and the United Nation's Convention on the Rights of Persons with Disabilities (CRPD),³ is an issue for any legislation dealing with involuntary treatment. Conventional mental health legislation, which uses a diagnostic test for involuntary treatment, could be regarded as being incompatible with Article 14 (1) (b) of the CRPD – 'the existence of a disability shall in no case justify a deprivation of liberty'. No UK mental health legislation is currently compliant with the CRPD.

Proponents of fusion legislation argue that capacity, as the test for involuntary treatment, is a functional test, i.e. a particular ability at a particular time, and therefore not directly linked to diagnosis or disability. However, the MCA retains a 'diagnostic' element; the person is unable to make a decision because of an impairment of, or a disturbance in, the functioning of the mind or brain. It therefore arguably still fails to satisfy Article 14 (1) (b) of the CRPD. Nevertheless, the MCA is fully compliant with the ECHR, and its strong rights- and principles-based ethos moves the legislation significantly towards CRPD compliance.

Content of the MCA

The MCA revokes the MHO for those aged 16 and over and puts common law into statute.

Capacity test

Statutory decision-making will come into play when a person lacks capacity. There is a presumption that the person has capacity, there must be no unjustified assumptions based on age, appearance or condition, there must be a respect for decisions even if unwise, the person must be given all practical help and support, and the act must always be in the person's best interests.

There are two tests to be satisfied in reaching a decision about a person's decision-making capacity: a diagnostic test – there must be an impairment of, or a disturbance in, the functioning of the mind or brain, and; a functional test – the person is unable to understand the information relevant to the decision, to retain the information long enough to make the decision, to appreciate the relevance of that information and use or weigh the information as part of the process of

making that decision, and communicate the decision. There must be a causal link between the two tests – the person is unable to make a decision because of impairment or disturbance in the brain or mind.

Looking at the functional test, the specific difference between this and other definitions of lack of capacity is the use of the word ‘appreciate’. The consultation document⁴ emphasises the importance of the inclusion of the appreciation element: its inclusion moves a decision about capacity from a purely cognitive test (p. 13, para. 2.22). The consultation document gives as an example: ‘A person whose insight is distorted by their illness or a person suffering from delusional thinking as a result of their illness may not, therefore, meet this element of the test’ (p. 13, para. 2.22).⁴

Protection from liability

The legislation puts into statute the common-law definition of necessity and protects the person (D) doing the act from liability if D takes reasonable steps to establish whether the person (P) lacks capacity in relation to the matter in question and D reasonably believes that it is in P’s best interests for the act to be done. There is therefore a shift in emphasis from the MHO, which confers statutory powers, to a situation where non-consensual intervention is predicated on protection from liability for D.

Future decision-making

The Act includes a robust lasting powers of attorney system. A lasting powers of attorney must be registered with the Office of Public Guardian before being activated and extends to health and welfare decisions, when the attorney reasonably believes that the person lacks capacity and must always act in the person’s best interests.

In addition, advance decisions to refuse treatment must be complied with, if valid and applicable under common law. This means that an effective advance decision to refuse treatment for a mental disorder (or indeed any disorder) cannot be overridden, if made when P had capacity. However, the Act allows that, if there is doubt, D will be protected from liability if he or she gives life-sustaining treatment or treatment required to prevent a serious deterioration in P’s condition. Advance decisions were not put into statute in order for the courts to continue to develop the law in the light of the MCA.

Safeguards

The Act provides for a proportionate increase in the number of safeguards that must be met if D is to be protected from liability as the seriousness of the interventions or acts being done to P increases. These additional safeguards must be met in addition to the general safeguards.

- For acts of restraint, D must reasonably believe that there is a risk of harm to P, and that the act of restraint is proportionate to the likelihood and seriousness of that harm.
- For serious interventions or treatment with serious consequences, there must be a formal assessment of capacity and a written statement of incapacity by a suitably qualified person, and a nominated person must be in place, who should be consulted and whose views should be taken into account. Serious interventions include, but are not limited to, serious treatment for physical illness, any intervention that causes the person serious distress or serious side-effects, affects seriously the options that will be available to P in the future or has a serious effect on his/her day-to-day life. The decision whether or not an act is a serious intervention or treatment with serious consequences rests with D. However, some acts are always serious interventions. These are: (a) deprivation of liberty, (b) attendance for certain treatments requirement and (c) community residence requirement.
- Certain serious interventions must be authorised by a trust panel. These include acts (a), (b) and (c) above, or the act is the provision of treatment with serious consequences and the nominated person objects, P resists or it is being done while the person is being deprived of their liberty.
- For attendance for certain treatment requirements, D must reasonably believe that failure to impose the requirement would be more likely than not to result in P not receiving the treatment.

- For community residence requirements, the prevention of harm condition must be met.

The trust panel will be made up of three persons with relevant expertise. The application will be made by a ‘prescribed person’ and must include a medical report and a care plan. The statutory criteria will differ depending on the measure for which authorisation is being sought.

- For treatment with serious consequences when the act amounts to a deprivation of liberty, the ‘prevention of serious harm’ condition must be met. D must reasonably believe that failure to detain P in circumstances amounting to a deprivation of liberty would create a risk of serious harm to P or serious physical harm to others, and the detention of P is a proportionate response to the likelihood of harm and the seriousness of the harm concerned.
- For attendance for certain treatment requirements, D must reasonably believe that failure to impose the requirement would be more likely than not to result in the person not receiving the treatment.
- For community residence requirements, the ‘prevention of harm’ condition must be met.
- For compulsory treatment with serious consequences against the wishes of the nominated person, the ‘prevention of serious harm’ condition must be met.

A second opinion is required when the act is the provision of electroconvulsive therapy or is a treatment with serious consequences where the question of best interests is finely balanced, or is the continuation of medication beyond 3 months (if the medication is treatment with serious consequences) when the person is an in-patient or in a care home, or is subject to requirements to attend for treatment in the community.

The Act provides for the provision of an independent mental capacity advocate (IMCA). An IMCA must be in place when the Act requires an act to be authorised or, although not requiring authorisation, is a serious compulsory intervention. The role of the IMCA is to support and represent P; the IMCA must be consulted but is not a decision maker.

Where an authorisation has been granted, an application can be made to a review tribunal in respect of the authorisation. This provides a judicial review of the decision to ensure that it has been made in accordance with the law and that the criteria for the authorisation have been met. Applications to the tribunal can be made by P and the nominated person. Cases may also be referred to the tribunal by the Department of Health, the Attorney General or the High Court. The trust must refer to tribunals when authorisation has been extended for 1 year (for those aged 16–17) or 2 years (for those aged 18 or over).

The clauses describing the additional safeguards to be put in place do not apply when the situation is an emergency. D is protected from liability if there is a reasonable belief that delay would create an unacceptable risk of harm to P. However, D is expected to take reasonable steps to ensure that the safeguard is met by the relevant time.

Children and young people

The Act cannot be applied to children under the age of 16 because it puts into statute the common law presumption of capacity. For those aged 16–17, the MCA will operate alongside the Children (Northern Ireland) Order 1995, and additional safeguards will be put in place. The original MHO will continue to be in place for the small number of under-16s who require compulsory assessment/treatment in hospital for mental disorder. This has been the subject of some controversy; if the current legislation is discriminatory and stigmatising, it is difficult to argue for its continued use in one particular group. It has been argued that a legislative framework for those under 16 must be brought forward. This will be a difficult task, not least because a capacity-based framework will have to grapple with the complex question of emerging capacity in young people. The government has indicated that their intention is that there will eventually be legislation for those under 16, but at present, this is some way off.

Criminal justice provisions

There are new disposal options following a finding of unfitness to plead or insanity, including public protection orders (PPOs) and supervision and assessment orders. There are powers to remand an accused person to hospital, to transfer prisoners to hospital for treatment, for interim detention orders and for immediate hospital direction on conviction. Although the MCA contains powers for involuntary admission to hospital in various circumstances, treatment decisions are based on capacity to consent and subject to the core provisions of the Act. This means that there are circumstances under which a person can be admitted to hospital against their capacitous wishes; however, they cannot be treated against their capacitous wishes.

New criteria form the basis for entry into the criminal justice provisions. A ‘disorder’, a ‘disorder requiring treatment’ and ‘an impairment of, or disturbance in, the functioning of the offender’s mind or brain’ replace mental illness and severe mental impairment. A disorder is broadly defined to include any disorder or disability, whether mental or physical: a disorder requires treatment if any of its symptoms or manifestations could be alleviated or prevented from worsening by treatment.

A person can be remanded to hospital if the medical report condition or the treatment condition are met. The medical report condition is that the person has or may have a disorder, that a report should be made into that person’s condition, that an assessment would be impracticable in custody, and that it would be practicable to assess the person in hospital. The treatment condition is that the person has a disorder requiring treatment, that failure to provide in-patient treatment would ‘more likely than not’ result in serious physical or psychological harm to the accused person or serious physical harm to others, and that remanding the person to hospital would be likely to result in significantly better clinical outcomes.

PPOs replace hospital orders. A PPO can be made when detention conditions are met. These are that: ‘there is an impairment of, or a disturbance in, the offender’s mind or brain’, that ‘appropriate care and treatment is available’, that dealing with the person without detention ‘would create a risk, linked to the impairment or disturbance, of serious physical or psychological harm to others’ and that depriving the person of their liberty would be a proportionate response to the likelihood and seriousness of that harm. Restrictions may be added where the restriction conditions are met.

A prisoner can be transferred to hospital where they have a disorder requiring treatment, failure to provide treatment would be ‘more likely than not’ to result in serious harm to the person or serious physical harm to others, and appropriate treatment is available.

Patients admitted to hospital under the MCA criminal justice provisions will remain there following tribunal only if the ‘prevention of serious harm’ condition is met. The criteria for the ‘prevention of serious harm’ condition differ for those subject to PPO and for transferred prisoners or those subject to hospital direction. The criteria for those subject to PPO are: the person has ‘an impairment of, or a disturbance in, the functioning of the mind or brain’; releasing the person would create a risk of serious harm to others; and depriving the person of their liberty is proportionate to the likelihood and seriousness of the risk.

The criteria for transferred prisoners or those subject to hospital direction are: the person has the disorder for which they were transferred; effective treatment can be given; and it is ‘more likely than not’ that discharging the person to prison would result in serious harm to the person or serious physical harm to others.

Discussion

The MCA is unique in that it repeals separate mental health legislation, replacing it with a single piece of legislation applicable across all medical specialisms and social care, whereby involuntary treatment is only permitted when the person (a) has impairment of decision-making capacity and (b) the intervention proposed is in the person’s best interests.

The arguments for and against replacing conventional mental health legislation with a law based on capacity have been well rehearsed in a recent debate.⁵

The removal of mental health legislation that makes decisions about involuntary treatment based on diagnosis and risk will require a significant change in practice for professionals working in mental health in Northern Ireland. It is some-

what ironic that such a radical piece of legislation, based on non-discrimination, is being introduced in a jurisdiction that spends the lowest proportion of its health budget on mental health of any UK nation.⁶

The Act must work across a wide and diverse range of settings – care homes, mental health services (both in-patient and community) and general hospitals. It will affect staff who have little previous knowledge or experience of the principles behind capacity assessment. It is therefore imperative that a comprehensive training and supervision programme is put in place, which will have considerable resource implications.

The inclusion of the ‘appreciation’ element introduces a difference in the definition of capacity in the MCA compared with that used in other jurisdictions. The addition of the ‘appreciation’ element moves the definition of capacity away from purely cognitive terms towards the concept of capacity being affected by factors such as emotional colouring, delusions and lack of insight.⁷ Because of this difference, it cannot be assumed that studies that have demonstrated the reliability of capacity assessments⁸ will automatically apply in the case of the MCA. The reliability of the use of capacity assessments using this definition of capacity in routine clinical mental health practice requires to be evaluated.

The shift away from compulsory intervention based on in-patient treatment when a particular threshold of risk is reached may facilitate earlier intervention and allow for a proportionate response across a wide range of treatment and care settings. On the other hand, there is a more widely expressed concern that capacity legislation may delay appropriate treatment.

Trust panels can authorise a very wide range of interventions. As health and social care professionals work under the principle of beneficence, there is a risk of ‘slippage’, with staff making decisions about impaired capacity based on a person making foolish or unwise choices. This could lead to the unintended consequence of the Act leading to a greater rather than a lesser restriction of a person’s autonomy and self-determination.

There is a plethora of issues that could potentially affect clinical practice; for example, exactly what constitutes serious interventions, how to manage fluctuating capacity, the question of decision-making capacity in patients with personality disorder, patients who retain capacity but present a risk to self or others, and the potential conflict between human rights (especially the right to life) and autonomy. Some of these issues may be addressed by the code of practice, others may be left to clinicians or courts.

Conclusions

Fusion legislation (of which the MCA is an example) is a radical change in the approach to involuntary psychiatric treatment. It is an exciting and innovative development and there are substantial potential benefits, including the reduction of stigma, the protection of patient autonomy, and the removal of confusing parallel mental health and mental capacity legislation. It is also more compliant with CRPD and ECHR. Much of the practical impact of the MCA depends on the development of a comprehensive code of practice and the provision of a comprehensive training and supervision programme. In addition, as Szmulker & Kelly have pointed out,⁵ the gathering of data on its implementation is vital and the MCA must be subject to a rigorous and comprehensive evaluation.

1.6.94 Measuring relational security in forensic mental health services

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Abstract

Aims and method Relational security is an important component of care and risk assessment in mental health services, but the utility of available measures remains under-researched. This study analysed the psychometric properties of two relational security tools, the See Think Act (STA) scale and the Relational Security Explorer (RSE).

Results The STA scale had good internal consistency and could highlight differences between occupational groups, whereas the RSE did not perform well as a psychometric measure.

Clinical implications The measures provide unique and complimentary perspectives on the quality of relational security within secure services, but have some limitations. Use of the RSE should be restricted to its intended purpose; to guide team discussions about relational security, and services should refrain from collecting and aggregating this data. Until further research validates their use, relational security measurement should be multidimensional and form part of a wider process of service quality assessment.

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Serious incident investigations in forensic mental health services have been linked to relational security breakdowns.¹ However, relational security has been described as the ‘poor relation’² when compared with physical or procedural security. This is most likely due to definition difficulties. Chester & Morgan³ noted that numerous conceptualisations of relational security exist, all referencing different phenomena, such as ‘therapeutic relationships’ and ‘boundaries’, without describing how such concepts can affect security.³ The authors noted that the most practically useful definitions

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emphasise exactly how relational issues affect security, in two stages: (1) staff knowledge of patients and therapeutic relationships; and (2) how patient knowledge and therapeutic relationships are used to foresee potential and manage actual security incidents, for example: ‘The professional relationships between staff and patients so that ... the staff to get to know ... their patients, their moods and problems, to facilitate interventions before these become major problems, or lead to incidents of a security nature’ (p. 171).⁴ As such, relational security is intrinsically linked to short- and long-term assessment and management of risk in mental health and forensic services.

Relational security is therefore a service quality indicator of interest within forensic and general mental health services. Its measurement should allow practitioners to explore background causes and respond accordingly with appropriate interventions. Due to the definitional complexities, there are subsequent challenges to measurement. Previously available tools only measure partial aspects of relational security or individual patient needs.³ However, two tools have been developed in recent years, the Relational Security Explorer⁵ and the See Think Act scale.² As limited research has examined the clinical utility of these measures, the present study examines their psychometric properties to support the aim of relational security measurement.

Method

Design

The study employed a within-participants (reliability testing) and between-participants (assessing the measures’ ability to identify differences between occupational groups according to the variables level of security, ward gender and length of experience working in secure services) cross-sectional questionnaire design.

Participants

Participants were recruited from a forensic service for people with intellectual disability. As guidance recommends that relational security implementation should involve all occupational groups working within secure services,⁶ the study invited all staff who have contact with patients as part of their role to take part in the study ($n = 216$), and of these 41% ($n = 89$) responded. The majority of the participants were female (63%), and the average length of service working in secure services was 6 years (range 0.12–20). The majority of participants were from the nursing department (57%), followed by occupational therapy (16%), psychology (9%), social work (6%), psychiatry (2%) and housekeeping (8%), and two participants identified their occupation as ‘other’. The level of security in which respondents worked in at the time of the study was medium (23.6%), low (27%) and locked rehabilitation (16.9%). There are no national data available which describe the demographics of the forensic mental health workforce, although the reported characteristics reflected the socio-demographic and occupational breakdown of the study service and the broader mental health workforce as a whole,⁷ being predominantly female and with nursing staff comprising the largest department followed by other members of the multidisciplinary team. As participants responded anonymously, it was not possible to undertake any analyses comparing participants with non-responders.

Measures

See Think Act (STA) scale²

The STA scale is the first attempt to create a direct measure of relational security. The 28 items were developed from the Department of Health conceptualisation of relational security,⁶ and reflect relational security scenarios (e.g. ‘We speak up if we think we can see that a colleague has been put in a difficult position that could weaken security’). Individual staff members complete the questionnaire in relation to the ward they work on, and select how closely their ward team resembles provided statements on a 4-point Likert scale, with scores of 3 ‘Just like our team’, 2 ‘Quite like our team’, 1 ‘A little like our team’ and 0 ‘Not like our team’. A principal components analysis confirmed a four-component structure of the measure: Therapeutic Risk Management, Pro-Social Team Culture, Boundaries and Patient

Focus.² Initial examinations indicated good convergent validity with related measures (e.g. EssenCES⁸), and internally consistent subscales.² There is currently no normative data available for the STA scale.

The Relational Security Explorer (RSE)⁵

The RSE is a tool designed to help clinical teams working within secure settings to communicate and assess their competence in relational security. The tool requires users to provide a numerical score of their team's confidence in eight areas of relational security: Therapy, Boundaries, Patient Mix, Patient Dynamic, Personal World, Physical Environment, Visitors and Outward Connections on a scale ranging from 1 (no confidence) to 10 (extremely confident). The RSE was not developed as a psychometric measure; however, the tool requests clinical teams to provide a numerical score of their confidence in each of the eight areas. In doing so, the tool lends itself for use as an outcomes measure and, anecdotally, the authors are aware of service's collecting and analysing this data, despite it not being validated for this purpose. This is in line with the suggestion that when numerical indices and cut-off points are available, clinical decisions tend to be reduced to those numbers.⁹ Participants were asked to complete the RSE on an individual, rather than a team basis, to investigate the tool performance as an outcomes measure.

Procedure

The researcher arranged one-to-one meetings with staff eligible for the research, at which informed consent was sought. Once obtained, staff members were asked to complete and return the questionnaires. A debrief form was provided for participants, which detailed further information about the study.

Ethics

Ethical approval was obtained from the London Metropolitan University Research Ethics Review Panel. The National Research Ethics Service Committee for the East of England – Norfolk was also approached for ethical review of the project, who advised that as the relational security measures were being used in routine clinical practice within the study service, the study does not require National Health Service ethical approval.^{10,11}

Data analysis

Prior to analysis, assumption testing for parametric tests was completed. The assumption of homogeneity of variance was violated, and the data were negatively skewed, violating the assumption of normal distribution. Transformations of the data were attempted, but this did not reduce the skew. A number of cases appeared as outliers for all outcome variables, and notably, these cases were all from the housekeeping department. Data were therefore examined using non-parametric methods. This point was discussed with our statistician, who assured us that the loss of power associated with the non-parametric tests was small.

Therefore, internal consistency was examined using Spearman's Rho correlation to calculate the Corrected Item-Total Correlation (CITC) coefficient values for subscales of the STA and the RSE. Convergent validity was analysed by correlating subscales of the STA scale and the RSE using Spearman's Rho. The Sidak adjustment was used to adjust for multiple comparisons.

Non-parametric statistical tests were used to examine the association between scores on the STA and the RSE, and the variables requested in the demographic questionnaire (length of experience working in secure services, the ward and level of security worked on, the gender of the patients on their ward, and staff department/occupational discipline). Analysis between individual wards and staff occupational discipline could not be completed due to small and unequal numbers between the groups. To examine the association between level of security and the subscales of the two measures, the Kruskal-Wallis test was used. The Wilcoxon Mann-Whitney *U*-test was used to examine the association between gender of patients and the subscales. To examine the association between length of experience working in secure services and the subscales, Spearman's Rho correlation was used.

Results

Internal consistency

Internal consistency was assessed using CITC coefficients. A CITC value above 0.5 is considered high, but if less than 0.3, items within a subscale may be measuring more than one construct. All RSE subscales exceeded the CITC 0.30 cut-off, although there was some variation, with the Personal World subscale having the highest internal consistency at 0.80, and the Physical Environment subscale the lowest at 0.49. All the STA subscales had CITC scores over 0.9. *Table 1* displays the CITC coefficient values for each subscale of the two measures.

Corrected Item-Total Correlation (CITC)

Measure	CITC
Relational Security Explorer	
Therapy	0.66
Boundaries	0.61
Patient Mix	0.57
Patient Dynamic	0.65
Personal World	0.80
Physical Environment	0.49
Visitors	0.62
Outward Connections	0.68
See Think Act scale	
Therapeutic Risk Management	0.90
Pro-Social Team Culture	0.96
Boundaries	0.92
Patient Focus	0.92

Convergent validity between measures

There was little convergent validity between the subscales of the two measures. All four subscales of the STA scale correlated significantly with each other, whereas subscales of the RSE did not. The Spearman's Rho values are detailed in *Table 2*.

Correlations matrix of the subscales of See Think Act scale and Relational Security Explorer

	See Think Act scale	Relational Security Explorer										
See Think Act scale												
Therapeutic Risk Management	1											
Pro Social Team Culture	0.808` ** <#TFN 1>`__	1										
Boundaries	0.780` ** <#TFN 1>`__	0.878` ** <#TFN 1>`__	1									
Patient Focus	0.812` ** <#TFN 1>`__	0.846` ** <#TFN 1>`__	0.795` ** <#TFN 1>`__	1								
Relational Security Explorer												
Therapy	0.424	0.436	0.344	0.413	1							
Boundaries	0.470	0.411	0.367	0.341	0.469` ** <#TFN 1>`__	1						
Patient Mix	0.444	0.468	0.582` ** <#TFN 1>`__	0.401	0.338	0.293	1					
Patient Dynamic	0.453	0.482	0.457	0.401	0.515` ** <#TFN 1>`__	0.300	0.668` ** <#TFN 1>`__	1				
Personal World	0.485	0.487	0.391	0.465	0.588` ** <#TFN 1>`__	0.439` ** <#TFN 1>`__	0.319	0.447` ** <#TFN 1>`__	1			
Physical Environment	0.091	0.182	0.247	0.246	0.251	0.249	0.110	0.173	0.239	1		
Outward Connections	0.320	0.236	0.171	0.278	0.273	0.266	0.297	0.300	0.556` ** <#TFN 1>`__	0.186	1	

Correlation is significant at the 0.01 level.

Between-groups analysis

Level of security

Significant differences in scores on the two measures were found between staff working in different levels of security. Staff working on medium secure wards tended to have the lowest scores on both measures, followed by staff on low secure wards, with the highest scores on rehabilitation wards. On the STA scale, this reached statistical significance on the Therapeutic Risk Management ($P < 0.001$), Boundaries ($P = 0.012$) and Patient Focus ($P = 0.034$) subscales. There were also significant differences on the RSE, on the Patient Mix ($P < 0.001$), Patient Dynamic ($P = 0.008$) and Personal World ($P = 0.011$) subscales. Descriptive data for this variable are presented in *Table 3*.

Descriptive statistics for level of security on the See Think Act scale and Relational Security Explorer

	Level of security, mean (s.d.)		
See Think Act scale			
Therapeutic Risk Management	2.34 (0.44)	2.54 (0.39)	2.8 (0.25)
Pro-Social Team Culture	2.34 (0.49)	2.52 (0.48)	2.68 (0.41)
Boundaries	2.5 (0.43)	2.64 (0.41)	2.83 (0.31)
Patient Focus	2.5 (0.45)	2.76 (0.49)	2.76 (0.34)
Relational Security Explorer			
Therapy	7.46 (1.61)	7.47 (0.26)	8.07 (1.61)
Boundaries	7.85 (1.21)	8.3 (0.26)	8.3 (1.21)
Patient Mix	7.54 (0.97)	7.1 (1.56)	8.71 (0.61)
Patient Dynamic	7.15 (1.34)	7.1 (1.34)	8.3 (0.83)
Personal World	7.31 (1.7)	7.41 (1.18)	8.5 (1.09)
Physical Environment	7.23 (1.7)	7.88 (1.4)	8.07 (1.33)
Visitors	7.0 (1.09)	7.0 (1.12)	7.64 (1.98)
Outward Connections	7.23 (1.36)	7.17 (1.74)	8.07 (1.59)

The scale for the See Think Act scale is 0–3.

The scale for the Relational Security Explorer is 1–9.

Ward gender

There were no differences in STA scale scores between staff working on wards caring for male patients, as compared to female patients. However, on the RSE, staff working with male patients reported higher scores on the Patient Dynamic ($P = 0.024$) subscale, compared with staff working with female patients.

Length of experience working in secure services

There was no correlation between the number of years staff had been working in secure services, and their confidence in relational security, on the STA scale or the RSE.

Discussion

Serious incidents within forensic mental health services can be linked to breakdowns of relational security.¹ Available measures should therefore provide insight into the quality of relational security within services, direct exploration of strengths and weaknesses, and prompt timely, appropriate interventions before an incident occurs. Furthermore, tools should be accessible to all occupation groups.⁶ This study therefore evaluated the psychometric properties of the STA and the RSE, including internal consistency, convergent validity and their ability to highlight differences between groups.

Study limitations include a relatively small sample size, and participants being drawn from a single service, which limit generalisability. It is categorised as a preliminary study for these reasons. However, the study reports interesting findings in relation to the specific tools examined and the wider task of measuring relational security by investigating the perspectives of staff members across occupational professions and levels of security. The study setting, a secure intellectual disability service, may be viewed as a strength, as previous studies have been completed only within generic forensic psychiatric services, and as a weakness, due to the extent of the study findings generalising to non-intellectual disability services. Research comparing patient characteristics between mainstream forensic and specialist intellectual disability services is scarce, however there are a number of notable differences between the two populations which may have an effect on relational security. These include communication difficulties which could affect the development of therapeutic relationships, increased levels of behavioural incidents,¹² and higher assessed risk on structured clinical judgement tools.^{13–15} That said, the present research reports many findings which echo those of previous research.²

Test–re-test reliability was not examined in the present research, although it may be an interesting area for further study. At present, the stability of relational security levels are unclear, and it may not be realistic or relevant to expect stability over time, as relational security is a fundamentally a dynamic concept.

The internal consistency aspect of reliability was examined, with the STA scale demonstrating high levels in accordance with previous research.² Its subscales correlated significantly, suggesting they are statistically related concepts. Internal consistency for the RSE was adequate but its subscales did not all correlate significantly, possibly indicating that some of the concepts measured are statistically unrelated. Although the RSE and the STA both aim to measure relational security, convergent validity was low. Collectively, these findings suggest that the RSE does not perform as well as the STA as a psychometric outcome measure. This raises questions regarding the practice of collecting and analysing data from the RSE, despite not being validated for this purpose. Lodewijks *et al*⁹ explicitly advise against the use of numerical indices and cut-off points, due to clinicians' tendency to reduce clinical decisions to numbers if they are available.

Particular subscales of the two measures were able to detect differences between groups in relational security confidence, thus facilitating the comparison of wards and staff disciplines within a service, potentially between services comparisons, and directing intervention as necessary. Significant findings were reported between wards of different levels of security, with relational security confidence lowest on medium secure wards, increasing on low secure wards, and highest on rehabilitation wards. Tighe & Gudjonsson² also reported this effect, as well as authors investigating social climate in secure settings.^{16,17} A possible explanation for this is that medium secure wards represent the beginning of the care pathway accepting newly admitted patients and, as such, staff have had less opportunity to develop the knowledge of patients and therapeutic relationships necessary to achieve good relational security. As patients progress

through the low secure and rehabilitation stages of the care pathway, this provides an opportunity for the components necessary to relational security to develop.

The study also compared relational security confidence between staff working with male and female patients. This was examined as authors have documented difficulties in building therapeutic relationships with women, due to their clinical complexity.^{18,19} However, there were few differences between these two groups on the subscales of the two measures, although staff working with male patients reported higher scores on the Patient Dynamic ($P = 0.024$) subscale of the RSE.⁵

It was expected that staff with more experience working within secure services would be more confident in their judgements of relational security, but there were no significant associations. However, relational security relies on knowledge of patients and therapeutic relationships, within a dynamic environment. For example, if a new patient is admitted to a ward, all staff, regardless of experience will begin to develop their knowledge and their therapeutic relationships with this patient at the same time. Furthermore, if an experienced staff member is asked to move onto a different ward, they will know little about the patients on that ward and have to develop new knowledge and therapeutic relationships. In this sense, all staff members, regardless of experience, are repeatedly beginning and developing their knowledge of individual patients and new therapeutic relationships.

Housekeeping staff felt less confident in relational security, as compared to all other departments. This is probably due to the measures tapping into areas of clinical practice that housekeeping staff would not be involved in, and the comparable lack of training offered to this group. However, guidance recommends that relational security implementation should involve all occupational groups working within secure services.⁶ As housekeeping staff are a daily presence on forensic wards, they are equally as vulnerable to relational security issues and in a position to witness threats to security. Further research should investigate ways to support all occupational groups with relational security.

Measuring relational security: further considerations

Some points are of note when interpreting data obtained from relational security measures. Initial assumption testing indicated negatively skewed data, suggesting that most participants rated their confidence in relational security at the top end of each measures' respective scale. This could indicate that staff working in this particular service are highly confident in their relational security practice. However, it is unclear how confidence scores relate to the actual quality of relational security within a ward, for example is a highly confident team an experienced team or a complacent team? It could also indicate positive responding, as essentially, measures are asking individuals to rate themselves in an aspect of their role in which they are expected to be competent. Introducing some negatively worded items could improve this.

High scoring may also be due to the way the two tools conceptualise relational security. Both measures are based on the STA conceptualisation of relational security,⁶ which places much of the responsibility onto staff and teams, thus neglecting the 'quantitative' aspects of relational security, for example 'staff-to-patient ratio and amount of time spent in face-to-face contact' (p. 434)²⁰ and the supportive role and responsibility of service management. For example, to achieve quality therapeutic relationships with patients, ward staff and teams need to be stable, with minimum staff ward moves, turnover and absenteeism,³ factors outside of staff members' control. Incorporating items reflecting such aspects of relational security could provide a more comprehensive picture.

Normative data are not currently available for either of the two measures, which limits the interpretability of the results. Both measures are designed to be used by staff members in relation to one specific ward. However, many employees work across multiple wards in secure services, with 27% respondents in this sample working across wards. These participants were typically from occupational departments other than nursing, such as psychology, psychiatry, social work and occupational therapy.

Conclusions

The increased attention relational security is receiving within the forensic field is a welcome advance. There is growing awareness around the importance of this concept, and resources aiming to raise awareness and support the implementation of relational security are widely available.²¹ However, until recently there have been few mechanisms to assess the quality of relational security within services. The results of this study suggest that the STA scale and the RSE hold unique and complimentary roles attempting to support relational security. The RSE did not perform well as a psychometric measure, and therefore its use should be limited to its intended purpose – as a tool to guide team discussions about relational security – and services should refrain from using the RSE as an outcomes measure. However, deciding on a numerical score of relational security confidence may serve a function within the context of a team discussion, for example, if one team member feels the ward should score highly, whereas another member feels the ward should be given a lower score, this could suggest team splitting and form a basis for discussion. At present, the STA scale is best placed to provide insight into the quality of their relational security, while taking into account the aforementioned issues when interpreting the data.

Further research is needed in all areas of relational security: definition, implementation and measurement. This research should examine the relationship between relational security and negative outcomes, such as institutional aggression or serious incidents. Future studies should evaluate the clinical utility of the RSE, examine the psychometric properties and provide normative data for the STA. Until more is known about relational security, the approach to implementing and measuring it should be multidimensional,²² i.e. incorporating staff, patient and service management perspectives.

The authors are grateful to Paul Bassett for his help with statistical analysis.

1.6.95 Profile. The constant psychiatrist: an interview with Michael Kopelman

Norman Poole¹

date

2017-12

Contents

- *Profile. The constant psychiatrist: an interview with Michael Kopelman*

From his journal-lined office in St Thomas' Hospital Professor Michael Kopelman could quietly yet assiduously observe the powerful in their Palace of Westminster just across the Thames. Following retirement in 2015 he has become ever more alarmed by the spectacle: “Our society, in my view, is becoming more and more authoritarian. It's very worrying the direction we are moving in. Even within our university system and the NHS things have become much less democratic than they used to be, and much more authoritarian. It's both sad and frightening.” A perpetually crumpled mac under his arm, the Professor appears much like an MI6 officer in a le Carré novel grown disillusioned with the culture of edicts, diktats and target-driven performance for the workers while those in positions of power sit removed and aloof.

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‘Now it’s really the chief executive and his executive team who run things. With no disrespect to any particular individual, some of whom are very good, I can’t see that they have proper accountability. We doctors have accountability. We can be hauled before the GMC. But managers and commissioners, who are changing the healthcare environment, often for the worse, are not held to account in the same way.’

The Professor’s comportment is at one with his assertion, ‘These are matters I feel strongly about.’

Indeed. For just as the anti-heroes in le Carré’s novels battle with the bureaucracies in which they work, Professor Kopelman is exasperated by perceived wisdom, particularly with regard to a matter close to his professional heart, the modern memory clinic. ‘The memory clinics that are being set up under the Dementia Strategy are not what I would advocate.’ A Fellow of the Academy of Medical Sciences and founding member of the Memory Disorders Research Society, Professor Kopelman appreciates the diversity of problems that have an impact on cognition.

‘There is a wide range of memory disorders to be diagnosed, and the early diagnosis of dementia, even by the very experienced, is difficult. There are very sad implications if you get it wrong. The earlier we go for diagnosis the more likely we are to get it wrong, whatever the clinical/genetic/biomarker tools that we have.’

Criticising the consensus again, he says: “‘I think, and I’m not popular for saying this, that nurse-led diagnostic teams making early diagnosis is not the direction to go in. The direction to go is better care for those with established diagnoses of dementia. What we have at present is shameful, and in my view it’s actually now worse than in the 1980s.’” Professor Michael Kopelman. It is perhaps this disillusionment that partly drives his medico-legal work, in which he is fearless in tackling injustice head-on. On many occasions he has been involved in headline-grabbing courtroom dramas that could themselves be the stuff of fiction. Interestingly, he highlights a radical human rights lawyer as the anti-establishment role model for his own legal work.

‘Gareth Peirce is superb at using the legal rules to beat authoritarians and government. She plays within the system, but she does it better than the government lawyers and beats them. That fits my temperament. Not shouting or protesting on the streets, but playing the system to get justice for people.’

Clashes with the establishment have seen Professor Kopelman fight for the falsely convicted and for Guantánamo detainees. He said: “‘I got into false confession cases, which I see as a form of memory disorder, and was involved in overturning convictions; one from 50 years ago, another after 25 years, and a delusional memory case at 26 years.’” He added: “‘Then with two others – a therapist and a GP – I wrote a report in 2010 on people who had come back from Guantánamo, including some prominent names, and this resulted in them getting substantial amounts of compensation. Ken Clarke announcing this in Parliament made the somewhat ambiguous statement, “We must never let this happen again.” I feel in some ways I have done more good from this sort of work than anything else, and that’s what I’m going to do in my retirement.’” His colleagues obviously agree as Professor Kopelman has previously been elected to serve as president of the British Academy of Forensic Sciences.

This ability to perform scalpel-sharp analyses of intricate legal cases and their relation to esoteric psycho-pathology originates in his wide-ranging reading list at medical school and a first degree in psychology. ‘I had gone into psychology and enjoyed it, and before that – oh I hate to say the cliché – I was interested in people, and enjoyed literature from the psychological angle. So this is what I was curious about.’ Upon gaining a place studying medicine at Middlesex University, he was not your typical medical student: ‘I read Luria quite early on, when I should have been reading anatomy textbooks!’

Paradoxically, a contemporary model of memory claims that it evolved to enable planning for the future, or mental time travel.¹ Professor Kopelman’s forays into the science of memory were thus doubly prescient: “‘I’d been interested in the neuropsychology of memory, which was just developing at the end of the 60s and 70s. I was reading quite a lot of the amnesia stuff at an early stage and I was interested in the more biological aspects of psychology. I knew I would either do neurology with an interest in cognitive neurology or psychiatry with an interest in neuropsychiatry, and I’ve ended up in the middle discipline.’” That’s rather too modestly put given that Professor Kopelman actually ended up as president of both the British Neuropsychological Society and the International Neuropsychiatric Association, and is currently Presiding President of the International Neuropsychological Society.

The influence of psychology so early in his academic career may well contribute to his continued aversion to reductive thinking about mental disorder: ‘I get a bit anxious about what I call naive reductionism, the kind of approach that

thinks that all PTSD and depression are just disorders of the hippocampi or the frontal lobes or whatever. I think that is very simplistic.’ Adding, ‘We have to remember the brain is operating within a social context and not to underplay the importance of our social context.’ It is to his own social context that his mind now turns. Between confrontations with government barristers and completing research programmes at St Thomas’, where he can still be found a few days of the week, Professor Kopelman divides his time between a beautiful 18th-century home in Surrey and a cottage in Norfolk. It is apparent that similarities to le Carré’s heroes don’t just end with the raincoat.

1.6.96 Handbook of Secure Care

Lindsay Thomson¹

date

2017-12

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- *Handbook of Secure Care*

The *Handbook of Secure Care* is a useful book for those new to the field of forensic mental health and is most relevant to those practising in England and Wales. It examines the relationship between mental disorder and offending, with individual chapters on personality disorder, intellectual disability, autism spectrum disorder and acquired brain injury. Strangely, there is little on psychosis which is the fundamental diagnosis within secure care.

The work considers the needs of specific populations such as women, young and older people, and outlines the provision of secure psychiatric services for these groups. It focuses on the basic components of secure care and includes information on risk assessment and management, and on recovery. The latter chapter is of particular use in defining the challenges we face in secure care and ways to redefine our conventional thinking. The fundamentals of psychological treatment in secure care are clearly set out and there is a helpful description of the role of nursing within that setting.

There is discussion in the first chapter on the evolution of secure and forensic mental healthcare, as well as information on the number of secure beds, but I would have welcomed an analysis of the overall estate, the needs for planning and the methods of provision. Similarly, details on pathways into or out of secure care, or on the legislation that allows us to detain people within these settings would have been valuable.

Notably, there is a good chapter by Penny & Exworthy on human rights in secure psychiatric care – the Human Rights Act 1998 underpins much of what we do in secure care, making this especially relevant. It is followed by a chapter on quality assurance and clinical audit. It is my view that the human rights considerations and the quality improvement agenda are so crucial to our work that it would have been beneficial to place these chapters near the beginning of the book to emphasise their importance.

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1.7 2016

1.7.1 The access and waiting-time standard for first-episode psychosis: an opportunity for identification and treatment of psychosis risk states?

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date

2017-2

Abstract

Expansion of early intervention services to identify and clinically manage at-risk mental state for psychosis has been recently commissioned by NHS England. Although this is a welcome development for preventive psychiatry, further clarity is required on thresholds for definition of such risk states and their ability to predict subsequent outcomes. Intervention studies for these risk states have demonstrated that a variety of interventions, including those with fewer adverse effects than antipsychotic medication, may potentially be effective but they should be interpreted with caution.

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- *The access and waiting-time standard for first-episode psychosis: an opportunity for identification and treatment of psychosis risk states?*

With the advent of the new access and waiting-time standard for first-episode psychosis published by NHS England in February 2015,¹ there is now a definite move to adopt service models aimed at preventing transition to psychosis in vulnerable individuals, as originally developed in 1994 by the Personal Assistance and Crisis Evaluation clinic in Melbourne.² There is an expectation that early intervention in psychosis services will now also offer interventions for at-risk mental state for psychosis (ARMS), based on our evolving understanding of best practice in this area.

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This move is exciting for a number of reasons. It represents a commitment from the Government to support mental health service development and reform, especially preventive approaches, at a time when many services are experiencing cuts. Cost-effectiveness of ARMS services has been demonstrated.³ Second, as a treatment paradigm the preventive strategy represents a possibility that we can alter the trajectory of a potentially serious condition and improve outcomes in all domains, including symptoms and functioning. Third, we may be able to use, at an earlier stage of illness, more benign treatments that are potentially less costly, less stigmatising and better tolerated.² This preventive model also represents an opportunity to broaden treatment paradigms within mental health, not just for psychosis but for other disorders, fitting perfectly with another current health development strategy – low-stigma, accessible and responsive youth mental health services. Debate continues as to whether such services are appropriately placed within established early intervention for psychosis or whether new, dedicated teams with a more public health emphasis should be created. However, existing services have expertise in both defining first-episode psychosis thresholds and offering relevant clinical support packages for both ARMS and first-episode psychosis.⁴

The criteria commonly used in the UK for ARMS depend on the presenting clinical features, relative functional impairment and help-seeking.² Consistent quantification of distress relating to these features is currently lacking. It also remains unclear how these clinical risk features differ from more widespread psychotic phenomena in the general population. Psychotic experiences in non-help-seeking populations appear relatively common, affecting about 5%,⁵ and higher in child and adolescent samples;⁶ there is apparent sharing of aetiological risk factors with schizophrenia. Clinical outcomes of this non-help-seeking group are unknown. Psychosis transition threshold is commonly defined by three Positive and Negative Syndrome Scale items (delusions, hallucinations or conceptual disorganisation) achieving adequate severity for at least 7 days,⁷ but such psychosis thresholds are not without controversy.⁸ The large majority of those identified as ARMS do not cross this severity threshold within 3 years of follow-up, although many remain functionally impaired or develop other disorders.² Whether other transition criteria, or modifications of existing criteria, are better able to predict longer-term outcome remains to be established. The reliability of identifying such thresholds in clinical practice is also less than in research settings,⁹ despite using widely available tools.² This is further complicated by concurrent substance misuse, common in such clinical populations. However, the definition and adoption of such thresholds is clearly necessary to educate clinicians, decide when to appropriately intervene and support research. The complexity of the psychosis sub-syndrome groups (including individuals with a family history of psychotic illness, those with schizotypal disorder or the attenuated psychosis syndrome, those with brief limited intermittent notable severity psychotic episodes and those help-seeking or not) and their undetermined probable outcomes may lead to services primarily adopting a more discrete threshold for inception, such as the DSM-5 research-appendix-defined attenuated psychosis syndrome, which has marked clinical overlap with ARMS-defined populations.⁹

Without clear diagnostic robustness of a condition, and with a wide variation in clinical outcome, interpretation of intervention studies is problematic. Initially, randomised studies of diverse interventions for operationally defined ARMS (termed ultra high risk for psychosis) seemed to show similar beneficial effects *v.* control. Reviews pooling outcomes of these studies clearly advocated intervention.^{7,10} More recent randomised studies have demonstrated less clear benefits over control than earlier studies, as is often seen in health research (arguably ‘active’ controls were used in many of these studies). Primary intervention recommendations of supportive counselling/case management for this clinical group have emerged, as previously used as a control intervention. Several factors will need to be considered, with future investigations including previous low sample size due to recruitment problems, use of robust and consistent thresholds for group inclusion, and transition to psychosis to reduce heterogeneity of outcome, consistent inclusion of functional outcomes, translation of findings to usual clinical care (away from research clinics), ensuring timely publication of results and the importance of replication of existing findings.

While considerable progress has been made in this area, we remain at the early stages of defining a risk syndrome for psychosis. The currently adopted clinical threshold for ARMS seems to be a valid construct to identify clinical need but the heterogeneity of subsequent clinical outcomes is wide. Specific interventions for ARMS are unclear, aside from those for commonly identified comorbidities (such as anxiety, depression and substance misuse). Intervention studies to date highlight the importance of methodological rigour and consistency of diagnostic thresholds used, to which end the DSM-5 attenuated psychosis syndrome may be a positive step.⁹ Biological models for psychosis risk need replication, clinical validation and combining with clinical markers in larger, longitudinal studies to enhance risk determination.^{2,11,12}

Despite these caveats, this field of study represents an important advance in the development of preventive psychiatry. The current move to incorporate earlier psychosis states in more widespread clinical services, with appropriate threshold

definition and outcome monitoring, may also have important societal impact.

1.7.2 Plans, hopes and ideas for mental health

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date

2017-2

Abstract

Mental health and the failings of the mental health services are in the spotlight as never before. Nowhere is this more apparent than in the often dire situation with regard to child and adolescent mental health. At the same time, there is a renewed interest in the scope for prevention of mental illness and distress, and in population approaches to mental well-being. It may come as a surprise to some that others have given such serious consideration to strategic approaches to public mental health as long ago as the 1950s. It appears that such consideration was squeezed out by the dominant concerns of serious and enduring mental illness and a prevailing biological view of psychiatry. The time is right to engage with this agenda in recognition of the importance of public mental health, not only for the individual and for families, but also for society as a whole and for the economy. The publication of a review of the subject by the Faculty of Public Health and the Mental Health Foundation is to be commended. Let us make sure it leads to action.

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- *Plans, hopes and ideas for mental health*

The recent announcement by UK Prime Minister David Cameron of a new initiative for mental health, with a particular emphasis on parenting classes, ¹ is most welcome. It comes at the end of a year in which there has been an increasing concern for the state of the nation's mental health, with a flurry of documents and reports, a campaign led by *The Times* newspaper ² and an increasing demand for parity of resourcing between mental and physical health. Interestingly, some of the pressure to do something specifically about child and adolescent mental health is coming from the independent schools sector. The schools have been expressing increasing concern about the mental well-being of the young people in their care, faced by an apparently steady increase in the incidence of distress manifested by levels of general anxiety and depression, and specifically the levels of eating disorder, self-harm and other behavioural manifestations. Not for the first time in public health, something that has long been a problem for the most disadvantaged in society is being taken seriously once it becomes an issue for the privileged. Nor should we ignore the opportunity presented for progress by the mobilisation of enlightened self-interest by those in positions of power and influence. After all, in Victorian times, the fact that cholera knew no social boundaries led to sanitary reform which was of benefit to rich and poor alike. More recently, once it became apparent that HIV/AIDS was not only a disease of stigmatised minorities, the research dollars rolled in.

As a public health physician who began his career as a psychiatrist and family doctor and is finishing as President of the UK's Faculty of Public Health, I find particular poignancy in returning to the theme of public mental health for my swansong year, a theme which I have chosen for the Faculty to focus on in 2015–2016. I appreciate and welcome this

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opportunity to share some thoughts with clinical colleagues in psychiatry based on 40 years of trying to make sense of some of the questions raised within a public health paradigm.

My journey from psychiatric registrar in Newcastle in the 1970s offers some perspective. As a student I was one of those medics whose interests spanned the humanities as well as the sciences. History and politics were always as interesting to me as biology, and when I came across the prospectus for the public health masters course at the London School of Hygiene & Tropical Medicine sometime in third year, it was clear to me that sooner or later I would be signing up. For the next 10 years I would religiously send for the latest edition. Fortunately, my interest was nurtured and kept alive by the remarkable social orientation of the Newcastle course, not just in family and community medicine but also in such mainstream clinical areas as paediatrics, psychiatry and obstetrics. The school was imbued with the spirit not just of the pioneering, community-oriented paediatrician Sir James Spence, but also that of Aberdonian obstetrician Dugald Baird through his Newcastle disciples. The strong social and community base was reinforced by a series of Deans of Medicine, who, while hard-nosed neurologists and endocrinologists themselves, supported the work of those such as Donald Irvine, who was centrally involved in establishing the country's first general practice training programme and later oversaw the General Medical Council. When I signed up for the psychiatric training rotation under the formidable Sir Martin Roth, amazingly comprehensive and intellectually stimulating as it turned out to be with placements in all aspects of mental health services, I found myself frustrated at the failure of those services to focus upstream to prevention and the promotion of mental health.

While as a registrar in the heady years of the challenges posed to orthodox practice by the likes of R.D. Laing and Thomas Szasz, I was exposed to the whole spectrum of ideas, from Freud and Jung to Kraepelin, Sargent and Eliot Slater. Although we had opportunities to cut our teeth on individual, group and marital therapy, the broader public health agenda remained elusive. I came to the conclusion that what was on offer was all too little and too late, and as soon as I had finished my training I moved into general practice in the hope of finding more fertile soil for prevention.

My next move took me to Southampton, where the pioneering dean of the new medical school, Donald Acheson, had created an exciting opportunity which seemed tailor-made for somebody like myself. In a university-run health centre in the local community, based on lines recommended by the celebrated Birmingham professor of public health Thomas McKeown, there were to be specialoid general practitioners – GP paediatricians, GP mediatrians (caring for grown-ups), GP geriatrians and a GP psychiatrist (me). Part of the time we would teach medical students, and the remainder was spent providing a combination of general practice, including out-of-hours services, and specialist expertise to the practice patients as well as supporting each other. As far as possible, we would look after the population of the Aldermoor estate (a public health notion), and consume our own smoke.

It was a stimulating time, but there were problems reconciling the competing claims of medical school and service as well as staffing issues. Southampton was within spitting distance of the London School of Hygiene & Tropical Medicine, so it was time to make the logical step into public health, and it was quite clear that I had made the right move. Validation came from, among others, John Wing and Julian Leff from the Maudsley, who also taught social psychiatry at the school, from visiting teachers from the London School of Economics (LSE), such as Bryan Abel Smith, who confirmed what students suspected, namely that 'public health is the political wing of medicine' and that 'Parliament is the dispensary of public health', and others that placed population health at the centre. It was one of those group learning experiences which stays with you down the ensuing years as a highlight and a transformational experience. Yet there was something missing.

In those days students on the public health masters courses at the School had the enormous privilege of a 2-year course, 1 year spent in the classroom and 1 year on a dissertation. The dissertation was a kind of blank cheque that enabled you to pursue something of special interest that would hopefully be built on in future years. And this is where my problem reasserted itself. What would be a suitable dissertation that majored on prevention and mental public health? I was already a member of the social psychiatry section of the Royal College of Psychiatrists and I took advice from as many people as I could find, including Sir Martin Roth. I drew a blank. The nearest anybody could get was early diagnosis and treatment in the community, what I now knew to be secondary prevention in public health, tertiary prevention being rehabilitation. Primary prevention was nowhere to be found.

And so in the end I hit on planned parenthood, something much better understood in a holistic sense in global health circles, and I carried out a series of studies into family planning and abortion at the population level of Wessex. In my subsequent career as a public health academic, as a regional and county director of public health, as an adviser to the World Health Organization on the Healthy Cities project, and most recently, as President of The UK's Faculty of Public

Health, I have reconciled my angst that as a generalist with a population and environmental focus, all my work has ultimately to be judged by its impact on mental health and well-being. So what have I learned and what observations can I make faced with the promise that finally mental health is to be taken seriously?

One of the problems with mental health, as with physical health, is that the dominant approach is to work backwards, from a focus on treatment towards an interest in prevention. The exception is when there is an emergency, a disaster or a war, when needs must apply a public health population-based triage model if harm is to be minimised.

In the 1980s I attended a short course at the School for would-be volunteers to work in refugee camps in the Horn of Africa. One message stays with me almost 40 years later. If a small group of volunteers (doctors, nurses, engineers and so on) is deployed into a camp of 12 000 women and children in dire circumstances (the men are likely to be either already dead or off fighting somewhere), the first thing to do is not to start treating sick patients. Rather, it is to carry out a quick census of who is there and what skills they have, and to set about mobilising the expertise and supporting it.

This is not our traditional medical model, based as it is on putting up your plate outside a consulting room and offering services to those who can afford to pay, with no concern for the denominator of those with unmet need. Take the example of child and adolescent psychiatry. The large community surveys such as those on the Isle of Wight and in South London found that around 10% of children and adolescents suffer from such a level of emotional or conduct disorder as to require specialist help.³ In a borough of 500 000 population (about 70 000 children and adolescents), this will equate to about 7000 potential patients. In a fortunate district perhaps, optimistically, 1000 of those could be adequately managed by a typical child and adolescent mental health service (CAMHS). No district will ever have that kind of establishment. At the risk of being written off as a loony baby boomer, I would quote Mao Zedong: who is said to have claimed that 'If the practice doesn't work, the theory is wrong'. We are starting at the wrong end of the telescope or focusing on the wrong part of the pyramid of needs. So what would public health say and what is to be done?

In 1961 Gerald Caplan published a book titled *An Approach to Community Mental Health*. Caplan was educated at Manchester medical school and worked at the Tavistock Institute in London and the Hadassah Centre in Jerusalem before moving to the USA, where his work was hugely influential, not least with the programme of community mental health centres under President Kennedy. I came across his book in the 1980s and have carried it round with me ever since.

Reading it again now, it is as relevant and fresh today as it was when it was written, and it is a mystery to me why it has not been a blueprint for how we have approached mental health during the intervening years. Perhaps it is because it includes a (very sensible) chapter on ego psychology, when British psychiatry has for so long been under the shadow of organic theorists and psychopharmacology? In essence, what Caplan proposes is a comprehensive community approach to preventive psychiatry and the provision of services which builds on individual and community assets including those of what he calls 'caretaking agents' and those in special positions in everyday life. He includes in this not just doctors and nurses but clergy, teachers, policemen and so on, and advocates a system built on up-skilling those in a position to play a protective and supportive role in everyday life as a first line.

Caplan describes administrative actions that can protect and support good mental health as well as personal and clinical interactions and redefines the role of those with specialist psychiatric expertise in building and supporting both capacity and capability for mental health and well-being. For me, using the example of child and adolescent mental health, this translates into a life cycle approach that starts with planned parenthood, builds on it with the Prime Minister's parenting classes, and ensures that all those in key interactions with parents and children have adequate skills to promote mental health and respond quickly to signs of distress. This extends to children themselves having the opportunity at school to develop mental resilience and skills for mutual mental health assistance with their peers. The administrative part includes key action on wider determinants of health such as economic and social security, housing and access to good educational and work opportunities. If all this is implemented, the question then arises as to what the formal system should be offering in primary care, building on recent developments in Improving Access to Psychological Therapies (IAPT) and how serious breakdown and risk can be handled for the whole population of patients for whom this becomes necessary.⁴

One of the enemies of adopting this kind of comprehensive approach to mental health is the prevailing narrow and reductionist model of scientific evidence as illustrated by recent controversy over the concept of mental well-being as

a researchable paradigm. ⁵ For Caplan, ““Our lack of knowledge in regard to the significance of the different factors has to be remedied by a continuation of existing research into aetiology. But, meanwhile preventive psychiatrists have been able to learn a lesson from public health colleagues in regard to handling of the problem of the multifactorial nature of the picture ... The incidence of cases of clinical tuberculosis, for example, in any community is no longer conceived of in public health circles as being merely dependent upon the single factor of the presence or absence of the tubercle bacillus. It is recognised that there are many complicated issues that will determine whether a particular person exposed to the germ will contract the clinical disease: issues involving virulence of the germ, host susceptibility and various environmental factors’.” ⁶” In public health we have learned to take a whole-systems approach to whole and sub-populations and to use multiple interventions acting on the health ‘field’.

The list of factors of interest to those concerned with protecting and improving mental health, mental well-being and resilience, in addition to the proximal factors of those aspects of personal security already mentioned and the managed challenges that enable people to grow and thrive, includes a set of constructs such as locus of control, self-esteem and coherence. These can be difficult constructs to operationalise for research purposes, especially when they interact in complex systems, but tools can be developed, for example the Rosenberg Self-Esteem Scale, ⁷ and in recent years mixed-methods and compound outcomes such as those used in Social Return on Investment ⁸ have paved the way for practical interventions based on pragmatic considerations.

We must be careful to avoid the dangers of scientism. When John Snow took the handle from the Broad Street pump during the 1854 cholera epidemic in Soho, the cause of cholera was still believed to be the miasma. This was 20 years before Pasteur’s ground-breaking research. And still nowadays a whole system of education based on the evidence-free assumption that team sports are character forming underpins the British public schools system.

Caplan’s book concludes with a remarkably contemporary proposal for the development of comprehensive community psychiatry based on 11 concepts and assumptions that could well provide the starting point for a consideration as to how any new government funds might be committed. For myself, I have come to the conclusion that in addition to those things which government can and should do through ‘the pharmacy of public health’, there are three approaches, tried and tested in recent years, that should be regarded as delivery systems.

1. ‘Total place’ and ‘defined population’ as developed through Healthy Cities, Healthy Schools, Healthy Prisons and other settings. ⁹
2. Asset-based community development as proposed by John McKnight and colleagues in Chicago. ^{10,11,12,13} This approach maps and mobilises the gifts and talents of individuals, families and communities on the basis that:
 - they are half-full, not half-empty
 - it takes a village to raise a child
 - 90% of health and social care is lay care
 - unless professional practice supports self-efficacy it can be part of the problem rather than part of the solution.
3. Community-oriented primary (and secondary) care based on an epidemiological understanding of populations and responsibility for them, as practised by Sidney Kark and his colleagues over many years at the Hadassah Medical School in Jerusalem. ¹⁴

In conclusion, I am optimistic that we have an opportunity to re-launch mental health in this country at the same time as developing parity and integration with physical health. The Faculty of Public Health is playing its part by launching a new public mental health report in June to share best practice among public health practitioners. ¹⁵

There is a particular opportunity to pursue this approach in England, where NHS England’s *Five Year Forward View* ¹⁶ with its integrated ‘new care models’ is driving transformational change. However, the paradigm shift to a public health model with co-production at its heart is a precondition. More of the same just won’t do.

1.7.3 Capacity *in vacuo*: an audit of decision-making capacity assessments in a liaison psychiatry service

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2017-2

Abstract

Aims and method We aimed to audit the documentation of decision-making capacity (DMC) assessments by our liaison psychiatry service against the legal criteria set out in the Mental Capacity Act 2005. We audited 3 months split over a 2-year period occurring before, during and after an educational intervention to staff.

Results There were 21 assessments of DMC in month 1 (6.9% of all referrals), 27 (9.7%) in month 16, and 24 (6.6%) in month 21. Only during the intervention (month 16) did any meet our gold-standard ($n = 2$). Severity of consequences of the decision (odds ratio (OR) 24.4) and not agreeing to the intervention (OR = 21.8) were highly likely to result in lacking DMC.

Clinical implications Our audit demonstrated that DMC assessments were infrequent and poorly documented, with no effect of our legally focused educational intervention demonstrated. Our findings of factors associated with the outcome of the assessment of DMC confirm the anecdotal beliefs in this area. Clinicians and service leads need to carefully consider how to make the legal model of DMC more meaningful to clinicians when striving to improve documentation of DMC assessments.

Contents

- *Capacity in vacuo: an audit of decision-making capacity assessments in a liaison psychiatry service*
 - *Method*
 - *Results*
 - *Discussion*

All doctors are often required to make assessments of their patients' decision-making capacity (DMC). This role is prominent in liaison psychiatry services, as psychiatrists may be asked to provide a second opinion on DMC for other medical specialties (e.g. regarding consent for a surgical procedure). In the UK, psychiatric second opinion tends to be requested following refusal of treatment by a patient,¹ but also when the assessment is likely to be highly complex or

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is driven by an underlying psychiatric disorder.^{1,2} DMC is also routinely assessed in the UK in psychiatric patients in emergency settings such as accident and emergency (A&E) departments. At the time of the audit guidance by the Care Quality Commission³ recommended that assessments regarding DMC to consent to treatment and admission should be made on all patients at the point of admission to a psychiatric hospital to clarify whether it was an admission authorised through the consent of a patient with DMC or under the ‘best interests’ procedures in a patient who is assenting but lacking DMC.

In England and Wales the legal criteria through which DMC is assessed are provided by the Mental Capacity Act 2005, with further guidance in its Code of Practice.⁴ Under the Act, for a person to lack DMC evidence is required that they suffer from ‘an impairment of, or a disturbance in the functioning of, the mind or brain’ (Section 2(1)), and that as a consequence of this they are unable to perform at least one of the following tasks: ‘(a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate [their] decision’ (Section 3(1)). DMC is ‘decision specific’ rather than a ‘blanket’ or global ability: it is tailored to the specific decision at hand and recognises that different factors may influence different decisions.

There are additional considerations during the assessment of DMC, in that the assessor must also take heed of the principles of the Mental Capacity Act 2005 which include that ‘A person must be assumed to have capacity unless it is established that he lacks capacity’ and ‘A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success’ (Section 1). Recently the House of Lords Select Committee on the Mental Capacity Act 2005 heavily criticised the implementation of the Act: ‘Our evidence suggests that capacity is not always assumed when it should be. Capacity assessments are not often carried out; when they are, the quality is often poor. [...] The presumption of capacity, in particular, is widely misunderstood by those involved in care’.⁵

We know that patients lacking DMC to consent to treatment are common in both general medical in-patient (around 40%)⁶ and psychiatric in-patient settings (around 60%).⁷ An assessment and decision regarding DMC has significant repercussions for the patient, either respecting autonomy or paving the way to surrogate decision-making under ‘best interests’. It is therefore important to document clear justification for a decision reached, under the statutory criteria of the Mental Capacity Act 2005. Previous work in the USA has shown poor documentation of DMC in a retrospective study of in-patient lumbar punctures authorised by a surrogate decision-maker (3 patients had DMC documented out of 25 procedures authorised by a surrogate, although in 21 cases there was enough information to ‘infer’ lack of DMC).⁸

Our aim was to audit the documentation of DMC assessments provided by our liaison psychiatry service against the Mental Capacity Act 2005 and its Code of Practice, and the guidance issued by contemporary literature.⁹ Subsequently, we employed an educational intervention in our service to see whether this improved documentation of the assessments. We collected detailed information on the factors influencing the assessment of DMC to see whether this had an impact on the quality of DMC assessment or of the intervention.

Method

All new referrals received by the King’s College Hospital Liaison Psychiatry Team, South London and Maudsley NHS Foundation Trust (SLaM), during the month of November 2011 were collated. The team is split into the accident and emergency team and the general in-patient team covering all referrals. In working hours there are also specialist child and adolescent mental health services (CAMHS), older adults, neuropsychiatry and perinatal psychiatry teams. All referrals outside of working hours are taken on by the general service. CAMHS referrals were excluded from this audit.

Assessments of DMC performed by members of the team are completed without a formal template or form and were documented in the SLaM electronic medical record (EMR) as free text. All patient contacts by the team need to be recorded in the SLaM EMR.

The EMR was searched for documentation of assessments of DMC by searching for the word ‘capacity’ and any statement declaring that the patient had or lacked DMC was taken to be an assessment of DMC. The entire duration of the patient episode related to that referral was audited. Statements that suggested the patient may or may not have DMC but that did not make formal declaration were taken by this audit to be an assessment of DMC. The exception to this were statements that suggested the person may lack DMC, but that formal assessment could be delayed.

We set our gold-standard to require documentation of: (1) justification of the timing of the assessment/attempts to maximise DMC in accordance with the principles of the Mental Capacity Act 2005 and; (2) the full statutory criteria of DMC (presence or absence of a disorder of ‘mind or brain’, and performance on the four key abilities). We excluded the need for an explicit statement linking psychopathological features of the disorder of ‘mind or brain’ to any deficit found in the four key abilities given that some patients were found to not have a disorder of ‘mind or brain’.

Further information was gathered, including: basic demographic information, whether the assessment took place in or out of hours, the decision for which DMC is being assessed, the professional background of the assessor, and whether the person agreed or objected to the intervention/option proposed. The severity of potential consequences to the patient regarding refusal of the intervention for which DMC was assessed was also quantified, and classed as mild, medium and severe risk of adverse outcome (by a psychiatrist with experience of DMC assessments and patient management in this clinical environment). An example of a severe risk is a refusal of admission into a psychiatric hospital by a patient with florid psychosis or refusal of life-sustaining medical treatment; an example of mild risk is a refusal to contact relatives for information-sharing regarding the patient’s clinical episode.

Following the audit in November 2011 (month 1), we analysed the initial results. Given that none had met our gold-standard (see below), we designed an educational intervention to improve clinicians’ understanding of the legal framework of the assessment of DMC and how to document this appropriately. The intervention took place during the week psychiatrists in training (senior house officers (SHOs)) change jobs (February 2013, month 16), and continued for the following 4 weeks. It involved the lead auditor (B.S.) meeting with the medical (SHO) and nursing (psychiatric liaison nurses (PLNs)) members of the liaison team and explaining the gold-standard of DMC documentation; presenting this to the on-call SHOs during their induction as they may cover the team out of hours; and emailing the SHO cohort and the senior doctors on call (specialist registrars (SpRs)) on a weekly basis with the guidance. Posters with the guidance were put up in the departmental offices seen by the PLNs and SHOs.

The 4-week period in February 2013 (month 16) during which the intervention was applied was audited, along with the month of July 2013 (month 21), using the methods described above. This audit was reviewed and approved by the trust Psychological Medicine Audit Committee in January 2012.

Results

In month 1, there were 21 (6.9%) assessments of DMC for 306 referrals, in month 16 there were 27 (9.7%) assessments for 278 referrals, and in month 21 there were 24 (6.6%) assessments for 365 referrals (*Table 1*). Overall, DMC was assessed in 72 (7.6%) out of a total of 949 referrals.

Frequency of DMC assessments, demographics, and number meeting audit standards by month *a*

	Month 1	Month 16	Month 21	Total sample
Total referrals, <i>n</i>	306	278	365	949
DMC assessments, <i>n</i> (%)	21 (6.9)	27 (9.7)	24 (6.6)	72 (7.6)
Age, years: mean (s.d.)	45.2 (14.8)	39.3(15.4)	45.6 (15.0)	43.1 (15.2)
Female, <i>n</i> (%)	12 (57.1)	14 (51.9)	14 (58.3)	40 (55.6)
Patients found to have DMC, <i>n</i> (%)	6 (28.6)	16 (59.3)	14 (58.3)	36 (50)
Assessments documenting the statutory criteria, <i>n</i> (%)	2 (9.5)	6 (22.2)	2 (8.3)	10 (13.9)
Assessments meeting the audit gold-standard, <i>n</i> (%)	0	2 (7.4)	0	2 (2.8)

Some patients had more than one DMC assessment. There were no significant differences between months.

None met the gold-standard in months 1 or 21, however, 2 (7.4%) did during the intervention in month 16 (*Table 1*) and both of these assessments were performed by the SHOs who had received the educational intervention. Results were similar when using our lower standard of documentation of the full statutory criteria: $n = 2$ (9.5%) in month 1, $n = 6$ (22.2%) in month 16 and $n = 2$ (8.3%) in month 21. The majority of those failing this standard missed out several elements; only 3 (4.2%) assessments missed reaching the standard through missing only one of the four key abilities, whereas 38 (52.8%) assessments documented none of the four key abilities. We therefore cannot conclude the educational intervention had any impact at all.

Where recorded, we looked at how frequently the key abilities to be tested were lacking in people who lacked DMC. Lacking the ability to 'use or weigh' information was most common ($n = 19$, 73.1% where recorded), followed by 'understanding' ($n = 10$, 43.5% where recorded), 'retaining' ($n = 8$, 57.1% where recorded) and 'communication' ($n = 4$, 33.3% where recorded).

The majority of assessments of DMC were performed by doctors ($n = 51$ (70.8%) *v.* $n = 21$ (29.2%) assessments performed by the PLNs). Of the PLNs' assessments only 3 (14.3%) patients were found to lack DMC, whereas of the doctors' assessments 33 (64.7%) patients lacked DMC (*Table 2*). PLN assessment was significantly more likely to result in a positive DMC than a doctor assessment (OR = 11.0, 95% CI 2.9 to 42.5). The doctors met the gold-standard ($n = 2$, 4%) and full statutory criteria ($n = 9$, 18%) more often than the PLNs ($n = 0$ and $n = 1$, 5% respectively).

Outcome of DMC assessment based on assessing clinician

	DMC present		
Assessing clinician, n (%)			
PLN	3 (14)	18 (86)	21 (29)
Doctor	33 (65)	18 (35)	51 (71)
Total, n	36	36	72

DMC, decision-making capacity; PLN, psychiatric liaison nurse.

We separated the types of decisions to be made by the patient into those that involved 'psychiatric admission or treatment' and 'medical admission or treatment'. For the purposes of the audit, decisions to start a new admission in hospital or discharge oneself from a current admission were seen as interchangeable. Medical and psychiatric decisions were not mutually exclusive and a proportion of patients were assessed for both. There were assessments of DMC that did not focus on these decisions, but they were a minority and focused on decisions not normally tested in this setting, such as DMC to make a decision around ongoing homelessness ($n = 1$) and ongoing abusive relationship/domestic abuse ($n = 2$). These non-treatment-focused assessments of DMC all occurred as part of the psychiatric assessment by a PLN or doctor rather than following a request for second opinion from the medical teams.

We found that the proportion of assessments of DMC for medical admission or treatment formed the majority of assessment at the start of the audit month 1 ($n = 17$, 81%), but this reduced over the course of the audit in month 16 ($n = 12$, 44%) and month 21 ($n = 8$, 33%; Pearson's $\chi^2 = 9.91$, $P = 0.007$) (*Table 3*). Conversely, assessments for psychiatric admission or treatment were the minority at the start of the audit ($n = 5$, 24%) and increased in month 16 ($n = 13$, 48%) and month 21 ($n = 13$, 54%), although the differences were not statistically significant.

Decisions for which DMC was assessed and numbers agreeing with the intervention by month

	Month 1	Month 16	Month 21	Total sample $n = 72$
Decisions to be made, n (%)				
Medical admission or treatment	17 (81) ^a <#TFN4>`__	12 (44) ^a <#TFN4>`__	8 (33) ^a <#TFN4>`__	37 (51)
Psychiatric admission or treatment	5 (24)	13 (48)	13 (54)	31 (43)
Agreement status, n (%)				
Agreeing	5 (24)	15 (56)	12 (50)	32 (44)
Not agreeing (or unable to express a choice/not documented)	16 (76)	12 (44)	12 (50)	40 (56)

DMC, decision-making capacity.

Pearson's $\chi^2 = 9.91$, $P = 0.007$.

We separated the choices of people who were having their DMC assessed into agreeing with the intervention proposed by the assessor/medical team and objecting/unable to express a choice/unknown. Fewer people were assessed who agreed with the intervention in month 1 ($n = 5$, 24%), but in months 16 and 21 they made up half of those assessed (Table 3). Agreement with the intervention was strongly associated with a finding of DMC: 26 (81%) of those agreeing with the intervention were found to have DMC, compared with only 10 (25%) of those who did not agree (either objecting or otherwise) (Table 4). This was highly statistically significant (Pearson's $\chi^2 = 22.50$, $P < 0.001$). Most assessments made by the PLNs were done in patients agreeing to the intervention ($n = 15$, 71%), contrary to doctor assessments ($n = 17$, 33%).

Outcome of DMC assessment based on agreement with the proposed intervention *a*

	DMC present		
Agreement status, n (%)			
Agreeing	6 (19)	26 (81)	32 (44)
Not-agreeing (or unable to express a choice/not documented)	30 (75)	10 (25)	40 (56)
Total, n	36	36	72

DMC, decision-making capacity.

Pearson's $\chi^2 = 22.50$, $P < 0.001$.

A logistic regression was performed to ascertain the effects of the assessor (PLN or doctor), agreement with the intervention and consequences of the decision. Initial models also included decision to be made and underlying mental disorder, however, these were removed from the final model as they had no effect.

The final regression model was statistically significant (Pearson's $\chi^2 = 45.81$, $P < 0.001$). The model explained 64.7% of the variance (Nagelkerke R^2) and correctly classified 81.2% of the outcome of the assessments of DMC.

Factors associated with the finding of lack of DMC were: more severe consequences of the decision (OR = 24.4, 95% CI 3.47 to 171.8), not agreeing with the intervention (OR = 21.8, 95% CI 4.0 to 118.8), and assessment by doctor rather than PLN (OR = 14.9, 95% CI 2.1 to 104.5).

Discussion

We have shown evidence that documentation of 72 DMC assessments in 3 sampling months in a liaison setting was poor, with only 2 assessments reaching our gold-standard. The impact of a legal education intervention was very limited and was not sustained beyond the month in which it was applied.

There are several possible reasons as to why the proportion of assessments meeting our gold-standard was so low, even after the educational intervention. Clearly, a lack of documentation of all components of the assessment of DMC does not necessarily equate to these components not having been considered by the clinician assessing DMC. However, there is limited documentary justification of the nature of the clinical assessment and the legal model of DMC. Perhaps elements of the education intervention itself (design, style, length etc.) may not have been an effective means of conveying the information, although our audit was not designed to evaluate this. The explicit reference to the principles of the Mental Capacity Act 2005 in our gold-standard might have set the standard too high, but even our more lenient 'full statutory criteria standard' was only achieved in 13.9% of assessments during the course of the audit.

Where lies the difficulty in translation of the legal model to clinical assessments? In situations where evidence is presented to the Court of Protection (the civil court in England and Wales with the jurisdiction for cases in which an individual lacks DMC), the Court requires completion of prescribed forms that demand a level of evidence similar to our gold-standard. In a busy clinical environment it is easy to see how documentation of the presence or absence of DMC could be considered to be sufficient by clinicians. A process that might slow the system down (or be perceived as such) can be expected to be powerfully resisted.

It is interesting that the assessments of DMC by PLNs result more often in the patient being concluded to have decision-making capacity. This finding needs to be approached with caution given that DMC assessments were triggered by several different reasons in our audit, including either: (1) a second opinion assessment of DMC, usually in the context of a patient refusing treatment, in which the assessment would be performed by a doctor; or (2) an assessment of DMC in the context of admission to psychiatric hospital performed by any clinician.

As doctors performed all second opinions of DMC assessment, usually in the context of a patient refusing treatment, and they assess all patients who will need compulsory admission to hospital, there is a referral bias. The majority of DMC assessments performed by the PLNs were in the context of a patient agreeing with the suggested intervention, and hence were used to support the clinical assessment. If there is no dispute around the intervention offered, then DMC assessment has little consequence and it is easier to presume DMC.

The strong association between lack of DMC, high severity of outcome, refusal and lack of assent is striking. To our knowledge this is the first piece of work that has clearly demonstrated this association in real clinical practice. It would seem to suggest that clinicians when assessing DMC in practice use an outcome test of DMC rather than the functional test the law requires. Kim *et al*¹⁰ have shown that assessments of DMC by clinicians using video simulations of consent discussions around involvement in research are risk sensitive. This echoes early work on conceptualising DMC as necessarily risk sensitive.² Owen *et al*¹¹ reported an association between treatment refusal and DMC assessed using the MacArthur Competency Assessment Tool for Treatment. Although the association is striking, we consider it to be largely expected, given the selection bias that assessments of DMC performed as a second opinion by our service are normally prompted by treatment refusal in the context of a possible mental disorder, when refusal is likely to result in significant harm to the patient. It is reassuring that there are a proportion of assessments where people are found to have DMC despite the refusal and high severity of consequences, and we submit that this is evidence of careful clinical consideration of each case on its own merits.

Our audit has shown that there are limitations in the recording of assessments of DMC, and that uptake of an educational intervention was limited. We consider that this is likely due to the perceived disconnect between the legal assessment and clinical assessment. We would recommend that the next step in the audit cycle should include an educational intervention on the assessment of DMC with a formal evaluation, with exploration and focus on clinical factors and their relationship to legal criteria in order to be more acceptable for clinicians.

In conclusion, we have found evidence for the anecdotal belief on the impact of severity of consequences and agreement status of the patient on the outcome on their assessment of DMC. Reassuringly, these factors were not totally deterministic of the outcome but they do suggest that, in practice, the functional test of DMC is yet to fully bed down.

We would like to thank Dr Lisa Conlan for her support and advice during the audit process.

1.7.4 Personality disorder: still the patients psychiatrists dislike?

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Abstract

Aims and method In 1988, Lewis and Appleby demonstrated that psychiatrists hold negative attitudes towards patients with personality disorder. We assessed the attitudes of psychiatry trainees towards patients with borderline personality disorder and depression, expecting an improvement. 166 trainees were block randomised to receive one of four case vignettes that varied by diagnosis and ethnic group. We used Lewis and Appleby's original questionnaire and the Attitudes to Personality Disorder Questionnaire (APDQ).

Results We received 76 responses. Lewis and Appleby's questionnaire showed more negative attitudes towards personality disorder than depression, with no significant patient ethnic group effects, and the APDQ also showed a (weak) trend towards more negative attitudes to personality disorder. In subgroup analysis, only in the White British patient group were there significantly more negative attitudes to personality disorder. Factor analysis showed significantly less sense of purpose when working with personality disorder.

Clinical implications The perceived greater lack of purpose in working with personality disorder should be the target of clinical training and intervention. Targeted interventions that include training in managing personality disorder, supervision and practice in non-specialist, general psychiatry settings are important.

Contents

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 - * *Lewis & Appleby's 22-item semantic differentials*
 - * *APDQ*
 - *Discussion*

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* *Limitations*

* *Recommendations*

Personality disorder is characterised by an enduring dysfunctional and distressing pattern of inner experiences, behaviours and interpersonal interactions.¹ Almost a quarter (24%) of people seen in primary care² and 50% of people in secondary mental health services meet the criteria for a diagnosis of personality disorder.³ Patients with personality disorder have high rates of comorbidity⁴ and service utilisation.⁵ A meta-analysis, which identified 391 relevant publications and finally included 14, showed significant differences in prevalence between Black and White groups (although no differences between Asian or Hispanic groups compared with White groups), raising the question of whether there is a neglect of diagnosis in some ethnic groups.⁶

Although there is good evidence that borderline personality disorder (BPD) is a helpful diagnostic construct,⁷ some studies contest the validity (but not the clinical utility) of the diagnosis.⁸ Potter¹ stresses that the psychological and interpersonal dynamics that patients with BPD bring to the clinical setting cause frustration and consternation among clinicians, such that BPD is now a diagnosis that can carry pejorative connotations and compound the stigma that such patients already face. Many patients with BPD feel rejected and disbelieved by clinicians.⁹ Improving clinicians' attitudes toward patients with BPD could bring them clinical benefit.¹⁰

Against this background, there have been systematic efforts to study clinicians' attitudes to personality disorder. A systematic review of the literature shows that healthcare professionals in general have negative attitudes towards such patients.^{11,12} A large study⁷ demonstrated that the clinician's occupational subgroup was significantly related to the attitude they adopted towards patients with BPD: staff nurses had the poorest self-ratings on overall caring attitudes, whereas social workers had the most caring attitudes. Social workers and psychiatrists self-rated highly on treatment optimism, whereas staff nurses rated poorly on empathy and treatment optimism. Overall, the authors suggested that education about the nature and treatment of BPD can lead to more positive attitudes, but also that clinicians with greater levels of experience in terms of both number of BPD patients and years of practice were more likely to express positive attitudes towards such patients. Bodner *et al*¹³ demonstrated that psychologists were less likely than psychiatrists and nurses to express antagonistic judgements towards patients with BPD and suicidal tendencies, whereas nurses were less likely to show empathy than psychiatrists and psychologists. They identified a number of factors influencing attitudes, including motivation to improve diagnostic skills, seniority, training and supervision, gender and familiarity with treatment modalities.

In 1997, Bowers *et al*¹⁴ developed a new instrument called the Attitude to Personality Disorder Questionnaire (APDQ). The APDQ is a reliable and valid measure of attitude to personality disorder, and is useful for outcome studies. It was tested among nurses and prison officers.¹⁵⁻¹⁷ One of these studies¹⁶ revealed that psychiatric nurses' attitudes were more negative than those of prison officers. Prison officers more often liked and showed an interest in prisoners with personality disorder, and they showed less fear and helplessness, less anger, more optimism about treatment and less frustration. The other studies found that nurses considered people with personality disorder difficult to treat; they were pessimistic about the efficacy and outcome of treatment and felt they were poorly trained to care for such patients.

Over 20 years ago Lewis & Appleby¹⁸ demonstrated that psychiatrists hold negative attitudes towards patients with a diagnosis of personality disorder, and that the diagnostic label was more influential on their attitudes than the patient's gender or class. Patients given a previous diagnosis of personality disorder were seen as more difficult and less deserving of care than controls. The authors concluded that a diagnosis of personality disorder carries enduring negative sentiments and is not used to guide effective treatment. For example, people with this diagnosis may experience difficulties when seeking help for psychiatric symptoms such as depression. The authors proposed that the concept of personality disorder be abandoned.

In 2002 the National Personality Disorder Development Programme was introduced in the UK, accompanied by the publication of *No Longer a Diagnosis of Exclusion*¹⁹ and *Breaking the Cycle of Rejection*,²⁰ policy attempts that aimed to improve the evidence base of effective interventions for patients with personality disorder in specialist personality disorder services and, it was hoped, would also mitigate stigma.

Given the above, it seemed timely to see whether the attitudes of psychiatrists towards BPD showed any change. We selected psychiatric trainees, despite the difference in seniority/experience compared with Lewis & Appleby's original study (mean 16.5 years of psychiatric practice), as they are on the front line of service provision and are the next

generation of consultant psychiatrists. Considering the findings of McGilloway *et al*⁶ and the multi-ethnic patient population in east and north-east London our sample was drawn from, we also examined the impact of ethnicity on attitudes.

Objectives

The objectives of the study were: to assess the attitudes of psychiatry trainees towards patients with BPD compared with depression to assess the impact of patient ethnicity on the attitudes of trainees to BPD.

Method

The study population consisted of the cohort of doctors training in psychiatry on the north-east London rotations (East London NHS Foundation Trust and North East London NHS Foundation Trust) between February and July 2013: core trainees 1–3, specialist trainees 4–6, general practice vocational trainees and foundation year 2 doctors. Overall, 166 doctors in training were block randomised in blocks of 8 to receive one of four different case vignettes (*Box 1*) that varied by previous diagnosis (BPD or depression) and ethnic group (White British or Bangladeshi). The case vignettes were modified versions of those used by Lewis & Appleby.¹⁸

Box 1 Case vignettes used in the study

Case 1

A 25-year-old White British woman is seen in out-patients. She complains of feeling depressed and crying all the time. She is worried she may be having a 'breakdown' and is requesting admission. She says she has thought of killing herself by taking an overdose of tablets at home. She has a history of an overdose 2 years ago after a relationship break-up, following which she saw a psychiatrist who diagnosed her with depressive episode. She recently lost her job and is worried about how she will pay the bills. She is finding it difficult to sleep and her GP prescribed nitrazepam, which she says has been helpful and which she would like to continue.

Case 2

Same as case 1, but the patient is Bangladeshi.

Case 3

Same as case 1, but the previous diagnosis is borderline personality disorder.

Case 4

Same as case 3, but the patient is Bangladeshi.

We used the following tools to measure attitudes:

Lewis & Appleby's 22 semantic differentials on a 6-point scale. Using the original scoring conventions, the semantic differentials were scored so that a higher score represented responses that were more rejecting or that indicated lack of active treatment.

APDQ: a questionnaire that consists of 37 affective statements about patients with personality disorder (e.g. 'I like personality disorder people', 'I feel drained by personality disorder people', 'I feel patient when caring for personality disorder people'). Respondents rate the frequency of their experiences of these feelings on a 6-point Likert scale: never, seldom, occasionally, often, very often and always. The responses can be summed to give a total score; the higher the score, the more positive the attitude towards patients with a personality disorder. Five subfactors can be scored: factor 1, enjoyment: warmth, liking for and interest in contact with patients with personality disorder factor 2, security: the lack of fears, anxieties and helplessness in relation to patients with personality disorder factor 3, acceptance: the absence of anger towards patients with personality disorder and a sense of being different from them factor 4, purpose: feelings of meaning and purpose in working with patients with personality disorder factor 5, enthusiasm: energy and absence of tiredness.

For the purposes of this study we modified the affective statements to ‘I like these patients’, ‘I feel drained by these patients’ etc. to correspond to the case vignette of either personality disorder or depression.

Analysis

As regards Lewis & Appleby’s 22-item semantic differentials, we compared mean and s.d. scores on items. We assessed the structure of the items by running a principal components analysis. We summed scores of the most dominant factors that explained most of the variance and compared them by diagnosis and by ethnic group.

The APDQ scores (mean, s.d.) were compared for trainees across the four case vignettes. These were compared as groups that differed by diagnosis or by ethnic group in logistic regression analyses, to assess the role of diagnosis and ethnic group. We used the original APDQ factors as an additional variable to assess differences by patient ethnic group and diagnosis.

The study was granted ethical approval by the South West London REC 3 (ref. 10/H0803/159). We obtained the names and positions of all trainees in the rotation from the core training scheme manager for the north-east London rotations. We contacted all trainees via email asking them to complete questionnaires online (on the SurveyMonkey platform, www.surveymonkey.co.uk). All respondents gave informed consent and all responses were anonymous.

Results

We received 76 responses (response rate 46%). However, a small number of respondents failed to answer a number of questions. We thus analysed data from 73 responses to Lewis & Appleby’s questionnaire ($n = 19$ for case 1, case 3 and case 4, and $n = 16$ for case 2) and 68 responses to the APDQ (17 for case 1, 15 for case 2, 20 for case 3, and 16 for case 4). Respondent characteristics are given in *Table 1*.

Respondent characteristics

	Depression	Borderline personality disorder				
Gender						
Female	12	10	22	13	8	21
Male	5	5	10	7	9	16
Unknown	3	1	4	0	3	3
Ethnicity						
White	8	6	14	11	9	20
Black/Asian/mixed/other	6	7	13	6	4	10
Unknown	6	3	9	3	7	10
Qualification in UK						
Unknown	10	8	18	11	8	19
	3	1	4	1	3	4
Current level						
GP/FY	2	5	7	4	0	4
CT1–3	10	5	15	11	12	23
ST4–6	5	3	8	5	5	10
Unknown	3	3	6	0	3	3

GP, general practice vocational trainee; FY, foundation year; CT, core trainee; ST, specialist trainee.

Lewis & Appleby's 22-item semantic differentials

The scale was subject to principal components factor analysis followed by an orthogonal rotation to identify 16 of the 22 items loaded (loading of greater than 0.5) on the first factor (eigenvalue 10.42, explaining 71% of the variance), with two further candidate factors (eigenvalue 1.68, explaining 11.5% and eigenvalue 1.00, explaining 6.1%, respectively) (*Table 2*). Only items from the first factor were summed to compare attitudes, as the second and third factors were accounted for by 3 items each and did not show a clear conceptual distinction between each other. The mean and s.d. score of factor 1 was compared by diagnosis and by ethnic group (case 1: mean 42.42, s.d. = 8.54; case 2: mean 48, s.d. = 8.71; case 3: mean 53.68, s.d. = 11.99; case 4: mean 51.53, s.d. = 10.51). The scores did not vary by ethnic groups. The rank sums showed significant differences by diagnosis, with higher scores (more stigma) towards personality disorder than depression (overall Kruskal–Wallis $\chi^2 = 11.38$, d.f. = 3, $P = 0.01$) (*Table 3*).

Principal components analysis

	Mean (s.d.)	Loading					
Factor 1 (eigen value 1.042)							
Poses difficult management problem	3.25 (1.18)	4.20 (1.30)	(0.5955)	(0.0826)	(0.0343)	(0.1059)	(0.6261)
Unlikely to improve	2.17 (0.94)	3.64 (1.48)	(0.6828)	(0.2932)	(0.0333)	(0.4351)	(0.2574)
Cause of debts under patient's control	3.67 (1.22)	3.28 (1.31)	(0.6678)	(0.2539)	(0.1938)	(0.2264)	(0.4007)
No mental illness	2.53 (1.38)	3.00 (1.57)	(0.7153)	(0.2039)	(0.0041)	(0.3236)	(0.3403)
Case does not merit NHS time	2.64 (1.15)	2.97 (1.06)	(0.6820)	(0.2883)	(0.0797)	(0.1921)	(0.4085)
Unlikely to complete treatment	2.67 (1.15)	3.95 (1.23)	(0.7376)	(0.1704)	(0.1875)	(0.3877)	(0.2414)
Unlikely to comply with advice and treatment	2.89 (0.95)	3.56 (1.27)	(0.8410)	(0.1506)	(0.0388)	(0.2516)	(0.2052)
Suicidal urges under patient's control	2.91 (1.00)	2.64 (1.40)	(0.8697)	(0.0496)	(0.1665)	(0.0827)	(0.2066)
Likely to become dependent on one	4.08 (1.11)	4.72 (0.79)	(0.7435)	(0.3069)	(0.2593)	(0.0553)	(0.2827)
Condition not severe	3.25 (0.94)	3.54 (0.91)	(0.8259)	(0.3129)	(0.1401)	(0.1625)	(0.1740)
Admission not indicated	3.25 (1.50)	3.55 (1.40)	(0.9096)	(0.0398)	(0.1405)	(0.0416)	(0.1496)
Not a suicide risk	2.56 (0.99)	3.00 (0.99)	(0.8246)	(0.0480)	(0.1447)	(0.2903)	(0.2126)
Does not require sickness certificate	2.42 (1.59)	3.08 (1.51)	(0.8481)	(0.2232)	(0.0573)	(0.1831)	(0.1942)
Dependent on BZs	3.29 (1.18)	3.08 (1.23)	(0.8432)	(0.2268)	(0.0802)	(0.0578)	(0.2279)
Psychotherapy referral not indicated	1.91 (1.16)	1.95 (1.11)	(0.9452)	(0.0484)	(0.0436)	(0.0273)	(0.1017)
Antidepressants not indicated	1.83 (1.16)	3.47 (1.59)	(0.8676)	(0.2914)	(0.0017)	(0.1573)	(0.1377)
Factor 2 (eigen value 1.68)							
Manipulating admission	2.91 (0.95)	2.68 (1.32)	(0.0609)	(0.6055)	(0.208)	(0.2771)	(0.5095)
Unlikely to arouse sympathy	2.46 (1.09)	3.08 (1.36)	(0.1055)	(0.6853)	(0.1458)	(0.3179)	(0.3969)
Would not like to have in one's clinic	2.86 (1.40)	3.36 (1.55)	(0.3862)	(0.4406)	(0.1868)	(0.0396)	(0.6203)
Factor 3 (eigen value 1.00)							
Taking an overdose would be attention seeking	2.97 (1.03)	3.64 (1.35)	(0.2184)	(0.4940)	(0.6602)	(0.1606)	(0.2466)
Should be discharged from out-patient follow-up	1.61 (1.10)	1.82 (0.93)	(0.3843)	(0.3520)	(0.6137)	(0.0264)	(0.3511)
Likely to annoy	3.11 (1.28)	3.64 (1.48)	(0.4816)	(0.1173)	(0.5391)	(0.1399)	(0.4441)

BPD, borderline personality disorder; BZ, benzodiazepine; NHS, National Health Service.

Means: higher values indicate greater agreement with statement; there was a 6-point scale between the two statements of the semantic differential.

Attitudes to BPD based on the four test vignettes (factor 1: Kruskal–Wallis equality-of-populations rank test)

Case vignette	Respondents, <i>n</i>	Rank sum
1	19	460.50
2	16	564.50
3	19	860.50
4	19	815.50

$\chi^2 = 11.38$, d.f. = 3, $P = 0.01$

APDQ

Multiple regression analysis of overall scores showed a weak trend towards lower scores in assessment of attitudes towards patients with a previous diagnosis of BPD compared with patients with a previous diagnosis of depression (lower scores indicate more negative attitudes in the APDQ and this is consistent with findings from the Appleby measure); however, this difference fell just short of statistical significance ($z = 1.75$, $P = 0.08$). There was no significant ethnic difference in attitudes towards patients. In subgroup analysis, only among White British patients with a previous diagnosis of BPD was there a lower overall score compared with White British patients with a previous diagnosis of depression ($z = 1.98$, $P = 0.047$).

This outcome had already been subjected to factor analysis by the original inventors of the measure. When we assessed scores on the basis of the five factors (using Kruskal–Wallis equality-of-populations rank) there was no statistically significant difference in scores for factors 1 (enjoyment), 2 (security), 3 (acceptance) and 5 (enthusiasm). However, there was a statistically significant ($P = 0.03$) difference found for factor 4 (purpose), with higher scores in attitudes (more positive) towards patients with depression (mean 4.60) compared with patients with a previous diagnosis of BPD (mean 4.15).

Discussion

Since the original study of Lewis and Appleby nearly 30 years ago, a number of studies spanning from 1993 to 2012, as summarised in the introduction, have consistently shown that clinicians hold negative attitudes towards personality disorder. Our finding of more negative attitudes towards personality disorder compared with depression among psychiatric trainees, using the same instrument as Lewis and Appleby, is in line with previous research. However, it is difficult to show and theorise a sense of longitudinal change. This is mainly because different studies have looked at different professional groups, including nurses, prison officers, social workers, psychologists and psychiatrists, with varying training and levels of experience, and in different countries and/or care settings. In addition, our study examined the attitudes of a less experienced sample of psychiatrists than the Lewis and Appleby study, and this has to be taken into consideration when comparing current attitudes with previous ones. However, the ongoing finding of more stigma towards patients with personality disorder, almost 14 years after the introduction of the National Personality Disorder Development Programme, is disheartening.

More encouraging is the lack of evidence of differences in attitudes to patients with personality disorder of different ethnicity. The greater negative attitudes to personality disorder than depression in White British but not in Bangladeshi

patients raises questions of differences in how clinicians may view the disorder in different ethnic groups, especially given that culture influences significantly what is considered to be a person and personality. Culture influences a number of factors relevant to the construct of personality disorder, such as learning inside and outside the family, the threshold when personality vulnerability cannot be compensated for by the person, and the social threshold when such decompensations are labelled pathological.^{21–23} If one accepts personality pathology as universal,²⁴ perhaps this finding can also raise further questions regarding under-diagnosis of personality problems in certain ethnic groups, although supporting such a link is beyond the scope of this paper and further research is needed looking into both the universality of personality disorder and issues of under-diagnosis or misdiagnosis.

The question of why psychiatrists stigmatise personality disorder is complex and not simple to answer. In addition to the issues discussed above in relation to caring for these often emotionally draining patients, it is of relevance that specific features of BPD can cause negative attitudes. It is known that a wide range of impulsive and potentially self-damaging behaviours are observed, especially early in the course of the disorder.^{25,26} These include gambling, irresponsible money handling, reckless driving and unsafe sexual practices,²⁷ as well as problematic substance use, self-harm, suicidal behaviour and disordered eating.^{28–31} Most of these behaviours carry strong moral connotations, sometimes challenging social norms, and can thus provoke negative reactions, triggering clinicians' implicit beliefs and possibly prejudices towards such behaviours.

While mounting anti-stigma campaigns may be required, the finding of a greater lack of purpose in clinicians in working with personality disorder allows for more modest and targeted intervention. Lack of purpose and therapeutic pessimism raise the importance of designing targeted interventions which may include training in personality disorder. As personality disorder is prevalent in all psychiatric settings, this is an important part of training for all psychiatrists.

Limitations

Limitations of the present study include the small sample numbers, which, despite a reasonable response rate for a questionnaire study, makes it difficult to rely on comparisons between the groups, and thus compromises the power of the study. Our study population is taken from only two mental health trusts in the UK. However, the trusts cover both inner and outer London areas, and the training programmes are similar to those of others in the UK, as there is a specific framework for postgraduate training in psychiatry.

Recommendations

Increased training in evidence-based practice for generalist mental health professionals in borderline personality disorder may address the issue of clinicians' lack of sense of purpose. The emphasis is thus on increasing the skills of clinicians in managing personality disorder in general psychiatric settings, which usually lack the structure, training and resources to deal with these complex patients. The difficulties faced by general psychiatry clinicians have been acknowledged in the literature, and in that respect 'structured clinical management' has been discussed as an effective way of working with BPD patients in non-specialist settings, as long as certain principles are followed and interventions implemented.³²

It has been shown that people with personality disorder present specific challenges to the therapeutic alliance.^{33–35} Training and supervision^{36–39} as well as participation in a Balint group⁴⁰ can improve negative attitudes.

Patients with personality disorder can provoke strong countertransference reactions, there is thus an ongoing need for clinicians to monitor their countertransference when working with such patients. This highlights the ongoing need for psychotherapy training. Evidence-based psychotherapy treatments have a documented applicability as a useful model for general psychiatrists.⁴¹ Supervision and further training is also necessary for consultants, as they often supervise trainee doctors and inevitably influence them through their own attitudes to these patients.

Recent research on stigma reduction has identified certain key ingredients that anti-stigma initiatives should take into consideration: a recovery emphasis and having multiple forms of social contact are especially important for maximising outcomes.⁴² These key ingredients can be taken up to introduce specific initiatives to reduce stigma against personality disorder. For example, Knaak *et al*⁴³ found that a 3-hour workshop on BPD and dialectical behavioural therapy (DBT)

was successful at improving attitudes and behavioural intentions towards persons with BPD. This is in line with those studies that show that training and education programmes tend to improve attitudes.

1.7.5 Pokorny's complaint: the insoluble problem of the overwhelming number of false positives generated by suicide risk assessment

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Abstract

Alex Pokorny's 1983 prospective study of suicide found that 96.3% of high-risk predictions were false positives, and that more than half of the suicides occurred in the low-risk group and were hence false negatives. All subsequent prospective studies, including the recent US Army Study To Assess Risk and Resilience in Servicemembers (STARRS), have reported similar results. We argue that since risk assessment cannot be a practical basis for interventions aimed at reducing suicide, the alternative is for mental health services to carefully consider what amounts to an adequate standard of care, and to adopt the universal precaution of attempting to provide that to all of our patients.

Contents

- *Pokorny's complaint: the insoluble problem of the overwhelming number of false positives generated by suicide risk assessment*
 - *Pokorny's pioneering study*
 - *Other prospective studies of suicide*
 - *Implications for mental health services*

1

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Pokorny's pioneering study

It is over 30 years since the publication of Alex Pokorny's landmark prospective study of suicide among consecutive first admissions to the Houston Veterans Administration Medical Center.^{1,2} Pokorny examined a cohort of 4800 men using a comprehensive array of relevant and reliable rating scales and assessed 803 (17%) to be at high risk of suicide because of the presence of a combination of risk factors. In the next 5 years, 30 (3.7%) high-risk patients and 37 (0.9%) of the 3997 lower-risk patients died by suicide, an odds of suicide that was 4 times greater in the high-risk group.

The 37 suicides among lower-risk patients were in effect false negatives. Pokorny considered false negatives to be inevitable because patients sometimes conceal their suicidal plans and their circumstances change over time. What concerned him more was the overwhelming proportion of false positives, because 96.3% of the patients categorised as high-risk did not commit suicide. He concluded: "We might tolerate 50% false negatives; if we could apply a screening test that would correctly identify only half of the future suicides without false positives that would be very helpful. However, with currently known tests to identify the actual suicides, we will also have to make a great many false-positive identifications, labeling up to a quarter of the total group as future suicides when only 1% to 5% actually are. From a cost-benefit standpoint, the application of such a test is simply not feasible."¹

Other prospective studies of suicide

There have been relatively few prospective studies of the factors associated with subsequent suicide, probably because of the methodological and logistical difficulties involved. Not long after Pokorny, Goldstein *et al*³ followed up a cohort of 1906 patients diagnosed with affective disorders and found that none of the 46 suicides occurred among the group, albeit smaller than in Pokorny's study, defined as being at high risk. More recently, two prospective studies examined the proportion of suicide deaths among those considered to be at high risk.⁴⁻⁶ Madsen *et al*^{4,5} reported a suicide rate of 0.14% among those defined as high risk in a national study of the suicide of psychiatric in-patients in Denmark, and Steeg reported the suicide of 0.5% of patients identified as being at high risk among a large cohort of people who presented to emergency departments in three English counties after self-harm.⁶

Faced with growing concern about suicides among veterans and current serving members of the U.S. Armed Forces, the U.S. Department of Veterans Affairs and the U.S. Department of Defense included the use of risk stratification in clinical practice guidelines.⁷ As part of the Study to Assess Risk and Resilience in Servicemembers (STARRS), Kessler and associates then examined factors associated with suicide among 53 769 American soldiers in the 12 months after discharge from military psychiatric hospitals,⁸ with the benefit of the very detailed longitudinal US Army personnel database and highly sophisticated statistical techniques derived from artificial intelligence research. They identified a high-risk group comprising 2689 admissions, or 5% of the sample, from which there were 36 suicides, corresponding to a 22 times increased risk of suicide in that group. However, in other respects the results were eerily familiar, as nearly half of the suicides occurred among the 51 080 low-risk patients, and only 1.3% of the high-risk group died by suicide, leaving an overwhelming number of false positive cases.

The problem remains of the disturbingly high suicide rates among psychiatric patients as a whole. For example, in the Madsen study, the rate of suicide of psychiatric in-patients was 72 times that of the general community, at 860 per 100 000 patient years, and in the Steeg study the suicide rate among all patients presenting to hospital after self-harm was 622 per 100 000 patient years. Hence, although we know that all of the patients under our care are at greatly increased risk of suicide compared with the wider community,⁵ our ability to distinguish between groups of patients with respect to the probability of subsequent suicide risk is, at best, quite modest.

Implications for mental health services

This observation has important implications for mental health services, given the unrealistic expectations for risk assessment to prevent serious adverse events, and the way risk assessment has changed professional practice.⁹ If risk stratification is to be a part of how mental health services approach suicide prevention, we need to carefully consider the interventions offered to patients believed to be at high risk but denied to those assessed to be at lower risk. Because the vast majority of high-risk patients will not die by suicide, any intervention has to be shown to be somewhat effective, but also benign enough so as not to infringe on the rights of the many with false positive assessments. However, if we do have an effective and benign intervention, it is then hard to justify denying this to low-risk patients, who, after all, are still many times more likely to die by suicide than the general community.

If there is no effective and yet benign intervention to justify offering different treatments to groups of patients on the basis of risk stratification, how can mental health services respond to the knowledge that our patients are at greatly increased risk of suicide compared with the wider community?

The alternative is the application of universal precautions to all patients, including the design of in-patient facilities that minimise the opportunity to attempt suicide,¹⁰ the provision of community treatment for all patients in the weeks after discharge from hospital,¹¹ and safety planning at the point of contact in emergency departments.¹² Most importantly, every patient should have access to timely, individualised, high-quality treatment for psychiatric disorder. Modifiable factors associated with suicide should be addressed in all patients, not only those considered to be at greatest risk. Moreover, no intervention can be justified on the basis of the assessed risk alone. We go so far as to suggest that the assessed risk of suicide on its own is not a sufficient reason for restrictive interventions such as involuntary detention in hospital or other coercive treatment,^{13,14} which would then need to be justified on additional grounds, including the patient's inability to recognise the potential benefit of treatment and their particular circumstances and treatment needs. In any case, preventive detention in hospital of all patients assessed to be at high risk of suicide would be impossible, because of the huge numbers of patients identified and the long duration of secure detention that would be required to protect such patients.

Addressing the modifiable risk factors in populations of patients involves ensuring the adequate identification, assessment and treatment of patients with a range of mental disorders, addressing substance use and, wherever possible, limiting the availability of potentially lethal means to die by suicide. Treatment should be with the patient's consent, or provided on the basis that the patient lacks the capacity to consent, rather than being based on perceived risk, which we now know we are not able to reliably assess.

A further implication for mental health services of the demonstrated limitation of risk assessment is in responding to lawsuits for failing to predict the suicides of individual patients. While the suicide of any patient might be foreseeable in the legal sense of being not fanciful or far-fetched, mental health services cannot be reasonably expected to be able to identify which patients will die by suicide. Expert evidence in one recent case on the estimated probability of suicide after discharge included absurdly high estimates of between a 5 and 70% chance of suicide within days of discharge.¹⁵ Instead of guessing the probability with the help of hindsight bias,¹⁶ negligence claims after suicides should hinge on the accepted standard for care of people with various psychiatric disorders, regardless of the presence of known risk factors. Services should be concerned about the adverse consequences of failing to provide an adequate standard of care to any patient they assess or treat, not only those considered to be at high risk.

Pokorny's complaint that the overwhelming number of false positives renders suicide risk assessment unfeasible is just as valid in 2016 as it was in 1983. His finding, which has been replicated in all subsequent studies, poses a challenge to military and civilian mental health services that have been developed around a model of identifying and managing risk. In response, we recommend abandoning attempts to design interventions based on risk stratification and instead aim to provide an adequate standard of care to all of our patients.

1.7.6 Juvenile delinquency, welfare, justice and therapeutic interventions: a global perspective

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Abstract

This review considers juvenile delinquency and justice from an international perspective. Youth crime is a growing concern. Many young offenders are also victims with complex needs, leading to a public health approach that requires a balance of welfare and justice models. However, around the world there are variable and inadequate legal frameworks and a lack of a specialist workforce. The UK and other high-income countries worldwide have established forensic child and adolescent psychiatry, a multifaceted discipline incorporating legal, psychiatric and developmental fields. Its adoption of an evidence-based therapeutic intervention philosophy has been associated with greater reductions in recidivism compared with punitive approaches prevalent in some countries worldwide, and it is therefore a superior approach to dealing with the problem of juvenile delinquency.

Contents

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 - *What is juvenile delinquency?*
 - * *Who counts as juvenile?*
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 - * *Between the less and more punitive systems*
 - *Trends in youth crime*
 - * *Juvenile gang membership*
 - *Forensic child and adolescent psychiatric services*
 - *Treatment*

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- * *Prevalence of mental health problems among juvenile offenders*
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 - * *Common challenges to a therapeutic youth justice pathway*
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Recent years have seen sustained public and academic interest in criminality and mental health, with attention often focused on antisocial behaviour by children and adolescents. The scale of the problem of juvenile delinquency has provoked mixed responses from governments and the media across the world, with calls for improved rehabilitation and support for juvenile offenders competing with voices advocating more punitive approaches.¹ Meanwhile, decades of rigorous academic scrutiny have shed light on the complex and diverse needs of children who come into conflict with the law.²⁻⁵ Much of the growing body of literature on juvenile offenders shows considerable overlap between criminological, social and biomedical research, with a consensus emerging around the significance of a developmental understanding of the emergence of juvenile delinquency.

Importantly, juvenile offenders have consistently been identified as a population that suffers from a markedly elevated prevalence and severity of mental disorder compared with the general juvenile population.^{6,7} Meeting the needs of these young offenders presents practical and ethical challenges concerning treatment and management, including liaison with other agencies.

What is juvenile delinquency?

Who counts as juvenile?

Juvenile delinquency is a term commonly used in academic literature for referring to a young person who has committed a criminal offence, although its precise definition can vary according to the local jurisdiction. The specific reasons underlying these differences are unclear, but they may arise from the lack of an agreed international standard.⁸

A 'juvenile' in this context refers to an individual who is legally able to commit a criminal offence owing to being over the minimum age of criminal responsibility, but who is under the age of criminal majority, when a person is legally considered an adult. The minimum age of criminal responsibility varies internationally between 6 and 18 years, but the age of criminal majority is usually 18 years.

In some cases individuals older than 18 years may be heard in a juvenile court, and therefore will still be considered juveniles; indeed, the United Nations (UN) defines 'youth' as between 15 and 24 years of age. The term 'child delinquents' has been used in reference to children below the age of 13 who have committed a delinquent act,⁹ although elsewhere 'children' are often defined as being under 18 years of age. The term 'young offenders' is broad, and can refer to offenders aged under 18 years or include young adults up to their mid-20s.

What is a crime?

A 'delinquent' is an individual who has committed a criminal offence. Delinquency therefore encompasses an enormous range of behaviours which are subject to legislation differing from one jurisdiction to another, and are subject to changes in law over time. Whereas acts of theft and serious interpersonal violence are commonly considered to constitute criminal offences, other acts including alcohol consumption and sexual behaviour in young people are tolerated to very differing degrees across the world. Sometimes these differences arise as a consequence of historical or cultural factors, and they may be underpinned by traditional religious laws, such as in some Middle Eastern countries. Some offences may be shared between jurisdictions but be enforced to differing standards – for instance, 'unlawful assembly', often used to prevent riots, is applied in Singapore to young people meeting in public in groups of five or more as part of police efforts to tackle youth gangs. Furthermore, 'status offences' – acts that would be permissible in adults but criminalised in children, such as consumption of alcohol or truancy – not only vary between jurisdictions, but contribute to discontinuity when comparing juvenile delinquency with adult populations in the same jurisdiction.

Lack of clarity can also arise in jurisdictions where a young offender is processed via a welfare system rather than a youth justice process. Countries with a high minimum age of criminal responsibility may not technically criminalise young people for behaviour that would normally be prosecuted and therefore classed as 'delinquent' elsewhere.

Not all incarcerated juveniles are 'delinquent', since some may be detained pre-trial and may not be convicted of an offence. Even if convicted, it would be wrong to assume that every 'juvenile delinquent' meets criteria for a diagnosis of conduct disorder; offences vary considerably and may not be associated with a broad repertoire of offending behaviour. Also, most 'juvenile delinquents' do not pose an immediate risk of violence to others, and the vast majority of convicted juveniles serve their sentences in the community.

To meet the diagnostic criteria of conduct disorder requires evidence of a persistent pattern of dissocial or aggressive conduct, such that it defies age-appropriate social expectations. Behaviours may include cruelty to people or animals, truancy, frequent and severe temper tantrums, excessive fighting or bullying and fire-setting; diagnosis of conduct disorder can be made in the marked presence of one of these behaviours.¹⁰

Overall, the term 'juvenile delinquent' is used extensively in academic literature, but requires some care. It can be a potentially problematic term, and in some contexts can strike a pejorative tone with misleading negative assumptions. For several years the UN has used the phrase 'children in conflict with the law' to describe the breadth of the heterogeneous group of individuals under the age of 18 who have broken the law or are at risk of doing so.

General principles of juvenile justice

Welfare v. justice models

The sentencing of an individual convicted of a criminal offence is largely driven by three key considerations: retribution (punishment), deterrence and rehabilitation. In the case of juvenile offenders the principle of rehabilitation is often assigned the greatest weight.¹¹

Special consideration for juveniles within the criminal justice system is not a new concept. In Roman law, the principle of *doli incapax* protected young children from prosecution owing to the presumption of a lack of capacity and understanding required to be guilty of a criminal offence. Most countries have some provision for special treatment of children who come into conflict with the law, however, the degree to which this is provided varies across the world.^{1,12} In some countries a 'welfare' model prevails, which focuses on the needs of the child, diagnosis, treatment and more informal procedures, whereas other countries favour a 'justice' model, which emphasises accountability, punishment and procedural formality.

Belgium is frequently cited as an example of a country with a strong welfare process, supported by a high minimum age of criminal responsibility of 18 years. Similarly, France built a strong welfare reputation by placing education and rehabilitation at the centre of youth justice reforms in the 1940s. New Zealand in 1989 established the widely praised system of Family Group Conferencing as an integral part of youth justice, with a focus on restoration of relationships and reduction of incarceration that would be considered part of a welfare approach. In contrast, the UK and the USA

have traditionally been associated with a justice model and low age of criminal responsibility – 10 years in England and Wales, and as low as 6 years in several US states.

Within welfare or justice models, a young person may at some point be ‘deprived of liberty’ – defined as any form of detention under official authorities in a public or private location which the child is not permitted to leave. Locations in which children may be deprived of liberty include police stations, detention centres, juvenile or adult prisons, secure remand homes, work or boot camps, penitentiary colonies, locked specialised schools, educational or rehabilitation establishments, military camps and prisons, immigration detention centres, secure youth hostels and hospitals.¹³

Between the less and more punitive systems

The UN supports the development of specialised systems for managing children in conflict with the law. When the first children’s courts were set up in the USA in the 1930s, they were widely praised as a progressive system for serving the best interests of the child. Although informality was championed as a particular benefit, in the 1960s substantial concerns arose about due process and the protection of the legal rights of minors. The subsequent development of formal juvenile courts occurred in the context of a continuing ethos of rehabilitation of young people, with a move away from incarceration of juveniles in the 1970s, especially in Massachusetts and California. However, following a marked peak in juvenile offending statistics during the 1980s and 1990s, public and political opinion swung firmly in a more punitive direction. This was accompanied by legal reforms that increased the severity of penalties available to juvenile courts and lowered the age threshold for juveniles to be tried in adult criminal courts.

When the UN Convention on the Rights of the Child entered into force in 1990, the USA was not a signatory owing to 22 states permitting capital punishment of individuals who had committed their crimes as juveniles. It is reported that 19 juvenile offenders were executed in the USA between 1990 and 2005. Although this number may represent a small percentage of the total who faced the death penalty in the USA during that period, the practice was widely criticised by international bodies and organisations.¹⁴ A landmark ruling in the US Supreme Court¹⁵ outlawed the execution of juvenile offenders in the USA, but to date a small number of countries worldwide still implement this practice, sometimes as a result of religious laws.

However, it would be wrong to assume that welfare systems are automatically preferable to a juvenile justice approach, since welfare arrangements can be equally coercive in terms of deprivation of liberty of juveniles. They may lack due process, safeguards for obtaining reliable evidence from young people, processes for testing evidence, and procedures for scrutiny or appeal following disposal.

Trends in youth crime

The USA witnessed a dramatic increase in arrest rates of young people for homicide and other violent crimes in the 1980s and 1990s, sometimes referred to as the ‘violence epidemic’.¹⁶ The ensuing moral panic led to harsh and punitive policy changes in juvenile justice and, although official statistics document a subsequent fall of 20% in court case-loads between 1997 and 2009, victimisation surveys have indicated a degree of continuity in high levels of offending, consistent with a reported increase in juvenile offending between 2000 and 2006.¹⁷

In common with the USA and several other high-income countries, the UK also experienced a rise in juvenile offending in the 1980s and 1990s, but figures from the Youth Justice Board for England and Wales appear to indicate a general improvement in recent years. Between 2009/2010 and 2014/2015 a 67% reduction has been observed in the number of young people entering the juvenile justice system for the first time, a 65% reduction in the number of young people receiving a caution or court disposal and a 57% reduction in the number of young people in custody.¹⁸ These figures support an overall decrease in juvenile offending noted since the early 1990s.¹⁹

Youth crime figures from Australia have documented a 4% reduction in the overall number of young offenders in 2013/2014,²⁰ although the number of violent offences committed by young people in the urbanised and densely populated region of Victoria has increased by 75% between 2000 and 2010.²¹

The Nordic countries have witnessed an increase in the number of law-abiding youths from 1994 and 2008.²² In Sweden, both objective levels of juvenile crime²³ and self-reported involvement in juvenile crime²⁴ have fallen between

1995 and 2005. Similarly in Finland, where, despite fluctuating trends in juvenile drug use, juvenile property and violent crime is reported to have decreased between 1992 and 2013.²⁵

To summarise, whereas regional and annual trends in juvenile offending are observed and expected, a global trend characterised by decreased juvenile offending appears to have emerged in recent years. Indeed, UN data from a sample of 40 countries lend support to this conclusion, indicating a decrease in the proportion of juveniles suspected (10.9% to 9.2%) and convicted (7.5% to 6%) of crime between 2004 and 2012, respectively.²⁶

Juvenile gang membership

Influence on crime involvement

One of the features of urbanisation across the world has been the rise of youth gangs, groups of young people often defined by geographical area, ethnic identity or ideology; recent reports indicate a rise in groups with extremist views. Explanatory models for the rise in youth gangs include factors such as economic migration, loss of extended family networks, reduced supervision of children, globalisation and exposure to inaccessible lifestyle 'ideals' portrayed in modern media.

Authorities in Japan attributed a surge in serious youth crime in the 1990s primarily to juvenile bike gangs known as 'bosozoku', who were deemed responsible for over 80% of serious offences perpetrated by juveniles, putatively bolstered by a crackdown on yakuza organised crime syndicates.²⁷ Although difficult to quantify, gang involvement appears to feature in a large proportion of juvenile offences, and there is evidence that gang membership has a facilitating effect on perpetration of the most serious violence including homicide.²⁸

Mental health

Compared with general and juvenile offender populations, juvenile gang members exhibit significantly higher rates of mental health problems such as conduct disorder/antisocial personality disorder, post-traumatic stress disorder (PTSD), anxiety disorders and attention-deficit hyperactivity disorder (ADHD).²⁹ Gang members, compared with non-violent men who do not belong to a gang, are far more likely to utilise mental health services and display significantly higher levels of psychiatric morbidity, most notably antisocial personality disorder, psychosis and anxiety disorders.³⁰ Gang membership has also been positively correlated with an increased incidence of depressed mood and suicidal ideation among younger gang members.³¹ Prevalence of ADHD is significantly greater in incarcerated youth populations (30.1%) than in general youth population estimates (3–7%),³² therefore it may be reasonable to expect a similarly increased prevalence in juvenile gang members. ADHD has also been associated with a significantly increased risk of comorbid mood/affective disorder.³³

Forensic child and adolescent psychiatric services

Increased awareness of constitutional and environmental factors that contribute to juvenile offending has strengthened a public health perspective towards the problem, and in the UK entry into the youth justice system has been adopted as an indicator of general public health.³⁴

Dictionaries frequently define 'forensic' as meaning 'legal', implying a relationship with any court of law. Indeed, many forensic psychiatrists, particularly in child and adolescent services, undertake roles that encompass multiple legal domains relevant to mental health, including criminal law, family and child custody proceedings, special educational tribunals, and immigration or extradition matters.

Specialist forensic psychiatric services vary considerably between countries,³⁵ but usually forensic psychiatrists assess and treat individuals in secure psychiatric hospitals, prisons, law courts, police stations and in the community under various levels of security, supervision and support. In some countries there has been a trend towards forensic psychiatrists working almost exclusively with courts of law, providing independent specialist opinion to assist the court.

In the UK, forensic child and adolescent psychiatry has emerged as a clinical subspecialty. Some services are based in specialist secure hospitals for young people and cater for the relatively small number of high-risk young offenders with the most severe mental disorders. In the absence of such specialist resources, young people may be managed in suboptimal environments such as juvenile prisons, secure residential placements or secure mental health wards for adults, or even fail to receive treatment at all.

In light of growing evidence-based interventions for juvenile offenders within a public health framework,³⁶ the role of child and family mental health services may increase over time. Aside from direct clinical roles, practitioners in forensic child and adolescent psychiatry are also well placed to work with a wide range of partner agencies on the planning and delivery of broader interventions for the primary and secondary prevention of juvenile delinquency.

Treatment

Prevalence of mental health problems among juvenile offenders

Rates of mental health problems among juvenile offenders are significantly higher than in their non-offender peers, with two-thirds of male juvenile offenders in the USA suggested as meeting criteria for at least one psychiatric disorder.³⁷ One in five juvenile offenders is estimated to suffer severe functional impairment as a result of their mental health problems.³⁸ Paradoxically, these needs are often unmet,^{39,40} despite evidence of increased contact with mental health services, particularly among first-time juvenile offenders.^{41,42} Of additional concern are the reported associations between mental health problems and mortality in incarcerated juveniles,⁴³ including an elevated suicide rate for males.⁴⁴ Mental health problems must be a target in interventions for juvenile offenders; however, treatments which focus solely on clinical problems are unlikely to result in benefit for criminogenic outcomes.⁴⁵ There is therefore a clear need for effective interventions which address both the clinical and criminogenic needs of these individuals.

Evidence-based treatments for mental health problems

Treatment of PTSD

Estimates regarding the prevalence of PTSD among juvenile offenders suggest that 20 to 23% meet the clinical criteria,^{46,47} with prevalence rates significantly higher among females than males (40% v. 17%).⁴⁶ Moreover, with 62% experiencing trauma within the first 5 years of life⁴⁷ and up to 93% experiencing at least one traumatic event during childhood or adolescence,⁴⁸ this should be a target for intervention.

Cognitive-behavioural therapy (CBT) is regarded as the most effective intervention for adults with PTSD⁴⁹ and also has demonstrated efficacy for juvenile non-offenders.^{50,51} There is limited evidence suggesting a significant reduction in self-reported symptoms of PTSD following group-based CBT in male juvenile offenders,⁵² and of an adapted version of CBT, cognitive processing therapy,⁵³ also resulting in a significant reduction in self-reported symptoms of PTSD and depression compared with waitlist controls.⁵⁴

A trauma-focused emotion regulation intervention (TARGET) has received preliminary empirical support for use in this population. TARGET resulted in nearly twice as much reduction in PTSD symptom severity as treatment as usual (TAU),⁵⁵ in addition to significant reductions in depression, behavioural disturbances and increased optimism.⁵⁶

Mood/anxiety disorders and self-harm

Juvenile offenders in the UK present with a high prevalence of mood and anxiety disorders (67% of females, 41% of males), self-harm (11% of females, 7% of males) and history of suicide attempts (33% of females, 20% of males).⁵⁷ Similarly high prevalence has also been observed cross-culturally, namely in the USA,^{37,58} Switzerland⁵⁹ and Finland.⁶⁰

Despite such high prevalence, there appears to be a paucity of high-quality evaluations regarding the effectiveness of interventions for juvenile offenders with mood and/or anxiety disorders, or problems with self-harm. However, the limited evidence that is available suggests that group-based CBT may aid symptom reduction.⁶¹ Recovery rates for major depressive disorder following group-based CBT are over double those for a life skills tutoring intervention (39% *v.* 19%, respectively), although no significant difference was noted at 6- or 12-month follow-up. CBT also resulted in significantly greater improvements in self- and observer-reported symptoms of depression and social functioning.⁶²

However, group-based CBT is not reported to be significantly different from TAU in reduction of self-harm,⁶³ whereas individual CBT is not significantly different from TAU in outcomes for depression, anxiety, conduct disorder or PTSD.⁶⁴ Yet recruitment to and retention in intervention seems good, suggesting that CBT is feasible to implement in juvenile offender populations.⁶⁴

Evaluations of alternative interventions have posited muscle relaxation as effective in improving juvenile offenders' tolerance of frustration.⁶⁵ Dialectical behaviour therapy (DBT) has also been reported to significantly reduce incidences of physical aggression in a juvenile offender population⁶⁶ and among juvenile non-offenders expressing suicidal ideation.⁶⁷ It significantly reduced serious behavioural problems and staff punitive actions among juvenile offenders within a mental health unit, although no similar significant reductions were observed for those without mental health problems.⁶⁸

Evidence-based treatments for conduct disorder: family approaches

Relationships with family and peers are recognised as key factors in the criminogenic profile of juvenile offenders.⁶⁹ Multisystemic therapy (MST) is a family-focused intervention targeting characteristics related to antisocial behaviour, including family relationships and peer associations,⁷⁰ with evidence from US and UK studies suggesting MST is a beneficial intervention for juvenile offenders. When compared with conventional services offered by juvenile offending services, MST was associated with a significant reduction in the likelihood of reoffending,⁷¹ maintained 2 and 4 years post-treatment.^{72,73} Offenders engaging in MST are reported to be significantly less likely to become involved in serious and violent offending.^{73,74} Significant improvements have also been observed in both self- and parent-reported delinquency,⁷⁴ family relations and interactions,⁷³ and home, school, community and emotional functioning.⁷¹ A cost offset analysis of MST among UK juvenile offenders suggested that combining MST and conventional services provides greater cost savings than conventional services alone, as a result of its positive effects on recidivism.⁷⁵ Qualitative impressions of MST from juvenile offenders and their parents indicate that key components of a successful delivery of MST include the quality of the therapeutic relationship and ability to re-engage the offender with educational systems.⁷⁶

Some evidence also exists regarding the efficacy of MST when delivered to non-offender antisocial juvenile populations outside the USA and the UK. Compared with TAU, MST resulted in a significantly greater increase in social competence and caregiver satisfaction, and a significant reduction in referrals for out-of-home placements, in Norwegian juveniles exhibiting serious behavioural problems.⁷⁷ However, no significant difference between MST and TAU was reported in outcomes for antisocial behaviour and psychiatric symptoms in Swedish juvenile offenders.⁷⁸ MST was also found to have no significant benefit over TAU in outcomes including recidivism in a sample of Canadian juvenile offenders.⁷⁹ These differing outcomes have been posited as the result of barriers in transferring MST from US and UK populations owing to differing approaches to juvenile justice between countries (i.e. a welfare *v.* justice approach).⁷⁸ The heterogeneous nature of studies concerning MST in juvenile offender populations prevent a firm conclusion being drawn as to its superiority over alternative interventions, although this does not diminish the positive outcomes which have been observed.⁸⁰

Substance misuse

Motivational interviewing represents a promising approach for juvenile offenders, particularly as a treatment for substance misuse.⁸¹ Group-based motivational interviewing has received positive feedback from participants when implemented with first-time juvenile alcohol or drug offenders,⁸² and compared with TAU, juvenile offenders in receipt of motivational interviewing have greater satisfaction and display lower, though not statistically significant, rates of recidivism at 12-months post-motivational interviewing.⁸³ There is therefore preliminary evidence for the acceptability and feasibility of motivational interviewing for substance-misusing juvenile offenders, but future research regarding long-term outcomes is warranted. To date, motivational interviewing for difficulties faced by juvenile offenders beyond that of substance misuse does not appear to have received much research attention. Juvenile offenders are known for their difficulty to engage in rehabilitative services, therefore further investigation of the effectiveness of motivational interviewing in encouraging engagement is warranted.

Preliminary investigations have also developed a conceptual framework for the delivery of mindfulness-based interventions (MBI) to incarcerated substance-misusing juveniles, with qualitative impressions suggesting this is a potentially feasible and efficacious intervention.⁸⁴ Although literature regarding the effectiveness of MBI in juvenile offenders is scarce, qualitative feedback has indicated positive reception of this style of intervention, with particular improvements in subjective well-being reported by juvenile participants.⁸⁵

Employment and education

Engaging juvenile offenders with education and skills-based training is an important component of successful rehabilitation, with positive engagement in meaningful activities associated with improvements in areas such as self-belief⁸⁶ and protection against future participation in criminal activities.⁸⁷ It is concerning therefore that an evaluation of the use of leisure time over a 1-week period by probationary juvenile offenders in Australia indicated only 10% of this time was spent engaging in productive activities, such as employment or education, with 57% used for passive leisure activities, a level 30% higher than that of their non-offender peers.⁸⁸

Efforts to engage juvenile offenders in vocational and/or occupational activities have shown benefits in a number of areas. A specialised vocational and employment training programme (CRAFT) emphasising practical skills was evaluated against conventional education provision to juvenile offenders in the USA. Over a 30-month follow-up period, those engaged in CRAFT were significantly more likely to be in employment, to have attended an educational diploma programme and to have attended for a significantly longer period of time.⁸⁹ Benefits have also been reported with regard to risk of reoffending, with an after-school programme in the USA incorporating practical community projects, educational sessions and family therapy resulting in a significant reduction in recidivism at 1-year follow-up.⁹⁰

Qualitative investigations of US juvenile offenders suggest there is not a lack of interest in pursuing education among this population, but rather a disconnection with educational systems when education providers are perceived not to care about students' progress.⁹¹ Ensuring education providers are perceived as proactive and caring in this regard may therefore be an important consideration for efforts to engage juvenile offenders with educational systems. Significant barriers to engagement include difficulties in obtaining accurate information regarding the offender's educational history, in addition to identifying community-based education providers willing to accept previously incarcerated juveniles on their release.⁹²

Language and communication

Difficulties with language and communication skills appear to be prevalent among juvenile offenders, with estimates of those falling into the poor or very poor categories ranging from 46 to 67%; overall, up to 90% of juvenile offenders demonstrated language skills below average.⁹³ Specifically, high rates of illiteracy are reported in this population,⁹⁴ with evidence to suggest that an awareness of such problems among juvenile offenders themselves is associated with dissatisfaction and poor self-esteem.⁹⁵ These difficulties may act as barriers to engagement in therapeutic interventions, particularly those delivered in group settings, as well as re-engagement with educational systems. Awareness of the challenges these young people face with regard to confidence and ability to communicate is important, and potential involvement of a speech and language therapist could be considered. Preventing deficits in language and communication through effective schooling and appropriate support in the early years of life may serve as an aid to effective engagement in rehabilitative interventions, and may also mitigate the risk of engagement in criminal activities in the first instance.

Delivery of therapeutic services

Common challenges to a therapeutic youth justice pathway

There are common obstacles to smooth care pathways between different parts of systems, such as in transitions between secure settings and the community, between prisons and secure psychiatric settings, and between child and adult services. In some jurisdictions individuals can only be treated pharmacologically against their will in a hospital setting, a safeguard which limits the extent to which individuals can be treated in prison, but there is still great scope for intervention by prison mental health teams in juvenile prisons.

Factors associated with good outcomes

A meta-analysis has revealed three primary factors associated with effective interventions for juvenile offenders: a 'therapeutic' intervention philosophy, serving high-risk offenders, and quality of implementation.⁹⁶ These findings are consistent with factors posited as correlating with good outcome in residential centres for troubled adolescents and juvenile offenders: good staff-adolescent relations, perception of staff as pro-social role models, positive peer pressure, an individualised therapeutic programme approach, developmentally appropriate programmes and activities, clear expectations and boundaries, and placement locations which allow for continued family contact.^{97,98}

In the community, coercive styles of engagement have been found to be less successful at achieving adherence among juvenile offenders than a client-centred approach.⁹⁹

Factors associated with poor outcomes

'Scared Straight' programmes expose juveniles who have begun to commit offences to inmates of high-security prisons, yet these approaches have been discredited due to evidence that risk of recidivism may in fact increase following such exposure.¹⁰⁰ Similarly poor outcomes have been observed in programmes modelled on military boot camps, in which harsh discipline is considered to be of therapeutic benefit,¹⁰¹ and initiatives such as curfew, probation and hearing juvenile cases in adult court were also shown to be ineffective in reducing recidivism.¹³

Over recent years it has been repeatedly demonstrated that exposure to juvenile court itself appears to have a detrimental effect on juvenile offending.¹⁰²⁻¹⁰⁴ This may be partially explained by effects of labelling, stigma and negative self-image associated with a criminal conviction, but also the practical consequences of sentences, including assortment of delinquent peers in community or prison sentences. Incarceration presents several additional harms, including disturbance of care and pro-social relationships, discontinuity in education, association with delinquent peers, and exposure to violence. Half of detained young offenders in the UK reported victimisation during their current prison term,⁵⁷ while 12% of incarcerated youth in the USA reported sexual victimisation in the previous year.¹⁰⁵ International agreements state that deprivation of liberty (such as juvenile prison) should be used as a last resort and for the shortest time necessary, so should be reserved for the highest-risk offenders. The cost of juvenile antisocial behaviour is known

to be high, and to fall on many agencies.¹⁰⁶ The current climate of austerity in public services demands that any interventions should be not only effective, but also cost-effective, raising a clear challenge – and opportunity – for the implementation of interventions for this population of vulnerable young people. For example, parenting programmes have demonstrated sustained benefits for this population,^{107,108} with economic analysis indicating gross savings of £9288 per child over a 25 year period.¹⁰⁹ Considered together with wider costs of crime, these gross savings exceed the average cost of parenting programmes (£1177) by a factor of approximately 8 to 1.

Conclusions

Many argue that we have a long way to go before arriving at ‘child friendly’ juvenile justice.¹¹⁰ Around the world there are variable and inadequate legal frameworks that are not age-appropriate, there is a lack of age-appropriate services and establishments, and a lack of a specialist workforce, leading to challenges around training and supervision to work with this vulnerable population. In the UK and other high-income countries worldwide, forensic child and adolescent psychiatry is a multifaceted discipline incorporating legal, psychiatric and developmental fields. This approach has navigated clinical and ethical challenges and made an important contribution to welfare and justice needs by its adoption of an evidence-based therapeutic intervention philosophy.

1.7.7 ‘Doc, can I fly to Australia?’ A case report and review of delirium following long-haul flight

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Abstract

Air travel is now a common feature of most of our elderly population’s lives. There is little by way of warnings, rules or recommendations for our patients with psychiatric diagnoses, in particular dementia, who intend to travel by plane, in contrast to other specialties. In this article I highlight an adverse outcome of long-haul air travel as a result of delirium and resulting accelerated decline in overall cognitive function. I review literature related to the topic and suggest ways to minimise precipitating factors for stressors prior to and during flights. This article suggests that more thought should be given to the title question.

Contents

- ‘Doc, can I fly to Australia?’ A case report and review of delirium following long-haul flight
 - Case presentation
 - * Outcome

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- *Discussion*
- *Recommendations*

Short-haul and long-haul air travel are now commonplace among the elderly population. Evidence suggests such travel is on the increase from the late 1990s, with as many as 1 in 5 people above the age of 65 passing through the main UK international airports in 2014.^{1,2} Little thought is given to short weekend breaks abroad or long-distance holidays with family with mental and physical impairments. In-flight adverse events are difficult to ascertain from information and figures produced by airlines, and apart from the well-recognised morbidity they are not well reported.³ Syncope, respiratory problems and vomiting continue to provide the bulk of in-flight emergencies, with around 1 medical emergency occurring in every 600 flights.⁴ There are no data focusing on the elderly population or people with a diagnosis of mental illness, although one recent source cited ‘anxiety’ as a reason for non-traumatic in-flight complaints.⁵

In this case report I highlight an incident where a delirium has had a significant impact on an elderly patient, resulting in an accelerated decrease in function, long-term impairment and associated symptomatic control with medications that otherwise could have been avoided. I will highlight ways of minimising chances of negative outcomes following air travel in the elderly population.

Case presentation

A 73-year-old man was initially referred to the memory clinic in December 2013 with a history of gradual deterioration of short-term memory and increased dependence on family over an approximate 18-month period. This was with a background of stable multiple sclerosis with no other medical history of note. He was functioning well owing to a supportive family and positive routine activities undertaken mostly with his wife and had a strong academic background which could have contributed to masking of cognitive defects. He was given a diagnosis of a mild cognitive impairment based on impaired short-term memory, as evidenced by clinical evaluation and formal cognitive testing. He scored 80/100 on the Addenbrooke’s Cognitive Examination III; most points were lost in the memory parts (where he scored 10/26) and less so in the fluency part (scoring 10/14) of the test. He was referred to neuropsychology, for brain imaging and was to be seen back in the clinic in 6 months’ time. There were no treatable cardiovascular risk factors at this point; however, the patient was counselled on exercise and diet as well as basic activities to promote cognitive training in keeping with present guidance. The patient and his wife were informed it was difficult to give prognosis and although evidence is varied, a person with amnesic (memory loss) mild cognitive impairment would be at around 1 in 5 risk of being diagnosed with dementia at a later stage. From this presentation and clinical evaluation, it was thought that an Alzheimer’s dementia was the most likely future diagnosis.

The patient then travelled by plane from Scotland to Australia, which involved a short connecting flight to London. On descent from the air to Australia, he experienced an episode of agitation and bizarre, nihilistic delusions about Nazis taking over the plane. After landing, he was admitted to a large, well-known teaching hospital in Australia. He continued to exhibit challenging behaviours such as agitation, wandering and resistance to attempts at basic care from nursing staff. The patient required assistance with feeding and one-to-one nursing care for the majority of the in-patient stay.

The patient’s medical investigations included a positron emission tomography (PET) scan, magnetic resonance imaging (MRI) brain scan, lumbar puncture, electrocardiogram (ECG), chest X-ray, urinalysis, basic blood tests and whole-body computed tomography (CT) over the course of admission without an obvious cause being found for such a dramatic decline and previously unseen behaviours. Of note, any cerebrovascular accident, pneumocephalus, acute kidney injury, external and middle-ear disease and sepsis were ruled out on admission. It was noted that there were no particular risk factors in terms of family history, smoking, hypertension, dyslipidaemia and diabetes which could have increased the risk of most of the proposed diagnoses. Basic observations, including oxygen saturations, were largely unremarkable throughout his admission. He was reviewed by both the neurology and neuropsychiatric teams who came to a joint conclusion that he was experiencing a delirium and previously undiagnosed Alzheimer’s dementia.

He was treated with antipsychotics and given a short trial of intravenous steroid given the history of multiple sclerosis (although not indicated by way of imaging) without any improvement in clinical state.

The patient stabilised enough for repatriation to the UK with a nurse escort after approximately 4 months of in-patient care. At this stage he showed significant deterioration in executive functioning from baseline assessment, limited capacity for new learning, confabulation and required assistance with all personal needs. On descent of the aircraft the patient again deteriorated, with disorientation, agitation and paranoid features once again predominant. Admission to hospital and further investigations gave us no obvious clues to an ongoing acute event. Brain imaging in both Australia and the UK remained unchanged with CT showing generalised atrophy and MRI revealing a minor degree of small vessel disease and smaller than expected hippocampal volume, and suggested Alzheimer's as the only radiological explanation for the presentation.

Outcome

The episode has had a significant effect on the patient's level of functioning and a sizable knock-on effect on his family. He is now a patient in a National Health Service (NHS) long-term care facility requiring assistance with all basic activities of daily living and without much by way of coherent or meaningful conversation. He continues to be managed with antipsychotic medications and benzodiazepines which allow him to be settled on the ward and nursing staff to assist with his needs. It is difficult to ascertain whether there has been any further deterioration in the patient's disease process, however, there has not been any improvement seen. His family continue to harbour feelings of guilt at the original decision to fly to Australia without consultation with medical staff and disappointment at being unable to care for the patient in their home.

My overall aim for writing this case is for the reader to acknowledge the case of a patient with a likely dementia who has had a stark and accelerated decline in function as a result of a change in environment and residual delirium after going on two long-haul flights. Pinpointing the precise mechanism for the delirium continues to be a challenge owing to the number of medical staff involved and the difficulties with communication between continents. Prolonged hypoxia or changes in cabin pressure would seem to be the most obvious causative factors for the delirium given the collateral history, with particular focus on symptoms becoming pronounced on descent. However, this is without any firm scientific basis and is not backed up by anything discovered on clinical examination or investigation.

Discussion

Air travel has become a normal part of everyday life in the UK, with Heathrow, the third-busiest airport in the world, estimated to see approximately 1300 take offs and landings in an average day.⁶ The advent of 'no frills' airlines in the mid 1990s has seen a marked rise in short-haul flights and regional airports have expanded as a result. Combined with the total standardised prevalence of dementia syndrome in the 65+ population, which is thought to be 7.1% at most recent estimates,⁷ air travel is now a common component for a sizable amount of the older population.

From a literature search it would appear that air travel in the elderly population is a safe practice, given that there is little evidence to suggest otherwise. However, there have been a number of reports recently of people with dementia getting lost in airports resulting in national press- and social media-aided searches.^{8,9} Roberto Castiglioni, an adviser to the UK Civil Aviation Authority, has described the impact dementia could have on air travel as 'a ticking time bomb that medical research and the travel industry are yet to address'.¹⁰

There is one reported case of an older man in Australia, a seasoned traveller, who in 2009 developed delirium on a long-haul flight and spent a long period of time as an in-patient as a result.¹¹ The authors state that the patient's decline was precipitated by air travel, but they do not expand on this. They propose that a brief cognitive screening tool to be used prior to travel be developed.

A useful review, also from Australia,¹² summarises the physical hazards associated with air travel and states that people with early dementia may be more prone to developing delirium in flight. It sets out practical ways to minimise this risk.

In contrast to the above there are strict criteria for air travel for physical ailments which are well publicised and adhered to by all the major airlines. For example, the Civil Aviation Authority suggest 14 days have passed prior to air travel following a coronary artery bypass grafting (CABG) procedure and most airlines will not allow women with single pregnancies beyond 36 weeks to travel with their companies. Compare this with the less stringent statement that they would have 'concern' (rather than instruction not to travel) with patients who may exhibit or develop 'disorganised and

disruptive behaviours' in flight, as set out in the Civil Aviation Authority's 'fitness to fly' guidance.¹³ This is a likely reflection on the lack of morbidity and mortality figures available on the topic combined with the unpredictable course and variable stages of dementia and degree of severity of delirium.

It should also be noted that not only this case described but the others mentioned in the discussion involved movement to and from Australia. It would seem unlikely that this alone is a causative factor and indeed it is the length of flight or descent from high altitude that increases the likelihood of deterioration, but it is worth bearing in mind if the overall topic expands, as some have predicted.

Recommendations

Table 1 sets out practical ways to help minimise any air travel-related situations which may potentially cause upset to a patient. These can be addressed prior to travel by input from general practitioners (GPs) and optimising control of pre-existing conditions as well as assistance with travel insurance practicalities. Contact with airports and airlines with the aim of reducing transit time through airports and assistance getting on the plane as well as sensible seating choice (i.e. more leg room, access to lavatory) may also aid in reducing potential stressors.

A summary of recommendations

Pre-flight	In-flight
Attend GP	Stay well hydrated
Optimise chronic conditions	Comfortable clothing
Travel insurance	Familiar distractions
Consider group tours	Inform cabin crew
Assistance in airport	Assistance on/off flight
Extra leg room request	Avoidance of alcohol/unfamiliar foods
Minimise time through security checks	Aisle seating request

GP, general practitioner.

I believe GPs and old age psychiatrists should consider more extensive counselling when the title question is asked and indeed any questions around travel could be pre-empted by medical staff. Patients and carers should be made aware of the dangers posed by hypoxia, changes in pressure environments and barotrauma and the potential for adverse outcomes that these can have on mental state, particularly in those with pre-existing respiratory and ear, nose and throat (ENT) conditions. Little research has been carried out into the overall use, benefit or otherwise of anxiolytics in elderly (or indeed anxious) flyers and this should be explored. Informal discussions with colleagues in the community would suggest the use of benzodiazepines is accepted and relatively common.

1.7.8 Mental capacity and borderline personality disorder

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Abstract

The use of the Mental Capacity Act 2005 in assessing decision-making capacity in patients with borderline personality disorder (BPD) is inconsistent. We believe this may stem from persisting confusion regarding the nosological status of personality disorder and also a failure to recognise the fact that emotional dysregulation and characteristic psychodynamic abnormalities may cause substantial difficulties in using and weighing information. Clearer consensus on these issues is required in order to provide consistent patient care and reduce uncertainty for clinicians in what are often emergency and high-stakes clinical scenarios.

Contents

- *Mental capacity and borderline personality disorder*
 - *Applicability of the Act in borderline personality disorder*
 - *How does BPD affect capacity?*
 - *How this affects clinical practice*
 - *Conclusions*

Borderline personality disorder (BPD) is a severe mental disorder affecting around 1% of the population.¹ It is associated with significant psychiatric comorbidity,² impairment in social function³ and a high rate of service utilisation.⁴ Personality disorder as a whole is associated with reduced life expectancy.⁵ People with BPD may engage in self-harming behaviour as a way of regulating negative affect, particularly at times of crises.⁶ Assessing decision-making capacity in a patient with BPD who requires medical treatment following an act of self-harm is particularly challenging.⁷ In the overlap between the Mental Health Act 1983 and Mental Capacity Act 2005 (the Act), it is the decisions around physical healthcare treatment without consent, i.e. those that the Mental Health Act cannot be used to enforce unless treatment is recognised as treatment for mental disorder, that in our experience generate considerable anxiety. This is particularly true in a general hospital setting as exemplified in the tragic case of Kerrie Woollorton.⁸

The Mental Capacity Act is the legal framework used in England and Wales for assessing capacity. It also provides protection to a clinician who makes decisions on behalf of an incapacitous patient, providing its terms are satisfied and the clinician is acting in the patient's best interests. Assessment of capacity is time- and decision-specific, however, in our clinical experience there is inconsistency surrounding the use of the Act with BPD patients. This is partly the result of disputes relating to the nosological status of personality disorder as a whole.^{7,9} Such disputes are discordant with

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increasing knowledge about the natural history of BPD and its neurobiological abnormalities and treatability. In this article we explore the key reasons for inconsistency on whether BPD has the potential to give rise to the ‘impairment of, or disturbance in the functioning of, the mind or brain’ criterion of the Act, as well as highlighting the need for clearer guidance on the use of the Act with such individuals.

Applicability of the Act in borderline personality disorder

As indicated by Section 2(1) of the Act, patients must demonstrate an ‘impairment of, or disturbance in the functioning of, the mind or brain’ for the Act to apply – sometimes known as the ‘diagnostic threshold’. Applicability to patients with a psychotic illness or a severe affective disorder is rarely questioned, presumably because these conditions are clearly described and widely accepted as constituting mental disorders that have the potential to impair or disturb function.⁷ However, in one of the few discussions of the impact of personality disorder on competence to refuse treatment, Winburn & Mullen¹⁰ point out that personality disorder, although classed as such under the Mental Health Act 1983, ‘has always been considered to be at the margins of what constitutes mental disorder’. Although it is by no means an exhaustive list, paragraph 4.12 of the Mental Capacity Act Code of Practice¹¹ does not include personality disorder among the other conditions it recommends as having the potential to cause impairment or disturbance in the functioning of the mind or brain. Indeed, as recently as the past decade, lingering doubts about the nosological status of personality disorders in general were still being voiced by senior figures in academic psychiatry.⁹

Over the past 10–15 years, the empirical evidence base for personality disorders in general and particularly for BPD has expanded substantially. Robust longitudinal studies have charted the natural history of BPD¹² and shown that while symptomatic improvement is common, enduring impairment in social functioning³ is a defining feature of the condition. Cost of illness studies have shown that the costs of managing people with BPD exceed the costs associated with managing people with depression.⁴ Other studies have shown that the life expectancy of people with personality disorder is markedly reduced and that the loss of lived years is at least equivalent to that seen in schizophrenia.⁵ There is also growing evidence of underlying neurobiological abnormalities associated with BPD.^{13,14} Finally, the increasing number of well-conducted clinical trials which show that effective treatment is possible provides further evidence supporting the validation of the construct of BPD.¹⁵

In summary, as a result of considerable research endeavour, we now know that BPD is, without doubt, a valid category of mental disorder. As such, it must be considered ‘an impairment of, or a disturbance in, the functioning of the mind or brain’. Therefore, not only is the Mental Capacity Act framework applicable to people with BPD, but it is clinically inappropriate not to consider its relevance when assessing people with BPD. There is a need for greater consensus regarding this, to eradicate the assumption that capacity assessments, *tout court*, cannot apply to such patients.^{7,11}

Perhaps another reason why this assumption has been so pervasive relates to Parsons’s notion of the ‘sick role’.¹⁶ This illustrates the link between illness and its social benefits: among these, the absolution of responsibility.¹⁷ The doctor’s role is key, as it is the doctor who confers this role on the patient and provides social sanction for receipt of those benefits.¹⁶ Doctors are often divided as to whether patients with BPD can be thought of as being ill and thus entitled to a sick role.^{9,18} As the Act requires the presence of an ‘impairment’ or ‘disturbance in function’ to be applicable, one might view its application to BPD patients as being synonymous with sanctioning an adoption of the sick role. Such a view may not sit comfortably with a clinician who may view a volitional act of self-harm as being ‘manipulative’.^{9,18}

The issue of volitional control and, by inference, manipulation, therefore seems the crux of the matter. Pickard¹⁹ points out that it is hard to accept that patients with a personality disorder completely lack control over their actions. She qualifies this by pointing out they ‘may not always have full conscious knowledge of why they are behaving as they do’.¹⁹ Similarly, Szukler has speculated that suicidal impulses may sometimes stem from ‘an inner disturbance the [person] finds difficult to describe’.⁷ The question for clinicians is that, in situations where high-stakes decisions must be made, how does the phenomenology of BPD impair an individual’s ability to understand and reflect on both the risks and benefits of treatment, and also the motivation underlying their behaviour?

How does BPD affect capacity?

Fuchs²⁰ identified that, at the extremes of emotional dysregulation, BPD patients become enveloped in that mental state to the extent that they are unable to view things objectively. Over time, repetition of this cycle leads to the chronic feelings of emptiness that characterise the disorder, meaning that patients ‘miss the experience of agency or authorship of their life’.²⁰ Broadly speaking, this key concept can be illustrated in two general clinical scenarios.

The first is a patient presenting as an emergency at the extreme of an episode of emotional dysregulation. Self-harming behaviours may serve an affect regulation function⁶ and assessment of capacity to accept or refuse treatment following a severe episode of self-harm is a common clinical scenario. The framework for decision-making, per the Act, requires the patient to understand the pros and cons of treatment for their condition. If the self-harm is life threatening, accepting treatment would therefore be life saving, and to refuse, by inference, a decision likely to result in death.

To ‘use or weigh’ relevant information about options in the process of deciding is the element of the capacity test that causes most interpretative difficulty in BPD. As Principle 4 of the Act states: ‘a person is not to be treated as unable to make a decision merely because he makes an unwise decision’. Deciding to refuse life-saving treatment may be unwise, but it is not the decision *per se* that we are assessing, rather how ‘accountable’ the patient is for the decision.^{21,22} Elliot has argued that in depression, even though patients may understand the risks, ultimately the disorder may affect whether they ‘care’ about that risk, thus reducing the ‘authenticity’ of the decision.²² If depression can lead to a pathological lack of ‘care’ about one’s own interests, could the drive to emotionally regulate via self-harm lead to a pathological ‘resistance’ to acting in one’s own best interests that robs BPD patients of decision authenticity?

Research has suggested that key interpersonal schemas in BPD include sadomasochistic behaviour, where patients hurt themselves in an internalised ‘punitive parent’ mode.²³ The relevance to treatment refusal here seems clear. In addition, as Szmukler points out, any capacity assessment is essentially a dynamic between the patient and the doctor.⁷ Refusal of the doctor’s recommendation could also be viewed within this sadomasochistic paradigm. This is surely the source of the sense of ‘manipulation’¹⁸ frequently felt by doctors treating these patients.

The great trap in these scenarios is assuming that refusal of life-saving treatment is equivalent to a wish to die and an acceptable ‘unwise’ decision. While this may indeed be the case in some instances, this *de facto* assumption endangers the lives of some BPD patients, as in some cases the decision to refuse *per se* may simply be a manifestation of the disorder, rather than a carefully considered wish to die. The risk to these patients is compounded by an intolerance of ‘manipulation’ felt by the doctor, who in turn may take this as evidence that the patient has full insight into the situation and accept their refusal as an unwise but capacitous decision. In summary, as a direct consequence of the mental disorder itself, BPD patients may unwittingly become caught up in a destructive iatrogenic cycle of harm.

A second clinical example which aptly illustrates the lack of ‘authorship’ of life¹⁹ that may occur for people with BPD while dealing with doctors has been provided by Winburn & Mullen.¹⁰ They describe the case of a BPD patient who was judged incapacitous to refuse a potentially life-saving blood transfusion. Her decision to refuse treatment was viewed as a consistent, chronic behavioural pattern and overall constituted a ‘disturbed form of engagement ... rather than an effort to disengage’. Case law reflects these views, as seen in the case of *B v Croydon Health Authority*,²⁴ where a young woman with BPD was starving herself to the point where enforced nasogastric feeding was considered. Lord Justice Hoffman wrote in his judgment that he found it difficult to conclude that the patient had capacity, despite her seeming to have a good understanding of the risks and options. It was this that made him question whether her choice was truly autonomous, because, while being able to make cogent and articulate statements about her wishes, it was hard for him to deem someone capacitous when she is ‘crying inside for help but unable to break out of the routine of punishing herself’.

How this affects clinical practice

The assessment of mental capacity in BPD patients is complex and may therefore cause clinicians significant anxiety where high-stakes decisions are to be made. It is conceivable that such anxiety may lead to risk-averse practices. In her review of suicide risk management in BPD patients, Goodman²⁵ highlighted the influence of medico-legal concerns on clinicians, by referring to a survey²⁶ that had shown that 85% of clinicians working with BPD patients had, within the past year, practised in a way ‘that would relieve their anxiety over medicolegal risks’. In our example of the BPD patient refusing life-saving treatment following self-harm and where capacity is marginal, risk-averse practice would presumably involve erring on the side least likely to result in death, i.e. a judgement of incapacity, detention and enforced treatment.

However, Pickard¹⁹ points out that it is particularly in the interests of patients with BPD that we attribute decision-making responsibility to them where possible, as this is the basis of some of the most effective psychological treatments for BPD, where self-control and mentalisation development are key. Szmukler suggests that when capacity could be argued from both sides, ‘one might conclude that ... the patient’s account, although not the one preferred by the clinician, is an adequate one, and sufficient to demonstrate that the patient has capacity’.⁷ Law states that ‘with regard to the degree of incapacity the nearer to the borderline the more weight must in principle be attached to [the patient’s] wishes and feelings’.²⁷ In application to BPD this would appear to imply that if the incapacity is only marginal the patient should, in effect, be approached as if with capacity.

So how do we balance over- and under-attributing capacity to BPD patients in clinical practice? Buchanan’s work²⁸ is relevant to this problem. He describes that when capacity is in doubt, we may vary our threshold for deciding what constitutes true incapacity, based on the stakes of the decision. Thus, when the negative consequences of a decision are likely to be severe, the clinician would require a more robust demonstration of capacity.²⁸ In essence, the clinician is balancing possible infringement of autonomy with negative consequences of the outcome of the decision. Ultimately, capacity is judged legally to be either present or absent, but as Lord Donaldson pointed out in the case of *Re T (Adult: Refusal of Treatment)*,²⁹ doctors should consider whether the capacity that is there is ‘commensurate’ with the seriousness of the decision.

One might argue that proportionality merely reflects the clinicians’ increasing anxiety about higher-stakes situations, thus not addressing the underlying problem: that there is little consensus and guidance on whether and how BPD may affect decision-making. Clearer guidance and consensus on how BPD may affect decision-making abilities in different clinical scenarios will reduce anxiety for clinicians and may help the Act become more predictable in its application.

Conclusions

Borderline personality disorder is a mental disorder. The use of the law in treating patients with BPD should be predictable and its application to clinical scenarios reproducible. The current use of the Mental Capacity Act 2005 in assessing decision-making capacity in such patients is lacking in these respects.

While BPD should be viewed as a mental disorder, this only means the Act is applicable; it is not synonymous with the view that people with BPD necessarily lack capacity for decision-making or responsibility for their actions. The psychopathology of BPD and specifically the way this affects the ‘using and weighing’ element of decision-making capacity is extremely complex and not acknowledged widely enough either in clinical practice or within the Mental Capacity Act itself. This leads to inconsistency in patient care. Further research into this field, along with clearer clinical consensus and legal guidance, is urgently required.

1.7.9 Perceptual distortions and deceptions: what computers can teach us

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Abstract

The nature of perception has fascinated philosophers for centuries, and has more recently been the focus of research in psychology and neuroscience. Many psychiatric disorders are characterised by perceptual abnormalities, ranging from sensory distortions to illusions and hallucinations. The distinction between normal and abnormal perception is, however, hard to articulate. In this article we argue that the distinction between normal perception and abnormal perception is best seen as a quantitative one, resting on the degree to which the observer's prior expectations influence perceptual inference. We illustrate this point with an example taken from researchers at Google working on computer vision.

Contents

- *Perceptual distortions and deceptions: what computers can teach us*
 - *The problem of perception*
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 - *Tipping the balance*
 - *Contemporary accounts of hallucinations*
 - *Limitations*
 - *Conclusions*

No mental state examination would be complete without a statement relating to abnormalities of perception. According to Fish, perceptual abnormalities may be classified as either sensory distortions (e.g. hyperacusis and dysmegalopsia) or sensory deceptions (e.g. illusions and hallucinations), with both categories deviating from veridical perception.¹ The clean simplicity of this definition underlies part of its clinical utility, but also gives the impression that the characteristics of 'normal' veridical perception are well understood. The nature of perception, however, has troubled philosophers for centuries,^{2,3} and has been the focus of intense investigation by neuroscientists and psychologists in recent decades.⁴⁻⁷ Just how does the brain transform the light hitting the retina into the infinitely complex three-dimensional world that we see when we open our eyes? How much of what we perceive is really present in the sensory data hitting our eyes, and to what extent do our prior expectations shape our perception? Do we perceive the world as it really is, and if not, does that mean that our normal perceptions are distorted or deceptive? If so, in what way does normal perception differ

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from abnormal perception? These questions may seem to be only of philosophical relevance, but researchers working in the fields of perceptual neuroscience and computer vision are regularly confronted by them.

In this article we outline some exciting insights into how the brain may construct reality. Intriguingly, these findings have come from the field of machine learning, a branch of computer science and robotics.

The problem of perception

How does your visual system construct a representation of the world? Perhaps most readers would reply that the brain extracts the information about the physical world that is contained within incoming sensory signals. Much of the neuroscience of the past half-century has investigated perceptual processing starting from this assumption.^{4,8} The account of perceptual processing found in most undergraduate textbooks states that the sensory processing pathway (including the sensory epithelia, subcortical nuclei, thalamus, sensory cortices and heteromodal association cortices) extracts information from incoming sensory data in a stepwise manner. If all goes smoothly we perceive the world ‘as it really is’.

There are several problems, however, with the view that perception proceeds by extracting information from the incoming signals alone. Perhaps the most damning consideration was recognised by George Berkeley in the 18th century as the ‘inverse optics’ problem,^{2,4} which states that information collected by the sensory epithelia is insufficient to allow an unambiguous mapping back on to real-world sources. The light hitting the retina, for example, forms a two-dimensional image, which has an infinite number of possible three-dimensional ‘real-world’ sources. The image conflates information about object illumination, reflectance and transmittance.⁴ Computer vision faces similar problems. A car, for example, looks different from different viewing angles and distances, and in different lighting conditions. The problem of inferring the state of the world from sensory data alone is (mathematically) ill-posed.⁹ One powerful illustration of this principle is demonstrated by the famous Necker cube illusion,⁵ where the sensory information alone is insufficient to resolve the question of the orientation of the wire cube and there is no simple mapping between sensory data and perception (*Fig. 1*).

Expectation is necessary for perception

If sensory data alone cannot support perception, how does the brain create accurate perceptual representations of the world? It is now appreciated that ill-posed problems such as vision can be made tractable by using contextual information to impose constraints on the interpretation of ambiguous data. In the case of vision, for example, past experiences of seeing similar visual scenes sets up expectations about the likely current state of the world, and any new sensory data are interpreted in light of these expectations. Consistent with this hypothesis, the sensory processing pathways in the brain do not just support one-way ‘bottom-up’ information flow (from low-level data in the primary sensory cortex to more complex representations in heteromodal association cortices), but also support ‘top-down’ information flow, whereby information about the current expected state of the world cascades down from high cortical areas to influence information processing in low sensory areas.^{9,10} Some have argued that the ‘heavy lifting’ of perceptual processing is performed by these top-down pathways, which make predictions about the state of the world that are tested against sensory data.¹⁰

The ability of the brain to make sense of sensory information has inspired computer scientists working on computer vision and similar problems to take a similar approach. Recently, researchers at Google created an impressive visual recognition system using a processing architecture inspired by the human brain, called an ‘artificial neural network’ (ANN).¹¹ ANNs consist of artificial ‘neurons’ that are organised into layers, reminiscent of the brain’s hierarchical organisation. These networks are particularly good at detecting features and patterns in new data, and using these features to perform classification tasks. This is similar to what the brain does when engaged in perceptual inference, which may be thought of as the detection of objects and meaningful patterns in sensory data. New data enter the ANN at the lowest ‘input’ layer (analogous to light hitting light-sensitive neurons in the retina) and is processed sequentially by progressively higher layers of the network. At each layer the network attempts to extract patterns and features from these data, with higher layers of the network extracting increasingly more abstract features. At the highest layer a ‘decision’ is made about what the data represent.

Importantly, a new ANN must be adequately ‘trained’ before it can perform successful pattern detection and classification tasks. During training the network is exposed to many different data-sets (e.g. images) and attempts to classify the data appropriately. The network is able to self-calibrate, guided by its successes and errors, in a process analogous to synaptic plasticity. After exposure to thousands of images of, say, cats, the network learns to recognise cats in images to which it has never before been exposed.

The well-trained ANN is primed to recognise salient features and patterns in new data in much the same way that the brain is primed to recognise the patterns in sensory data that are most important for detecting behaviourally relevant objects. Prior to training, the ANN is essentially blind to meaningful patterns in new data. In both the well-trained ANN and the mature human visual system the final decision about what a new image represents is the product of a delicate balance between the information contained within the image itself and the readiness of the network to detect certain features within new data.^{9,10}

Tipping the balance

Perception is therefore the product of two sources of information: the sensory data and prior expectations about the sort of information that the sensory data contain. What happens, however, when prior expectations are given too much weight?

The Google researchers provide an intuitive example of the problems that inappropriately strong prior expectations can cause in their ANN.¹¹ As mentioned previously, the highest layers of the ANN contain latent representations of objects that the network has been trained to see. The Google researchers asked a network trained to see bananas to detect and enhance ‘banana-like’ features in an image that contained only meaningless noise. This manipulation inappropriately weighted prior expectation relative to sensory data. The result was that the network was able to ‘perceive’ objects where none existed in the image itself (akin to a ‘guided hallucination’) (see the Google Research Blog article for examples¹¹). Although the mechanisms employed by this simple network manipulation are not intended to be biologically plausible, the simple experiment demonstrates the power that inappropriately held prior expectations might have on resulting perception.

To what extent can inappropriately held prior expectations influence human perception? This question has relevance to descriptive psychopathology and psychiatry. Karl Jaspers, the father of descriptive psychopathology, postulated that ‘illusions due to affect’ and ‘illusions due to inattentiveness’ may arise when a person has a strong prior expectation about the state of the world and is confronted with noisy and ambiguous sensory data.¹² This exaggerated prior expectation may be informed by the semantic context of a situation (in what have come to be termed ‘completion illusions’), the observer’s current emotional state¹³ (in ‘affect illusions’), or active imaginative processes acting on inherently ambiguous sensory data (in ‘pareidolic illusions’).^{1,12,14,15} It may be argued that in these situations the observer comes to impose their prior expectations on the ambiguous sensory data.

Contemporary accounts of hallucinations

We have argued that perceptual inference always relies on both incoming sensory data and a prior expectation about what these data are likely to represent. Additionally, we have outlined the hypothesis that illusions and hallucinations may be the result of an imbalance between these two sources of information. This simple account is consistent with contemporary theories of illusions and hallucinations, which also implicate a miscalibration between these two sources of evidence.

One of the most influential contemporary accounts of perceptual inference is that of hierarchical predictive coding.^{9,16,17} At the heart of the predictive coding account is the notion that the brain maintains a dynamic representation of the world, which is the brain’s best prediction about the state that the world is likely to be in. Incoming sensory data are compared against this representation. If there is a good match between the prior prediction and the sensory data the current representation of the state of the world is reinforced. If there is a mismatch, a ‘prediction error’ signal drives an updating of the brain’s current representation of the world, which is subsequently re-tested against the real-world data. The iterative process of matching the brain’s predictions to sensory signals underlies perceptual inference.^{10,16,17} This process can become disrupted when the balance between prior predictions and incoming sensory data is changed. The brain’s internal representation of the world will be resistant to change, and thus dominate perceptual inference,

if the prior prediction is given a greater weight than the incoming sensory data, as may happen when the incoming sensory data are noisy.^{9,16,17} It has been proposed that in some pathological states the brain may mistake its own prior predictions for new incoming sensory data, resulting in perceptual and cognitive abnormalities that share some similarity to acute psychosis.¹⁸

Another influential account of complex visual hallucinations is the perception and attention deficit (PAD) model, which was developed after studying clinical populations who experience recurrent complex visual hallucinations.¹⁹ It was found that people in these populations had combined deficits in low-level sensory processing and attention. The PAD model proposes that in order to perceive an object, the perceptual object must first be selected from a pool of candidate ‘proto-objects’, in a process guided by sensory data, prior expectations and attentional processes. In people who have a combined deficit in sensory processing and attention it is conceivable that proto-objects from a misrepresentative pool become inappropriately bound to the visual scene, resulting in a hallucination.¹⁹

Both the predictive coding and PAD accounts of illusions and hallucinations propose that an overweighting of prior expectation relative to sensory data may underlie certain perceptual abnormalities. This overweighting may be a direct result of inappropriately held prior expectations (as can occur in states of high emotional arousal), or may be secondary to a decrease in the quality (or precision) of incoming sensory data (as may occur in states of low attention, fatigue or sensory impairment).^{19,20}

Limitations

There are several limitations and unanswered questions in this ‘expectation-based’ model of hallucinations and illusions. First, although Google’s ANN provides a nice visual example of the power of overweighted prior expectation, it has key structural and functional differences when compared with the human visual system. Among these are the fact that Google’s network hierarchy has many more layers than our current best estimates in the primate brain.^{11,21} Moreover, Google’s network was trained to ‘see’ objects in a ‘supervised’ way, whereby it was told what the images actually represented during training. This bears little resemblance to the ‘unsupervised’ learning that occurs in the brain.

Perhaps more importantly, expectation-based accounts of illusions and hallucinations fall short of explaining some of the most frequently encountered perceptual abnormalities in clinical practice. The hallucinations recounted by patients with psychosis or organic disorders are often bizarre, and seem entirely unexpected given the environmental context.¹⁹ Furthermore, although the account of hallucinations given above applies to all sensory modalities, it is unclear why perceptual abnormalities often occur preferentially in one sensory modality in clinical populations (e.g. auditory verbal hallucinations in schizophrenia).¹⁵ These questions remain unanswered, and pose an ongoing challenge for computational accounts of perceptual abnormalities in psychiatry.

Conclusions

Although psychiatrists ask patients about perceptual abnormalities on a daily basis, it is not often that we stop to ponder what actually distinguishes normal perceptions from perceptual distortions and deceptions. Current work in psychology, neuroscience and computer science paints a picture of normal perception as being inextricably linked to prior expectations about the state of the world. Perception depends on a delicate balance between the sensory information that we are confronted with, and the prior expectations we have about the world. If the balance is disturbed then perceptual inference becomes disrupted. Without prior expectations, perception is a mathematically ill-posed problem^{4,9} (as illustrated by *Fig. 1*), yet when prior expectation dominates the perceptual process, humans (and ANNs) can come to perceive objects which do not exist in the sensory data. As a result, the division between veridical perception and perceptual distortions or deceptions is more subtle than one of clear qualitative difference.

1.7.10 Adherence to medication in the community: audit cycle of interventions to improve the assessment of adherence

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Abstract

Aims and method To investigate whether medication adherence is monitored during follow-up in out-patient reviews. A retrospective audit was carried out with a sample of 50 follow-up patients with a diagnosis of schizophrenia or schizoaffective disorder. Following this, interventions were made prior to the re-audit (including text messaging clinicians and prompt sheets in the out-patient department to encourage adherence discussions).

Results There was an improvement on all the standards set for this audit following the interventions. More doctors had discussed medication adherence (62% second cycle v. 50% first cycle) with their patient and there was increased discussion and documentation regarding medication side-effects (60% second cycle v. 30% first cycle). More clinicians discussed the response to medication (60% second cycle v. 46% first cycle).

Clinical implications Treatment adherence is not regularly monitored or recorded in clinical notes in routine psychiatric out-patient appointments. This highlights the need for regular training to improve practice.

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- *Adherence to medication in the community: audit cycle of interventions to improve the assessment of adherence*
 - *Aims*
 - *Method*
 - *Results*
 - * *Audit cycle 1*
 - * *Re-audit*
 - *Discussion*

The World Health Organization defines adherence as the extent to which a person's behaviour – taking medication, following a diet, and/or executing lifestyle changes – corresponds with agreed recommendations from a healthcare provider.¹ Although often used interchangeably with the term 'compliance', adherence is preferred by many as it

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acknowledges the patient's role in the decision-making process.² It has been claimed that increasing the effectiveness of adherence interventions may have a far greater impact on the health of the population than any improvement in specific medical treatments.³

Non-adherence to treatment is a major barrier to effective treatment in psychiatry, particularly in individuals with psychotic disorders. Rates of non-adherence vary between 24 and 40% based on medication refill rates available from pharmacy records.^{4,5} This is understandable in view of the different populations, variety of diagnoses, variable follow-up periods and, most importantly, the different definitions and measurement methods used in research.⁶ It has been reported in the literature that non-adherence rates to medication for bipolar disorder typically range between 20 and 60%, with an average of 40%.⁷⁻⁹ In schizophrenia, a systematic review of 39 studies reported a mean rate of medication non-adherence at 41%.¹⁰ When the analysis was restricted to the five methodologically most rigorous studies, which included defining adherence as taking medication at least 75% of the time, the non-adherence rate increased to 50%.¹⁰ Non-adherence to treatment in schizophrenia is often associated with potentially severe clinical consequences.^{11,12} It is also estimated that up to 40% of the total annual cost of schizophrenia, which amounts to £400 million in the UK, could be due to non-adherence to treatment.¹³

The National Institute for Health and Care Excellence (NICE) guidelines^{14,15} recommend that treatment adherence be regularly monitored in patients with schizophrenia but there is relatively little information about how this is done in clinical practice. In general, doctors uniformly underestimate the degree of non-adherence in their patients.¹⁶

Aims

This audit was aimed at investigating whether medication adherence is monitored during the follow-up of patients diagnosed with schizophrenia or schizoaffective disorder. We also evaluated the ways in which medication adherence is discussed during out-patient reviews and recommend practice improvement.

Method

We conducted a retrospective audit in 50 patients presenting to the out-patient follow-up clinic in two UK community mental health teams providing treatment for patients within the complex care team. The clinics were based in the Black Country Partnership NHS Foundation Trust. Only patients with a diagnosis of schizophrenia or schizoaffective disorder who were currently under out-patient follow-up were included. A random sample of patients was generated by taking every fifth patient from the list provided by the clinic administrator. The last clinic letter was reviewed to collect data via the medical notes and electronic healthcare records.

The standards were identified using the NICE guidelines on medicines adherence and treatment of psychosis and schizophrenia.^{14,15} The guidelines have emphasised what should be reviewed and discussed in out-patient clinics. Specifically, they recognise that the treatment should be regularly and systematically reviewed to monitor treatment adherence. During the titration of treatment the following should be regularly monitored: response to treatment, including changes in symptoms and behaviour side-effects of treatment emergence of movement disorders weight waist circumference pulse and blood pressure adherence overall physical health.

The NICE guideline on treatment adherence explicitly states that when reviewing medication the clinician should enquire about adherence: “‘If non adherence is identified, clarify possible causes and agree any action with the patient. Any plan should include a date for a follow up review.’¹⁵” As a consequence, the standards set out for this audit were that: 100% of patients should have a discussion with the doctor regarding the medication, including response and side-effects 100% of patients should have a discussion with the doctor regarding adherence to medication if medication is stopped, reasons for this should be explored. In light of this we constructed a data collection tool for the audit (*Box 1*).

Box 1 Information gathering tool for the audit

- Was adherence to medication discussed?
- Did the clinician ask the patient about any periods when they had missed taking medication?
- Did the patient mention missing any medication and was this discussed with the patient?

- Had the patient missed any medication over the past month?
- Were side-effects of the medication discussed?
- Did the clinician ask the patient whether these side-effects had impact on their adherence?
- If non-adherence was noted to be a significant problem, were any strategies to improve adherence discussed?
- Was the response to medication discussed?
- If medication was stopped, were reasons for this explored?

Results

Audit cycle 1

Data were collected over a period of 4 weeks. The results showed that adherence was discussed and documented only in 50% of consultations, side-effects were discussed only in 30% of consultations and response to medication was discussed in 46% of cases. Further questioning in terms of assessing adherence appeared to be poorly done, with less than 10% of consultations assessing adherence in greater detail.

The results of this initial audit highlighted either a gap in clinical practice or poor documentation. The results were discussed with colleagues in the weekly audit meeting in the hospital and recommendations were made to improve the practice (*Box 2*)

Box 2 Recommendations following the first audit cycle

1. Provide formal training to doctors regarding assessing adherence during the induction for junior trainees and through a session delivered in the local teaching programme for the rest of the clinicians.
2. Provide a list of questions to be asked regarding adherence in clinics.
3. Provide a text reminder to doctors on clinic days to remind them to assess adherence.
4. Re-audit following implementation of changes.

As a consequence of the initial audit, a change in practice was brought about by introducing information sheets in each clinic room with possible questions concerning adherence to ask when assessing patients in clinic. A brief session on adherence was also added to the junior doctor induction. Then, a text message reminder was sent to colleagues. This included consultants, specialty doctors and trainees (core and foundation year 2) at the start of each clinic for a period of 3 months. The text message was very brief, reminding colleagues to discuss adherence with their patients in clinic. The colleagues' consent was sought prior to this 3-month trial. We initially planned to send the text reminders using [NHS.net](#), which provided such a service, but that stopped in early 2015. As a result, we sent out a group message using the work mobile phone.

Following this period a re-audit was carried out. It again focused on patients with schizophrenia and schizoaffective disorder but only spanned the intervention period of the prior 3 months.

Re-audit

As before, a random sample of 50 patients was selected. A similar procedure was carried out, but only patients reviewed after the initial audit were included. The same data collection tool was used (*Box 1*). The results are illustrated in *Fig. 1*.

Fig. 8: Comparison of key audit results.

The results indicated an improvement in all three key comparisons. More doctors had discussed medication adherence with their patient over the past 3 months (62% v. 50%, $P = 0.22$), and there was increased discussion with patients and

documentation of side-effects (60% v. 30%, $P = 0.0025$). More clinicians discussed the response to medication with their patients in the second audit (60% ($n = 30$) v. 46% ($n = 23$), $P = 0.16$). The results regarding further questions about adherence continued to be poor, with only 4% ($n = 2$) asking about whether the patient had missed any doses of medication. However, it was felt this may be secondary to a lack of documentation rather than being a true reflection of practice.

P -values revealed a significant difference in the two audits for the discussion about side-effects, with an improvement noted following the interventions. However, there was no significant difference on discussions about adherence and response to medication between the two audits.

Discussion

Improving treatment adherence is at the heart of clinical psychiatry. It requires building a therapeutic relationship with patients, understanding their needs and tailoring treatment accordingly. Monitoring treatment adherence is a continuous process during which the need to continue medication in the long term is regularly stressed. We need to identify the barriers and help patients and carers to overcome these. This can only be achieved if the treatment is regularly monitored for its efficacy, side-effect burden and acceptability to patients.

This audit presents a rather disappointing picture of the conversation about treatment adherence, which is not common in clinical encounters. Such discussions took place in just half of the consultations, whereas questions about possible side-effects and response to medication were raised even less frequently. The first variable improved to about 60% after regular reminders and inclusion of this topic in the junior doctor induction, but this result was not statistically significant. However, the results were statistically significant concerning discussions about side-effects, with a significant improvement noted following the interventions. This perhaps highlights the need for regular training to improve the monitoring of treatment adherence.

It has been shown that simple questions about different aspects of medication-taking behaviours can be effective in improving treatment adherence.¹⁷ Most of the information regarding assessment of adherence is based on clinical experience or limited research. Clinicians can start by asking patients ‘Have you missed any pills in the past week?’ A positive response indicates there may be a problem with adherence. Clinicians should bear in mind that patients tend to overestimate their actual adherence to therapy and that the accuracy of the self-report depends on the patient’s cognitive abilities, attitudes and openness towards the therapist.⁶ Some simple questions that can be asked in routine clinical care include: ‘How are you taking your medications?’, ‘Have you ever forgotten to take your medications?’, ‘Are you experiencing any adverse drug reactions?’, ‘How are you feeling since you started the medication?’⁶

The results of the audit should be interpreted in the light of some limitations. It is possible that these questions are asked but not regularly documented. Patient medication adherence was not directly measured in the audit. The study had a small sample size that represents a snapshot of clinical encounters, which may not be generalisable. The discussion about treatment adherence may have taken place in different settings such as the in-patient setting or with other members of the multidisciplinary team such as the community psychiatric nurse. We used text message reminders, which has helped the clinicians ask about adherence. Text messages have often been used to remind patients about medication, but they have not been commonly used to alter the clinicians’ behaviour, and can prove a simple and effective method for improving adherence with good practice.

1.7.11 Training in quality improvement for the next generation of psychiatrists

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Abstract

Quality improvement (QI) projects have been shown to positively influence patient care. They provide opportunities for trainees to present and publish their work locally and nationally, and to gain valuable leadership and management experience. We describe a pilot project to engage in QI trainees across a National Health Service trust and a school of psychiatry. After the first year of this programme over half of psychiatry trainees in the school (58% of core trainees and 47% of advanced trainees) are participating in 28 individual QI projects and QI project methodology is to become embedded in the core psychiatry training course. Specialty doctors, consultants, foundation doctors, general practitioner trainees, medical students and the wider multidisciplinary team have all become engaged alongside trainees, working with patients and their families to identify problems to tackle and ideas to test.

Contents

- *Training in quality improvement for the next generation of psychiatrists*
 - *What is a QI project?*
 - *Practical steps to carrying out a QI project*
 - * *Testing changes: the 'plan, do, study, act' (PDSA) cycle*
 - * *Implementing and spreading changes*
 - *Training in QI for the next generation of psychiatrists – a pilot programme*
 - * *Results so far*
 - * *Future plans*

Foundation doctors and core medical trainees are being trained to undertake quality improvement (QI) projects and are doing so competently and effectively. ^{1,2} QI projects have been embedded in the Foundation Programme curriculum, ³ with an expectation that trainees plan, implement, complete and present a QI project as part of their training, using the results to improve patient care. QI projects have been widely adopted across medicine and are in many areas superseding traditional audit as a way to develop services. However, the development of this methodology has been slower in the mental health field and QI projects are new to most psychiatrists. Here we outline and summarise in simple steps how to undertake a QI project. We also describe our cross-deanery project led in Avon and Wiltshire Mental Health Partnership NHS Trust and the Severn School of Psychiatry, which aims to train and support psychiatrists of the future to become actively engaged in QI projects.

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What is a QI project?

QI projects aim to improve patient safety, treatment effectiveness and efficiency, and the patient experience. They are real-time, dynamic processes involving focused, progressive, small-scale changes through a simple structured framework, which enable visible and effective change over a short period of time. QI projects are becoming increasingly important because of the limited resources available in the National Health Service (NHS). They can support service change and to achieve this may engage all professional groups, including trainees. Increasingly, evidence of QI is becoming a training requirement and is taking the place of audit as a subject to discuss at trainee reviews and job interviews.

Often the relationship between audit and QI projects is not clearly understood. Audit is also generally about quality improvement, beginning with identifying an audit subject, selecting audit standards and measuring the level of performance, then making improvements and re-auditing (*Fig. 1*). The focus is therefore on data collection.⁴ This area of practice has been criticised, as often the audit cycle has been left incomplete and the improvement part of the cycle left neglected.^{5,6} QI projects are advantageously placed as they can be seen as part of the improvement element of the audit cycle, where the focus of the project is explicitly on making a service improvement instead of collecting data.⁷ Although more complex than an audit, QI projects focus on changing complex adaptive systems and can empower doctors to investigate problems, identify solutions and work within a team to raise standards.

Practical steps to carrying out a QI project

The first step in developing a QI project is identifying a specific aspect of clinical practice that could be improved. This may be something that has been highlighted by an audit or identified by the wider team. It may be aligned to the local trust's quality and safety agenda, something that has been identified as a clinical incident or near-miss, or raised by patients or their families as a problem or idea to test. Finally, it may simply be an area recognised by local clinicians as something which is time consuming or frustrating and which could be improved. The project has a small focus initially, so rather than looking at 100 patient notes one might begin with just a single patient, or instead of trying to improve a whole hospital the focus may be on a single ward. Once an improvement has been proven to work on a small scale, it can be then tested on another patient or another ward, gradually being systematically scaled up and spread to become embedded in an entire hospital or trust. Depending on complexity, the projects can be undertaken within a 6-month training post.

The Institute for Healthcare Improvement recommend asking three questions⁹ based on the 'model for improvement' when planning a project: What are you trying to accomplish? This helps to set the aim of the project, which should be SMART (specific, measurable, achievable, realistic and timely). How will you know that a change is an improvement? This helps to think about what can be measured to illustrate the impact of the change. What would be an easy measurement? This needs to be done at baseline and then repeated at regular intervals so that the change can lead to learning and to show that it works. What changes can we make that will result in improvement? Possible ideas of changes to implement to make an improvement can be brainstormed. The current sequence of events already used can be examined and areas for improvement identified, for example by eliminating unnecessary tasks or steps, clarifying roles within the process, or by reducing delays and duplication.

Testing changes: the 'plan, do, study, act' (PDSA) cycle

The 'plan, do, study, act' (PDSA) cycles can be used as a way to develop, test and then implement a change on a small scale and in a real work setting (*Fig. 2*).^{9,10} Multiple PDSA cycles will be required to fully implement a QI project.

Stage 1: plan

The first stage is about planning a test of change. This involves taking a single idea and making a prediction as to what might happen when the change is implemented. A test and way of measuring whether what actually happens meets that prediction needs to be designed so that the impact of the change can be evaluated and learned from. This might be numerical data, such as increasing numbers of reviews of patients, or reducing numbers of critical incidents, and may also include patient and/or staff satisfaction scores or comments. Once you have determined what you are going to measure, make a baseline measurement. Determine what target you are aiming for: is it realistic? Plan the time you have available: for example, do you want to complete the project within the time frame of a training post? The planning stage can take time, but good planning will ensure a more successful project.

A useful tool for the early stages of planning a QI project is a driver diagram (*Fig. 3*), which can help to identify what steps could be taken to make an improvement. This has three columns: outcome (the aim of the project) and primary and secondary drivers. Primary drivers are the overall improvement areas that need to be addressed to achieve the desired outcome. Secondary drivers are the specific areas where changes or interventions can be made, motivated by the primary drivers.

Stage 2: do

Following careful planning, one small area of change can be identified. The second stage of the PDSA cycle is where the change is actually implemented. Measures of the impact of change should be taken from an early point and frequently to monitor the effect of the change. Any problems or unexpected results are noted while the change is carried out.

Stage 3: study

The third stage involves analysing collected data and comparing that with the predictions made. A graphical representation of the measurements taken can be a useful way of plotting results to illustrate the pattern observed as changes are made.¹² A goal line can be shown so one can see at a glance where the work is in relation to achieving the aim. Changes or improvements that are made (in repeated PDSA cycles) can annotate the graph to clearly demonstrate the impact of those changes (*Fig. 4*).

Stage 4: act

In the final stage of a PDSA cycle you can ask whether the change you made achieved your aim. If not, what modifications to the change could be made? Or what other ideas can be put in place? When you are ready to make another change, the next PDSA cycle can be outlined.

Implementing and spreading changes

By going through several PDSA cycles a small change can be tested and refined. Once a successful improvement has been proven on a small scale, it can then be tested on a larger scale. This might be across several wards or across several community teams. Once these pilot changes are proven to be successful, they can be embedded in everyday practice and incorporated into local trust policy.

Training in QI for the next generation of psychiatrists – a pilot programme

This is the first year of a pilot developed in the Severn Deanery to support core and advanced trainees to become involved in QI. The programme is being led by an advanced trainee (E.E.) as part of an Educational Fellowship awarded by the Deanery.

Until 2015 it has been a deanery requirement of trainees to carry out an audit project annually. This was amended so that all trainees are to be involved in either an audit or a QI project each year, and if an audit is undertaken trainees are encouraged to use QI methodology for the implementation of change part of the cycle. The structure of training and supporting trainees to undertake their own QI projects was adapted from the local Foundation School ¹ and the Royal College of Physician's 'Learning to make a difference' programme. ² A half-day training session was developed to teach trainees about QI and project methodology, including using PDSA cycles in practical examples, so that they could undertake their own projects. This was delivered by E.E. alongside the local trust audit and QI department lead. Trainees were encouraged to come up with their own ideas for projects and to work with other trainees to implement changes, under the supervision of a higher trainee, specialty doctor or consultant. They were supported in including the wider multidisciplinary team in developing and implementing projects, as it was felt that this would be more likely to lead to successful and sustainable changes being made.

Training was initially targeted at trainees, but a growing number of specialist doctors and consultants requested to attend and they were invited to a second training session. A resource handbook was developed and a series of short follow-up sessions put in place to provide further advice about QI methodology and to help support trainees' projects. Trainees were asked to register their projects by completing a short online form on the local trust audit and QI academy webpage so the trust can monitor participation.

Results so far

In the first year of this programme, QI projects (28 in total) are being undertaken by 58% of core trainees (21 of 36) and 47% of advanced trainees (16 of 34). A growing number of specialty doctors (6 of 54; 11% of the Trust's total), consultants (24 of 111; 22%) and colleagues from the wider multidisciplinary team, as well as foundation doctors and medical students, are becoming involved in projects. Examples of current projects being undertaken by trainees in the Deanery are shown in *Box 1*. Some trainees have chosen to undertake educational QI projects, which are being used to improve training and trainee representation in their organisations and are felt to be a way of engaging trainees in the trust.

Evaluation of the programme so far through post-course questionnaires and semi-structured interviews held at the end of projects has shown globally positive feedback from consultants and high engagement and enjoyment from trainees. Trainees report high satisfaction owing to being able to choose their own QI projects rather than being instructed what to do. All trainees report that training sessions and follow-up advice has been helpful, and feel that this should be provided to all staff across the multidisciplinary team. One trainee fed back that 'the quality improvements often end up involving other team members so it would be good to get them on side', whereas another trainee highlighted that 'training is needed for senior staff members who we may need to get on board.' Additionally, trainees reflected that most projects needed senior input to facilitate implementation and sustainability of successful changes, and several projects have needed advice on governance issues, which has been provided by the Trust's Quality Academy, responsible for audit and QI projects.

We have found that owing to the nature of our work in mental health, QI projects sometimes need to be structured in a different way than they would be in an acute hospital setting. Careful consideration is needed to find the most appropriate method of change measurement, as frequently qualitative data may be available and innovative methods of quantitative data have been required. We have also found that QI projects have often had to run over a longer period than they perhaps would in an acute hospital, perhaps owing to the longer in-patient stay in a psychiatric hospital.

During the pilot we found that forming close links with the trust Quality Academy provided invaluable assistance in setting up the scheme. The Academy has a QI project lead, who provides advice and training for trainees; they have been particularly helpful with guidance regarding governance and what permissions might need to be sought. Support

from trust medical management leads, including the medical director and director of medical education, has also been key.

As well as positively influencing patient care, trainees report that projects are providing them with invaluable opportunities for leadership and management experience. One advanced trainee leading a QI project reported they had gained ‘experience of leading a team as well as networking with other teams, management experience through attending meetings and presenting ideas, plus the project has provided opportunities to present at a departmental and regional level, as well as an opportunity for publication. This is in addition to positively influencing the future of mental health services’. Many trainees are beginning to present and publish their work and we encourage trainees to do so even if a project has not been fully successful, as much will have been learned by the trainees, and can be learned by the Trust, from all projects.

Box 1 Quality improvement projects being undertaken by trainees across the Severn Deanery

- Improving handover between trainees
- Ensuring physical health monitoring of patients prescribed antipsychotics
- Improving the quality of letters written to general practitioners
- Ensuring timely access to radiology results
- Promoting awareness of mental health in an acute hospital
- Providing support for new consultants
- Advance care planning in later life
- Improving the quality of ward rounds in forensic services
- Training nursing staff about physical healthcare issues
- Providing patients and their families with information regarding child and adolescent mental health services (CAMHS)
- Improving the local academic programme
- Developing an out-of-hours handbook for trainees on call
- Ensuring physical health assessments for patients in early intervention in psychosis
- Improving access to mental health assessments for women during the antenatal period
- Improving trainee representation across the mental health trust

Box 2 Useful resources

- The Institute for Healthcare Improvement website (www.ihl.org) provides many free resources to guide professionals through a quality improvement (QI) project (e.g. short videos which describe the steps involved).
- BMJ Quality (<http://quality.bmj.com>) has an online guide to implementing a QI project and then writing it up, producing a publishable paper as a result. It can be useful to buy a licence to do this and follow the steps (licences last for 1 year so in the case of longer-term projects it may be prudent to sign up later rather than at the start of a project). Note that demonstration of clear ‘plan, do, study, act’ (PDSA) cycles is required for successful publication. There is a growing database of published QI projects which may prove inspirational for ideas that can be developed in psychiatry.
- Local audit departments may be able to support projects directly and help identify potential QI project areas. Health Education England also publishes innovative ideas which can provide further inspiration (<http://hee.nhs.uk/>). Service user groups can be another source of ideas for QI projects.

Future plans

The training course is to be incorporated into the Deanery core trainees' course and it is expected that all new core trainees who have joined the Deanery in the 2015 summer intake will participate in a QI project each year. Formal evaluation of the impact of training and QI projects is to be undertaken for this cohort. Those trainees who have successfully completed a QI project will be encouraged to become mentors and local QI leads in their area for future projects, providing sustainability for the projects as well as supervision, teaching and leadership experience for trainees.

QI projects undertaken by trainees and their seniors are to be regularly presented at the Trust's Medicines Advisory Group meetings, which will not only spread innovative ideas but further encourage psychiatrists to become involved in projects. Connections are being developed with service user groups and local patient safety programmes to help trainees define problems to tackle and ideas to test. Links have been made with the West of England Academic Health Science Network and the Royal College of Psychiatrists' South West Division E-volution programme (www.rcpsych.ac.uk/workinpsychiatry/divisions/southwest/innovationinthesouthwest.aspx) to promote the wider spread of quality improvement and innovation.

We have compiled a list of useful resources (*Box 2*) and tips for developing a QI project (*Box 3*) drawing on our own experience in the Trust.

Box 3 Top tips for completing a quality improvement (QI) project

- **Take time to plan your project.** You may be keen to start putting in place changes and improvements, but ensuring careful planning will mean that a project is more likely to be successful.
- **Have a SMART aim.** Be clear and focused. Have a clear aim so that everyone knows what you are trying to achieve. Make your aim SMART (specific, measurable, achievable and agreed, relevant and time-bound).
- **Keep it small.** This will help ensure an improvement works. Once it is proven to work on a small scale, it can be rolled out more widely.
- **Think outside the box.** Get a group of interested trainees, consultants and the wider multidisciplinary team to think about the project with you and help brainstorm ideas for improvements. This will engage others and help the project to be a success. Get advice from your audit department.
- **Work in a team.** This is more fun, you will come up with more ideas and will feel more motivated.
- **Involve key stakeholders.** Who needs to know about the project for it to be a success? Do you need any approval to carry out changes? This might be a team consultant and team or ward manager, or it could include your clinical director, medical director or director of medical education or head of school. You could present your idea at a local academic meeting.
- **Sustainability.** Think about how you can make your improvements continue, especially if you are in a training post and will be moving on in 6 months or a year. You will need to involve your multidisciplinary team and local team managers.
- **Organise your time.** Think about how much time you have available to complete the project. Set yourself a time frame and stick to it. If you will be moving from a training post, think about whether you want to continue making changes after you leave or whether you need to do some succession planning.
- **Make the most of the opportunity.** After all that hard work, make sure you get some rewards! Present your work locally, submit a poster to a conference, and write up your work and get it published. QI projects frequently provide leadership and management experience, and often teaching opportunities which you can mention at your annual review of competence progression (ARCP), annual appraisals and at job interviews.

We are grateful to Janet Brandling and Emma Adams (AWP Quality Academy), Bridget Kelly (AWP Medical Education Project Manager) and Katherine Finucane (Consultant and QIP Lead, North Bristol Trust) for guidance and support in developing QI projects across the Severn Deanery.

1.7.12 The most important things I have learnt in my career as a psychiatrist

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Abstract

This paper is something of a patchwork, incorporating many issues that have intrigued me during 34 years of research. I have included the importance of maintaining a solid base in clinical work, alongside research activities, and being alert to the possibility of a somatic condition contributing to psychiatric symptoms. I stress the value of careful observation of patients, their response to treatments and reasons for dropping out. In addition, I have included 14 more lessons, learned from my experience of research, which I hope will be of use to those readers who aspire to become researchers.

Contents

- *The most important things I have learnt in my career as a psychiatrist*
 - *Lesson 1: always bear in mind the possibility of an underlying medical condition*
 - *Lesson 2: make careful observations on patients and their response to treatments*
 - *Lesson 3: always listen carefully to the patient's narrative*
 - *Lesson 4: the value of qualitative studies*
 - *Lesson 5: it is all too easy to become fascinated with esoteric research and to allow its demands to divert you away from basic clinical work*
 - *Lesson 6: formulating a question*
 - *Lesson 7: the danger of linear thinking*
 - *Lesson 8: searching the literature*
 - *Lesson 9: focus on a single topic*
 - *Lesson 10: applying for funding*
 - *Lesson 11: anticipate the concerns of the ethics and research and development committees*
 - *Lesson 12: appreciate the value of user-researchers*
 - *Lesson 13: team building*
 - *Lesson 14: the staff in an institution are often more institutionalised than the patients*
 - *Lesson 15: presenting at conferences*

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- *Lesson 16: writing up the results*
- *Lesson 17: submission to a journal*
- *Maintaining safety*
- *Finale*

I was attracted to psychiatry by my experience as a medical student at University College Hospital. Students on the psychiatry firm were expected to take on a psychotherapy patient, supervised by one of the senior therapists. This was the first time in my medical training that I felt valued as a clinician and treated as a responsible adult. (There is an important lesson here for improving the very low recruitment of medical students to psychiatry.)

Having graduated as a doctor I was keen to begin my study of psychiatry and sought advice from Sir Martin Roth, president of the Royal College of Psychiatrists at that time. He was adamant that I had to obtain the Membership of the Royal College of Physicians before applying for training in psychiatry. This was daunting as the Physicians' exam had a very low pass rate. I spent 3 arduous years as house officer in hospitals in London's East End before passing the exam. However, in a strange way it felt like coming home. This was because my father and his family lived in a house in the East End, at least until it was completely destroyed by a German bomb. By working with East Enders I learned to appreciate the fortitude and strength of people in the lowest stratum of society, and I never forgot that.

Throughout my career I always continued with clinical work alongside my role as director of two research teams, holding weekly out-patient clinics and having consultant responsibility for half an acute admission ward at the Maudsley Hospital and later at Friern Hospital. In addition, I supervised community mental health teams for their work with families. In this paper I will present the important things I have learned from both my clinical and my research activities.

Becoming a Fellow of the Royal College of Physicians (FRCP), I applied to the Maudsley training scheme and was accepted. When I met the other trainees in my intake, I found to my chagrin that only half of them had passed the Physicians' exam. There was one occasion in my psychiatric practice when my medical expertise proved its value. An out-patient in my clinic was complaining of anxiety and breathlessness, specifically when leaving her home and being in crowds. Naturally, I diagnosed a phobic condition and prescribed an anxiolytic. As she was about to leave the clinic, she said, 'By the way, doctor, I have a rash on my legs'. I asked her to show it to me and immediately recognised the raised purplish bumps of erythema nodosum. I referred her to the medical specialists who took over the treatment of her medical condition and cured her of her breathlessness.

Lesson 1: always bear in mind the possibility of an underlying medical condition

There is an expanding literature on comorbidity between psychiatric and medical conditions that partly contributes to the high mortality rate in psychiatric patients.

Lesson 2: make careful observations on patients and their response to treatments

Observant clinicians remain curious about puzzling aspects of everyday psychiatry, and this attitude can stimulate research projects which have the potential to lead to breakthroughs in psychiatric treatments. For example, my concern about the failure of antipsychotic medication to suppress auditory hallucinations in one in four patients led me to develop avatar therapy, ¹ a novel and effective treatment for this debilitating condition.

Lesson 3: always listen carefully to the patient's narrative

Do not dismiss the patient's belief about the cause and nature of their illness. It has been shown that the greater the disparity between the patient's and the physician's understanding of the patient's illness, the less likely the patient is to adhere to the prescribed treatment. The same caveat applies to the family carers' beliefs about the patient's illness, even if they depart widely from your own understanding. UK psychologists were the first to adapt Beck's cognitive therapy for depression to treat psychosis (CBTp). My experience of working with family carers of people with schizophrenia taught me that many low expressed emotion family carers had developed effective coping strategies for dealing with the patient's difficult behaviour, for example, distraction, reality testing and time out, which closely resembled CBTp. If professionals had listened to these family carers, and given credence to their narratives, they would have introduced CBTp much earlier, saving considerable suffering. While CBTp alleviates the anxiety of patients with persecutory auditory hallucinations, it has little impact on their frequency or volume, as opposed to avatar therapy.¹

Lesson 4: the value of qualitative studies

Qualitative studies provide information of a different nature to quantitative studies, such as patients' experience of novel therapies, but they are of equal importance. Quantitative and qualitative studies are not in competition, but complement each other and are very informative when employed in tandem. An example is the current large-scale replication study of the value of avatar therapy.² Standard quantitative measures of the participants' assessment of the power and malignancy of their persecutory voices are augmented by the participants' accounts of their experience of standing up to the avatar they have created as a proxy for their persecutor.

Lesson 5: it is all too easy to become fascinated with esoteric research and to allow its demands to divert you away from basic clinical work

Working with patients is the crucible that generates the questions that inspire research projects. I cannot emphasise enough the importance of maintaining contact with everyday psychiatric patients, and not being lured exclusively by the glamour of exotic conditions. When I was granted a chair, I was the only professor in the Institute of Psychiatry (now Institute of Psychiatry, Psychology and Neuroscience (IoPPN), King's College London) who held clinics for local patients. Happily, that situation has now changed.

My research career began in earnest in 1968 when I was offered a position in John Wing's Medical Research Council Social Psychiatry Unit at the Institute of Psychiatry. I spent 34 years as a researcher, focusing mainly, but not exclusively, on psychosis. Many of the important lessons I learned were as a result of my research experiences, and it is these I wish to share with you, in the hope that they will inspire you to undertake your own research projects. There are so many unanswered questions in psychiatry that we need many more researchers to tackle these. Sir Aubrey Lewis, who founded the Institute of Psychiatry, was dedicated to promoting research and insisted that trainees conduct their own research project in order to pass their final exam. Sadly this requirement lapsed after Sir Aubrey retired.

Lesson 6: formulating a question

Junior colleagues would often approach me, eyes shining with excitement, saying that they wanted to do research 'with a capital R'. I would then ask them what they would like to do their research on and would be met by a baffled silence, clearly expecting me to spell out a project for them. If a topic engages your curiosity, you need to do some hard thinking and formulate a question that you want to answer. A well-constructed question can be developed into a series of hypotheses, which will determine the trajectory of your research project. A well-designed research study will always generate new unanswered questions that will then form the basis for the next study. The results of a research project you did not expect are as important as those you anticipated, and should lead you on to a new study. Consider the following sequence.

When Christine Vaughn joined the Social Psychiatry Unit, she decided that she wanted to embark on a PhD to replicate the findings of Brown, Birley and Wing that high expressed emotion in family carers significantly predicted relapse of schizophrenia.³ This pioneering study was surprisingly neglected by the psychiatric community, probably because of

the prevailing adherence to biological explanations for schizophrenia. Christine and I decided that a replication would attract the attention these findings deserved.

We discussed collaborating on this project and I suggested that it would add value to the research if we included a group of patients with depressive disorder to ascertain whether expressed emotion was a specific predictor for schizophrenia or whether it would predict relapse of depression as well. In the event it turned out to be a more potent predictor for relapse of depression than for relapse of schizophrenia, as shown by Jill Hooley in her PhD in the USA.⁴ In addition, our study replicated the protective effects of medication and low contact with the carer against the stress of high expressed emotion that the earlier study had revealed. This stimulated me to consider the possibility of intervening in high expressed emotion families to lower expressed emotion and contact between the patient and the family carers. There were two compelling reasons for this: primarily, to determine the direction of causality (do high expressed emotion attitudes cause relapse of schizophrenia or does the patient's disturbed behaviour provoke high expressed emotion attitudes?); and also to determine whether our family interventions could improve the outcome of schizophrenia.

For this project I assembled a team of therapists with different areas of expertise: a cognitive-behavioural therapist with experience of working with groups, a psychodynamic psychiatrist, a psychiatrist from Germany who was a trained psychoanalyst and myself as an eclectic therapist with no strong adherence to any one theory of family functioning. The therapy used by this heterogeneous team was remarkably effective, succeeding in reducing the patients' relapse rate over 9 months from 50% to less than 10%.⁵ The success of this trial led to two more randomised controlled trials (RCTs), including a cost-benefit study. The accumulation of this evidence plus ten replications in different countries led the National Institute for Health and Clinical Excellence (NICE) to recommend that family carers of a patient with schizophrenia must have professional input. This outcome justified the 15 years it took to complete the sequence of RCTs.

Lesson 7: the danger of linear thinking

Linear thinking results from the idea that causal action flows in one direction only, from cause to effect, from producer to produced, analogous to a series of billiard balls in motion. The issue of linear thinking in the social sciences, including psychiatry, merits some discussion.

Linear thinking forms the basis of almost all biological research in psychiatry. It has a long history, having been first formulated by the Greek philosophers Anaximander and Plato. In the modern era, Von Bertalanffy was the first to challenge linear thinking.⁶ He stated that we must think in terms of systems of elements in mutual interaction. At that time, the development of cybernetics promoted systems thinking. The process of feedback whereby missiles could monitor and correct their trajectory was recognised as analogous to the biological system's capacity to maintain and organise itself in nature. This formulation was seen as very relevant to the process of family therapy. The family theorist Gregory Bateson wrote: 'I think that cybernetics is the biggest bite out of the Tree of Knowledge that mankind has taken in the last 2000 years'.⁷ It is ironic that a technology developed to destroy human beings should contribute to our understanding of family relationships.

Homeostasis is a concept fundamental to systems theory. It is achieved by negative feedback loops, which stabilise the system by reducing deviation between goal and performance (cf. missiles). By contrast, positive feedback loops reinforce or amplify deviations, producing novelty and instability and an increase in the complexity of the system, leading to new properties. Applying this understanding to social relationships, which are of central importance to psychiatry, feedback represents the direct perceptual report of the effect of one's behaviour on others, for example, the perception of a smile in response to one's own smile.

Robert Dubin considers that the difficulty of avoiding linear thinking stems from our propensity to look for isolatable one-way causes.⁸ Feedback processes can easily be overlooked, not only because the linear perspective is the dominant mode, but also because they tend to be unnoticed owing to their very pervasiveness.

Earlier I stated that one compelling reason for working with high expressed emotion families was, I quote myself, 'to determine the direction of causality'. You will now recognise this as a prime example of linear thinking. In actuality I was aware that there were multiplex interactions between patients and their family carers, but this was too complex to investigate at that time.

Now I will give you some practical advice on initiating research and carrying it through to publication.

Lesson 8: searching the literature

Electronic databases have made this much simpler and more efficient. Decide on the criteria for your search, and be overinclusive rather than underinclusive (obviously, irrelevant papers can be deleted without needing to read them). Summarise what has been established. This requires a critical attitude to research by others, however eminent they may be. Weigh up the evidence and come to a conclusion. This may be that the question you formulated has been adequately answered, in which case, back to the drawing board!

Lesson 9: focus on a single topic

Avoid being too ambitious. If your initial project produces useful results, you can always extend it. Seek advice from experienced colleagues. They can warn you about pitfalls in your chosen area of research.

Lesson 10: applying for funding

When applying for funding, choose the funding body carefully, paying close attention to their mission statement. It is often worthwhile beginning with a pilot study which can be mounted with minimal or no costs. For instance, determining whether your catchment area will provide sufficient patients for your study. This will show potential funders that you are a serious contender.

Lesson 11: anticipate the concerns of the ethics and research and development committees

Gaining approval from these committees is now an obligatory hurdle to surmount. There are a number of actions you can take to improve your chances of being approved. Anticipate objections from committee members, and be prepared to be able to counter them. In my recent trial of avatar therapy, I anticipated that there would be anxiety in the committee about patients' response to being faced with their persecutor in the shape of the avatar. Therefore, with the aid of my IT specialist, we constructed a bright red 'stress button' which the patient could press in case of high anxiety or for any other reason. This switched off the avatar image on the monitor, which was replaced by an image of a tropical beach with *The Four Seasons* by Vivaldi playing in the background. In the event, only 2 patients out of 18 pressed the stress button, and both were able to continue with the session after reassurance.

Lesson 12: appreciate the value of user-researchers

Involve service users in your study. They should certainly be asked to read the instructions for potential participants, and to suggest changes to the wording. Users can be recruited to play a more important role in your study. The IoPPN has established a list of user-researchers. These are users who have largely recovered from a psychiatric illness and are willing and able to be trained in research procedures. For example, in my avatar therapy trial, I employed a user-researcher who had heard voices himself 8 years previously and was now completely well. I trained him in the assessment tools and he achieved high interrater reliability with me, enabling him to undertake the role of an independent assessor, for which of course he was paid. The employment of users will be greatly appreciated by the ethical committee. If you do appoint a user-researcher, they must be included as an author.

Lesson 13: team building

If you are ambitious and wish to undertake a major study you will need a team, preferably multidisciplinary in nature. Diversity of professional expertise is an asset, as we experienced in our development of working with families. Consult a statistician early on in designing the study. Statisticians are understandably grumpy if they are asked at the last minute to conduct the data analysis without having given any prior input. Develop a cohesive group and deal with rivalry. The media often depict research as a gentlemanly pursuit of the truth. That is a fallacy. There are glittering prizes to be won through research, and the world of research is as competitive and cut-throat as multinational capitalism.

Be fair to junior members of the team. Encourage and support them and give them experience in presenting and appropriate representation in publications. In mid-career I left the Maudsley to take charge of a dysfunctional research group working in a traditional psychiatric hospital. It had been managed by two absentee directors and was in a state of anarchy, with one member of staff suing the directors. The aggrieved staff member left and I had to dismiss another member of staff. I knew my intervention would be resented so introduced a Friday lunch-time picnic in the extensive grounds of the old psychiatric hospital, followed by a game of croquet on the lawn next to the former medical superintendent's villa. I reasoned that being able to knock my balls around would diffuse aggression, and so it did.

There were two reasons for my leaving the Maudsley to work in Friern, a typical 19th-century asylum. One was to emerge from the shadow cast by John Wing, the director of the Medical Research Council Social Psychiatry Unit. Although John left me to pursue my own research interests, he was nearing retirement and I knew that to stand a chance of taking over the directorship of the Unit, I would have to prove that I was capable of mounting important research independently from him. The other reason was the split in the profession of psychiatry between the academics and psychiatrists working in provincial hospitals; the latter felt overburdened by their workload and disregarded by the academics, whom they saw as existing in a 'cloud 9' environment, protected from the realities of jobbing psychiatry. Given that in that era the great majority of psychiatrists were working in antiquated buildings, with insufficient support from psychologists, occupational therapists and other ancillary staff, I felt that I needed to experience the reality of life in an asylum.

It felt to me like another world. The Italianate Gothic frontage was forbidding, as was the original plaque designating the building as the West Sussex Pauper Lunatic Asylum. The entrance corridor was a third of a mile long. At that time it was the longest hospital corridor in Europe. It had windows throughout its length, but they were so low I could only see through them by stooping uncomfortably. At the end of the corridor was a faint glimmer of light from the world outside. Despite the gloom that descended on me, in time I began to appreciate the good qualities of Friern. It was set in extensive grounds, which included a football field and a 9-hole golf course, on which I never saw anyone playing. There was a chapel and a synagogue, and a factory outlet where low-cost clothes were available. Although the main gate was always open, very few patients ventured out into the street. Patients wandered around the grounds unhindered and sexual liaisons were undoubtedly formed, as one of the long-stay patients in my care regularly developed gonorrhoea. I began to appreciate how easy it would be to become accustomed to the environment of the asylum and to forget the existence of the outside world.

Lesson 14: the staff in an institution are often more institutionalised than the patients

Not long after I moved to Friern Hospital the Regional Health Authority decided to close Friern and Claybury hospitals in accord with the government policy of that time. I realised that this was a unique opportunity to evaluate this policy. I succeeded in obtaining funding from the Regional Health Authority, later supplemented by funding from the Department of Health. This enabled me to form a group of researchers under the title of TAPS: The Team for the Assessment of Psychiatric Services. Friern Hospital had been opened in 1851 with 1000 beds. The number of patients grew exponentially, reaching 2500 in the 1940s. The discharges of many patients between 1940 and the beginning of the TAPS programme had reduced the number of long-stay patients to 800.

The first step in the TAPS project was to conduct a comprehensive assessment of the symptoms and the problem behaviours of all the remaining patients in the two hospitals who did not have dementia. Complete data on all 700 patients were collected by the team, a mammoth undertaking. A 5-year follow-up was conducted on this group of patients, of whom only a tiny number were lost to the study, thanks to the efforts of the excellent administrative assistant who made regular checks on the patients' locations in the community. Meanwhile, an extraneous researcher, not a TAPS

member, carried out a survey of all the nursing staff looking after the remaining patients, asking them to estimate the number of patients who could be resettled in the community. The total percentage estimated by the nursing staff was one-third. If this was accurate, the possibility of closing the two hospitals within the 10-year limit set by the managers was negligible. However, the TAPS team had already begun asking individual patients for their preferences when the hospitals closed: one-third wanted to leave the hospital and live in the community, one-third opted to stay in the hospital and one-third were uncertain. In the event, all the patients considered suitable to live in the sheltered homes in the community by the resettlement teams adapted well to life in the outside world, and when asked where they would prefer to live a year later, 84% wanted to stay where they were.⁹

Friern hospital did close on time 10 years after the decanting began. The Claybury closure was delayed because the consultants there went on strike against the closure decision, but the strike collapsed after 6 months and the closure went ahead. So psychiatrists can be as institutionalised as nursing staff.

Lesson 15: presenting at conferences

Always try out your presentations with a sympathetic audience and take note of their criticisms and comments. The golden rule for slides is ‘never put more on a slide than you can get on a T-shirt’. I am often amazed at seeing experienced researchers cramming a slide with illegible lists of data and *P*-values and then saying to the audience, ‘You probably won’t be able to read this but what it shows is ...’ – if it can’t be read, don’t show it!

Lesson 16: writing up the results

Avoid the pall of conventional scientific writing. Break through the conventional anonymity of the passive voice. Humanise your writing to make it attractive to the reader. Keep the language simple and avoid too many technical terms. Always spell out abbreviations the first time they appear in a paper, including the abstract. Pay special attention to the clarity and layout of tables and figures – ensure that they are essential for the understanding of your results. Editors dislike large numbers of tables and figures since they occupy space that could be used to publish another paper. Avoid duplicating results in the text as well as in tabular form.

Lesson 17: submission to a journal

Choose the journal carefully, surveying past issues for the types of papers published. Always read instructions to authors with great care and observe them, particularly the word limit – if you exceed this, your paper will bounce back rapidly. Find out the proportion of submissions accepted, if possible. Always treat the reviewers’ comments seriously and couch your responses respectfully, even if you think the reviewers are idiots. Don’t give up at the first rejection, but look for alternative journals. There are so many journals being published now that there is considerable overlap in their remit. If you are inexperienced, do not be too ambitious in choosing a journal with a high impact factor. I sent my recent paper on avatar therapy serially to *Nature*, *New Scientist* and *Archives of General Psychiatry*, all of which rejected it without sending it for review. So much for hubris! It was eventually published in the *British Journal of Psychiatry*. I was mollified when following a press conference the paper went global.

Maintaining safety

I am interpolating this issue, not to raise your anxieties, but to convey the important advice I received from a senior colleague early in my clinical career. What he said was ‘never let the patient get between you and the exit door of your clinic’. A colleague and friend of mine at the Maudsley Hospital was unaware of this advice and preceded the patient into his clinic; the patient then stabbed him in the back with a pair of scissors. Fortunately, the wound was superficial.

Finale

Do not be put off by the hard work and inevitable disappointments. They are more than compensated for by the intellectual excitement generated by research and the knowledge that you are improving the lives of your patients.

1.7.13 Dudleigh Oscar (John) Topp FRCPsych, MBBS, MFCM, DPM

: Formerly Principal Medical Officer, HM Prison, Brixton

John Topp

date

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- *Dudleigh Oscar (John) Topp FRCPsych, MBBS, MFCM, DPM*
– : *Formerly Principal Medical Officer, HM Prison, Brixton*

John Topp, who died on 23 February 2016, was a Principal Medical Officer who was one of the first to draw attention to the increased rate of suicide among the prison population. In the late 1970s, he showed that suicide was three times as common in prisoners as in the general population, that it was most common in those with sentences longer than 18 months and that the greatest risk was in the first few weeks in custody. ¹ He subsequently advised on suicide prevention in prisons.

Topp always felt deeply that the prison medical services were often unfairly maligned. He knew that the antiquated estate and restrictive budget did nothing to enhance the practice of modern medicine; yet, he felt that on the whole prisoners were given good care within these constraints. He found the hospital officers of the Prison Medical Service to be generally excellent but felt that many were denied opportunities to achieve the nursing qualifications they desired. Much criticism, he felt, would have been spared if training had been far better resourced and achievement suitably rewarded. Nevertheless, his view was that although the service was not superficially attractive, for those prepared to put effort and interest into it, there could be considerable work satisfaction – something he enjoyed himself despite much frustration.

Dudleigh Oscar Topp, always known as John, was born on 11 September 1924 in Hove, the son of a bank manager. A practising Roman Catholic, he was educated at the Xaverian College in Brighton and attended King's College London, from where he went to Charing Cross Hospital Medical School, qualifying in 1949. After house posts at Oldchurch Hospital, Romford, he served as a captain in the Royal Army Medical Corps in Northern Ireland. He joined the Prison Medical Service in 1953 at Wakefield prison and later became Senior Medical Officer at Brixton prison, from where he was promoted to Principal Medical Officer to serve regionally and centrally, administrating various aspects of the prison medical services.

He retired on medical advice in 1984 but remained actively interested in prison affairs and wrote books on the history of the Prison Medical Service. His particular regret was that the Prison Medical Association, which he founded towards the end of his career with the object of promoting the highest standards of medical care in English prisons, did not survive his retirement. However, he lived to learn of the inception of an Academy of Prison Medicine which naturally had his full approval.

Living latterly in Weymouth, where he had the close companionship of two local retired hospital chief officers, he became the founder president of the Pickering Society, a nationwide group of retired hospital prison staff of all categories. It was named after a respected director of prison medical services under whom most of them had served.

Soon after qualifying, John married his childhood sweetheart Joyce Stoner, a nurse from Brighton. They had four daughters, three of whom trained as nurses at the Westminster Hospital, where two of them met and married doctors. There are now eight grandchildren and five great-grandchildren. Tragically, Joyce died in 1975 of carcinoma of the stomach, following which he married her friend Peggy Lange, then a Principal Nursing Officer in Sunderland.

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1.7.14 Anthony Carl (Tony) Kaeser FRCP, FRCPsych

: Consultant in Old Age Psychiatry, Basildon sector, Thameside Community Healthcare NHS Trust

Mike Lowe

date

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- *Anthony Carl (Tony) Kaeser FRCP, FRCPsych*
 – *: Consultant in Old Age Psychiatry, Basildon sector, Thameside Community Healthcare NHS Trust*

Tony Kaeser, who recently died aged 84, was one of the pioneer consultant psychiatrists who from the 1960s onwards developed departments of psychological medicine in district general hospitals at the time when long-stay mental asylums were being phased out. In the years following his appointment in 1969 as a general adult psychiatrist to Runwell Hospital, he was involved in innumerable planning meetings with the then North East Thames Regional Health Authority to advance the new purpose-built department of psychological medicine at Basildon District General Hospital. This was eventually opened in 1977. It was Tony's attention to detail which improved the ward day areas for the patients – initially they were going to look out on to industrial sites, but with some reconfiguring of the layout the views were transformed to field and countryside vistas.

In the 1980's Tony was appointed convenor for training approval visits for the East Anglian Division of the Royal College of Psychiatrists. He provided liaison psychiatry services at Basildon District General Hospital and was the consultant psychiatrist for the Regional Plastic Surgery and Burns Unit at St. Andrew's Hospital, Billericay for 11 years. He was Chairman of the Basildon General Hospital District Consultant Staff Committee. For the last 7 years of his career he chose to work full time in psychogeriatrics. Despite his heavy clinical load, his professional services were extended willingly to staff and their families from all areas of the National Health Service (NHS) in South Essex.

He was a Foundation member of the Royal College of Psychiatrists. The College recognised his abilities by inviting him in 1984 to act as convenor leading the first team to visit the large Hong Kong training scheme. Shortly before retiring, Tony became a General Medical Council Examiner for doctors with health problems and for a number of years in retirement was one of two Lord Chancellor's Visitors for England. He was also an Area Visitor for the Royal Medical Benevolent Fund until he reached their retirement age.

Tony was born in London in 1932. He qualified at St. Mary's Hospital in 1957 and after house jobs in general medicine he obtained the MRCP and entered the Maudsley training scheme. After obtaining the DPM he was appointed senior

registrar at the Maudsley and Institute of Psychiatry. From there he was appointed consultant psychiatrist to Runwell Hospital.

A gentle, kindly, impressively ethical doctor, he was considered in his thinking and conversation but precise, soundly analytical and unfailingly wise. His manners to everyone he encountered were impeccable and right to the end he retained his genuine interest in people. When he became ill himself, he wanted to know about the lives of his carers.

His personal life was varied and fulfilling. He inherited his father's stamp collection. He loved a wide range of music and enjoyed playing his pianola. He joined in regular contract Bridge sessions with medical colleagues throughout his career and retirement, and these only came to an end 4 years before his death. Tony had a great sense of fun and participated in the staff Christmas show for patients. His performances in playing the femme fatale were such a success that he resigned himself to being typecast. He took delight in the achievements of the members of his family. His wife Wendy was an NHS health visitor and they had 2 children and 6 grandchildren, one of whom is a dancer with the Royal Ballet.

In the latter years of his retirement he experienced gradually declining health. He had been diagnosed with a rare hereditary form of amyloid heart disease and although his cognitive faculties were largely undiminished, progressive cardiac failure slowly developed and he died on 18 May 2016. In line with his commitment to humanistic principles, Tony donated his body tissues for the benefit of others and his brain for research into amyloid disease.

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1.7.15 Klaus Minde MD FRCP(C)

: Formerly Chairman, Division of Child and Adolescent Psychiatry, McGill University, Montreal

Philip Graham

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- *Klaus Minde MD FRCP(C)*
– : *Formerly Chairman, Division of Child and Adolescent Psychiatry, McGill University, Montreal*

Klaus Minde, who recently died at the age of 82, was an academic child and adolescent psychiatrist renowned for his pioneering work in a variety of fields – especially infant psychiatry – and for the development of child mental health services in low-income countries. His early research was in the field of hyperactivity in children. Working with Gaby Weiss and John Werry, he was one of the first to carry out studies of medication in this condition.

In 1961, shortly after he had started his training in child psychiatry, his first child Thomas was born prematurely; he and his wife Nina, a psychologist, were not allowed to touch him – they could only gaze at him through the window of the nursery until they could take him home when he was 4 weeks old. This distressing experience stimulated Klaus' interest in the development of premature babies and the ways parents could be involved in their care. He carried out a number of observational studies¹ which – allied with the development of ideas on mother-infant bonding promoted

by two paediatricians, Marshall Klaus and John Kennell – helped to change practices in the nursing care of premature babies.

From 1971 he spent 2 years on secondment setting up a child psychiatric clinic at Makerere University, Uganda. As well as establishing a service, he carried out a significant amount of research, conducting comparative studies of disorders in Canada and Uganda.² Idi Amin, the brutal, idiosyncratic president of the country, was in power at the time. Klaus described how Amin, as chancellor of the university, required every professor to be present when he had decided to address them. While everyone was waiting for him, 3 empty limousines would arrive, followed – 3 minutes later – by Amin on a bicycle that he had mounted just before entering the university.

In 1983 he spent a sabbatical year in London, where he met John Bowlby, whose work on attachment had so impressed him. He was able to persuade Bowlby to visit Canada to talk about his ideas. After his official retirement from his chairmanship in 2000, he and his wife spent a year in Johannesburg, South Africa, where they worked with very disadvantaged children and families in the townships of Alexandra and Soweto. Once again he carried out research, this time on the assessment of attachment.³ In addition, Nina and he organised a mutual support group of grandmothers looking after their grandchildren (orphaned by the country-wide epidemic of AIDS), which became a model for similar groups in the area.

Klaus always had a strong interest in the plight of disadvantaged children and their need for psychiatric services. From 1994 to 1999 he worked with native Canadian children, acting as a consultant to the Cree Board of Health in Mistissini, Quebec; from 2009 to 2015 he was a consultant to Dans La Rue, an organisation caring for street children in Montreal.

Klaus was born in Leipzig in 1933 in the same year as Hitler came to power in Germany. His father was technical director of Germany's public radio and strongly opposed the Nazi movement. As one of the few senior people who had refused to join the Nazi party, his father was promoted after the war but was later sacked when a communist state was imposed in Eastern Germany in 1949. Klaus attended a humanist school and also rebelled against the ruling party. He wanted to study medicine but given his family background and outspoken political views, he had no chance of entering an East German medical school. Leaving his family behind – it was many years before his mother could join him – he travelled to West Germany and obtained a place to read medicine in Munich. After qualification he won a Fulbright scholarship which enabled him to go to New York and gain experience in paediatrics at Bellevue Hospital and psychology at Columbia University. He then undertook residency training in psychiatry at McGill University in Montreal, remaining in Canada, except for his sabbatical periods, for the rest of his professional life. He was Director of Research at the Hospital for Sick Children, Toronto, from 1973 to 1986 and after a spell at Queen's University in Kingston, Ontario, he was appointed Chairman of the Division of Child and Adolescent Psychiatry at McGill University from 1989 to 2000.

With his boundless energy and enthusiasm, Klaus could set audiences alight with his rhetoric, promoting the cause of better care not just for newborn babies but for children with physical and mental disabilities and for the socially disadvantaged. His whole body, especially his gesticulating arms and plentiful hair, seemed to be engaged in getting over his messages to his audiences, who loved it!

After retirement he continued to mentor colleagues and see patients until he suffered a major stroke shortly before his death on 6 July 2016. He is survived by Nina, his three sons and four grandchildren.

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1.7.16 College Members whose deaths were reported at Council meetings between October 2015 and October 2016

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Adabie, Kenneth Horn, *Affiliate*, Croydon, London, UK
Al-Hindawi, Amir Abdul Amir Ali, *Affiliate*, Rotherham, South Yorkshire, UK
Arshad, Muhammad, *Affiliate*, Cheadle, Cheshire, UK
Baker, Ronald Stewart, *Fellow*, Southwold, UK
Barker, Montagu Gordon, *Fellow*, Bristol, UK
Barker, Philip, *Fellow*, Calgary, Alberta, Canada
Betts, Timothy, *Fellow*, Birmingham, UK
Bhate, Suryakant Ramji, *Fellow*, Newcastle upon Tyne, UK
Browne, Elizabeth Foster, *Foundation Member*, London, UK
Burrows, Graham Dene, *Fellow*, Richmond, Victoria, Australia
Burvill, Peter Walter, *Fellow*, Como, Western Australia, Australia
Carney, Michael William Patrick, *Fellow*, Bathampton, Bath, UK
Cheyne, Alexander Ian, *Fellow*, Kippen, Stirling, UK
Choudhary, Prasoon Chandra, *Fellow*, Aberdare, UK
Davies, Stephen Lewis, *Member*, Breaston, Derby, UK
Denson, Raymond, *Member*, Thunder Bay, Ontario, Canada
Discombe, Anne-Marie, *Member*, Glasgow, UK
Edmonstone, Yvonne Grace, *Fellow*, Inverness, UK
El Gorashi, Gamal El Din Suleiman, *Member*, Canterbury, UK
Fielder, Michael Hugh, *Member*, London, UK
Forrest, Derek William, *Fellow*, Wirral, UK
Frame, Archibald Hamilton, *Fellow*, Glasgow, UK
Galea, Abraham, *Fellow*, Mosta, Malta
Galley, Margaret Walton, *Foundation Affiliate*, Castletown, Isle of Man
Galley, Wilfred, *Foundation Affiliate*, Castletown, Isle of Man
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Graham, Alexander John, *Fellow*, Law, Carlisle, UK
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Hall, Peter, *Fellow*, Upton upon Severn, UK
Halpenny, John Vincent, *Member*, Swords, Co Dublin, Ireland
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Kerry, Raphael James, *Fellow*, Sheffield, UK
Lipscomb, Colin Francis, *Member*, Qualicum Beach, British Columbia, Canada
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1.7.17 A Practical Guide to the Mental Capacity Act 2005: Putting the Principles of the Act into Practice

Martin Curtice¹

date

2017-2

¹

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- *A Practical Guide to the Mental Capacity Act 2005: Putting the Principles of the Act into Practice*

The Mental Capacity Act 2005 (MCA) – which applies specifically to England and Wales – pervades several aspects of daily clinical care within many clinical as well as non-clinical environments, such as care homes.

The authors of *A Practical Guide to the Mental Capacity Act 2005* – whose backgrounds are social work and advocacy – observe that ‘Seven years on [...] the MCA is still not being adhered to nor fully embraced within practice’. Their aim was to produce a ‘theory-to-practice breakdown of the MCA’ and this was readily achieved with a fluent and erudite style of writing and continued emphasis on the practical aspects of implementing the MCA. There were useful case studies and checklists for practice, as well as practical top tips such as videotaping advance statements. A minor gripe would be that, if anything, such checklists and top tips could have been used more often throughout the book; for example, at the end of each chapter. The most useful chapter was that on best interests – very salient practical advice was afforded on the best interests process and assessments, including how to chair meetings and using documentation. This chapter tried to demystify the abstract concept of best interests by conceptualising such decisions as complex and less complex. Another strong chapter – probably reflecting the authors’ expertise in this area – was on advocacy and empowerment, which examined the various roles of the independent mental capacity advocate within the MCA process.

The undoubted highlight was the evocative account of the 2004 case of *HL v UK* which was the catalyst for the introduction of Deprivation of Liberty Safeguards (DoLS) legislation, to plug the now legally infamous ‘Bournewood gap’. HL was a patient with autism and challenging behaviour who was admitted to hospital on an informal basis. He was regarded as being compliant with care but unable to consent to admission; however, this was found to be a contravention of Article 5 of the European Convention on Human Rights (the right to liberty). The account is written by HL and his carers Mr and Mrs E. Although events regarding HL and his carers began in 1993, the account is a fascinating perspective of one of the most, if not the most, important mental health cases in legal history in terms of its potential impact on tens of thousands of people, carers and clinicians on a daily basis. The authors provide useful views on how and why the DoLS legislation has not been implemented well so far.

Overall, this is an excellent short text which should be required reading for those involved in care touching upon the use of the MCA, and would be ideal for medical and nursing students. But with the Court of Protection seemingly currently engaged in trying to crystallise the core essence of DoLS legislation – and with further recent key judgments emerging in the areas of best interests, end-of-life care and DNACPR (do not attempt cardio-pulmonary resuscitation) – it seems likely that this, as well as other similar guides, will need to be updated again in the near future to keep the readership up to date with key developments.

1.7.18 A Clinician’s Brief Guide to the Mental Capacity Act (2nd edn)

Martin Curtice¹

date

2017-2

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Contents

- *A Clinician's Brief Guide to the Mental Capacity Act (2nd edn)*

This book aims to provide a comprehensive overview of the Mental Capacity Act 2005 (MCA) – which applies specifically to England and Wales – and its implementation in practice.

The authors are all practising psychiatrists and although the style and content is tailored for a medical readership, the guide is suitable for all grades of doctors and all specialties, not just psychiatry. It is also ideal for medical and nursing students. With a punchy and concise writing style, the book has copious amounts of practical advice for clinicians throughout, and at times uses a common sense question-and-answer format with questions that clinicians are likely to pose, which reflects real-life practice.

Importantly, this work sought to translate lengthy and wordy court judgments into concise and simplified reviews outlining key basic principles for clinicians to use in daily practice. Possibly the most interesting chapter was that regarding the role of the Court of Protection. This busy court – which according to the authors hears approximately 23 000 cases annually, a figure that will surely inevitably rise – is often referred to in the media as the secretive court. However, this excellent chapter goes a long way in debunking various perceptions. It also explains the court process and is infused with sage, detailed and practical advice, from how to handle requests for assessments, writing reports and interviewing patients to giving evidence in court and even finding your way there if you need to! The authors suggest that Court of Protection proceedings tend to be more ‘informal and inquisitorial than formal and adversarial’ but that they can still be stressful, which is why they wish readers ‘good luck’. But despite the suggestion that a degree of luck might be needed, anyone new to such court proceedings will be far more prepared having read this chapter than not.

Needless to say, the thorny issue of implementing Deprivation of Liberty Safeguards (DoLS) was discussed at length in a chapter that provided important context by describing the evolution of this legislation and case law. Notwithstanding, owing to a glut of more recent key DoLS judgments, the book is already a little out of date as DoLS case law and guidance have evolved rapidly. It seems likely that an update will be needed soon to keep readers informed of key developments. Nevertheless, there was a good description of practical issues in using and applying DoLS since the *Cheshire West* case in 2014, a case which triggered an upsurge in the use of this legislation. The authors aptly summed up the state of DoLS understanding from further case law since *Cheshire West* by saying it did ‘little to ease the quandaries of health and social care staff in their decision-making in relation to deprivation of liberty’.

Another notable chapter was the one on the assessment of capacity, which provided comprehensive and practical advice, breaking the process down into its components and getting into its minutiae, thus challenging the reader to re-evaluate their own methods for assessing capacity. Other useful sections included advice on how to resolve conflict emanating from complex best-interests meetings and on seeking consent. Although not concluded at the time of publication, the latter resonates with the 2015 seminal Supreme Court case of *Montgomery v Lanarkshire* which has redefined the rules of seeking consent and has implications for how clinical negligence will hence be assessed.

All in all, this is an excellent guide which would aid those involved in care touching upon the use of the MCA.

1.7.19 Motivational Interviewing: A Guide for Medical Trainees

Ed Day¹

date

2017-2

Contents

- *Motivational Interviewing: A Guide for Medical Trainees*

I first encountered motivational interviewing as a trainee when I read Miller and Rollnick's classic 1991 book *Motivational Interviewing: Preparing People to Change Addictive Behavior* and the key concepts have always resonated with me. Although it seems obvious that a man requiring major surgery due to cardiac disease should stop smoking, it is rarely helpful to insist that he does so. People have ambivalent feelings when it comes to changing entrenched behaviours and it is often better to elicit their own reasons for change. After all, it has been said that people believe what they hear themselves say. Perhaps because of its apparent simplicity, motivational interviewing has become an important technique for most UK addiction therapists and its influence has gradually spread to other areas of practice. Therefore, does the world need another book on motivational interviewing?

This book is written by a group of trainees spanning all specialties of medicine, with the goal of demonstrating how motivational interviewing can fundamentally improve the doctor-patient relationship. Motivational interviewing is a way of being rather than an intervention and the book reminded me of its roots in Carl Rogers' person-centred approach to therapy, based on building empathy, congruence and positive regard. As someone who bemoans the biomedical nature of British psychiatry, I was surprised that it succeeded in reawakening my interest in interviewing skills that not only elicit information but also provide therapeutic insights and direction.

Like the practice of psychiatry, motivational interviewing is straightforward to do but hard to do really well. It is not easy to learn from books and so the editors provide lots of dialogue to illustrate key points, and a series of videos on a linked website. They add personal reflections, as well as illustrations of the integration of motivational interviewing into electronic case records and its use in less familiar settings such as paediatrics. There is also a practical emphasis on how to teach and supervise motivational interviewing in the real world. Their enthusiasm for the subject was infectious and I was left in agreement that learning motivational interviewing should be a priority in medical education.

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1.7.20 Waking Up: Searching for Spirituality without Religion

Matthew M Nour¹

date

2017-2

Contents

- *Waking Up: Searching for Spirituality without Religion*

Sam Harris has been waiting to write this book for over a decade. This may surprise some. The subject matter – dealing reverently with human spiritual experience – is at odds with Harris’ (in)famous public persona as a strident critic of religion. Yet, for the past 20 years Harris, who has degrees in philosophy and neuroscience, has been on a personal quest in search of ‘transformative insights about the nature of one’s own consciousness’.

Harris defines spiritual practice as the efforts people make, through meditation, use of psychedelics or other means, to fully bring their minds into the present. This practice leads to the insight that our sense of having a unified self is an illusion and that this illusion causes us much psychological suffering. Harris aims to convince his reader of this using philosophical thought experiments, discoveries of contemporary neuroscience and personal experience. He also encourages his reader to test these hypotheses about human consciousness ‘in the laboratory of your own mind’, through meditation practices inspired by Buddhist Dzogchen and Vipassana teaching. He argues that these spiritual insights can be accepted independently of the metaphysical baggage of traditional religion, and laments that until recently they have been under-investigated by an ‘impoverished’ neuroscience.

The resulting book is an ambitious mosaic: part memoir, part neuropsychology text and part meditation guide. A key strength is Harris’ clear, lively and personal writing style, which instils the prose with an endearing conversational air. Many readers will feel, however, that by focusing almost exclusively on solitary meditation practices and psychedelic drug-induced experiences, Harris has omitted important dimensions of human spiritual experience, such as the self-transcendence which may be arrived at when contemplating art or engaging in communal ceremonial practices. Moreover, the occasional barbed criticism of monotheistic religion will deter some readers, but play well to the Harris faithful.

Waking Up is a book for the general public and is not intended to have a clinical application. Why, then, is it being discussed in the pages of this journal? My answer is twofold. First, as psychiatrists we are interested in all dimensions of human experience. Consequently, the growing scientific interest in the mystical/spiritual experience and its potential therapeutic implications is of great importance for our specialty. Second, psychiatrists are humans and all humans may benefit from being reminded from time to time that our conventional sense of a unified self sitting some 2 inches behind the eyes is likely to be a pernicious illusion.

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1.7.21 Deconstructing the OSCE

Deborah Cooper¹

date

2017-2

Contents

- *Deconstructing the OSCE*

This volume contests that it is possible to develop a generic way to approach different Observed Structured Clinical Examination (OSCE) scenarios, regardless of medical specialty. Perhaps surprisingly, it is not filled with possible exam scenarios, but rather looks at the underlying barriers to good performance. In this regard, it provides a behavioural and psychological schema for approaching the OSCE. The book makes no apologies for aiming at those who have already had a previous attempt at passing the OSCE, and given that pass rates for membership exams are generally around 50–60%, it is a resource available to a great number of doctors in training.

The initial chapters look at the common emotional and cognitive responses which typically follow an unsuccessful examination attempt – they do a good job of validating these experiences and feelings. Subsequent chapters aim to improve general exam strategy. These include the perhaps more neglected areas of good exam performance; for example, how to establish rapport with the actor or patient, and how to run a good study group and learning environment. An especially useful chapter is that which explores challenging scenarios such as ‘the angry relative’ or ‘the crying patient’. Although these passages are brief, practical tips are given to aid communication in these often difficult situations.

In addition, there are worksheets that support the doctor in understanding that the way they think about the exam influences their emotions and, ultimately, their exam performance. The psychiatry trainee will be no stranger to this process; however, I wonder whether trainees from other specialties might find the experience alienating.

This work undoubtedly highlights that poor exam performance is often not related to lack of knowledge, but to cognitive and emotional barriers. As a result, it may provide a good starting point for ongoing study where examination performance has proven problematic.

1.7.22 Schizophrenics can be good mothers too

Duncan Double¹

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- *Schizophrenics can be good mothers too*

To protect her children the author of this book chose to publish it under a pseudonym, Q. S. Lam. However, it's easy to break her anonymity and she accepts it can only be partial. She is a British Bangladeshi artist who has had several psychotic episodes, including postpartum. She has been diagnosed with schizoaffective disorder but prefers to describe herself as having a different sort of brain.

Her friend Stephen Fry has described the book as 'brilliant' – an endorsement displayed on the book cover – and Alastair Campbell has tweeted the same. Artwork and poetry complement the narrative of the author's personal and family history, which includes episodes of psychosis, and the description of the dissociated parts of herself and how she recovers. She does not take antipsychotic medication.

She makes remarks – not always very complimentary – about each mental health practitioner that she has seen over the years, dating back to the time when she first sought help. Also discussed is the impact of her mental health problems on her husband and children. She moved to Brussels, as her husband works there.

The psychiatrist she has most identified with is Erik Thys, who is also an artist. He did not advise Q.S. not to have a second child; instead, he said it was 'doable'. Q.S. openly questions whether it was fair on her children that she became a mother and dedicates the book to them.

The strength of this book is its honesty. Q.S. has experienced multiple sexual assaults by men and considers whether her mental health issues are a sane response to an insane situation. She reveals her heart and mind, truthfully expressing what she feels and thinks, and I found the directness of the book attractive. As Q.S. notes, doctors generally don't like their authority to be challenged. However, in my opinion there needs to be an open discussion about the stigmatisation of mothers with mental health problems.

1.7.23 Epistemic injustice in psychiatry

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date

2017-4

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Abstract

It has been argued that those who suffer from medical conditions are more vulnerable to epistemic injustice (a harm done to a person in their capacity as an epistemic subject) than healthy people. This editorial claims that people with mental disorders are even more vulnerable to epistemic injustice than those with somatic illnesses. Two kinds of contributory factors are outlined, global and specific. Some suggestions are made to counteract the effects of these factors, for instance, we suggest that physicians should participate in groups where the subjective experience of patients is explored, and learn to become more aware of their own unconscious prejudices towards psychiatric patients.

Contents

- *Epistemic injustice in psychiatry*
 - *Epistemic injustice and psychiatric patients*
 - * *Measures to counter epistemic injustice*
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 - *Possible ways of overcoming epistemic injustice*
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Epistemic injustice is a harm done to a person in her capacity as an epistemic subject (a knower, a reasoner, a questioner) by undermining her capacity to engage in epistemic practices such as giving knowledge to others (testifying) or making sense of one's experiences (interpreting). It typically arises when a hearer does not take the statements of a speaker as seriously as they deserve to be taken. The prime case of epistemic injustice is testimonial: the hearer deflates the level of credibility she gives the speaker because she is (often unconsciously) prejudiced against the social group to which the speaker belongs. Common examples include sexism and racism. In such cases the testimony of a woman or a person from an ethnic minority background will be given deflated credibility, based on the prejudicial associations between that group and negative stereotypes. The reason we chose this approach is that epistemic injustice provides an account for why, despite the best intentions, physicians often do not believe what psychiatric patients tell them. Clarifying some of the reasons for this common prejudicial stereotype of patient unreliability may make it possible to explore ways of overcoming the epistemic injustice that we suggest patients, and in particular psychiatric patients, are vulnerable to.

It is worth noting here that it is prejudicial or negative stereotypes, not stereotypes *per se*, which often give rise to epistemic injustice. We rely on stereotypes as heuristic aids in making credibility judgements because they are often empirically reliable generalisations. However, negative attitudes towards people with a mental illness may lead to negative stereotypes and to generalisations which are resistant to counter-evidence, owing to what philosopher Miranda Fricker calls an 'ethically bad affective investment'.¹ It is these kinds of stereotypes that may lead to epistemic injustice.

Epistemic injustice and psychiatric patients

Epistemic injustice is important in psychiatry because of the persistent negative stereotypes that affect people with mental disorders in particular and lead to a credibility deficit. The consequence is that patient testimonies and interpretations are not acknowledged as credible, and patients are thus undermined in their capacity as knowers and contributors to the epistemic effort to reach a correct diagnosis and treatment. We suggest that people with mental disorders are even more susceptible to epistemic injustice than those with physical illnesses, for reasons that are detailed below.

We have argued in the past that people with physical illnesses are vulnerable to epistemic injustice.^{2,3} Here we suggest that people with mental disorder may be susceptible to even greater epistemic injustice than people with physical illnesses. This is mainly owing to the high prevalence and great power of negative stereotypes of psychiatric illness. As a consequence, the patient may be telling the truth, but the doctor deflates the level of credibility which she gives to the patient ('credibility deficit') and thereby does the patient a distinctive kind of injustice, namely epistemic injustice, which undermines the patient specifically in her capacity as a giver of knowledge. This has detrimental effects on individual psychiatric patients, but also on the funding of psychiatric services and the public perception of mental disorder. Many people are influenced by negative stereotypes about mental disorders, are ill informed about their true nature, and have little understanding of how to treat them. Some measures to improve the current situation are suggested below.

Measures to counter epistemic injustice

The notion of epistemic injustice has been developed by Fricker.¹ She was interested in how social identity and power affects people's status as knowers. She gives the example of a White police officer who stops a Black car driver and asks him whether the car belongs to him. If the driver truthfully says that the car is his, but the policeman does not believe him because of racial prejudice, then he does the driver an injustice in his capacity as a knower.⁴

The main type of epistemic injustice that Fricker discusses is 'testimonial injustice'; it emerges from the fact that testifying, i.e. giving information to others, depends crucially on one's perceived credibility. If a person is seen as lacking credibility, her testimony will be ignored or treated with suspicion, or it might not be solicited at all. Of course, she may lack credibility for a good reason, for instance if she is a known liar. However, testimonial injustice occurs when a person suffers a 'credibility deficit' owing to some negative stereotype or prejudice associated with her social group (e.g. gender or race). This credibility deficit is unjustified and hence constitutes an epistemic injustice. Fricker analyses how negative racial and sexist prejudices unfairly deflate the credibility of people of Black and minority ethnic background and women, such that what they say is ignored, marginalised or otherwise excluded from epistemic consideration. Since being able to give information to others is essential to social life and agential action, testimonial injustice harms those who experience it.

Carel and Kidd have argued that people with physical illnesses are more vulnerable to epistemic injustice than healthy people.^{2,3} The testimonies of patients are often presumed to be irrelevant, unreliable, confused or otherwise lacking in credibility, owing to negative stereotypes associated with ill persons. Such stereotypes include viewing ill persons as cognitively impaired or emotionally compromised, owing either to their somatic condition or to their psychological reactions to it; or as existentially unstable, gripped by anxieties such that they 'cannot think straight'; or as psychologically dominated by their illness in a way that warps their capacity to accurately describe and report their experiences (e.g. 'the moaner' or 'the drama queen' stereotype). Because illness often evokes strong feelings in those affected, their emotions are often taken by health professionals to have a detrimental effect on patients' thinking, distorting the accounts they give of their illness. This pattern may be more acute in cases where subjective symptoms are driving the clinical encounter, such as unexplained breathlessness (see www.lifeofbreath.org), chronic pain, or other medically unexplained symptoms.⁵

Of course, the credibility of an individual is context dependent: if someone is talking about a subject on which she is an acknowledged expert then she is much more likely to be believed than if she is talking about something she is known to have little knowledge of.

Epistemic injustice – real-life situations

We are sufficiently aware of the existence of people's unconscious desires and beliefs to know that they can be mistaken about their own desires and beliefs, but it is also the case that they have exclusive access to many of their desires and beliefs. In the interests of epistemic justice, physicians should accept what people with mental disorders say about these matters as true unless there is good reason not to. Moreover, psychiatric patients who have experience of psychiatric services become reluctant to disclose psychotic symptoms because they know it might make them more likely to be diagnosed with a psychotic illness, and in some cases detained in hospital and medicated against their will. If they nonetheless disclose such symptoms, then psychiatrists might conclude that the symptoms are more severe in the sense that the patients are unable to inhibit their expression and/or that their executive function is also impaired.

Here we give three examples of epistemic injustice affecting psychiatric patients (Boxes 1, 2 and 3). Their purpose is to show that epistemic injustice can be a real problem in psychiatry, with possibly devastating effects on the individuals who are telling the truth. The personal details of the patients concerned have been altered to preserve their anonymity.

One of the important factors which can predispose to epistemic injustice is a widespread misunderstanding of the relationship between emotion and cognition, and the positive contribution made by emotional input to a broader conception of rationality.⁶ A consequence, in a medical and psychiatric context, is that the 'soft evidence' offered by patients is often met by credibility deflation. In practice this may lead to patient reports being ignored or discounted, especially when time pressure and other constraints are at play. Conversely, if the 'hard evidence' provided by objective investigation (e.g. blood tests) is regarded as more reliable, then the opinions of health professionals who can access and interpret that evidence may enjoy credibility inflation. In some cases it may be better for the doctor to try to treat on the basis of the symptoms reported by the patient rather than on the basis of an abnormal blood test result or an abnormal scan alone. An example of this is the PSA (prostate-specific antigen) test, which is a notoriously unreliable guide for the treatment of prostate cancer.

Box 1 Example of epistemic injustice in psychiatry 1

When one of the authors (P.C.) was a medical student in Munich, Germany, he saw a young man on an acute psychiatric ward who said he was a relative of the then Soviet leader. The responsible consultant took this to be a grandiose delusion, and therefore as evidence of a psychotic illness; it later turned out to be true.

Box 2 Example of epistemic injustice in psychiatry 2

The second example is of a woman in her early 50s, a former nun. The police contacted mental health services because they had been alerted by someone doing work on her house. They found evidence of smoke damage to the house, but not of fire damage. She was admitted to a psychiatric ward and detained under section 2 of the Mental Health Act. She claimed that she had been burning incense in the house for many years to drive away evil spirits. During the week she had spent on the ward there was no evidence of her trying to ward off evil spirits or attempting to start a fire, or of any psychotic symptoms. The mental health tribunal members concluded that her beliefs about incense and evil spirits were compatible with her religious faith, that there was no evidence of a psychotic illness, as had been claimed by the psychiatrist and one of the psychiatric nurses, and that section 2 should therefore be rescinded.

Box 3 Example of epistemic injustice in psychiatry 3

The third example is of a young man who was admitted to psychiatric hospital on section 2 despite the fact that he had agreed all along to be admitted and remain in hospital as a voluntary patient. He had been standing near the edge of a high cliff for about an hour until passers-by called the police. The staff involved in his care on admission did not believe that he could be trusted to remain in hospital on a voluntary basis and argued in the tribunal for the maintenance of the section. His community psychiatric nurse attended the tribunal, stating that he should never have been placed on a section, because he had had suicidal thoughts for many years, had gone to the same cliff many times in the past, had been admitted to hospital on several occasions as a voluntary patient, and had misgivings about the stigma attached to being placed on a section. All this had been documented in the hospital notes. She conceded that there would always be a risk of self-harm, but that it was a matter of managing the risk without compulsory detention and with the help of his friends and family. After hearing this evidence the tribunal members decided to rescind the section.

A psychiatric example is to do with making a diagnosis of epilepsy. Here a patient may have some epileptiform waves on the electroencephalogram (EEG), but unless there is also clinical evidence of altered consciousness and/or involuntary

movements which fit into a recognised pattern, a diagnosis of epilepsy cannot be made. An EEG can confirm but cannot exclude the diagnosis, which is essentially clinical.⁷

In very general terms, there are two types of contributory conditions for epistemic injustice affecting people with mental disorders: global and specific. Global factors are those that can affect any patient at risk of psychiatric disorder or those diagnosed as having psychiatric disorders. The fear of stigma among those at risk can make early intervention difficult and those who have been diagnosed may avoid service use and relapse more frequently.

Global contributory conditions for epistemic injustice

There are three global contributory conditions for epistemic injustice in psychiatric illness: problems associated with, and partly caused by, the mental disorder the higher value placed by health professionals on ‘hard’ or objective evidence compared with patient reports the entrenched negative stereotypes associated with mental disorders.

1. Problems related to mental disorder

Psychiatric patients are often disadvantaged – cognitively, socially and economically – and these disadvantages are frequently thought to be the patient’s fault. People with mental disorders are often badly educated because the illness has interrupted their education (‘dropouts’); they are often financially impoverished because the effects of the illness may make them unemployable (‘lazy’, ‘dependence culture’); and they are frequently socially isolated (‘loners’). They may become dependent on substances such as nicotine, alcohol and street drugs (‘lack of willpower’) and frequently experience physical illnesses. Causes of physical illnesses include substance misuse, self-neglect secondary to mental disorder and/or substance misuse, and psychotropic medication, such as atypical antipsychotics causing cardiovascular problems (‘down to lifestyle’).

People with mental disorders are thus often seen to have largely brought these disadvantages on themselves and are stigmatised and held responsible for them,¹ even though some conditions contributing to mental disorders, such as genetic factors and a dysfunctional environment, are outside the person’s control. To the extent that such negative stereotypes are shared by their voters, politicians, who often look to save public money, will not be motivated to redress the imbalance in mental health funding: in 2010/2011 mental health services were allocated only 10.8% of the National Health Service (NHS) budget, although mental disorders constituted nearly 22.8% of the disease burden in the NHS.⁹ Simon Wessely, the president of the Royal College of Psychiatrists, notes that despite rising demand, spending on adult mental health by NHS trusts has fallen by 8% since 2010.⁹ A recent parliamentary report advocates ‘whole person’ care, which includes mental and physical health, and highlights some of the barriers to parity of esteem for mental health.¹⁰

2. Hard v. soft evidence

Health professionals are trained to place higher value on ‘hard’ or objective evidence, namely the results of investigations, than on ‘soft’ or subjective evidence provided by patients. In fact, some such objective evidence (e.g. from X-rays or magnetic resonance imaging (MRI) scans) is heavily dependent on interpretation, for instance by a radiologist. This gives health professionals epistemic power, because only they have access to this evidence and have the training to interpret it. Montgomery¹¹ has argued that medicine is not itself a science but rather an interpretive practice that relies on clinical reasoning. A physician looks at the patient’s history along with the presenting physical signs and symptoms and juxtaposes these with clinical experience and empirical studies to construct a tentative account of the illness with what Montgomery calls ‘clinical judgment’. In psychiatry, there is virtually no hard evidence and diagnoses have to be made mainly on the basis of what patients say and how they behave. However, some psychiatrists regard their patients as objects of their epistemic enquiry rather than participants in an epistemic search for the correct diagnosis and best treatment. Anthropologist Tanya Luhrmann¹² argues that insurance companies exercise a more powerful influence over the content of healthcare than do doctors, in that they promote a biological approach to psychiatry because it yields explicit therapeutic rationales, targeted treatments and quantifiable outcomes that can be audited more easily.

Despite the lack of objective evidence in psychiatry, many psychiatrists are influenced by their general medical training and import this bias into the field. Although many acknowledge the biopsychosocial model of mental disorders, they often retain their biological orientation.¹³ Biological psychiatry has been dominant since the 1950s, when the first antipsychotic drugs were introduced, and there is little evidence that this is changing in any significant way. This is partly because the biological approach has practical benefits (e.g. psychiatrists can save time by focusing on drug treatments). Based on his experience working as a liaison psychiatrist in a large medical hospital, one of the authors (P.C.) believes that psychiatry itself is stigmatised within medicine and that some psychiatrists feel that they will be more respected by their medical colleagues if they approach mental disorders from a biological perspective. P.C. also senses that some patients might prefer this attitude, feeling exonerated if they are told that their mental disorder is caused by a 'chemical imbalance in the brain' which can be ameliorated by a drug.

3. Negative stereotypes

People with mental disorders are socially stigmatised and are frequently described with derogatory terms such as 'mad', 'crazy' or 'weird'. The term 'stigma' comes from the ancient Greek word denoting the mark made on slaves by a pointed instrument. Stigma involves negative associations that attach to a social group. Sociologist Erving Goffman¹⁴ argued that stigmatised people are considered abnormal by society and are not fully socially accepted. As a consequence, they constantly try to adjust their social identities. These additional cognitive and social burdens increase the pressures on stigmatised people, exacerbating their already difficult social and cognitive situation. Thornicroft¹⁵ points out that patients often describe the stigma they encounter as worse than the mental disorder itself. Stigma affects every aspect of their lives, including employment, accommodation, financial resources and sense of citizenship. It is a major problem throughout the world.

One of the negative stereotypes associated with mental illness is that people with a mental illness are responsible for their condition. For example, people diagnosed with depression are often told to 'get a grip' or to 'pull themselves together'. Illness, not only mental illness, is often seen as a mark of moral, social and epistemic failure (e.g. drug/alcohol dependence is sometimes seen as weakness of will). Such failures are shaped by group-specific values and commitments – for instance, certain religious groups regard depression as a punishment by God for their sins.¹⁶

However, in a legal setting, the poor insight of patients into their mental state may be recognised by the court as a factor which reduces the patient's responsibility for their actions. Although this diminishes their epistemic status, it also protects them, so recognition of their diminished responsibility may lead to them being treated in hospital rather than imprisoned.

Thus, those who are influenced by negative stereotypes about psychiatric patients may feel justified in cutting funding for mental health services because they think that many psychiatric patients are to blame for their mental health and other problems. In the case of depression, many people who have no personal experience of the illness tend to think that depressed people only need to think more positively for their depression to disappear.^{17,18} The fact that psychiatric services are more poorly funded than other services in the NHS suggests that negative stereotypes about mental disorders may have a role in funding distribution. These negative stereotypes are also influential in the broader context of widespread ignorance about the true nature of mental disorders and their treatment.

Types of stigma and their effects

General stigma

General stigma has negative effects on the prevention, early intervention and treatment of mental disorders. The formulation of a diagnosis has the advantage of making resources available for treatment, as well as providing the best available treatment. Moreover, there is evidence that early treatment improves the prognosis (e.g. in schizophrenia).⁷ On the other hand, having a diagnosis also leads to stigma and discrimination, which can act as a barrier to recovery, for instance making it more difficult to find employment and accommodation.¹⁵

Self-stigma

People with mental illness often accept and internalise negative stereotypes, and this in turn leads to low self-esteem, shame, demoralisation, confidence loss and giving up goals.

Structural stigma and discrimination

Patients typically report that they feel their views are not sufficiently elicited or considered by those who plan and organise psychiatric services.¹⁹ We have already seen that psychiatric provision for approaches other than the biopsychosocial model is severely under-resourced.

Specific contributory conditions

So far we have discussed global contributory conditions for epistemic injustice. In addition to these global conditions, there are specific problems which can lead to further kinds of epistemic injustice as a consequence of the particular nature of the mental disorder in question. Here are two examples, which illustrate how the symptoms of particular disorders may reduce the credibility of what patients report about their own experiences to an extent that constitutes epistemic injustice.

Dementia

The first example is dementia, an acquired impairment of cognitive function without impairment of consciousness. The central feature of its commonest form, Alzheimer's disease, is memory loss, especially of episodic memory, but there can be a wide range of other cognitive impairments as well. The main negative stereotype associated with dementia is the belief that the impairment of cognitive function is severe and global; that the person has or will rapidly and inevitably become a 'vegetable'. In fact, this is hardly ever the case, except perhaps in the final stage of the illness.²⁰

The personality of the individual and some cognitive functions are often well preserved. Thus, patients with mild to moderate dementia can be much more reliable informants than they are often thought to be. There is a need for careful neuropsychological assessment to establish the severity of the impairment. If a person's memory is badly affected, much can be gained by staying in the present in conversations, thereby minimising the occurrence of behavioural markers of epistemic incapacity that can exacerbate the risk of epistemic injustice.²⁰

Schizophrenia

The second example is schizophrenia. Perhaps the most common stereotype associated with it is that because of their delusional beliefs, people with schizophrenia are unpredictable and violent. This may diminish their status as truth-tellers because it may be concluded from one false (delusional) belief that none of their beliefs are credible. In fact, although violent behaviour can occur in schizophrenia, it is much rarer than is thought. There is a small but significant increase in violence in patients with schizophrenia (in any one year 8% of such patients will commit an act of violence compared with 2% of the general population). There is, however, a much stronger association between violence and substance misuse than with schizophrenia. The proportion of all violent acts committed by those with schizophrenia is 3–4%. This leaves 96–97% of all violent acts committed by people who do not have this disorder. The risk of an individual patient with schizophrenia committing homicide is less than 1 in 3000. Moreover, the rates of suicide are much higher than homicide rates in psychiatric patients as a whole.²¹ Thus, although the risk of violence is much higher in patients with schizophrenia than in the general population, the risk is lower than is suggested in the media.²¹ It also seems likely that other factors apart from the illness itself may play a part, such as the influence of alcohol and illicit substances at the time of the offence, and social factors.

Such negative stereotypes are problematic for several reasons, beyond their empirical inadequacy. They encourage unwarranted attitudes of suspicion and distrust towards people with schizophrenia, which, in turn, can contribute to

their social isolation; this is in itself epistemically impairing. Many of our epistemic practices are intrinsically social, such as testifying (giving information to others) and interpreting (making sense of one's experiences), and it is no coincidence that Fricker focuses her analysis of epistemic injustice on those two practices.¹ Social isolation and epistemic impairment can be mutually reinforcing.

In the case of schizophrenia, this problem takes on a specific form: it is integral to our social and epistemic agency that other people perceive us as a person – an agent – capable of engaging, in a sustained and reasonable way, in testifying, interpreting and other epistemic practices. A self is a locus of epistemic and social agency. Yet stereotypes about schizophrenia abide, typically the widespread but mistaken notion that schizophrenia is chiefly characterised by a personality split, as in the good Dr Jekyll and the evil Mr Hyde. The term 'schizophrenia' was coined by the psychiatrist Eugen Bleuler to capture a split between components of the mind – knowledge, emotion and will. This idea of a split has been abandoned in modern diagnostic criteria.²² However, the stereotype of 'split personality' is, of course, a perfect example of a fragmented epistemic self with whom one cannot effectively engage either socially or epistemically.

The rare cases of homicide by patients with schizophrenia are given intense coverage in the press. Examples include Christopher Clunis, who killed a stranger who happened to be standing on the same platform at Finsbury Park tube station in London in 1992; and Matthew Williams, who had a diagnosis of paranoid schizophrenia and killed a young woman in an act of cannibalism in 2014. This creates the impression that violence on the part of patients with schizophrenia is much more common than in fact it is, a phenomenon described by psychologist Daniel Kahneman as 'what you see is all there is', namely jumping to conclusions from limited evidence: another feature of prejudice that might lead to epistemic injustice.²³ Such jumping to conclusions on limited evidence can lead to prejudice ('people with schizophrenia are violent') and hence to epistemic injustice, if a patient says she does not have violent thoughts and is not believed.

As demonstrated in this section, the specific deficits found in dementia and schizophrenia can increase the susceptibility of such patients to epistemic injustice, in addition to the global factors which apply to all mental disorders.

Possible ways of overcoming epistemic injustice

One effective way to integrate the subjective perspective of patients into medicine and psychiatry may be changes in medical and psychiatric training with a view to emphasising the psychological aspects of patient care. 'Schwartz rounds', which allow health professionals to focus on the existential, ethical and personal aspects of a medical case, are growing in popularity in the UK. We suggest that this approach should not only be taught to medical students but should become part of clinical practice.²⁴ Regular interpersonal dynamic meetings with members of a multidisciplinary team, which create a forum for discussing problematic emotional contacts with patients, can enhance understanding of these aspects of patient care and reinforce their importance.¹³

Medical students should be taught to believe what psychiatric patients tell them, unless there is good reason not to do so. Students are frequently told to put patients first, but the experience of many patients is that they are often treated as cases rather than people, and that what is important to doctors is different to what is important to patients. By listening carefully to what patients tell them, doctors can make a conscious effort to imagine how things seem from the patient's perspective. In this way the relationship can become a genuinely collaborative one, rather than one in which the doctor decides what is in the patient's best interests.²⁵

Fricker¹ notes that hearers, in this case the physicians, need to practise giving more credibility to members of groups they fear they may be giving too low levels of credibility to: in this context, to psychiatric patients. Hearers may become aware of a cognitive dissonance: they may notice that on occasions they fail to live up to their belief that members of these groups are to be taken seriously, and then make a conscious effort to give them a higher level of credibility. The hope is that, with time, this corrective policy will become second nature.

Conclusions

We have suggested that there is even greater risk of epistemic injustice in psychiatry than in general medicine. There is a need for psychiatrists to be trained to listen carefully to what patients are telling them and to engage with them in collaborative decision-making, to allow patients to have a greater epistemic role and to overcome the risk of epistemic injustice. Changes are also required in the social and political arena. Media editors should reduce the stigmatisation of psychiatric patients in media reports, especially if epistemic failure (such as reliance on negative stereotypes) can be a cause of moral failure (such as treating persons with mental disorders in an unfairly hostile or suspicious manner). Similarly, politicians should ensure that there is a fairer distribution of healthcare resources, not merely to mitigate the economic cost of mental ill health.

Prejudices against people with mental disorders are entrenched in our society in what Fricker calls the ‘collective social imagination’.¹ They go unchecked because they operate below the radar of the conscious scrutiny of our own beliefs. Those who are in a position to influence public opinion have a special responsibility to oppose these prejudices. We hope that this editorial will increase awareness of the risks of epistemic injustice in psychiatry and thus contribute to this goal.

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1.7.24 Psychiatry and the geriatric syndromes – creating constructive interfaces

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date

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Abstract

Integrating mental and physical healthcare is difficult to achieve because of professional and organisational barriers. Psychiatrists recognise the problems resulting from fragmentation of services and want continuity of care for patients, but commissioning and service structures perpetuate these problems. One way forward may be to follow the syndromic model employed by geriatricians as a means of avoiding over-emphasis on diagnosis above the pragmatics of implementing multi-component, co-ordinated care. Commissioners need to be made aware of the overlap and complementarity of skills possessed by old age psychiatry and geriatric medicine to create joint services for people vulnerable to dementia and delirium. A re-forged alliance between the two specialties will be necessary to turn integrated care for frail, elderly people from rhetoric into reality.

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People with severe mental illnesses such as schizophrenia die younger than expected, losing an average 15 years of their lives to cardiovascular and other diseases. ¹ This has led to calls for a more integrated approach to care, with greater emphasis on physical health. In this article, we examine some current issues in the care of older people with severe mental illnesses such as dementia and delirium. We argue that existing systems compartmentalise care and lack the sophistication to deal with the complexity of these illnesses. We suggest that a more collaborative approach between old age psychiatry and geriatric medicine in both hospital and community settings could yield benefits.

Geriatric medicine occupies a position of unfashionable scepticism about the ‘medical model’ of care and its corollary of single-mode interventions. Under the banner of ‘comprehensive geriatric assessment’ attention is paid to function, mental health, and social and environmental factors as well as (usually multiple) acute and chronic medical diagnoses. Elements of prevention, rehabilitation, palliation and mental health models are used flexibly. Care often includes cessation of medicines, recognition of burdens placed on patients by medical intervention, and the prioritisation of comfort, rather than an expectation that death is delayed. ² Old age psychiatry can learn from geriatric medicine by embracing complexity, comorbidity and the ultimate inevitability of deterioration, signalling a return of old age psychiatry to its origins. ³

What is a geriatric syndrome?

Geriatric syndromes are states of ill health which occur with high frequency in older people but which do not fit into discrete disease categories. They are typically explained by a range of organ dysfunctions and diseases, have functional and social implications, and therefore require care that is complex and traverses traditional disciplinary boundaries. Delirium, falls, immobility and urinary incontinence have been described as geriatric syndromes, but the term is loose and may also include pressure sores and sarcopenia. Dementia and other mental health problems can be thought of in similar terms. ⁴

Dementia as a geriatric syndrome

Dementia is common towards the end of life; 6% of people who die aged 65–69 years and 58% of those who die aged 95 or over have dementia. ⁵ The aetiology of late-onset dementia is often multifactorial. ⁶ Dementia causes functional decline, and contributes to falls and incontinence. Multi-morbidity is usual ⁷ and the symptom burden in the last year of life of people with dementia exceeds that of people dying with cancer. ⁸ Dementia causes problems with safety awareness and loss of independence, and is a source of much carer strain. Crises are frequent, and usually have physical, mental, social or care-system contributors. People with dementia frequently transit between home, hospital and care home. These ‘unique and changing personal, psychosocial and physical needs’ are acknowledged in the Memory Services National Accreditation Programme, ⁹ but secondary care memory clinics are unlikely to be the only way to address them. ^{10,11}

A more comprehensive and accessible form of engagement is needed, in the form of primary care liaison psychiatry or

rapid response community mental health teams (CMHTs). CMHTs for older people led the way in delivering dementia care within communities (long before community geriatrics was a tangible entity).¹² These teams are under threat, with proposed merger into 'ageless' community teams. This would require increasing focus on psychopathology and behaviour, with a likely prioritisation of single (psycho)pathologies. Failure to recognise and appreciate the special needs of patients with dementia and the skills of CMHTs in addressing them risks diminishing patient care.¹³ At the same time, the need to address physical and functional comorbidity suggests that an overt alliance between old age psychiatry and geriatric medicine is needed.

Delirium as a psychiatric syndrome

Delirium and dementia frequently co-occur in older people in the general hospital. Dementia has achieved a high national profile in the UK. By contrast, delirium barely enters public discourse. Two-thirds of elders acutely admitted to hospital with delirium have underlying dementia^{14,15} and half of people with dementia in acute hospitals have delirium.¹⁶ Informant history is vital in identifying the two syndromes, but persistent, subacute and subsyndromal delirium is common and the syndromes can be difficult to distinguish, especially where prior dementia was undiagnosed, leading to the coining of the term 'cognitive spectrum disorders' to cover both.¹⁷ Between 10 and 20% of delirium in older people does not have an identifiable precipitant¹⁸ and the cognitive impact of delirium may persist for months or merge into the onset of a dementia syndrome.¹⁹ Some survivors develop post-traumatic stress disorder. Uncertainties also exist as to the division of clinical responsibility between geriatricians and psychiatrists. Arguably, neither specialty can do it well in isolation.

The development of health services in the UK over the past 20 years has seen psychiatrists focus on patients in the community while geriatricians have increasingly assumed responsibility for the acute medical intake, militating against collaboration. The diagnostic uncertainties and sequelae of delirium imply the need for systematic follow-up, which geriatric medicine is poorly placed to provide. Psychiatry has a role in working with the third sector and primary care to highlight the malign effects of delirium even in the context of successfully treated acute physical illness.

The publication of delirium guidelines from the National Institute of Health and Care Excellence (NICE) has been a major advance in the promotion of delirium management,²⁰ but evidence is weak that any specific intervention or programme of delirium care improves outcomes.²¹ Conversely, there is evidence that multi-component interventions aimed at preventing delirium can reduce its incidence and improve outcomes.^{22,23}

Establishing a role for delirium prevention in hospitals and community settings is a challenge given the low profile of delirium training in medical and nursing schools, poor recognition by clinicians, and competing imperatives for healthcare organisations. Conceptualising delirium as both a safety risk to individual patients and an organisational risk due to increased length of stay and adverse health outcomes provides an incentive for change. Old age psychiatrists, with their emphasis on the importance of assessing mental health alongside physical health, can valuably contribute to both delirium care and education.²⁴

Why is delirium prevention not taken more seriously in community psychiatry?

Prevalence studies of delirium in any setting are fraught with the problem of distinguishing delirium from dementia.²⁵ A Swedish study of very elderly people found that 52% of people with dementia had experienced delirium within the previous month compared with 5% of those without dementia.²⁶ Work in the Netherlands revealed a delirium prevalence of 9% in care homes.²⁷

The evidence for the value of delirium prevention programmes in care homes has yet to be established, but there is evidence that coordinated programmes to reduce the prescribing of culprit medications are effective in preventing delirium.²⁸ A trial of the effectiveness of multi-component delirium education in preventing the disorder in care homes is underway in the UK.²⁹

People with dementia who are living in their own homes and are in receipt of care from CMHTs are also at high risk of delirium. Behavioural and psychological symptoms in dementia (BPSD) are associated with morbid – ities that contribute to delirium, such as falls, nutritional deficits and polypharmacy. Delirium can cause a similar range of symptoms, which may become chronic and constitute BPSD.³⁰ Delirium is triggered by physical illness, injury,

medications or medication withdrawal, and rightly remains the domain of primary care and geriatricians, but unless psychiatry co-owns the delirium agenda, the cross-over of skills from the management of BPSD will fail to shape delirium prevention, assessment and management. The similarities between delirium prevention programmes and those for the non-pharmacological management of BPSD are striking.^{31,32}

Frailty

Frailty is a state of vulnerability to decline in the face of stressors, in the context of precarious multisystem physiology and social adversity.³³ Epidemiological evidence highlights the importance of frailty in elderly populations. It has proven difficult to operationalise, but recognisably overlaps with dementia in cross-sectional studies.³⁴ One view conceptualises it as the effect of cumulative deficits³⁵ and the other as a phenotype characterised by three or more of the following factors: unintentional weight loss, self-reported exhaustion, poor grip strength, slow walking speed and low physical activity.³⁶ However, geriatricians recognise that frailty will often manifest through geriatric syndromes – falls, immobility ('off legs'), delirium ('more confused'), urinary or faecal incontinence (often associated with delirium, dementia and immobility) and susceptibility to drug side-effects (antidepressants making a patient 'very drowsy').³⁷ The maturation of old age psychiatry as a specialty has been facilitated by the advent of specific therapies for Alzheimer's disease, but an emphasis on prescribing for Alzheimer's disease has selected against attendance by frail elders and those with non-Alzheimer pathology (particularly vascular dementia) and cognitive deficits outwith a full-blown dementia syndrome.

Comprehensive geriatric assessment aims to consider the full range of factors contributing towards frailty (*Table 1*). Its implementation is linked to better outcomes.³⁸ It has parallels with biopsychosocial assessment, although this does not have similar evidential weight behind it, and indeed has been criticised by the psychiatric profession as 'mere eclecticism'.³⁹ The accusation of vagueness laid against biopsychosocial assessment suggests that it needs to find a home within an operationally defined, evidence-based structure such as comprehensive geriatric assessment. The two processes differ only in the emphasis and differential expertise of the clinicians undertaking them. Geriatricians recognise that they tend to neglect the mental health dimension, which may be reduced to a brief cognitive assessment or screening test for depression. There is therefore a fertile opportunity for mutual learning between geriatrics and psychiatry in the area of the assessment of frailty.

Components of comprehensive geriatric assessment

Domains	Items to be assessed
Medical	Co-morbid conditions and disease severity
	Medication review
	Nutritional status
	Problem list
Mental health	Cognition
	Mood and anxiety
	Fears
Functional capacity	Basic activities of daily living
	Gait and balance
	Activity/exercise status
	Instrumental activities of daily living
Social circumstances	Informal support available from family or friends
	Social network such as visitors or daytime activities
	Eligibility for being offered care resources
Environment	Home comforts, facilities and safety
	Use or potential use of telehealth technology etc.
	Transport facilities
	Accessibility to local resources

Reproduced from Martin, 2010. ⁴⁰

Sustainable integration

The needs of older people with mental health disorders are not well served by a retreat to psychiatric specialisation, restrictive referral criteria or commissioning models based on activity alone. Geriatric medicine recognises and embraces complexity and uncertainty, and responds by flexibly utilising a variety of models, albeit at times with tensions between them. Old age psychiatry can learn from comprehensive geriatric assessment. Geriatric medicine needs to take mental health more seriously, to increase the depth and sophistication with which it assesses the mental state, and can learn from person-centred care and recovery models. The logical future for both disciplines is in collaboration and integration that transcends organisational and cultural barriers.

A sustainable integration of physical and mental healthcare for older people will require more than cooperation between clinicians. The joining of forces between psychiatrists and geriatricians can take place at an organisational level when mental health and community trusts merge. However, we also need a flexible, accessible, consultative model of psychiatry that seeks to empower a broad range of community practitioners and will be the means to generate influence on problems that are just too common and multi-morbid to be addressed solely by clinic-based approaches or a single professional discipline. This reinforces the need for CMHTs for older people, and highlights the need to change the commissioning model from one based on activity defined by clinic attendances. Crises in care homes, for example, often represent a complex interplay of medical, mental, social and environmental issues best addressed by timely multi-disciplinary input rather than transferring responsibility on to a single discipline. Accessible advice on a broad range of cases managed primarily by other teams ('liaisons') allows for teaching and upskilling while preserving specialty provision for patients with more severe, less tractable mental health problems. These teaching and support roles need a commissioning model.

CMHTs are in a good position to identify dementia and promote delirium prevention measures. Working alongside community geriatrics will strengthen old age psychiatry by allying it with the developing evidence base and increasing its workforce.

The Rapid Assessment Interface and Discharge (RAID) model developed in Birmingham has captured the attention of policy-makers through its widely publicised potential financial savings. But it also demonstrates the total immersion of mental health practitioners in the multi-professional melee that is acute hospital care. ⁴¹ Why not import this style of working into primary care and scale down the centralised psychiatric clinic? This has been tried in Gnosall, Staffordshire, where a model of primary care liaison psychiatry has created a well-received, effective service for people with dementia. ⁴²

Conclusion

Psychiatrists must lobby commissioners to recognise the plight of those frail, elderly patients who are not living well but dying with the multiple comorbidities of dementia within a healthcare system that fails to accommodate complexity. People with dementia are prone to crisis and comorbidity, necessitating attention to physical health (parity of esteem) equal to that developing for other severe mental illness. Emphasising geriatric syndromes (and the importance of sound mental health assessment within comprehensive geriatric assessment) is a good way to defend old age psychiatry while at the same time developing integrated physical and mental healthcare for older people. An invigorated liaison psychiatry, underpinned by a re-forged alliance between old age psychiatry and geriatric medicine, gives a pointer to how integration might work, and enables parity of esteem for mental and physical health.

1.7.25 Police liaison and section 136: comparison of two different approaches

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Abstract

Aims and method Two police liaison and section 136 schemes were developed alongside police services at different sites within the same NHS trust. In one, a mental health nurse worked with frontline police attending incidents related to mental health. The other involved nurses providing advice from the police control room. Section 136 detentions were measured over two 6-month periods (6 months apart) before and after practice change. Data analysed included total numbers of section 136 assessments, outcomes following subsequent assessment, and relevant diagnostic and demographic factors. Association of any change in section 136 total numbers and proportion subsequently admitted was investigated in both sites.

Results The model involving a nurse alongside frontline police showed significant reduction in section 136 numbers (38%, $P < 0.01$) as well as greater admission rates ($P = 0.01$). The scheme involving support within the police control room did not show any change in section 136 detention but showed a non-significant ($P = 0.16$) decrease in subsequent admission.

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Clinical implications Mental health nurses working alongside frontline police officers can help improve section 136 numbers and outcomes.

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Section 136 of the Mental Health Act 1983 enables an individual police officer to remove any person found in a place to which the public have access appearing to have a mental disorder and to be in immediate need of care or control to a place of safety, such as a hospital, police station or a purpose-built section 136 unit. The section can only be used if the officer believes it is in the interests of that person or necessary for the protection of others. Although section 136 can be an important care pathway to enable an individual to receive appropriate support, it can also be a very distressing experience for them – some report feeling criminalised and punished for having a mental illness. ¹ Its use is also costly given that it requires the input of an approved mental health professional (AMHP) and two doctors for the assessment, plus police and often nursing time to manage the detained person and staff the place of safety.

Background and aims

The Mental Health Act Commission has highlighted the challenge of collating data on the use of section 136, ² but figures have only been gathered at a national level by the Health and Social Care Information Centre over the past 5 years. ³ These combine police and mental health records on section 136 detentions but have limited detail on outcomes. At a national level the rates of section 136 detentions to places of safety between 2010/2011 and 2014/2015 increased from 14 111 to 19 406. ³ Attempts to combine inconsistently recorded data have shown a steady upward trend at a rate greater than has been seen with use of the other Mental Health Act sections for detention. ⁴

Significant variation is seen regionally in section 136 use. Outcomes from such detentions, often seen as markers of how appropriately the detention has been applied, are also seen to vary from region to region: from areas where around 60% are admitted to hospital ⁵ to those where 68% are discharged. ⁶ While theories to explain these variations have included a rural/urban divide, police culture, socioeconomic deprivation and diagnostic factors, ⁷ the available data have been limited in both accuracy and detail.

In response to concerns about the growing use of this police power and regional variation, there has been a national drive to improve inter-agency working between police and mental health services. Both the Bradley Report ⁸ and the Crisis Care Concordat ⁹ placed emphasis on local agencies working more closely to improve the experience of individuals in a mental health crisis and to intervene as early as possible within the criminal justice system. Areas have responded differently to the challenge. This paper analyses various aspects of section 136 and changes observed with

different ways of inter-agency working within two areas of the same National Health Service (NHS) trust, in Ipswich and Norwich.

The local response in Ipswich has been a Commissioning for Quality and Innovation (CQUIN)-funded pilot scheme developed in partnership between Norfolk and Suffolk NHS Foundation Trust (NSFT) and Suffolk Constabulary. The scheme commenced in April 2014 and involves two experienced mental health nurses working on alternate shifts alongside frontline police officers, 7 days a week from 14:00 until 00:00, to help assess and appropriately divert members of the public who present with potential mental health-related emergencies. Accompanied by a police officer (individuals vary with police rota), they are seen as the initial point of contact for officers attending a potential mental health-related event. They are able to perform face-to-face assessments in a dedicated police car but can also provide advice to other officers over the phone.

Norwich was chosen as the control site as it was closely matched by size, ethnicity and measures of deprivation (*Table 1*). Norwich also established a police liaison service (funded by the police service) to address the same national concerns. It employed 4 mental health nurses on rotation providing support to the local police force between 8:00 and 22:00, 7 days a week. However, they were based in the police control room and offered telephone advice to police officers without face-to-face contact with the public.

Results: population parameters *a*

	Ipswich	Norwich
Population	442 000 <i>b</i>	483 000 <i>c</i>
Index of deprivation ranking <i>d</i>	72	61
White British, %	82.94	83.65

2011 census data. ¹⁰

Ipswich, Suffolk Coastal, Babergh and Mid-Suffolk local authorities.

Norwich, North Norfolk, South Norfolk and Broadland local authorities.

Lower value indicates higher deprivation.

The aims of this study were to examine changes in and between Ipswich and Norwich regarding section 136 detentions and hospital admission rates of detained individuals. This would enable us to build on past research and consider what factors were driving the use of section 136 locally, and in turn better understand any impact the police liaison projects may have had.

Method

This retrospective study compared numbers and outcomes of section 136 assessments, characteristics of detained individuals and some follow-up data. Information was obtained prior to and following differing changed practices within the trusts for the two areas. Numbers of section 136 detentions were gained from local section 136 suite records and cross-referenced with data gathered at trust level in an attempt to capture all section 136 assessments in Ipswich and Norwich. Further data pertaining to each individual were then collected retrospectively from hospital records using electronic notes (Eplex in Ipswich and Carenotes in Norwich). Data were gathered for two 6-month periods: 1 June – 30 November 2013 and 1 June – 30 November 2014. This was to limit any impact on results of the preparation for and introduction of services. This also allowed for comparison of the same 6-month cycle (a year apart) pre- and post-intervention in both areas and between areas.

The project was viewed as service evaluation by the trust's research and development department and thus did not require ethics approval. The exact information gathered and hypotheses to be tested were agreed at the planning stage. Data were entered into Minitab (version 16) to allow for appropriate statistical analysis. The exact data collection questions can be found in *Box 1*.

Such a study set-up meant that each location had a control group prior to intervention and an experimental group post-intervention. Analysis was conducted pre- v. post-intervention in both locations and between the locations. Null hypotheses were that there were no differences between locations or between pre- and post-intervention. Population sizes covered by each section 136 suite were established by combining police force estimates of the locality from which officers were detaining people and the 2011 census local authority population sizes.¹⁰ Chi-squared statistical tests were used where appropriate. We used *t*-tests when comparing section 136 numbers per 100 000 population, Fisher's exact test for comparing proportions, and the Mantel–Haenszel procedure to identify possible confounding factors.

Results

Demographics

As seen in *Table 2*, there were no significant differences in the study participants' age or gender pre-intervention compared with post-intervention in either area individually or between the areas. There were no significant differences in ethnicity either, with the overwhelming majority of individuals assessed being of White British background.

Results of section 136 assessments in two study areas *a*

Numbers of section 136 assessments

There was strong evidence to suggest, over the total time periods, that Norwich had proportionately fewer section 136 assessments per 100 000 population than Ipswich ($P = 0.01$). This difference was greater in the pre-intervention period. Between the two 6-month periods there was a small, non-significant increase in those detained under section 136 in Norwich but a large reduction in section 136 assessments in Ipswich post-intervention ($P = 0.01$) (Table 2 and Fig. 1).

Fig. 9: Section 136 assessments and subsequent admissions.

Box 1 Survey questions

1. Pre- or post-intervention?
2. Ipswich or Norwich?
3. Date of assessment?
4. Time of assessment?
5. Gender?
6. Age?
7. Ethnicity?
8. Broad ICD-10 category?
9. Number of section 136 assessments the individual had in the previous 6 months?
10. Any contact with mental health services in past 2 weeks?
11. If so, what type of contact?
12. Main reason for section 136?
13. Any specified location?
14. Was the individual admitted?
15. If so, was this under detention?
16. If admitted, what was the length of admission?
17. If not admitted, was follow-up offered by secondary mental health services?
18. If so, was the first appointment complied with?
19. If not admitted, was the individual subject to a further section 136 assessment within the subsequent 4 weeks?

Admission

Over all the data collected, there was no significant difference in admission to hospital following section 136 assessment between Ipswich and Norwich. Prior to intervention, although admission was less likely in Ipswich than in Norwich, this was non-significant. In Ipswich there was a significant change in admission post-intervention ($P = 0.01$), with a higher conversion to admission. Post-intervention, there was a difference between Ipswich and Norwich ($P = 0.04$), with higher admission in the former. Thus the interventions were associated with a proportionate increase in admissions following section 136 in Ipswich. Although data suggested that the admission proportion decreased in Norwich, this was non-significant ($P = 0.16$).

Apart from weak, non-significant evidence to suggest that in Norwich those admitted post-intervention were more likely to have been detained than pre-admission ($P = 0.10$), there was no other association between detention under the Mental Health Act following admission and pre- and post-intervention status.

Contact with community mental health services

Any contact with community mental health services (CMHS) in the 2 weeks prior to section 136 assessment was measured. In Norwich, data provided strong evidence that in the pre-intervention period there were more individuals who had some contact with CMHS than in the post-intervention period ($P = 0.01$) and when compared with Ipswich ($P = 0.01$). In Ipswich there was no evidence of any difference between contact pre- v. post-intervention.

For those individuals who were not admitted to hospital following section 136 assessment, the proportion that had at least one subsequent 136 assessment in the following 4 weeks decreased in both sites, but the change was significant only in Norwich ($P < 0.01$ v. $P = 0.14$ in Ipswich).

In Ipswich there was moderate evidence to suggest that, if not admitted, people were more likely to be offered follow-up from secondary mental health services post-intervention than pre-intervention ($P = 0.04$). If follow-up was offered in Ipswich, there was strong evidence to suggest that the first follow-up contact was more likely to be kept post-intervention than pre-intervention ($P < 0.01$). In Norwich there was evidence that a person was more likely to be offered follow-up prior to as opposed to after the intervention ($P = 0.02$), but no evidence to suggest any difference between compliance rates pre- v. post-intervention.

Diagnosis

There was weak non-significant evidence to suggest that people assessed in Ipswich were more likely to have been deemed to have 'no mental illness' prior to the intervention compared with post-intervention ($P = 0.08$), but in Norwich there was strong evidence to the contrary ($P < 0.01$).

Counts of pre- and post-intervention broad ICD-10 categories of individuals assessed from each site are shown in *Fig. 2*.

Time of day

We were unable to obtain the exact time of implementation of the actual section 136 order for individuals. Time between implementation and assessment following the order is influenced by many factors. Trust policy states that this should happen within 3 hours.

In Ipswich the triage service was funded for 10 hours per day (between 14:00 and 00:00). As an estimate within this study, following implementation of the order, individuals who were assessed between 15:00 and 03:00 were deemed to have been assessed in a time period in which the triage service was operating. Within these time periods, the numbers assessed and numbers admitted are shown in *Table 2* (numbers admitted following assessment out of these time periods are also shown). Thus, a similar proportion were assessed within the triage hours both pre- and post-intervention (72.2% and 69.2%).

As stated above, admission following section 136 in Ipswich was more likely after the triage service commenced. On further analysis this effect was seen to be confounded by assessment within/outside triage times (Mantel-Haenszel odds ratio 5.44, $P = 0.02$) with a significant association in the triage times ($P = 0.05$). This indicated that the triage service intervention had most association with differing admission rates within the triage times.

Unfortunately, due to a large number of missing assessment time data in Norwich, a similar analysis was not deemed feasible.

Discussion

This retrospective study evaluated the impact of two recently developed police liaison schemes based in closely matched semi-rural areas within a single mental health NHS trust, with a focus on section 136 rates and outcomes before and after the projects were established.

The pre-intervention findings show that Suffolk Constabulary was detaining significantly higher numbers of people for assessment in the Ipswich area than the police force in Norwich. This difference matches the only data available prior to 2013/2014 on section 136 rates for the two regions, from 2005/2006, in which the Independent Police Complaints Commission (IPCC) analysed regional variation across England and found Suffolk to be a medium-rate user and Norfolk a low-rate user of section 136 detentions to police custody.¹¹

Well-matched local population demographics and demographic profiles of those detained would indicate that differences are not linked with variation in race, gender or age. The diagnostic profiles of those detained also show little variation between sites. These observations are significant given that a number of studies have identified common factors pertaining to those detained under section 136, such as Black men being over-represented, and the typical individual tending to be a young male, unemployed, with a psychiatric history and diagnosis of schizophrenia.¹²

As police officers are the sole implementers of S136 detentions, their attitudes and training around mental health can be considered an important variable. Qualitative studies have identified high rates of concern among police officers over inadequate training in relation to mental illness,¹³ and poor understanding of their role in relation to section 136.¹⁴ Informal feedback from the two police forces involved in this study indicates that mental health training is similar and thus would be an unlikely source of variation.

The IPCC report also observed that low-rate forces used alternative powers such as breach of the peace and that well-known 'suicide spots' such as seaside cliffs were observed in police force areas with high rates.¹¹ Data we have gathered on both police forces show a similar arrest rate (15 v. 16 per 1000 population) but a slightly higher crime rate (49.76 v. 43.98 per 1000 population) in Suffolk compared with Norfolk.¹⁵ However, there are also lower levels of policing per 1000 of population in Suffolk (3.11 v. 3.33).¹⁵ The impact of these slight differences is hard to interpret. Ipswich has a locally well-known 'suicide spot' but numbers of detentions relating to its locality were not significant.

Findings from the post-intervention data support the theory that a mental health liaison service to the police can have a significant impact on section 136 rates and also suggest which model is more effective. The Ipswich site showed a 38% reduction in the use of the police power during the post-intervention study period. In that time, there were no other significant changes to police or mental health policy or resourcing locally. This reduction is in contrast to the steady increase in the use of section 136 nationally.¹⁶ The Norwich site with support based solely in the police control room, by contrast, showed no significant change in overall numbers of section 136 detentions. The data provide some possible explanations for this observed difference between the sites.

It could be speculated that the impact of a liaison service with experienced mental health nurses in Ipswich, where rates were higher 10 years ago¹¹ and pre-intervention rates were high in this study, was to enable the local constabulary to achieve a greater level of confidence in dealing with mental health-related crises that is already present in Norwich. The detention outcome data in Ipswich may be seen to lend weight to this idea. Post-intervention we observed a proportionate increase in admission rates, an increase in offer of community support if discharged and a reduction in those deemed to have 'no mental illness'. These outcome measures can be interpreted as markers of a service better able to identify those with mental health needs and, combined with an increase in engagement, suggest it is better at signposting to appropriate services.

By contrast, the Norwich data post-intervention show a proportionate decrease in admission rates, decrease in follow-up being offered and increase in 'no mental illness' assessments despite overall numbers remaining approximately the same. It could be inferred that support based in the police control room is only effective for individuals known to mental health services, whereas members of the public unknown to services need to be assessed face-to-face to provide effective input from a specialist service. Our recording of those who had contact with mental health services in the 2 weeks prior to detention showed that for both areas approximately 50% were either known to or actively open to mental health services, which is lower than estimates from previous research of around 75–84%.¹² The near equal percentage of those in contact with mental health services prior to detention in Ipswich could further suggest that the face-to-face liaison service is able to affect detention rates for both those known to mental health services and those not known.

The data relating to time of assessments in Ipswich suggested that while the liaison service had a greater impact on conversion to admission rates during their working hours, there was a near-even drop in section 136 rates across all hours. This could indicate that multi-agency working has promoted an ability among the local police force to better identify those who should be detained for further assessment. Lending further weight to this perception is the fact that the service in Ipswich was only in operation 76% of the time due to planned leave and sickness.

A follow-up to the Bradley Report claims that similar schemes are producing positive results, including reduced section 136 rates.¹⁷ We believe that our study provides an evidence base for these as yet unpublished findings, and lends weight to the value and impact of closer inter-agency working between police and mental health services. The breadth of data and comparison of models available in this study may help to guide the development of future schemes and their refinement.

Limitations

Within this study we gathered data regarding individuals detained to places of safety under section 136 within the two main urban areas in Norfolk and Suffolk, namely Norwich and Ipswich. There will have been a few occasions where these sites were occupied and people were subsequently taken to other localities. Although we can say that both areas are equally resourced and from experience know these numbers to be small, this should be acknowledged as a weakness. Estimations of section 136 rates per population size in each area must be viewed with caution as the local authority boundaries do not equate to areas that the 136 suites serve, and it was difficult to achieve clarity on this. The study could not define the areas where the section 136 detention was made and this may have been outside the area covered by the triage services, which may have led to an underestimate of the impact of either service.

While this study builds towards a better understanding of the model that is most effective in police liaison work, it lacked a detailed analysis of the work done directly by the mental health nurses and police officers involved. Any future studies should include these data alongside qualitative feedback from relevant professionals and individuals to enable a fuller understanding of the impact of such a service.

1.7.26 Online media reporting of suicides: analysis of adherence to existing guidelines

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Abstract

Aims and method To assess the compliance of contemporary online media output with guidelines for the responsible reporting of suicidal acts. A search engine was used to identify online media

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reports of suicide from UK sources over the course of 1 month. Each article was assessed against guidelines for the responsible reporting of suicide produced by the Samaritans, a UK mental health charity.

Results We identified 229 articles, of which 199 failed to comply with at least one of the Samaritans' guidelines. Failure to mention support sources, excessive detail about the method used and undue speculation about the trigger for suicide were the most commonly breached guidelines. Significant differences were found between the quality of local and national media sources, with local media sources being broadly more compliant with guidelines.

Clinical implications This study highlights the urgent need for the implementation of responsible reporting guidelines in online media articles as a component of suicide prevention efforts.

Contents

- *Online media reporting of suicides: analysis of adherence to existing guidelines*
 - *Method*
 - *Results*
 - * *Compliance with the responsible reporting guidelines*
 - * *Additional features of online media*
 - *Discussion*
 - * *Local v. national media sources*
 - * *Additional features of online media*
 - * *Policy considerations*
 - * *Limitations*
 - * *Next steps*

Responsible media reporting of suicide is considered to be key to current international suicide prevention efforts.¹ Previous studies suggest that media reports of completed suicide can influence the rate of future suicidal acts and the method chosen.²⁻⁶

Guidelines to promote responsible reporting practices exist in a number of countries.⁷ Studies suggest that they can alter the content of media reports,⁸ although the general awareness and use of the guidelines has been found to be poor.⁹ In the UK, the 2012 Editors' Code of Practice from the Press Complaints Commission prohibits the reporting of suicide with excessive detail about the method used,¹⁰ but established responsible reporting guidelines tend to include additional features in an attempt to prevent copycat behaviour.¹¹

After a detailed literature review, no studies could be found comparing a significant number of contemporary UK media reports of suicide against responsible reporting guidelines, despite the fact that the media have been implicated in the phenomenon of 'suicide clustering' observed in the UK.¹² Other studies have focused on newspaper and television reports, and scant attention has been paid to online media sources, despite the fact that 84% of households in the UK have access to the internet and 55% of adults use the internet to access news.¹³ This is the most rapidly growing method of accessing news media, particularly for younger individuals,¹³ who may be more vulnerable to the content of media reporting.^{14,15}

This study sought to evaluate the compliance of online media reports of suicidal acts from UK-based sources with responsible reporting guidelines, and to identify the prevalence of the inclusion of other potentially harmful features of online media, namely comments sections and links to other internet features, for example pro-suicide websites.

Method

A search was performed on the Google News UK search engine using the keyword ‘suicide’ with the location filter set to include articles of UK provenance only. The analysis included reports which made reference to an attempted or completed suicide published by local and national media sources during 28 consecutive days in November 2014. Articles about suicide bombing and euthanasia were excluded, as were those behind a media paywall.

Each report meeting the inclusion criteria was assessed against an adapted version of the ‘Ten things to remember when reporting suicide’ contained in the document issued by the Samaritans.¹⁶ This is one of the more prominent and widely used sets of guidelines for journalists in the UK.¹⁷ As a direct search for articles was undertaken, it was not possible to assess whether each article was given undue prominence, for instance a homepage splash, so this criterion from the Samaritans’ guidelines was not used, leaving nine criteria for article comparison (*Box 1*).

Data were collected on compliance with each section of the guidelines and those meeting all criteria were considered to be compliant with responsible reporting of suicide. Analysis was undertaken to determine the overall compliance with guidelines, the frequency with which each guideline was breached, and whether there were any differences based on whether articles originated from a local or a national media source. Differences between local and national media sources in the proportion of articles breaching any guidelines were calculated using the chi-squared test. Data analysis was performed in STATA 11 for Windows XP.

Box 1 Guidelines for the reporting of suicide assessed in the study. Adapted from the Samaritans¹⁶

1. Leave out technical details about the method of suicide, such as describing the type of ligature used or the number and types of pills taken in an overdose. Never suggest that a method is quick, easy, painless or certain to result in death.
2. Language matters. Avoid dramatic headlines and terms such as ‘suicide epidemic’ or ‘hot spot’.
3. Include references to support groups and places where suicidal people can find help.
4. Treat social media with particular caution and refrain from mentioning websites or networks that promote or glamorise suicide.
5. Avoid dramatic or sensationalist pictures or video. Refrain from including content from suicide notes.
6. Do not give undue prominence to photographs of a young person who has died and avoid repeated use of images such as galleries.
7. Do not brush over the complex realities of suicide and its impact on those left behind.
8. Speculation about the ‘trigger’ for a suicide, even if provided by a close family member, should be avoided.
9. Use statistics with caution. Make sure you have the most recent data and are comparing like with like.

In addition to comparison against the Samaritans’ guidelines, the inclusion of user-generated comments, threads and internet links to other articles was noted.

Results

Overall, 229 articles met the inclusion criteria: 68 articles from local media sources and 161 articles from national media sources. The majority (214 articles) came from media organisations which offer both a print and online platform, with national publications such as the *Guardian*, the *Telegraph* and the *Daily Mail* making up the bulk of national media output, and an array of smaller local outlets each contributing a smaller number of articles to the total. Fifteen articles were found in a range of online-only outlets such as the International Business Times, Yahoo UK, The Huffington Post and Wales Online. Ten articles were found on the websites of media network providers such as the BBC, ITV and STV.

Compliance with the responsible reporting guidelines

Of the 229 online articles included for analysis, 199 (86.9%) breached at least one of the Samaritans' guidelines. The mean number of guideline breaches per article was 2.2, with only a small variation between local and national media sources (2.1 v. 2.2 breaches per article, respectively; $P = 0.08$).

The most commonly breached aspects of the guidelines were a failure to include reference to sources of support for those considering suicide (69.4%), the inclusion of excessive technical detail about the method used (31%) and undue speculation about the reasons for suicide (30.1%) (*Table 1*). The other guidelines were breached in less than 25% of articles, with just 2 articles mentioning organisations that promote suicide and 1 article using statistics irresponsibly, telling readers the proportion of people completing suicide after jumping from a well-known landmark.

Compliance with reporting guidelines

	All sources	Local	National	Difference between local and national <i>P</i>
Articles, <i>n</i>	229	68	161	–
1 breach, <i>n</i> (%)	199 (86.9)	55 (80.9)	144 (89.4)	0.08
Breaches per article, mean	2.2	2.1	2.2	–
Specific guideline breaches, <i>n</i> (%)				
1. Excessive technical detail about the method	71 (31.0)	25 (36.8)	46 (28.6)	0.22
2. Sensationalist or irresponsible language	38 (16.6)	20 (14.7)	28 (17.4)	0.04* <#TFN1>`_
3. No sources of support	159 (69.4)	48 (70.6)	111 (68.9)	0.81
4. Mentioning places that promote or glamorise suicide	2 (0.9)	0 (0)	2 (1.2)	0.36
5. Dramatic pictures, videos, content of suicide notes	41 (17.9)	6 (8.8)	35 (21.7)	0.02* <#TFN1>`_
6. Picture galleries	30 (13.1)	1 (1.5)	30 (18.6)	0.001** <#TFN2>`_
7. Narrative brushes over the complex realities of suicide	20 (8.7)	5 (7.4)	15 (9.3)	0.63
8. Undue speculation about the triggers	69 (30.1)	18 (26.4)	51 (31.7)	0.43
9. Irresponsible use of statistics	1 (0.4)	0 (0)	1 (0.6)	0.52

P < 0.05,

$P < 0.01$.

Additional features of online media

Sixty-four articles included additional features which could contribute to readers encountering unsuitable material, such as the inclusion of user-generated comments sections and links to other articles which may similarly be poorly adherent to reporting guidelines (Table 2).

Articles with additional adverse features

	All sources <i>n</i> (%)	Local <i>n</i> (%)	National <i>n</i> (%)	<i>P</i>
Articles with additional adverse features	64 (27.9)	11 (16.2)	53 (32.9)	*0.01
Links to other articles about suicide	37 (16.2)	5 (7.4)	32 (19.9)	*0.02
User-generated comment threads	39 (17)	7 (10.3)	32 (19.9)	0.08

$P < 0.05$.

Discussion

This study evaluated the compliance of 229 online reports of suicide with the guidelines issued by the Samaritans. To our knowledge, this is the first study looking at the content of online media reports of suicide and the first in the UK looking at a selection of contemporary media output. Of note, the majority of articles included in the study failed to meet the Samaritans' guidelines for the responsible reporting of suicide. The results support findings from the limited number of studies undertaken elsewhere in the world that suggest media reporting of suicide is poorly compliant with available guidelines.^{18–21}

Of particular concern is the finding that 69.4% of reports failed to include a reference to a potential source of support for those readers who may be experiencing suicidal thoughts themselves; this was consistent across local and national sources. Lack of responsible information awareness and signposting support undermines suicide prevention efforts and fails to provide an alternative perspective to the often distressing narrative of articles. The finding that most articles omit references to support groups has been replicated in other studies from around the world: just 1% of Indian newspaper sources,¹⁹ 3% of US sources²¹ and 8.6% of Chinese sources⁸ included a reference to a support group.

Our finding that 31% of articles contained an excessive level of detail about methods used to complete a suicide is a significant cause for concern. The experience in other countries supports the idea that publication of suicide methods can perpetuate attempts and trends in methods chosen by others in 'copycat suicides'.^{2–5,22} In the course of assessing media reports for this study, the inclusion of details about the blood concentration of cyanide to achieve death, and the exact location and time of suicides by train, as well as details of places where suicides by jumping were completed, were all noted.

The finding that 30.1% of articles engaged in speculation about the reason for suicide was also a cause for concern. The journalistic tendency to simplify the reasons behind a suicidal act or engage in undue speculation about the surrounding circumstances can have a damaging impact on the bereaved family¹⁷ as well as readers who may over-identify with the person mentioned in the article, potentially increasing the deleterious impact for vulnerable individuals. This tendency to make articles more 'readable' may also be reflected in the fact that 8.7% of articles brushed over the complex realities of suicide, often failing to mention the family left behind or the impact of the suicidal act on others.

That being said, only one report included the irresponsible use of statistics and only two reports directed readers towards pro-suicide websites.

A qualitative observation was that where a particular fact about a suicide attempt is known, it will usually feature in other articles from other outlets about the same act. For example, very specific details about a method used were usually re-reported in all articles discussing the same event without due regard for the reporting guidelines.

Local v. national media sources

When comparing reporting by national and local media sources, local sources were overall more compliant with guidelines, with significant differences in the use of sensationalist language, dramatic pictures, videos or the content of suicide notes and the use of galleries, as well as the use of additional features of online media. The exact reason for the broadly better compliance with guidelines among local sources is not fully understood, but it may be because local media sources are closer to the subject of the article and local reporters may be more sensitive to the feelings of the bereaved family and local community.

Additional features of online media

The unique additional features of online media (compared, for example, with newspaper articles or television reports) could also compound their negative impact on readers; 16% of articles included links to other reports of suicide. Our finding that a majority of articles about suicide fail to meet responsible reporting guidelines and that the mean number of guideline breaches is 2.2 per article raises the possibility that the negative impact of irresponsible reporting is likely to be amplified by the inclusion of links to other potentially non-compliant reports.

Previous findings that discussion forums can increase suicidality among younger users²³ suggest that the addition of comments sections which can facilitate discussion should be avoided with online reports of suicide. Despite this, 17% of analysed reports had a comments section for user-generated content, and concerning comments such as the deceased person being 'brave' or 'at peace now' were frequently a feature of these.

Policy considerations

There is an evident need to evaluate the reasons for journalistic non-compliance with the existing guidelines of suicide reporting in the UK. Given the increasing use of online media and the apparent poor quality of reporting, there is a need to focus efforts on increasing the compliance of reports with responsible reporting guidelines. Suitable measures should also be established for non-compliant and potentially harmful articles to be flagged for urgent review.

Limitations

Although a standardised tool was used to identify breaches of media guidelines, judgements about breaches were not cross-checked between researchers. In addition, although the search sought to capture publications over a period of time, this work cannot account for potential seasonal changes in data.

Next steps

The present study uncovers an urgent need to address the fact that the majority of online articles assessed do not comply with existing guidelines on the responsible reporting of suicide. It highlights a significant public health concern because potentially vulnerable people have access to material which may provoke suicidal behaviours and which does not signpost them to support resources. Given the increasing weight of evidence that media reporting can affect suicide rates, there is an urgent need for the implementation of responsible reporting guidelines in online media articles. We propose that work be done to clarify and publicise the guidelines, and to train and encourage journalists to use them, and that a strong consideration be given to the role of more formal regulation and monitoring.

1.7.27 Caregiver burden and distress following the patient's discharge from psychiatric hospital

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Abstract

Aims and method Caring for someone with a mental illness is increasingly occurring within the community. As a result, family members who fulfil a caregiving role may experience substantial levels of burden and psychological distress. This study investigates the level of burden and psychological distress reported by caregivers after the patient's admission.

Results This study found that the overall level of burden and psychological distress experienced by caregivers did not differ according to the patient's legal status. However, the caregivers of those who were voluntarily admitted supervised the person to a significantly greater extent than the caregivers of those who were involuntarily admitted. Approximately 15% of caregivers revealed high levels of psychological distress.

Clinical implications This study may emphasise a need for mental health professionals to examine the circumstances of caregivers, particularly of those caring for patients who are voluntarily admitted, a year after the patient's admission.

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 - *Method*
 - * *Participants*
 - * *Informed consent*
 - * *Psychometric instruments*
 - * *Setting*

1

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- * *Ethical approval*
- * *Statistical analysis*
- *Results*
 - * *Demographic and clinical characteristics*
 - * *Caregiver burden*
 - * *Factors associated with caregiver burden*
 - * *Psychological distress*
 - * *Factors associated with psychological distress*
 - * *Post hoc analysis*
- *Discussion*
 - * *Summary of findings*
 - * *Comparison with previous research*
 - * *Implications*
 - * *Strengths and limitations*

One in four families worldwide is affected by mental illness.¹ With the onset of illness, a family member may assume a caregiver role for their unwell relative, which may result in positive and negative experiences for the caregiver.² While caregivers convey a sense of satisfaction and well-being from their caregiving relationship, they also report feeling burdened.³ Such burden may be characterised by both objective difficulties, such as being unable to leave the family home and work, and subjective difficulties, such as psychological distress.⁴

Should a patient become severely unwell, it is often the caregiver who intervenes to initiate emergency psychiatric treatment.⁵ Caregivers can experience significant obstacles in gaining the assistance of a mental healthcare team for their relative⁶ and involuntary admission in particular can be associated with high levels of caregiver burden.⁷ This is important, as the level of burden experienced by caregivers can significantly predict treatment adherence and outcome in the patient.⁸ Furthermore, caregivers who experience high levels of burden reveal an increased incidence of physical and mental health problems and health-related risk behaviours.⁸ However, less is known about the level of burden or psychological distress that caregivers experience in the period following admission. Additionally, the limited research to date has focused on caregivers of involuntarily admitted patients and there is very little known about the caregivers of those admitted voluntarily.

For this reason, we aim to determine the level of burden and psychological distress reported by caregivers approximately 18 months after the patient's admission to an acute mental health unit. We also aim to determine whether clinical (specifically legal status) and demographic factors were associated with the level of burden and psychological distress reported by caregivers.

Method

Participants

Participants consisted of caregivers of either involuntarily or voluntarily admitted patients. Caregivers were recruited from two concurrent studies: the Service Users' Perspectives of their Admission (SUPA) study⁹ and the Prospective Evaluation of the Operation and Effects of the Mental Health Act 2001 from the Viewpoints of Service Users and Health Professionals study. The former was conducted in south-east Dublin and North Wicklow and involved both involuntarily and voluntarily admitted patients. The latter was conducted in Galway and Roscommon and included involuntarily admitted individuals and individuals who were brought to hospital under the Irish Mental Health Act, 2001, but were not subsequently involuntarily detained (i.e. they accepted a voluntary admission).

As patients were recruited before caregivers in these studies, our inclusion and exclusion criteria for caregivers stemmed from those applied to patients (*Fig. 1*). Patients were excluded if they could not provide informed consent, had a diagnosis of dementia or had a moderate to severe intellectual disability that rendered them unable to participate in the study. Patients who received a sole diagnosis of a personality disorder or substance misuse were also excluded from participating, as these individuals cannot be admitted involuntarily under the Irish Mental Health Act, 2001. Caregivers who were younger than 18 at the time of interview or who had a moderate to severe intellectual disability that impeded their ability to consent were similarly excluded from participation in the study.

Informed consent

Informed consent was obtained from all individual participants included in the study. The consent process consisted of three steps. First, patients were asked to consent to their caregiver being contacted and informed of the study approximately 1 year after their discharge. Second, caregivers were contacted by telephone by a researcher who introduced the study and arranged a time of interview. Finally, informed consent was sought from caregivers at interview.

Psychometric instruments

The Involvement Evaluation Questionnaire (IEQ) was employed as a measure of caregiver burden and caregiving.¹⁰ It consisted of 27 core items divided into four sections: urging, supervision, tension and worrying. Scores on the IEQ ranged from 0 to 108, with larger figures representing a higher level of caregiver burden. The IEQ is a reliable instrument, with Cronbach's alpha 0.74–0.85 for each subscale and 0.90 for the total score.¹¹ The IEQ also included a short, 12-item General Health Questionnaire (GHQ-12) that measured psychological distress. Scores on the GHQ-12 ranged from 0 to 12, with higher scores indicating that the caregiver was experiencing emotional difficulties.¹² The GHQ-12 is a reliable measure of psychological distress with an alpha coefficient of 0.87.¹³ Finally, diagnostic and clinical information pertaining to the patient was taken from a Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID).¹⁴

Setting

The study included caregivers of individuals admitted to an acute mental health unit in one of five hospitals in Ireland that covered a combined urban and rural catchment population of over 590 000 individuals.

Ethical approval

The study received ethical approval from the governing ethical committees in all of the study sites: St John of God Hospitaller Order Provincial Ethics Committee, Newcastle Hospital Ethics Committee and University Hospital Galway Ethics Committee.

Statistical analysis

All data were entered into a Microsoft Access database and analysed using SPSS Version 22 for Mac. As the data were not normally distributed, multiple Mann–Whitney U and Kruskal–Wallis tests were used to determine whether burden and psychological distress scores differed between caregivers of involuntarily and voluntarily admitted individuals, and according to clinical and demographic factors. Effect sizes (r) were used to measure the magnitude of differences between scores. A small, moderate or large effect size corresponded with values equal to or less than 0.10, 0.30 and 0.50, respectively.

Results

Demographic and clinical characteristics

Sixty-five caregivers participated in the study; 42 (65%) were female. The mean age of caregivers was 54 years (s.d. = 15). The majority of caregivers were married ($n = 49$, 75%), 5 (8%) were single, a further 5 (8%) were divorced and the remaining 6 (9%) were widowed. Most caregivers were the person's parents ($n = 37$, 57%), 11 (17%) were spouses or partners, 8 (12%) were siblings, 6 (9%) were children and 3 (5%) were other relatives. The mean length of time between caregiver and patient interviews at baseline was 584 days (s.d. = 165). The median duration of the index admission was 34 days (interquartile range (IQR) 17.5–50) and 24 (36.9%) patients were readmitted within 1 year of the index admission.

Forty-six (71%) individuals were involuntarily admitted and 19 (29%) were voluntarily admitted. The majority were male ($n = 33$, 51%). The mean age of patients was 39 years (s.d. = 12). The majority of patients were single ($n = 41$, 63%), 16 (25%) were married and the remaining 8 (12%) were divorced.

Caregiver characteristics across legal status are given in *Table 1*.

Comparison of caregiver characteristics across legal status

Characteristic	All caregivers	Caregivers of involuntarily admitted patients	Caregivers of voluntarily admitted patients	Statistical test	<i>P</i>
Age, years: median (IQR)	54 (43–67)	54 (43–66)	54 (39–68)	$U = 340$	0.94
Gender, <i>n</i> (%)					
Male	23 (35)	14 (30)	9 (47)	$\chi^2 = 1.7$ d.f. = 1	0.19
Female	42 (65)	32 (70)	10 (53)		
Marital status, <i>n</i> (%)					
In relationship	49 (75)	34 (74)	15 (79)	$\chi^2 = 0.2$ d.f. = 1	0.67
Not in relationship	16 (25)	12 (26)	4 (21)		
Education, <i>n</i> (%)					
Primary/secondary	16 (30)	12 (33)	2 (13)	$\chi^2 = 2.8$ d.f. = 1	0.09
Tertiary	37 (70)	24 (67)	13 (87)		
Household, <i>n</i> (%)					
Living together	37 (57)	23 (50)	14 (74)	$\chi^2 = 3.1$ d.f. = 1	0.08
Living separately	28 (43)	23 (50)	5 (26)		
Relationship, <i>n</i> (%)					
Parent	34 (71)	25 (78)	9 (56)	$\chi^2 = 2.5$ d.f. = 1	0.12
Partner	14 (29)	7 (22)	7 (44)		

IQR, interquartile range.

Caregiver burden

The median level of burden in the sample was 13.00 (IQR 6.00–22.00). The median level of burden in caregivers of involuntarily admitted patients was 11.50 (IQR 6.25–20.75) and in caregivers of those voluntarily admitted it was 18.00 (IQR 5.00–34.00). Caregivers' overall scores of burden did not significantly differ ($U = 328$, $P = 0.18$, $r = 0.17$). However, caregivers of voluntarily admitted patients supervised the person to a greater extent than caregivers of involuntarily admitted patients (median IEQ supervision scores 2 v. 0, $U = 258$, $P < 0.001$, $r = 0.38$). The particular items of the subscale of supervision on which caregivers of voluntarily admitted individuals scored higher were ensuring that the person had enough sleep ($P = 0.02$) and that they did not drink too much alcohol ($P = 0.05$).

Factors associated with caregiver burden

There was no significant association between the level of caregiver burden and the caregiver's gender, patient's gender, diagnosis, level of functioning, relationship to caregiver or living in the same household as the patient (*Table 2*).

Involvement Evaluation Questionnaire (IEQ) and General Health Questionnaire (GHQ-12) scores according to demographic and clinical characteristics

	IEQ					
Ca regiver gender						
Male	9 (5–22)	3 (1–8)	0 (0–2)	2 (0–5)	3 (1–7)	1 (0–2)
Female	14 (8–23)	4 (1–7)	0 (0–1)	3 (2–6)	6 (3–8)	1 (0–3)
Patient gender						
Male	10 (5–23)	4 (1–9)	0 (0–2)	2 (1–4)	5 (2–8)	1 (0–2)
Female	14 (8–22)	3 (1–8)	0 (0–2)	4 (2–7)	5 (3–8)	1 (0–3)
Di agnosis						
Af fective	11 (7–21)	3 (1–6)	0 (0–2)	3 (1–6)	4 (1–7)	1 (0–2)
Ps ychotic	14 (8–21)	5 (1–12)	0 (0–3)	3 (0–6)	6 (3–9)	1 (0–3)
GAF score						
Higher func tioning	12 (5–23)	3 (1–8)	0 (0–2)	4 (0–7)	5 (1–9)	1 (0–2)
Lower func tioning	14 (7–21)	4 (1–9)	0 (0–2)	3 (1–6)	5 (2–8)	1 (0–3)
Relat ionship of ca regiver to patient						
Parent	11 (5–21)	3 (1–6)	0 (0–2)	3 (1–6)	5 (3–8)	1 (0–3)
Partner	21 (7–28)	6 (1–11)	1 (0–2)	4 (2–7)	4 (2–10)	1 (0–2)
Ho usehold						
Living t ogether	15 (6–24)*	2–10)*	0 (0–2)	4 (1–6)	6 (2–9)	1 (0–2)
Living sep arately	9 (6–20)	2 (1–5)	2 (1–6)	2 (1–6)	4 (1–7)	1 (0–3)

GAF, Global Assessment of Functioning; IQR, interquartile range.

P 0.05. On applying a Bonferroni correction, no variable reached significance.

Psychological distress

Nine caregivers (15%) reported high levels of distress (defined as a score of 4 on GHQ-12). The median score of psychological distress was 1.00 (IQR 0.00–2.50): 1.00 (IQR 0.00–3.00) in caregivers of involuntarily admitted patients and 0.00 (IQR 0.00–1.00) in caregivers of voluntarily admitted patients. Caregivers of involuntarily or voluntarily admitted patients did not significantly differ in their levels of psychological distress ($U = 302, P = 0.19$).

Factors associated with psychological distress

No significant association was found between the caregiver's level of psychological distress and the caregiver's gender, patient's gender, diagnosis, level of functioning, relationship to caregiver or whether they lived in the same household as the patient (*Table 2*).

Post hoc analysis

We hypothesised that subsequent admissions from the index admission could affect the burden and psychological distress of caregivers and therefore further analysis examining this was performed. Caregiver burden was higher when the patients had been readmitted (16.0 *v.* 9.5, $U = 281.5, P = 0.04$) and there was a trend for a higher level of distress (1.0 *v.* 0.0, $U = 277, P = 0.06$). Legal status for the index admission was not associated with readmission ($\chi^2 = 0.28, n = 61, P = 0.60$).

Discussion

Summary of findings

The findings indicated that overall levels of burden and psychological distress did not differ between caregivers of involuntarily and voluntarily admitted patients at approximately 18 months after discharge from an acute mental health unit. However, caregivers of voluntarily admitted patients engaged in significantly higher levels of supervision than caregivers of those involuntarily admitted. Such supervision focused on, for example, ensuring that the patient slept sufficiently. *Post hoc* analysis also suggested that caregiver burden is associated with readmission to hospital.

Comparison with previous research

To our knowledge, no study to date has examined whether differences in the patient's legal status at admission accounted for differences in caregiver burden (objective and subjective) at more than 1 year follow-up. Our findings, however, support those of Boydell *et al.*,⁷ who also emphasised that overall burden was not linked to involuntary admission in caregivers of patients with first-episode psychosis. Our scores of burden and psychological distress are substantially lower than those reported by other authors.¹¹ Thus, the similarity in scores between caregivers in this sample may be due to a reduction in overall caregiver burden following the person's admission to hospital regardless of legal status.¹⁵

Implications

The finding that caregivers of voluntarily admitted individuals supervised the person to a greater extent is interesting and warrants discussion. It is possible that this additional supervision is a positive experience and that it results in an earlier detection of warning signs and prevents potential relapses from progressing to an involuntary admission. This finding highlights the need for caregivers of both voluntarily and involuntarily admitted individuals to receive support and psychoeducation. Interestingly, the *post hoc* analysis suggests that it may be the frequency of admissions that results in higher burden, as opposed to the legal status of the admissions. Furthermore, a longitudinal replication of this study assessing burden at various time points may provide us with a clearer picture of the caregiver's experience of burden.

Strengths and limitations

The study encompassed a number of strengths and limitations. Our sample included caregivers of involuntarily and voluntarily admitted individuals from both rural and urban geographical locations. Another strength of the study was that the caregivers did not self-select to the study. Nonetheless, our process of consent may have introduced bias, as those who consented for their caregiver to be interviewed may have had closer family relationships. Additionally, there was a significant gap between the index admission and the caregiver interviews, which introduces a number of potential confounders, such as readmission to hospital.

We thank Alastair Fetherston for designing the database for this study.

1.7.28 Unlocking an acute psychiatric ward: the impact on unauthorised absences, assaults and seclusions

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Abstract

Aims and method The acute psychiatric in-patient service in Christchurch, New Zealand, recently changed from two locked and two unlocked wards to four open wards. This provided the opportunity to evaluate whether shifting to an unlocked environment was associated with higher rates of adverse events, including unauthorised absences, violent incidents and seclusion. We compared long-term adverse event data before and after ward configuration change.

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Results Rates of unauthorised absences increased by 58% after the change in ward configuration ($P = 0.005$), but seclusion hours dropped by 53% ($P = 0.001$). A small increase in violent incidents was recorded but this was not statistically significant.

Clinical implications Although unauthorised absences increased, the absence of statistically significant changes for violent incidents and a reduction in seclusion hours suggest that the change to a less restrictive environment may have some positive effects.

Contents

- *Unlocking an acute psychiatric ward: the impact on unauthorised absences, assaults and seclusions*
 - *Method*
 - *Results*
 - *Discussion*
 - * *Strengths and limitations*
 - * *Final consideration*

The locking of psychiatric institutions is an important topic because detention involves significant restrictions on human rights, enshrined in the Universal Declaration of Human Rights. However, studies that have evaluated the impact of unlocking a psychiatric ward are rare; we were only able to identify four such studies spanning 7-decade-long assessing in this area. Lang *et al*¹ evaluated a policy change that resulted in a ward changing from being largely locked for 6 months to being largely open for 6 months and found that negative outcomes were more common during the closed time period. Other studies are considerably older^{2,3} and were largely positive in their findings, with the exception of the study by Molnar *et al*,⁴ which reported an increase in the frequency of ‘elopement’ (unauthorised absence) from 2.5 to 7% of admissions in the context of changing ward policy to allow a largely unlocked environment.

Any consideration of locked psychiatric wards must be viewed in the context of emerging policy that recommends minimising the use of locked psychiatric wards⁵ and emphasises a duty to provide psychiatric care in the least restrictive environment. A desire to provide least restrictive care created the impetus for our local psychiatric service to shift from an acute in-patient environment consisting of two locked wards and two unlocked wards to four largely unlocked wards. It also provided the opportunity to evaluate the impact of the change through reporting of long-term data detailing adverse events, such as unauthorised absences, ward violence and rates of seclusion, prior to and following the changes in ward environment.

Method

Data for this study were taken from the acute in-patient service in Christchurch, New Zealand. The service is the sole provider of acute in-patient services to adults aged 18–65 in the city of Christchurch, outlying towns and rural areas, with the exception of forensic patients, patients with an intellectual disability and in-patients requiring planned detoxification from substances, who are admitted elsewhere. The acute in-patient service receives admissions from community and emergency psychiatric services when care in the community is no longer feasible, with a typical case mix consisting of patients with affective disorders, psychotic disorders and personality disorders.

The service underwent major architectural change in 2013. Before, the service was configured with two locked wards (totalling 20 beds), two wards (totalling 44 beds) that were predominantly unlocked except overnight, and a seclusion area with 3 seclusion rooms. In response to service development initiatives and the desire to provide less restrictive care, the wards were reconfigured into 4 largely unlocked 16-bed wards (except overnight when the wards remain locked). At the end of each ward is a zone called the ‘high care area’, which is quieter than the general ward and provides care for up to three of the more unwell patients. Each high care area is continuous with its adjacent ward and can be designated ‘high care’ when doors are closed or locked, or be regarded as part of the general ward when extra clinical input is not required. The décor and bedrooms of the high care area are identical to the adjacent ward, but an

additional lounge, bathroom and courtyard are provided in order for the high care area to act as a self-sufficient unit when required. All wards, including the high care areas, are intended to be unlocked as much as possible but each ward or high care area can be locked separately in order to detain a patient if this is deemed necessary. The high care area bedrooms were not outfitted for seclusion but the seclusion area remained unaltered and could still be used if required. *Figure 1* presents details of the ward layout. If the ward or a high care area is locked, it is recorded in the restraint register as an environment restraint, and is therefore available for review.

In addition to these structural changes, nursing staff numbers increased, from 27 nurses routinely rostered on the wards to 34 nurses. However, if a nurse was required to provide one-to-one supervision after the change, this needed to occur within existing staff levels, whereas previously this was not the case. The frequency of one-to-one supervision pre- and post-change was not systematically recorded and is not readily available for review.

The acute in-patient service routinely records data on unauthorised absences, seclusions and violent incidents. Unauthorised absences include patients who are under involuntary mental health legislation and leave the ward without permission or fail to return from authorised leave, and voluntary patients who leave the ward outside of their agreed treatment parameters or fail to return from agreed leave. Nursing staff follow procedures when absences occur, including filling out a form documenting the absence which is then collated in a central database.

Violent incidents are assessed clinically and categorised into a number of subcategories including verbal abuse, threats of violence and assaults; all are recorded and collated centrally.

Seclusion is initiated by nursing staff as an intervention of last resort for managing a situation of imminent or actual violence. In response to international and New Zealand initiatives,⁶ seclusion reduction initiatives became embedded into the routine care environment of the acute in-patient service from 2010 and the goal of reducing seclusion occurred alongside the plan to provide a less restrictive environment through the ward redevelopment. Although seclusion rates are likely to be reduced by the seclusion reduction initiatives, the change in ward environment had the potential to hinder or assist the goal of reducing seclusion. As a consequence, we report seclusion rates which are collated centrally on a database and are therefore available for review.

The AWOL (absent without leave), violent incidents and seclusion databases have all collected data over an extended period. In de-identified form, they provided the opportunity to examine rates of unauthorised absences, seclusions and violent incidents for 18 months prior to the change in ward configuration and compare this to 18 months following the change. The mean rates and standard deviations of the monthly adverse events were calculated for the pre- and post-change 18-month intervals. As the data were non-parametric in nature, the Mann-Whitney *U*-test was used to compare the 18 months prior to the change with the 18 months following the change. The change in ward environment was staggered during June and July 2013; this time period was therefore not included in any data analysis as our goal was to examine a longer-term impact of the policy change as opposed to short-term effects during and following the transition.

We also report frequency and duration of the use of environmental restraint to clarify whether or not the intended change to a largely unlocked environment was successful or resulted in frequent locking of the newly configured wards. The frequency of Safety Assessment Code (SAC) 1 and 2 incidents (adverse events involving serious, major or extreme harm to patients) involving psychiatric in-patients is also provided pre- and post-change and examined for the possibility of a change in more serious adverse events that would not be detected by previous methods.

Ward occupancy data are routinely collected by means of a census taken at midnight every 24 hours. Admission data to the acute in-patient service and the forensic service are also recorded daily. Forensic in-patients are predominantly admitted from forensic out-patient services, courts and prisons, and not from general out-patient services. However, we examined admission and occupancy data for these services to test for the possibility that changes in outcome data were confounded by variations in occupancy or transfer to the more secure environment of the forensic service. The rate of monthly admissions pre- and post-change was compared using the Mann-Whitney *U*-test.

Although this was a study of group data and individual files were not accessed, ethics approval was sought and granted by the local University of Otago ethics committee (reference number HD 14/21).

Results

Longitudinal data on monthly unauthorised absences are presented in *Fig. 2*. The mean rate for the 18 months prior to the new ward configuration (December 2011-May 2013) was 16.9 (s.d. = 7.7) compared with 26.7 (s.d. = 11.2) for 18 months following the change in ward configuration (August 2013-January 2015). This represented a mean increase of 9.7 unauthorised absences per month and a percentage increase of 58% that was statistically significant ($P = 0.005$). As some literature suggests unauthorised absences may be seasonal, means were also calculated for the year pre- and post-change to ensure identical calendar months were compared, and the results were similar (16.6 (s.d. = 9.1) v. 29.6 (s.d. = 7.5), respectively).

Violent incidents were examined through the extraction of data recorded under the category of aggression, which includes verbal abuse, verbal threats, physical threats and physical assaults. Specific data were also extracted on physical assaults to assess for more significant violence. *Figure 3* shows the longitudinal data for all violent incidents and the mean monthly rates for 18 months pre- and 18 months post-ward changes, which were 72.3 (s.d. = 34.5) and 78.2 (s.d. = 43.1), respectively. This represented a mean increase of 5.9 violent incidents/month, or an 8% increase in incidents, which was not statistically significant ($P = 0.696$). With regard to physical assaults, the mean difference of 2.8 assaults/month, from 11.5 (s.d. = 5.9) before to 14.3 (s.d. = 10.1) after, was also not statistically significant ($P = 0.628$) (*Fig. 3*).

Another assessed variable was the longitudinal data on monthly seclusion hours over the study period as well as the mean rates of monthly seclusion (hours/month) (*Fig. 4*). The mean length of seclusion prior to the change was 391.5 (s.d. 203.0) compared with 185.2 (s.d. 135.6) following the change. This represented a mean drop of 206 hours/month or a percentage drop of 53% that was statistically significant ($P = 0.001$).

Occupancy was recorded according to bed nights/month and converted to a percentage of available bed nights. Occupancy varied between 80 and 101%, with a mean occupancy of 91% over the study period. It is likely that the single month that experienced more than 100% occupancy was very busy and included extra persons in rooms (e.g. partners, who do not routinely stay) being entered in the census data. Percentage occupancy data were largely stable over the study period and were without systematic trends that could account for the significant increases in unauthorised absences or significant reduction in seclusion hours. In keeping with the occupancy data, the rate of new admissions to the acute in-patient service was also largely stable over the study period (mean monthly admissions for the 18 months pre-change 100.4 compared with 107.8 for the 18 months post-change, $P=0.071$). The mean number of monthly admissions to the forensic service increased from 3.1 before the new ward configuration to 4.4 after; however, the increase was not caused by in-patients from the acute in-patient service as a total of 3 patients were transferred from the acute in-patient service to the forensic service for the 18 months prior to the ward change compared with 4 patients in the 18 months following the change.

The frequency of environmental restraint (locking of the high care areas or whole wards) revealed that, on average, there were 16 times per month when either a high care area or a whole ward was locked following the change in ward configuration. This meant that on average, each of the four wards had 4 periods each month in which part or the whole of the ward was locked. The frequency of locked periods/month varied from 0 for some wards to a maximum of 19, when the high care area of one ward was locked on multiple occasions in response to a single patient's multiple attempts to leave. In 37% of the environmental restraints, just the high care areas were locked as opposed to whole wards (affecting only 1–3 patients at a time). The mean time an area was locked was 120 minutes, and the range varied from 1 minute to 920 minutes. These results can be compared with the period prior to the new ward configuration, which had two wards (affecting up to 20 patients) constantly locked and occasional periods when the two open wards were locked in response to clinical pressure.

The total number of SAC1 and SAC2 events involving in-patients was 14 over the study period. Of these, 10 occurred before the change in ward configuration, 0 occurred during the transition period, and 4 occurred after the changes were made. For SAC1 incidents resulting in the death of a patient, 7 occurred prior to the ward changes (4 deaths occurred on the ward, 2 while patients were on granted leave, and 1 while on unauthorised absence from the ward) and 4 deaths occurred following the ward changes (3 on the ward and 1 while on granted leave). No SAC2 incidents occurred for patients who were on leave in the community or during an unauthorised absence.

Discussion

This study examined a range of adverse indicators over an extended time period in order to clarify whether or not a change in ward environment from two locked and two unlocked wards to a largely unlocked environment was associated with an increase in adverse events. The principal finding was that a significant increase in unauthorised absences occurred. However, significant decreases in the use of seclusion and non-significant increases in violent outcomes were also observed, although the reduction in seclusion occurred alongside national and local initiatives to minimise the use of seclusion.

The new ward configuration still made provision for the locking of wards. However, this was only done for relatively short periods (mean 120 min) and less often than prior to the ward redevelopment, when 2 wards affecting 20 patients were continuously locked. In addition, in 37% of the occasions when locking occurred, only a high care area was locked, meaning that 3 or fewer patients were affected. These numbers suggest that the unlocking of two wards and the change in ward environment did not result in wide-spread or prolonged locking of the new ward configuration.

The occupancy and admission data were without systematic trends to explain the changes noted. In addition, there was minimal flow of patients from the acute in-patient service to the forensic service, suggesting that more difficult patients who may be over-represented in adverse incident data were not transferred to forensic services after the wards were reconfigured.

Previous studies of unauthorised absences from psychiatric wards have raised concerns about rare but serious adverse events that have occurred while patients are absent.⁷ Although the low base rate of these events makes analysis difficult, it is reassuring for those considering a transition to the provision of a largely unlocked environment that of the 14 SAC1 and SAC2 events occurring over the study period, 10 occurred prior to the ward change and only 4 occurred afterwards. In addition, of the adverse events resulting in the death of a patient, 7 occurred before the ward changes and 4 afterwards. Although total numbers of unauthorised absences increased, there was only one death involving a patient who had left the ward without being granted leave, and it occurred prior to the ward change. All other community deaths over the study period involving in-patients occurred for patients who had been granted leave.

Strengths and limitations

One strength of the study was the routine collection of outcome data by hospital staff who were unaware that the data would later be used for study purposes. As a consequence, changes in reporting behaviour could not arise as a result of study influences because of the retrospective nature of the study conception and design. A further strength is the longitudinal nature of the data-set that allowed us to make before-and-after comparisons and consider longer-term effects, as opposed to solely focusing on the transition period during which staff are adapting to changes. These longer-term effects were thought to be more important in evaluating the impact of the change in environment and can be taken into account by service leaders in other locations considering similar changes. Although the longer-term outcomes were our primary area of interest, it is also reassuring that the transition period did not coincide with any SAC1 or SAC2 events, or a spike in the other adverse events evaluated by the study.

Our main limitation was that the study design was not experimental in nature. As the study was uncontrolled, our methodology allows comments to be made on associations between adverse events and the ward changes, but demonstrating causation is not possible. In particular, there was a service initiative to reduce seclusion that started prior to the study period. There were also increases in the numbers of routinely rostered nursing staff on the acute in-patient service after the ward change. This means that the relative influences of the change in ward configuration, the seclusion-reducing initiatives and the changes in nursing numbers on the adverse event rates are hard to quantify. It is therefore possible that increases in seclusion might have been observed if the changes in ward configuration had occurred in isolation. However, it is also reassuring to note that no such increases were seen in the presence of the seclusion reduction focus and nursing number changes that also occurred over the study period.

Final consideration

Studies such as ours that have evaluated the impact of unlocking psychiatric wards are rare. We were only able to identify 4 previous studies over 7 decades in our literature review. These studies were largely supportive of unlocking psychiatric wards, although the Molnar *et al*⁴ study also identified an increase in unauthorised absences following changing ward policy. However, after the initial increase, the rate subsequently decreased following an intervention to better manage risk and absconding.⁴

As stated, the unlocking of our in-patient ward should not be viewed in isolation. Although the findings were mixed with respect to adverse outcomes, we suggest that clinical attention and adaptations to nursing practice and clinical care have the ability to mitigate adverse outcomes when changes in environment occur. This conjecture is supported by the ability of some psychiatric units to markedly reduce seclusion rates⁸ in the presence of administrative and clinical support, and scrutiny of seclusion practice. It is likely that the reduction of seclusion hours demonstrated in this study occurred largely as a result of nursing and management strategies already in place to reduce seclusion in our service. However, seclusion hours continued to fall despite the change in ward configuration, meaning that the less restrictive environment did not have a negative impact on seclusion rates or supported the continued reduction of seclusion. Further support for the ability of service improvement initiatives to minimise adverse outcomes is given by the studies of Bowers *et al*,^{9,10} who trialled anti-absconding interventions in acute psychiatric wards with positive results, and the study by Nijman,¹¹ who demonstrated a reduction in aggressive incidents through a systematic focus on aggression alongside an intervention to reduce aggression. These studies suggest the importance of nursing practice interventions in addition to any environmental measures for reducing rates of absconding and aggression.

Adverse outcomes varied after the change to a largely unlocked environment, with increases in absconding, reductions in seclusion and non-significant increases in violent incidents. The real-world nature of this study does not allow clear inferences to be made regarding whether or not the unlocking of the ward was causally linked to these changes in adverse outcome rates. However, the longer-term nature of the database, with the ability to scrutinise the adverse outcomes pre- and post-change in ward configuration, strengthened the ability of this study to examine the change. The change to a largely unlocked environment was stimulated by a desire to provide care in the least restrictive way possible. Our findings constitute a cautious endorsement of this approach. Although unauthorised absences increased, other adverse outcomes were stable or improved. Thus, providing acute in-patient psychiatric care in a largely unlocked environment appears feasible, particularly in the presence of other service improvement strategies.

1.7.29 Psychiatry trainees' experiences of cognitive-behavioural therapy training in a UK deanery: a qualitative analysis

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Abstract

Aims and method To explore core psychiatry trainees' experiences of cognitive-behavioural therapy (CBT) training by using interpretative phenomenological analysis of semi-structured interviews conducted with seven core trainee psychiatrists in Yorkshire and the Humber Deanery.

Results Four key themes emerged: (1) barriers to training; (2) guidance, with emphasis on the importance of supervision groups; (3) acquisition of new skills and confidence; (4) personal influence on the training experience.

Clinical implications Many trainees in Yorkshire have a positive experience of CBT training; however, some also experience barriers to acquiring the relevant skills. Further research should build on the positive factors and barriers identified here, with a view to guiding improvements in training nationwide.

Contents

- *Psychiatry trainees' experiences of cognitive-behavioural therapy training in a UK deanery: a qualitative analysis*
 - *Aims*
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In 2009 the Royal College of Psychiatrists revised the curriculum for psychiatric training to include specific psychotherapy elements within the core curriculum for all psychiatry trainees.^{1,2} The curriculum outlines general and specific competencies.² To achieve these competencies, trainees must complete a psychotherapy Assessment of Clinical Experience (ACE) as a workplace-based assessment (WPBA), attend case-based discussion (CBD) groups and undertake two psychotherapy cases in two modalities.² This revision was an attempt to ensure that core trainees get sufficient experience of psychological treatments to be able to utilise them accurately, evaluate their effects intelligently and, where appropriate, deliver them competently. Cognitive-behavioural therapy (CBT) is one of the recommended modalities of psychological treatments. Psychiatry trainees are expected to be competent to deliver CBT effectively, and CBT is a valuable skill that enriches and informs their practice.³⁻⁵

The current literature suggests that prior recommendations for training in psychotherapies have not been widely implemented,⁶⁻⁸ despite trainees expressing an interest in acquiring such skills.⁸ Historically, trainees have been unaware of new curriculum guidelines⁷⁻⁹ and barriers to the training have been identified. These include lack of supervision,¹⁰ limited availability of suitable cases for training,⁹ and lack of protected learning time.^{4,11-16} A small study¹⁷ suggested working with low-complexity patients in the primary care setting as a way of overcoming these barriers, with protected time to do so. However, this has not been trialled on a wider scale, and limited data are available about whether this is a preferred route of training.¹⁷ Indeed, little qualitative research exists on the experiential accounts of psychiatric trainees undergoing the current training programme.

Aims

This study aims to explore the experiences of CBT training, delivery and supervision in core trainee psychiatrists who have trained in Yorkshire and the Humber Deanery. This work aims to identify barriers that lead to negative experiences of CBT training and identify the factors that facilitate a positive training experience. We also hope this study will guide improvements to CBT training for core trainee psychiatrists to enable trainees to meet the Royal College of Psychiatrists' objectives and, ultimately, become more competent and psychologically minded psychiatrists.

Method

This was an exploratory, qualitative study. Semi-structured telephone interviews and face-to-face interviews were used for data collection, and interpretative phenomenological analysis (IPA) was employed. IPA is a qualitative tool that enables the exploration of an individual's perception of events and how they 'make sense' of experiences.^{18,19} Approval for the study was granted by the Research and Development Department, Faculty of Medicine and Health, University of Leeds.

Recruitment

Twelve core trainee psychiatrists in Yorkshire who had recently completed CBT cases under supervision were invited to participate in the study via email. One trainee declined participation as they were no longer working in the area and four trainees did not respond to the recruitment emails. Seven participants consented to take part in the study.

Participants

The participants were a small, purposeful sample of seven core trainee psychiatrists (CT2 and CT3). Three participants were male. Two participants had worked in a psychotherapy post and one expressed an interest in specialising in psychotherapy.

Procedure

The semi-structured interviews were guided by a review of the pre-existing literature concerning psychotherapy training experiences. This was piloted and amended as necessary. The questions concerned core trainees' experiences of CBT training and the generalisability of acquired competencies, the feasibility of training, the impact of supervision, the emotional aspects of training, and understanding of the College's curriculum. The interviews lasted between 12 and 24 min and were recorded. The recordings were transcribed verbatim to produce the raw data for the study.

Analysis

The process of IPA¹⁹ was conducted by both interviewers, who listened to interview recordings and read and re-read the transcripts to familiarise themselves with the data. Initial interpretations of the data (descriptive summaries and points of interest) were entered as annotations in the margins of the transcripts. Emergent themes were then drawn and recorded in a table after cross-checking them against the transcript. This process was repeated for each transcript. Initially, the researchers searched for connections between the themes within the transcripts, and then between the transcripts. Thematic connections were identified and emergent themes were clustered, and a list of subordinate themes was compiled. Subordinate themes were clustered into superordinate themes. The superordinate themes and sub-themes were verified against the transcripts to ensure that they were grounded in evidence and then they were organised into a master table (*Table 1*). Last, quotations which best encapsulated each theme were identified.

Themes

Superordinate themes	Subordinate themes
1. Barriers	<ul style="list-style-type: none"> a. Time b. Cases c. Patients d. Access to learning resources
2. Guidance	<ul style="list-style-type: none"> a. The role of supervision b. Learning from peers c. Sticking to the curriculum
3. Acquisition	<ul style="list-style-type: none"> a. Gaining new skills b. Models of mental illness c. Personal influence d. Confidence

Results

Three superordinate themes were identified, with three or four subordinate themes each, and are described below.

Barriers

Barriers to CBT training and the impact that this had on learning was a prominent theme across all of the interviews. Some participants had personally experienced barriers to training and others described the impact that barriers had had on their peers.

Time

The impact of insufficient time for learning was a theme that occurred across all seven interviews. Participants disclosed how shift work caused disruption to their CBT training.

‘if we were on-call that day or on nights or on leave, um, you ended up missing some of the sessions because of that and I think because CBT is quite structured, so you learn one thing in one session and then progress on to the next bit in the next session, so if you miss a bit I think it becomes a bit more difficult to get your head around it’ (participant 2).

One participant described the challenges encountered in maintaining protected learning time amidst other work commitments: “‘Because I was working in the ward [...] it’s quite difficult to get out of that to get supervision and do other things’ (participant 6).”

Conversely, another participant perceived that colleagues respected protected learning time, suggesting that trainees’ experiences varied depending on where they were working: “‘There’s no problem getting time away from your day job to go [to] the CBT training’ (participant 7).”

One participant, who had worked in a psychotherapy job, acknowledged that this job provided more time for training than other jobs: “‘I did a psychotherapy job in my last 6 months, so I was able to spend a lot more time and pick up a

lot more cases than perhaps other people have experienced' (participant 4)."

One participant expressed concern that lack of time may prevent the use of CBT in future practice: "depending on the workload you're not always able to provide the adequate time per patient' (participant 2)."

The time delay between beginning CBT training and being allocated a patient case was identified as a barrier.

Cases

Participants felt that there was a shortage of CBT cases available for trainees and this had a significant impact on their CBT training.

'I think the barrier is there is a big waiting list and that is a problem, like you have to wait to get a case [...] and obviously if there [aren't] enough patients [...] you [won't] get a case and there's loads of trainees and this is kind of a mandatory thing, everybody has to have a case' (participant 3).

Participants felt that it would be beneficial to have more than one case: "I would say if we had at least two cases that might be better but again it is very difficult to get a CBT patient because we have got loads of trainees and, um, not a lot of CBT we do, we get for trainees because [...] if it is not simple for trainees they do not consider it, to give it to us, and there is a long waiting list, I think you know that, there is a big waiting list for CBT, so like I had to wait for nearly ... more than a year actually' (participant 3)."

A participant who had worked in a psychotherapy post observed that one case would not have provided sufficient CBT experience: "I work in psychotherapies so I have had more than one case and [I] have had good exposure to CBT. I just don't know whether if I hadn't had this job, this exposure would be enough' (participant 1)."

Patients

Six of the participants discussed the impact of the patient on their experience of CBT. First, participants felt that completing a CBT case was more challenging if the patient did not engage. Second, they discussed the impact of patients not attending sessions or discontinuing with treatment; this was perceived to be a substantial barrier to training that was not taken into account by the College's curriculum.

'if the patient doesn't engage or doesn't complete therapy – this could potentially be a problem. In fact [the trainee] might not have the time to undertake another case and complete it' (participant 7).

However, participants acknowledged that the impact of the patient on CBT training was a factor that is difficult to control.

'It's totally up to the [patient] whether he or she will continue or not and if she leaves before you complete the full therapy then you have to wait for the next patient so that is a problem but I don't know the way to change it because it's totally up to the patient if they will continue or not' (participant 3).

Conversely, one participant acknowledged that a good doctor-patient relationship could have a positive impact on the experience of CBT training.

'seeing results from patients as well has been really good' (participant 4).

Access to learning resources

Participants expressed concern about keeping skills up to date as time elapsed.

‘I think the Royal College [of Psychiatrists] run a CBT module, but it’s all things that you have to pay for [...] and I think that most people feel like they pay for enough exam material [and] for the Royal College exam, and probably don’t have [a] mountain of spare cash to be spending on more e-learning stuff, so it might be good if the trust wanted to sort of do something with CBT, or if the Royal College will give out [an] e-learning module – I think that would be quite useful, and for people who are not seeing cases that regularly – I think it might kind of just update you with CBT’ (participant 4).

Conversely, others thought that the time and experience was ‘ample’: “‘I’ve been given adequate texts to read and stuff in my spare time. I have ample opportunity to discuss any complications that arise with my case so [...] all in all it’s been really good’ (participant 2).”

Guidance

The participants perceived that supervision was an important feature within their experience of CBT training. The superordinate theme of guidance was identified across all interviews, with the subordinate themes of supervision, peer learning and curriculum.

The role of supervision

There was an overall satisfaction with supervision from all the participants, who felt that they had continued support and advice. Feedback and reassurance from supervision encouraged the trainee to gain confidence and it was highlighted that the participants felt able to ask their supervisor for advice.

‘I would say that the supervision was really good, it was tailored down to trainees’ need [...] the supervisor was approachable’ (participant 5).

‘there were quite a few things that needed improvement and I felt that supervision enabled me to identify these areas and work on improving these sets of things’ (participant 1).

It appeared that the expertise of the supervisor themselves was respected and was useful to the majority of the participants. All of the participants had a consultant psychiatrist as their supervisor.

‘expert opinion on where you are going with your cases, so you feel like you do a good job with the patient’ (participant 4).

‘has a lot of experience on this ground so that was quite helpful’ (participant 3).

In terms of emotional support, there appeared to be a consensus that, if required, emotional support from supervision would be present.

Interviewer: ‘And, do you feel like you had enough emotional support if needed during your training?’

Participant: ‘I suppose I would, yes. It was never an issue, but I would imagine that if I had felt stressed I would have found support’ (participant 1).

Learning from peers

Three of the participants discussed how helpful peer learning was in their training, in particular as regards case supervision conducted in group sessions.

‘Well, I actually used to love and look forward to [...] supervision, because every time – because our supervision was a group sort of supervision – I learn not only from my case, but [I] also learn from other people’s cases. Because people have different aspects they need supervision [for], so I will kind of learn quite generally because it’s quite enjoyable to keep on listening to different cases, including mine – and following it up through week after week. So I really enjoyed it’ (participant 6).

Sticking to the curriculum

In contrast to the optimism surrounding supervision, the participants did not consider the College curriculum to be a sufficient source of guidance.

I: ‘Also, how aware were you of the Royal College guidelines before you started your CBT training?’

P: ‘Um ... not very.’

I: ‘And do you feel that there is any way in which they could be accessed more easily?’

P: ‘I wouldn’t even know how you access them now to be honest.’

I: ‘Okay, that’s okay. Okay.’

P: ‘I’m assuming that you look on the Royal College website but I never have’ (participant 7).

This lack of awareness of the Royal College of Psychiatrists’ curriculum guidelines was found in other participants, who reasoned that the guidelines are too extensive and incomprehensible. However, it transpired that six participants had acquired the competencies outlined in the curriculum despite the fact they were unaware of what these were.

‘The curriculum for core training is huge and extremely vague mostly – so you need to trawl through that document, probably most people haven’t’ (participant 4).

P6: ‘I’ve been able to explain to the patient what CBT is and what it is used for and also, sometimes I’ve been able to use the skills I’ve learnt in CBT, to offer treatment to the patient.’

I: ‘Do you feel like you are able to deliver CBT?’

P6: ‘I think I feel that way’ (participant 6).

One participant relayed that the curriculum needed to be more flexible owing to the nature of the therapy itself being unpredictable and time consuming.

‘I do think they need to be a bit flexible, because say if a patient drops out of therapy and say you have done 10 sessions that now doesn’t count as a case!’ (participant 4).

Acquisition

The participants felt that they acquired a great deal via their CBT training, in terms of gaining specific CBT skills, but also in learning generic skills that could be applied to psychiatric practice and learning which patients would be suitable for CBT. They acquired a new insight into models of mental illness and learnt to conceptualise mental illness in accordance with the CBT model. Trainees also discussed their personal influence on their experience and thus their acquisition of CBT skills. Last, they grew in confidence as they gained experience working with their CBT case.

Gaining new skills

The trainees felt that they gained a great deal from their CBT training, in terms of both specific CBT skills and also broader transferable skills that could be applied to their psychiatric practice.

‘I enjoyed it. I think basically it’s really important [...] for [a] psychiatric trainee or for a psychiatrist to have experience in CBT’ (participant 1).

Most of the participants felt that they gained a greater understanding of what CBT entails and how it works. This enabled them to confidently explain CBT to patients.

‘it gave a clear understanding for me of what exactly CBT involves and how it has a beneficial effect on patients’ (participant 5).

Three participants described how the training helped them to identify which patients would be suitable for CBT. They felt confident in referring patients for CBT. However, others felt that they needed more experience to accurately assess patients for CBT.

‘I mean, now like when I will refer patients for psychotherapy I would now know what are the categories that I need to check before referring and whether the patient is suitable for CBT or not because I have practical experience of doing it and I know that I’ve some idea whether the patient [would benefit] from CBT or not’ (participant 3).

Some of the participants felt confident using CBT techniques. However, they acknowledged that they had limited experience and that they were not fully equipped to deliver formal CBT.

‘And do you feel like you would be able to deliver it as well?’ P: ‘Delivering, to be honest – no. Because, I think, err, having done only one short case of CBT, without any supervision, I won’t be able to take up a case on my own I guess ...’ (participant 5).

Although not all of the participants felt confident in delivering CBT, they felt that they had gained transferable skills that could be used elsewhere in their psychiatric practice.

‘Sometimes in my session now [...] I see people with [...] anxiety and other disorders; I am able to use the very same skills I used in my CBT session to kind of handle the situation around me’ (participant 6).

The participants hoped that they would continue to use the skills that they had gained. However, some expressed concern about losing skills over time, particularly if they did not use CBT regularly in their job.

‘if you’re not in touch then you may lose some skills. That may be a problem in the future because you’re not going, not actually keeping doing it, practising it, yeah, so maybe it can impact on practice in the future’ (participant 3).

Models of mental illness

Six participants talked of the training causing a shift in their understanding of mental illness, moving them away from the diagnosis exclusively, and focusing on the wider problems for their patient, allowing them to reach the criteria of the curriculum and develop their emotional intelligence.

‘what I found out is that [pause] maybe some of these people do not have defined mental illness but they definitely have a problem, and just basically move me away from having to diagnose a patient with something, so [I was able to] focus on the problem rather than the diagnosis, and sometimes the problem did not correspond to an ICD-10 diagnosis, and I think this is really useful because, eh, usually in everyday life, people have problems – rather than psychiatric diagnosis’ (participant 1).

‘Well it has given me the insight into looking at the behaviour and thoughts, in terms of how people are affected, and how to help them – that’s not what I was thinking before, because before I was thinking in terms of the medical model, and now I’m thinking more about other things like their thoughts and their

behaviour, and their emotion – and how all of that is part of their illness, and how to use that to treat their illness’ (participant 6).

The trainees described how this increased awareness affected the management of their patients.

‘it does change your thinking about your practice, and you know – what else is out there, other than, you know, medication and that kind of thing, there are other ways that people can benefit from secondary care’ (participant 4).

‘having done CBT training [pause] it helped me to identify that there are some mental disorders which need both medications and psychotherapy’ (participant 5).

The benefits of having time to reflect as part of psychotherapy training gave trainees a different perspective on the patient that they were treating.

‘and I think when you’re using CBT to make them think differently about their illness and their actions it makes you think differently about it as well [...] and you certainly see patients’ difficulties from a different point of view [...] and it gives you time to figure that out’ (participant 2).

Personal use of this new way of looking at models of mental illness was cited; the participants described how this changed how they see themselves.

‘within myself, it changed me in such a way, the way I am able to kind of evaluate my behaviour, with what I do and what I think – so I use it on myself quite a bit. If I find myself in a difficult situation, even in day-to-day life – I use the same principle on myself to kind of look at how things are done, and change things differently. So I think that’s how personally CBT has influenced me’ (participant 6).

Personal influence

Several of the participants acknowledged that they had a particular interest in CBT. Two had worked in a psychotherapy post and one hoped to specialise in psychotherapy. Furthermore, the participants acknowledged that their personal interest may have affected their experience of CBT training and they may have gained more from the training as a result.

‘Personally, I am interested in psychotherapy anyway, so I wanted – I want to be able to use CBT [pause] later on in my career, so [pause] so that’s one of the reasons why I think it was really useful’ (participant 1).

Confidence

The majority of the participants talked of increased confidence during their training and afterwards. This is in regards to their own skills and understanding, as well as recognition of when to refer a patient for CBT.

‘since my first case, [I] have got a lot more fluent [than] in the beginnings of therapy’ (participant 4) .

One participant expressed a lack of confidence in referring patients for CBT because their CBT supervision was still ongoing at the time of the study: “‘I don’t think I’m confident at the minute because I suppose I’ve been given a patient, I’ve not assessed someone for it as such but, um, I’m continuing to have CBT supervision [...] so I think by the end of it I will be able to, yes, to figure out who would benefit from it’ (participant 2).”

Overall, there was a positive association between experience and confidence.

‘Do you know, I feel much more confident about CBT ... because I know what it is, so I feel much more confident’ (participant 3).

Discussion

A number of barriers that affect trainees' experiences of CBT training have been identified here; chiefly a lack of protected learning time, a shortage of available cases for training purposes and difficulties arising due to problems with patient engagement and therapy completion.

Having protected time for CBT training was high-lighted as crucial for psychiatry trainees, who reasoned that the difficulty in completion and the formulaic structure of CBT require a regularity and dedication to carry it through. The 'inevitability' of work disruptions and shift patterns were the main source for these disruptions recognised in this study. As previous work suggests, there was variability within this, dependent on where one is a trainee and what jobs one is assigned. Trainees in a dedicated psychotherapy post were more positive about their ability to complete and transfer their CBT skills. We propose that this may be due to the trainee having a personal interest in 'talking therapies' in addition to the granted protected time to acquire these skills in a psychotherapy post, a proposition which resonates with previous work in this area.⁴ This variation resulting from chance permeates to the level of patient allocation as well – as each trainee is allocated a different patient, standardisation of experience becomes problematic. One aspect that helped with this was peer-group learning, insofar as the experience of each trainee is shared and hence multiple cases are acquired instead of just the one that each trainee has had. This echoes previous recommendations to utilise novel ways, such as peer-group learning, to assist CBT supervision and skills acquisition.³ Thus, ensuring that protected learning time is provided and that it is a feasible task is likely to improve the trainees' experience.

Concerning the shortage of cases, further enquiry would be beneficial to explore the feasibility of targeting the long waiting lists for both the patients and the trainees by enabling trainees to take on a broader range of patient cases. A larger study would be beneficial in exploring this, continuing with the idea to source cases from primary care.¹⁷ This could help to relieve the pressure for the trainee to complete one 'ideal' CBT case, and thus the patient being a barrier to learning could have less impact. It was also suggested that it could be beneficial to provide a follow-up course that can be accessed freely to ensure that skills are maintained over time. Furthermore, the training experience could be improved if the Royal College of Psychiatrists' curriculum took into account the effect of patients discontinuing with therapy and allowed a degree of flexibility for cases in which almost all sessions had been completed. Moreover, as prior literature suggests, further dissemination and accessibility of the College curriculum is still warranted.

A number of factors that facilitated a positive experience of CBT training in Yorkshire were identified. Supervision was highly valued and deemed to be an important facilitating factor during the training. Further research could be useful in order to elucidate how the benefits of supervision are mediated and thus enable similar supervision to be conducted elsewhere.

In accordance with the College curriculum, this study suggests that psychiatric trainees in Yorkshire report enhancements in their emotional intelligence and being able to refer for CBT accurately and evaluate its effect intelligently after the training. A broad positive association was relayed from the participants between exposure to CBT and confidence in recognition and delivery of skills learned. However, although trainees' overall confidence about psychotherapy increased, further experience is deemed necessary for the trainees to feel able to deliver CBT competently. On the whole, trainees gained a broader perspective of models of mental illness and learned transferable skills, which have now influenced their clinical practice.

Although a robust study design was employed and triangulation of the data was used to increase the validity of the findings, the qualitative nature of the study has inherent limitations.²⁰ Nonetheless, the study provides a valuable insight into the experiences of psychiatry trainees in Yorkshire and paves the way for further research in other deaneries across the UK in order to gain a clearer insight into the experiences of core trainee psychiatrists in general, with the aim of improving CBT training and ultimately enabling psychiatrists to become more emotionally aware, competent and confident.

1.7.30 Antipsychotic prescribing of consultant forensic psychiatrists working in different levels of secure care with patients with schizophrenia

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Abstract

Aims and method To detect any differences in the antipsychotic prescribing practices of consultant forensic psychiatrists working in different levels of secure care with patients diagnosed with schizophrenia, and to identify potential reasons for any differences. Prescribing data were collected from four secure hospitals within one National Health Service trust. A questionnaire was sent to consultant forensic psychiatrists working at those hospitals as well as those working in the trust's community forensic services.

Results Consultants working in high security prescribed more oral antipsychotics than consultants working in medium and low security, who prescribed more depot antipsychotics, as established via the prescribing data. The questionnaire provided insight regarding the reasons for these preferences.

Clinical implications There were differences in the antipsychotic prescribing practices of consultant forensic psychiatrists working in different levels of secure care, and, overall, the rate of depot antipsychotic prescribing was lower than might be expected. Although it was positive that the rate of polypharmacy was low when compared with earlier studies, the lower-than-expected rate of depot antipsychotic prescribing has clinical implications.

Contents

- *Antipsychotic prescribing of consultant forensic psychiatrists working in different levels of secure care with patients with schizophrenia*
 - *Aims*
 - *Method*
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- * *Pattern of prescribing*
- * *Consultant questionnaires*
- *Discussion*
 - * *Findings*
 - * *Adherence*
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Schizophrenia is an enduring mental illness characterised by remissions and relapses. Treatment is available in the form of psychosocial interventions but the mainstay of effective management is antipsychotic medication.^{1–3} Antipsychotic efficacy is reduced by poor adherence and it is estimated that the risk of relapse is 2 to 6 times greater for patients not taking antipsychotic treatment.¹

Forensic psychiatrists working in secure hospitals are likely to have case-loads with high levels of comorbidity, non-adherence and risk;^{4,5} a history of aggression has been found to predict the use of high-dose antipsychotic treatment (total antipsychotic doses totalling greater than 100% maximum *British National Formulary* dose).¹

Paton *et al*⁶ reported on an in-patient census. Most (97%) of the 53.2% diagnosed with psychosis were prescribed an antipsychotic. Polypharmacy (the prescription of more than one antipsychotic agent) was common. Of those prescribed a regular antipsychotic, 51.6% were prescribed a first-generation agent, 11.3% were prescribed clozapine and 33% were prescribed a depot agent (80% of these patients had a psychotic illness). High-dose prescribing was more common when a depot agent was prescribed.

No previous studies have examined the prescribing patterns of forensic psychiatrists working in differing levels of security. It is important to identify such patterns to build on existing knowledge and to identify areas requiring change.

Aims

To detect any differences in the antipsychotic prescribing practices of consultant forensic psychiatrists working in different levels of secure care within a National Health Service (NHS) trust, and to identify potential reasons for any differences. We hypothesised that there would be no significant differences in prescribing patterns in this clinician group.

Method

Settings and sample

Covering a vast geographical area, the NHS trust studied is one of the largest in England and provides services in a variety of settings. Its secure hospitals feature one high secure hospital, two medium secure hospitals and one low secure hospital. Information on antipsychotic prescribing was collected on all in-patients with schizophrenia in these four hospitals in July 2014. A questionnaire was sent to the 34 consultant forensic psychiatrists based at the hospitals and 3 community-based consultant forensic psychiatrists working within the same trust.

Procedure

Prescribing patterns

In July 2014, the electronic healthcare records were used to produce a list of all current in-patients at the trust's four secure hospitals. The clinical records (electronic and paper healthcare records, and pharmacy records) were then used to ascertain which of these patients had schizophrenia. Further information was collected about patients with schizophrenia (gender, age, ethnicity, length of stay, antipsychotic medication prescribed), to produce an anonymised data-set detailing the percentage of patients diagnosed with schizophrenia at each hospital, and the proportion of patients with schizophrenia prescribed different types of antipsychotic medication.

Consultant questionnaires

Owing to the absence of a validated instrument, a semi-structured self-report questionnaire was developed to assess forensic consultants' attitudes to the prescription of oral and depot antipsychotic medications. The questionnaire was designed to take less than 5 min to complete. Consultants were asked in which level of security they worked and then three further questions: Disregarding the special case of clozapine, when treating a patient with schizophrenia do you have a general preference for either oral or depot antipsychotic medications? (Yes/No) Please indicate the strength of any preference on the scale below (0–100 anchored Likert scale: 0 – oral, 100 – depot). What are the reasons behind any stated preference? ((a) Improves adherence, (b) Better clinical outcome, (c) More convenient for the patient, (d) More convenient for the clinical team, (d) The next level of security/community team would expect/prefer it). There was also space for a free-text response. The three community consultants were asked two further questions: How important is the route of antipsychotic administration in your considering whether to accept a patient on to your caseload? (0–100 anchored Likert scale: 0 – very important, 100 – not at all important). How likely are you to accept a patient currently prescribed an oral antipsychotic (not clozapine)? (0–100 anchored Likert scale: 0 – very unlikely, 100 – very likely). The Likert scale is an ordinal psychometric assessment of attitudes or opinions, typically lacking concrete answers to accommodate neutral or undecided feelings. It was selected for this questionnaire owing to the speed and ease of completion, low cost, ease of distribution, and providing results amenable to analysis.

The Likert scale has been criticised for failing to measure the true attitudes of respondents, as it gives only 5 to 7 options of choice, and also for the space between each choice in reality possibly not being equidistant. In view of this, and in an attempt to further maximise freedom on behalf of the responder and to avoid railroading respondents into giving polarised responses, the Likert scale was amended to include some characteristics of an analogue scale.

The questionnaire was sent, with a cover letter, to all forensic consultants working in the four secure hospitals and in community forensic services in the NHS trust. After 3 months, the questionnaire was sent again to encourage non-responders. All data were supplied anonymously.

Ethical considerations

The project proposal was reviewed by the trust's research and innovations department and approved as service evaluation; research ethics approval was therefore not required. Patient anonymity was preserved throughout the study.

Analytic strategy

SPSS version 21 (Windows 10) was used for data analysis. Chi-square and ANOVA were used where appropriate. All tests were two-tailed and $P < 0.05$ was used to determine statistical significance.

Results

Demographic information

In July 2014, there were 556 patients detained at the four secure hospitals; 265 (48%) were diagnosed with schizophrenia. The sample characteristics are summarised in *Table 1*.

Sample characteristics of in-patients at each of the four secure hospitals

	High secure hospital	Medium secure hospital 1	Medium secure hospital 2	Low secure hospital	<i>P</i>	<i>a</i>
Total number	339	69	85	63	–	
Schizophrenia, <i>n</i> (%)	139 (41)	53 (77)	33 (39)	40 (63)	**	: $\chi^2_{sup:2} = 38.52$, d.f. = 3
Ethnicity, <i>n</i> (%)						
White British	100 (72)	41 (77)	21 (64)	17 (42)	**	: $\chi^2_{sup:2} = 15.23$, d.f. = 3
White other	5 (4)	0 (0)	1 (3)	2 (5)	0.500	: $\chi^2_{sup:2} = 2.34$, d.f. = 3
Black/Black British	19 (14)	3 (6)	4 (12)	11 (28)	**	: $\chi^2_{sup:2} = 9.25$, d.f. = 3
Asian/Asian British	9 (6)	5 (9)	2 (6)	3 (7)	0.902	: $\chi^2_{sup:2} = 0.58$, d.f. = 3
Mixed/other ethnicity	6 (4)	4 (8)	5 (15)	7 (18)	**	: $\chi^2_{sup:2} = 9.42$, d.f. = 3
Age, years						
Mean (s.d.)	40.0 (9.8)	36.9 (8.7)	36.5 (8.8)	38.1 (10.3)	0.100	ANOVA $F_{(3,261)} = 2.10$
Median (range)	38.6 (21.9–66.3)	37.2 (19.6–60.0)	35.2 (21.8–58.2)	35.9 (19.8–62.0)	–	
Length of stay, years						
Mean (s.d.)	6.4 (4.5)	2.1 (1.9)	1.9 (1.4)	3.0 (3.9)	**	ANOVA $F_{(3,261)} = 26.86$
Median (range)	5.9 (0.1–21.4)	1.5 (0.1–8.0)	1.4 (0.03–5.6)	1.5 (0.3–18.2)	–	
Female patients, <i>n</i> (%) <i>b</i>	5 (3.6)	0 (0)	1 (3.0)	4 (10.0)	0.093	: $\chi^2_{sup:2} = 0.58$, d.f. = 3
Age, years: mean (s.d.)	43.1 (5.9)	–	–	41.7 (13.4)	0.373	ANOVA $F_{sub: (2,7)} = 1.14$
Age, years: median (range)	41.1 (36.9–54.3)	–	–	39.7 (25.7–62.0)	–	
Length of stay, years: mean (s.d.)	4.9 (2.4)	–	–	1.1 (0.4)	0.053	ANOVA $F_{sub: (2,7)} = 4.62$
Length of stay, years: median (range)	6.5 (1.3–6.8)	–	–	1.1 (0.5–1.6)	–	

Bold denotes significance ($P < 0.05$).

As medium secure hospital 2 had only 1 female in-patient, means and medians for age and length of stay have not been calculated.

Medium secure hospital 1 provides a male-only service. The high secure hospital and medium secure hospital 2 have wards specialising in the care of patients with personality disorder, whereas medium secure hospital 1 and the low secure hospital do not, hence the differences in the rate of schizophrenia. The proportion of patients from Black and minority ethnic (BME) groups was high when compared with the general population ⁷ (29% v. 14% respectively). The rate was highest for the low secure hospital (53%). This significant finding mirrors an earlier study ⁸ which found an overrepresentation of BME groups admitted to low secure services across the UK.

There was little difference in mean patient age between the four hospitals, and expected differences in the mean lengths of stay.

Pattern of prescribing

Of all patients with schizophrenia, 3% ($n = 8$) were not prescribed antipsychotic medication and 12% ($n = 33$) were prescribed antipsychotic medication constituting polypharmacy. The most common polypharmacological combination was clozapine augmented with a second-generation oral antipsychotic. Data regarding the prescription of antipsychotic medication are summarised in *Table 2*.

Antipsychotic prescribing for patients with schizophrenia at the four hospitals

	High secure hospital	Medium secure hospitals	Low secure hospital			
Regular first-generation antipsychotic only, n (%)						
Oral	6 (4)	2 (4)	0 (0)	2 (2)	2 (5)	10 (4)
Depot	17 (12)	7 (13)	8 (24)	15 (17)	9 (22)	41 (15)
Regular second-generation antipsychotic only, n (%)						
Oral	59 (42)	8 (15)	10 (30)	18 (21)	11 (27)	88 (33)
Depot	1 (1)	9 (17)	0 (0)	9 (10)	6 (15)	16 (6)
Clozapine only, n (%)	33 (24)	18 (34)	10 (30)	28 (33)	8 (20)	69 (26)
Total, n	139	53	33	86	40	265

Excluding clozapine.

Clozapine was prescribed to 26% of all patients, with the highest prescription rate observed in medium security hospitals (33%).

Excluding polypharmacy and clozapine use, more patients were prescribed a second-generation oral agent than a first-generation oral agent (33% v. 4%); this was true for all four hospitals. In general, this pattern was reversed for depot agents, with more patients being prescribed a first-generation depot agent than a second-generation depot agent (15% v. 6%). 70% of patients with schizophrenia in high security were prescribed an oral antipsychotic only (including clozapine), compared with 56% of patients in medium security and 52% of patients in low security (*Table 2*). It emerged that 13% of patients with schizophrenia in high security were prescribed a depot antipsychotic only, compared with 28% of patients in medium security and 37% of patients in low security. Owing to the relatively small sample sizes, data from the two medium secure hospitals and one low secure hospital were combined for statistical analysis, as shown in *Table 3*.

Oral and depot antipsychotic prescribing for schizophrenia in high security and the other hospitals

	High secure hospital	Other hospitals <i>a</i>	Total, <i>n</i>
One type of regular oral antipsychotic only, <i>n</i> (%)	98 (70)	69 (55)	167
One type of regular depot antipsychotic only, <i>n</i> (%)	18 (13)	39 (31)	57
Other, <i>b n</i> (%)	23 (17)	18 (14)	41
Total, <i>n</i>	139	126	265

Medium secure hospital 1, medium secure hospital 2, low secure hospital.

More than one type of antipsychotic prescribed regularly, no regular antipsychotic prescribed.

Chi-square testing revealed a significant difference in the rate of prescribing of oral and depot antipsychotic medication between the high secure hospital and the other hospitals ($\chi^2 = 12.78$, d.f. = 2, $P < 0.01$). The data suggest that more oral medication was used in high security and more depot medication was used in the other hospitals. *Table 4* shows the route of medication administration for patients with schizophrenia broken down by ethnicity. When medication was prescribed (i.e. excluding the 'no antipsychotic prescribed' category), chi-square analysis showed a statistically significant difference between the ethnic groups ($\chi^2 = 6.90$, d.f. = 2, $P < 0.05$); depot antipsychotics appear to be used more frequently for patients from BME groups.

Medication administration for patients with schizophrenia by ethnicity

	Regular depot antipsychotic only	Regular oral antipsychotic only	Regular depot and oral antipsychotic	No antipsychotic	Total
BME patients, <i>n</i> (%)	23 (29.5)	48 (61.5)	5 (6.4)	2 (2.6)	78
White patients, <i>n</i> (%)	34 (18.2)	142 (75.9)	5 (2.7)	6 (3.2)	187
Total	57	190	10	8	265

Consultant questionnaires

The questionnaire was sent to the 34 consultant forensic psychiatrists based at the four secure hospitals in the trust (19 at the high secure hospital, 10 at the two medium secure hospitals and 5 at the low secure hospital), as well as to the 3 forensic consultants working in community forensic services within the same trust. The overall response rate was 78% (74% high secure, 80% medium secure, 80% low secure and 100% community). Limitations in the data collected leave us unable to comment on any differences (e.g. gender, age, years of experience) between consultants who did and did not respond.

Of the hospital-based consultants responding to the questionnaire, 35% expressed a preference for oral medication and 42% expressed a preference for depot medication; 23% did not express a preference. The mean score on the 0–100 scale, where 0 indicated a preference for oral and 100 for depot medication, was 37 (s.d. = 20) for respondents from high security and 74 (s.d. = 22) for respondents from other settings (medium security and low security); ANOVA demonstrated a significant difference between the two groups ($F_{(1,24)} = 19.759$, $P < 0.01$). Thus, those working in high security preferred oral medications and those working in other settings preferred depot medications.

Most (89%) expressing a preference for oral medications worked in high security. The following reasons were given: convenience for patient, adherence, safety, less invasive, improved engagement, increased patient responsibility and improved therapeutic relationship. Most (73%) expressing a preference for depot medications worked in medium or

low security, and their reasons were: adherence, clinical outcome, expectation from next level of security, reduced side-effects, reduced tension between patient and team, easier risk management in community, 'mental health review tribunal'/'Ministry of Justice' reassurance, and reduced adverse events.

All of the community-based forensic consultants expressed a preference for depot medication; stated reasons included adherence, clinical outcome and convenience for the patient.

Community-based forensic consultants were asked two further questions (see Method). It emerged that route of administration was important for consultants when considering whether or not to accept a patient (mean rating for question 1, where 0 was 'very important' and 100 was 'not at all important', was 31 (s.d. = 17)). Considering question 2, consultants were also likely to accept patients currently prescribed an oral antipsychotic (not clozapine) (mean rating 72 (s.d. = 21), where 0 – very unlikely, 100 – very likely).

Discussion

Findings

This study demonstrates a similar rate of antipsychotic prescribing (97%) as a previous study; ⁶ 3% of patients were not prescribed antipsychotic medication. Consultant psychiatrists may opt not to prescribe antipsychotic medication in the context of a drug-free trial related to diagnostic uncertainty or severe side-effects, or because a patient has refused to take such medication.

This study reveals significant differences in the antipsychotic prescribing practices of consultants working in different levels of secure care. Consultants in high security were found to prescribe more oral antipsychotics, and those in medium and low security were found to prescribe more depot antipsychotics. It may be that the likelihood of high secure patients having an extended period of supervised care ahead of them reduces the bearing of adherence on antipsychotic selection.

The overall rate of depot antipsychotic prescribing was lower than that found by Paton ⁶ and also lower than that quoted in the Maudsley guidelines. ⁹ Polypharmacy was less prevalent than in Paton's study; ⁶ this finding was welcome but perhaps unsurprising as over a decade later the risks associated with polypharmacy are better understood and many trusts have guidelines restricting polypharmacy. The Care Quality Commission also actively discourages polypharmacy. The most common combination of clozapine augmented by a second-generation oral antipsychotic is in keeping with usual approaches to treatment-resistant schizophrenia.

BME patients with schizophrenia were significantly more likely than their White counterparts to be prescribed a depot antipsychotic. This finding builds upon existing research. ^{10,11}

Significant differences in the opinions expressed by consultants were found: consultants working in high security preferred oral antipsychotics and consultants working in other settings preferred depot antipsychotics. Overall, 31% of all respondents expressed a preference for oral antipsychotics and 89% of these worked in high security, whereas 48% of respondents expressed a preference for depot antipsychotics and 79% of these worked in medium and low security and the community. Comments from community consultants suggest there is no expectation that patients should be prescribed a depot antipsychotic before they are deemed suitable to be managed by community services.

It is noteworthy that the presence of a community forensic team may mean that the area served by the NHS trust in this study is not typical of other areas in England and Wales. Community forensic services are not available countrywide and it may be that general adult psychiatrists accepting patients from secure services hold different views than their forensic colleagues.

Adherence

Both consultants preferring oral antipsychotics and those preferring depot antipsychotics listed 'adherence' as a reason for their preference. For patients with schizophrenia, poor adherence can be related to forgetfulness, disorganisation, complexity of regime, cost, lack of insight, ambivalence, poor relationship with therapist, stigma, side-effects and lack of perceived efficacy.^{3,12} Higher rates of non-adherence have been reported in patients with schizophrenia prescribed oral medication than those prescribed depot medication¹³ and patients treated with depot medication have been found more likely to continue medication, and to continue it for longer, than patients treated with oral medication. It has been suggested that improved adherence is likely to lead to better clinical and functional outcomes.¹⁴

Stone & Niz¹⁵ found that non-adherent patients with schizophrenia were more likely to enter the criminal justice system and suggest that consideration be given to using depot antipsychotics (or clozapine) as a first-line treatment for offenders with schizophrenia. Arango *et al*¹⁶ studied patients with schizophrenia and a history of violence. Of those who were violent again, those prescribed oral antipsychotics were violent sooner, and more frequently, than those prescribed depot antipsychotics. The authors link improved adherence to reductions in violence. It may therefore appear counterintuitive that the forensic population studied were prescribed less depot medication than patients in an earlier, mixed population, study⁶ and the rates quoted in the Maudsley guidelines.⁹

Efficacy

Reviews comparing the efficacy of oral and depot antipsychotics^{12,17} report that mirror-image and some large cohort studies have favoured depot preparations but randomised controlled trials (RCTs) have not.

Lafeuille *et al*¹⁸ compared outcomes in patients who relapsed on an oral medication and were then 'switched' to a depot antipsychotic with those who remained on an oral medication. 'Switched' patients had fewer readmissions and fewer emergency presentations. Johnson¹⁹ found that 33 months after being discharged from hospital, 40% of patients prescribed depot antipsychotics relapsed, in comparison with 60% of patients prescribed oral antipsychotics. David & Adams' review³ of non-forensic patients with schizophrenia identified little difference between oral and depot antipsychotics in terms of relapse rates or side-effects, but depot formulations were found superior in bringing about 'important global change'. Leucht *et al*²⁰ present a systematic review and meta-analysis of 10 RCTs carried out between 1975 and 2010; there were significantly fewer relapses in out-patients prescribed depot medication than in those prescribed oral medication.

Psychiatrist attitude

Haddad *et al*²¹ report that 50% of psychiatrists said that their use of depot antipsychotics had reduced in the previous 5 years, and 23% said that their use had increased (the 5-year time-span included the introduction of second-generation depot agents). Despite 89% opining that depot administration was associated with better adherence, and 98% opining that depot administration was associated with reduced relapse rates, only 4% said that depot was their 'first choice' route of administration for patients requiring long-term treatment. The findings from the current study may go some way in explaining the possible cognitive dissonance demonstrated by Haddad *et al*'s findings, i.e. consultant psychiatrists may consider many things other than adherence when deciding on antipsychotic treatment.

Potkin *et al*²² reviewed prescriber-patient conversations and found that depot antipsychotics were discussed only half of the time when a patient prescribed an oral antipsychotic wished to discuss a change in medication.

Advantages and disadvantages of depot antipsychotic medication

Previous studies have commented on perceived advantages and disadvantages of depot medications.^{1,3,12–14,19,22,23} Advantages have included a more constant plasma level, improved bioavailability, reduced availability of medication for overdose, improved adherence, more time to intervene when non-adherence is identified, reduction in family conflict and reduced treatment costs. Studies assessing patient attitude towards depot medication have revealed generally positive attitudes.^{3,22}

Disadvantages have included concern about side-effects, effect on therapeutic relationship, risk of high-dose prescribing, inappropriateness of use post-neuroleptic malignant syndrome, less flexibility and delayed response (i.e. mental state improvement on initiation, side-effect reduction on discontinuation). Potkin *et al*²² found that the usual reason for a patient declining depot medication was needle phobia.

This study adds to the existing literature by providing a forensic perspective on the advantages and disadvantages of depot medication.

Limitations

This study encountered a number of limitations which restrict the generalisability of the findings to wider forensic and indeed non-forensic settings. These include the small sample size, particularly with regard to the community consultants, the use of a non-validated questionnaire, and not including patients in the private sector (who in 2007 accounted for 35% of patients in England).²⁴

Clinical implications

Community teams caring for forensic patients with schizophrenia do not seem to have an expectation that patients should be prescribed a depot antipsychotic medication before they are deemed suitable for their service. It could be argued that given the relatively low rate of depot antipsychotic prescribing found in this study, and the superiority of depot preparations in terms of adherence, readmission and relapse rates, ‘important global change’ and, notably, risk of violence revealed through this literature review, consultants working with forensic populations should consider taking steps to increase their use of depot antipsychotic medications.

Directions for future research

Future research could attempt to evaluate the opinions of a more representative sample of consultant forensic psychiatrists, or the opinions of general adult psychiatrists and non-medical practitioners, particularly nurses,³ who may be expected to receive the handover of patients formerly known to forensic services. It would also be interesting to establish whether or not the perceived effectiveness of different types of antipsychotics influences prescribers’ choices. Future research could further explore the finding that BME patients are more likely to be prescribed a depot antipsychotic than their White counterparts. It may also be useful to undertake a follow-up study, where patients stepped down from high or medium security are followed up some time after discharge and any changes in antipsychotic prescription are identified and investigated.

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1.7.31 Niemann–Pick type C disease – the tip of the iceberg? A review of neuropsychiatric presentation, diagnosis and treatment

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Abstract

Niemann–Pick type C (NP-C) disease is a rare neurodegenerative lysosomal storage disorder. It is highly heterogeneous, and there is limited awareness of a substantial subgroup that has an attenuated adolescent/adult-onset disease. In these patients psychiatric features, often a psychosis, may dominate the initial impression, although often there is an associated ataxia and cognitive impairment. Typically, patients experience a substantial diagnostic delay. In this review we highlight the importance of early recognition and discuss the pathophysiology, neuropsychiatric presentation and recent changes in the investigation and work-up of these patients, and treatment options.

Contents

- *Niemann–Pick type C disease – the tip of the iceberg? A review of neuropsychiatric presentation, diagnosis and treatment*
 - *Pathophysiology*
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 - * *Cognitive decline*
 - * *Psychiatric symptoms*
 - * *Neurological features*
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 - *Investigation and diagnosis*
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 - * *Disease-specific treatments*
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Inborn errors of metabolism (IEM) are a collection of diseases that result from a deficiency in a metabolic pathway

¹

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(usually an enzyme), leading to altered intracellular synthesis and catabolism.¹ IEMs are individually rare but collectively common. Most are diagnosed during childhood, but there is increasing awareness of later-onset variant forms that may present in adults, often with a mix of both cognitive and psychiatric problems.²

Niemann–Pick type C (NP-C) disease is a neurodegenerative, pan-ethnic, globally occurring lysosomal storage disorder. Lysosomal storage disorders are a subgroup of nearly 60 IEMs that also includes Gaucher's disease, Tay–Sachs disease and the mucopolysaccharidoses. Although the lysosomal storage disorders are individually rare, their collective prevalence is 1:5000;³ they are usually the consequence of an enzyme deficiency and follow an autosomal pattern of inheritance. NP-C is rare, with a 'classical' clinical incidence of approximately 1:100 000.^{4–7} It follows an autosomal inheritance pattern, the result of mutations in one of two genes: *NPC1* (chromosome 18q 11-12) or *NPC2* (chromosome 14q 24.3),⁸ with *NPC1* accounting for 95% of cases.^{4,6} However, unusually, neither of these genes encodes an enzyme; they encode intracellular transporter proteins: *NPC1*, a late endosome/lysosomal transmembrane-bound protein and *NPC2*, a soluble protein.⁹

NP-C, like many other IEMs, has historically been considered a severe neurological and systemic disease of children, but this does not reflect the wide range of its presentations and severities. In a substantial subgroup of patients the illness has an adolescent/adult onset, with cognitive decline and neuropsychiatric symptoms predominating and survival that can extend even into their 7th decade.¹⁰ Most of these patients never receive an accurate diagnosis and for those who do, it is often after many years' delay with frequent misdiagnoses.^{1,4,10–12}

This is a timely review of adult- and adolescent-onset NP-C. A recent publication suggests that the frequency of this late-onset disease may be far higher than the 1:100 000 'classical' incidence.^{4–7,13} Wassif *et al*⁶ predicted a prevalence as high as 1:19 000–36 000, based on exome sequencing data of known disease-causing mutations. With easier and more readily available diagnostic tests, a disease-specific treatment⁴ and ongoing clinical trials, there has never been a more important time for a heightened awareness of NP-C.

Pathophysiology

The lysosome is an intracellular organelle, often termed the recycling centre of the cell. It has an acidic interior containing hydrolytic enzymes (hydrolases). These hydrolases, together with the integral transporter proteins (such as NPC1 and NPC2), traffic, break down and recycle cellular products. A defect in these results in the accumulation of partially metabolised substrates and a shortage of other lysosomal products. This 'traffic jam' leads to a complex chain of events, resulting in cell dysfunction and death and the consequent disease phenotype.

NP-C was described more than 100 years ago by Albert Niemann as an infantile disorder with hepatosplenomegaly and neurodegeneration,⁹ but the exact function of the NPC1 and NPC2 proteins has still to be fully elucidated. We know that a loss of function of either results in an identical clinical phenotype, suggesting a shared pathway for the two proteins. NPC1, a large transmembrane protein of the late endosome/lysosome and NPC2, a soluble lysosomal protein,⁸ work cooperatively to traffic intracellular lipids. Loss of function in either protein leads to the accumulation of cholesterol and a range of sphingolipids in the late endosomal/lysosomal intracellular compartment. This disrupts lysosomal calcium homeostasis, resulting in a host of secondary cellular trafficking defects.¹⁴ The neuropathological sequelae of these defects include Alzheimer's-like neurofibrillary tangles, neuronal degeneration, neuroaxonal dystrophy and demyelination.^{6–18} Also, as endogenously synthesised cholesterol is necessary for axonal membrane maintenance and repair, white matter tracts are severely affected, with the corpus callosum showing the most striking axonal loss.^{18,19} Purkinje cells of the cerebellum, basal ganglia and thalamus are characteristically vulnerable in NP-C, leading to the often pronounced cerebellar dysfunction and ataxia in NP-C patients.¹⁵

Neuropsychiatric presentation

An organic cause can be found in a sizeable proportion of patients presenting with psychosis. For example, Johnstone *et al*²⁰ showed that a causative organic disease could be found in 6% of patients with a first episode of psychosis. Several IEMs are known to cause both psychoses and cognitive decline in adults. A recent systematic review² highlighted six metabolic disorders that should be considered in adult patients with psychosis: homocysteine metabolism disorders, urea cycle disorders, Wilson's disease, acute porphyrias, cerebrotendinous xanthomatosis and NP-C.

NP-C can vary widely in both age at onset and symptoms. A useful classification system subdivides NP-C into four groups based on the onset of neurological disease: early infantile/late infantile/juvenile/adolescent/adult onset.⁴

Typically, the earlier the onset of neurological disease, the more aggressive the disease process (*Fig. 1*).^{4,21,22}

Patients with adolescent/adult-onset NP-C have a neuropsychiatric disease involving varying degrees of cognitive decline, psychiatric and neurological symptoms.⁴ At presentation, psychiatric symptoms often dominate the clinical impression, and a substantial period may pass before neurological symptoms develop or are recognised by treating clinicians.²² In many patients this delay is confounded by early neurological features, commonly an ataxia misinterpreted as a side-effect of psychotropic medication, and the challenge of eliciting subtle cognitive decline in a depressed or psychotic patient.^{22,24} This diagnostic delay is often measured in years or sometimes even decades,^{10,24} with patients frequently receiving a range of incorrect neurological and psychiatric diagnoses before NP-C is confirmed. Incorrect diagnoses made in patients with NP-C include:¹² psychotic syndromes/Alzheimer's disease and frontotemporal dementia/progressive supranuclear palsy/Parkinson's disease/parkinsonism/spinocerebellar ataxia/Wilson's disease/multiple sclerosis/Creutzfeldt–Jakob disease/Wernicke encephalopathy.

Cognitive decline

The neurodegenerative disease leads to dementia in almost all NP-C patients. NP-C is sometimes referred to as 'childhood Alzheimer's'. Although this is used as an easy identifier rather than for its accuracy, the two diseases share some neuropathological features.

In patients with adult/adolescent onset, cognitive decline features to a greater or lesser extent in almost all cases. If found in combination with other disease features, further investigations should be performed.²⁵ To highlight a possible diagnosis, the three most useful clinical features are: cognitive decline, psychosis and progressive ataxia. Consequently, these have been utilised in a patient group-initiated awareness campaign 'Think again, think NPC' (<http://think-npc.com>). This clustering of symptoms to help identify patients has been further investigated by Wijburg *et al*²⁵ who have developed 'The NP-C Suspicion Index'. This index attributes scores to different clinical features to identify the likelihood of a patient having NP-C, with pre-senile cognitive decline (< 40 years) considered a strong indicator.²⁵

The cognitive profile in adult patients with NP-C usually starts with problems in word fluidity, working memory and executive dysfunction.^{4,8,26} There may also be a frontal lobe syndrome with perseveration and loss of interpersonal distance that manifests as excessive familiarity.²⁶ At this early stage of cognitive impairment, the Mini-Mental State Examination (MMSE) often fails to identify deficiencies in these areas. However, with disease progression, a more global impairment of function develops, meeting the diagnostic criteria for dementia.^{4,5,21,22}

Psychiatric symptoms

Psychiatric symptoms associated with NP-C can vary. In juvenile- and adolescent-onset patients, intellectual disability, behavioural problems and attention-deficit hyperactivity disorder (ADHD) have been reported.^{4,11,22} Many of these patients receive further psychiatric diagnoses at a later stage.⁴ One case report describes a patient with an autism spectrum-like disorder preceding a schizophrenia-like illness before eventually receiving their final diagnosis of NP-C.²⁷

In adult patients both affective disorders and psychoses are reported.^{4,5,22} An NP-C case series describes general psychiatric symptoms in 38% of early adult-onset patients,²² with the literature suggesting that a schizophrenia-like disorder

is found in 25–40% of adolescent- and adult-onset NP-C patients.^{4,22} This psychiatric disease may initially be indistinguishable from schizophrenia, with auditory hallucinations, delusions and disorders of thought and behaviour; however, certain features are suggestive of an organic cause: neurological or visceral features, cognitive impairment, treatment resistance or even a paradoxical worsening of psychosis with drug therapy, visual hallucinations, unusual in classical forms of schizophrenia.⁴

Although the psychosis may be resistant to therapy, atypical antipsychotics can be useful, but caution should be taken to avoid worsening of any pre-existing dystonia.^{4,18}

Other major psychiatric illnesses described in NP-C include: depression generally susceptible to selective serotonin reuptake inhibitor (SSRI) therapy,⁴ bipolar disorder, often sensitive to mood stabilisers such as sodium valproate,^{4,18} obsessive–compulsive behaviour, catatonia, often in younger patients and sometimes resistant to treatment, although electroconvulsive therapy (ECT) has been used successfully.^{4,18}

Neurological features

Adolescent- and adult-onset NP-C patients almost always have some neurological features at presentation, although these may at first be subtle and eclipsed by psychiatric features. In the more aggressive late infantile/juvenile-onset group, patients are often first described as being clumsy and struggling at school. This then progresses to the development of frank neurological disease that may include limb and gait ataxia, seizures, gelastic cataplexy (the loss of muscle tone with emotional stimuli), dysarthria, dystonia, dysphagia and dementia. Prognosis in these patients is poor, with death from the consequences of their advanced neurological disease typically in their late teenage years or early adulthood.^{4,7}

Adolescent and adult patients share some of these disease features, but in their case the illness is more insidious in its onset and slower in progression. Cerebellar dysfunction, especially ataxia, is the most commonly identified neurological feature, although dysarthria and dystonia are also frequently present.^{4,18,22} Interestingly, epilepsy, common in infantile and juvenile disease, and cataplexy (20% of classical NP-C patients), are both rarely seen.²²

The most important neurological sign in NP-C, as it is both highly prevalent and specific, is a vertical supranuclear gaze palsy (VSGP).^{4,7} VSGP is seen in only a limited number of other neurodegenerative diseases and rarely so early in their disease process. In NP-C it nearly always heralds the onset of the neuropsychiatric disease, regardless of the patient's age.^{4,22}

The gaze palsy, initially in the vertical plane, progresses to also involve horizontal eye movements as the brainstem pathology advances. Initially, the VSGP is subtle and may be missed. It involves vertical voluntary saccadic movements only, especially of downward gaze, and at this stage slow pursuit eye movements are preserved.⁴ If saccadic eye movements are not tested, the initial VSGP will be missed. Saccadic eye movements are easily tested by requesting the patient to look up and then down in quick repetition. (See <http://think-npc.com/could-it-be-np-c> for a video demonstrating saccadic eye movement testing in NP-C.)

Systemic features

NP-C is a neurovisceral disease, but in adolescents and adults the visceral component is rarely of clinical significance, although splenomegaly with or without hepatomegaly is usually present.⁴

In the perinatal and early juvenile forms, systemic manifestations may be pronounced, with severe and sometimes fatal liver and pulmonary disease.⁴ Interestingly, regardless of the patient's age, visceral disease, when present, always precedes neuropsychiatric features, often by years or even decades. The severity of this visceral disease offers little insight into the likely onset or severity of the patient's later neurological disease.^{4,5} There are cases of patients with paediatric liver disease who only develop neuropsychiatric features many decades later in adulthood.¹²

In adolescent- and adult-onset patients, hepatosplenomegaly – although frequently present – is often unrecognised. When present it is usually less pronounced and nearly always asymptomatic.⁴ The proportion of patients with hepatosplenomegaly in one case series was 85%, but within the adolescent/adult cohort it was reported lower, at nearer to

50%.⁵ However, another group reported that splenomegaly (with or without hepatomegaly) was found on abdominal ultrasound in closer to 90% of patients, regardless of the patient's age.^{4,22} Because of this, Bonnot *et al*² incorporate an abdominal ultrasound scan into their diagnostic 'work-up' algorithm for IEMs causing a schizophrenia-like illness.²

A patient with splenomegaly (especially in the absence of liver disease) with a co-existent neurodegenerative or psychiatric disorder is strongly suggestive of NP-C⁴ and should be appropriately investigated. A history of paediatric liver disease in such patients should also raise clinical suspicion.

Investigation and diagnosis

Rapid advancements in gene sequencing and liquid chromatography/tandem mass spectrometry (LC-MS/MS) have led to significant change in the available approaches to diagnosing NP-C, with both easier and more affordable tests available or in development.²⁸

Bonnot *et al*² suggest an algorithm for the work-up of a patient with a schizophrenia-like illness and a possible IEM. They suggest that with initial suspicion, a clinical and ophthalmological assessment and a cerebral magnetic resonance imaging (MRI) scan should be performed. Subsequent investigations should be performed based on these findings, with an abdominal ultrasound scan to identify hepatosplenomegaly if NP-C is considered. If this is positive, then disease-specific NP-C tests can be performed.² However, this pragmatic approach has some limitations: not all patients with NP-C have hepatosplenomegaly,^{4,5,22} and with easier plasma diagnostic tests available these should be performed earlier in the diagnostic process.

Historically, the diagnosis of NP-C was made histopathologically, by both cholesterol esterification studies and filipin staining of cultured skin fibroblasts,⁴ with most patients receiving a combination of different tests performed prior to this good, but costly and difficult, definitive investigation. These tests may have included: chitotriosidase measurements, white cell enzyme studies to exclude other lysosomal storage disorders, and fluorescent and electron microscopy of both bone marrow aspirate and liver biopsy specimens.²⁸ Because of the difficulties with the filipin staining test, the most widely performed and accessible definitive diagnostic test is now the sequencing of the *NPC1* and *NPC2* genes. Next-generation sequencers make this far easier to perform, especially if the genes concerned are included on a multi-gene panel appropriate for patients presenting with a certain disease phenotype – such as neonatal cholestatic jaundice.²⁹ But this approach is not without some limitations either. In 10% of patients only a single pathogenic mutation can be identified, and in some patients new mutations of uncertain clinical significance may be identified.

More recently, highly specific and sensitive oxidative cholesterol metabolites for NP-C have been identified.³⁰ This 'oxysterol test' can be performed on a plasma sample and is now used as the first-line diagnostic test with subsequent genetic confirmation at one of the principal UK reference laboratories for lysosomal storage disorders. Although it has a positive predictive value of > 97% in an NP-C enriched population such as infants with cholestatic jaundice,²⁸ its accuracy as a screen in broader populations is still being clarified. With the recent advances in LC-MS/MS, other candidate metabolites for diagnostic tests are being identified, with several in the pipeline. These are likely to be available in the near future as cheaper and widely accessible plasma or urine diagnostic tests.²⁸

Treatment options

Disease-specific treatments

Miglustat, a small iminosugar molecule, is licensed in the European Union for the treatment of the progressive neurological manifestations of NP-C in both adults and children.⁴ It reduces the accumulation of the downstream toxic metabolites, glycosphingolipids (GSL), by competitively inhibiting the first step in their synthesis.³¹ It has been shown to stabilise certain key neurological manifestations in a randomised controlled trial (RCT), a retrospective cohort study and in clinical experience.^{4,32,33} However, in adults it may take a year or longer to identify a discernible clinical benefit.⁴

Multiple other therapies are currently under clinical investigation for NP-C, of which two studies are at the Phase 2b/3 pivotal trial stage: arimoclomol, a small molecule that induces the heat shock protein response – a normal cellular stress response³⁴ cyclodextrins, ring-like sugar molecules that reduce lipid storage and in animal models have both substantially reduced the burden of disease and greatly prolonged lifespan.^{35,36}

Symptomatic treatments

Complex neuropsychiatric diseases have a profound effect on the patient, their family and carers. Consideration of the patient's nutritional status, swallow safety and toileting/bowel function, as well as their mobility and safety, is important, with a multidisciplinary team involved and access to appropriate agencies as needed. Timely discussions around issues of capacity, care and end-of-life planning are also necessary.

Cognitive impairment

Appropriate support services should be involved. Although miglustat may stabilise the cognitive decline, there is no evidence that cognitive-enhancing drugs such as cholinesterase inhibitors have a beneficial role.⁴

Psychiatric illness

Psychosis usually responds to antipsychotic medications, but some NP-C patients are resistant to treatment or even show (paradoxical) worsening with the initiation of drug therapy (a useful diagnostic red flag in unidentified NP-C). Atypical antipsychotics should be used and frequent neurological assessments performed to identify worsening of any pre-existing dystonia. If it occurs, dose reduction or an alternative antipsychotic may be used, supplemented if necessary with sodium valproate.⁴ Depression typically responds well to SSRIs,³⁷ and in some patients, when effectively treated, this leads to improvements not only in their mood but also their cognition and neurological disease. Bipolar disorder in NP-C has responded to mood stabilisers such as sodium valproate and catatonia has been treated successfully with ECT.^{4,18} Sleep disturbance in NP-C may manifest as sleep inversion, narcolepsy or obstructive sleep apnoea and can be treated with melatonin and continuous positive airway pressure ventilation (CPAP).⁴

Neurological disease

Patterson *et al*⁴ have published recommended treatment strategies for a range of different NP-C neurological complications.

Prognosis

Accurate prognostic predictions in NP-C are difficult. There is poor genotype-phenotype correlation in disease course, with affected siblings not infrequently following different disease trajectories. The extent and severity of visceral disease offers little insight into the severity of later neurological disease, an additional challenge when counselling parents of a newly diagnosed infant with liver disease.

The most useful prognostic indicator is the age at neuropsychiatric disease onset.

Summary

The largest subgroup of NP-C patients is likely to be an undiagnosed/misdiagnosed adult population with a neuropsychiatric disease. Consequently, NP-C highlights the need for continual diagnostic review in patients with psychosis, especially if there is coexistent cognitive decline and/or ataxia.

1.7.32 The mini-PAT as a multi-source feedback tool for trainees in child and adolescent psychiatry: assessing whether it is fit for purpose

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Abstract

This paper discusses the research supporting the use of multi-source feedback (MSF) for doctors and describes the mini-Peer Assessment Tool (mini-PAT), the MSF instrument currently used to assess trainees in child and adolescent psychiatry. The relevance of issues raised in the literature about MSF tools in general is examined in relation to trainees in child and adolescent psychiatry as well as the appropriateness of the mini-PAT for this group. Suggestions for change including modifications to existing MSF tools or the development of a specialty-specific MSF instrument are offered.

Contents

- *The mini-PAT as a multi-source feedback tool for trainees in child and adolescent psychiatry: assessing whether it is fit for purpose*
 - *Research on the use of MSF for doctors*
 - *The mini-PAT as an MSF tool*
 - *Use of the mini-PAT in child and adolescent psychiatry training*
 - *Potential issues with using MSF tools*
 - *Does the mini-PAT suit the needs of trainees in child and adolescent psychiatry?*
 - *Conclusions*

Multi-source feedback (MSF) can motivate doctors to improve and change their practice.^{1,2} It gives doctors an overview of how others see them and compares this with their own view as well as the results of their peer group.³ MSF evolved in Canada and the USA out of a public demand for accountability to patients as well as an acceptance that assessments examining clinical decision-making and medical expertise do not address other essential competencies, such as interpersonal skills, professionalism and communication.³ MSF tools were originally designed to be formative, that is, to lead to awareness of and improvements in performance through feedback. More recently, however, they are being used for summative purposes, namely to provide information for revalidation and the annual review of competence progression (ARCP) which determines whether a trainee is considered fit to proceed with their training. As such, MSF tools need to be sufficiently reliable and valid. Reliability refers to the reproducibility of assessment measures or scores over repeated tests under identical conditions, and validity refers to the degree of confidence that an assessment measures what it is intended to measure. An associated term, feasibility, is a measure of whether an assessment instrument is practical, realistic and sensible given the circumstances and context.⁴

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Research on the use of MSF for doctors

Ramsey *et al*⁵ published a landmark study showing that it was feasible for internal medicine physicians to obtain peer assessments about their humanistic qualities, clinical practice and communication skills. They also came to important conclusions about the reliability of MSF – for example, that 11 peer ratings were needed to ensure a reliability coefficient of 0.7 (the minimum acceptable for workplace-based assessments (WPBAs)) and that the results were not substantially affected by the relationship between the rater and the person being rated nor by the method used to select the raters. The findings of this study also suggested that a doctor's medical knowledge (determined by examination marks) was not predictive of how peers subsequently rated their interpersonal relationships or communication skills.

The finding that reliable and valid MSF questionnaires can be developed and be feasible to use for assessing doctors has been replicated across settings and specialties.^{2,6-9} A number of systematic reviews have also been published, all of which conclude that MSF as a method of assessing communication skills, collegiality, humanism and professionalism in doctors has high reliability, validity and feasibility.¹⁰⁻¹⁵

The mini-PAT as an MSF tool

The mini-PAT is used by the Royal College of Psychiatrists as an MSF instrument for trainees. It is well known because of its widespread use in the Foundation Programme.^{16,17} The mini-PAT was derived from the Sheffield Peer Review Assessment Tool (SPRAT) following a mapping exercise against the foundation curriculum,⁶ thus ensuring its content validity. The SPRAT contains 24 questions assessing a doctor's competencies and professional attributes, and it maps directly on to General Medical Council (GMC) standards of good medical practice,¹⁸ again establishing its content validity. These standards include good clinical care, maintaining good medical practice, teaching and training, appraising and assessing, relationships with patients and working with colleagues. The SPRAT was the first MSF tool validated in the UK for use by paediatric consultants as part of their appraisal.¹⁹ It has also been shown to be reliable, needing as few as four raters to determine whether a doctor is in difficulty or not (more in borderline situations), and feasible, taking only 5–6 minutes to use with good return rates (more than 70%).²⁰ It can also discriminate between the more and less experienced trainee.²¹

In developing the mini-PAT, nine questions which did not map on to the curriculum for the Foundation Programme were removed from the SPRAT. These included questions relating to the management of complex patients and leadership. One question about probity and health was added while the free-text element and six-point scale (where 1 indicates 'very poor' and 6 indicates 'very good') remained unchanged.⁶ The resulting mini-PAT was thought to reflect the importance for foundation doctors of developing communication skills, team work and other humanistic qualities in relation to patient care in addition to their medical knowledge.³

In his critical analysis of the mini-PAT, while accepting its content validity and feasibility, Abdulla stated that it 'lacks sufficient field evaluation and has not gone through any stringent criteria that are required for the validation of an assessment tool'.³ Data on the reliability and validity of 693 mini-PAT assessments on 553 foundation year 1 and 2 (F1/F2) doctors have subsequently been published.⁶ The mean scores of the two groups were found to be significantly different when using the same criterion standard (i.e. expectation for F2 completion), with 19.6% of F1s and 5.6% of F2s being assessed as borderline or below the expectations for F2 completion. This was used as evidence of internal standardisation and construct validity, as was the finding that the trainees scored higher in the domains of working with colleagues and relationships with patients compared with the clinical skills domains. Overall, 53% of F1 doctors and 74% of F2 doctors could have been assessed by no more than 8 assessors based on their mean scores. Factor analysis revealed that the two main factors were humanistic qualities and clinical performance. The authors concluded that the mini-PAT was a valid and reliable MSF tool for assessing foundation doctors.

Use of the mini-PAT in child and adolescent psychiatry training

In child and adolescent psychiatry, the process when using the mini-PAT is as follows: twice a year, the trainee provides contact details of between 8 and 12 co-workers who see them on a frequent basis in a range of situations. These people and the trainee then complete the mini-PAT online. Presumably based on the findings of Archer *et al*,⁶ it is suggested that at least 8 forms must be completed to ensure the assessment is reliable. There is, however, no research specifically related to the mini-PAT on the minimum number of assessors required to give a valid result.³ The form uses a 6-point Likert-type rating scale. Trainees are rated according to the standard expected at each stage of training. A score of 4 corresponds to the expected standard, with higher or lower scores suggesting the trainee's performance is better or worse.²² The responses are analysed centrally and a report is then sent to the trainee's educational supervisor who delivers the feedback in person.²³

Potential issues with using MSF tools

Several issues that have been identified in relation to the use of MSF tools for medical practitioners in general are also relevant to their use in child and adolescent psychiatry. One is the trainee's choice of rater. Although several authors have found that MSF assessment is not necessarily biased by allowing the doctor to select their own raters,^{5,24,25} others have found that factors such as the seniority, gender and profession of raters can significantly influence the assessment. For example, Archer *et al*²¹ found that consultant raters using the SPRAT gave significantly lower mean scores to paediatric trainees than more junior doctors did; similarly, Bullock *et al*²⁶ found that consultants and senior nurses were more likely to give 'concern' ratings when assessing junior doctors than were peers or administrators. Thus, there is a trend for assessors to be more critical with increasing seniority. When considering the mini-PAT, Archer *et al*⁶ found that assessors' scores were affected by their occupation, the length of time the trainee had been working with them, and the working environment. They suggested standardising the number of consultants used as raters by each trainee. These findings support the need for more detailed guidance in rater selection from the Royal College of Psychiatrists. Trainees are currently only advised that raters be chosen from a broad range of co-workers.⁴ In addition, Abdulla³ suggests that selection bias can be reduced if the list of raters is discussed and agreed on beforehand with the trainee's supervisor.

Measurement errors, such as the central tendency and halo effect, can also occur and are particularly likely when behaviours which cannot be easily observed are being assessed.²⁷ A particular issue for non-doctor raters is knowing what standards they should expect for a doctor at that stage in their training. In an attempt to reduce measurement errors, Abdulla³ suggests better education for mini-PAT raters. This could be provided by the Royal College of Psychiatrists as part of their online mini-PAT package.

It has been shown that doctors' self-assessments do not correlate well with peer or patient ratings.^{7,28} Violato & Lockyer²⁹ studied psychiatrists, internal medicine physicians and paediatricians, and found that all were inaccurate in assessing their own performance. Those psychiatrists who were rated by peers to be in the bottom quartile saw themselves as 'average', whereas the psychiatrists in the top quartile significantly underrated themselves. This indicates that poorly performing doctors often lack insight, not always accepting negative feedback from others and querying its validity.³⁰ Overeem *et al*³¹ advise that trained facilitators should encourage trainees to reflect on MSF results and help them set concrete goals for improvement. Offering coaching to help trainees identify their strengths and weaknesses may help facilitate changes in performance.³² Making the feedback highly structured can help trainees acknowledge feedback from all sources rather than just the medical scores which they tend to value more.^{5,33-35} Although taking the mean of the scores may be the most reliable approach,³⁶ attention should also be given to the free-text comments which might highlight specific performance issues and which may also make the feedback more acceptable.³⁵ These findings highlight the importance of the MSF feedback process, which should include the development of a relevant action plan in collaboration with the doctor.

It has been proposed that a single, generic MSF tool be used in the UK.³⁷ Research supporting this includes Violato & Lockyer's^{29,38} study of the use of one MSF tool for internal medicine physicians, paediatricians and psychiatrists. Although they found no specialty differences in response rates or reliability, it is of note that of the items clustered into the same four factors across the specialties, for psychiatry the most discriminating factor was communication whereas for the other two specialties the most important was patient management. By contrast, Mackillop *et al*³⁹ evaluated the

use of a generic MSF tool across specialties and concluded that, although the generic content was appropriate for most specialties, some would benefit from specialty-specific content.

Does the mini-PAT suit the needs of trainees in child and adolescent psychiatry?

In child and adolescent psychiatry, the mini-PAT is currently used to assess trainees. Although the mini-PAT has content validity for foundation doctors, having been mapped against their curriculum, this does not necessarily mean it is also a valid tool for other grades or for use across specialties. In the making of the mini-PAT, some questions were removed from the SPRAT, namely those relating to management of complex patients and leadership.⁶ However, these items are highly relevant to trainees in child and adolescent psychiatry. Davies *et al*⁴⁰ modified the SPRAT for trainees in histopathology following a blueprinting exercise against the histopathology curriculum to establish content validity. They concluded that specialty-specific MSF is feasible and achieves satisfactory reliability. A similar approach blueprinting the SPRAT against the child and adolescent psychiatry competency-based curriculum⁴¹ could therefore be considered. The SPRAT also requires fewer raters than the mini-PAT in order for the results to be sufficiently reliable,⁶ thus adding to its potential suitability for child psychiatry trainees who often work in small teams.

Alternatively, a specialty-specific MSF instrument for child and adolescent psychiatry trainees could be developed, to reflect the differences in their practice compared with other specialties and the greater importance placed on communication, interpersonal skills, emotional intelligence and relationship building.⁴ Tools taking these attributes into account have been developed for use with consultant psychiatrists and have been found to be feasible to use as well as being reliable and valid.^{42,43} The child and adolescent psychiatry competency-based curriculum⁴¹ gives details of intended learning outcomes (ILOs), which are either mandatory or selective, some of which tap into these areas. The ILOs range from those that are predominantly clinical (e.g. managing emergencies (mandatory), paediatric psychopharmacology (mandatory) and paediatric liaison (selective)) to those that focus on more humanistic skills (e.g. professionalism (mandatory) and establishing and maintaining therapeutic relationships with children, adolescents and families (mandatory)). The ILO on professionalism includes: 'practicing Child and Adolescent Psychiatry in a professional and ethical manner; child and family centred practice; understanding the impact of stigma and other barriers to accessing mental health services and inter-professional and multi-agency working'.⁴¹ Some of the necessary associated skills which trainees are expected to attain include: supervising junior psychiatric staff, working with colleagues within the team and with other agencies to put the child's needs as central, and acting as an advocate for the child. There is scope to develop this area of the curriculum even further; the American Board of Pediatrics (ABP) published guidelines for the teaching and evaluation of professionalism in paediatric residency programmes⁴⁴ as well as standards of professional behaviour against which paediatricians, including those in training, can be evaluated.⁴⁵ Both are of relevance to child and adolescent psychiatrists.

If developed, a child and adolescent psychiatry specialty-specific MSF instrument would need to map on to the relevant ILOs. It could also include feedback from patients and families (which is not currently routinely collected as part of the WPBAs) to reflect the need to balance the views of the child (who is the patient) with those of their carers.

Conclusions

MSF tools such as the mini-PAT can provide reliable and valid information on areas of a trainee's performance such as communication skills and other humanistic qualities affecting patient care for which other forms of assessment, such as written examinations, are unhelpful. MSF tools have their predominant strength when used for formative assessment and were generally designed for this purpose. They are most appropriately used within a portfolio of other WPBAs and can help in making decisions about a doctor's fitness to practice or to continue training.⁴⁶ Rater bias and measurement error could be reduced by offering more detailed guidance to trainees in their choice of rater as well as to raters in the use of the tool. Measurement error could also be reduced by encouraging trainees to obtain a larger number of returns than the minimum of eight recommended by the Royal College of Psychiatrists.³ The quality of the feedback to the trainee is also important and educational supervisors would benefit from training in this area.

Although the mini-PAT is used widely across specialties, it has only been properly evaluated for use with foundation doctors. Interested researchers, clinicians or educationalists might now want to consider developing a modified version of the SPRAT or a specialty-specific MSF tool that is more appropriate for the needs of trainees in child and adolescent

psychiatry. This would reflect the differences in their day-to-day practice compared with that of other trainees but would obviously need to be mapped to the curriculum and evaluated in practice to ensure content validity and reliability.

1.7.33 James Patrick Watson MD, FRCP, FRCPsych

: Formerly Professor of Psychiatry, King's College London and Honorary Consultant Psychiatrist, South London and Maudsley NHS Trust

Tom K. J. Craig Nick Bouras

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James (Jim) Watson, who died after a stroke on 3 August 2016 aged 80, was among a small band of British psychiatrists who trained in the 1960s and 70s to take psychiatry out of the asylums and establish robust services in general hospital and community settings. They were also responsible for developing a wide range of specialist mental health services. Jim was deeply committed to improving the standards of clinical care, from early implementation of behavioural therapy through in-patient group therapies and the understanding and management of behaviour on hospital wards. He championed the relationship between staff and patient as key to recovery in psychiatry, deploring the move to ever fewer acute beds, reductions in staffing levels and organisational changes that resulted in fractured continuity of care and consequent erosion of the essence of good mental healthcare.

His clinical interest was reflected in his research, which included evaluations of community mental health, telemedicine and treatments for psychosexual disorders, for which he established one of the earliest specialist multidisciplinary clinics and training programmes in Britain. With his personal style, he led a vibrant, outward-facing, creative and very happy department, in which a serious commitment to excellence went along with a refreshing lack of pomposity and a keen sense of work being enjoyable. This was in no small part due to Jim's dedication to improving the quality of psychiatric services, not least by ensuring excellence in the education and training of psychiatrists and by making sure that medical students had a varied and stimulating exposure to psychiatry.

Under his leadership, Guy's Hospital Medical School had the enviable reputation of having the highest proportion of medical students opting for a career in psychiatry. In the postgraduate field, he was an inspirational leader of the South East of England training scheme for psychiatry, chairman of the Royal College of Psychiatrists' Specialist Training Committee and chairman of the Association of University Teachers of Psychiatry. In the mid-1990s he launched an MSc in mental health studies – a programme directed at professionals from all disciplines involved in delivering mental health services. This course was extraordinarily successful: consistently oversubscribed, with unprecedented numbers of applicants. Its success spawned further collaborations with university departments overseas, notably in Egypt and the Middle East, where he worked with colleagues to develop a diploma in psychiatric practice for wider dissemination across the region. His determination to improve mental healthcare led him to a lengthy involvement with mental healthcare in Pakistan. From the early 1990s, he collaborated with colleagues there, visiting regularly and helping to train staff for mental health clinics in rural settings that have now expanded to more than 15 centres, some of which are co-located with a mosque and madrasa. Jim was also connected with several other international projects involving, among other countries, Greece and the former Yugoslavia.

Jim was the eldest of three sons. His father was a teacher and his mother a doctor. He attended the Roan School for Boys in Greenwich, where he excelled academically and in sport. He studied medicine at Trinity College, Cambridge,

where he was a senior scholar. In 1957 he transferred to King's College Hospital Medical School for clinical studies, qualifying in April 1960. It was there that he met his fellow student and future wife Christine Colley – they were married in April 1962.

After training in psychiatry at the Bethlem Royal and Maudsley Hospitals and Institute of Psychiatry, he was appointed as consultant and senior lecturer in psychiatry at St George's Hospital London in May 1971. He was appointed to the Chair of Psychiatry at Guy's Hospital Medical School in September 1974, steering his department through the union with St Thomas's Hospital in 1982 and onward to the final merger with King's College in 2000. In addition, he served as honorary consultant psychiatrist to the British Army from 1980 to 2000 and was the vice-president of the Royal College of Psychiatrists from 1998 to his retirement.

After retirement, Jim continued to contribute actively to the field, providing teaching and mentorship to psychiatrists in the Sussex Partnership NHS Foundation Trust. He maintained his collaboration with colleagues in Pakistan, advising on setting up a new School of Nursing as well as the development of a service and training resource for children with learning disabilities and autism. He took part in continuing education meetings with colleagues in Cheltenham, chaired a patient support group in a local general practitioner practice and was trustee of the Soundwell Music Therapy Trust which provides music therapy for people suffering from mental ill health.

Jim enjoyed a very happy family life, having four sons whose diverse careers in music, international school teaching, hospital medicine and clinical psychology were a great source of pride and affection. In 2002, he and Christine exchanged London life for a Cotswold home where he could indulge his enthusiasm for vegetable gardening – a throwback to his maternal ancestors who had traded as market gardeners, supplying mustard and cress to Queen Victoria.

Jim's passing will be felt as a great loss to psychiatry and by the many clinical and academic colleagues who had the privilege of knowing and working with him.

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1.7.34 Irving Gottesman

: American psychologist and behaviour geneticist who radically changed traditional views of schizophrenia

Peter McGuffin

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 - : *American psychologist and behaviour geneticist who radically changed traditional views of schizophrenia*

The research and writings of the clinical psychologist and behaviour geneticist Irving Gottesman, who has died aged 85, radically changed the way psychologists and psychiatrists think about schizophrenia and, more generally, about

what Irv called the ‘origins of madness’ (which was the subtitle of his 1991 book *Schizophrenia Genesis*).

His path to becoming a dominant figure in psychiatric genetics began at an international conference in 1961 when, as a psychology lecturer at Harvard University, he was introduced to Eliot Slater, director of the Medical Research Council (MRC) psychiatric genetics unit at the Institute of Psychiatry in London, and the doyen of psychiatric genetics of his day.

Slater agreed that Irv might join his unit provided he brought his own funding. Irv duly won a three-year grant from the US National Institutes of Health (NIH) and arrived in London in 1963. Slater was an austere and imposing figure and the building that housed his unit was equally austere, a makeshift postwar prefabricated building, affectionately known by staff as ‘the hut’, on the fringe of the campus of the Maudsley hospital in Camberwell. Although its physical environment was poor, the unit had much intellectual capital, provided by Slater himself, his deputy director Valerie Cowie, a psychiatrist trained in the new techniques of cytogenetics, and a brilliant if self-effacing senior research assistant, Jerry Shields.

The hut also housed another world-class asset, the Maudsley Twin Register. Begun by Slater in 1948, it contained the names of all patients entering the Maudsley and Bethlem Royal hospitals who had been born a twin. Irv’s successful NIH proposal was for a study of schizophrenia using the register and Slater paired him with Shields to carry out the work.

The principle of the classic twin method is straight-forward. Identical or monozygotic (MZ) twins share all their genes, whereas fraternal or dizygotic (DZ) twins share half their genes. MZ and DZ twins usually share the environment in which they are raised. Therefore if a disorder such as schizophrenia shows greater co-occurrence (‘concordance’) in MZ versus DZ twins this is evidence of a genetic effect. Similarly, absence of 100% concordance in MZ twins is evidence of environmental effects. The Gottesman-Shields Twin Study (1967) clearly confirmed the proposition that both genes and environment play a role in schizophrenia (at a time when theorists in the US and Britain were blaming parents, particularly mothers, for ‘causing’ the disorder).

One of Irv and Jerry’s major contributions was to propose a plausible mode of inheritance for schizophrenia. One of the big puzzles about familial common diseases at the time was that none (including physical disorders such as heart disease, diabetes, some cancers) showed the simple ratios of affected:unaffected within families predicted by Mendel’s laws.

The most widely accepted solution for schizophrenia was Slater’s model invoking the idea of a dominant gene with ‘incomplete penetrance’ (some people carry the gene but do not show the disorder). Irv and Jerry boldly proposed an alternative polygenic model, derived from the work of the Edinburgh mathematical geneticist DS (Douglas) Falconer, in which liability to develop schizophrenia has a normal ‘bell-shaped’ distribution in the population (like height or weight) contributed to by many genes. But, unlike height or weight, there is a threshold effect, so that only the 1% or so of the population with the highest liability show the disorder.

The Gottesman-Shields polygenic model of schizophrenia eventually gained ascendancy, even though the final clinching piece of evidence emerged only in 2014 with the publication of a huge genome-wide molecular study of tens of thousands of subjects showing that more than 100 genes are involved.

Another far-reaching conceptual innovation was their idea of ‘endophenotypes’. Irv and Jerry proposed in their 1972 book, *Schizophrenia and Genetics*, that the genetic basis of psychiatric disorders could be better understood, and specific genes more readily identified, by the discovery of biological characteristics that lie a step closer to DNA than the clinically observable symptoms and signs, the ‘exophenotypes’, by which disorders are defined. Irv continued to elaborate the endophenotype concept over ensuing years and it provoked thousands of papers by others, a sort of Higgs boson for biological psychiatry. Unlike the Higgs particle, the existence of endophenotypes has yet to be proved experimentally for any of the major disorders.

Irv was born in Cleveland, Ohio, to Hungarian-Romanian Jewish emigre parents, Bernard, an insurance agent, and Virginia (nee Weitzner). He was a science enthusiast from an early age and began a physics degree while serving as an officer in the US navy, later switching to psychology. He completed his PhD at the University of Minnesota on the genetics of personality but initially had great difficulty in getting his findings published because of the prevailing orthodoxy in US academia in the late 1950s that behaviour was entirely due to nurture and nothing to do with nature.

After his postdoctoral fellowship in London, Irv returned in 1966 to the biology-friendly department of psychology in

Minneapolis and set up one of the first behaviour genetics training programmes in the US. He thereafter held chairs in Washington University in St Louis (1980–85), where I first came under his mentorship as a visiting MRC fellow, and at the University of Virginia (1986–2001), where he set up a clinical psychology doctorate, before returning to Minnesota, where he remained for the rest of his career.

He won many plaudits and prizes worldwide but retained particular affection for and gratitude to the UK, where his recent awards included honorary fellowship of the Royal College of Psychiatrists and King's College London.

Irv is survived by his wife, Carol (nee Applen), whom he married in 1970, and their sons, Adam and David, and grandchildren, Josh, Ava and Fiona.

Irving Isadore Gottesman, clinical psychologist and geneticist, born 29 December 1930; died 29 June 2016

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1.7.35 The Other Side of Silence: A Psychiatrist's Memoir of Depression

Tom Brown¹

date

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- *The Other Side of Silence: A Psychiatrist's Memoir of Depression*

Linda Gask is an eminent academic psychiatrist with an outstanding international reputation. I state this upfront because it is none too obvious from this book – owing to her self-effacing style – and in my opinion, it is very relevant. I should also declare an interest as Linda and I were in the same year at Edinburgh University's medical school and I have heard small snippets of this story from her over the ensuing years.

In this excellent book Linda Gask shows what may be achieved despite living with a recurrent depressive illness; hope emerges even from her darkest moments and this work should encourage many. It is striking for its frankness and honesty – no small achievement given that she clearly must have known it would be read not only by colleagues, but by patients past and present, some of whom would have known little about her. She even mentions her failure to pass the MRCPsych exam at the first attempt and describes her – surprising to some! – experience of how sensitive and supportive a very senior academic colleague was at this time.

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The book chronicles her life and career and the impact of her illness, including thoughtful reflections on its roots (in her early life). She teaches us about depression through the mirror of her own illness and that of her patients, and brings this to life through the use of clinical vignettes. She emphasises the importance of both biological and psychosocial factors in the origins of this illness and her description of treatments is both fair and accurate. Her accounts of her interactions with patients are particularly helpful and should be of value to any doctor, whether trainee or senior. I especially valued her comments on those whose failure to improve is ascribed to personality disorder, which is, alas, an all too common tactic of many psychiatrists.

This is an exceptional book and should be read by many, both doctors and patients. The high-profile endorsements on the cover are entirely deserved. Some years ago Linda wrote another excellent book entitled *A Short Introduction to Psychiatry*. I gave it to many medical students to read. I will give this to many more.

1.7.36 Mentalisation-Based Group Therapy (MBT-G): A Theoretical, Clinical, and Research Manual

Gwen Adshead¹

date

2017-4

Contents

- *Mentalisation-Based Group Therapy (MBT-G): A Theoretical, Clinical, and Research Manual*

This book presents a challenge for a reviewer because it is both a theoretical text and a technical manual. The technique in question is mentalisation-based group therapy (MBT-G) and one of this book's functions is to assist supervisors of MBT-G in rating therapists on quality of technique and adherence to the MBT-G guidelines. So, at first sight, you might not be drawn to this publication unless you are a group therapist – and trained in MBT-G.

However, I encourage people who are not psychotherapists or trained in MBT to consider this manual as a useful introduction to the concept of mentalising. Mentalisation is an old concept in psychology and refers to our human ability to understand ourselves as agents who make choices and form intentions. This ability includes an understanding and perception of *other* people as having minds that form intentions, which are real and distinct from our own.

All psychiatrists need a valid and reliable model of mind with which to work clinically, and the concept of mentalisation fits the bill. Mentalising capacities are crucial to our social existence, across the lifespan; failure to mentalise successfully is a feature of all mental disorders. The healthy mind is constantly mentalising, with odd lapses in reasoning and dialogue that are neither too severe nor too frequent. When the mind is disordered – through any cause – mentalising fails and immature modes of thinking dominate, often with catastrophic results in terms of social identity and function. The restoration of mentalising then becomes a crucial aspect of all psychiatric treatment.

There are several books on mentalising and mentalisation-based therapy by Karterud's collaborators in the UK (Peter Fonagy and Anthony Bateman) and the USA (Jon Allen). I found this particular book of interest because it approaches mentalising from a philosophical perspective: that of hermeneutics and how we interpret the world. Karterud suggests that the way we interact with and interpret others comes before our experience of our own minds; that the social self is

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primary in developmental terms. Such a relational approach to mind is a vital complement to models of mind that are either atomistic or mechanical. We have no evidence that the mind works like a machine, but there is growing evidence that the mind is organic and dynamic, responding, developing and evolving in response to the environment – which, for human beings, is the experience of other minds.

MBT is recommended by the National Institute for Health and Care Excellence for the treatment of borderline personality disorder and treatment trials of MBT for antisocial personality disorder are ongoing. But understanding mentalising is a broader objective which all psychiatrists need to achieve. This work is obviously essential reading for trained MBT-G therapists, but it is a useful introduction to mentalising in its own right.

1.7.37 The Narcissist Next Door. Understanding the Monster in Your Family, in Your Office, in Your Bed – in Your World

Jon Patrick¹

date

2017-4

Contents

- *The Narcissist Next Door. Understanding the Monster in Your Family, in Your Office, in Your Bed – in Your World*

I find myself split in my thinking about this book. On the one hand, I can see its appeal as an airport read; requiring little effort to get through, and full of celebrity and political commentary as well as easily digestible chunks of scientific evidence.

At that level, it's enjoyable. Especially so when it allowed me to neatly project all my ugly narcissism into reports about Kanye West and Sarah Palin. Perhaps a first for them to be mentioned in the *Bulletin*, no doubt adding to their narcissistic satisfaction, should they or their agents be subscribers.

At another level – and this is where I'm split – it is an exercise in quite contemptuous character assassination. Kluger's portrayal of his example subjects is cold and sneering at times. Furthermore, he often seems to conflate the concepts of narcissism and psychopathy, leading to a sense that the more narcissistic of us are one step away from becoming serial killers or workplace tyrants.

There are only brief mentions of how the presentation of narcissism might be related to inner vulnerability, and this left me wondering if Kluger might have been looking at the mirror crack'd. Even as I write this I wonder if I too am succumbing to the narcissistic appeal to feel superior to what we read – this is hard to contain when I am a UK reader and the author mentions former prime minister 'Malcolm Browne' (referring to Gordon) and the football team 'Aston Vista'. Such mistakes feel sloppy, arousing my narcissistic contempt; perhaps a response to feeling as though the author does not care enough about the UK to check facts properly.

Coming from a psychoanalytic tradition, where this subject has been a preoccupation of clinicians since Freud's 1914 *On Narcissism: An Introduction*, Kluger's view on the dilemma of the narcissist saddened me. We are all narcissists to

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some degree; it's what allows us to get out of bed in the morning and feel like we are good people who might be loved. The pathological narcissist is someone who has found their early experiences to be lacking and who has lost their trust in acceptance by others. To manage this insufferable situation, they create an outer self that is contemptuous of need and full of itself, and project away their dependent, vulnerable selves onto others. Sometimes, they are contemptuous and dismissive of needy people. Sometimes, if society is lucky, and the person more creative, they will look after others who are vulnerable – to repair the damage they feel inside themselves.

1.7.38 The Vegetarian

Ginevra Read¹

date

2017-4

Contents

- *The Vegetarian*

This short novel, winner of the Man Booker International Prize 2016, is translated from Korean and tells the story of Yeong-hye, a young woman in modern day South Korea. It is a fascinating and thought-provoking narrative that starts with Yeong-hye choosing to become vegetarian. This seemingly unremarkable and straightforward choice turns out to be nothing of the sort – vegetarianism is almost unheard of in Korea but, more importantly, Yeong-hye is on the verge of serious mental illness. Yeong-hye's stance is challenged by all of those around her, but she remains steadfast. It transpires that becoming vegetarian is the prodromal seed of an all-encompassing psychosis which will take Yeong-hye on a journey from being vegetarian to believing that she is vegetal in nature and therefore food is superfluous to her needs.

Clinicians will be acquainted with the somewhat perplexing process by which this intricate and emotive story develops. Information appears not in neat chronological order but in a tangle that needs some work to unpick. Yeong-hye's story is told in three parts. We hear first from her husband, then her brother-in-law and finally her sister, all the while following the unravelling of Yeong-hye's internal and external world, in a tale that deepens in complexity and darkness as it unfolds. Interspersed italicised monologues allow us a brief glimpse of Yeong-hye's muddled (and muddling) mind. By portraying thoughts that mingle with dreams and memories in a way that confuses the reader as to what is real and what is not, Kang elegantly conveys something of Yeong-hye's mental state. We don't hear much about Yeong-hye's premorbid adult life, other than through her husband, who says she was 'ordinary' and functioned to his liking. We can, however, sense the weight of the oppression she is subject to and guess that although becoming vegetarian may have marked an important transition point in her illness, it is unlikely to have been the beginning of it. The husband's account of Yeong-hye's condition reveals, through the lens of his own narcissism, a shocking lack of concern for his wife beyond her role in satisfying his immediate needs. He views Yeong-hye as an object and a possession, and this is most apparent in his remorseless and matter-of-fact description of raping her. A meal with her husband's boss tells us something about society's inflexible expectations and demonstrates that the lack of compassion experienced by Yeong-hye is multifaceted. We see Yeong-hye's father in action and learn a little about her upbringing; as a result, the degree

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to which she has been repressed and forced to endure throughout her life becomes clearer, and the powerful, subversive resistance enacted through her illness begins to make sense.

The second part of the book is equally disturbing and leads us to the brother-in-law, a less than successful video-artist who becomes obsessed with Yeong-hye's pre-pubertal appearance and whose paraphilic behaviour uncomfortably exposes her vulnerability.

In the final part of the book, several years later, we join Yeong-hye's sister In-hye as she visits her in a psychiatric hospital. In-hye now faces the repercussions of preceding events and the resulting family disintegration. We hear more about the sisters' childhood and the abuse which they experienced; we learn that In-hye continues to suffer her own anguish as a corollary and that she in some way envies her sister's position.

This is an astonishing book. Strange, surreal and beautifully written. The idea that people could find themselves surrounded by such brutal inhumanity and lack of connection that they reject their current existence and instead opt for transformation into a life form that does not involve thought or feeling is indescribably sad, but probably not beyond imagination for most psychiatrists. Readers will find that they must piece together the jigsaw of Yeong-hye's life, and as hard as they try, the image is not clear and the final pieces can never be found – an experience to which most of us surely relate.

1.7.39 The Psychedelic Policy Quagmire: Health, Law, Freedom, and Society

Adam G. Van Hagen¹

date

2017-4

Contents

- *The Psychedelic Policy Quagmire: Health, Law, Freedom, and Society*

The resurgence of psychedelic research has opened up a new realm of possibilities in consciousness research. However, public policy surrounding the use of psychedelics has struggled to acknowledge that they may be effective therapeutic treatments or tools for enhancing self-awareness and exploring consciousness. Highlighting the need for redress, this anthology argues that current international public policy is not scientifically or culturally informed and is thus divorced from the empirical evidence that is supposed to inform its construction and implementation.

The book examines the complex policy issues surrounding psychedelic-based healing modalities and calls for an urgent shift in policy regulating the research and application of psychedelic substances. At its core, it is a scathing criticism of legal frameworks and regulatory policies that control the use of and research on psychedelics, and goes so far as to suggest that current structures and mechanisms impose a status quo of consciousness, thereby preventing people from fully enacting their right to freedom of religion, thought and conscience. At the very least, policy makers and ethicists need to give due attention to medical and psychotherapeutic research on psychedelics and the role they have in facilitating direct spiritual experiences. This includes acknowledging the transformative effect that experience may have on the self, as well as the right of all people to freedom of religion, thought and conscience.

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Any book that rates these substances highly as a connection between the individual, society and the human race as a whole will find its detractors. That being said, *The Psychedelic Policy Quagmire* presents a strong case for the notion that psychedelics have transcended seemingly outdated legal, academic, cultural and spiritual paradigms. Although – by the editors’ own admission – this volume is by no means definitive, it will undoubtedly prove to be a lightning rod in the academic community. With its focus on research and policy that maximise the benefits of the use of psychedelics, reduce the potential dangers of misuse and remove impediments to achieving these ends, it is inevitable that this book will be a catalyst for lively and robust debate. Recommended to academics and researchers in various fields, including psychology, psychiatry, anthropology and the arts, this work should challenge many long-held assumptions about these fascinating substances.

1.7.40 Spirituality and Narrative in Psychiatric Practice: Stories of Mind and Soul

Paramabandhu Groves¹

date

2017-4

Contents

- *Spirituality and Narrative in Psychiatric Practice: Stories of Mind and Soul*

Telling stories is probably as old as human culture. Our ancestors used storytelling to entertain, instruct and make sense of their experience. A psychiatric history, when well taken, should be more than a fact-finding mission to provide a diagnosis and treatment plan. To be effective in providing treatment, helping with healing and promoting recovery, we need to know what matters to our patients. This includes the realm of belief and practice encompassed by the broad term spirituality. A book then that explores both spirituality and narrative is welcome.

Spirituality and Narrative in Psychiatric Practice, like the term spirituality, is broad in its scope. On the one hand, we have agnostic atheist Jeremy Holmes describing in his chapter “Meaning without ‘believing’ ” the spiritual nature of mentalising. As he puts it, ‘an intensely practical and loving pathway to spiritual aliveness’. On the other hand, there are writers from a theistic background, such as mental health chaplain Beaumont Stevenson, who considers how God or a higher power may manifest in the everyday stories of patients, providing a greater frame of reference than the story of self that often limits a human’s potential. The early chapters give a range of perspectives on narrative. With characteristic clarity Andrew Sims indicates how through careful psychopathological appraisal from attending to the patient’s story, it is possible to distinguish between spiritual experiences and psychiatric symptoms. Later chapters explore narrative and spirituality in a wide variety of themes such as affective disorders, offending behaviour, psychosis and the end of life.

The subtitle of the book is *Stories of Mind and Soul* and it is the stories that really shine. To preserve anonymity some are composite – made up from several people’s histories or typical examples – and therefore feel somewhat artificial; nevertheless, they engage the reader and serve didactic purposes well. Others are the words of individuals who have been willing to share their stories, and these have a greater ring of authenticity. In particular, the chapter by Jo Barber stands out as an honest and moving account of someone who has struggled with mental health problems and for whom

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spirituality has been important – at times problematic but often a resource that has supported her ongoing journey of recovery.

As the editors note in their concluding chapter, pressures on service delivery may get in the way of the time and space to listen well to patients' narratives. However, for good psychiatric practice, not taking a good history is a short-cut we can ill afford. This work is a timely reminder of the importance of the fundamental tool of psychiatry and a welcome enjoiner to attend to what is significant to our patients.

1.7.41 Big data in mental health research – do the *ns* justify the means? Using large data-sets of electronic health records for mental health research

Peter Schofield

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date

2017-6

Abstract

Advances in information technology and data storage, so-called 'big data', have the potential to dramatically change the way we do research. We are presented with the possibility of whole-population data, collected over multiple time points and including detailed demographic information usually only available in expensive and labour-intensive surveys, but at a fraction of the cost and effort. Typically, accounts highlight the sheer volume of data available in terms of terabytes (10^{12}) and petabytes (10^{15}) of data while charting the exponential growth in computing power we can use to make sense of this. Presented with resources of such dizzying magnitude it is easy to lose sight of the potential limitations when the amount of data itself appears unlimited. In this short account I look at some recent advances in electronic health data that are relevant for mental health research while highlighting some of the potential pitfalls.

Contents

- *Big data in mental health research – do the *ns* justify the means? Using large data-sets of electronic health records for mental health research*
 - *Recent advances*
 - *Do big data mean high-quality data?*
 - *Are the data we routinely collect aligned with research agendas?*
 - *How complex is the analysis of big data?*
 - *Do big data mean more or less transparency?*

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Recent advances

The most extensive electronic health data available for research in the UK are collected in primary care. For example, the Clinical Practice Research Datalink (CPRD) covers approximately 5 million active patients, with longitudinal records going back to 1987. This in turn is now linked to hospital episode statistics (HES) and mortality data, providing one of the world's largest longitudinal health data-sets. ¹ As with any big data project much depends on the quality of the data. This may be enhanced in primary care, as general practitioners (GPs) have a financial incentive to accurately record certain treatments and outcomes under the quality and outcomes framework (QOF). ²

While there is no national equivalent for psychiatric care, HES data provide at least some information about psychiatric in-patient stays nationally. There are also examples of local schemes providing comprehensive psychiatric data for research use, often on a very large scale. For example, the Case Register Interactive Search (CRIS) system covers the full clinical record of over 250 000 patients from the South London and Maudsley (SLAM) catchment area. ^{3,4} This can be linked with neighbourhood census data, primary care records, HES data and educational data from the National Pupil Database (NPD). A feature of CRIS is that it comprises the entire clinical record so that much of what is available is in the form of free text which, through recent advances in the use of natural language processing (NLP) techniques, is now accessible for large-scale research. ⁴ For example, a recent project used free-text-mining algorithms to extract information about cannabis use to investigate the relation with clinical outcomes for just over 2000 patients with first-episode psychosis. ⁵ Another recent study supplemented coded diagnostic and treatment data with data extracted from free text to look at delays in treatment and diagnosis for patients presenting with bipolar disorder. ⁶

With over 50 publications to date using this data-set, CRIS has proved particularly useful for research into mortality outcomes for people with severe mental illness, ^{7,8} hard-to-reach groups such as homeless people ^{9,10} and, more recently, services for people in the early stages of psychosis. ^{11,12}

These examples are, however, still limited to either specific geographical regions or a relatively small subsample of the population. We have, of course, recently come close to a universal data-set of health records with the, ultimately ill fated, care.data proposal. Originally intended to link primary care data with existing hospital records, this would have provided whole-population data for research use. Arguably, this was unsuccessful because it was presented in a way that failed to reassure the public their data would be safe. ¹³ While this has now been scrapped, it is still the government's aim that something similar is implemented. ¹⁴

Allowing whole-population health data to be made available for research has, however, long been an accepted part of life in Nordic countries. For example, since 1968 all Danish citizens have had a unique personal identification number allowing data linkage across a range of health, welfare, employment and education data. ¹⁵ This arguably represents a gold standard for mental health research, with all psychiatric in-patient admissions (since 1969) and all out-patient contacts (since 1995) providing longitudinal data for the entire population over nearly five decades. ¹⁶ Because of the scale of longitudinal data collected, register-based studies using data such as these have proved particularly useful for aetiological research into relatively rare disorders such as schizophrenia. For example, a number of landmark papers have highlighted urban/rural differences in psychosis incidence ^{17,18} and also documented the increased risk of psychosis for migrants and refugees. ^{19,20}

Do big data mean high-quality data?

All these developments in the resources available for research are to be welcomed. However, simply having the ability to access data on this scale is not enough. What we gain through the sheer volume of data and breadth of coverage could be offset by ill-informed analysis and interpretation that fails to account for the limitations of the data. One fundamental limitation is that almost all examples of what we think of as big data are collected for purposes other than research. Health records, just like any bureaucratic product, are shaped by administrative convenience rather than the search for scientific truth. For example, if we look at the way that depression is recorded in primary care, it would be a mistake to take this at face value.^{21,22} For some time, recording a diagnosis of depression on the electronic record has triggered a series of prompts and demands on the clinician, which many saw as unnecessarily burdensome. This became a disincentive to code a formal diagnosis and instead alternatives, such as 'low mood', would be entered, although treatment itself remained unaffected. This has meant that GP records can show an exceptionally low prevalence of depression compared with what we know from national survey data.^{23,24} In this case, a failure to understand what statisticians term the data-generating process would lead to a fundamental misinterpretation of what these data represent. Furthermore, the quantity of data collected here makes no difference to the validity of our conclusions. In fact, having more data is likely to help reinforce any erroneous claims.

Looking at health informatics more broadly, a classic example of what can go wrong if we fail to understand the data-generating process is that much cited example of big data, Google flu trends. Here, the frequency and location of a selection of Google search terms, based on health-seeking behaviour, were used to predict where and when the next flu epidemic would occur.²⁵ This was shown to more accurately predict epidemics compared with previous epidemiological studies and was therefore held up as an exemplar of the ascendancy of big data in health research.²⁶ That is, until Google flu trends stopped predicting accurately and eventually proved no better than estimates based on flu prevalence from a few weeks before.²⁷ This was in part a result of changes Google had made to their search engine, including the introduction of the auto-complete feature that meant searches no longer worked in quite the same way as when the algorithm was first devised. This problem was further exacerbated as the original search terms were never actually made public so could not be externally validated. Clearly, electronic health records are not subject to the same technical issues as a search algorithm. However, as we outline above, changes in the data-generating process, such as how diseases are coded, could make an important difference to results. In some ways, Google flu trends is the perfect example of the hubris associated with big data; as one of the early evangelical accounts confidently stated, 'society needs to shed some of its obsession with causality in exchange for simple correlations: not knowing why but only what'.²⁶ Although this might make sense if we are simply mining data looking for patterns, this approach alone has little to offer in the way of research evidence.

Are the data we routinely collect aligned with research agendas?

A further limitation of research using administrative data is that we rarely have any control over what is collected and therefore risk the research agenda being set by what data are available. One field in which there have been major advances in recent years is ethnicity and mental health, partly due to the availability of electronic health records where patients' ethnicity is now routinely coded. In particular, large-scale case registers have been used to document the increased incidence of psychosis among Black and minority ethnic groups, as well as exploring possible risk factors to explain these differences.²⁸⁻³¹ These findings have been validated using other methodologies. However, there is a risk that we now focus research attention on what are often fairly crude categories, while neglecting other forms of minority status or more nuanced definitions of ethnicity simply because of the available data. For example, it is likely that other forms of marginalised status may also be relevant as risk factors where individual characteristics (such as sexuality, social class or marital status) are at variance with what is usual in a locality.^{32,33} However, these are typically not recorded in register data and are therefore unlikely to receive as much research attention. Where relevant risk factors are not being recorded, research has the potential to inform the data collection process to not only benefit research but also enhance clinical care.

How complex is the analysis of big data?

Another inherent danger is in the way we analyse these data. Often, the more data we have to analyse the more likely it is that we miss patterns in the data that could confound the associations we are interested in. For example, there might be temporal patterns in longitudinal data, such as long-term disease trends, that make it difficult to distinguish effects in before-and-after study designs. Short-term events such as the shift from ICD-9 to ICD-10 in the 1990s could confound our results when comparing changes in rates of diagnosed psychiatric disorders. Data might also be spatially patterned, with different environmental risk factors operating in different areas. This might be further patterned by administrative structures where, for example, differences in mental health outcomes in particular areas may reflect the performance, and reporting practices, of different mental health trusts. Considerable advances have been made in recent years in the tools available for analysing data patterned in this way. In particular, multilevel modelling and Bayesian analysis techniques allow us to simultaneously account for effects operating at temporal, individual, spatial and administrative levels. However, these are still not easily accessible to many researchers, or research consumers, although their use and accessibility are increasing. Implicit in these methods is a fundamentally different approach to that of small-scale studies, such as randomised controlled trials, where the aim is to remove complexity from the data through random allocation. With big data we can no longer rely on random assignment and rely instead on being able to model the complexity inherent in the data to account for possible confounding effects.

Do big data mean more or less transparency?

Admittedly, complex data of this kind can be difficult to analyse, but it also presents an ever-increasing number of choices about how the analysis could be conducted. We might use different diagnostic categories, we could follow our sample over different time periods and look at a variety of different subgroups. We might use different statistical methods for the same analysis and we could also adjust for different sets of covariates. This growing array of possibilities also increases the opportunities to pick and choose our analysis until we find the most impressive-looking *P*-value. This tendency, often termed *P*-hacking or *P*-fishing, can be found in any statistical analysis, unless of course the method is predetermined and published in an advance protocol. However, big data exacerbate this tendency by increasing the possibilities for analysis. Often this means that statistically significant effects, which appear to show something important, cannot then be reproduced and our analysis is ‘over-fitted’ to our data. The US statistician Andrew Gelman describes this potential as the ‘garden of forking paths’.³⁴ He argues that this need not necessarily mean deliberate deception on the part of the analyst, but is often the result of unconscious bias as reasonable analysis decisions are made but they are contingent on the data. The accumulation of these decisions, at different stages in the analysis, ultimately leads to a statistically significant result being more likely. What is required, argues Gelman, is greater transparency so that we are able to retrace the steps made in the analysis to assess for ourselves the significance of findings. A related problem with large data-set analysis is that often very low, highly statistically significant *P*-values can be found for what amount to clinically insignificant effects. It is argued that these tendencies have led to what has been described as a ‘reproducibility crisis’ in science.³⁵ In response, the American Statistical Association recently issued a statement calling for greater transparency in the reporting of results and a move away from simply reporting *P*-values below a certain threshold ($P < 0.05$).³⁶

Complementary methods

Clearly, there are some inherent problems in the analysis of large-scale health records data, both for the unwary and for the unscrupulous. However, there is nothing either inherently good or bad about the use of these kinds of data for mental health research. Ultimately, this comes down to understanding the human story behind how the data were created, having the analytical skills to best interpret the data and being transparent in the way results are reported. What big data can then give us is one version of the truth to complement what we are able to discover using other methods. In fact, one of the best examples of big data that we have in UK mental health, CRIS, also includes a parallel community survey component, the South East London Community Health Study (SELCoH).³⁷ This is intended both to provide a parallel sample of community controls to match the case register and to yield detailed information about individual circumstances and attitudes otherwise absent from medical records.

There are of course a number of well-established national community survey resources, such as the Adult Psychiatric Morbidity Survey and the annual Health Survey for England, that are not dependent on health service use or subject to the diagnostic bias that occurs in health records data.^{38,39} We must also not forget the potential for qualitative research to address many of the questions in mental health research that are beyond the reach of statistical analysis. With the increased emphasis on evidence-based medicine, qualitative methods have increasingly been sidelined. For example, the *BMJ* recently announced that, in future, qualitative studies would have a low priority in the journal.⁴⁰ In response, 76 senior academics from 11 countries wrote an open letter calling for the journal to reconsider.⁴¹ They cite the complementary role that qualitative research can have, particularly where there is a failure to reproduce the results of analyses of large-scale health data-sets.

Last, let us not forget that the research we do is only meaningful in that it relates to the, essentially individual, experience of mental disorder. Whatever volume of data we analyse, whether we look at $n = 100$ or $n = 1\,000\,000$, ultimately we are interested in what this can tell us about the experience of $n = 1$.

The author would like to acknowledge the contribution of Justin Lock, who provided the inspiration for the title of this editorial.

1.7.42 Vitamin D deficiency in adolescents in a tier 4 psychiatric unit

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2017-6

Abstract

Aims and method To review the current clinical practice and guidelines for testing and treating vitamin D deficiency in adolescents admitted to a tier 4 adolescent psychiatric unit in north London. The blood test results of 56 patients admitted between 2012 and 2014 were examined to determine whether vitamin D levels had been tested. For those individuals who were tested for vitamin D, results were analysed by gender and ethnicity.

Results Of 56 patients admitted, 48% were tested for vitamin D deficiency and in 81.5% of cases we uncovered deficiency or severe deficiency; 18.5% had the minimum levels of vitamin D for bone health as per our trust guidelines.

Clinical implications Adolescents within tier 4 adolescent mental health services may be at higher risk of vitamin D deficiency and so assessment of vitamin D levels should be considered as part of a standard physical health review for this group of young people.

Contents

- *Vitamin D deficiency in adolescents in a tier 4 psychiatric unit*

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It is well known that vitamin D plays a role in bone health. In addition, vitamin D receptors have been found in several areas of the brain and are reported to be involved in neuroimmuno-modulation, neuroprotection, neuro-plasticity and brain development.¹ Given that some of these receptors are found in brain areas implicated in mental illnesses such as depression,¹ it is plausible that vitamin D and/or vitamin D deficiency have a role in the pathogenesis of mental illness.

Existing guidelines identify risk factors for vitamin D deficiency²⁻⁴ (details available from the authors on request), although there is little that relates specifically to adolescents or individuals within mental health settings. We hypothesised that patients in a tier 4 adolescent psychiatric unit in north London may be at increased risk of vitamin D deficiency, potentially having had reduced exposure to sunlight as a result of their psychiatric presentations. Linked to this, according to data from the UK National Census in 2011,⁵ there is a higher proportion of individuals with increased skin pigmentation (black and minority ethnic (BME)) compared with the national average within inner London schools, which may reflect general population trends in urban areas.

Aim

We examined the blood test results of all patients admitted to Simmons House, a tier 4 adolescent psychiatric unit, to review our management of individuals with vitamin D deficiency, make recommendations for future practice and identify areas where further study is needed.

Method

The blood test results of patients admitted to the unit between 2012 and 2014 were examined after a clinical observation that a number of patients had vitamin D deficiency. Patient notes were checked to determine gender, ethnicity, whether they were tested for vitamin D levels and the result of the test. The results were classified according to local laboratory reference ranges at the Whittington Hospital NHS Trust in London: <25 nmol/L severe deficiency, 25–50 nmol/L deficiency and 50 nmol/L minimal vitamin D levels for bone health. The results were also mapped to other guidelines, such as National Institute for Health and Care Excellence (NICE) guidelines (<25 nmol/L ‘low vitamin D status’) and those outlined by the Endocrine Society and Society for Adolescent Health and Medicine (>75 nmol/L ‘adequate’).^{4,7}

Results

Of 56 patients on the unit between 2012 and 2014, 48% ($n = 27$) were tested for vitamin D deficiency. According to local laboratory reference ranges (Whittington Hospital NHS Trust), 81.5% ($n = 22$) were deficient or severely deficient (40.7% deficient and 40.7% severely deficient) and 18.5% had the minimum levels for bone health. Applying the NICE guidelines, 40.7% of patients had low vitamin D status. No individuals tested had levels of >75 nmol/L (a level recommended in other guidelines).^{4,7} The results are summarised in *Table 1*.

Vitamin D levels in the tested patient sample

	Pa- tients <i>n</i>	Tested for vitamin D levels (%)	D efficient or severely deficient (%)	Minimum level of vitamin D for bone health (%)	Vitamin D at $>$ 75 nmol/L
Male	14	8 (57)	6 (75)	2 (25)	0 (0)
Fe- male	42	19 (45.2)	15 (79)	4 (21)	0 (0)
White	39	18 (46.1)	13 (72.2)	5 (27.8)	0 (0)
BME	17	9 (52.9)	9 (100)	0 (0)	0 (0)
To- tal	56	27 (48)	22 (81.5)	5 (18.5)	0 (0)

BME, Black and minority ethnic.

<50 nmol/L

>50 nmol/L

Results by ethnicity

Nearly half of adolescents who were White were tested (46.1%, 18/39), and 72.2% ($n = 13$) were deficient or severely deficient in vitamin D. In individuals from BME groups, who were potentially at higher risk of vitamin D deficiency due to increased skin pigmentation, 52.9% (9/17) were tested for vitamin D levels and 100% were deficient or severely deficient. There was no significant statistical association between ethnicity and vitamin D deficiency ($\chi^2 = 3.07$, $P = 0.136$ (Fisher's exact test)).

Results by gender

Three-quarters of the sample were female ($n = 42$); 14 were male. Of the 57% ($n = 8$) males tested, 75% ($n = 6$) were deficient or severely deficient in vitamin D, whereas of the 45.2% ($n = 19$) females tested, 79% ($n = 15$) were deficient or severely deficient in vitamin D. There was no statistical association between gender and vitamin D deficiency ($\chi^2 = 0.05$, $P = 1.000$ (Fisher's exact test)).

Discussion

Are adolescents at risk?

There is emerging evidence that the adolescent population in general is at risk of vitamin D deficiency.⁸ Although risk factors may vary, depending on geographical location, seasonal changes, latitude and variations in ultraviolet light levels, there has also been a suggestion of a worldwide re-emergence of rickets in the paediatric population.⁹ The Royal College of Paediatrics and Child Health identifies adolescents as having an ‘increased need’ for vitamin D,¹⁰ and the draft NICE guidelines⁶ stated that young people undergoing rapid periods of growth are at an increased risk of vitamin D deficiency, although this did not appear in the final guideline.²

Which guidelines to use?

An update to the NICE guidelines regarding vitamin D deficiency was published in November 2014 with the aim of increasing vitamin D supplement use among at-risk groups.² The guidelines include the findings of the *National Diet and Nutrition Survey* showing that 8–24% of children (depending on age and gender) may have vitamin D deficiency (details available from the authors on request). It is also noted that up to 75% of Asian adults may be deficient in vitamin D. The groups at risk of vitamin D deficiency, including adolescents, are: people who have low or no exposure to the sun, for example those who cover their skin for cultural reasons, those who are housebound or confined indoors for long periods, and people with darker skin, for example people of African, African-Caribbean or South Asian origin.

There appears to be a lack of consensus between various guidelines in defining a biochemical vitamin D deficiency. NICE guidelines² give a level of <25 nmol/L as low vitamin D status, but local laboratory reference ranges and recommendations made in other guidelines vary. For example, the Endocrine Society⁴ and the Society for Adolescent Health and Medicine⁷ provide different recommendations regarding required vitamin D levels, which appear to be higher than those in the NICE guidelines.² *Table 2* summarises the guidelines.

Vitamin D levels by guideline

	Whittington Hospital NHS Trust laboratory interpretation	NICE guidelines	Endocrine Society and SAHM interpretation
< 25 nmol/L	Severe deficiency	Low vitamin D status	Deficiency
25–50 nmol/L	Deficiency	n/i	Deficiency
>50 nmol/L	Minimal levels for bone health	n/i	Recommended or ‘adequate’ level

SAHM, Society for Adolescent Health and Medicine; n/i, no interpretation offered in the guideline.

Prevention and treatment

Vitamin D deficiency can be treated with oral or intramuscular supplementation, usually in the D₃ form (cholecalciferol), as this may be more effective than vitamin D₂ in raising serum 25(OH)D levels.¹¹ NICE guidelines outline the daily vitamin D intake requirements to minimise the risk of deficiency in various age groups, with 400 IU for ‘at risk’ adults. Similar requirements have been suggested for adolescents.⁸ Medical causes of vitamin D deficiency, other than reduced sunlight exposure, should also be considered, for example reduced parathyroid hormone levels or malabsorption disorders such as coeliac disease. No single treatment recommendation for vitamin D deficiency is given in national guidelines.

How much sun exposure is recommended?

A recent NICE guideline, published in February 2016, outlines the risks and benefits of sunlight exposure.¹² It recognises that advice on sunlight exposure to date has been available from many sources and that the information has often been ‘inconsistent and potentially confusing’.¹² Young people and their parents/carers could be confused, worrying about balancing advice to limit sun exposure, because of the increase in incidence of skin cancer and other skin disorders, with a need to have sun exposure for vitamin D production.^{13,14} The new NICE guideline acknowledges that, with a proviso that ‘a simple definitive message telling different groups how often and how long they can be exposed to sunlight to ensure minimum risk but maximum benefit’ is not possible because of the multiple biological, social and environmental factors that contribute towards an individual’s risk-and-benefit profile.¹² Specific risk factors for skin cancer such as a family history of the disease should always be considered when giving sun exposure advice, and the NICE guideline also mentions groups who should take ‘extra care to avoid skin damage and skin cancer’. This includes young people.¹²

It is suggested that skin colour charts may be helpful in making judgements about sun exposure advice. Individuals with naturally very light skin (skin types I and II) are at greater risk of sunburn and skin cancer and require shorter times of sun exposure to synthesise vitamin D compared with those with darker skin types (types V and VI), who are at increased risk of vitamin D deficiency in the UK.¹²

Advice should be tailored for the time of year and the time of day. For example, in the UK between March and October and between 11 am and 3 pm, short periods of sun exposure to the forearms, hands or lower legs are required to synthesise vitamin D, whereas longer times are required between 3 pm and 11 am.¹² Between October and March, there is ‘very little of the ultraviolet B wavelength the skin needs to make vitamin D’.¹²

With so many factors to consider, it is perhaps not surprising that the general advice given in the NICE guideline remains equivocal, with an emphasis on providing consistent, balanced messages regarding the risks and benefits of sunlight exposure for each individual. It is suggested that: ‘short (less than the time it takes for skin to redden or burn), frequent periods of sunlight exposure are best for vitamin D synthesis. In addition, this type of exposure is less likely to result in skin cancer’.¹² This advice is broadly similar to advice published in a multiagency consensus document in 2010 (<https://www.cancerresearchuk.org/sites/default/files/vitaminD-consensus.pdf>).⁷

Study recommendations

If it were assumed that all of the individuals in our study who were not tested – deliberately or by accidental omission – had ‘optimum’ vitamin D levels, then 39.3% ($n = 22$) of the total sample had vitamin D deficiency. However, it seems unlikely that all of the non-tested patients had optimal levels given that, for example, 8 BME patients were not tested and 100% of those who were tested were deficient or severely deficient in vitamin D.

Factors influencing whether patients on Simmons House Adolescent Unit were tested for vitamin D before 2015 have not been explored in this project. The apparent idiosyncrasy of testing is beyond the scope of the present study but was one of the reasons for the study and subsequent recommendations detailed in the *Appendix*.

The results could suggest that all individuals within Simmons House at risk of vitamin D deficiency were identified and their levels tested accordingly. Alternatively, it may be that a proportion of the 52% of individuals not tested had an undetected vitamin D deficiency, particularly those from BME backgrounds given that 100% of the BME patients who were tested had deficiency or severe deficiency. As increased skin pigmentation is identified as a specific risk factor for vitamin D deficiency in the NICE guidelines, it could be that all adolescents with increased skin pigmentation admitted to a tier 4 adolescent psychiatric unit should have their vitamin D levels checked. This may be particularly relevant in units with culturally diverse populations. Specific recommendations made for Simmons House are detailed in the *Appendix*.

Perhaps any adolescent with a mental illness of a severity that requires in-patient admission is at risk of reduced sun exposure and consequent vitamin D deficiency, no matter their ethnicity. It could be suggested that all patients within tier 4 adolescent psychiatric units should be considered at high risk of vitamin D deficiency and tested, unless there was clear evidence to the contrary, such as a confirmed history of adequate sun exposure and theoretically sufficient dietary intake.

Choosing a particular treatment regime depends on clinical need and consideration of local guidelines. Recommendations given in various London NHS trusts guidelines (St Bartholomew's and The London NHS Trust, Royal Free Hospital NHS Trust and The Whittington Hospital NHS Trust; details available from the authors on request) range from treating a deficiency with oral cholecalciferol in doses of 2000 to 6000 IU per day, or once-weekly doses of 20 000 IU, all for a minimum of 3 months before rechecking vitamin D levels. Once the serum 25(OH)D level has been normalised, the recommended maintenance doses range from 400 to 1000 IU of cholecalciferol per day, with NICE suggesting 400 IU per day as a prophylactic dose for those at risk of deficiency. Therefore, at the very least, it seems that prophylactic supplementation of 400 IU of vitamin D₃ per day should be considered for adolescents at risk of vitamin D deficiency, or treatment of a confirmed vitamin D deficiency initiated after discussion with the adolescent and/or their family/carers. Treatment regimens should be in line with local guidelines until a sufficient evidence base is established to provide national guidelines.

More research is needed into the prevalence of vitamin D deficiency in all age groups, both in the general population and in hospital settings (general and psychiatric hospitals). The topic is likely to appear in the medical literature frequently in years to come, with hypothesised links between vitamin D deficiency and a multitude of medical conditions ranging from cancer to psychosis,¹⁵ multiple sclerosis¹⁶ and the possibility of a worldwide re-emergence of rickets in the paediatric population.⁹ The relationship between vitamin D and mental illness is not known. A meta-analysis¹⁷ published in the *British Journal of Psychiatry* in 2013 supported an association between low vitamin D concentrations and depression, mostly based on observational studies. However, the nature of the association is not yet known to be causal and the paper also noted that the quality of evidence in this particular area to date is poor; no randomised control trials have been performed.¹⁷

If an association between depression and vitamin D deficiency were to be confirmed through future study, vitamin D supplementation could potentially be a cost-effective treatment adjunct with minimal adverse effects. In the meantime, the beneficial effects of vitamin D on bone health have been clearly demonstrated. Future research might include a nationwide project through the Royal College of Psychiatrists' Quality Network of Inpatient CAMHS Units (QNIC; qnic.org.uk) to which almost all tier 4 units in the UK are allied for appraisal and accreditation. Additionally, consideration of whether the child and adolescent population attending tier 3 child and adolescent mental health services (CAMHS) should be tested for their vitamin D status requires further thought.

1. All admissions to Simmons House should be considered at high risk of vitamin D deficiency, especially individuals with increased skin pigmentation or with a history suggestive of a lack of sun exposure. Therefore, vitamin D levels should be included as part of the routine physical assessment.
2. If blood tests are refused or clinically inappropriate, prophylactic treatment should be considered with 400 IU cholecalciferol (vitamin D₃) orally once daily, assuming informed consent is gained.
3. If a vitamin D deficiency is detected, baseline corrected calcium levels should be tested, plus a full bone mineral profile and testing of parathyroid hormone levels, along with routine admission blood tests (e.g. full blood count, urea and electrolytes, liver function tests, random blood glucose, thyroid function tests and lipid profile).
4. Treatment of a vitamin D deficiency should consist of high-dose cholecalciferol (vitamin D₃) (5000–6000 IU) orally daily for 3 months. Vitamin D levels and corrected calcium levels should then be checked again and a maintenance dose of cholecalciferol (vitamin D₃) 400 IU commenced once daily when vitamin D levels have normalised. Continuation of treatment should be tailored to each individual, based on severity of the deficiency and ongoing risk factors for vitamin D deficiency. Longer-term management of supplementation should be discussed with primary care colleagues.
5. Patients and/or their families/carers should be made aware of potential side-effects of treatment i.e. vitamin D toxicity or hypercalcaemia, which may present with anorexia, weight loss, vomiting and polyuria.
6. Ongoing examination of blood test results (serum vitamin D levels) should take place and internal audit on clinical practice should continue.

1.7.43 Adherence to NICE guidance on lifestyle advice for people with schizophrenia: a survey

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Abstract

Aims and method The STEPWISE trial (STRUCTURED lifestyle Education for People With Schizophrenia, schizoaffective disorder and first episode psychosis) is currently evaluating a lifestyle education programme in addition to usual care. However, it is difficult to define what constitutes 'usual care'. We aimed to define 'usual care' for lifestyle management in people with schizophrenia, schizoaffective disorder and first-episode psychosis in STEPWISE study sites. Ten National Health Service (NHS) mental health trusts participated in a bespoke survey based on the National Institute for Health and Care Excellence (NICE) guidance.

Results Eight trusts reported offering lifestyle education programmes and nine offered smoking cessation support. Reported recording of biomedical measures varied.

Clinical implications Although recommended by NICE, lifestyle education programmes are not consistently offered across UK NHS mental health trusts. This highlights missed opportunities to improve the physical health of people with psychotic illness. Our survey benchmarks 'usual care' for the STEPWISE study, against which changes can be measured. Furthermore, future studies will be able to identify whether any progress in clinical practice has been made towards achieving the NICE recommendations.

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The prevalence of overweight (body mass index (BMI) >25 kg/m²) and obesity (BMI>30 kg/m²) in adults with schizophrenia is approximately twice that in the general population and while it has increased in both groups in the past 30 years, the rate of increase is greater in people with schizophrenia. ¹ Weight gain often occurs after initiation of antipsychotic treatment: over 50% of individuals gain more than 7% of their initial body weight within the first 12 months of treatment, with up to 86% gaining weight with some types of antipsychotic. ² Compared with the general population, people with schizophrenia consume more fat and refined carbohydrates and fewer vegetables, ³⁻⁵ are less physically active and experience higher levels of deprivation, ⁴⁻⁷ all of which are associated with obesity. The National Institute for Health and Care Excellence (NICE) recommends that people with psychosis or schizophrenia, particularly those taking antipsychotics, should be offered access to a combined healthy eating and physical activity programme to aid in the prevention of weight gain and its related comorbidities, leading to improved quality of life. ⁸ They should be supported by clinicians to make choices about antipsychotic medication, informed by discussions of likely benefits, possible side-effects, such as weight gain and metabolic disturbance, and impact on other aspects of their physical health. For those who smoke, help should be offered to stop smoking. ⁸

The STEPWISE study (STructured lifestyle Education for People WItch SchizophrEnia, schizoffective disorder and first episode psychosis; ISRCTN19447796) was commissioned to evaluate the extent to which a structured lifestyle education programme can support weight loss, compared with usual care, when delivered to adults with schizophrenia, including those with schizoffective disorder or first-episode psychosis, in a community mental health setting. In pragmatic trials, practitioners are often allowed ‘considerable leeway in deciding how to formulate and apply’ the treatment in a control arm defined as ‘usual care’. ⁹ While the result may be reflective of the care received by patients outside the trial, there is often variation in care in an active control arm, which may be difficult to document. ^{10,11} For this reason, study teams often try to capture the active content of the control arm of their trials. ¹² In this paper we describe a survey of ‘usual care’ for the management of weight and other lifestyle factors in people with schizophrenia, schizoffective disorder and first-episode psychosis in the ten participating study sites.

Method

Research tool

The survey instrument consisted of 14 questions, which were a combination of closed and open design, with the aim of eliciting information about the implementation of the recent NICE guidance on psychosis and schizophrenia at National Health Service (NHS) mental health trusts in the UK, and consequently what is offered as 'usual care'. The survey was developed for the research study, based on the physical health aspects of the NICE recommendations in clinical guideline 178.⁸ Questions followed the baseline assessment tool published alongside the NICE guidance. The instrument was piloted with one study site investigator (J.M.) on two occasions, and each led to substantial changes to the tool. For instance, the second iteration revised questions to ascertain proportions of patients to whom certain criteria apply, rather than closed questions such as 'Are patients referred to a healthy eating programme?' The final version of the tool also clarified which questions related to all patients with schizophrenia, schizoaffective disorder and first-episode psychosis, and which questions related to patients with first-episode psychosis only (the questionnaire is included in the *Appendix*). This is in line with the additional recommendations specified in the NICE guidance for patients with first-episode psychosis who have recently been prescribed antipsychotic medication; these additional questions were not applicable to the management of patients with established mental illnesses.

Survey structure

Trusts were initially asked whether they offered a healthy eating and physical activity programme. Subsequent questions asked for more information about these programmes, including whether they were combined or separate for healthy eating and physical activity; how patients accessed them; and how often patients were referred to such services. Additional information was sought on the availability of smoking cessation services in this population and whether discussions took place between patients and clinicians prior to antipsychotic treatment initiation, including benefits of treatment, interactions with other substances and other possible side-effects.

In addition, NICE recommend that a number of physiological measures should be recorded both prior to the patient starting antipsychotic medication and annually thereafter. Respondents were asked to comment on how likely it was that each measure would be recorded at both of these time points in their trust and how often patients on antipsychotic medication have their weight recorded.

Sample selection

The STEPWISE trial has ten centres in a variety of urban, suburban and rural locations across England: Sheffield Health and Social Care NHS Foundation Trust, Leeds and York Partnership NHS Foundation Trust, Bradford District Care NHS Foundation Trust, Greater Manchester West Mental Health NHS Foundation Trust, South London and Maudsley NHS Foundation Trust, Sussex Partnership NHS Foundation Trust, Southern Health NHS Foundation Trust, Devon Partnership NHS Trust, Somerset Partnership NHS Foundation Trust and Cornwall Partnership NHS Foundation Trust. A representative from each centre was invited to complete the survey.

Respondents

The principal investigators at each of the ten centres for the STEPWISE trial were initially approached. Some of them completed the survey themselves, while others delegated to trust physical health leads or equivalent as they were better placed to answer the questions. Contact was made via email in the first instance, with an invitation to attend a teleconference with the STEPWISE research assistant (L.S.) to complete the survey. Those who did not provide a response to the invitation within 4 weeks were contacted again by reminder emails and/or by telephone. Six of the ten sites' surveys were completed through discussion via teleconference. The remaining four sites' surveys were completed independently by a trust representative and written responses were provided to the STEPWISE research assistant.

No sites required more than one reminder email/telephone call in order to arrange completion of the survey. As the survey information was requested from members of a research team, a favourable ethical opinion from an NHS Research Ethics Committee was not sought and consent was unnecessary. Responses provided organisational data only and did not include any personal data. Responses from all sites were received between 22 May and 28 October 2015.

Analysis

Descriptive statistics in the form of counts were produced for quantitative variables. Supporting information provided by respondents and information yielded from qualitative questions was summarised in narrative form.

Results

Healthy eating and physical activity programmes

Eight respondents reported that their trust offered programmes on healthy eating and physical activity, which were mostly separate programmes. Supplementary information indicated that provision was *ad hoc* and interventions were rarely standardised. Most respondents reported routinely inviting patients to access services such as discounted local gym memberships, cooking groups and activity groups delivered by local authorities and third-sector organisations. Two trusts reported offering one-on-one advice sessions with healthy living advisors or health trainers, but the sessions were usually advice-giving and often more clinically focused rather than looking at the patient's physical well-being.

Those trusts that offered trust-led programmes reported that these were available in principle to all of their patients rather than specific groups based on diagnosis. However, interventions were often accessed only by certain groups of patients, usually through particular clinicians or clinics. One trust estimated that 70% of their eligible patients are referred to such services by mental health professionals, based on recent Commissioning for Quality and Innovation (CQUIN) results; other respondents were unaware of routine data from which they could quantify referrals. Six trusts reported offering lifestyle advice through open-ended group courses, three through courses delivered over a fixed period and four through drop-in sessions.

Smoking cessation advice

Six respondents indicated that patients who smoke were offered help to stop some of the time, three reported help was offered all of the time, and one said this was not offered at all. Respondents who selected 'some of the time' were unable to quantify this, but felt that this occurred most of the time. Although it varied whether smoking cessation services were offered by the trusts or external services, most offered a combination of the two. Seven trusts reported offering trust-led smoking cessation services, while others had trained smoking cessation advisors but had no formal trust-offered service. Most trusts reported signposting outpatients to external services, some of which were managed by primary care, with advice leaflets available within the trust.

Antipsychotic treatment initiation

Table 1 shows the reported levels of discussion about likely benefits of treatment, as well as potential weight gain, diabetes and metabolic side-effects and any other possible side-effects, across all respondents. Most trusts who reported that the recommended discussions took place 'some of the time' felt that this would be most of the time, but there was a lack of evidence to support this. One site reported that discussions would be dependent on the clinician, but that resources were available to clinicians to support the discussions. Another site suggested that such discussions may be part of an ongoing process rather than all happening in one session, depending on the patient's level of capacity.

Discussions with patients when deciding on antipsychotic treatment ($n = 10$ NHS trusts)

	All of the time	Some of the time	Not at all
Topic			
Likely benefits	7	3	0
Weight gain	5	5	0
Diabetes and metabolic side-effects	3	7	0
Other possible side-effects	5	5	0
Other substances			
Alcohol	5	5	0
Tobacco	2	8	0
Other prescribed medications	3	7	0
Non-prescribed medications	0	10	0
Illicit drugs	3	7	0

Table 1 also shows how often respondents reported discussions taking place regarding the use of alcohol, tobacco, prescribed and non-prescribed medications and illicit drugs, at the time of antipsychotic treatment initiation.

Table 2 shows how likely trusts considered that physiological measures would be recorded prior to treatment initiation.

Recording of physiological measures prior to antipsychotic treatment initiation ($n = 10$ NHS trusts)

	Very likely	Likely	Neither likely nor unlikely	Unlikely	Very unlikely
Weight	3	4	1	2	0
Weight plotted on a chart	1	3	1	3	2
Waist circumference	0	2	3	3	2
Pulse	3	4	1	1	1
Blood pressure	4	2	1	2	1
Fasting blood glucose	0	5	1	2	2
Random blood glucose	2	4	0	3	1
HbA1c	2	2	1	2	3
Blood lipid profile	2	4	0	2	2
A sassessment of any movement disorders	2	4	2	0	2
A sassessment of nutritional status, diet and level of physical activity	3	3	1	3	0

Ongoing monitoring of weight and other physiological measures

It was clear from the responses that there were variations in recording patients' weight at the time points recommended by NICE (first at 6 weeks post-treatment initiation, then at 12 weeks, at 1 year and annually thereafter), both between trusts and within trust services. Some confusion exists regarding responsibility for annual patient reviews in the community and whether these should be completed by the general practitioner (GP) or the trust. Half of those surveyed reported that it was neither likely nor unlikely that patients would have their weight recorded weekly for the first 6 weeks, with three other trusts reporting that this was very unlikely. There was an even spread across all response categories as to whether weight was recorded at 12 weeks, but at 1 year four of those surveyed reported that patients were very likely to have their weight recorded. Six respondents reported that weight was likely or very likely to be recorded annually thereafter, although this was where the confusion arose regarding responsibility for these reviews.

Table 3 shows trusts' consideration as to how likely it was that physiological measures would be recorded at least annually in patients taking antipsychotic medication. One site felt they were unable to answer this question, so we present data reflecting responses from nine trusts.

Recording of physiological measures at least annually for patients on antipsychotic medication ($n = 9$ NHS trusts)

	Very likely	Likely	Neither likely or unlikely	Unlikely	Very unlikely
Weight	3	4	0	2	0
Weight plotted on a chart	0	3	3	2	1
Waist circumference	0	2	2	3	2
Pulse	2	4	1	1	1
Blood pressure	3	4	1	1	0
Fasting blood glucose	1	2	5	1	0
HbA1c	2	2	4	1	0
Blood lipid profile	2	1	4	2	0
A assessment of any movement disorders	1	4	3	1	0
A assessment of nutritional status, diet and level of physical activity	3	1	3	2	0

There was no correlation between which of the recommended physiological measures were recorded by trusts prior to antipsychotic treatment initiation or annually thereafter, although generally those trusts who were likely to record particular measures prior to treatment initiation were also likely to record the same measures at least annually thereafter.

Discussion

Principal findings

It was clear from this survey that there was great variation between different NHS mental health trusts in the provision of healthy eating and physical activity interventions routinely offered to patients, as well as variation between clinicians within the same trust, with interventions often accessed only through particular clinicians or clinics. Commonly, trusts reported signposting or referring patients to programmes offered by external services, such as gym memberships and activity classes.

Most patients had access to a smoking cessation service should they require it, and referrals to such services were reported to occur most if not all of the time at nine out of the ten trusts surveyed, regardless of whether the service was offered within the trust or run externally.

When deciding on antipsychotic medication with newly diagnosed patients, there was also variability in the reported discussions that took place across trusts. All trusts reported that the likely benefits, weight gain, diabetes and metabolic and other possible side-effects were discussed with the patient at least some of the time; the possible interference of other substances with prescribed antipsychotic medication was also discussed.

Although at the early stages in the course of antipsychotic treatment it was reported unlikely that trusts would record a patient's weight, as recommended by NICE, by 1 year after treatment initiation a larger proportion of trusts reported weight recording, with an increase for annual reviews thereafter, despite the uncertainties regarding responsibility for undertaking annual reviews in the community.

Study strengths and limitations

A strength of this survey was that its design was based on the NICE guidelines to which mental health trusts should be adhering. This meant that trusts' compliance with these recommendations could be assessed, allowing us to elicit information on what programmes (if any) trusts were offering in usual practice and how these compared with what is recommended by NICE. This also allowed us to try to define 'usual care' in relation to the STEPWISE study, using a standard approach across all trusts.

The survey was, in principle, a suitable method to elicit the same information from all respondents; however, it was clear from the responses that owing to the variability of services offered it was often difficult to provide a succinct account using this survey tool. The narrative information provided by the respondents proved more useful in gaining a fuller picture of their usual care than the descriptive statistics, which in some cases were a best guess, as clear data were not always available.

Furthermore, responses were based on one member of staff's knowledge of usual care in practice, and although this person was usually best placed to answer the questions, from the survey responses received knowledge may have been limited, especially as some interventions offered were particular to a specific clinic or clinician and usual care may vary within and between community mental health teams in any given NHS organisation. In addition, how representative 'usual care' is in comparison with NHS trusts not taking part in the STEPWISE study remains unknown.

The levels of detail regarding the content of available services also varied, perhaps indicating that the respondent had more involvement with some programmes than others. Therefore, it was considered likely that additional interventions may have been offered within trusts of which the survey respondent was unaware.

In relation to implementation, a weakness in the survey was highlighted when some responses were received through telephone discussion while others were completed by the respondent and returned to the researcher. No systematic differences between telephone and paper copy responses were identified, although more supporting information was often provided through telephone responses, as these were elicited through more of a conversational discussion. This difference in response methods may have caused questions to be perceived differently, although all telephone participants had a copy of the questionnaire available to them at the time of completion. Perceptions of appropriate levels of detail can change with different methods of completion, which may lead to variation in results. However, as such

variation was evident between practices offered as ‘usual care’ in the ten trusts surveyed, the impact of these differences in completion method is considered likely to be small.

The variability in the information elicited has not allowed for a common picture across all sites, as although a type of programme is recommended by NICE, a particular standardised programme is not available across all trusts. However, the survey did provide sufficient baseline information to allow any changes in usual practice during the course of the STEPWISE study to be monitored at a trust level, rather than across all study sites as a whole. This will enable assessing at the end of the STEPWISE study the extent of potential contamination between the intervention and control arms of the trial, based on changes in practice reported in the survey.

Context

Although there may be an increased awareness of the potential benefits of some treatments, this does not ensure that such treatments are implemented effectively. Evaluations and methods of improving the implementation of NICE guidelines often have limited attention.¹³ A systematic review undertaken by Berry & Haddock¹³ noted that the research around the implementation of NICE guidelines on schizophrenia is relatively limited, suggesting that these patients have poor access to psychological interventions such as cognitive-behavioural therapy (CBT). Some barriers to implementation of NICE guidelines were reported, such as insufficient support from trust management and the needs of organisations. The paper also highlights that whereas NICE considers randomised controlled trials (RCTs) to be the gold standard when developing an evidence base for its guidelines, RCTs have also been criticised for their poor ability to reflect the ‘real world’. The authors suggest that targeting these barriers is key to facilitating successful implementation of the guidelines.¹³

It is therefore important to identify which aspects of the guidance are not currently being followed, in order to target these areas for implementation and improve clinical care. Not only is it important to consider the implementation of guidance relating to monitoring of biomedical measures, but there is also likely to be a limited effect unless this is combined with sufficient intervention in behaviour or treatment. Similarly, the mere fact of guidance or a trial does not necessarily lead to substantive changes or better outcomes. Repeating the survey annually will allow identification of any substantive, systematic changes within the organisations, both since the introduction of the NICE guidelines and throughout the duration of the STEPWISE trial.

From a research perspective, the reported variation also has implications for our study when defining ‘usual care’. If all trusts adhered to all recommendations in the NICE guidelines, we could be sufficiently confident that contamination between trial arms would be minimal. However, as different levels of compliance with different recommendations were evident, this does not allow for standardised ‘usual care’ across the study. This does mean that usual practice can be compared over time within each trust individually, in order to assess how much ‘usual care’ has changed throughout the course of their participation in the STEPWISE study.

The Royal College of Psychiatrists’ National Audit of Schizophrenia includes standards on the monitoring of physical health in patients with schizophrenia. The audit report in 2014 noted that the provision of interventions is poor when there is evidence of physical health risks.¹⁴ It highlighted barriers to intervention, such as availability of staff time, facilities and equipment, the need for formal systems to conduct annual reviews, and the need for more formal arrangements regarding responsibility for physical health between primary and secondary care.¹⁴ Standard 5 in the audit specifically looks at interventions offered for particular physical health risks. The overall results show that intervention for BMI > 25 kg/m² was evident in 71% of patients, while interventions for smoking were reported in 59% of patients.¹⁴

For the ten trusts surveyed, the audit reported a range of 47–83% of patients receiving intervention for elevated BMI, and 33–67% receiving intervention for smoking. Overall, the audit also showed wide variation in the monitoring of physical health risk factors. For example, the range across all participating trusts for monitoring of BMI was 5–92% of patients and 16–99% for the monitoring of glucose control. This is supportive of the information yielded from the study survey and highlights variability in services offered across trusts.¹⁴

Implications for stakeholders

This survey indicates that the ten sites surveyed are not fully compliant with NICE physical health recommendations on the management of patients with schizophrenia. However, as the guidelines were published in March 2014, this is not surprising, because services require time to commission and set up. In some respects, this alleviates the concerns that the ‘usual care’ arm of the STEPWISE trial may converge with the intervention arm, as there are no reported standardised programmes offered across any of the trusts surveyed. However, there is such variability observed that it becomes clear that ‘usual care’ is not the same for all participants in the trial or in the wider population group.

We have not tried to assess the success or potential effect of any one aspect of the physical health programme in comparison with others. Although it may be argued that smoking cessation could have a greater effect on physical health than healthy eating or physical activity programmes, despite the lower compliance with NICE guidance, any discussion is likely to be subjective. Furthermore, NICE does not prioritise any one element, coming from an understanding that all aspects are important and contribute to improved physical health.

As a future direction, it may be useful to try to identify patients at higher risk of cardiovascular events, using recording of cardiovascular disease risk factors in combination with risk engines to calculate risk accurately. This identification process could then drive intervention. This may be of interest to trusts as a method of offering a physical health intervention to those patients who are likely to receive the most benefit clinically. A suitable risk engine to calculate this would be the PRIMROSE cardiovascular disease algorithm,¹⁵ as this has been developed specifically for people with severe mental illness. The PRIMROSE model includes additional variables for psychiatric diagnosis, psychotropic medication, harmful use of alcohol, antidepressants and social deprivation score, unlike similar prediction models used in the general population. This is perhaps why PRIMROSE performed better than some other available published risk models, which may overpredict the risk of cardiovascular disease in this population.¹⁵

Further research

The survey will be repeated with the same ten NHS trust representatives at 12 and 24 months after the first iteration. This will allow the STEPWISE study team to consider how trusts are implementing the NICE guidelines and, consequently, whether convergence has occurred between the two arms of the STEPWISE trial at an individual trust level. As STEPWISE progresses, the participating NHS organisations may become more aware of the need to undertake physical health interventions and so ‘usual care’ may improve, potentially diminishing the effect of the STEPWISE intervention.

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1.7.44 Are men under-treated and women over-treated with antidepressants? Findings from a cross-sectional survey in Sweden

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Abstract

Aims and method To examine gender differences in self-reported depression and prescribed antidepressants (ADs). The Hospital Anxiety and Depression Scale was used to assess depression, and information on prescribed ADs was obtained from the Swedish Prescribed Drug Register.

Results Depression was reported by 11.7% of the participants (12.3% men and 11.2% women). ADs were prescribed for 7.6% of the participants (5.3% men, 9.8% women). Among men, 1.8% reported depression and used ADs, 10.5% reported depression but did not use ADs, and 3.6% used ADs but did not report depression. The corresponding figures for women were 2.6%, 8.6% and 7.2%.

Clinical implications Men report depression to a greater extent than women but are prescribed ADs to a lesser extent, possibly a sign of under-treatment. Women are prescribed ADs without reporting depression more often than men, possibly a sign of over-treatment. Although the causes remain unclear, diagnostic and treatment guidelines should benefit from considering gender differences in these respects.

Contents

- *Are men under-treated and women over-treated with antidepressants? Findings from a cross-sectional survey in Sweden*
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1

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* *Summary of findings*

Depression is currently considered one of the largest and fastest growing health hazards.¹ Although only a small percentage of all those with mental health problems contact healthcare professionals and obtain a diagnosis, depression is one of the most common causes of sick leave and disability.^{2–5} Diagnosed depression was relatively unusual 20 years ago, but the incidence has increased remarkably with the introduction of new diagnostic guidelines and antidepressant drugs. What was previously considered psychological distress was then interpreted as a disease, with the risk of over-diagnosis and over-treatment.^{6–10} The point prevalence of depression in the general population is now estimated as 3–9%.^{1,11,12} There is an explicit gender impact on diagnosed depression, with a 2:1 ratio of women/men; about one in four women and one in ten men will develop depression severe enough to require treatment at some time in their lives.^{1,2,11,12} Moreover, depression may present differently in women and men. Women may be more prone to somatic symptoms of depression, whereas men appear to have more melancholic symptoms and to be more susceptible to drug misuse and aggressive behaviour.^{13–17} To date, however, there is no clear understanding of what causes these gender disparities in depression. They are considered likely to be a combination of several factors: biological, social and behavioural.^{18,19}

Depression is a long-lasting and, if left untreated, often chronic condition. Treatment usually lasts at least 6–12 months, and includes pharmacological therapy with antidepressants (ADs).²⁰ The use of ADs has increased dramatically in recent years.²¹ According to the national Swedish Prescribed Drug Register (SPDR), almost 9% of the Swedish population was prescribed ADs in 2014, and 65% of these ADs were prescribed for women.²² Similar patterns have been found in other countries.^{23–25} The explanation for this escalation, especially seen in women, remains unclear, but has sometimes been interpreted as a sign of inappropriate use.^{8,9} Nevertheless, despite the widespread use of ADs, depression has repeatedly been shown to be inadequately treated in the general population. Some studies have found that fewer than one in four patients with depression are prescribed ADs and that the duration of treatment is often shorter than recommended.^{26,27}

The ADs prescribed are primarily selective serotonin reuptake inhibitors (SSRIs), although others, for example serotonin–noradrenaline reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs), are also used depending on illness severity, the patient's age and various adverse drug reactions.^{20,28,29} Gender impact has been observed not only on the number of ADs prescribed but also on their type. For example, women are prescribed SSRIs more often than men.³⁰

We examined gender differences in the relationship between self-reported depression and prescribed ADs, in the prevalence of self-reported depression, and in the number and type of prescribed ADs.

Method

Participants

A questionnaire was sent to a random sample ($n = 16\,000$, aged 18–84 years) of the Swedish population (totaling 9.5 million); responses were received from 7725 people (48.3%), as presented in *Fig. 1*. The study complies with ethical research requirements, as approved by the Regional Ethical Review Board in Uppsala, Sweden (Dnr 2012/073). Participation in the study was voluntary and information about its purpose was sent out with the questionnaire. Filling in and returning the questionnaire was considered to be equivalent to the respondent giving their agreement to participate in the study.

Assessment of depression and prescribed antidepressants

Self-reported depression was assessed using the Hospital Anxiety and Depression Scale (HADS).³¹ Of the 7725 available participants, 7618 (3435 men, 4183 women) filled in the HADS form (*Fig. 1*) and all analyses were based only on these participants. The HADS was developed to detect patients with high levels of psychological distress and does not include assessment of somatic symptoms. It contains two subscales, one each for anxiety and depression, each consisting of 7 items (score range 0–21) capable of distinguishing between these diagnoses. Higher scores indicate higher levels of psychological distress. Each subscale has three categories based on the score: 0–7 (normal), 8–10 (borderline) and 11–21 (abnormal). In this study, a cut-off level of +8 was used on the depression scale; this level indicates at least mild depression and provides an optimal balance between sensitivity and specificity.³²

Information on depression obtained from the HADS was linked (through the participants' identification number, a unique lifetime personal identifier given to all Swedish citizens) to prescription data. Prescribed ADs were obtained from the SPDR, a national register held by the National Board of Health and Welfare, which gathers data on all dispensed prescriptions for patients in ambulatory care from the entire Swedish population.^{22,33} We collected information on ADs 0–6 months prior to the HADS evaluation. SPDR drugs are classified according to the Anatomical Therapeutic Chemical (ATC) classification system.³⁴ The ADs (N06A) were categorised as TCAs (N06AA, e.g. amitriptyline, imipramine), SSRIs (N06AB, e.g. citalopram, fluoxetine), 'others' (N06AX, including SNRIs (e.g. venlafaxine) and tetracyclic antidepressants (TeCAs, e.g. mirtazapine)), and monoamine oxidase inhibitors (MAOIs; N06AF, N06AG, e.g. moclobemide). The MAOIs were excluded due to few users.

Analyses

The Statistical Analysis System software (SAS9.2, Cary, North Carolina, USA) was used to perform chi-squared tests (χ^2, P) to examine gender differences in the relationship between self-reported depression and prescribed ADs, and in prevalence of self-reported depression, prescribed ADs, and type of ADs prescribed. Logistic regression analysis (odds ratios (OR) with 95% confidence intervals) was used to examine gender differences in self-reported depression, controlling for age.

Results

In total, 11.7% of the study population (12.3% men, 11.2% women; ², n.s.) was classified as having self-reported depression. Logistic regression analysis showed that the difference between men and women was statistically significant, i.e. men reported depression more often than women (OR 1.226 (CI 1.062–1.414)). According to the SPDR, 7.6% of the study population had been prescribed at least one AD during the 6 months prior to the HADS evaluation. Significantly more women than men were prescribed ADs: 5.3% of the men and 9.8% of the women were prescribed at least one AD ($P < 0.0001$).

Table 1 presents gender differences in the relation between prescribed ADs and self-reported depression in the study population. Among the men, 1.8% reported depression and used ADs, 10.5% reported depression but did not use ADs, and 3.6% used ADs but did not report current depression, while 84.1% were neither depressed nor used ADs. The corresponding figures for women were 2.6%, 8.6%, 7.2% and 81.6%. The gender difference was statistically significant (² $P < 0.001$) in all age groups except the youngest, and was most marked in the groups aged 45–64 and 65–74 years.

Relation between self-reported depression (assessed using the HADS) and prescribed antidepressants (ADs) in the study population ($n = 7618$), Sweden 2012/2013

	Men	Women									
18–34	593	1.7	8.9	2.0	87.4	831	1.8	9.8	3.6	84.8	N.S.
35–44	475	1.9	11.8	2.3	84.0	576	3.1	8.7	6.8	81.4	<0.01
45–64	1277	1.8	10.6	4.6	82.9	1537	3.3	9.0	8.3	79.4	<0.001
65–74	740	1.5	9.9	3.6	85.0	811	2.1	6.8	9.2	81.9	<0.001
75–84	350	2.3	12.6	3.7	81.4	428	1.9	7.9	7.0	83.2	<0.05
Total	3435	1.8	10.5	3.6	84.1	4183	2.6	8.6	7.2	81.6	<0.001

² analyses comparing men and women.

The participants who had received at least one prescribed AD during the 6 months studied ($n = 592$: men $n = 182$, women $n = 410$) were analysed with respect to the type of AD prescribed (*Table 2*). SSRIs were the most commonly prescribed ADs for both men (62.8%) and women (71.0%), although women were prescribed them more often than men, particularly in the age group 45–64 years (² $P < 0.05$). By contrast, there was no statistically significant gender difference for the TCAs (men 14.8%, women 10.2%), except for in the age group 45–64 years. Further, men were prescribed ‘other’ ADs (e.g. SNRIs and TeCAs) significantly more often than women (men 39.3%, women 28.1%; ² $P < 0.01$).

Types of antidepressant (ATC classification) among participants prescribed at least one antidepressant ($n = 592$), by age and gender, Sweden 2012/2013

	Users, n	SSRIs (N 06AB)	TCAs (N 06AA)	Others (N 06AX) ^a								
18–44	144	42	102	69.1	73.5	NS	9.5	5.9	NS	38.1	29.4	NS
45–64	260	82	178	58.5	71.3	<0.05	20.7	12.4	<0.05	37.8	25.8	<0.05
65–84	188	58	130	64.4	68.5	NS	10.2	10.8	NS	42.4	30.0	<0.05
Total	592	182	410	62.8	71.0	<0.05	14.8	10.2	NS	39.3	28.1	<0.01

ATC, Anatomical Therapeutic Chemical; NS, not significant; SSRIs, selective serotonin reuptake inhibitors; TCAs, tricyclic antidepressants.

For example, serotonin–noradrenaline reuptake inhibitors, tetracyclic antidepressants.

² analyses comparing men and women.

Discussion

The present study found that the relationship between self-reported depression and prescribed ADs differs by gender. As in several other studies,^{26,27} the majority of those who reported depression in our study did not use ADs, and overall, men used ADs to a lesser extent than did women, although they reported depression to a greater extent. This could have been caused by several factors. Many people, especially men, prefer not to seek healthcare.³⁵ Women are clinically diagnosed with depression far more often than men, probably not only because they are more depressed but also because they are more likely to seek healthcare, thus increasing the chance that their depression will be detected.³⁶ Also, diagnostic criteria for depression originate from a female norm and symptoms provided by women, leading to an increased likelihood that depression in women will be diagnosed.¹⁵ Depression in men has a different presentation than the classic depressive symptoms more often than in women, and this could lead to men's mental health problems not being recognised and therefore being under-treated.^{13,35}

In contrast to diagnosed depression, previous studies using HADS to assess depression have mostly found no gender differences or, like our study, found a higher prevalence of depression in men.^{37,38} Since men experience more melancholic symptoms and women more somatic symptoms (e.g. increased appetite and weight, and hypersomnia),¹³⁻¹⁷ the reversed gender differences in depression assessed with HADS compared with clinically diagnosed depression could be due to the fact that HADS's focus is more on melancholic rather than somatic symptoms. Whether the HADS might be more sensitive than other scales in detecting depression in men is as yet unclear.

Other factors that could explain the relatively low use of ADs in our study among the sample with depression might be that the depressed participants may have been reluctant to accept treatment with ADs, a choice that is possibly more common among men; they may not have needed drug treatment, perhaps because other treatments were used (in mild depression psychotherapy is considered as effective as drugs); or they may not have had the prescribed drug dispensed. Many patients do not adhere to treatment instructions, for example do not even obtain their prescribed drugs (primary non-adherence), and prior studies have suggested that both gender and illness severity affect adherence.³⁹⁻⁴²

In our study, it was twice as common for women as for men to use ADs when not currently depressed. This could indicate that their depression was in remission, but it could also mean that women are being over-treated with ADs. Several studies have found AD use to be higher among women, and the increased prescription of ADs in recent decades is especially notable among women.^{23-25,30,43} The higher level of AD prescribing to women may in part be attributed to the greater consumption of healthcare among women in general.^{36,44} Apropos of this, there are studies that show that women are more likely than men to receive a prescription during their medical visits.⁴⁵ The lower threshold for prescribing ADs has led to a debate about the possibility of over-prescription or of ADs being sometimes prescribed where alternatives would be better.⁷⁻⁹ It seems that even mild symptoms are now considered indicative of disease and treated with medications, although the efficacy is often limited in mild to moderate depression.^{7,46,47} Further, an expanding number of indications (e.g. neuropathic pain, anxiety disorders, eating disorders and sleep disorders) seen more often in women than in men are contributors to the increasing trend to prescribe ADs, and this could explain some of the AD use without depression seen in our study.^{9,48}

As in other studies, the SSRIs were the main drugs in our study.^{28,30} Because of gender differences in the pharmacokinetics and pharmacodynamics of ADs, and because depression may present differently in women and men, it has been suggested that men and women could differ in their response to treatment and that pharmacological treatments should therefore be chosen by gender.⁴⁹⁻⁵¹ The women in our study used SSRIs more often than the men. It could be that somatic symptoms respond better to SSRIs than to TCAs. Another cause might be gender differences in adverse drug reactions. However, supporting data are limited and sometimes conflicting, and current treatment guidelines do not take gender into account.^{49,50,52} Regardless, it is important to continue to examine any differences between men and women concerning pharmacotherapeutic efficacy and adverse drug reactions.

Limitations

The SPDR offers complete data on all dispensed drugs; however, it does not give information on actual usage. Also, ADs during the 6-month period were analysed without distinguishing whether the drugs had been used for a long or a short time. Moreover, ADs are sometimes prescribed for indications other than depression, which we could not control for. However, previous studies have reported that depression remains the main indication for AD use.⁵³ Participation in the study was voluntary and there may have been selection biases. For example, non-responders were more likely to be men than women. It is also possible that people with current symptoms of depression would be less likely to respond, introducing further bias to participant selection. Depression assessed using the HADS (in the previous week) was not directly linked to prescribed ADs via the SPDR (0–6 months prior to the HADS evaluation). However, depression is often a prolonged state, and problems in this respect that were encountered in the previous week were probably not temporary. Finally, it is important to emphasise that a cross-sectional design does not permit evaluation of causality to be derived from the results.

Summary of findings

The relationship between self-reported depression and use of ADs differed by gender. Overall, men were prescribed ADs to a lesser extent than women, although they reported depression to a greater extent. By contrast, women were prescribed ADs without reporting depression more often than men. This may be a sign for under-treatment among men and over-treatment among women. Further, men and women were prescribed different types of ADs, possibly because of gender differences in treatment outcomes and adverse drug reactions. Although the causes of these findings remain unclear, diagnostic and treatment guidelines should benefit from considering gender in these respects.

1.7.45 An analysis of whether a working-age ward-based liaison psychiatry service requires the input of a liaison psychiatrist

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Abstract

Aims and method This article presents a 12-month case series to determine the fraction of ward referrals of adults of working age who needed a liaison psychiatrist in a busy tertiary referral teaching hospital.

1

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Results The service received 344 referrals resulting in 1259 face-to-face contacts. Depression accounted for the most face-to-face contacts. We deemed the involvement of a liaison psychiatrist necessary in 241 (70.1%) referrals, with medication management as the most common reason.

Clinical implications A substantial amount of liaison ward work involves the treatment and management of severe and complex mental health problems. Our analysis suggests that in the majority of cases the input of a liaison psychiatrist is required.

Contents

- *An analysis of whether a working-age ward-based liaison psychiatry service requires the input of a liaison psychiatrist*
 - *Method*
 - * *Involvement of a liaison psychiatrist*
 - *Results*
 - * *Referrals which required the involvement of a psychiatrist*
 - *Discussion*

Liaison psychiatry services in England have recently seen considerable expansion, following the positive evaluation of the Rapid Assessment Interface and Discharge Team (RAID) service in Birmingham.¹ The independent evaluation suggested that this well-staffed multidisciplinary liaison psychiatry service returned considerable cost savings for people with mental health problems in that general hospital and those attending the emergency department.

The 2015 annual survey of liaison psychiatry in England demonstrated that many services are too poorly resourced to be delivering benefits to patients as envisaged by the RAID study,² while the recent *Guidance on Developing Models for Liaison Psychiatry Services* has shown great variability in service provision.³ The relative lack of consultant psychiatric input suggests that the specialist skills offered by consultant liaison psychiatrists may be poorly understood. To examine the multidisciplinary liaison psychiatry team, we aimed to determine the proportion of referrals to a ward-based liaison service which required the involvement of a psychiatrist in a busy tertiary teaching hospital in England. This project was carried out as part of a registered audit (Audit Project 2125) with Manchester Mental Health and Social Care Trust.

There are many descriptions of the activity of liaison services, but we believe this is the first time the role of a psychiatrist has been addressed in depth. We hope our findings will help inform decisions regarding staffing and the configuration of multidisciplinary liaison psychiatry teams. We focused on a ward-based liaison service for adults of working age.

Method

We carried out a case series of the electronic records of consecutive referrals to a ward-based liaison service at a large teaching hospital in Manchester, over a 12-month period from 18 June 2013 to 17 June 2014. The hospital has approximately 750 beds, with a large renal and critical care unit. There is also a maternity unit on site, with over 8500 deliveries per annum, and an eye hospital. Our liaison service reviews referrals covering an age range of 16–65 by the next working day. Routine alcohol referrals, covered by two specialist nurses, may also be received by our service.

The following details were recorded for each referral: age, gender, number of face-to-face contacts carried out by the team, amount of time the team had ongoing contact with the patient (days), reason for referral, referrer type, psychiatric diagnosis using clinical judgement according to ICD-10 criteria,⁴ employment of the Mental Health Act 1983, and disposal.

Involvement of a liaison psychiatrist

To determine the proportion of patients who required the input of a psychiatrist, we developed criteria for contacts or interventions that required medical input and could not be undertaken by a non-psychiatrist. We deemed the involvement of a psychiatrist would be necessary in any of the following scenarios: Mental Health Act employed, rescinded or considered; medication management; treatment with psychotropic medications commenced in the general hospital; complex diagnostic matters; behavioural disturbance in physically unwell patients where advice about appropriate sedation is required; complex capacity assessments; and a specific request for a consultant psychiatrist opinion. Each case was reviewed and rated by a member of the team. *Box 1* provides detailed criteria for each of these scenarios. We recognise that there are many other kinds of interventions a psychiatrist may carry out as part of liaison work, but we wished to focus solely on interventions which could not be carried out by someone other than a psychiatrist. Many of the interventions therefore require some kind of expertise involving medical knowledge or prescribing of psychotropic medication in patients who are physically unwell.

Summary scores for normally distributed data are presented as means and standard deviations (s.d.). The activity data were not normally distributed, so summary scores are presented in the form of medians and interquartile ranges (IQR). Comparisons of continuous activity data were carried out using non-parametric statistical tests. Mann-Whitney *U*-tests were used to compare continuous data. As in some cases we had few activity data, with only one or two patients in each group, groups with very small sizes (two patients or fewer) were not included in the statistical analyses.

Results

The service received 344 referrals over the study period and carried out 1259 face-to-face contacts with patients. The average number of 'face-to-face' contacts per patient was 3.7 (s.d. = 5, range 1–33). The median age of patients seen was 48 years (IQR 36–59), and 184 (53.4%) were female. At any one time, between 8 and 15 patients were under review by the team. The majority of referrals were from physicians (all medical departments) ($n = 227$, 66.0%), 59 (17.2%) were from surgery, 31 (9%) from the maternity hospital and 23 (6.7%) from the critical care unit. One referral came from the eye hospital and a further 3 were from the liaison service for older adults, but these patients were best managed by the adults of working age team.

Table DS1 in the online supplement provides a snapshot of the patients under the care of the service on one day in May 2014, and is typical of the kind of patients who are under review by the service at any given time. Five patients had severe mental illness (four had schizophrenia and one had bipolar disorder). Two had been treated under the Mental Health Act and there was a possibility that one more person may have needed treatment. One person was on a community treatment order (CTO). Four patients had voiced recent suicidal ideas, two had complex organic mental disorders, and three had psychological reactions to physical illness or difficulties with their behaviour in an acute hospital setting.

Referrals which required the involvement of a psychiatrist

Table 1 illustrates the number of referrals which needed a psychiatrist. Of the 344 referred patients who saw a psychiatrist, we deemed on the basis of our criteria that a psychiatrist was required for 241 patients (70.1%). Patients who required a psychiatrist needed more face-to-face contacts than those who did not require a psychiatrist (median 2 (IQR 1–5) v. median 1 (IQR 1–2)), and were under the liaison service for a greater period of time (median 7 days (IQR 1–14) v. median 1 day (IQR 1–7)).

Referrals and service workload depending on whether patient required a psychiatrist or not

		Face-to-face contacts	Days in contact with service, median (IQR)	
Requires psychiatrist	241 (70.1)	1039 (82.5)	2 (1–5)***	7 (1–14)***
Does not require psychiatrist	103 (29.9)	220 (17.5)	1 (1–2)	1 (1–7)
Total	344	1259	2 (1–5)	4 (1–13)

IQR, interquartile range.

$P < 0.001$ (requires v. does not require a psychiatrist).

According to our criteria, the most common reason for psychiatric input was medication management (*Table 2*): 77 patients (32.0%) required input regarding their current psychotropic medication use. Of interest, 10 of these patients were referred for clozapine management which required over 100 face-to-face contacts from the team. 56 patients were started on treatment for their mental health problems while they were in hospital (i.e. patient started on psychotropic medication). There were complex diagnostic issues in 38 patients and the Mental Health Act was considered in 23 patients, but only actually implemented in 18. In 14 cases the patient required a complex capacity assessment, 10 patients presented with challenging behaviour requiring advice about sedation, and a specific consultant opinion or involvement was requested in 6 patients. The categories are not mutually exclusive.

The number of patients who required a psychiatrist according to the categories in the study

Clinical categories	<i>n</i>	Percentage of total requiring psychiatrist
Medication management	77	32.0%
Treatment with psychotropic drugs	56	23.2%
Complex diagnostic issues	38	15.8%
Mental Health Act	23	9.5%
Management of severe mental illness	17	7.1%
Complex capacity assessments	14	5.8%
Management of behavioural disturbance	10	4.1%
Specific liaison consultant review	6	2.5%

Box 1 Definitions of categories used to determine whether the involvement of a liaison psychiatrist was required

- Mental Health Act: situations where the Mental Health Act has been applied or its potential use has been seriously considered
- Medication management: consultation in which there was a specific issue about psychotropic medication the patient was taking due to a change in their physical health. This may involve stopping, switching or another action.

- Management of behavioural disturbance in the general hospital: involving advice about medication, where a psychiatrist has provided assessment, advice and guidance about using sedating medication. The psychiatrist will have considered the patient's underlying physical health problems (e.g. renal failure) in making the decision regarding type and dosage of medication. Other non-pharmacological aspects for management of acute behavioural disturbance in physically unwell patients are not considered here, as they are not exclusively carried out by liaison psychiatrists
- Complex diagnostic matters: diagnosis or understanding of a clinical problem which required knowledge of specific medical disorders
- Capacity: requests for medically complex capacity assessments, where the patient has a history of a psychiatric condition which may be interfering with their judgement to give informed consent to potentially life-saving treatment
- Treatment with psychotropic medications commenced in the general hospital: treatment with a psychotropic agent that was commenced in the general hospital by the liaison team, in a patient who had ongoing physical health concerns
- Specific request for consultant liaison psychiatrist opinion: the referring consultant specifically requested a consultant psychiatric opinion or involvement

Box 2 Categories of clinical scenarios where we judged a psychiatrist was required (examples)

- **Mental HealthAct:** Female (age range 50–60) with diagnosis of schizophrenia. Admitted with a ruptured oesophagus. Clozapine had been stopped prior to admission as she had refused to take it. Her psychosis had relapsed and she was floridly psychotic in hospital. Following repair of her oesophagus she required 6–8 weeks bed rest for the repair to heal. She was treated under Section 3 of the MHA with covert medication (clozapine). Her mental state returned to normal. She had a good physical and mental health recovery. She later agreed to continue to take clozapine on a voluntary basis.
- **Medication management:** Female (age range 30–40) admitted following collapse and found to have very low sodium. Diagnosis of schizophrenia. In discussion with medical team, all psychotropic medication was stopped. Haloperidol started cautiously. Usual medications re-started after physical recovery. Discharged to CMHT.
- **Management of behavioural disturbance:** Male (age range 40–50) who was admitted with delirium, barricaded himself and 3 other patients in a 4-bedded side room. History of hydrocephalus and other abnormal neurological signs. Input required sedation to manage the current situation and to facilitate medical investigations including brain MRI.
- **Diagnosis:** Male (age range 50–60) admitted from nursing home with a history of severe weight loss. History of schizophrenia and extrapyramidal side-effects attributed to neuroleptics. Huntington's chorea diagnosed by consultant psychiatrist.
- **Capacity:** Male (age range 50–60) with history of schizophrenia. Jumped off a bridge when 22 years of age, paraplegic following this. Psychosis treated well for years on clozapine. Developed bowel obstruction, multi-organ failure. Clozapine stopped. On regular haemodialysis. Chronically psychotic. Refusing dialysis. Complicating factors, low mood, chronic psychosis (at times he believes he is Christ and can be resurrected).
- **Treatment with psychotropic drugs commenced in the general hospital:** Male (age 60–70) admitted after stabbing his wife in the back and then stabbing himself 4 times in the abdomen. Diagnosed with depressive disorder. Treatment started with antidepressants while receiving medical treatment on ward. Mood improved.
- **Specific request for consultant liaison psychiatric opinion:** Male (age range 40–50) with a history of gastric problems and feeding difficulties. Had had gastrectomy and had been started on TPN. Had been in hospital for over a year. Staff suspected that reliance on TPN was far more than clinically indicated but all efforts to reduce it failed. Patient was aggressive on occasions with staff, made frequent complaints about staff and at times threatened self-harm. Consultant opinion was specifically sought regarding the risks of moving to home with TPN feeding.

CMHT, community mental health team; MHA, Mental Health Act; MRI, magnetic resonance imaging; TPN, total parenteral nutrition.

Table 2 shows the number of patients who required a psychiatrist according to the categories developed for this study.

Clinical illustrations of actions or interventions which were judged to require the involvement of a psychiatrist, according to each category, are provided in *Box 2*.

Table 3 shows the number and percentage of patients who required input from a liaison psychiatrist according to the most common psychiatric diagnoses. Patients with bipolar affective disorder, schizophrenia, Korsakoff's psychosis, amnesic syndrome and somatoform disorder required the involvement of a psychiatrist in over 80% of all cases, whereas for patients with anxiety/panic disorder, adjustment disorder or dementia the requirement was much lower.

Patients who required input from a liaison psychiatrist according to diagnosis

Psychiatric diagnosis	Required psychiatrist (% of total seen)
Somatoform disorders	9 (100.0%)
Bipolar affective disorder	23 (92.0%)
Amnesic syndrome	11 (91.7%)
Korsakoff's psychosis	11 (91.7%)
Schizophrenia	42 (82.4%)
Depression	100 (74.1%)
Miscellaneous including eating disorders, intellectual disability	5 (71.4%)
Personality disorder	9 (69%)
Substance misuse	11 (68%)
Delirium	15 (65.2%)
Anxiety/panic disorder	6 (50.0%)
Dementia	2 (33.3%)
No diagnosis	8 (32.0%)
Adjustment disorder	2 (20.0%)

Discussion

Our findings suggest that a ward-based liaison psychiatry service for working-age adults in a large teaching hospital requires the input of liaison psychiatrists. We deemed that a psychiatrist was essential in the assessment or management of approximately 70% of all referrals to the service, whereas approximately 30% could be reviewed by other members of a liaison team. We based this judgement on clear, definable actions or aspects of care that necessitated the involvement of a psychiatrist. A consultant liaison psychiatrist would of course have many other roles, but for the purposes of this study we limited our focus to interventions or actions where the role of a psychiatrist was unequivocal.

Many of the patients seen by the service had complex physical and mental health needs. Table DS1 provides a snapshot of the work, and illustrates that it is necessary to involve a psychiatrist in the management of a large proportion of referrals. Out of the 12 patients under the care of the team on one day in May 2014, 9 required the input of a psychiatrist.

Certain patients with diagnoses such as adjustment disorder and dementia were unlikely to require psychiatric input, whereas high rates of psychiatric involvement were required for patients with severe mental illness and somatoform disorders. Psychiatric input was also needed in the management of patients with Korsakoff's psychosis, because locally a formal diagnosis from a psychiatrist is required in order to access particular kinds of Social Services support.

This study has three major limitations. First, data were based on routine clinical entries made using a National Health Service (NHS) electronic record system. It is possible that this may have led to an underestimation of the numbers of patients requiring psychiatric input due to a lack of recording certain data (e.g. details about psychotropic medication). It is very unlikely that it would have led to an overestimate of our findings. Second, this study was undertaken in a teaching hospital, with a large critical care unit, a large renal unit, a very busy maternity hospital and other specialist centres. It may not reflect the work of a liaison service in a district general hospital, but it emphasises the need to take account of local variations in acute hospital services when planning a liaison service. Third, this liaison service is a ward-based service only. Approximately a third of liaison services run out-patient clinics for complex cases requiring psychiatric time. Clinics can take psychiatrists away from acute ward cover and require different planning and staff resources compared with a ward-based liaison service.

The methods we employed, however, can easily be used by other services to estimate the requirement for input from a liaison psychiatrist, and this is likely to vary depending on the setting and age range of patients seen. As this research team consisted entirely of psychiatrists, we may have overestimated the need for the skills of our own discipline when creating the criteria and applying them. However, we have provided clinical examples to illustrate our decision-making process and thus expose it to critical examination.

Our results suggest that liaison psychiatrists have a pivotal role in ward-based liaison services for adults of working age, and this may be particularly important in a teaching hospital setting. Our work also provides support for the recent commissioning guidance for liaison psychiatry services in England developed by the Department of Health, which suggests that liaison psychiatry services in a teaching hospital/inner city setting may require additional consultant psychiatric input.⁷

1.7.46 Civil and forensic patients in secure psychiatric settings: a comparison

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Abstract

Aims and method To evaluate differences between male patients in secure psychiatric settings in the UK based on whether they are detained under civil or forensic sections of the Mental Health Act 1983. A cohort of patients discharged from a secure psychiatric hospital were evaluated for length of stay and frequency of risk-related incidents.

Results Overall, 84 patients were included in the study: 52 in the forensic group and 32 in the civil group. Civil patients had more frequent incidents of aggression, sex offending, fire-setting and vulnerability, whereas forensic patients had more frequent episodes of self-harm.

Clinical implications Secure hospitals should ensure treatment programmes are tailored to each patient's needs. Civil patients require greater emphasis on treatment of their mental illness, whereas forensic patients have additional offence-related treatment needs. Regular liaison between forensic and general adult services is essential to help ensure patients can return to appropriate settings at the earliest opportunity in their recovery.

Contents

- *Civil and forensic patients in secure psychiatric settings: a comparison*
 - *Method*
 - *Results*
 - *Discussion*
 - * *Limitations*
 - * *Practice recommendations*

Further to the closure of the asylums and subsequent rare but high-profile failures in community care, forensic psychiatry in the UK has rapidly expanded, with the development of high, medium and low secure in-patient services across the country as well as specialist forensic mental health teams in the community.¹ Alongside its expansion, an ongoing debate related to its interface with general psychiatry has persisted.² In England and Wales, the forensic v. general psychiatry divide extends to the subdivision of in-patients detained under the Mental Health Act 1983 into those affected by civil and forensic sections. Patients detained under Part II of the Act are termed 'civil patients'. They can be detained under Section 2 for assessment and treatment for up to 28 days where there is suspicion of a mental disorder. Section 2 can be converted to Section 3 for further treatment. Alternatively, patients can be admitted directly under Section 3 when there is a known mental disorder. Patients detained under Part III of the Act are termed 'forensic patients', given their involvement in the criminal justice system through the courts and prisons.

While forensic units have expanded, there has been an overall reduction of in-patient bed numbers in the UK, which have fallen from 155 000 in 1954 to just 18 166 as of 31 March 2014. The number of patients detained in all settings under civil sections during 2013/2014 was 32 781, of which 25 300 were under Section 2 and 7481 were under Section 3. During 2013/2014 there were 1847 detentions under forensic sections: 99 under Section 35 or 36, which is admission for assessment or treatment via the courts; 763 under Section 37 hospital orders, allowing detention in hospital instead of a prison sentence; and 457 under Section 47, which allows transfer of a serving prisoner to hospital.^{2,3}

Secure psychiatric hospitals are generally geared towards providing assessment, treatment and rehabilitation for forensic patients, since they are the majority group in such hospitals. In particular, Coid *et al* found that 69% of patients

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in medium security were detained under forensic sections.⁴ Despite this discrepancy in distribution, research into whether there are differences between these groups is limited. The only study we could identify was that by Reed (2004),⁵ who evaluated the differences between civil and forensic in-patients in a low secure intellectual disability setting and found, surprisingly, that the forensic patients were less likely to be aggressive or use weapons but more likely to harm themselves.⁵ It is not known whether these findings are isolated to intellectual disability settings. Therefore, we present findings from our evaluation of male patients discharged from a secure psychiatric hospital (excluding intellectual disability – the hospital does not cater for such patients) and suggest recommendations on how to meet the differing clinical needs identified in each group.

Method

The study was conducted as part of a service evaluation into length of stay at St Andrew's Healthcare, Birmingham, and registered with the St Andrew's Clinical Audit Team. In keeping with previous similar evaluations, ethical approval was not required as the study evaluated retrospective, non-patient-identifiable data from health records as part of service evaluation.⁵ Data were retrospectively collected for all discharges from the two medium and three low secure wards since the opening of the hospital in March 2009 to the study end point of 30 December 2014. The source of data were patients' electronic health records, including medical reports, Historical Clinical Risk Management-20 (HCR-20) assessments, Care Programme Approach records, electronically recorded risk incident logs and discharge summaries.

Summary statistics were calculated for all patients evaluated. Patients were then grouped by whether they were initially detained under a civil or forensic section at the start of their admission to St Andrew's Birmingham. In order to evaluate illness severity between the two groups, Health of the Nation Outcome Scales for Users of Secure and Forensic Services (HoNOS-secure) assessment scores taken at admission and discharge were noted.⁶ A power calculation was not performed but all available data were used in the analysis. The average length of stay was calculated for each group. SPSS version 16 for Windows was then used to calculate independent *t*-test statistics to examine any between-group associations and frequency of various types of incidents.

Results

In total, 93 male patients were discharged from the hospital during the data collection period; 9 patients were excluded from the study: 7 were excluded as their admission was less than 3 months and unlikely to be representative of the treatment phase being evaluated, and discharge would also have occurred prior to the standard Care Programme Approach meeting held 3 months after admission, where a formal diagnosis would have been made. One patient was excluded as they were informal during the course of their admission and one was excluded due to death from natural causes. Therefore, 84 patients were included in the study, with 32 in the civil group and 52 in the forensic group. In the civil group, 16 patients were admitted from general adult services, 1 from a police station, 7 from low secure services and 8 from medium secure services. The legal status of patients in the civil group remained unchanged during the course of their admission, apart from one patient who became informal in the days prior to discharge. None of the patients in the civil group switched to being forensic patients following convictions in court. Regarding the forensic group, 4 patients were admitted from general adult services, 3 from low secure services, 16 from medium secure services, 28 from prison and 1 from a high secure hospital. In this group, 14 patients changed their legal status prior to discharge; 11 changed from being sentenced prisoners under Section 47/49 to being detained under a notional Section 37, as they had gone past what would have been their automatic release date from prison. Two patients switched from being remanded prisoners under Section 48/49 to being sentenced under a Section 37 hospital order at court and one patient switched from Section 48/49 to a Section 37/41 hospital order with restrictions after sentencing at court.

Table 1 outlines the baseline characteristics of each group, including diagnosis, age, ethnicity and Mental Health Act status on admission. All patients were male, with a mean age of 37 years (range 20 to 63 years). *Table 2* shows the mean length of stay, HoNOS-secure scores on admission and discharge, and frequency of risk-related incidents.

Patient characteristics

	Civil group <i>a</i> <i>n</i> (%)	Forensic group <i>b</i> <i>n</i> (%)
Primary diagnosis		
Psychosis (schizophrenia, schizoaffective disorder, delusional disorder)	30 (94)	46 (88)
Personality disorder	2 (6)	3 (6)
Affective disorder (depression, bipolar affective disorder)	0 (0)	3 (6)
Secondary diagnosis		
Personality disorder	5 (16)	11 (21)
Substance misuse	18 (56)	33 (63)
Alcohol misuse	1 (3)	7 (13)
Ethnicity		
Black	10 (31)	13 (25)
White	18 (56)	27 (52)
Other	4 (13)	12 (23)
Legal status		
Section 2	1 (3)	
Section 3	31 (97)	
Section 37		8 (15)
Section 47 (notional 37)		5 (10)
Section 37/41		12 (23)
Section 48/49		7 (13)
Section 47/49		20 (39)

n=32.

n=52.

Length of stay in secure care and frequency of risk-related incidents

	Civil group <i>a</i>	Forensic group <i>b</i>	Independent <i>t</i> -test <i>c</i>
Length of stay, days: mean (range)	587 (95–1396)	523 (105–1407)	$t = 0.75, P = 0.96$
Mean HoNOS-secure score:			
admission	25.31	24.62	$t = 0.39, P = 0.07$
discharge	20.16	18.77	$t = 0.81, P = 0.94$
Risk incidents per 30 days, mean			
Violence (includes assaults against staff or peers)	0.92	0.34	$t = 2.01, P = 0.02$
Self-harm (threats or acts)	0.06	0.21	$t = 2.09, P = 0.02$
Unauthorised leave (attempts or episodes of absconding or escape)	0.22	0.05	$t = 1.17, P = 0.44$
Substance misuse (intentions or incidents of illicit drug misuse)	0.06	0.12	$t = 1.14, P = 0.15$
Self-neglect (poor self-care/diet)	0.41	0.25	$t = 1.39, P = 0.17$
Fire-setting (threats or acts)	0.08	0.02	$t = 1.76, P = 0.002$
Sex offending (sexual comments or contact offences)	0.06	0.03	$t = 1.09, P = 0.04$
Vulnerability (being intimidated, bullied or assaulted)	2.10	0.29	$t = 4.88, P = 0.00$
Verbal aggression (abusive comments)	2.10	1.62	$t = 0.87, P = 0.36$
Other unspecified risk incidents	1.85	1.99	$t = 0.33, P = 0.36$

$n=32$.

$n=52$.

d.f=82.

Discussion

The study found no significant difference in length of stay or severity of illness based on HoNOS-secure scores at the start or end of admission between the civil and forensic groups. However, it should be noted that HoNOS-secure is not a specific measure of mental state, since it also evaluates behavioural functioning and a range of security measures. This study identified that civil patients in secure settings have more frequent incidents of aggression, sex offending, fire-setting and vulnerability, whereas forensic patients have more frequent episodes of self-harm. This finding challenges the preconception that forensic patients are more ‘dangerous’ and difficult to manage.² One explanation for this may be that the civil patients in this study represent a cohort of general adult patients that have been placed in forensic services due to their frequency of aggressive and difficult to manage behaviours, whereas the more stable forensic patients have been admitted due to severe but more isolated offences.

The higher frequency of incidents in the civil group may make engaging with specialist treatment programmes practically more difficult for this group, which may in turn become a factor that limits their motivation to engage. Secure hospitals should be aware that civil patients, due to higher frequency of risk incidents, may have differing needs to forensic patients. Therefore, we suggest that civil patients who present with a high frequency of incidents will benefit from a greater emphasis on treatment of their mental illness combined with behavioural interventions, with less of a requirement to engage in specialist treatment programmes or to complete formal psychological therapy programmes that are often required in forensic settings. Further research is needed to explore whether the higher frequency of incidents among civil patients affects the therapeutic milieu on the ward and has an adverse impact on outcomes for forensic patients engaging in specialist treatment interventions. The higher frequency of vulnerability incidents among civil patients highlights the difficulty they experience in forensic settings and suggests a greater need for vigilance and robust safeguarding for this patient group, who may be at risk of reprisal assaults by their forensic peers. The findings of our study must also be considered in light of the Schizophrenia Commission report,⁷ which comments that patients

stay too long in secure services, and highlights funding cuts and acute bed closures in general adult services as part of the problem.

We conclude that our study supports the need to focus more on preventive interventions, such as avoiding delays in assessment, ensuring early treatment and supporting alternatives to admission such as crisis and home-based treatment teams, to help avoid admissions. Regular liaison between forensic and general adult services is essential to help ensure patients can return to appropriate settings at the earliest opportunity in their recovery. This may only be possible with careful consideration when commissioning services at all levels of care.

The finding that forensic patients have a greater frequency of self-harm incidents should be treated with caution as the numbers in this study are small and self-harm is a rare outcome. One possibility is that forensic patients may find the criminal justice system and their conviction distressing, leading to a greater risk of self-harm and potentially suicide. We suggest that clinical teams should be aware of this risk in these patients and ensure careful monitoring, risk management and support for patients during criminal proceedings.

Limitations

This study has a number of limitations. Most significantly, it is a comparison of forensic and civil patients conducted in a secure mental health hospital and the findings cannot be used to compare differences between forensic and general adult patients in non-secure settings. In addition, the civil patients in the study are likely to represent patients with greater treatment resistance whose aggressive behaviours have led to them being transferred to secure settings. It remains possible that the section status assigned to the patient on admission may be misleading, as quite often patients who commit offences when unwell are not prosecuted.⁸ The study is reliant on accurate recording of risk incidents in patients' records. Although some degree of inaccuracy in recording of incidents may have occurred, it is anticipated that this would have occurred evenly between both groups and thus not affected the validity of the results. This study, in line with previous work, evaluates data for a cohort of discharged patients in order to evaluate comparable groups. It is possible that the study may underestimate the severity of risk incidents, since the most challenging patients would not have been included in the analysis as they have not yet been discharged from hospital. It is anticipated that the impact of this factor would be evenly distributed between each group.

Practice recommendations

Secure hospitals should ensure all treatment plans are based around the individual. There should be an emphasis on managing the mental illness of civil patients and tailoring treatments based on this goal, which will help reduce risks and hopefully shorten length of admission. Forensic patients are more likely to have additional offence-related treatment needs which would require specific interventions. Regular liaison between forensic and general adult services is essential to help ensure patients can return to appropriate settings at the earliest opportunity in their recovery. This can only be possible with careful consideration when commissioning services at all levels of care.

We thank Catherine Clarke, Psychology student at the University of Birmingham, for her help in the study.

1.7.47 Known unknowns and unknown unknowns in suicide risk assessment: evidence from meta-analyses of aleatory and epistemic uncertainty

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Abstract

Suicide risk assessment aims to reduce uncertainty in order to focus treatment and supervision on those who are judged to be more likely to die by suicide. In this article we consider recent meta-analytic research that highlights the difference between uncertainty about suicide due to chance factors (aleatory uncertainty) and uncertainty that results from lack of knowledge (epistemic uncertainty). We conclude that much of the uncertainty about suicide is aleatory rather than epistemic, and discuss the implications for clinicians.

Contents

- *Known unknowns and unknown unknowns in suicide risk assessment: evidence from meta-analyses of aleatory and epistemic uncertainty*
 - *Can knowing about suicidality reduce uncertainty about suicide?*
 - *Can knowing about a wider range of risk factors reduce uncertainty about suicide?*
 - *Implications of the limits to epistemic uncertainty*

Uncertainty is the psychological state of being unsure, of having doubt, of not fully knowing. Uncertainty is central to modern medicine, where its recognition drives diagnostic efforts and leads to the pursuit of evidence-based practice. All medical decision-making occurs under conditions of varying uncertainty about diagnosis, optimal treatment and prognosis. This is true in the assessment of suicidal patients.

Uncertainty has two underlying components: epistemic uncertainty that results from a lack of knowledge, and aleatory uncertainty that results from random or chance events.¹⁻³ In medical practice, both types of uncertainty are at play. A teenage tobacco user might or might not develop cancer later in life. This is mostly a matter of chance, a chance that will increase with heavier and longer tobacco use. This longitudinal cancer risk is probabilistic, akin to the throw of a die, and further knowledge might not greatly reduce uncertainty about what will eventually happen. In middle age, the same smoker might develop haemoptysis. A chest X-ray would reduce uncertainty about the presence or absence of lung cancer, but it might be more clearly resolved by a biopsy. Uncertainty in this case is not probabilistic – the smoker either has or does not have cancer. This is now a question that can be resolved with more information. Chance is no longer playing a part.

It is generally considered that uncertainty in suicide risk assessment can be greatly reduced by a detailed assessment of the patient's suicidal thoughts, plans and actions, and attention to other demographic and clinical factors. Suicide risk assessment guidelines and relevant peer-reviewed publications often contain long lists of questions to ask and factors to consider.⁴⁻⁷ This approach assumes that more substantial knowledge of the patient, their illness, circumstances and intentions will reduce the epistemic uncertainty in the assessment. Few would doubt that chance also plays a major part in suicide. The course of underlying illness, the vagaries of individual decision-making and impulsivity, and the patient's future circumstances are all sources of aleatory uncertainty.

In this article we consider the uncertainty surrounding suicide using the framework of epistemic and aleatory uncertainty. In order to do this, we use recent meta-analytic research to interrogate the proposition that uncertainty about

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suicide risk can be reduced by knowing more about suicidal thoughts and behaviours, or by the knowledge of a wider range of suicide risk factors.

Can knowing about suicidality reduce uncertainty about suicide?

No small number of references could begin to do justice to the importance that suicidal ideation and behaviours have assumed in suicide research. Several recent systematic meta-analyses have synthesised the quantitative peer-reviewed literature on the statistical relationship between suicidality and suicide. Each of these meta-analyses has cast doubt on the notion that knowing more about suicide ideas, or suicidality more broadly, reduces uncertainty about suicide.

Two meta-analyses published in 2011, one examining risk factors for suicide by psychiatric in-patients⁸ and the other examining risk factors for suicide by recently discharged patients,⁹ found that the association between suicidal ideation and suicide was statistically weak, with diagnostic odds ratios (OR) of less than 3. In 2015, Chapman *et al*¹⁰ published a meta-analysis finding that suicidal ideation was significantly associated with suicide among patients with schizophrenia spectrum conditions. However, suicidal ideation was not significantly more likely to lead to suicide than no suicidal ideation among patients with mood disorders (OR = 1.49, 95% CI 0.92–2.42).

A 2016 meta-analysis¹¹ examined the broader question of whether self-injurious thoughts and behaviours deserve their status as strong predictors of future suicidal behaviour. This study found that self-injurious thoughts and behaviours are only weakly associated with later suicide attempts (OR = 2.14, 95% CI 2.00–2.30) and death from suicide (OR = 1.54, 95% CI 1.39–1.71). The authors concluded that assessments of suicidality provided an improvement in prognostic accuracy that was only marginally above chance.

Another 2016 meta-analysis examined the psychometric properties of both individual risk factors and suicide risk assessment scales (the Beck Hopelessness Scale, Suicide Intent Scale and Scale for Suicide Ideation) among populations of people who self-harm.¹² The authors found a modest statistical association between previous self-harm and suicidal intent and later suicide, concluding that individual risk factors are ‘unlikely to be of much practical use because they are comparatively common in clinical populations’. With respect to use of suicide risk scales they considered that they ‘may provide false reassurance and [are], therefore, potentially dangerous’.

Thus, five recent meta-analytic summaries of the peer-reviewed literature have each reached similar conclusions – knowing about suicide thoughts and behaviours can only reduce uncertainty about future suicide to a modest extent.

Can knowing about a wider range of risk factors reduce uncertainty about suicide?

If enquiries about our patients’ suicide ideas, plans and actions do not help very much, what else should mental health professionals do to reduce uncertainty? The most common and obvious answer is to consider a comprehensive range of other suicide risk factors. Again it is simply not possible to describe the full range of articles, guidelines and peer-reviewed papers that consider the range of potentially important risk factors for suicide. A weakness of this literature is that although very large numbers of risk factors for suicide have been identified, there is no widely accepted way in which this information can be combined to improve the predictive strength of suicide risk assessment. Further, despite widespread recommendations for a comprehensive consideration of suicide risk factors, there are doubts as to whether combining risk factors can ever produce clinically useful predictive models. More than 30 years ago, Pokorny¹³ concluded his paper describing a landmark prospective suicide prediction study with the statement that it ‘is inescapable that we do not possess any item of information or any combination of items that permit us to identify to a useful degree the particular persons who will commit suicide, in spite of the fact that we do have scores of items available, each of which is significantly related to suicide’.

We recently published a meta-analysis that further examined the dilemma posed by Pokorny.¹⁴ We synthesised the results of all the published longitudinal prospective studies that used multiple risk factors to model future suicide among cohorts of psychiatric patients. We included experimental studies that employed multiple regression or survival analysis and studies that validated suicide risk prediction instruments. Our main outcome measure was the odds of suicide in high-risk patients compared with lower-risk patients. One of the aims of the meta-analysis was to determine if the observed between-study variability in this OR could be explained by the number of risk factors used in the predictive modelling. The results were very clear. We found a pooled OR of 4.84 (95% CI 3.79–6.20) derived from 37 studies

and 53 samples of patients. This indicates that the rate of suicide among high-risk patients can be expected to be about 5 times the rate of suicide of low-risk patients. While this sounds like it might be a clinically useful finding, these odds do not meaningfully improve on the pooled ORs of about 4 that are associated with some individual suicide risk factors among psychiatric patients – factors such as depression, hopelessness and prior suicide attempts.^{8,9} The meta-analysis also found that 56% of suicides occurred in high-risk groups (sensitivity) and 44% occurred among the lower-risk group. Over an average follow-up of 5 years, 5.5% of high-risk patients, but 1% of low-risk patients, died by suicide. This 5.5% suicide mortality over a period of 5 years means the probability of suicide of high-risk patients over clinically important durations is extremely low. For example, the weekly probability of suicide of a high-risk patient over the 5-year follow-up can be estimated at $0.055/(5 \times 52) = 0.0002115$ or 1 in 4700 people. In practical terms, what this means is that if a patient is deemed at higher risk of suicide because of the presence of one or more risk factors (recall that the number of risk factors seems unimportant), our best estimate of the incidence of suicide in the following week is about 1 in 4700. Even if there was a hypothetical dynamic risk factor that transiently increased the next-week risk of suicide by 10 times, strict supervision of almost 500 high-risk people for 1 week would be needed to prevent one suicide – assuming that such supervision were 100% effective.

Relevant to the present paper, the meta-analysis found that the predictive models that used more suicide risk factors had no more statistical strength, and no better discrimination between high-risk and lower-risk groups, than studies that used fewer factors (slope 0.007, 95% CI 0.016 to 0.03, $P = 0.53$). In fact, studies that employed two factors had a similar predictive strength to studies that employed ten or more factors. *Figure 1* plots the diagnostic odds with 95% confidence intervals effect size of models using 2 or 3 factors (8 samples), 4 or 5 factors (11 samples), 6 or 7 factors (7 samples), 8 or 9 factors (5 samples) and 10 or more factors (22 samples) with obviously overlapping confidence intervals. We concluded that multivariate models offered little advantage over single risk factors and that multivariate models that relied on more suicide risk factors performed no better than those that use fewer risk factors.

Implications of the limits to epistemic uncertainty

The findings of these recent meta-analytic studies undermine one of our profession's main assumptions about suicide risk assessment. Suicidal ideation,¹⁰ suicide behaviour^{11,12} and more complex modelling¹⁴ offer predictive advantages only a little better discrimination than chance. Hence, most of our uncertainty about suicide risk is aleatory; knowing more does not help because epistemic uncertainty plays only a minor part.

So what should clinicians do? First, we believe that this fundamental problem with suicide risk assessment needs to be acknowledged. We need to acknowledge our powerlessness to usefully classify individuals or groups of patients according to future suicide risk. We need to acknowledge this to ourselves, and communicate this to health departments, to the courts, and most importantly, to our patients and their families.

Second, we need to provide a more universal standard of care, involving a complete and sympathetic assessment of every patient, their illness and their circumstances. Such assessment is needed to guide individualised treatment plans, and might also have the intrinsic benefit of reducing suicidality.¹⁵ Where modifiable risk factors are found, we need to try to modify them. For example, patients who present with suicidal ideation when intoxicated should not be summarily discharged when sober and denying suicidal ideation, but should be offered access to addiction services that have some prospect of reducing suicide risk and improving their lives, irrespective of their overall risk category.

Third, we need to be very sparing in our use of involuntary treatment as a reaction to suicide risk. It is likely that very few patients who we admit to hospital would have died by suicide as out-patients over the period of time usually associated with a contemporary length of stay. Patients making ongoing immediate threats might still be admitted to hospital, as such threats are a crucial communication and legitimate focus of care without recourse to notions of probability. However, suicide risk is simply not a sufficient warrant for making paternalistic decisions about involuntary hospital care. Equally, we should be careful not to automatically deny low-risk patients voluntary in-patient treatment when they want it. Many suicides are by low-risk patients and we should not pretend we are able to peer into their future any more than we can discern the future of a higher-risk patient.

1.7.48 Drug information update. Unconventional treatment strategies for schizophrenia: polypharmacy and heroic dosing

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Abstract

The majority of patients respond to antipsychotic monotherapy at standard doses, but a subset of patients will require more heroic measures that include antipsychotic polypharmacy and high-dose monotherapy. Indeed, research has shown that roughly 30% of patients with psychosis are prescribed multiple antipsychotic medications. We discuss the potential benefits and challenges of these approaches and provide a rationale for why and when they should be utilised.

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– *Summary*

Schizophrenia is one of the most challenging psychiatric disorders faced by clinicians today, affecting roughly 1% of the population.¹ Many out-patient clinics and virtually all in-patient facilities manage these often complex clinical cases. Since the introduction of the first-generation antipsychotics (FGA) and subsequent development of the dopamine hypothesis, blockade of dopamine 2 (D₂) receptors has been the primary goal of pharmacological intervention. Even with the development and proliferation of the second-generation antipsychotics (SGA), D₂ blockade remains central to effective control of positive symptoms whereas serotonin 2A (5-HT_{2A}) plays an important but secondary role in the modulation of dopamine, theoretically improving negative symptoms while reducing the risk of extrapyramidal symptoms.²

The term ‘dopamine hypothesis’ of schizophrenia is slowly being phased out, as more sophisticated imaging studies have identified the nature of the dopamine dysfunction and its locus within the striatum. The striatum is a major component of the basal ganglia, and is divided functionally into the dorsal sensorimotor portion, the central associative striatum, and the ventral limbic striatum. Recently it has been found that the best correlation between positive symptoms of psychosis in schizophrenia and levels of D₂ activity is in the rostral caudate, a portion of the central associative striatum.^{3,4} We thus have *in vivo* confirmation of excessive D₂ neurotransmission and the relationship to the positive symptoms of schizophrenia. In the limbic striatum low dopamine release is directly related to the severity of negative symptoms; the lower the dopamine levels, the greater the negative symptom severity.³

While the goal of treatment is normalisation of D₂ neurotransmission in the striatum, a subset of patients do not respond to traditional treatment algorithms which include antipsychotic monotherapy at dosing levels defined in registrational trials. Consequently, many patients continue to exhibit uncontrolled positive and negative symptoms as well as manifesting aggressive and impulsive behaviours.⁵ It has been argued that ‘unconventional’ strategies for better management of treatment-resistant psychosis should be employed.^{6–8} The two primary methods we discuss in the following pages include antipsychotic polypharmacy and high-dose monotherapy.

Why do standard treatments sometimes fail?

To effectively treat the positive symptoms of schizophrenia it is important to achieve at least 60% striatal D₂ blockade with antipsychotics.⁹ The exception is clozapine, which has been shown to have some antipsychotic effect at as little as 20% blockade.¹⁰ Beyond 80% D₂ occupancy, risk of extrapyramidal side-effects (EPS) increases, leading to non-adherence and treatment failure. Therefore, the ‘sweet spot’ of D₂ receptor blockade for most patients is between 60 and 80%.⁶ However, in some treatment-resistant cases, particularly when aggression and impulsivity are of concern, moving beyond 80% may be necessary.^{6,8,11–14} Moreover, there is significant evidence from the literature that a substantial portion of patients tolerate plasma antipsychotic levels consistent with >80% D₂ occupancy.

One of the early imaging studies from 1997 noted that a large fraction of patients stabilised on low-dose oral haloperidol had plasma levels associated with >80% D₂ occupancy;¹² however, prior clinical studies found that even at a plasma haloperidol level of 6 ng/ml (predicted 90% D₂ occupancy), only 30% experienced adverse effects.¹³ A similar pattern is seen with risperidone. The pivotal trials studied doses of 10 mg and 16 mg, which correlate with a plasma active moiety level of 70 ng/ml and 112 ng/ml, respectively.¹⁵ The plasma level of 70 ng/ml would correspond to a D₂ occupancy of 85%;¹⁴ however, despite this high level of predicted D₂ occupancy, the proportion of patients on 10 mg who required anti-Parkinsonian treatment was only 31%.¹⁶

Pharmacokinetic failure

Pharmacokinetics is the umbrella term that covers drug absorption, bioavailability, distribution, metabolism and excretion. The role of pharmacokinetics in antipsychotic treatment failure is relatively simple. Through abnormal pharmacokinetic processes such as poor absorption, rapid metabolism and enzymatic polymorphisms, antipsychotic plasma levels do not reach the threshold associated with 60% striatal D₂ occupancy. This leads to continued psychotic symptoms. It also leads to frustration and confusion for clinicians in that the patient does not sufficiently respond to standard treatment algorithms.

Pharmacodynamic failure

Pharmacodynamics encompasses receptor binding and sensitivity, postreceptor effects, and chemical communication. Pharmacodynamic treatment failure with regard to antipsychotics is the inability to provide significant amelioration of psychotic symptoms in spite of achieving plasma levels associated with at least 60–80% D₂ occupancy.¹⁷ Although adequate drug plasma levels are achieved, patients with treatment-resistant psychosis present with continued positive, cognitive and aggressive symptoms. The treatment failure associated with pharmacodynamic influences is hypothesised to be related to lack of D₂ receptor sensitivity or hypersensitivity. When patients manifest a lack of extrapyramidal adverse effects or akathisia, increasing drug doses to achieve plasma levels that are associated with >80% D₂ blockade may be necessary to provide symptom control.^{18–20} The overriding principle is that there are a subset of patients who both tolerate and require high levels of D₂ antagonism for symptomatic relief.

The importance of being patient

While recent studies have demonstrated that minimal response after 2 weeks on a particular antipsychotic dose portends a low likelihood of week 6 response on that dose, the full therapeutic effects of adequate D₂ receptor blockade in schizophrenia may not be apparent until many weeks or months later.⁷ Therefore, patience in pharmacological treatment of psychosis is critical when a patient exhibits partial response.^{7,11} For example, Robinson and colleagues found that in a sample of 118 first-episode patients with schizophrenia or schizoaffective disorder only 20% responded to treatment at 4 weeks. The picture was quite different at 52 weeks; roughly 87% responded to treatment.²¹ Other studies of ziprasidone, risperidone and olanzapine have shown continued improvement over several months of treatment.¹¹

Strategies to use prior to heroic measures

We believe polypharmacy and high dosing should not be the initial approach to treating schizophrenia. However, considering that roughly 30% of patients with psychosis are on multiple antipsychotics, the practice is far from rare.^{22,23} In an effort to address the growing practice of antipsychotic polypharmacy and high dosing of antipsychotics in spite of little support in the literature, Stahl provides 12 case-based recommendations.⁷ We review several below.

Utilise monotherapy first to include clozapine

Sequential trials of at least two SGAs are recommended. If both trials fail, consideration of an FGA is appropriate. Also, it is important to not overlook clozapine as monotherapy. The efficacy of clozapine in treatment-resistant schizophrenia, particularly with regard to aggression and violence, is well documented.^{24–26} However, some clinicians may be hesitant to initiate a trial of clozapine owing to fear of side-effects such as agranulocytosis.

Monitor blood levels

Securing drug plasma levels is the only way to know whether treatment failure is due to a pharmacokinetic issue such as rapid metabolism or a cytochrome P450 polymorphism, or simply poor adherence with oral therapy. Likewise, blood levels can alert you to pharmacodynamic abnormalities which occur when treatment response does not correlate with adequate dosing. Blood level monitoring of both FGAs and SGAs can provide the clinician with important information which can guide the treatment plan for patients with treatment-resistant psychosis. This is supported by the recent work of Lopez & Kane as relevant to haloperidol, fluphenazine, perphenazine, risperidone, olanzapine and clozapine.²⁷

Time may not be on your side

As noted above, it takes some patients longer than others to respond to antipsychotic treatments. Granted, it may not be possible to wait several weeks (and certainly not months) in acute settings or when a patient's behaviour is potentially harmful to self or others, but when possible, allowing adequate time for full response may be all that is needed when a patient has exhibited a partial response. The result of impatience is that a second antipsychotic may be prescribed or a single medication may be dosed in an unnecessarily aggressive manner.

Double-check the diagnosis

It is common practice to rethink the primary diagnosis if the treatment plan appears ineffective. Once pharmacokinetic, pharmacodynamic or time-course failures have been ruled out, the presence of substance misuse or a personality disorder or neurological illness should be considered.

Antipsychotic polypharmacy

Although a number of published treatment guidelines for schizophrenia are available, some of which conflict with each other, it is clear that clinicians should utilise a monotherapy approach to antipsychotic medication use.²⁸ Multiple trials of antipsychotic medications, generally SGAs to include clozapine, are recommended. In fact, divergence from this sequential clinical progression has historically been met with scepticism, caution and outright criticism.^{29–36} It is certainly understandable why this is the case. The literature is replete with evidence supporting the efficacy of monotherapy for schizophrenia. Furthermore, the pitfalls associated with combining antipsychotics are well documented. Increased side-effects, higher medication costs, scant information supporting efficacy, and suboptimal outcomes are all problematic with regard to antipsychotic polypharmacy.^{29–36} So, why the need to even review the topic? The reality is that patients included in research studies are generally those who are able to give consent, exhibit less violence and less impulsivity, have lower rates of chemical dependency, and are less likely to have histories of sequential trials of antipsychotics at documented therapeutic levels.^{7,8} In other words, consistent with much of psychiatry research, they are healthier and not mirror images of the patients seen in clinical practice. Therefore, we believe a strict adherence to a treatment guideline based on highly selective samples does not necessarily translate well to community-based out-patient clinics and in-patient facilities.

We acknowledge that antipsychotic monotherapy is sufficient for the majority of patients with schizophrenia and that adherence to established guidelines should generally occur. Indeed, recent studies support this position. A 2004 study by Suzuki and colleagues revealed that when patients with schizophrenia were switched from multiple antipsychotics to monotherapy, roughly half maintained gains whereas a quarter showed improvements. Another quarter of the sample decompensated.³⁷ In a similar study by Essock and colleagues it was found that patients switched to monotherapy maintained gains, but also showed improvement in metabolic effects assumed to be caused by antipsychotic polypharmacy. It should be noted that approximately a third of patients required multiple antipsychotics.²³ However, some evidence supports the use of antipsychotic polypharmacy. A recent meta-analysis of randomised controlled trials comparing antipsychotic monotherapy and polypharmacy highlighted that polypharmacy may be superior to monotherapy in certain clinical cases.³⁸

In addition to achieving adequate D₂ occupancy, antipsychotic polypharmacy also exploits other receptor-binding properties that could lead to improvement in other schizophrenia symptom clusters. For example, serotonergic, noradrenergic and histaminergic binding theoretically ameliorate depression, anxiety, insomnia, impulsivity and aggression. On the flip side, however, the patient is potentially exposed to adverse side-effects from multiple receptor binding or excessive binding via similar properties shared by antipsychotics (e.g. excessive histaminergic binding leading to daytime sedation or appetite stimulation and weight gain). Consequently, combining antipsychotics should be done rationally based on their binding profiles. One clear example is the need to avoid combining the partial D₂ agonism of aripiprazole with antipsychotics with full D₂ antagonism. The binding interference may lead to a worsening of symptoms due to aripiprazole's high affinity for the D₂ receptor, and the fact that even low doses such as 10 mg achieve 83% D₂ occupancy, and thus may displace full antagonists.⁶

High dosing of antipsychotics

Antipsychotic polypharmacy is not the only means of addressing the more complex and treatment-resistant cases of schizophrenia. High-dose monotherapy is a viable option as well. In fact, it has been argued that if the goal is to occupy a greater degree of D₂ receptors in order to address treatment-resistant positive and aggressive symptoms, high-dose monotherapy is the preferred option when compared with polypharmacy. High-dose monotherapy does, however, come at a greater financial expense and the risk of increased metabolic and other potential treatment-limiting side-effects.¹¹

It is impossible to know what dose of a particular antipsychotic is required to achieve the intended outcome. Therefore, the prudent action is to start low within the US Food and Drug Administration (FDA)- and British National Formulary (BNF)-approved guidelines for the particular medication. The medication can be gradually increased outside the FDA-approved dosing window until therapeutic response occurs or the patient develops intolerable side-effects. It is important that informed consent is obtained and treatment rationale is well documented when this occurs. Below we discuss the typical dosing ranges and special considerations for high dosing of the antipsychotics. A more detailed analysis can be found in Stahl & Morrissette's review of the topic.¹¹

Clozapine

Clozapine is typically only recommended after subsequent trials of other antipsychotics have failed. This is primarily owing to its side-effect profile. At typical dosing of 300–450 mg/day, clozapine binds to less than 50% of D₂ receptors, but as noted earlier, the antipsychotic benefits with this medication can be seen at as low as 20% occupancy.¹⁰ A meta-analysis by Davis & Chen revealed that patients on high levels of clozapine responded more frequently than those on low levels.³⁹ Clozapine can be dosed as high as 900 mg/day, but seizure risk does increase with higher plasma levels, so titration to this dose should be done slowly. Furthermore, due to the diverse binding profile of clozapine, improvement in multiple symptom clusters is possible.

Quetiapine

Quetiapine has a relatively weak affinity for D₂ receptors and often requires high dosing to achieve intended outcomes. Only at the upper range of 400–800 mg/day are the antipsychotic properties of the medication seen. It is generally believed that a dose of 1200 mg/day is no more effective than the typical dosing range and carries greater incidence of metabolic effects; however, clinical practice has shown that 1800 mg/day may be useful in treating violent patients.^{2,5,39}

Olanzapine

Doses of olanzapine between 10 and 20 mg/day equate to 60–80% D₂ occupancy. Higher doses of 40–60 mg daily appear to be more effective, particularly with aggressive patients and in some forensic settings.^{2,32,40,41} A note of caution is that as plasma levels increase the risks of anticholinergic and metabolic effects also increase.^{5,10}

Risperidone/paliperidone

Risperidone reaches 70–80% of D₂ occupancy at doses between 2 and 6 mg/day. The risk of EPS is positively correlated with dose. Doses above 8 mg/day are generally not considered beneficial for most patients, but in some, the side-effects may not appear until higher dosages.⁵ As noted previously, even at 10 mg/day only 31% of patients required anti-Parkinsonian medication in the pivotal trials, again providing evidence that a subgroup may both require and tolerate higher dosages and plasma levels.¹⁶ Risperidone's active metabolite paliperidone has less chance of drug–drug interactions as it is not metabolised by the liver. Similar to risperidone, paliperidone carries increased risk of EPS as the dose increases.¹¹

Ziprasidone

Data support the use of high doses of ziprasidone, particularly in forensic settings at 360 mg/day.^{2–5,40,41} It can be difficult to achieve adequate plasma levels with ziprasidone in out-patient settings as food is required to increase absorption. It has been reported that ziprasidone has historically been under-dosed due to concern about increased agitation and QTc prolongation.

Aripiprazole

Aripiprazole has a different mechanism of action compared with the 'first wave' of SGAs. Contrary to its predecessors, high doses of aripiprazole may not result in increased efficacy in schizophrenia. This is due to its partial agonist properties and high affinity for D₂ receptors.¹¹ Doses of 40 mg/day are associated with 96.8% D₂ occupancy, so further increases will not have an impact on D₂ neurotransmission to any considerable extent.

Asenapine, iloperidone, and lurasidone

Asenapine, iloperidone, and lurasidone are newer atypical antipsychotics. Consequently, there is limited information that supports their use in high doses. Although doses of asenapine of 30–40 mg/day may be effective for some treatment-resistant cases, there are virtually no data supporting use at these higher doses, and the buccal absorption of asenapine declines significantly for each 5 mg increase in the dose. As with asenapine, there are limited to no data supporting the use of iloperidone at high doses. One treatment-limiting issue with iloperidone is orthostatic hypotension. Lurasidone is approved up to 160 mg/day for schizophrenia, but higher dosages have not been studied for efficacy, only for safety (e.g. thorough QT studies up to 600 mg). Similar to ziprasidone, lurasidone should be taken with food to increase absorption.¹¹

Summary

Schizophrenia is a relatively common psychiatric disorder but it is often difficult to treat. Although antipsychotic monotherapy at standard dosing levels is sufficient for the majority of patients, a subset will require ‘unconventional’ approaches such as antipsychotic polypharmacy and higher than normal dosing. If done cautiously and rationally, these approaches can provide much-needed benefit for those most in need of relief.

1.7.49 Should compulsory admission to hospital be part of suicide prevention strategies?

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Abstract

The World Health Organization report *Preventing Suicide: A Global Imperative* provides governments with guidance for comprehensive suicide prevention strategies. However, it does not mention the role that compulsory admission to hospital of psychiatric patients should have in policies for suicide prevention. This was a missed opportunity for international discussion and guidance about a measure that, although widely used, is becoming increasingly controversial in light of the existing evidence and human rights norms.

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Legal and policy approaches to suicide have been changing significantly in the past decades. Notably, the decriminalisation of suicide attempts in many countries has been followed by an increasing recognition that the stigma around suicide must be grappled with and that adequate social and healthcare policies can reduce the rate of suicide in the population. In other words, the focus has shifted from criminal punishment and moral condemnation to awareness, support and prevention.¹

The 2014 World Health Organization (WHO) report *Preventing Suicide: A Global Imperative*¹ is an important step in this direction. It draws attention to the discrepancy between the magnitude of suicide as a health problem worldwide

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and the low priority it is given by national governments. The report also describes the risk and protective factors in suicide prevention based on state of the art research and offers guidance for comprehensive strategies for suicide prevention. The central message in the document is that suicides are preventable but this requires actions such as restricting access to the means of suicide, reducing excessive use of alcohol, collecting and collating good-quality data about suicide and suicide attempts, providing training for gatekeepers, improving the quality of mental healthcare services, and promoting responsible reporting of suicide by the media. The report is also clear that taboo, stigma, shame, guilt and discrimination surrounding suicide hamper effective suicide prevention policies as they discourage vulnerable people from seeking help.

However, despite its emphasis on the need for comprehensive strategies for suicide prevention, the compulsory admission to hospital of people at risk of suicide was not discussed in the WHO report. This should not come completely as a surprise given that compulsory admission to hospital was also ignored in the previous United Nations (UN) and WHO documents on which this report was built.²⁻⁴ Moreover, the literature on suicide prevention rarely lists compulsory admission to hospital among the measures for suicide prevention, and those who do normally do not distinguish between voluntary and compulsory admission.⁵⁻⁷

This gap in international guidelines and in the scholarly literature needs to be addressed. Compulsory admission to hospital is widely used as a measure for suicide prevention, but the trade-offs involved and the human rights implications make it a topic in which guidance and further discussion are urgently needed.

Compulsory admission to hospital for suicide prevention

Compulsory admission to psychiatric hospitals or psychiatric wards is allowed in many countries as a measure to prevent self-harm.⁸ In England and Wales, for instance, the Mental Health Act 1983 (MHA) provides the legal framework for the compulsory admission and treatment of patients with mental disorders of a nature or degree that warrants their detention in a hospital and who ought to be so detained in the interests of their own health or safety or with a view to the protection of other persons. Whether the patient has capacity to decide on their stay in hospital and has objected to it will not affect the legality of a detention under the MHA. A recent publication shows that there were over 63 000 detentions under the MHA in the period from 1 April 2015 to 31 March 2016.⁹ Considering the body of literature associating suicide with mental disorders^{6,10} (see, however, Hjelmeland *et al*¹¹) and that statistically people with mental disorders are at a higher risk to themselves than to others,¹² it is plausible to assume that prevention of self-harm is a common reason for compulsory admission to hospital.

Some would interpret this authorisation to detain as actually a duty to detain when there is a high and immediate risk of a person taking their own life. A failure to do so can be considered medical negligence and may also be a breach of human rights. In the case of *Rabone & Anor v Pennine Care NHS Foundation Trust* [2012],¹³ the Supreme Court unanimously held that the failure of the hospital staff to detain Melanie, a voluntary psychiatric patient who hanged herself from a tree after being allowed to spend the weekend with her family, was a breach of her right to life under Article 2 of the European Convention on Human Rights. According to the Court, given her history of depression and self-harm, including a previous suicide attempt, the hospital staff should have used their powers to detain Melanie under the MHA to protect her from the 'real and immediate risk of suicide' when she demanded to leave the hospital.

Even though this precedent applies to the UK only, it shows that a national strategy for suicide prevention may be incomplete without a policy for compulsory admission to hospital. In hindsight, it is clear that the deaths of people like Melanie could have been avoided were they admitted to hospital and put under close observation, treated, managed and prevented from having access to the means to take their own life.

Compulsory admission to hospital: trade-offs and human rights

When looking at individual cases of suicide and at the data from population-based studies there is evidence that compulsory admission to hospital saves lives.^{14,15} However, this does not answer the question of how, when or whether it should be used to prevent suicide. Compulsory admission to hospital involves trade-offs and has human rights implications that need to be considered in clinical, policy and legal decisions about its role in strategies for the prevention of suicide.

There is now compelling evidence that suicide, being a low-frequency event, is very difficult to predict. The clinical methods for predicting suicide among patients have a very poor predictive capacity.^{16–20} A recent meta-analysis revealed that, over an average follow-up of 5 years, almost half of all suicides are likely to occur in patients considered at low risk, and that 95% of high-risk patients will not die by suicide.²¹ This creates a trade-off between the need to be sensitive to the risk of suicide to reduce the chance of false negatives and the need to be specific to avoid false positives that may lead to unnecessary detentions. Assuming that it is impossible to predict whether a person is going to take their own life and that the best we can do is to estimate that 1 out of X people in a certain cohort will die by suicide, then a society that allows compulsory detention of people at risk of suicide has to admit that to save one person it will have to unnecessarily detain $(X - 1)$ people.

There are also concerns about whether compulsory detention may increase the risk of suicide in some cases. First, some people may not seek treatment because they are fearful of being forced to accept treatments not of their choice or of being detained for prolonged periods.²² This would go against the WHO recommendation that a national effort to prevent suicide should encourage people to seek help. Second, there is an association between suicide and psychiatric admission to hospital, as suicide risk peaks in the period immediately after admission to hospital and shortly after discharge.^{5,6,14,23,24} This association can be explained in part by the fact that individuals with higher risk of suicide are more likely to be admitted to hospital,²⁵ but some argue that admission to psychiatric in-patient care might actually increase the risk of suicide. The stigma, discrimination, impact on employability, trauma, isolation and the feeling of dehumanisation caused or augmented by compulsory admission to hospital may contribute to the extremely high risk of suicide in the first few days of admission and after discharge.^{17,22,26,27} Although further research is necessary, this hypothesis does not seem farfetched given that people who are detained, disconnected from their social circle and experience trauma, abuse and emotional distress are at a higher risk of suicide.¹ Hence, it is possible that some of the $(X-1)$ people unnecessarily detained will in fact die by suicide as a result of compulsory admission.

The trade-offs and tragic choices in compulsory admission to hospital have clear human rights implications. Health systems and professionals who are under pressure to be sensitive to the risk of suicide to avoid breaching a patient's right to life will do so at the expense of specificity. This leads to an increase in unnecessary detentions, which interferes with the right to freedom of movement, autonomy, bodily integrity and private life of those detained. It may also affect the right to life of those whose risk of suicide increased as a result of their stay in hospital. Therefore, the rules and practices regarding the compulsory admission to hospital of people with mental disorders to prevent suicide are always choices between different rights and rights-holders.

There are also concerns about whether compulsory admission to hospital is inherently discriminatory against people with mental disorders as it denies them the right to decide about their own treatment. This concern is reflected in the discussions about whether compulsory admission to hospital is compatible with the UN Convention on the Rights of Persons with Disabilities (CRPD), in particular Article 14, which establishes that 'the existence of a disability shall in no case justify a deprivation of liberty'. The UN Committee on the Rights of Persons with Disabilities,²⁸ for instance, affirms in its guidelines on Article 14 of the CRPD that the 'legislation of several States parties, including mental health laws, still provide instances in which persons may be detained on the grounds of their actual or perceived impairment, provided there are other reasons for their detention, including that they are deemed dangerous to themselves or others. This practice is incompatible with Article 14 [...]'. Others, however, worry about how the prohibition of compulsory detention and treatment for people with mental disorders will affect the protection of other rights of people with disabilities, such as their rights to health and to life.²⁹

The need for guidance

In conclusion, four things can be said about compulsory admission to hospital as a measure for suicide prevention. First, it can save the lives of those who, without the care, treatment and management received in hospital, would have taken their own life. Second, owing to the poor suicide predictive capacity of the existing methods, false positives will occur and this results in unnecessary hospital admissions, which can be aggravated if legal accountability encourages defensive clinical practice. Third, there is the possibility that compulsory admission to hospital is partially responsible for the suicides of those who failed to seek help owing to the fear of involuntary detention or for whom the experience of being admitted to hospital contributed to the decision to take their own life. Fourth, it is still unclear how and if compulsory admission to hospital of people on the basis of their mental impairment and the risk of danger to themselves can be reconciled with the CRPD.

The trade-offs involved and the need for measures for the prevention of suicide to be compliant with human rights make the creation of guidelines concerning their use challenging, but necessary. The WHO is a forum in which an evidence-informed, international, multi-stakeholder discussion can shed light on the role (if any) that compulsory admission to hospital should have in a national policy for the prevention of suicide. It is unfortunate that the otherwise commendable 2014 report missed this opportunity. It may be uncomfortable for those advocating policies to prevent suicide to discuss compulsory admission to hospital as this is a measure in which the line that separates protection and harm can be very thin, and there is controversy about where it lies. However, as those working in the area of suicide prevention already know, avoiding a difficult issue is never the best way to deal with it.

1.7.50 Improving the quality of mental health services using patient outcome data: making the most of HoNOS

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Abstract

Efforts to assess and improve the quality of mental health services are often hampered by a lack of information on patient outcomes. Most mental health services in England have been routinely collecting Health of the Nation Outcome Scales (HoNOS) data for some time. In this article we illustrate how clinical teams have used HoNOS data to identify areas where performance could be improved. HoNOS data have the potential to give clinical teams the information they need to assess the quality of care they deliver, as well as develop and test initiatives aimed at improving the services they provide.

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A commitment to improving the quality of healthcare is central to the aims of the National Health Service (NHS).¹ This commitment involves developing and evaluating new interventions and treatments, obtaining feedback from patients and learning from mistakes.² It also involves monitoring and improving patient outcomes. Despite repeated calls for greater use of patient outcome measures in mental health, available evidence suggests that very few services use them to monitor change over time.³ There are a number of important barriers which make it difficult to implement systems for monitoring patient outcomes, including access to reliable and valid measures, the need to protect patient confidentiality and the time and money needed to collect, analyse and report data.^{4,5}

While many initiatives aimed at improving the quality of NHS services have been ‘top-down’, it is widely acknowledged that front-line clinicians have a key role in efforts to improve service quality.^{6,7} However, unless clinical teams have access to information about patient outcomes, they cannot assess their performance or identify areas where performance could be improved.

For the past 20 years the Health of the Nation Outcome Scales (HoNOS) have provided a means of assessing the health and social functioning of people who use mental health services.⁸ HoNOS is a clinician-rated outcome measure comprising 12 scales covering symptoms, functioning, social relationships and environmental issues. Each domain is rated by the treating clinician on the scale of 0 to 4: 0 means no problem, 1 means a problem that probably requires no intervention and 2, 3 and 4 correspond to ‘mild’, ‘moderate’ and ‘severe’ problems. They are rated by staff using all available information – not as a questionnaire or interview – based on the worst state in the reference period, usually 2 weeks. There is a glossary, and training in their use is generally recommended.⁹ Although it is possible to calculate a total HoNOS score for a patient, individual scores on each of the 12 scales provide a better guide to the problems they are experiencing and targets for future interventions and treatments. Originally developed to measure the health and social functioning of working-age adults with severe mental illness, the scales have been modified to assess mental health of older adults (HoNOS65+),¹⁰ children and adolescents (HoNOSCA),¹¹ people with intellectual disability (HoNOS-LD),¹² in secure settings (HoNOS-Secure)¹³ and with acute brain injury (HoNOS-ABI).¹⁴

Use of HoNOS in mental health services in England was patchy until work started on the development of a commissioning tariff based on a Mental Health Clustering Tool, which needed HoNOS scores to be completed on all patients who are in scope of the mental health tariff.¹⁵ While these plans are still in development, this initiative has led to widespread use of HoNOS throughout the country. In recent years clinicians have begun to consider how these data might be used to assess and improve the quality of care they provide. In the next section we present how clinical teams in three trusts have used HoNOS data to identify problems with the care they provide and plan ways to improve it.

HoNOS use – examples of application

Example 1: using HoNOS to examine reasons for admission

Reasons for admission to hospital or to crisis resolution/home treatment (CRHT) teams are poorly understood yet very important in terms of ensuring that available resources are used effectively. As the number of beds decreases, thresholds for admission are becoming increasingly important to assess at a service level.

A team in Southampton used routine HoNOS data to explore mental health problems (such as psychotic symptoms, suicidality and aggression) experienced by adults who were admitted to in-patient units and people referred to CRHT services. They compared the proportion of people who had problems requiring intervention (a score of 2 or more on different HoNOS items) among 3409 people admitted to hospital and 2991 referred to local crisis teams (*Table 1*). The most prevalent problems among people referred to either service were suicidality and agitation, with levels of agitation higher among those admitted to hospital. Nonetheless, clinicians were surprised to see that only around half of patients admitted to hospital and 39% taken on by crisis teams scored as requiring intervention for suicidality and/or agitation. Even when people with significant problems with psychosis or accommodation status were included, a significant minority did not appear to have major problems requiring intervention.

HoNOS scale differences between hospital and crisis team admissions

Scores > 2 on HoNOS items	Hospital <i>n</i> = 3409 %	Crisis team <i>n</i> = 2991 %
1: Agitation	29	16
2: Suicidality	22	27
3: Accommodation	6	5
4: Delusions and hallucinations	13	9
1 or 2	47	39
1 or 2, 3 or 4	66	53

When these findings were discussed within teams, clinicians raised the possibility that people may be being referred to in-patient or CRHT services because of a combination of different problems at less severe level or that staff were under-scoring these items. It also led to discussions about the level of severity at which people were being referred to these services. Discussions based on this information led to a review of in-patient services (numbers of beds in the area were higher than in other comparable catchment areas),¹⁶ and a review of thresholds for access to CHRT services.

Example 2: outcomes of patients treated by assessment and brief treatment teams

Community mental health teams in central London used routine data from HoNOS to examine outcomes of treatment. Changes in mean HoNOS scores were calculated for patients under the care of assessment and brief treatment teams between April 2013 and September 2014 by comparing the mean severity from initial review with that from a follow-up. Scores of 3 (moderate) or 4 (severe) were categorised as 'high' and scores of 0 (absent), 1 (minimal) or 2 (mild) were categorised as 'low', and proportions of people moving between low and high scores were plotted (*Fig. 1*). In *Fig. 1* differences in severity of each subscale of HoNOS are presented for people in clusters 1–5 (single non-psychotic episode), clusters 6–8 (enduring non-psychotic) and clusters 10–15 (psychosis). The data showed that a smaller proportion of people in clusters 6 to 8 had made progress during their time with teams; among people in clusters 6 to 8, fewer who had high scores at baseline had lower levels at follow-up, especially compared with people in clusters 10 to 15. When data were examined from four other sector services in the trust a similar pattern emerged, with a greater proportion of patients in clusters 6 to 8 failing to show evidence of improvement or problems becoming more severe between the two time points compared with people in clusters 10 to 15.

When these data were presented to front-line staff they commented that it can be difficult to help meet the needs of people in clusters 6–8 (predominately people with personality disorder) through the types of interventions available to staff working in assessment and brief treatment teams. Although staff working in these services are able to refer patients to a local specialist personality disorder service, many do not want the group-based psychological treatment offered by this service or are too chaotic and poorly motivated to engage in psychological treatment. Discussions prompted by a review of these data led to the development and piloting of a six-session brief intervention package for people with personality disorder offered by members of the local specialist team (details available from the authors on request). This package of treatment is based on National Institute for Health and Care Excellence (NICE) guidelines¹⁷ and focuses on psychoeducation and skills training. It is hoped that some people who initially reject the offer of longer-term psychological treatment can be engaged through this extended assessment and that others will benefit more from this approach than they do from the care they are currently receiving.

Example 3: comparing outcomes of older adults admitted to in-patient units

Staff working on an in-patient mental health unit for older adults with dementia and other organic conditions used routine HoNOS65+ data to examine outcomes of people admitted to their service. It was noted that over a 3-year period the mean percentage improvement in scores on the depression scale of the HoNOS65+ declined (*Fig. 2*). Outcomes can only be properly understood with reference to context and interventions. These data were therefore compared with those from a similar unit in the same trust with the same operational policy, lengths of stay, diagnostic and demographic characteristics, and initial severity scores. Data from this unit showed that mean percentage improvement on the depression scale over the same period was approximately 50%. The team did not have and still do not have direct data on interventions, but in 2001 there was a pilot study of the systematic recording of care plans, and these data were linked to outcomes data. It transpired that in the unit with the poorer outcomes, all patients with dementia were automatically given night-time benzodiazepine hypnotics. Furthermore, there was a strong association between being given night-time benzodiazepines and poor outcomes. During discussion with the teams it was agreed that routine use of benzodiazepines was a plausible explanation of poor outcomes and this policy was revoked. Over the course of the next year mental health outcomes of patients admitted to the unit improved (*Fig. 2*).

Discussion

The examples given above illustrate how front-line clinical teams have used routinely collected HoNOS data to examine and to try to improve the outcomes of the patients they treat. While changes to mental health services will continue to be made in response to new national policy directives, new research findings and new technologies, we believe that one of the most effective ways to improve service quality is ‘bottom-up’: through local teams using local data to drive change. However, front-line clinicians face a number of significant challenges when trying to assess and improve the quality of the care they provide. Chief among these are limited time and other resources needed to collect data on patient outcomes. We are aware of numerous occasions when clinical teams have made changes to the services they provide but have not had the resources to examine whether these changes led to improvements in patient care. In other instances, baseline audits are conducted that identify problems in a service that teams try to correct, but staff have not had time to assess whether these changes benefited patients. To fulfil the NHS promise to patients to continuously work to improve service quality, clinical teams need to be able to access data on patient outcomes. Yet the experience of participants in the UK Routine Clinical Outcomes Network (www.ukrcom.org) suggests that very few services provide outcomes data to their teams. Embarking on new efforts to collect patient- and staff-rated outcomes is expensive and time consuming. By contrast, routinely collected HoNOS data in England provide an important source of clinician-rated patient outcomes that do not require additional resources to be spent and can be used to assess and improve the quality of care that teams provide.

Challenges to widespread HoNOS use

While the vignettes above illustrate how HoNOS data have been used by front-line clinical teams, a number of obstacles need to be overcome if this approach is to become more widespread.

First, concerns have been raised about the quality of routine HoNOS data.¹⁸ Available evidence suggests that if staff are provided with appropriate support and training, HoNOS can be used to generate reliable information that can be used to compare different services and examine changes in patient outcomes over time.¹⁹ Second, IT systems in trusts need to be able to generate reports on outcome data in a form that clinical teams find useful. Third, data from HoNOS and other routine outcomes scales need to be interpreted cautiously. Random variation and subtle changes in practice and case-mix may have led to changes in patients outcomes over time. Separating real and spurious differences can be difficult.²⁰ Finally, teams need to be given time and space to examine their data, learn from them and use them to evaluate their efforts to improve service quality. If staff are supported to generate reliable data and systems are available to deliver data to front-line clinical teams, then these data have the potential to be used in clinical audit and in alternative models for improving service quality, such as Plan–Do–Study–Act cycles.²¹ The latter approach may have some advantages over traditional audits because it allows the impact of changes in practice to be examined more frequently and provides a more iterative approach to developing changes aimed at improving patient outcomes.^{22,23}

At present, most staff see collecting outcome data as an ‘invisible task’, in which time is spent collecting and entering data for no purpose.²⁴ If systems can be implemented that deliver feedback to staff on service-level patient outcomes, staff are more likely to value collecting these data. For instance, in South London and Maudsley NHS Foundation Trust and Central and North West London NHS Foundation Trust, clinicians have organised meetings for staff in which HoNOS data are presented and discussed. Feedback from staff attending these meetings has shown they value getting this information and their comments have been used to refine the way that data are collated and presented (most staff indicated a preference for the categorical change model presented in *Fig. 1* rather than changes in total HoNOS scores).

While HoNOS scores collected through the current mental health payment initiative¹⁵ provide a rich source of routine data on patient outcomes, the timing of assessments is unlikely to be optimal for evaluating the impact of treatments and services. Further work is needed to establish when outcome assessments are best undertaken in different settings to compare services and assess the impact of quality improvement initiatives.

HoNOS data are not the only form of evidence that mental health services collect. For instance, psychiatric in-patients are asked to complete the ‘friends and family test’ (a two-item short patient-rated experience measure).²⁵ However, there is very little evidence that these data are being fed back to clinicians to allow them to reflect on differences in levels of patient satisfaction over time or between different teams.²⁶ Such data also have the potential to stimulate bottom-up efforts to assess and improve service quality if steps are taken to use them in this way. One of the great

strengths of HoNOS data is that they provide a summary of mental health, behavioural problems and social factors. Although this means that HoNOS can be used under circumstances where poor mental health or impaired cognition may limit the value of patient-rated data, there are drawbacks to relying solely on clinician-rated outcomes. The possibility that outcome data could be used to pay services based on patient outcomes could paradoxically reduce their value as a means to assess and improve service quality.²⁷ This is commonly known as Goodhart's law after the British economist Charles Goodhart: 'When a measure becomes a target, it ceases to be a good measure'.²⁸

Mental health trusts in England are currently collecting large amounts of outcome data using HoNOS. We believe that efforts by mental health services to use HoNOS data and other routinely collected patient outcomes have the potential to make better use of available resources and engage front-line clinicians in efforts to improve patient outcomes.

1.7.51 Personalisation and social care assessment – the Care Act 2014

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Abstract

The Care Act 2014 represents a significant change in legislation in England. For the first time it brings together various aspects of adult social care into a single statute succeeding earlier acts and policy. Given its importance to the lives of service users and carers, clinicians need to have a clear understanding of its implications. We provide an overview of why it was developed, its underlying principles and international comparisons, as well as implications for assessments, interventions and outcomes. The impact on the lives of patients and carers is discussed, as well as dilemmas and challenges the Act presents. While it addresses other important aspects of social care, including safeguarding, Mental Health Act section 117 aftercare and duty of candour, we focus on personalisation because of the opportunities it provides to enhance management plans for people experiencing mental health problems.

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Why was the Care Act 2014 developed?

The Care Act 2014 represents the latest evolution in current attitudes to care. It was asserted by Norman Lamb MP, Care and Support Minister in the UK coalition government, as ‘the most significant reform of care and support in more than 60 years’.¹ Think Local Act Personal (TLAP, a partnership of more than 50 organisations, including the National Health Service (NHS), ‘committed to transforming health and care through personalisation and community-based support’ (www.thinklocalactpersonal.org.uk/About-us/)) sees it as representing a significant change in legislation, of importance to service users and carers in England and Wales because ‘for the first time it puts them in control of their care and support. It also makes clear what kind of care they should expect’ (www.thinklocalactpersonal.org.uk/Browse/careact2014/).

Social care law can be seen to have begun with the National Assistance Act in 1948 that contained provisions for the basis of the modern welfare state. Direct payments as a method of personalisation were introduced in 1996 by the Community Care Act. More recent updates, such as the Carers and Disabled Children Act 2000 and the Health and Social Care Act 2001, broadened and refreshed these approaches. Separately, safeguarding of adults from abuse was dealt with by the Department of Health in *No Secrets*.² The Care Act 2014 succeeds earlier acts with a single statute. The golden thread running through the Act is the promotion of individual well-being (*Box 1*): “‘The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual’s well-being.’ (Care Act 2014 section 1(1)) ‘As a service user who has in the past been a carer to a diverse group of individuals, I feel that had a lot of these changes been made in the past, many people’s lives would have transformed sooner rather than later. That being said, we are now moving forward to enable individual lives to be more fulfilled.’ (Deb Barnes)”

Box 1 Scope: purpose of the Care Act (adapted from the Care Act 2014)

- a. To reform the law relating to care and support for adults
- b. To reform the law relating to support for carers
- c. To make provision about safeguarding adults from abuse or neglect
- d. To make provision about care standards
- e. To establish and make provision about Health Education England
- f. To establish and make provision about the Health Research Authority
- g. To make provision about integrating care and support with health services

Box 2 Care Act specified outcomes

The specified outcomes as defined in the Act are: managing and maintaining nutrition maintaining personal hygiene managing toilet needs being appropriately clothed being able to make use of the adult's home safely maintaining a habitable home environment developing and maintaining family or other personal relationships accessing and engaging in work, training, education or volunteering making use of necessary facilities or services in the local community including public transport and recreational facilities or services, and carrying out any caring responsibilities the adult has for a child.

What are the international comparisons?

In establishing the Care Act, a cap on spending for long-term social care was originally proposed to be introduced in April 2016. However, this has now been postponed until at least 2020. In 2014, The King's Fund reviewed international comparisons for health and social care provision.³ It highlights that The Netherlands introduced a 'universal' (i.e. available to all) system of insurance for long-term care in 1968. In the 1990s it introduced caps in response to rising costs, but this led to long waiting lists and the caps were abolished. Latterly, they have raised the threshold to access social care and outlined aspects of care that are expected to be delivered by families. Sweden established the right to tax-funded legislation in 1982/1983, whereas countries including Germany, France, Japan and South Korea all have mandatory long-term care insurance schemes.

Assessment under the Care Act

Assessment of needs, both for service users and their carers, is a core aspect of the Care Act. The process is divided into three stages: identifying needs, assessing eligibility and care planning.⁴ Each of these should be viewed not only as a gateway to support but as an intervention in itself.

Stage 1: identifying needs

The Act places a statutory duty on local authorities to provide assessments for any adult, including carers, appearing to have a need for care or support, regardless of the local authority's view of the level of that need or the individual's financial resources (section 9–10). It is important to note that in some areas this responsibility may be delegated by the local authority to partner organisations, such as NHS foundation trusts, and that assessment may be carried out by a range of professionals, including healthcare professionals. This assessment should address the person's needs in relation to the specified outcomes as defined in the Care Act (*Box 2*). It aims to identify the impact of these needs, the person's desired outcomes, and whether the provision of care and support services will be effective in contributing to the achievement of these outcomes (section 9(4), 10(5)). For clarity, we have used the term 'specified outcome' as a technical definition to refer to those outcomes specified in the Care Act (*Box 2*) and 'personal outcome' to describe all possible outcomes individuals may see as important.

It is crucial that the individual, their carer and any other person the individual requests be fully involved in the assessment process. Consideration should also be given to the most appropriate kind of assessment. Options for supported self-assessment, telephone assessment, joint assessment with other agencies or a combined assessment of the needs of, for example, the individual and their carer, may be appropriate (Care Act section 6(3)). In addition, in cases where the individual has significant difficulty in representing themselves at assessment and has no suitable advocate, the local authority is required to provide an independent advocate regardless of the individual's capacity under the Mental Capacity Act 2005.⁵

Stage 2: assessing eligibility

At the eligibility stage, the Care Act replaces previous Fair Access to Care (FACS) guidance on eligibility criteria^{6,7} with a national eligibility threshold based on the causes, extent and impact of the individual's needs (~Box 3). It should however be noted that local authorities are able, where considered appropriate, to meet non-eligible needs and may choose to do so, for example, in order to prevent further deterioration.

Well-being, individual personal outcomes and eligibility

In order to judge eligibility, impacts and contexts of needs are relevant: individual needs must be considered against the specified outcomes to determine whether or not they can be met, and reasons for this should be understood. Some social needs are not addressed by the Care Act, for example housing and debt. A homeless person would not be eligible purely by virtue of their homelessness, but the reasons for homelessness may make them eligible. For example, becoming homeless solely through relationship breakdown would not be considered potentially eligible. However, homelessness through an inability to manage a tenancy due to the impact of severe mental illness (i.e. impaired 'ability to maintain a habitable home' as defined in the specified outcomes) may well be eligible.

Furthermore, the impact on well-being is a personalised assessment and an individual perception, so that two people with the same needs in relation to specific outcomes could end up with a different assessment of eligibility. For example, obsessive-compulsive disorder could manifest in repetitive behaviours which affect an individual's ability to maintain family relationships and employment. These two specified outcomes may be fundamental for one person and significantly affect their well-being. Another person may have very different priorities or personal outcomes that they want to achieve; their well-being is not significantly affected and they would not be eligible.

The word 'significant' is not defined in the legislation, rather it is a judgement made by the local authority after considering the person's needs and what is important to them. However, well-being is a broadly defined and holistically assessed concept, relating to areas such as: personal dignity; physical and mental health and emotional well-being; protection from abuse and neglect; control by the individual over day-to-day life; participation in work, education, training or recreation; social and economic well-being; domestic, family and personal relationships; suitability of living accommodation; and the individual's contribution to society.⁵

Box 3 The National Eligibility Threshold (Regulation 2(1)14)¹¹

An adult's needs meet the eligibility criteria if – the adult's needs arise from or are related to a physical or mental impairment or illness; as a result of the adult's needs the adult is unable to achieve two or more of the outcomes [...] and as a consequence there is, or is likely to be, a significant impact on the adult's well-being.

The key to assessment under the Care Act is understanding what personal outcome (personal aim, wish or goal) the individual is looking for and what their needs are, before considering how these needs can be met. Person-centred assessment focuses on the individual and the difficulty they have in achieving personal outcomes, balanced with their strengths and support network; it does not start with service provision. For example, the assessment does not begin with 'the person needs residential care', but rather may find that 'the person is unable to wash, dress and feed themselves. This is having an impact on their personal dignity and their ability to continue to live safely in their own home'.

The local authority must consider what strengths, resources and capabilities the person has themselves and within their support networks and wider community. This strengths-based approach to assessment and care planning can maximise opportunities for utilising assets found within communities and normative support networks, thereby reducing dependence on service provision by meeting people's needs in more innovative and creative ways.

Stage 3: care planning

In developing and delivering preventive approaches to care and support, local authorities should ensure that individuals are not seen as passive recipients of support services, but are actively encouraged and supported to participate and are able to design care and support based around achievement of their goals. All assessments and subsequent care and support plans should be person-centred and genuinely engage the person and people involved in their care throughout.

Support plans should consider the broader needs identified by the assessment as well as the personal outcomes associated with the specified outcomes the individual is looking to achieve to maintain or improve their well-being. The person's own capabilities, assets and strengths and the potential for improving their skills, as well as the role of any support from family, friends or others that could help them to achieve what they wish for, should be incorporated into the plan. A person's independence should be maximised across these networks before any statutory service provision is considered to meet the desired personal outcomes.

Any person who requires ongoing support and has eligible needs is entitled to have these needs met through a personal budget. The Care Act 2014 has given parity to carers, who are now entitled to have their own eligible needs met through a carer's personal budget. A personal budget is an amount of money allocated for a person's support; this can be managed with or on behalf of the individual by the local authority or a broker, or can be paid to the individual as a direct payment. Person-centred care and support planning means that a person can receive part or all of their personal budget as a direct payment. Direct payments aim to enable a person to exercise the maximum possible choice over how they are supported, who they are supported by and where they are supported. The person must understand how much money is likely to be required to meet their eligible needs and have clear and realistic expectations of what is available locally. People who self-fund are entitled to receive necessary information, advice and support with support planning.

The third national TLAP survey⁸ demonstrated that over three-quarters of personal budget holders reported a positive impact of personal budgets on their lives. People with mental health difficulties were more likely than other groups to report a positive impact on relationships with carers, family and friends. However, older people were less likely than other cohorts to report a positive impact on mental health.

Review

Plans may be revised as a scheduled review or in response to changing needs or circumstances. The review should be a positive opportunity to consider whether the plan is enabling the person to meet their needs and achieve their desired personal outcomes. At this point it can be considered whether the support provided is working (be this through a carer, the community, through a direct payment or a commissioned service through a personal budget), whether new personal outcomes need to be defined, or whether any changes need to be made to care and support to achieve improvement.

Responsibilities of professionals

The Care Act places a responsibility on the local authority to inform the individual of their eligibility determination and produce a written record of whether any of their needs meet the eligibility criteria, and the reasons for this decision. Where an individual does not have eligible needs, the local authority must also provide information on what support may be available in the wider community, or what preventive measures might be taken to prevent or delay the condition progressing. This will require professionals responsible for eligibility decision-making to clearly evidence the reasons for their decisions and present these in an accessible format for the person concerned.

Implications for service users and carers

The Care Act 2014 has changed the ability that a service user or carer has to influence assessment of their own needs and eligibility. Whereas the FACS criteria ⁷ considered the needs of the individual, they did not consider their whole well-being and how this fits into their everyday lives, meaning that some service users may not have completely fitted into the specified categories. The criteria that the Care Act 2014 looks at focus on the individual in context, so that the impact on their well-being cannot now be overlooked or misjudged.

This holistic approach is mirrored by the TLAP 'I' statements, which make their markers for change much simpler to understand across a diverse range of individuals (*Box 4*). These statements complement the Care Act in allowing the individual service user to take control of everything that supports their specific needs and requirements. 'I' statements are presented in the form of first-person statements, for instance, 'I have the information and support I need in order to remain as independent as possible'.

'A service user or carer can automatically feel comfortable in all the statements as they are very clear and acknowledging. They allow you to take control of everything that supports your needs and requirements. The implications are quite dramatic; you feel worthwhile and not a burden to anyone and it allows you to take greater control of your own personal needs.' (Deb Barnes)

Box 4 Think Local, Act Personal 'I' statements ⁹

- Information and advice: having the information I need, when I need it
- active and supportive communities: keeping friends, family and place
- flexible integrated care and support: my support my own way
- workforce: my support staff
- risk enablement: feeling in control and safe
- personal budgets and self-funding: my money.

Dilemmas and challenges

The Care Act 2014 has introduced some major statutory changes to the way social care is delivered nationally, and as such presents a number of dilemmas and challenges to service users, carers and service providers.

Assessment as intervention

Assessment under the Care Act should be an intervention in itself rather than merely a process by which individuals are granted or denied access to funded services. This presents challenges both for local authorities as a whole and for individual professionals in a number of areas, including the necessary provision of reliable and up-to-date information about local services, and management of the time and resources required to ensure that assessments can be completed in a full and holistic manner.

Provision of appropriate and proportionate assessment

Assessment under the Care Act 2014 requires local authorities to become more flexible in administering assessments and to develop assessment processes which allow for this both internally and in collaboration with other organisations.

Measurement of efficacy

Whereas the Care Act 2014 defines specified outcomes for service users and carers, the way in which these are met will be highly specific to each individual service user and may create challenges in the ways local authorities monitor and measure the efficacy of service delivery.

Provision of services

Local authorities are expected under the Care Act to promote and shape the local market so as to achieve diverse provision of care and support in their area. This carries with it budgetary implications with regards to commissioning, funding and fee-setting, which must be considered not only in terms of local authority budgets but also in relation to providers' sustainability.¹⁰

Carer support

The Care Act broadens previous definitions of the carer role and requires assessment of support needs for anyone who feels that they fulfil this role.⁶ The challenge for local authorities is to provide sufficient information to all potential carers on their rights to assessment and possible financial support, while managing the potentially increased demand for these assessments and provisions.

Conclusion

Time will tell whether the aspirations of the Care Act are achieved. The emphasis is clear that care should be holistic and empowering; promotion of well-being is at its core. It is hoped that it will develop services that are inclusive, work in a person-centred way, and achieve specific outcomes. The introduction of the Care Act makes this way of working a statutory duty that public services will be measured by. It will be through individual lives and stories that success will be realised.

1.7.52 Dr Robert George (Rob) Jones FRCPsych

: Formerly Honorary Professor of Old Age Psychiatry, University of Nottingham

Tom Denning Tom Arie

date

2017-6

Contents

- *Dr Robert George (Rob) Jones FRCPsych*
– : *Formerly Honorary Professor of Old Age Psychiatry, University of Nottingham*

For over 30 years Rob Jones, who died recently at the age of 69, was a pillar of old age psychiatry in Nottingham and beyond. Qualifying in Manchester in 1970, he trained there in psychiatry and was particularly impressed with David Jolley's work in old age psychiatry. Following research with David Goldberg, he moved in 1980 to Nottingham as senior lecturer in psychiatry in the department of Health Care of the Elderly that Tom Arie had newly set up. This comprised physicians, psychiatrists and other health professions – Rob worked opposite John Bendall, the senior lecturer

in medicine, and was a key figure in the ambitious 1-month combined attachment in old age medicine and psychiatry for all medical students. The novel joint department attracted wide interest, visitors and attached workers coming from home and abroad. Courses in psycho-geriatrics sponsored by the British Council or the World Health Organization brought workers from more than 30 countries to Nottingham and Nottingham staff were often invited abroad. Rob also contributed to a British Council course in Warsaw.

Rob's research included studies of outcomes for care home residents and of community provision; he also participated in major national studies and published widely. He was involved in collaborations that have shaped the practice of old age psychiatry across the UK and internationally. These included the DOMINO-AD clinical trial,¹ which has shown that continuing anti-dementia drugs in people with moderate to severe Alzheimer's disease is worthwhile and does reduce the likelihood of entering a care home at least for a few months.

His most important research was around the care and services for older people with dementia, including, with Ian Rothera and others, a study of life expectancy after entering residential care.² More recently, he provided the psychiatry input into the Medical Crises in Older People programme led by John Gladman. This documented just how many very elderly, frail and vulnerable people are admitted to hospital.³ His later work included studies of care for people with dementia living at home and at the time of his death he was involved in the NIHR Programme Grant PrAISED: Promoting Activity, Independence and Stability in Early Dementia, led by Rowan Harwood.

Rob was a busy clinician and led a district service for older people which served some of the most socially deprived parts of Nottingham, whenever possible taking services to people's own homes. He retired from clinical work in 2013 but continued to be a trustee of the local Radford Care Group, reflecting his passion for the well-being of people living at home, particularly those with dementia. He continued also to work for the university, heading the teaching programme in Health Care of the Elderly until his full retirement in October 2015. Of course, this was not the last we saw of him! He carried on with his research interests, as well as work on public involvement in dementia research – he organised the monthly Centre for Dementia seminars at the Institute of Mental Health. His contributions were recognised by the university with an honorary professorship.

Rob Jones was born in Paignton, Devon, into a family of proud Welsh ancestry. His father edited the local newspaper and this doubtlessly contributed to his insatiable lifelong interest in current affairs. At home he was permanently tuned into BBC Radio 4 and his colleagues were often deeply impressed by his detailed knowledge of world news and politics, to say nothing of lower league football (Torquay United in particular). In Manchester he met Diane and they married in 1971.

Rob was a man of warm and generous personality. He was regarded with respect and affection by all who knew him. His enthusiasm and commitment to the cause of older people was inspiring. For the last 20 years of his career he led academic old age psychiatry in Nottingham, as well as the Trent Dementia Research Network from 2004 until the establishment of the Nottingham Centre for Dementia in 2014. A particular mission was to keep us psychiatrists in close alliance with our colleagues in geriatric medicine, notably through the combined medical student programme. He was especially noted for bundles of papers in carrier bags, festoons of keys and lanyards at his neck, and his characteristic hearty laugh.

Notwithstanding his interest in people, he was quite private. For example, nobody he worked with was aware that Rob had been living with multiple sclerosis for 15 years. Indeed, he completed numerous half marathons during this time. He was definitely not one to complain. After he suffered a myocardial infarction in 2015, we were able to welcome him back to work. It is no surprise, therefore, that his sudden death on 23 May 2016 from a cerebellar haemorrhage came as a blow to all.

He leaves his wife Diane, and his children Haydn, Rhian, David and Siân, along with nine grandchildren.

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1.7.53 Mental Health in the Digital Age: Grave Dangers, Great Promise

Melvyn W. B. Zhang¹

date

2017-6

Contents

- *Mental Health in the Digital Age: Grave Dangers, Great Promise*

Technology has always been a double-edged sword: there are associated risks and benefits. As a practising psychiatrist I increasingly rely on technology at work, using next-generation electronic medical records and at times recommending appropriate smartphone-based applications as additional therapy for my patients.

In contrast to numerous other titles about technology and its impact on healthcare – which have emerged as a result of the massive technical advances in the past decade – *Mental Health in the Digital Age* does not focus only on the benefits of the use of technology in mental healthcare. It offers a timely balanced perspective by also providing an in-depth analysis of the risks.

The risks highlighted in the book are not limited to addictive behaviours such as internet or gaming addiction, but also include cyberbullying and the increased risk of suicide due to pro-suicide websites and suicide pacts. Cyberbullying is perhaps one of the most common problems linked with the use of technology to date and it is not unusual for me and my team to see children and adolescents who refuse to go to school as a result of cyberbullying. Unlike conventional forms of bullying, cyberbullying implies the use of social networks and internet-based messaging services to harass an individual. This work examines not only the prevalence of the problem, but also the various prevention strategies available, such as having a specific academic curriculum to deal with the issue.

The authors review the existing literature comprehensively – referring also to current evidence – and look at the potential of technology across several areas of mental healthcare, including the provision of psychotherapy and the integration of patients' health records. They also discuss how recent advances – such as virtual reality – could in principle be a powerful tool in exposure therapy. As a team with an interest in e-health, my colleagues and I have been developing smartphone applications for various mental health disorders. The introduction of virtual reality technology means that we could perhaps tap on games and various other sensors and headset devices to create an interactive environment not just for psychotherapy but for other forms of interventions too.

This is a good guide for novices in e-health but equally a useful tool for the more experienced in this area. It would be helpful if a future edition included more detailed coverage of smartphone applications and their inherent risks and benefits – a topic of concern not only for clinicians, but patients at large.

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1.7.54 MCQs in Psychiatry for Medical Students

Suzanne Dash¹

date

2017-6

Contents

- *MCQs in Psychiatry for Medical Students*

Love them or loathe them, most medical student written examinations now take the form of multiple choice questions (MCQs). Some medical educators dislike this assessment style, suggesting it encourages students to learn isolated facts in a superficial way. Yet, undeniably, MCQs provide an objective, time-efficient manner of evaluation.

MCQs in Psychiatry for Medical Students is a valuable resource for medical students undertaking their psychiatry rotations. It includes MCQs and extended matching items grouped into chapters concerned either with a type of disorder – for example, psychotic disorders and alcohol and substance misuse disorders – or another important aspect of psychiatry, such as physical health, pharmacological treatments, psychology and psychotherapy.

Each MCQ is accompanied by a paragraph or two explaining the correct answer. More information is provided than is strictly necessary to understand the answer, but this is illuminating rather than turgid. The 400-plus contemporary references encourage the reader to consider issues in more depth than the superficial learning style many associate with MCQs, making the scope of this book potentially greater than is obvious from its title. In contrast, the three extended matching item questions in each chapter are not followed by explanations, making them far less informative.

Writing good MCQ distractor items is a challenge, and in a few places – especially questions on risk factors and protective factors – it is possible to guess the answer by eliminating answers simply based on whether they describe something positive or negative.

This is a must-have title for all medical students; it will pique the interest of many students and may even assist in recruiting future psychiatrists to the profession.

1.7.55 Falls in Scottish homicide: lessons for homicide reduction in mental health patients

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2017-8

Abstract

The sustained fall in Scottish homicide rates follows crime reduction measures informed by the epidemiology of suicide. The violence reduction unit targeted young men carrying knives in public. The restriction of weapons immediately to hand appears to have caused an absolute fall in homicide just as suicide reduction was observed following changes to domestic gas supply. Further homicide reduction may be accomplished in the domestic setting with targeted changes in kitchen knife design in home safety planning for high-risk households. Most commonly homicides involving those in recent contact with mental health services in the UK have domestic characteristics and similar safety planning may be targeted at those with mental disorder and a history of violence.

Contents

- *Falls in Scottish homicide: lessons for homicide reduction in mental health patients*

The sustained fall in Scottish homicide rates to 10.65 per million in 2015–2016 marks a 60% fall in the homicide rate since the peak of 26.3 per million in 2005.^{1,2} The greatest fall in homicide involves encounters between young men in public places. The Violence Reduction Unit, formed in 2005, utilised a public health approach to target young men with educational programmes and stiff penalties aimed at achieving reduction in knife carrying outside the home.³ From 2005 to 2016 police in Scotland recorded a 69% fall in cases of offensive weapon carrying.⁴ From 2008 to 2015, Scottish hospitals saw a 63% fall in admissions and a 50% reduction in deaths arising from assaults with a sharp object.⁵ Limiting the availability of a lethal weapon immediately to hand outside the home has been associated with a dramatic decline in homicide and serious injury.

The targeting of knife carrying in Scotland is an example of situational crime reduction, a highly successful approach inspired by the fall in suicide following changes to domestic gas supply.⁶ The model, aimed at increasing the difficulty of accomplishing a criminal act, arose from observing the marked decline in the UK suicide rate associated with the change from coal gas to natural gas.⁷ A major means of suicide – placing one’s head in an unlit oven and breathing in the gas – abruptly disappeared. Not only was there a dramatic fall in carbon monoxide suicides but a fall in the number of suicides overall. It can be inferred then that there are a group of individuals who, while apparently committed to dying by suicide, can be deviated from a life-ending course of action by a seemingly trivial inconvenience.

Despite the fall in overall Scottish homicides, this has not been observed in homicides associated with those in recent contact with mental health services.⁸ The stereotype of homicides associated with mental disorder involving stranger victims and unusual weapons in public places is false. In a 10-year review of 870 UK homicides carried out by current or recent users of mental health services, the homicide victim was a spouse or ex-spouse in 21% of cases, another family member in 18% and other acquaintances 46%; 15% were stranger victims, as opposed to 24% stranger victims for all homicides.⁸ Similar findings were observed in a 15-year series of 271 homicides carried out by mental health patients in England, where 42% occurred in the shared home of the victim and perpetrator, 25% at the victim’s home and 4% in the perpetrator’s home.⁹ To test the hypothesis that ordinary objects were used in such homicides, this cohort was re-examined: 45% overall involved a knife and of those knives that could be identified 85% were kitchen knives.¹⁰ Homicides associated with mental disorder typically have domestic characteristics, involving family or acquaintances in a domestic setting, not the homicide type targeted in the Scottish campaign.

The evidence would suggest that limiting weapon carrying in public reduces homicides outside the domestic setting, but how can this be achieved within the home where kitchen knives are required? Long sharp-tipped knives have limited specific culinary utility and alternative designs are available.¹¹ One design has an ‘r’ shaped tip and has been

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demonstrated as being as effective as wearing an anti-stab vest in a thrust to the torso (details available from the author on request), although similar benefits to safety may be achieved with a rounded or square tips.

Perhaps murder mythology in fiction and in the news media, with its emphasis on the exceptional and planned murder, obscures the possible benefits to changes to knife design, which may reduce the injury of unplanned acts of impulsive violence within the home.¹² Yet there is media bias for reporting the unusual, stranger homicide involving those with mental disorder.¹³ This obscures the role of promoting home safety measures utilised in domestic violence reduction for those with mental disorder and a history of violence and weapon use. Such a public health approach could be criticised for restricting freedom and would not stop a planned act of violence. Conversely, this may provide a way of generalising the benefits observed in Scotland to a domestic situation. The role of simple barriers to immediate weapon use in homicide reduction may also indicate strategies for violence reduction in other contexts.

The author gratefully acknowledges colleagues at The Orchard Clinic, Edinburgh, for their constructive comments and support.

1.7.56 Evaluation of the 13-item Hypomania Checklist and a brief 3-item manic features questionnaire in primary care

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2017-8

Abstract

Aims and method The mean delay for bipolar disorder diagnosis is 10 years. Identification of patients with previous hypomania is challenging, sometimes resulting in misdiagnosis. The aims of this study were: (a) to estimate the proportion of primary care patients with depression currently taking antidepressants who have undiagnosed bipolar disorder and (b) to compare a brief 3-item manic features questionnaire with the Hypomania Checklist (HCL-13). The sample comprised patients with a recorded diagnosis of depression, either on long-term antidepressant therapy or with previous multiple courses of antidepressants.

Results Of 149 participants assessed, 24 (16.1%) satisfied criteria for bipolar disorder. Areas under the curve (AUC) for the 3-item questionnaire and the HCL-13 were similar (0.79 and 0.72, respectively) but positive predictive values (PPV) were low.

Clinical implications Bipolar disorder may be underdiagnosed in primary care. A 3-item questionnaire could be used by general practitioners to screen for bipolar disorder in their patients with depression.

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Bipolar disorder affects at least 1–2% of the population and is associated with considerable psychosocial impairment.^{1–4} Accurate diagnosis can be difficult because patients tend initially to present in primary care for help with depression rather than with manic features, and many primary care practitioners do not systematically assess for a history of bipolar disorder.^{5–7} Recently the National Institute for Health and Care Excellence (NICE) recommended that all patients in the UK presenting to primary care with depression should be assessed for a history of manic features, specifically ‘previous periods of overactivity or disinhibited behaviour’.⁸

Recent screening studies of bipolar disorder in UK primary care have identified that between 7 and 10% of individuals with depression may have undiagnosed bipolar disorder, usually bipolar disorder type II.^{9,10} It is also the case that individuals with difficult to treat depression and those with poor response to antidepressants are more likely to have unrecognised bipolar disorder.¹¹

In this context, we aimed to estimate unrecognised bipolar disorder within a sample of primary care patients with depression who were taking antidepressant medications, as well as to evaluate the potential clinical utility of two short screening questionnaires for bipolar disorder: the 13-item Hypomania Checklist (HCL-13)¹² and a brief 3-item manic features questionnaire. Our focus on these brief assessment instruments was stimulated by the need for questionnaires that could be used easily in primary care consultations, which are usually no longer than 10–15 min.

Method

Sample

Practice managers of 9 primary care practices in the west of Scotland identified from their databases 2633 patients who (a) had a recorded diagnosis of depression and (b) were either currently taking long-term antidepressants (more than 12 months) or had had 3 or more courses of antidepressants in the past 5 years. Then, 1860 potentially eligible patients were reviewed by their general practitioner (GP) for eligibility and 1833 written invitations were sent by post, with participant information sheets, on behalf of the research team. There were 204 people who responded to this invitation and 151 were interviewed, giving a response rate of 8.23%. The study was approved by the West of Scotland Research Ethics Committee (reference: 13/WS/0071 18th, approval letter dated April 2013).

Assessment measures

A research nurse completed the Structured Clinical Interview for DMS-IV (SCID-1)¹³ in person in order to obtain a gold-standard diagnosis. An assessment of practice notes was also conducted to corroborate findings from the SCID-1 assessment and to clarify medication regimens. Participants completed the HCL-13 and a brief 3-item bipolar screening questionnaire. This 3-item questionnaire (with a maximum score of 6) was based on the three core diagnostic features for bipolar disorder taken from DSM-5: elevated mood, severe irritability and overactivity.¹⁴ The questions and scoring were as follows: Have you ever had a period of time when you were feeling so good, 'high', excited or 'hyper' that other people thought you were not your normal self or you were so 'hyper' that you got into trouble? (Definitely no (score 0), perhaps yes (score 1), definitely yes (score 2).) What about a period of time when you were so irritable that you found yourself shouting at people or starting fights or arguments? (Definitely no (score 0), perhaps yes (score 1), definitely yes (score 2).) What about a period of time when you were physically much more active than usual, for example, when you had lots of different projects on the go at the same time? (Definitely no (score 0), perhaps yes (score 1), definitely yes (score 2).)

Analyses

Analyses included the Student's *t*-test, chi-squared test and chi-squared test for association, and were conducted using SPSS version 21 for Windows. To assess the likely clinical usefulness of the HCL-13 and 3-item questionnaires, in terms of differentiating between bipolar disorder and major depressive disorder (MDD), we calculated sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) using MedCalc and verified these manually. Positive and negative clinical utility measures were calculated using an online calculator constructed by the developer of the MedCalc test (www.psych-oncology.info/cui.html).¹⁵

Results

Of those who had a full diagnostic assessment, two participants were excluded because their SCID results suggested a primary diagnosis of alcohol-related mood problems. In total, 24 participants from our final sample of $n = 149$ had a DMS-IV diagnosis of bipolar disorder (16.1%; 95% CI 10.8–23.2%) and the remainder had a diagnosis of MDD ($n = 125$, 83.9%).

There were no significant differences between the bipolar disorder group and the MDD group in terms of age, gender distribution and socioeconomic status (assessed using the Scottish Index of Multiple Deprivation, SIMD) (*Table 1*). However, as expected, the bipolar disorder group had higher mean scores on the HCL-13 (9.21 *v.* 6.61, $P = 0.001$) and on the 3-item questionnaire (4.79 *v.* 2.88, $P < 0.001$).

Characteristics of participants with major depressive disorder (MDD) and bipolar disorder

	MDD (<i>n</i> = 125)	Bipolar disorder (<i>n</i> = 24)	<i>P</i>
Age, years: mean (s.d.)	47.50 (10.50)	47.58 (8.79)	0.972 <i>a</i>
Females: <i>n</i> (%)	77 (62.6)	15 (62.5)	0.992 <i>b</i>
SIMD 1: <i>n</i> (%) <i>d</i> (most deprived quintile)	56 (45.5)	14 (58.3)	0.705 <i>c</i>
SIMD 2: <i>n</i> (%)	20 (16.3)	2 (8.3)	
SIMD 3: <i>n</i> (%)	15(12.2)	4(16.7)	
SIMD 4: <i>n</i> (%)	13 (10.6)	1 (4.2)	
SIMD 5: <i>n</i> (%) (most affluent quintile)	18 (14.6)	3 (12.5)	
HCL-13: mean (s.d.)	6.61 (3.36)	9.21 (2.77)	0.001 <i>a</i>
3-item questionnaire: mean (s.d.)	2.88 (1.84)	4.79 (1.56)	<0.001 <i>a</i>

HCL-13, Hypomania Checklist 13; SIMD, Scottish Index of Multiple Deprivation.

Student *t*-test.

Chi-squared test.

Chi-squared test for association.

No SIMD data for 1 participant with MDD.

ROC analyses

The receiver operating characteristics (ROC) curves in *Fig. 1* demonstrate that both the HCL-13 and the 3-item questionnaire performed well in terms of differentiating between MDD (*n* = 125) and bipolar disorder (*n* = 24). For the HCL-13, an area under the curve (AUC) of 0.72 (95% CI 0.61–0.84) demonstrates a ‘fair’ overall ability of the questionnaire to discriminate effectively between the two groups. Similarly, an AUC of 0.79 (95% CI 0.69–0.89) for the 3-item questionnaire also demonstrates a ‘fair’ overall ability. An AUC of over 0.80 is considered to demonstrate a ‘good’ overall ability to discriminate.¹⁶

Table 2 presents the sensitivity, specificity, PPV, NPV and likelihood ratio analyses. For the HCL-13, a threshold score of 8 points had a sensitivity of 75.0% and specificity of 55.28% but PPV was low at 24.66%. At a higher threshold of 9 points, the sensitivity was 70.83%, specificity was 63.41%, PPV was 27.42% and NPV was 91.76%. At the lower threshold of 7 points, the sensitivity was 79.17%, specificity was 52.03%, PPV was 24.36% and NPV was 92.75%. Therefore, a threshold of 4 points was chosen to give the best balance between different statistical parameters.

HCL-13 and 3-item questionnaire screening for bipolar disorder

Questionnaire	Threshold	Sensitivity (%) (95% CI)	Specificity (%) (95% CI)	PPV (95% CI)
HCL-13	13 points	4.17 (0.11–21.12)	99.19 (95.55–99.98)	50.00 (1.26–98.7)
	12 points	12.50 (2.66–32.36)	95.12 (89.68–98.19)	33.33 (7.49–70.07)
	11 points	45.83 (25.55–67.18)	87.80 (80.68–93.01)	42.31 (23.35–63.08)

Table 12 – continued from previous page

Questionnaire	Threshold	Sensitivity (%) (95% CI)	Specificity (%) (95% CI)	PPV (95% CI)
10 points	60.50 (40.59–81.20)	78.05 (69.69–85.01)	35.71 (21.55–51.97)	91.43 (84.35–96.00)
9 points	70.83 (48.91–87.38)	63.41 (54.25–71.91)	27.42 (16.85–40.23)	91.76 (83.77–96.00)
8 points	75.00 (53.39–90.23)	55.28 (46.06–64.25)	24.66 (15.32–36.14)	91.89 (83.18–96.00)
7 points	79.17 (57.85–92.87)	52.03 (42.84–61.12)	24.36 (15.35–35.40)	92.75 (83.89–96.00)
6 points	83.33 (62.62–95.26)	36.59 (28.09–45.75)	20.41 (12.93–29.74)	91.84 (80.40–96.00)
5 points	91.67 (73.00–98.97)	24.39 (17.10–32.95)	19.13 (12.39–27.52)	93.75 (79.19–96.00)
4 points	95.83 (78.88–99.89)	16.26 (10.22–23.99)	18.25 (11.94–26.12)	95.75 (79.19–96.00)
3 points	100.00 (87.75–100.00)	15.45 (9.56–23.07)	18.75 (12.40–26.60)	100.00 (82.35–100.00)
2 points	100.00 (85.75–100.00)	15.45 (9.56–23.07)	18.75 (12.40–26.60)	100.00 (82.35–100.00)
1 point	100.00 (85.75–100.00)	11.11 (6.05–18.25)	18.75 (12.40–26.60)	100.00 (75.29–100.00)
3-item questionnaire	6 points	45.83 (25.55–67.18)	88.62 (81.64–93.64)	44.00 (24.40–65.00)
	5 points	66.67 (44.68–84.37)	78.05 (69.69–85.01)	92.31 (85.40–96.00)
	4 points	83.33 (62.62–95.26)	64.23 (55.09–72.67)	95.18 (88.12–96.00)
	3 points	91.67 (73.00–98.97)	43.09 (34.20–52.32)	96.36 (87.47–96.00)
	2 points	95.83 (78.88–99.89)	28.45 (20.69–37.29)	97.22 (85.47–96.00)
	1 point	95.83 (78.88–99.89)	9.76 (5.14–16.42)	92.31 (63.97–96.00)

HCL-13, 13-item Hypomania Checklist; NPV, negative predictive value; PPV, positive predictive value.

Similarly, a threshold score of 4 on the 3-item questionnaire had a sensitivity of 83.33%, specificity of 64.23% and PPV of only 31.25%. At a higher threshold of 5 points, the sensitivity was 66.67%, specificity was 78.05%, PPV was 37.21% and NPV was 92.31%. At a lower threshold of 3 points, sensitivity was 91.67%, specificity was 43.09%, PPV was 23.91% and NPV was 93.36%. Therefore, a threshold of 4 points was chosen to give the best balance between these different parameters.

The positive clinical utility – the ability of the test to confirm cases of bipolar disorder – was poor for both tests. The negative clinical utility a measure of screening and excluding bipolar disorder, was slightly better for the 3-item questionnaire than the HCL-13 at our threshold values: 0.611 (95% CI 0.541–0.682) compared with 0.582 (0.509–0.655). These thresholds were chosen to give the best balance between sensitivity, specificity, PPV, NPV and positive and negative clinical utility

Discussion

One of the goals of this study was to estimate how common DMS-IV bipolar disorders might be in a sample of primary care patients taking antidepressant medication, specifically those patients who were either taking antidepressant therapy for more than 12 months or who had had multiple courses of antidepressants over the preceding 5 years. We found that 16.1% of our sample had bipolar disorder. This rate is higher than in previous literature from the UK. In samples of primary care patients, Hughes *et al*¹⁰ found a prevalence of 7.3% whereas Smith *et al* found a prevalence of 9.6%. Both studies assessed patients with depressive disorder who had been prescribed antidepressant medication. It is possible that the addition in our study of participants who had previously been prescribed multiple courses of antidepressants led to a higher prevalence estimate for bipolar disorder, because unrecognised bipolar disorder is more common in patients with more severe and enduring depression.¹⁷

We also aimed to compare the HCL-13 and a brief 3-item questionnaire in terms of their ability to differentiate between patients with MDD and bipolar disorder. We found that the AUC for HCL-13 was 0.72, while for the 3-item questionnaire it was slightly higher, at 0.79. For both tests the ability to discriminate between MDD and bipolar disorder in terms of sensitivity and specificity was reasonable, but PPVs were low. This is a function of the low prevalence of bipolar disorder in primary care setting, but represents a potential limitation in terms of the usefulness of these instruments to GPs in everyday clinical practice.¹⁸ In a review of brief screening instruments for depressive disorder in a low-income country, Hanlon *et al*¹⁹ concluded that the low PPV at acceptable sensitivity levels may preclude their use in clinical settings.

Nevertheless, we would argue that there may be some use in primary care for these brief screening instruments alongside additional assessments, for example whether patients have a strong family history of mood disorder. The 3-item questionnaire in particular may be useful to GPs in terms of fulfilling the NICE requirement to assess all patients with depression for a history of manic features. The high NPV of 95% means that clinicians may find this useful for excluding a diagnosis of bipolar disorder in their patients with depression. The NICE guidance states that the ideal instrument should be brief, easy to administer and to score, and should be able to be interpreted without extensive and specialist training.⁸

Strengths and limitations

This was a reasonably large study that took a systematic approach to screening patients in primary care settings. We used definitions of bipolar disorder and MDD based on formal diagnostic classifications by using SCID assessment. The study included a range of people from different social backgrounds, with the majority living in some of the most deprived areas of Scotland. However, it may have been helpful to have more baseline demographic information on patients, such as ethnicity, family history of bipolar disorder and age at onset of depression, and the study may be subject to recall bias because it relied on the patient's recall of prior episodes of manic symptoms rather than a corroborative history. There may also be an issue of selection bias, because GPs were able to exclude certain participants if they felt that they were not suitable for this study. As a result of this, and the fact that only one method of recruitment was used in this study, there was a relatively small final sample given the number of invitations sent, which may have led to ascertainment bias. Moreover, the SCID interviewer was not masked to HCL-13 and 3-item scores, which may also have been a source of bias.

Another potential limitation is that the 3-item questionnaire had no requirement for a minimum duration of symptoms. It is possible that individuals with brief periods of affective instability, such as those with borderline personality disorder, would be inclined to respond positively to these questions. Similarly, we did not take a history of alcohol or drug use, and while we did exclude alcohol or substance-induced mood disorders, the use of psychoactive substances could have led to false positives with the 3-item questionnaire.

Clinical implications

A brief 3-item questionnaire may be clinically useful for GPs who wish to screen for manic features in patients with MDD. This could prompt more detailed assessment, such as an appointment with a relative or friend to obtain a collateral history before assessing the need for a referral to secondary care. Further studies are required in larger samples to assess the clinical usefulness of this test in screening, ideally without the issues of recruitment faced in this study. It may also be helpful to develop the 3-item questionnaire further, perhaps with the addition of other items such as the duration of symptoms. While the addition of items would lead to a more statistically sound test, it would also take longer to administer such a test, which may make it less clinically useful.

A proportion of primary care patients with MDD, perhaps as many as 1 in 5, may have undiagnosed bipolar disorder. For busy clinicians working in a time-restricted environment, we suggest that a brief 3-item questionnaire may be a useful screening tool for bipolar disorder and a first step towards a more comprehensive assessment.

1.7.57 Flexible assertive community treatment (FACT) model in specialist psychosis teams: an evaluation

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Abstract

Aims and method The impact of flexible assertive community treatment (FACT) has been observed in people previously supported by assertive community treatment (ACT) teams, but its effect on those previously with a community mental health team (CMHT) has not been studied in the UK. An observational study was conducted of 380 people from 3 CMHTs and 95 people from an ACT team, all with a history of psychosis, following service reconfiguration to 3 FACT teams.

Results People previously with a CMHT required less time in hospital when the FACT model was introduced. A smaller reduction was observed in people coming from the ACT team. Both groups required less crisis resolution home treatment (CRHT) team input.

Clinical implications FACT may be a better model than standard CMHT care for people with a history of psychosis, as a result of reduced need for acute (CRHT and in-patient) services.

Contents

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Recent years have seen a widespread disinvestment from assertive community treatment (ACT), with many teams being merged into generic community mental health teams (CMHTs).^{1,2} Such changes have been criticised for moving away from evidence-based systems, instead adopting untested models of service delivery, with poorer quality care, described in a King's Fund report as 'a leap in the dark'.³ In some cases new services have adopted a flexible ACT (FACT) model, with people able to access intensive support delivered in the community using a team case-load and ACT principles, as and when they require it.^{4,5} In this model, care coordinators manage individual case-loads, but also work together to provide shared care for people at times of increased need, enabling seamless transition between high- and low-intensity care.

An observational study in the UK has not shown negative effects in people previously supported by ACT teams in terms of hospital admissions or need for crisis resolution home treatment team (CRHT) interventions.^{6,7} However, there have been no UK studies assessing whether there could be advantages for people previously supported by a CMHT but now receiving FACT. It might be expected that some people who have not previously had access to periods of more intensive support within the CMHT could benefit from the FACT approach, perhaps with a reduced need to have interventions from a CRHT or hospital admission.

Method

In South Warwickshire there had previously been a single, well-established ACT team, with outcome data over a 10-year period showing a reduced need for time in hospital.⁸ The area was also served by three generic CMHTs and a single early intervention team. The early intervention services were maintained, whereas each of the three CMHTs was divided into a team for people with a history of psychosis (recovery teams) and a team for people with other non-organic mental disorders. At the same time they became 'age-independent', with no upper age limit. The previous ACT team was disbanded and merged into the new recovery teams, which were configured to deliver services using the FACT model. A few months prior to the changes, the ACT team had absorbed a community rehabilitation team and therefore fidelity to the original ACT model had reduced. Characteristics of the ACT, CMHT and FACT teams are shown in *Table 1*.

Characteristics of the different teams

	CMHT	ACT	FACT
Case mix	People with psychotic or non-psychotic disorders	People with history of severe psychosis who have difficulty engaging with traditional services and often with comorbid problems	People with a history of psychosis
Age range, years	17–65 for new referrals, no upper age limit for existing users of the service	17–65 for new referrals, no upper age limit for existing users of the service	17 and upwards for new and existing users of the service
Care planning	Individual case management	Shared care	Individual case management with periods of shared care as needed
Interface with mental health professionals	Referrals made between professionals when needed	All professionals involved in delivery of care without referrals, on a needs-led basis	All professionals involved in delivery of care without referrals, on a needs-led basis
Care coordinator: patient ratio	30	12–15	25

ACT, assertive community treatment; CMHT, community mental health team; FACT, flexible assertive community treatment.

There was no change in acute hospital bed availability during the study period. However, a long-stay rehabilitation ward was closed at about the same time as the other changes took place, with most residents being discharged either to nursing homes or to intensive community placements with 24-hour live-in staff support. This group had been care-coordinated by the ACT team both prior to and following discharge.

The current study was a service evaluation of the new FACT-based recovery teams. It assessed their impact in enabling people to avoid time in hospital, to reduce the use of crisis home treatment support, and to examine how much face-to-face support people received from the new service. There were multiple changes associated with setting up the teams, all of which took place in June 2014. Many people experienced a change in care coordinator and/or consultant, and there were various teething problems with the transition. In order to avoid these becoming confounding variables, we chose to study a 13-month period starting 6 months after the creation of the new services: December 2014 until January 2016. We compared this with a 13-month period in the old services a year earlier (December 2012 until January 2014).

The trust uses a computerised notes system for all staff in the community, which constitutes the sole record of any contacts with clients. It can generate detailed reports on clinical contacts between specified time periods, broken down by team or staff member, and is routinely used for gathering trust performance data. Because people are constantly moving in and out of services, we decided to study only those people who were open to the new FACT service during the 13-month study period, and who had also been in one of the 3 CMHTs or the ACT team during the comparison 13-month period. Because of the closure of the rehabilitation ward, there was potential for a considerable impact on bed use data in the ACT arm of the study – the patients, having spent several years in hospital, were moving to nursing care or 24-hour live-in support. For this reason, we excluded from the bed use analysis those who were being discharged from hospital after several years into nursing or live-in community care.

Results

A total of 475 people who had also been with one of the previous legacy teams the year before were identified as being open to the new service. Of these, 95 had previously been with the ACT team and 380 with one of the CMHTs. Results were analysed separately for these two groups. Tests of significance between the old systems and the new FACT service were carried out using 2-tailed paired *t*-tests or, when data were skewed, using the Wilcoxon signed rank test. A Monte Carlo permutation test, as described by Good⁹ and derived from Fisher,¹⁰ was used when there was no standard statistical method available, such as to compare partially paired data. This type of testing gives a *P*-value directly (much like Fisher's exact test) without an intermediary test statistic such as a *t*-value. To keep the false detection rate (i.e. the overall type 1 error) low at 0.05 on account of multiple testing, we used the Benjamini-Hochberg¹¹ correction, which gave a significance level alpha of 0.0288. This means that *P*-values of less than 0.0288 are significant. Where a significant difference was observed in one group but not in the other, *post hoc* power calculations were carried out in order to check for any potential type 2 errors. Demographic and clinical characteristics of people from the two legacy teams are shown in *Table 2*.

Demographic and clinical characteristics of the cohorts

Previous team	ACT (<i>n</i> = 95)	CMHT (<i>n</i> = 380)
Gender, male: %	66.0	54.2
Age, years: mean	45.3	47.7
Time in services, years: mean	13.7	11.0
ICD-10 diagnosis, %		
Schizophrenia	78.3	53.4
Schizoaffective disorder	16.3	4.7
Bipolar affective disorder	4.3	28.2
Other	1.1	13.8

ACT, assertive community treatment; CMHT, community mental health team.

Face-to-face contacts with the FACT teams

For people previously with the ACT team, the number of face-to-face contacts with a member of the new FACT team reduced from 1.16 to 0.69 per week, with a corresponding reduction in mean duration of contacts from 65 to 38 minutes per person. These differences were statistically significant and are of similar magnitude to the changes observed in the other UK study of FACT.^{6,7} The number of contacts by support workers was not significantly different (0.25 compared with 0.29), but the proportion increased from 22 to 43%. In other words, the reduction of face-to-face contacts in the new FACT system for people previously in the ACT team was a result of less involvement of qualified staff. The number of community-based contacts reduced significantly in the new service, but the proportion was greater, indicating that, overall, more contacts had been lost in clinic settings compared with those in the community. For people previously with a CMHT there was very little difference in number and duration of contacts when the service adopted the FACT model. However, there was greater use of support workers and more contacts were in community settings, consistent with the principles of the FACT model (*Table 3*).

Contacts with FACT team compared with previous service (ACT or CMHT)

Previous team	ACT (<i>n</i> = 95)	CMHT (<i>n</i> = 380)				
Face- to-face c ontacts per week: mean	1.16	0.69	<0 .0001a	0.47	0.45	0 .6018a
Duration, minutes: mean	64.80	38.13	<0 .0001a	26.38	25.33	0 .5544a
By support worker: mean	0.25	0.29	0 .3941a	0.07	0.15	<0 .0001a
By support worker: %	21.45	42.60	<0 .0001b	14.18	33.86	<0 .0001b
In the community: mean	0.74	0.51	0 .0001a	0.25	0.29	0 .0314a
In the community: %	63.81	73.73	0 .0001b	52.42	63.85	<0 .0001b
CRHT use						
People with any face- to-face c ontact: <i>n</i> (mean)	28 (0.29)	16 (0.17)	0 .0023a	128 (0.34)	88 (0.23)	<0 .0001a
Face- to-face c ontacts: mean	5.83	1.94	0 .0237a	7.14	2.83	<0 .0001a
Duration of face- to-face c ontacts per person, minutes: mean	151.87	51.03	0 .0455a	250.98	97.15	<0 .0001a
People with any telephone or face- to-face c ontact: <i>n</i> (mean)	29 (0.31)	23 (0.24)	0 .1584a	134 (0.35)	119 (0.31)	0 .0190a
Hospital use						
Days in hospital: mean	31.76	25.86	0 .7413c	19.34	12.35	0 .0006c
Admissions: mean	0.20	0.12	0 .0776c	0.25	0.18	0 .0535c
People with any admission: <i>n</i>	15	11	0 .3458b	71	52	0 .0388b

ACT, assertive community treatment; CMHT, community mental health team; FACT, flexible assertive community treatment.

2-tailed paired *t*-test.

Monte Carlo permutation test.

2-tailed Wilcoxon.

P>0.0288 not significant (after Benjamini–Hochberg correction).

Contact with the CRHT and hospital use

The number of face-to-face contacts with the CRHT was compared before and after the changes, and significant reductions were seen in both groups. Similarly, the number of people who required any face-to-face support from the CRHT was significantly lower following the changes.

For people who had previously been with the ACT team there was a 19% reduction in number of days spent in hospital, which failed to reach statistical significance. However, the power calculated *post hoc* was only 4%, which indicates that the numbers were insufficient to conclude there was no difference following the change of model. There was also a reduction in mean number of admissions in this group but numbers were too low for a meaningful comparison to be made. In the CMHT group, reductions in bed use were much greater, with a 36% reduction following the introduction of the FACT model, which reached statistical significance. There was also a non-significant reduction in admissions in this group.

Discussion

People previously with a CMHT

There have been no other UK studies exploring the effect of the FACT model on people who had previously been with a CMHT. We observed that these people experienced less than half the number of face-to-face interventions with the CRHT than when they were with a CMHT, which was statistically significant. This is consistent with the FACT philosophy of enabling people to seamlessly move to a high-intensity team approach at times of increased need.¹² Hence, it is possible that during periods of crisis, people were able to receive intensive community support within the FACT team, reducing the need for transfer to the CRHT. Similarly, the reductions in bed use would be consistent with the ability of the FACT model to support people at times of crisis with less need for admission. There were no changes in background bed availability in the services that would provide an alternative explanation for these reductions.

People previously with the ACT team

The other UK evaluation of FACT considered 112 people who had previously been with an ACT service, comparing their hospital and CRHT use before and after the change,^{6,7} but without an appraisal of the impact of people going to FACT from a CMHT. Our findings for people who had previously been supported by the ACT team were similar, with no evidence of adverse consequences in terms of increased need for admission or increased crisis home treatment team contact in the first year. This was despite a considerable reduction in face-to-face support from mental health services. In fact, bed use was reduced, but not significantly, although this has to be interpreted with caution and may not be clinically meaningful as the number of people admitted during the study period was very low.

A possible explanation for this is that a FACT approach could be a more efficient model than ACT because people only receive high-intensity team-based interventions at times of need, freeing up resources for those who most need them. However, our previous follow-up study of the ACT population in South Warwickshire⁸ showed that most people, once they had been with the service for 5 years, reverted to a relatively low level of bed use. The average time with the ACT team had been over 6 years, and by the time the services changed most of these people were relatively stable. Hence, it might be expected that they would cope well with a move to a less intensive service. Any conclusion that there was no evidence of harm when moving from ACT to FACT would therefore be limited to the context of people who have already received a period of several years of intensive ACT interventions.

Limitations

Because there were a number of changes to services, including moving to an ‘age-independent’ model, caution needs to be exercised in interpreting the findings as being solely attributable to the FACT model. One of the limitations of the observational design is the possibility of regression to the mean or background variations which could contribute to reduced hospital use or less contact with the CRHT. Change point analysis can mitigate against this,^{13–15} particularly if combined with start points staggered in time in order to reduce the effect of wider system changes which might influence results. However, because the time period under study was relatively short and the changes in team structure occurred on the same date it was not possible to use this technique. The most robust method for addressing confounding factors would be a randomised controlled trial, but this was beyond the scope of our pragmatic evaluation. The pragmatic method was limited to routinely collected contact data and did not capture more personally meaningful information about satisfaction, social functioning and engagement with services, which are known benefits of ACT.¹⁶

ACT teams have had varying levels of success in terms of achieving fidelity to the model.¹⁷ Without the use of an objective measure, such as the Dartmouth Assertive Community Treatment Scale (DACTS),¹⁸ it is not possible to know with certainty the degree to which the South Warwickshire team was practising according to the ACT principles. Although previous DACTS measures taken several years earlier had shown high fidelity, this had been eroded with less use of shared case-loads and lower staff to patient ratios. Hence, the observations about the outcome for people who had been with the ACT team cannot be extrapolated with certainty to other ACT teams with higher fidelity. This argument also applies to the Firn studies^{6,7} of dismantling ACT teams, which failed to measure ACT fidelity. Although a FACT fidelity scale is available (from The Netherlands),¹² this has never been validated in a UK setting. As Dutch FACT teams also undertake the role of a 24-hour crisis home treatment service, it would not be meaningful to use this scale with a service in the UK, where this function is provided by separate teams.

Conclusions

This is the first study in the UK which has examined the impact of adopting the FACT model on people previously supported by a CMHT within a generic community psychosis service. Although limited by the observational design, the results are consistent with the hypothesis that FACT may be of benefit to this group, who previously did not have access to ACT. People who had been with the CMHT were able to receive increased support delivered with a team case-load at times of increased need, a key component of the FACT approach, thereby reducing their need for the help of the CRHT. We would argue that there is still a case for maintaining ACT teams, which have been much more rigorously assessed than FACT, and that the benefits to patients justify the investment in these services. However, where mental health providers are planning to disband ACT services, there would be value in configuring new teams according to the FACT model, which appears to be a safe alternative in the short term for people who have been with an ACT team for several years.

1.7.58 Burnout and psychiatric morbidity among doctors in the UK: a systematic literature review of prevalence and associated factors

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Abstract

Aims and method To systematically review the prevalence and associated factors of burnout and stress-related psychiatric disorders among UK doctors. An extensive search was conducted of PubMed, EBSCOhost and British medical journals for studies published over a 20-year span measuring the prevalence of psychiatric morbidity (using the General Health Questionnaire) and burnout (using the Maslach Burnout Inventory).

Results Prevalence of psychiatric morbidity ranged from 17 to 52%. Burnout scores for emotional exhaustion ranged from 31 to 54.3%, depersonalisation 17.4 to 44.5% and low personal accomplishment 6 to 39.6%. General practitioners and consultants had the highest scores. Factors significantly associated with increase in the prevalence of burnout and psychiatric morbidity include low job satisfaction, overload, increased hours worked and neuroticism.

Clinical implications The results indicate a worryingly high rate of burnout and psychiatric morbidity among UK doctors, which could have a huge negative impact on healthcare provision in general. Factors at personal and organisational levels contribute to burnout and psychiatric morbidity, and so efforts made to counter these problems should target both levels.

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Doctors have a legal duty broader than that of any other health professional and therefore a responsibility to contribute to the effective running of the organisation in which they work, and to its future direction.¹ In an environment where their health and well-being is not prioritised doctors sometimes become ill, manifesting features of burnout and/or stress-related psychiatric disorders. Such psychiatric morbidity, or ‘caseness’, is detected using self-reported instruments such as the General Health Questionnaire (GHQ).² Doctors also experience ‘burnout’, which is defined as a syndrome of exhaustion, cynicism and low professional efficacy.³ Maslach *et al* described burnout as a prolonged response to chronic emotional and interpersonal stressors on the job, and stated: ‘What started out as important, meaningful, and challenging work becomes unpleasant, unfulfilling, and meaningless. Energy turns into exhaustion, involvement turns into cynicism, and efficacy turns into ineffectiveness’.

Increased prevalence of psychiatric morbidity and burnout has been established in studies from different parts of the

world. A study of Italian physicians found an estimated prevalence of psychiatric morbidity to be 25%, and prevalence of burnout on the emotional exhaustion scale of the Maslach Burnout Inventory (MBI) to be 38.7%.⁵ Other studies have reviewed the factors associated with the development and maintenance of psychiatric illness and burnout among doctors. A survey of Australian doctors found that having medico-legal issues, not taking a holiday in the previous year and working long hours were all significantly associated with psychiatric morbidity.⁶ Self-criticism as a medical student was significantly correlated with psychological stress as a doctor in a cohort followed over 10 years by Firth-Cozens.⁷

Burnout among doctors can lead to self-reported suboptimal patient care,⁸ and to major medical errors.⁹ Psychiatric morbidity increases the likelihood of retirement thoughts and retirement preference.¹⁰ Behavioural responses to burnout established in the literature also include alcohol and drug misuse, physical withdrawal from co-workers, increased absenteeism, arriving for work late and leaving early, and employee turnover.¹¹ An extreme reaction to stress can be suicide, even though the pathway to this is complex and multifactorial. A UK survey of suicides between 1979 and 1983 ranked the medical profession as 10th in the list of high-risk professions.¹²

Mental ill health can be found within every workplace in every country. In the UK the total cost to employers of mental health problems among their staff is estimated at nearly £26 billion each year: £8.4 billion from sickness absences and £15.1 billion from reduced productivity at work.¹³ The National Institute for Health and Care Excellence (NICE) found that promoting the mental well-being of employees can yield economic benefits for the business or organisation, in terms of increased commitment and job satisfaction, staff retention, improved productivity and performance, and reduced staff absenteeism.¹⁴ For the National Health Service (NHS) to reap the benefits described by NICE, priority should be given to employee mental health. However, the constant structural changes to the NHS in England have created instability and lack of job security within the public health workforce.¹⁵ The Health and Social Care Act of 2012 has placed doctors at the centre of clinical commissioning groups in charge of shaping services and made them responsible for £65 billion of the £95 billion NHS commissioning budget.¹⁶ This imposes on doctors, especially general practitioners (GPs), a responsibility unlike any before,¹⁷ one which their training has not prepared them for. The ability to cope with the challenges of working in the NHS and the possibility of stress and burnout were highlighted in the annual meeting of the British Medical Association in 2013,¹⁸ and are the focus of this review.

Numerous research papers document burnout and stress-related psychiatric disorders in doctors worldwide, but none has presented the results in the form of a systematic review showing the prevalence and associated factors among UK doctors. The overall aim of this review was to redress this by assessing the prevalence of burnout and psychiatric morbidity among UK doctors working in different specialties, and to explore the associated identified factors. The objectives were to review the prevalence of the syndrome of burnout and psychiatric morbidity, to explore the nature of the relationship between burnout and psychiatric morbidity, and to identify other factors associated with the development and/or perpetuation of those conditions.

Method

Search strategies

The words 'burnout' and 'doctors' were put into the search field of the EBSCOhost website specifying the following databases: Academic Search Complete, CINAHL Plus, PsycINFO and PsycARTICLES. Limiters activated were: English language, human, apply related words, and a time limit of January 1993 to December 2013. A total of 562 articles resulted from this, reduced to 489 automatically after duplicates were removed; 28 articles were selected for further analysis, and out of these 9 remained based on the study inclusion and exclusion criteria. Using the same parameters but with the words 'psychiatric morbidity' AND 'doctors', a total of 97 articles were generated, reduced to 77 after the removal of duplicates, and from these only 1 was selected as new and appropriate. Again using the same parameters but with the words 'stress' AND 'doctors' NOT 'nurses', 3560 articles came up, reduced to 2259 after duplicates were removed; 23 new articles were reviewed in greater detail, and from these 5 new and appropriate articles were selected.

An advanced search on PubMed with the words 'doctors' OR 'physicians' AND 'stress', with a time limit of 1 January 1980 to 15 December 2013 and other limits (human, English language, clinical trial, journal article, reviews, lectures) generated 5973 articles. After careful analysis of the abstracts 28 new articles were identified for more detailed review, and from these 10 were selected as new and appropriate.

Two searches within the group of British medical journals with the phrases ‘burnout and doctors’ and ‘doctors and stress’ with the time limit of January 1993 to December 2013 yielded two new and appropriate papers.

A review of the reference lists of already-identified papers yielded three relevant papers.

Altogether, this extensive search yielded 30 relevant papers which were included in the units of analysis for this review (*Fig. 1*).

Fig. 10: Flowchart of the study selection process.

Inclusion criteria

Certain criteria had to be met before a study was included in the units of analysis: it had to answer any of the research questions for the measurement of the prevalence of psychiatric morbidity the study had to have used any version of the GHQ, and for the prevalence of burnout syndrome only the MBI was considered population group – only medical doctors in the UK irrespective of which organisation they work in minimum sample size of 50 published between January 1993 and December 2013 published in the English language.

The questionnaires

The GHQ is a well-validated and widely used screening tool for the detection of minor psychiatric disorders (psychiatric morbidity) in the general population.¹⁹ The GHQ-12 is self-administered and only takes about 5min to complete. It enquires about the experience of psychosocial and somatic symptoms in recent weeks. Each of the 12 items is measured on a 4-point Likert scale. Studies validating the GHQ-12 against standardised psychiatric interviews indicate that a cut-off score of 4 or above indicates a high probability that the individual suffers from a clinically significant level of distress (‘caseness’ or psychiatric morbidity).

The MBI is a 22-item self-report questionnaire, which is well recognised and widely used to measure burnout in relation to occupational stress.²⁰ It has three subscales: personal accomplishment (measured by 8 items), depersonalisation (measured by 9 items) and emotional exhaustion (measured by 5 items). Responses are rated for each item according to frequency on a 7-point scale from ‘never’ to ‘every day’. The total score for each subscale is categorised ‘low’, ‘average’ or ‘high’ according to predetermined cut-off scores, based on normative data from a sample of American health professionals. A high degree of burnout is indicated by high scores on the emotional exhaustion and depersonalisation subscales and low scores on the personal accomplishment subscale.

Data extraction

A simple paper data extraction tool was created in Microsoft Word, and the tables from this have been used to portray the results in the results section. Data were extracted by the author over the months of November and December 2013.

Results

A total of 30 papers considered relevant and appropriate based on the study inclusion and exclusion criteria were included in this review. *Table 1* summarises these papers.

Units of analysis included in this review

Study	Journal	Running head	Subs pecialty/grade
Sharma <i>et al</i> (2008) ²¹	<i>Ps ycho-Oncology</i>	Stress and burnout in colorectal and vascular surgical consultants	Surge ry/consultants
Ramirez <i>et al</i> (1996) ²²	<i>Lancet</i>	Mental health of hospital consultants: the effects of stress and	Surgery, gastro, oncology, radiology consultants
Wall <i>et al</i> (1997) ²³	<i>British Journal of Psychiatry</i>	Minor psychiatric disorder in NHS trust staff: occupational	Non-specific
Ramirez <i>et al</i> (1995) ²⁴	<i>British Journal of Cancer</i>	Burnout and psychiatric disorder among cancer clinicians	Oncology/consultants
Sharma <i>et al</i> (2007) ²⁵	<i>Colorectal Disease</i>	Stress and burnout among colorectal surgeons and	Surge ry/consultants
Kapur <i>et al</i> (1999) ²⁶	<i>Family Practice</i>	Sources of job satisfaction and psychological distress in	GP, medical house officer
Guthrie <i>et al</i> (1999) ²⁷	<i>BJPsych Bulletin</i>	Sources of stress, psychological distress and burnout	Psychiatry/non-specific
Benbow & Jolley (2002) ²⁸	• <i>International* Journal of Geriatric Psychiatry</i>	Burnout and stress amongst old age psychiatrists	Psychiatry/consultants
Orton <i>et al</i> (2012) ²⁹	<i>BMJ Open</i>	Depersonalised doctors: a cross-sectional study of 564 doctors	GP
McManus <i>et al</i> (2002) ³⁰	<i>Lancet</i>	The causal links between stress and burnout in a longitudinal study of UK	Non-specific
Kirwan & Armstrong (1995) ³¹	<i>British Journal of General Practice</i>	Investigation of burnout in a sample of British general practitioners	GP
Kapur <i>et al</i> (1998) ³²	<i>BMJ</i>	Psychological morbidity and job satisfaction in hospital consultants	Consultants/junior HO
Coomber <i>et al</i> (2002) ³³	<i>British Journal of Anaesthesia</i>	Stress in UK intensive care unit doctors	Intensive care/consultants

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Table 13 – continued from previous page

Study	Journal	Running head	Subs pecialty/grade
Appleton <i>et al</i> (1998) ³⁴	<i>British Journal of General Practice</i>	A survey of job satisfaction, sources of stress and psychological	GP
Newbury-Birch & Kamali (2001) ³⁵	<i>Postgraduate Medical Journal</i>	Psychological stress, anxiety, depression, job satisfaction	Junior HO
Cartwright <i>et al</i> (2002) ³⁶	<i>Journal of Clinical Pathology</i>	Workload and stress in consultant medical microbiologists	Microbiology/virology consultants
Caplan (1994) ³⁷	<i>BMJ</i>	Stress, anxiety, and depression in hospital consultants, general	Consultants (non-specific), GP
Burbeck <i>et al</i> (2002) ³⁸	<i>Emergency Medicine Journal</i>	Occupational stress in consultants in accident and emergency	Emergency medicine/consultants
Soler <i>et al</i> (2008) ³⁹	<i>Family Practice</i>	Burnout in European family doctors: the EGPRN study	GP
Bogg <i>et al</i> (2001) ⁴⁰	<i>Medical Education</i>	Training, job demands and mental health of pre-registration	Pre-registration HO
Upton <i>et al</i> (2012) ⁴¹	<i>Surgery</i>	The experience of burnout across different surgical specialties	Surge ry/consultants
Sochos & Bowers (2012) ⁴²	<i>The European Journal of Psychiatry</i>	Burnout, occupational stressors, and social support in psychiatric	Psychiatry, medicine/ senior HO
McManus <i>et al</i> (2004) ⁴³	<i>BMC Medicine</i>	Stress, burnout and doctors' attitudes to work are determined	Non-specific
Paice <i>et al</i> (2002) ⁴⁴	<i>Medical Education</i>	Stressful incidents, stress and coping strategies in the pre-registration	Pre-registration HO
Tattersall <i>et al</i> (1999) ⁴⁵	<i>Stress Medicine</i>	Stress and coping in hospital doctors	Non-specific
McManus <i>et al</i> (2011) ⁴⁶	<i>BMC Medicine</i>	Vocation and avocation: leisure activities correlate with professional	Non-specific

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Table 13 – continued from previous page

Study	Journal	Running head	Subs pecialty/grade
Deary <i>et al</i> (1996) ⁴⁷	<i>British Journal of Psychology</i>	Models of job-related stress and personal achievement among	Consultants
Thompson <i>et al</i> (2009) ⁴⁸	<i>The Clinical Teacher</i>	Contemporary experience of stress in UK foundation doctors	Foundation doctors
Berman <i>et al</i> (2007) ⁴⁹	<i>Clinical Medicine</i>	Occupational stress in palliative medicine, medical oncology	Oncology and palliative medicine registrars
Taylor <i>et al</i> (2005) ⁵⁰	<i>Lancet</i>	Changes in mental health of UK hospital consultants	Consultants

GP, general practitioner; HO, house officer.

Findings on prevalence

Seven studies ^{21,22,24,25,27,30,50} had quantifiable data on the prevalence of both psychiatric morbidity and burnout (an in-depth analysis of studies reviewed in this paper is included in an online data supplement to this article). Altogether 22 studies reported on prevalence of psychiatric morbidity, and the range was 17–52% (average 31%). GPs and consultants had the highest scores. Fourteen studies had burnout scores, with nine reporting scores as percentages and five as mean scores; one study ²⁸ had both percentage and mean burnout scores. For emotional exhaustion the scores ranged from 31 to 54.3% and mean scores ranged from 2.90 to 31.26; for depersonalisation the scores ranged from 17.4 to 44.5% (1.95–15.68) and for low personal accomplishment the range was 6–39.6% (4.36–34.21). GPs, consultants and pre-registration house officers had the highest levels of burnout in the studies.

McManus *et al*, ⁴⁶ in a UK-wide study carried out in 2009, had the largest sample size at 2845 doctors and reported prevalence of psychiatric morbidity at 19.2%. The other two UK-wide studies with samples of over 1000 cutting across specialties and grades ^{23,43} reported psychiatric morbidity prevalence rates of 27.8% and 21.3%, respectively. Taylor *et al* ⁵⁰ reviewed 1308 consultants from different specialties and found the prevalence of psychiatric morbidity to be 32%.

One longitudinal study ³⁰ found no significant increase in the prevalence of psychiatric morbidity over 3 years in a non-specific group of doctors. Another longitudinal study ⁵⁰ found a significant increase in psychiatric morbidity and emotional exhaustion among consultants over 8 years.

The only European Union (EU) study looking at the prevalence of burnout in GPs from 12 EU countries ³⁹ found lower average scores on all burnout scales compared with those of English GPs.

Findings on associated factors

Job satisfaction was found to be protective against the effect of stress on emotional exhaustion. The number of hours worked, job stress and overload were associated with increased psychiatric morbidity in eight studies. Two studies^{22,38} found that women had significantly higher psychiatric morbidity than men, but three studies^{27,34,45} did not find any association with gender. The personality trait of neuroticism was significantly associated with increase in psychiatric morbidity in three studies,^{35,43,47} while conscientiousness was a protective factor. Psychiatric morbidity was also positively associated with taking work home and with the effect of stress on family life.

Job satisfaction was negatively correlated with burnout in three studies.^{21,22,25} Age was an interesting factor; increased depersonalisation was found in younger doctors in five studies,^{21,22,27,29,31} whereas emotional exhaustion increased with age in two studies.^{22,41} Being single was associated with increased burnout scores, and neuroticism increased burnout significantly in two studies.^{43,47} Increased job stress and workload increased burnout in three studies, with significantly lower emotional exhaustion scores in part-time GPs.

Findings on the direct relationship between burnout and psychiatric morbidity

Three studies^{25,30,46} found significant positive correlations between psychiatric morbidity as measured by the GHQ, and burnout syndrome. Using the process of casual modelling, McManus *et al*³⁰ found that when scores were considered in 1997 and later in 2000, emotional exhaustion increased psychiatric morbidity, and *vice versa*. Personal accomplishment increased emotional exhaustion directly, and increased psychiatric morbidity directly but also indirectly through increasing emotional exhaustion. When other mental health problems were considered, anxiety and depression were found to increase psychiatric morbidity in three studies,^{35,37,38} and depression increased depersonalisation.⁴¹

Discussion

The findings indicate that the prevalence of psychiatric morbidity among UK doctors is quite high, ranging from 17 to 52%. This compares unfavourably with the results from a longitudinal survey of people living in private households within the UK, which found an 18-month period prevalence of common mental disorders to be 21%.⁵¹ Only 4 of the 22 studies that reported on psychiatric morbidity found prevalence of less than 21%,^{26,30,32,46} which is slightly better than 27% found in a study of palliative care physicians in Western Australia.⁵² An earlier study of junior house officers in the UK found psychiatric morbidity in 50% of doctors,⁵³ but this was in a period when the working pattern of junior doctors was relatively unregulated. More recent studies of junior doctors contained in this review found the prevalence of psychiatric morbidity to be around 19%.^{26,32} Concern over increasing prevalence of common psychiatric illnesses was borne out by the results from the study which found a 5% increase in morbidity among a cohort of consultants over an 8-year period.⁵⁰

This review also found a high prevalence of burnout among UK doctors measured using the MBI. It lends further support to the growing body of evidence which has found the syndrome of burnout to be prevalent all over the world among health professionals. In a sample of Australian doctors, 24% suffered burnout;⁵² in a New Zealand sample of medical consultants one in five did;⁵⁴ and in a cross-section of Japanese doctors 19% were affected.⁵⁵ This review found even higher rates of burnout, with the prevalence of emotional exhaustion ranging from 31 to 54.3%, which would suggest UK doctors are comparatively more prone to burnout. GPs generally had higher scores for burnout,²⁹ particularly in the study of European family doctors,³⁹ which found that the only countries in which GPs had higher burnout scores than England were Turkey, Italy, Bulgaria and Greece. Emotional exhaustion among a cohort of consultants was shown to have increased over an 8-year period,⁵⁰ with a prevalence of 41% in 2002.

This review has been able to pool together different studies which report on factors associated with the development and perpetuation of psychiatric morbidity and burnout. Neuroticism was positively and significantly correlated with psychological distress and burnout in three studies.^{35,43,47} Neuroticism refers to a lack of psychological adjustment and instability leading to a tendency to be stress-prone, anxious, depressed and insecure, and it has been shown to negatively predict extrinsic career success.⁵⁶ McManus *et al*,⁴³ in a 12-year longitudinal study on a cohort of students who started studying medicine in 1990, found that doctors who are more stressed and emotionally exhausted showed

higher levels of neuroticism all through their careers. Neuroticism was also positively associated with perceived high workload. The researchers concluded that neuroticism was not only a correlate but a cause of work-related stress and burnout. Similar findings were noted by Clarke & Singh⁵⁷ in a study looking at the pessimistic explanatory style of processing information, which is a manifestation of neuroticism. In that study neuroticism was shown to positively predict psychological distress in doctors, and the authors recommended that susceptible doctors should be offered cognitive-behavioural therapy (CBT) to alter their explanatory style.

In an editorial titled ‘Why are doctors so unhappy?’ Richard Smith stated that the most obvious cause of doctors’ unhappiness was that they feel overworked and under-supported.⁵⁸ Job stress, feeling overloaded and the number of hours worked were positively linked to psychiatric ‘caseness’ and burnout in many of the studies in the present review, and this cut across specialties and grades. A General Medical Council (GMQ survey⁵⁹ of doctors in training found that 22% felt their working pattern leaves them short of sleep at work, and 59% said they regularly worked beyond their rostered hours. Increasing job stress without a commensurate increase in job satisfaction was associated with the presence of psychiatric morbidity, and job satisfaction was also positively correlated with illness in six of the reviewed studies^{21,22,25,34–36}. Another significant finding was the correlation between psychiatric disorders and burnout, with the two feeding off each other, leading to worsening outcomes.

The public health importance of these findings cannot be overemphasised. GPs are at the frontline of healthcare delivery in the UK, and around 90% of all NHS contacts take place in primary care, with nearly 300 million GP consultations a year.⁶⁰ The estimated total number of GP consultations in England rose from 217.3 million in 1995 to 300.4 million in 2008, with a trebling of telephone consultations, and with the highest consultation rates among the growing population of elderly individuals.⁶¹ Increased live births of over 110 000 over the past 10 years,⁶² and an ageing population⁶³ have contributed to the pressure felt by services in general. However, in spite of the increased demand on primary care services, the proportion of the NHS budget that is spent on general practice has slumped to record levels, and GPs report that this has compromised the quality of care they can provide.⁶⁴ Under these circumstances, the added expectation from the UK Department of Health that GP surgeries should open for longer hours and should expand patient choice will undoubtedly lead to even more psychological distress and burnout among GPs.

A government-driven emphasis in the NHS on performance management and targets increases job demands and stress among managers,⁶⁵ and increases psychiatric morbidity among doctors. The current climate of austerity in the UK, and the expectation that doctors should continue to provide high-quality care to patients within an NHS intending to make £20 billion worth of savings,⁶⁶ further expose doctors to burnout and stress. Psychiatrists are already having to deal with the expected increase in demand for mental health services stemming from the economic downturn,⁶⁷ and the increase in suicide rates⁶⁸ among the working-age population. Psychiatrists are particularly vulnerable to burnout, and patient suicide is a factor significantly associated with stress and burnout in this group⁶⁹.

Burnout among doctors can affect the entire public health workforce because as a syndrome it is considered ‘contagious’.⁴ With the push for doctors to take up leadership positions at every level within the NHS a burnt-out doctor can negatively affect the entire healthcare delivery system. Unhealthy coping strategies in response to burnout and stress were identified in this review: these include retiring early, taking work home, taking it out on family, mixing less with friends, and avoidance, all of which work against the development of a healthy work-life balance.

Limitations

Some key limitations are worth highlighting. First, all the studies were cross-sectional surveys using questionnaires sent to the participants online or by post. Response rates varied, with some as low as 17%, and only in half of the studies was effort made to increase the response rate by sending reminders or repeat questionnaires. Non-response bias could have affected the results. Second, although the MBI was used in all the studies examining burnout, different versions of the MBI were utilised. With the GHQ some studies used the 28-item version but most used the 12-item version. The cut-off for ‘caseness’ using the GHQ also differed between studies and ranged between 3 and 5. However, these differences may not have significantly affected the overall findings given that a study to validate the two versions of the GHQ found no difference between them, and also established that the different cut-off for ‘caseness’ did not affect the questionnaire’s validity.²

The cross-sectional method used for the surveys makes it difficult to draw a firm conclusion on the outcomes from

a cause and effect perspective. Also, the number of potential confounders for the presence of burnout and common psychiatric disorders is vast and cannot be controlled for in surveys alone.

The fact that this literature review ends in 2013 may be considered a limitation, but the hope is that this paper will trigger more research in this area, and the author's intention is to update the literature review by 2023.

Recommendations

Doctors are ultimately responsible for the quality of care they provide at any time, and they need to be aware of their own vulnerability to burnout and psychiatric illness, and of their impact on patient care. Traditionally, doctors take pride in working a lot of hours,⁷⁰ and are 3 to 4 times less likely to take days off sick compared with other health professionals;⁷¹ this combination is a recipe for burnout. A whole list of support networks is available on the GMC website,⁷² and doctors should be encouraged to utilise these. However, there is a 'culture of fear' among doctors regarding the GMC, and 96 doctors, a lot of whom had mental health problems, have died by suicide since 2004 while being investigated by the GMC.⁷³ A lot more work is therefore needed to make the most vulnerable doctors feel supported.

At an organisational level, approaches designed to reduce the workload of doctors should be prioritised. Changes to doctors' contract of service should reflect an understanding of the impact of work-related factors on the health and well-being of doctors, and any such contract should contain the necessary protections to reduce the experience of psychiatric illness and burnout. The benefits of a healthy workforce on the quality of care provided in the NHS cannot be overstated.

1.7.59 The impact of transforming care on the care and safety of patients with intellectual disabilities and forensic needs

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Abstract

NHS England recently published a national plan to develop community services for people with intellectual disabilities and autism who display challenging behaviour by using resources from the closure of a large number of hospital beds. An ambitious timescale has been set to implement this plan. The bed closure programme is moving ahead rapidly, but there has been little progress in developing community services to support it. This paper discusses the impact of the gap between policy and practice on the care and safety of patients with intellectual disabilities and forensic needs who form a distinct subgroup of the target population and are being disproportionately affected by this government policy.

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 - *The policy context*
 - *Lack of investment in community services*
 - *The effects of Transforming Care*
 - *Discussion and conclusions*

The policy context

Building the Right Support, a national plan to develop community services and close hospital beds for people with intellectual disabilities and autism who ‘display behaviour that challenges’ (p. 4), was published last October by NHS England and its local authority partners.¹ The genesis of this plan was the Winterbourne View scandal in 2011, which involved the systematic abuse of people with intellectual disabilities in an independent sector hospital unit run by Castlebeck Care in Bristol, England.² This led to a concordat that committed the Department of Health to a rapid reduction in the number of people with intellectual disabilities and challenging behaviour in hospital beds by mid-2014.³ Under pressure from politicians and stakeholder groups, who claimed that the government had failed to deliver on its concordat promises and that the situation had worsened,⁴ the chief executive of the National Health Service (NHS) committed to a 2-year intellectual disability hospital closure programme during a parliamentary select committee hearing on services for people with intellectual disabilities and challenging behaviour in early 2015.⁵

The ensuing national plan includes the closure of 45–65% of local clinical commissioning group (CCG)-commissioned and 25–40% of NHS England national specialist-commissioned in-patient beds by 2018. This is a ‘starting point’ and commissioners are encouraged to be ‘ambitious in thinking about how much further they can go’ (p. 6; unless stated otherwise, all quotations in this commentary are from *Building the Right Support* document¹). The rationale for these numbers and timescale is unclear beyond what NHS commissioners and local authorities have told the plan’s authors ‘they believe is possible’, which was then ‘sense-checked’ against geographical variations in current in-patient service usage (p. 27). The money saved from these bed closures is to be reinvested in the development of community services (p. 6). The national plan is clear that this transition will involve significant costs. It is stated that commissioners ‘will need to invest in new community support *before* closing inpatient provision’ (p. 7, italics added). Also required is the ‘temporary double running of services as inpatient facilities continue to be funded whilst new community services are established’ (p. 44). Local Transforming Care partnerships were tasked with drawing up implementation plans to support a new model of care and to start delivering against these plans by 1 April 2016.

Lack of investment in community services

Unfortunately, little progress appears to have been made in agreeing, let alone implementing, new community service models to support the bed closure plans as envisaged in the national plan. The current authors work clinically with patients with intellectual and developmental disabilities who display offending and offending-type behaviours in inpatient and community services across six CCG areas in the north-east of England. As a group we have been closely involved in initiatives to increase hospital discharge rates and reduce readmissions, bed numbers and lengths of stay as well as to support and strengthen community services for people with intellectual disabilities who are at risk of offending. These innovations pre-date the Transforming Care programme and have already led to the closure of two inpatient units and a number of satellite beds in our services (40 beds in total). Despite our engagement and commitment to this transformation process we are concerned about the impact of the national plan, and the manner in which it is being implemented locally on patient care, patient safety and the safety of others.

The North East and Cumbria is one of six ‘fast-track areas’ in the national plan, set up with £2.06 million support from the NHS England Transforming Care programme to ‘help fund transitional costs and speed up implementation’

(p. 12). Fast-track areas aim to reduce in-patient bed usage by around 50% within 3 years, thereby ‘freeing up tens of millions of pounds which will be invested in community-based support to prevent hospital admissions’ (p. 13). The North East and Cumbria service model, which aims to deliver a 50% reduction in in-patient admissions, is currently in draft form and the ‘new community model’ embedded within the overall service model is not due to be considered by the North East and Cumbria Transforming Care Board until September 2016 at the earliest. Once the model is agreed, implementation plans will need to be developed, and resources including people and funds will need to be identified to enable it to be initiated. Judging by the pace of progress to date, this is likely to take considerable time. In the meantime, plans for in-patient bed closures are progressing rapidly, with 31 out of 112 beds (35%) across our medium- and low-secure and locked rehabilitation services currently empty as part of the closure programme.

The effects of Transforming Care

The impact on patient care and safety of the drive to close in-patient beds without first having developed or strengthened community services is already beginning to show locally. The population served by these in-patient services, in contrast to the intended target population, is relatively high functioning intellectually (that is, mild/borderline in intellectual disability terms),⁶ shows high levels of psychiatric comorbidity⁷ and personality disorder characteristics,⁸ and generally does not display ‘behaviour that challenges’, but outwardly directed high-impact offending behaviour that has resulted in criminal convictions and/or detention under the Mental Health Act 1983 on the basis of ‘abnormally aggressive’ and/or ‘seriously irresponsible’ behaviour. Chief among the behaviours that bring these patients into these services are serious violence and aggression, sex offences, damage to property and firesetting.⁹ The most recent national census data reflect this offending behaviour profile, in that 33% of patients with intellectual disabilities detained under the Mental Health Act in England are subject to Part III criminal sections, and 21% of that group are subject to Ministry of Justice restrictions, meaning that they cannot be discharged without the approval of the Secretary of State or a mental health tribunal.¹⁰ Just 17% of in-patients with intellectual disabilities in the census were informal – that is, not detained under the Act.

The imperative to empty and then close in-patient beds has resulted in pressure being applied on clinical teams through commissioner-led ‘care and treatment reviews’¹¹ to provide discharge dates for some forensic patients who continue to present levels of risk that local service providers and community teams are not adequately resourced to manage, or to consider transfers from NHS to independent hospital beds. Some evidence for the movement of patients around the in-patient system – possibly to create the illusion of progress – comes from a recent update from the NHS England Director of Transformation – Learning Disabilities,¹² who reported that in April 2016, 20 of the net 100 recorded discharges were in fact transfers to other hospitals, and the destination of a further 20 discharged patients was unknown.

There is also concern that owing to the pressure to discharge as quickly as possible to meet the national plan targets, patients’ rehabilitation is being hurried and/or truncated, resulting in some people being discharged before they are ready to take on the challenges of living in the wider community, or without the receiving community services being properly prepared to manage the risks these patients continue to present. The high level of clinical complexity and associated forensic risk in this population can require a significant period of assessment, formulation and specialist treatment to help patients develop thinking styles and attitudes, emotional control strategies and lifestyles less compatible with offending behaviour. A carefully considered and planned period of pre-discharge preparation is an important component of the treatment pathway and is essential to facilitating a successful transition from hospital to community care.

Another consequence of the current rapid bed closure policy is that people with intellectual disabilities and forensic needs who require urgent hospital treatment are being admitted to generic psychiatric services. This includes patients who have been previously detained in hospital under the Mental Health Act 1983 and discharged on community treatment orders, and who have been subsequently formally recalled to hospital owing to escalating risks of harm to themselves or others. Admission to acute psychiatry units can result in these patients being targeted and exploited by more able patients. In addition, they are unable to access appropriate assessment and treatment as the staff teams in these services have little or no experience of working with this population and lack the specialist skills required.¹³ This will result in longer periods of in-patient admission for these patients as access to suitable interventions aimed at reducing forensic risks is delayed.

One aim of the Transforming Care programme is to prevent people with intellectual disabilities and challenging

behaviours from undergoing unnecessary admissions to intellectual disability and mental health in-patient services. Whether an admission is necessary or not is inevitably a matter of judgement. With the requirement for commissioner agreement to admission, there is a real risk of the judgement of clinicians being circumvented. Efforts to prevent admission to hospital by increasing supervision and support to people in community settings to manage emerging risks have paradoxically resulted in situations amounting to *de facto* deprivation of liberty in some cases, where a short informal hospital admission to allow the risks to be assessed and required amendments made to care plans would have been a less restrictive and more clinically effective option.

Discussion and conclusions

People with intellectual disabilities who require treatment in hospital for behavioural, psychiatric and forensic problems should have access to the best evidence-based interventions available, delivered by caring staff with positive attitudes and person-centred values, in good-quality, safe environments. It is clear that a disproportionate number of people with intellectual disabilities are detained in hospital under the Mental Health Act ¹⁴ and, once detained, they have on average longer lengths of stay than detained patients who do not have intellectual disability. ¹⁵ The *Building the Right Support* national plan aims to address these inequities, albeit based on uncertain evidence and questionable assumptions.

There is no credible evidence or analysis presented to support the proposed bed reduction numbers. Between 1988 and 2015 the number of intellectual disability beds in the NHS reduced dramatically, from approximately 33 000 to about 2500. ¹ It is debatable whether this 90%-plus reduction over the past 30 years has been caused by centrally driven government policy initiatives, for example *Valuing People*, ¹⁶ or the impact of human services theories, such as social role valorisation, ¹⁷ on the deinstitutionalisation and community care movements in the 1980s and 90s. ¹⁸ Either way, looking at the most recent census of in-patient services for people with intellectual disabilities in England, ¹⁰ 83% were legally detained under the Mental Health Act 1983, with all of the scrutiny and protections this affords via mental health tribunals, hospital managers' hearings and Care Quality Commission inspections. It could be argued therefore that the majority of the remaining intellectual disability in-patient beds represent equipoise in the system and, as such, the current huge diversion of resources into forcing the closure of these remaining beds is unlikely to be successful in the long term.

The national plan starts from the supposition that all people with intellectual disabilities 'should have a home within their community' (p. 4). Seemingly underpinning this position is a belief that families and the community are always better for people with intellectual disabilities and that hospital services do not provide safety and sanctuary for some people. For many of our patients with forensic needs, their histories indicate that families and the community can be part of the problem rather than the solution. Putting to one side the fact that communities are generally not keen to embrace people who might have violently or sexually assaulted people in their midst, or set fire to their buildings, people with disabilities frequently experience abuse, aggression and violence in and by the community. ¹⁹ There are many examples of people like Brent Martin, who was brutally murdered in 2007 by his more able 'friends' in Sunderland 3 months after being discharged from hospital. ²⁰

A further assumption underpinning the national plan is that hospital admissions should be as short as possible. There is an apparent lack of understanding that the population managed and treated by in-patient forensic intellectual disability services is distinct from the population envisaged within the Transforming Care programme. Patients with significant forensic histories have frequently experienced high levels of abuse, neglect and deprivation. They require time to develop insight into their difficulties in relating to others, acquire skills in regulating their emotions and acknowledge their future support needs. The application of a bed closure policy and as yet unclear community service model that is designed for a very different population carries significant risks of harm for patients with intellectual disabilities and forensic needs, as well as for others. The implementation of that policy without the required and promised investment in and development of community services is especially concerning. Some of the unintended consequences of this approach might include more vulnerable offenders with intellectual disabilities being sent to prison rather than diverted to hospital for appropriate treatment as recommended in the Bradley Report ²¹ While imprisoned, such offenders will likely be targeted by other prisoners because of their disabilities and will remain at risk of re-offending, as they will be unable to access prison offending behaviour programmes ²² Finally, it is perhaps ironic that this policy will possibly lead to an increase in the use of independent sector hospital beds for people with intellectual disabilities – exactly where this all started.

1.7.60 Prevent: what is pre-criminal space?

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Abstract

Prevent is a UK-wide programme within the government's anti-terrorism strategy aimed at stopping individuals from supporting or taking part in terrorist activities. NHS England's Prevent Training and Competencies Framework requires health professionals to understand the concept of pre-criminal space. This article examines pre-criminal space, a new term which refers to a period of time during which a person is referred to a specific Prevent-related safeguarding panel, Channel. It is unclear what the concept of pre-criminal space adds to the Prevent programme. The term should be either clarified or removed from the Framework.

Contents

- *Prevent: what is pre-criminal space?*
 - *Pre-criminal space in the NHS England Framework*
 - *Coining of 'pre-criminal space'*
 - *Denotation and connotation*
 - *The derivation of pre-criminal space*
 - *Rhetoric*
 - *Opinion*

The Prevent Training and Competencies Framework¹ begins thus: “Prevent is part of the Government's counter-terrorism strategy CONTEST and aims to stop people becoming terrorists or supporting terrorism; as such it is described as the only long term solution to the threat we face from terrorism. Prevent focuses on all forms of terrorism and operates in a pre-criminal space, providing support and redirection to vulnerable individuals at risk of being groomed in to terrorist activity before any crimes are committed. Radicalisation is comparable to other forms of exploitation; it is therefore a safeguarding issue staff working in the health sector must be aware of. [...] Staff must be able to recognise signs of radicalisation and be confident in referring individuals who can then receive support in the pre-criminal space.” (p. 5) The Framework is cascaded down the National Health Service (NHS) hierarchies in England to ensure that all front-line staff in the NHS receive mandatory training in the Prevent process. NHS staff refer patients considered vulnerable to radicalisation to local Prevent leads and onward to Prevent case managers and the Channel panel. The Channel acts as a multi-agency panel along the lines of other safeguarding panels in England.

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This Training and Competency Framework follows from the *Prevent Duty Guidance*,² the *Channel Duty Guidance*³ and the *Channel: Vulnerability Assessment Framework*⁴ produced by the government following *CONTEST: The United Kingdom's Strategy for Countering Terrorism*⁵ and the Counter-Terrorism and Security Act 2015. The Framework does not name these documents but mentions two other documents which focus on multi-agency working. The first, *Safeguarding Children and Young People*,⁶ details the roles and competencies for healthcare staff when working with other professionals to safeguard children and young people. The second, *Building Partnerships, Staying Safe*,⁷ stresses the importance of effective interprofessional working.

The focus of the Framework is on training. Among the competencies listed within is to understand the concept of pre-criminal space. This article examines this term using publicly accessible government documents and internet searches performed on Google and Google Scholar. It is a textual analysis, read in the context of other government documents,⁸ which presumes that what is read may not necessarily be what the authors initially intended. Meanings applied to words, particularly new compound words, gain significance over time and use.⁹ One of the presumptions of this method is that textual analysis may not relate directly to what is happening in practice.

Pre-criminal space in the NHS England Framework

'Pre-criminal space' appears four times in the Framework document, including twice in the introduction: 'Prevent focuses on all forms of terrorism and operates in a pre-criminal space' (p. 5) '... individuals [...] can then receive support in the pre-criminal space' (p. 5) '... aware[ness that] [...] the health sector contribution operates in pre-criminal space' (p. 8) 'Understand [...] the concept of pre-criminal space' (p. 10). The meaning of 'pre-criminal space' can be deduced from these quotes. 'Prevent focuses on all forms of terrorism and operates in a pre-criminal space' suggests that pre-criminal space may relate to specific physical spaces and times where professionals 'operate' or act within the aims of the Prevent programme. The statement that 'individuals [...] can then receive support in the pre-criminal space' suggests that the professional activity involved is 'support'. What constitutes 'support' is detailed in the *Channel Duty Guidance*.³ The fact that 'the health sector contribution operates in pre-criminal space' implies that other health sector activities may not operate in the pre-criminal space. In what way NHS activity in this 'space' is different from that in other space is not stated anywhere. The need for health professionals to understand 'the concept of pre-criminal space' suggests that there is an important difference between what pre-criminal space is and what it is not. Read in the context of Prevent² and *Channel Duty Guidance*,³ pre-criminal space is likely to start on acceptance of a referral of a person within the Channel panel, or perhaps on referral or discussion of the possibility of referral by NHS staff to Channel personnel. Thus, pre-criminal space has temporal and spatial aspects. As the time and space is decided by negotiation with and between professionals, the term also has inter-professional dimensions. This is supported by Framework naming documents that focus on effective multidisciplinary work rather than the Prevent and Channel Duty guidelines.^{6,7}

The Framework document views the Prevent programme as part of the wider safeguarding agenda. However, there is one important difference compared with other safeguarding panels: the coordinator of the Channel process, the Channel Police Practitioner (CPP), is a police officer or is employed by the police (ref. 3, para. 30). Thus, unlike other safeguarding procedures, the police have a central coordinating function.

Coining of 'pre-criminal space'

The term pre-criminal space is new. It was introduced by this Framework and cascaded to all trusts by NHS England. The term does not occur in non-NHS Prevent documents or in CONTEST. References to pre-criminal space since the term was introduced are largely found in trust documentation and NHS PowerPoint presentations, together with some journalist reports and blogs. For instance, the *Telegraph* comments on the police use of the term and possible repercussions on state-Muslim relations.¹⁰

All NHS trusts in England are mandated to enact the Framework document and produce policy or guidance documents. None of these documents define pre-criminal space any further. Many use pre-criminal space with quotation marks, a few prefacing the term with 'so-called'. The usual statement is a reiteration of 'Prevent operates in the pre-criminal space'. Occasionally the hyphen is replaced by a space between 'pre' and 'criminal' but the words are never placed directly together. The most detailed definition we have found comes from a glossary in a Prevent document from

Mersey Care NHS Trust, beginning with a precautionary note: ‘These definitions relate to PREVENT and are not always authoritative in any wider context.’ ‘Pre-Criminal Activity/Space’ is explained by focusing on ‘multi-agency working to ensure that individuals are diverted away before any crime is committed’.¹¹ This definition merges ‘space’ with multi-agency activity.

Denotation and connotation

So far we have argued that pre-criminal space refers to the time when a person is engaged by the Channel panel and related professionals. It denotes the time, space and interprofessional activity involved in planning, coordinating support and possibly monitoring in the NHS England Prevent programme. What is unclear is whether the Channel process and panel meetings are in any way different from other multi-agency activities. This may be deduced by examining possible connotations of the term based on participants’ understanding of language use in its social context.

Pre-criminal space consists of three terms: ‘pre’ meaning before, ‘criminal’ as a person who has committed a crime or repeated crimes, and ‘space’ as a continuous physical area. ‘Pre’ appears to modify the second term, ‘criminal’, rather than space. Hyphens are not usually used after prefixes such as ‘pre’, unless the resulting meaning becomes ambiguous, for example ‘pre-order’ rather than ‘preorder’. Thus, the use of the hyphen both gives a separation between pre-crime and crime and creates the link. The term implies that the ‘space’ is pre-criminal, not the individual. While the use of the term ‘space’ suggests a physical space, such as a meeting room, there are no references to where the vulnerable person is to be supported. ‘Space’ in this context is used as a relational concept, common in expressions such as ‘I need space to think’, meaning ‘I need a place for myself, away from certain social relationships’.

The derivation of pre-criminal space

The etymology of the term is significant to the discussion. ‘Pre-crime’ and ‘space’, as separate words, suggest they are potentially independent concepts. The term ‘precrime’ was said to be coined by science fiction writer Philip K. Dick in his short story *Minority Report*.¹² The drama is based on the concept that crime has not occurred yet but will occur in future unless measures are taken. The belief that crime can be prevented by identification and intervention has a long history. In the 19th century, Lombroso’s theory of criminal atavism famously purported to identify future criminals by their abnormal physical appearance. In recent years, criminologists use the term pre-crime to criticise the move to criminalise people prior to the committing of crime.¹³ More recently, the term ‘pre-criminal space’ has been used in the US security industry in relation to Islamic fundamentalist terrorism.¹⁴ We find no evidence that the concept of ‘space’ in pre-criminal space derives from academic theorising about space. Depending on context, however, space connotes elements of time as well as physical or abstract forms of space. Space in pre-criminal space can thus gain different metaphoric associations depending on the immediate social context. Pre-criminal space may describe the physical space where ‘support’ is planned, ‘operated’ or monitored. It may also relate to the time that the person is subject to the Channel panel process, or to differences in the social rules of interprofessional interaction, as compared with different safeguarding panel discussions. Finally, it may refer to differing social identities of the person referred to the Channel panel and the professionals involved.

Rhetoric

The Framework provides an abbreviated and reasoned argument in support of the Prevent programme and the involvement of health professionals. Like all arguments, it persuades through the use of the metaphoric qualities which words gain in use. There are two sets of metaphors within the Framework, one pertinent to NHS professionals and the other to the police. The health metaphors are borrowed from structural engineering, with vulnerability and support suggesting the diathesis-stress model. The person is weakened from external assault or internal deficiency; structural support is provided from outside so the individual can withstand potential assaults or threats. Even the WRAP acronym (Workshops to Raise Awareness of Prevent) suggests physical bodily protection against external threat. The criminal justice terms (i.e. radicalisation, extremism, CONTEST, counter-terrorism, strategy) suggest a heightened spatial metaphor, polarisation and direction of movement. The creation of the term pre-criminal space may be an attempt to bridge the health and police use of metaphor: the health metaphor aiming for stability and predictability, while the criminal justice

metaphor focuses on adaptability. The lack of effective definition of pre-criminal space allows for evolving inter-agency norms during the Channel process to vary with context.

If new concepts emerge by visual analogy,¹⁵ pre-criminal space can be seen as an extension of crime prevention. It can be visualised as a system of continuous and contained passages. Prior to the vent (derived from the Latin root, as in *prevent*), professionals direct radicals, people who have an attractive or repulsive charge or energy, past the vent and into the channel. As the radicals pass along the vent their charge or energy becomes less strong and the radical no longer moves towards the extreme.

If the term pre-criminal space mobilises healthcare professionals and Channel partners towards a crime prevention role of health intervention, pre-criminal space has the potential to act as a form of ‘excitable speech’ to alert listeners to the threat of terrorism.¹⁶ The rhetorical use of the term pre-criminal space during the Channel process could be perceived as an attempt to persuade professionals to disclose information or make decisions they would otherwise not make in other safeguarding forums and in comparable circumstances.

Opinion

The Training and Competency Framework is an action plan, laying out who does what, when and with whom. For the implementation of Prevent, terms need to be defined to such a degree that the participants can understand the concepts involved. Indeed, the Framework itself asks NHS staff to understand the concept of pre-criminal space (p. 10). Pre-criminal space clearly denotes a period of time in the Prevent process without adding further meaning and keeping open the opportunity for the term’s possible rhetorical use in Channel meetings.

One synonym for pre-criminal space is crime prevention. This raises the possibility of changing the wording of the Framework to replace this obscure and newly coined term with ‘crime prevention’. Alternatively, discussion and clarification of the concept of pre-criminal space would allow it to define the participants’ relationships as the crime prevention activity proceeds. Further multidisciplinary research linking NHS documents to practice may enable the Prevent guidance and framework to be linked with practice. When the time comes for the Prevent framework to be updated (although no such date is given in the document), we recommend that the term should be clarified or removed.

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1.7.61 Drug information update. Atypical antipsychotics and neuroleptic malignant syndrome: nuances and pragmatics of the association

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Abstract

Neuroleptic malignant syndrome (NMS) is a rare but potentially fatal adverse event associated with the use of antipsychotics. Although atypical antipsychotics were initially considered to carry no risk of NMS, reports have accumulated over time implicating them in NMS causation. Almost all atypical antipsychotics have been reported to be associated with NMS. The clinical profile of NMS caused by certain atypical antipsychotics such as clozapine has been reported to be considerably different from the NMS produced by typical antipsychotics, with diaphoresis encountered more commonly, and rigidity and tremor encountered less frequently. This article briefly discusses the evidence relating to the occurrence, presentation and management of NMS induced by atypical antipsychotics.

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Neuroleptic malignant syndrome (NMS) refers to an idiosyncratic severe adverse reaction associated with the use of antipsychotics. It is a rare and unpredictable side-effect that has been associated with both first- and second-generation antipsychotics.^{1,2} It occurs in about 0.02–3% of individuals who are prescribed antipsychotics.³ NMS is generally characterised by rigidity fever, autonomic dysregulation, tremor, elevated creatine phosphokinase (CPK) levels and leucocytosis (*Box 1*).⁴ NMS is a potentially fatal adverse event. It can lead to permanent neurological impairment in survivors in the form of parkinsonian symptoms and cognitive deficits, which could be primarily ascribed to the raised core body temperature and ischaemia following rhabdomyolysis.^{5–7}

Atypical (second-generation) antipsychotics were initially considered to have negligible risk of inducing NMS due to their distinctive pharmacodynamic characteristics.⁸ In fact, side-effect profile has been one of the important distinguishing features between typical (first-generation) and atypical antipsychotics. However, considerable research evidence has accumulated to suggest that atypical antipsychotics are also associated with NMS.^{9,10} Clozapine was one of the earliest atypical antipsychotics implicated in the causation of NMS.¹¹ Subsequently, almost all of the atypical

antipsychotics have been associated with the occurrence of NMS. The clinical features of NMS induced by atypical antipsychotics have been reported to be somewhat different from those induced by typical antipsychotics.¹⁰

Atypical antipsychotics are among the most commonly prescribed antipsychotics.^{12,13} They are utilised for the treatment of a range of psychiatric disorders including schizophrenia, mania, depression with psychotic symptoms and personality disorders, and for behavioural symptoms in dementia and intellectual disability.^{14,15} Hence, understanding the clinical presentation and occurrence of NMS associated with atypical antipsychotics is of clinical relevance. This article discusses the evidence relating to the occurrence of NMS with atypical antipsychotics and various aspects of management for this condition. The authors reckon that the definition of ‘atypical’ antipsychotics itself may not have clear margins,¹⁶ yet the term ‘atypical’ remains in clinical usage to refer to those medications that have comparably smaller chances of causing extrapyramidal symptoms. We do not aim to present a systematic review of the topic, but rather a pragmatic review of the literature on NMS with atypical antipsychotics.

Reports of atypical antipsychotics causing NMS

Risperidone

Risperidone has been associated with probably the largest number of cases of atypical antipsychotic-induced NMS.^{9,17} It has been noted more frequently in the younger age group who had been antipsychotic naive. A severe clinical picture of typical NMS has been encountered, marked by rigidity, extrapyramidal symptoms, fever and highly elevated CPK levels. Tachycardia was more common than diaphoresis and autonomic dysregulation occurred frequently.⁹

Clozapine

Cases of clozapine-induced NMS, reported since the 1980s, typically occurred with rapid dose increases. Also, many patients who developed clozapine-induced NMS had a history of NMS with other antipsychotics. Tachycardia, tachypnoea, diaphoresis and autonomic lability were encountered frequently, possibly due to clozapine acting on adrenergic and muscarinic receptors.¹⁸ Rigidity and extrapyramidal symptoms were rare, possibly due to the lower affinity of clozapine to the D₂ receptor. The increases in CPK were lower and delayed when compared with other antipsychotics. The occurrence of fever and autonomic instability in patients receiving clozapine in the absence of rigidity may necessitate ruling out the diagnosis of clozapine-related agranulocytosis before a diagnosis of NMS.¹⁹ The clinical severity of clozapine-induced NMS has been described to be lower than with other antipsychotics, and hence such cases have infrequently required intensive care unit admissions. The infrequent occurrence of rigidity and extrapyramidal symptoms in patients with clozapine-induced NMS require a high degree of suspicion for this diagnosis. However, certain researchers have suggested that clozapine-induced NMS should not be considered as a diagnosis in the absence of typical features of NMS.²⁰

Box 1 Symptoms and signs commonly encountered in neuroleptic malignant syndrome

- Fever
- Rigidity
- Elevated creatine phosphokinase (CPK) levels
- Tachycardia
- Tachypnoea
- Altered mental state
- Fluctuating blood pressure
- Diaphoresis
- Leukocytosis

Olanzapine

Although olanzapine has been reported to present with the typical features of NMS, extrapyramidal symptoms and fever were absent in a small proportion of patients. Autonomic imbalances and diaphoresis are frequent, and are often the first signs to appear in patients with olanzapine-induced NMS. Nausea was infrequent, probably due to the antiemetic purported properties of olanzapine,²¹ but neurological impairments such as hemiplegia, ataxia and seizures have been reported.⁹ Several cases have been reported in patients receiving other medications apart from antipsychotics, for example mood stabilisers and antidepressants, and the clinical picture of NMS has been more severe in such patients.⁹

Amisulpride

Several cases of amisulpride-induced NMS have been described in the literature,^{22,23} many reported in elderly males. The clinical profile primarily involves an altered mental state, frequent rigidity and high levels of CPK, whereas high fever, tremor and other autonomic symptoms have been reported less frequently. The lower propensity to cause autonomic symptoms is probably due to low affinity in amisulpride for muscarinic, adrenergic, serotonergic and histamine receptors than in other antipsychotics.²⁴

Quetiapine

Quetiapine-induced NMS has been primarily reported in the elderly, although it has also been described in children.²⁵ Clinically, it presents with extrapyramidal symptoms and prominent autonomic symptoms such as tachycardia, blood pressure fluctuations, tachypnoea and diaphoresis. These prominent autonomic symptoms may be consequent to norepinephrine reuptake inhibition, histaminergic antagonism and serotonin toxicity associated with the use of quetiapine.²³ The outcome of quetiapine-induced NMS has been relatively poor, probably due to the older age of patients in whom it has been reported.⁹

Aripiprazole

Several case reports and case series have accumulated on the occurrence of NMS in patients receiving aripiprazole.^{26,27} Rigidity and altered mental state seem to be present frequently in such patients, while fever, diaphoresis and tachypnoea are less frequent. NMS has been reported to occur more commonly with fast upward titration of dosages of aripiprazole. The severity and duration of NMS seem lower than in other antipsychotic medications, probably due to the partial dopamine agonist activity of aripiprazole. Aripiprazole has also been implicated in combination antipsychotic regimens, when used alongside other atypical antipsychotics such as clozapine.²⁷

Ziprasidone

Few cases of ziprasidone-induced NMS have been described.^{28,29} The onset of NMS in these patients has been generally abrupt, with most displaying typical features such as alterations of mental state, fever, diaphoresis, tachycardia, blood pressure alterations, leukocytosis, tremor, and other extrapyramidal symptoms with high CPK. No fatality has been reported with ziprasidone to date, and recovery is usually achieved in about 10 days.

Paliperidone

Paliperidone has a similar pharmacodynamic profile to risperidone, but it has a lower affinity for dopamine receptors and higher serotonin antagonist activity. Paliperidone-induced NMS has been described mainly in patients who have been previously treated with other atypical antipsychotics and have had a recent dose increase or cross-titrations.^{30,31} Paliperidone-induced NMS presents with a typical clinical profile with mental state alteration, rigidity, diaphoresis, hyperpyrexia, tremor and other extrapyramidal symptoms, and the outcome is favourable, with resolution achieved in all cases.

Zotepine

Several cases of zotepine-induced NMS have been described in the literature.^{22,32} Rapid dose escalation was reported in one case, although NMS has also developed with the usual titration pattern. Zotepine-associated NMS presents with alterations of mental state, rigidity, diaphoresis, fever, tachycardia and leukocytosis, with less frequent occurrence of tremor, tachypnoea and alterations in blood pressure.

Other atypical antipsychotics and summary

At present, there is a single case report of iloperidone being considered as a cause of NMS.³³ The patient, who had schizophrenia, developed mutism, diaphoresis, diffuse lead pipe rigidity and tachycardia without fever or marked increase in CPK levels. The outcome was favourable, but the patient also required anticoagulation therapy for the management of comorbid pulmonary embolism.

Blonanserin was reported as a cause of NMS in a 30-year-old female with intellectual impairment.³⁴ The patient presented with fever, tachycardia, rigidity, extrapyramidal symptoms and leukocytosis after the initiation of blonanserin. Symptomatic improvement was seen after discontinuation.

Although different atypical antipsychotics have different NMS clinical symptom profiles, rigidity, tremor and fever are encountered less frequently with atypical antipsychotics, whereas diaphoresis is quite common. Clozapine is particularly associated with atypical presentations of NMS with infrequent CPK level elevations. Risperidone, on the other hand, produces a clinical picture more similar to the NMS induced by typical antipsychotics. Some of the atypical antipsychotics have also been associated with serious features such as myoglobinuria and acute renal failure.^{35,36}

Risk factors for atypical antipsychotic-induced NMS

A few significant risk factors for atypical antipsychotic-induced NMS have been identified. They have been reported in one study as male gender, confusion, dehydration and delirium.²⁵ Another study reported Black and minority ethnic background, antipsychotic polypharmacy, use of aripiprazole, and increasing dosing patterns.³⁷ More recently, it has been suggested that rapid dose escalation of the antipsychotic may be a risk factor for NMS.² The demographic profile of patients who developed NMS with atypical antipsychotics does not seem to differ substantially from that of patients with NMS induced by typical antipsychotics.

Management

Diagnostic uncertainty

The clinical picture and features of NMS with atypical antipsychotics seem to be different from those of typical antipsychotics. This had led to uncertainty over the diagnosis of NMS in patients on atypical antipsychotics who manifest only few of the NMS symptoms.³⁸ Among the core symptoms of NMS, fever is often encountered less frequently in patients with atypical antipsychotic-induced NMS.³⁸ The issue is further complicated by the various operational definitions of NMS.³⁸ The DSM-IV-TR defines NMS as the presence of severe muscle rigidity and elevated temperature after antipsychotic initiation along with two or more of: diaphoresis, dysphagia, tremor, incontinence, changes in level of consciousness, mutism, tachycardia, elevated or labile blood pressure, leukocytosis, or laboratory evidence of muscle injury (elevated CPK level). Various other criteria for NMS have been postulated, each with varying emphasis on the individual symptoms and signs.³⁹ Another set of criteria defines NMS in patients with either three major symptoms (hyperthermia, rigidity, elevated CPK level) or two major and four minor symptoms (diaphoresis, tachycardia, tachypnoea, abnormal blood pressure, leukocytosis, altered consciousness).⁴⁰ Yet another diagnostic system defines NMS through the presence of extrapyramidal symptoms and fever (37°C) alongside three minor symptoms within a 48-hour period.⁴¹ This may potentially mean that a case fulfilling the diagnosis of NMS according to one set of criteria may not do so with another set. The DSM-5 has taken a pragmatic approach of not explicitly stating the number of criteria required for the diagnosis of NMS.

It has been proposed that with the growing awareness of NMS, those in the early course of its development may benefit from early identification and immediate treatment. This may lead to an abortive course of NMS development, with an incomplete picture and only few of the criteria being met. Hence, some authors have proposed a dimensional concept of NMS, which takes into consideration the minor and subthreshold forms of NMS.^{38,42} This is likely to further our knowledge about NMS pathophysiology, clinical profile subtypes and appropriate management strategies.

Furthermore, various other medical and neurological conditions may present with a clinical picture similar to NMS (briefly mentioned in *Box 2*). Patient condition may require expedient decisions so that a rational line of management can be instituted. Hence, the clinician may need to take a brief and focused history for being reasonably sure about the diagnosis. Neuroimaging and electroencephalogram may be helpful for ruling out neurological pathologies mimicking NMS. For example, in patients with psychosis, catatonia may be considered as a differential diagnosis, especially when the patient is mute and exhibits staring. It may not be possible to exhaustively rule out all differential diagnoses, and at times management may need to be started on an empirical basis.

Treatment strategies for NMS

The management of NMS caused by atypical antipsychotics would not be substantially different from the management of NMS induced by typical antipsychotics (*Box 3*). NMS is a medical emergency and requires immediate attention for clinical management. Clinical diagnosis should be supplemented by laboratory tests, particularly CPK levels and total leukocyte counts. Once the diagnosis is suspected, the offending antipsychotic agent must be immediately stopped. Regular monitoring of the vitals should be carried out. The patient should be moved to the intensive care unit based on the severity of their medical condition. Intensive care would typically focus on monitoring of cardiorespiratory and renal status. Serial monitoring of serum electrolytes should be performed and corrected as required. In extreme hyperthermia, physical cooling measures may be instituted.

Several pharmacological options are available for the treatment of NMS.^{43,44} Dopaminergic agents such as amantadine and bromocriptine have been demonstrated to decrease the duration of and mortality associated with NMS. Amantadine 200 mg to 400 mg per day in divided doses is administered either through a nasogastric tube or orally. Bromocriptine is started at the dose of 2.5 mg three times a day and can be titrated upwards to 45 mg per day. Benzodiazepines, particularly lorazepam, can be given when underlying catatonia is suspected and where agitation is encountered in the patient. Lorazepam challenge can be done with 1 to 2 mg lorazepam administered parenterally, and may be continued in cases which show some response. Dantrolene is a muscle relaxant that can be applied in cases presenting with severe rigidity and hyperthermia. It is initiated at doses of 1–2.5 mg/kg body weight and can be repeated 6 hourly if improvement is seen. It can be administered orally after improvement with the parenteral preparation.

Box 2 Differential diagnosis of neuroleptic malignant syndrome

- Amphetamine toxicity
- Anticholinergic delirium
- Benign extrapyramidal side-effects
- Brain abscess
- Catatonia
- Heat stroke
- Malignant catatonia
- Malignant hyperthermia
- Meningitis or encephalitis
- Mid-brain structural lesions
- Non-convulsive status epilepticus
- Sepsis
- Serotonin syndrome
- Thyrotoxicosis

The altered mental state encountered during NMS also needs attention. If sedation is required, benzodiazepines may be a preferred choice. The medical management of the patient takes precedence over the underlying psychiatric disorder. As the patient's condition improves, discussion about further treatment options may be initiated.

Re-challenge with antipsychotics after NMS

One of the important considerations for a clinician is to whether to start another antipsychotic after a patient develops NMS. If the antipsychotic had been started for the control of psychotic symptoms, then the risk of psychosis without the cover of antipsychotics is high. The clinician may have to weigh the pros and cons of re-starting antipsychotic medication: the advantage of making the patient more manageable against the risk of inducing NMS.

Box 3 Treatment of neuroleptic malignant syndrome

- Consider shifting to intensive care unit
- Regular monitoring of vitals
- Monitoring of electrolytes and correction if required
- Management of medical comorbidity
- Physical cooling measures if required
- Dopaminergic medications: amantadine and bromocriptine
- Muscle relaxant: dantrolene
- Benzodiazepines: for management of agitation, when clinical suspicion of catatonia is present

Several reports of post-NMS antipsychotic re-challenge have been published.⁴⁵⁻⁴⁸ Indications for a re-challenge need to be clearly documented and other options of management (including electroconvulsive therapy) should be explored. Taking informed consent from the patient and/or family members/carers becomes necessary in such circumstances. Re-challenge should be done with an atypical antipsychotic with low propensity to cause NMS and dose titration should be gradual. Careful monitoring should be instituted, watching the evolution of symptoms of NMS. The re-challenge strategies thus adopted are in no way different from those post-NMS due to typical antipsychotics.

Conclusions

As psychiatrists, we are likely to encounter NMS induced by atypical antipsychotics during clinical practice. Although it is an uncommon adverse event of antipsychotic use, the potential fatality requires the clinician to take cognisance of this, and institute treatment immediately. The presentation of NMS induced by atypical antipsychotics, especially clozapine, may be quite different from NMS induced by typical antipsychotics – rigidity and tremor are encountered less frequently, while diaphoresis is probably encountered more frequently. Hence, a high degree of clinical suspicion may be required. Overall, the management of NMS induced by atypical antipsychotics is not broadly different to the management of that induced by typical antipsychotics. Additionally, an episode of resolved NMS does not preclude the subsequent initiation of antipsychotics, although due caution needs to be exercised while re-challenging antipsychotics in patients with a history of NMS induced by atypical antipsychotics.

1.7.62 Drug information update. Lithium and chronic kidney disease: debates and dilemmas

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Abstract

Lithium is an established treatment for bipolar disorder and an augmenting agent for treatment-resistant depression. Despite awareness of renal adverse effects, including chronic kidney disease, for the past five decades, there has been a lack of research evidence. This has led to debates around the existence and magnitude of the risk. This article discusses the current evidence base regarding the link between lithium and chronic kidney disease, monitoring of renal functions and its clinical implications.

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– Conclusions

Lithium is one of the oldest psychotropic medications. It remains the gold standard treatment for bipolar disorder and an augmenting agent for treating depression. Over the past few decades, additional benefits of lithium have also come to light, most importantly its role in preventing suicide and Alzheimer's disease.^{1,2} As it is often used as a maintenance treatment for lifelong disorders, concerns have been raised about its potential long-term organ toxicity, mainly the effect on glomerular function leading to chronic kidney disease (CKD).^{3–5}

Debate 1: does lithium cause CKD?

The association between CKD and lithium has been known for a long time, and monitoring renal function in patients receiving lithium therapy has been the norm for many decades. Despite this, there has been little research into the renal adverse effects of lithium so far. A link between lithium therapy and CKD has received increasing recognition, and there are several explanations for this. First, glomerular function decreases gradually as a normal part of the ageing process; increased life expectancy has led to increasing numbers of lithium patients being diagnosed with CKD. Second, there has been a resurgence of interest in lithium and its safe use, owing to its proven effectiveness in bipolar disorder in comparison with other mood stabiliser drugs and its anti-suicide effect. Last, more effective monitoring of renal function and the use of more sensitive measures to diagnose CKD, such as the estimated glomerular filtration rate (eGFR) rather than serum urea and creatinine levels, have led to the early identification of affected patients.

Despite significant progress over the past two decades, doubts still remain about the existence and magnitude of the risk.^{3–5} Unlike its tubular adverse effects, which more commonly present with polyuria and polydipsia, the glomerular adverse effects of lithium therapy appear after long-term use and might not normalise or improve after its discontinuation. It has therefore been difficult to attribute causality for this adverse effect.

The debate about lithium nephrotoxicity started in 1977, with reported abnormalities in renal biopsies from a small group of patients treated with lithium.⁶ Initial cross-sectional, case-control and small cohort studies with short-term follow-ups reported contradictory findings on the toxicity risk.^{7–10} In 1994, Bendz *et al* published a study of 142 patients who had been taking lithium for more than 15 years. The authors measured the glomerular filtration rate (GFR) by chromium-51-labelled ethylene diamine tetra-acetic acid (⁵¹Cr]EDTA) clearance and found that in 21% of patients the GFR was lower than in the demographic-matched population control group.¹¹ Two meta-analyses of these diverse studies failed to produce conclusive evidence for or against lithium nephrotoxicity. Although they showed that patients on lithium therapy had worse renal function than controls (as measured by serum creatinine levels or the eGFR), they reported that the clinical significance was questionable. Both meta-analyses highlighted poor quality data and significant heterogeneity among studies.^{12,13}

Recent epidemiological studies utilising large databases have consistently shown that CKD (defined as an eGFR of < 60 ml/min/1.73 m²) is common among lithium patients but that lithium therapy increases the risk of CKD. In addition, renal failure in patients with end-stage renal disease (ESRD) is not as rare as previously thought.^{14–17} In a retrospective cohort study using the General Practice Research Database, Close *et al* reported that patients taking lithium for bipolar disorder had a twofold increased risk of developing renal failure and a two-and-a-half-fold increased risk of developing CKD of any stage compared with lithium-naïve patients.¹⁴

The relationship between lithium therapy and renal failure or ESRD has been investigated in many other studies that mainly use data from databases of patients undergoing renal replacement therapy (dialysis or renal transplant). A Swedish study found that 0.81% of renal replacement therapy patients had kidney disease attributable to lithium-induced nephropathy. Moreover, the risk of ESRD in lithium-treated patients was nearly sixfold greater than in the general population.¹⁷ Another recent retrospective cohort study, of renal replacement therapy patients in Australia, reported that the incidence rate of ESRD due to lithium therapy had increased significantly from 0.14 cases per million population per year (95% CI 0.06–0.22) in 1992–1996 to 0.78 cases per million population per year (95% CI 0.67–0.90) in 2007–2011. This report emphasised that lithium-induced nephropathy is not a rare cause of ESRD, and is becoming more common.¹⁸ However, the debate is far from over and contradictory findings continue to be published. For example, in a review of patients with ESRD in Sweden, Aiff *et al* found 32 cases of ESRD in patients who had started taking lithium before 1980 but none in those who had started taking lithium after 1980. Hence, the authors suggested that the opposite was true: renal failure might not be a problem with the current practice of maintaining lower serum lithium levels along with

better monitoring of renal function.¹⁹ In a recent population-based retrospective cohort study in Denmark, Kessing *et al* also failed to identify any patients with lithium-induced ESRD. However, their findings indicated that bipolar disorder is independently associated with CKD.²⁰ Therefore, uncertainties about the magnitude of the CKD risk are yet to be resolved.

It is clear that not all patients taking lithium experience glomerular adverse effects. Most likely, only a select group of patients develop CKD and only a small proportion of these progress to ESRD.²¹ Moreover, the association between lithium therapy and CKD is unlikely to be entirely explained by coincidence or confounding variables (such as age, other psychotropic drugs or comorbid medical/psychiatric illnesses). Discrepancies among studies were largely due to methodological differences such as varied parameters to assess renal function and definitions of renal impairment, short-term follow-up, a lack of patients on long-term lithium therapy, combining high-risk and low-risk groups, choice of control group (healthy *v.* psychiatric patients), and an inability to control the confounding variables. Definitive data on the magnitude of the risk are still lacking. Moreover, in the absence of any pathognomonic histological or biochemical changes, lithium-associated CKD remains a diagnosis of exclusion.

Debate 2: is there any relationship between the tubular and glomerular adverse effects of lithium?

It was previously assumed that CKD is preceded by tubular adverse effects of lithium. However, differences in the prevalence of tubular and glomerular adverse effects and a lack of correlation between reduced glomerular function and tubular abnormalities on renal biopsy (in the form of tubular dilation and microcysts) argue against this assumption.^{22,23} Despite this, the presence of tubular adverse effects is suggested to increase the risk of CKD, hence the suggestion that treating or preventing tubular adverse effects might help to prevent deterioration of glomerular function.²¹

Debate 3: is it possible to identify patients at high risk of developing CKD/ESRD and to predict the prognosis of these adverse effects?

As only a small proportion of patients on lithium therapy experience CKD, early identification of these high-risk patients might help to prevent and manage this adverse effect. Over the years, researchers have tried to identify both susceptibility and treatment-related factors such as associations with ageing, comorbid physical/psychiatric health problems, cumulative lithium dose or treatment duration, dosing frequency, and number of toxicity episodes.

Acute lithium toxicity is known to cause acute renal failure, and many patients suffer renal impairment even after recovering from an acute episode. There is consistent evidence that acute nephrotoxicity episodes can lead to CKD.^{6,9,24} Recently, Clos *et al* suggested that lithium-associated CKD is primarily mediated by acute lithium toxicity, and that avoiding lithium toxicity can prevent renal impairment.²⁵ Studies suggest a relationship between impaired renal function and either persistent high serum lithium levels (>0.6mmol/L *v.* <0.6mmol/L) or a single serum lithium measure of > 1.0 mmol/L. As these were not prospective studies, it is difficult to establish a causal relationship, especially as reduced renal function can also increase serum lithium levels.^{26,27} On the other hand, a recent randomised placebo controlled trial of low-dose lithium therapy (serum lithium levels of 0.25–0.50 mmol/L) in elderly patients with mild cognitive impairment did not show a significant difference in eGFR over a 4-year follow-up period.²⁸ The study suggests that lower therapeutic levels of lithium might not impair renal function.²⁸ In contrast, other studies have failed to show a relationship between CKD risk and lithium dose or serum lithium levels.^{17,24} It is well established that higher serum lithium levels provide better protection against another affective episode (especially a manic episode). Therefore, the debate about what serum lithium level represents a balance between safety and effectiveness is likely to continue until more definitive data become available.

Once-daily dose is thought to be associated with less renal impairment than multiple daily doses.²¹ Although a few studies do not support this, none have so far reported disadvantages for once-daily dosing.²⁹ Therefore, although a definitive answer is lacking, it makes sense to adopt a once-daily dosing strategy. Comorbid physical health conditions such as diabetes or hypertension can independently cause CKD, but CKD is also commonly seen in lithium-treated patients, even in the absence of a comorbid physical illness. Therefore, comorbidity is unlikely to entirely explain the association between lithium and CKD.

So far, evidence about CKD risk factors is limited and somewhat contradictory. However, it indicates that lower therapeutic lithium doses might have a reduced detrimental effect on renal function and that acute lithium toxicity should

be avoided to prevent renal dysfunction. Furthermore, once-daily dosing might be safer than multiple daily doses.

Debate 4: how can we effectively monitor glomerular adverse effects?

Monitoring renal function in patients on lithium therapy has been the norm for many years, but there are significant discrepancies among the different guidelines on the parameters that should be used and the frequency of monitoring.^{30–32} The UK National Institute for Health and Care Excellence (NICE) recommends 6-monthly monitoring; the British Association for Psychopharmacology recommends annual monitoring; and the American Psychiatric Association recommends monitoring every 2–3 months for the first 6 months, followed by 6-monthly to annual measurements.^{30–32} However, they do not give specific guidance about the parameters for measuring renal function and continue to recommend measuring serum urea and creatinine levels, although recent guidelines have started to recommend measuring the eGFR. In other medical areas, measuring serum urea and creatinine levels is no longer a preferred option for monitoring renal function: standard practice is to monitor the eGFR. Many equations can be used to calculate the eGFR from serum creatinine concentration, with differing accuracies. Recent NICE guidelines on managing CKD suggest using the CKD Epidemiology Collaboration (CKD-EPI) equation. They also suggest using the CKD-EPI equation based on cystatin C levels if accurate GFR estimates are necessary.³³ Psychiatry guidelines do not recommend any particular method for calculating the eGFR.

The importance of measuring proteinuria to monitor renal function in CKD patients is now firmly established. Proteinuria is an independent predictor of CKD progression, cardiovascular disorders and all-cause mortality.³³ However, a role for estimating and monitoring proteinuria in lithium-related renal impairment is yet to be established. The evidence so far is sparse and contradictory: some reports suggest that proteinuria is linked to lithium-associated CKD and indicates a poor prognosis, while others suggest that lithium-associated CKD is not associated with proteinuria and that in the presence of proteinuria one should rule out other causes.^{5,10,21} However, recent publications have highlighted the importance of monitoring proteinuria in patients with lithium-associated CKD.^{21,34}

Unfortunately, psychiatric guidelines have not kept up with advances in nephrology, and we need guidelines for evidence-based monitoring of renal function. Recent publications suggest that renal function should be monitored regularly via the eGFR and that the degree of proteinuria should be measured in patients with a declining eGFR or an eGFR of <60 ml/min/1.73 m.^{221,34} However, these recommendations are developed for CKD associated with other aetiological factors, and more specific evidence-based monitoring guidelines need to be developed to screen and monitor lithium-associated CKD.

Dilemma 1: should lithium be stopped if a patient develops CKD?

The most common dilemma clinicians face is what to do if a patient on lithium therapy develops CKD. In this scenario, the clinician must decide whether to continue or discontinue lithium. Advice in the literature is contradictory, ranging from discontinuing lithium as soon as renal function starts to deteriorate (as evidenced by two consecutive tests) to continuing lithium even in the presence of CKD.^{18,35} The decision to discontinue lithium is based on the assumption that lithium is a causative factor for CKD and that its discontinuation would improve renal function or at least slow down deterioration. However, neither of these assumptions is completely supported by current evidence.^{4,5,36} Moreover, we still do not know whether lithium-associated CKD is reversible or irreversible. It has been suggested that this adverse effect might be reversible at the initial stages, only becoming irreversible after a certain threshold is reached.^{4,21} Presne *et al* suggested that the threshold might be somewhere between a GFR of 25 and 40 ml/min/1.73 m.²² Thus, the advantages of discontinuing lithium are uncertain.^{4,5,35,36} On the other hand, there is enough evidence to suggest that lithium discontinuation is associated with high risk of relapse for patients with mood disorders, especially those with bipolar disorder. Moreover, the illness might become treatment refractory.²¹ One of the advantages of lithium is its anti-suicide effect: the risk of suicide is known to increase after lithium discontinuation.³⁷ The decision to continue or discontinue lithium treatment should thus only be taken after careful assessment of the benefits and risks, and because of uncertainties surrounding these, it is essential that the decision-making process should include patients and all of the professionals involved, including nephrologists. Our experience agrees with a documented report that many psychiatric patients prefer to maintain their mental stability against the unknown risk of further deterioration in renal function.³⁸ In clinical practice, it is not unusual to request that a nephrologist makes this treatment decision. However, it is important that psychiatrists should not abdicate responsibility, because nephrologists might not be fully aware of

the risks associated with the psychiatric illness.^{5,21,34,35} Another option would be to continue lithium treatment while closely monitoring renal function. Many authors have suggested trying to keep the lithium level at the lower end of the therapeutic range, although there is not much evidence that this prevents further deterioration in renal function. However, as CKD patients are particularly prone to lithium toxicity, this strategy appears prudent.

Dilemma 2: should we consider lithium therapy for patients already diagnosed with CKD?

There is not much research evidence to support or dispute this decision. Lithium treatment may lead to further deterioration in renal function, which could be clinically important because the renal reserve is already low in patients with CKD. A study of elderly patients suggested that individuals with pre-existing CKD were more susceptible to a lithium-associated decline in renal function³⁶ On the other hand, we should not deprive such patients of an effective therapy because of unproven adverse consequences. In 2012, Werneke *et al* designed a mathematical model based on the existing, but limited, evidence to analyse the risks and benefits of continuing or discontinuing lithium therapy for CKD patients. They concluded that most patients should continue lithium treatment even if long-term renal adverse effects develop. They also recommended prescribing lithium to CKD patients because treatment benefits outweighed the risks.³⁵ However, at present there is not enough evidence to support any decision.

Conclusions

Limited knowledge of its renal (especially glomerular) adverse effects has led clinicians to either avoid or prematurely discontinue lithium therapy because of the perceived risk of a negative renal outcome. Over the past decade, a few large database studies have confirmed the existence of lithium-associated CKD, but uncertainty remains about the magnitude and determinants of the risks. Lithium therapy is here to stay and we should learn to optimise its efficacy and safety. There is a need for large-scale prospective studies focused on the early identification of high-risk patients and for developing evidence-based guidelines to monitor renal function in patients treated with lithium.

1.7.63 Shared decision-making in medication management: development of a training intervention

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Abstract

Shared decision-making is a collaborative process in which clinicians and patients make treatment decisions together. Although it is considered essential to patient-centred care, the adoption of shared decision-making into routine clinical practice has been slow, and there is a need to increase implementation. This paper describes the development and delivery of a training intervention to promote

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shared decision-making in medication management in mental health as part of the Shared Involvement in Medication Management Education (ShIMME) project. Three stakeholder groups (service users, care coordinators and psychiatrists) received training in shared decision-making, and their feedback was evaluated. The programme was mostly well received, with all groups rating interaction with peers as the best aspect of the training. This small-scale pilot shows that it is feasible to deliver training in shared decision-making to several key stakeholders. Larger studies will be required to assess the effectiveness of such training.

Contents

- *Shared decision-making in medication management: development of a training intervention*
 - *Method*
 - * *Consultation phase*
 - * *Training intervention: design*
 - * *Training intervention: delivery*
 - * *Evaluation*
 - *Results*
 - *Discussion*

Shared decision-making is a collaborative process in which clinicians and patients make treatment decisions in partnership. Both partners bring valuable contributions to this process: patients share their experiences, values and preferences, and clinicians support patients in clarifying these, as well as providing clinical expertise and evidence-based information about treatment options. Jointly, they aim to reach an agreement on the best way to proceed.^{1–3}

Shared decision-making is considered particularly relevant for preference-sensitive decisions, where there are several reasonable treatment options and evidence does not support a clear best choice. Different options require the balancing of possible benefits against potentially significant adverse or as yet unknown effects.^{3–5} Most medication decisions in mental health fall into this category, which makes psychiatric medication management an important area for shared decision-making.⁶

There are good reasons for encouraging adoption of shared decision-making in mental health. Many patients wish for greater participation in treatment decisions.⁷ In chronic conditions, where long-term healthcare decisions are required, studies have shown that shared decision-making improves satisfaction, adherence and well-being.⁸ Shared decision-making is at the core of recovery principles which promote autonomy and self-management skills, as well as being considered essential for delivering patient-centred care.⁹ National and international government initiatives,^{1,10–13} such as the UK Health and Social Care Act 2012 and the US Patient Protection and Affordable Care Act 2010, endorse shared decision-making, as do professional bodies^{14–16} and practice guidelines.^{17–21} Shared decision-making is an expected element of all NHS care (Health and Social Care Act 2012, s. 23, 26). Although there is evidence of its benefits, and many patients want greater involvement,⁷ the adoption of shared decision-making into routine clinical practice continues to be slow,^{22,23} especially in mental health.²⁴

A range of interventions has been developed to promote implementation of shared decision-making, predominantly in physical health.^{25–28} Although this is an evolving area, relatively few interventions focus specifically on treatment decisions in mental health.^{6,29–33} Evidence is sparse regarding the effectiveness of such interventions in general,^{23,25} and in mental health settings in particular,³³ although some promising results have been reported. These include a study of in-patients with schizophrenia or schizoaffective disorder who received five sessions of shared decision-making training;²⁹ a multifaceted programme based on shared decision-making concepts for primary care physicians treating patients with depression;³⁰ a peer-run Decision Support Centre in the waiting area of a psychiatric medication clinic;³¹ and online resources supporting shared decision-making.³² The limited evidence available points towards interventions being more effective when involving healthcare professionals and patients together, rather than only targeting one group.²³

The Shared Involvement in Medication Management Education (ShIMME) project was set up to promote shared decision-making of service users (the term ‘service users’ was used in the ShIMME project and has been retained here) in medication decisions by delivering a specially developed training programme to three key stakeholder groups: service users, care coordinators and psychiatrists. (In the context of the ShIMME project ‘care coordinator’ refers to psychiatric nurses, social workers, occupational therapists, psychologists, support workers, peer workers and students training in these disciplines.) To our knowledge this is the first UK-based project to deliver and evaluate such an intervention that targets multiple stakeholders simultaneously.

The project was a partnership between Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and Anglia Ruskin University. Reflecting the strong collaborative ethos, service users were active team members jointly with academic researchers, mental health practitioners and other professionals working within CPFT.

This paper describes the stages of the ShIMME project: consultations about shared decision-making, development and implementation of a pilot intervention, and evaluation of feedback. It is one of several articles relating to the project.^{34–36}

Method

Consultation phase

The initial phase of the project involved a literature review and consultation with local stakeholders about the process of shared decision-making. Data were collected via focus groups with practitioners and users of adult mental health services in CPFT. Four focus groups were conducted with service users ($n = 27$), two with psychiatrists ($n = 4$), one with community psychiatric nurses (CPNs, $n = 10$), and one with care coordinators other than CPNs ($n = 8$). Four individual telephone interviews were also conducted with psychiatrists. Discussion was generated in response to open questions about current practice in medication management, how decisions should ideally be made, perceived barriers to and facilitators of shared decision-making, and how shared decision-making training should be conducted. Consultation groups lasted around 90 min and were audio recorded. The anonymised transcripts were analysed using thematic analysis,³⁷ conducted with NVivo software (www.qsrinternational.com). This involved a detailed exploration of transcript texts by two team members who worked in collaboration to iteratively develop themes.

The following themes about shared decision-making in medication management, which are presented in more detail elsewhere,³⁴ emerged from this analysis and fed into the development of the training programmes.

1. Ongoing respectful, trusting, open and honest relationships are paramount – service users’ concerns and experiences need to be heard and taken seriously.
2. Differences of power in the consultation can be complex and a barrier to shared decision-making – clinicians can underestimate the effect this has.
3. Access to reliable, user-friendly information is essential, including information about reducing or coming off medication and adverse effects of medication.
4. All available treatment options should be considered, including non-pharmacological treatments.
5. The process of shared decision-making needs to be flexible, taking into account preferences and situations which may change over time. Acute stages of illness or crisis situations were identified as times when shared decision-making would be likely to be more problematic.
6. Broader stakeholders (beyond service user and prescribe!¹) have important roles in the shared decision-making process (e.g. other professionals, carers).
7. There is currently significant variation in medication management and the extent to which this involves shared decision-making.

Training intervention: design

A multidisciplinary working group including service users, academic researchers, psychiatrists, a mental health nurse and a pharmacist met regularly to develop the training intervention. The results of the consultations, literature review and examples of existing practice fed into the development.

Training was designed to be delivered to service users, care coordinators and psychiatrists in parallel but separate groups. The aim was to optimise the impact of the intervention by delivering it simultaneously to key stakeholders who are actively involved in medication management, while addressing the specific training needs and concerns of each group. Each group was facilitated by a service user trainer, and either a psychiatrist (for service user and psychiatrist groups) or a mental health nurse (for care coordinator groups), allowing participants to learn from two relevant perspectives.

The programme employed a range of interactive learning methods. These included specially commissioned video material showing different clinical scenarios, small group exercises, general group discussions, use of testimonials and role plays. The resource materials and hand-outs covered a diverse range of views and approaches, to raise awareness and stimulate discussion. All participants had access to the public section of the project website (www.shimme.arcusglobal.com) as well as a secure discussion forum for their group.

The training programmes for the three stakeholder groups covered the same core content: background to the project key components of shared decision-making in the clinical encounter and rationale for promoting shared decision-making barriers to and facilitators of shared decision-making awareness of the effects of power imbalances in psychiatric consultations developing collaborative relationships importance of clarifying personal preferences, values and experiences in shared decision-making the concept of a ‘meeting of two experts’ in the clinical encounter, with personal experience and clinical expertise complementing each other³⁸ accessing and appraising information about medication, including examples of decision aids raising awareness of adjuncts or alternatives to medication addressing issues around coming off or reducing medication trialling of versions of three paper-based tools developed for supporting and recording the shared decision-making process information about useful websites.

In addition to the core content, the service user groups focused on: practising setting personal goals and identifying preferences making use of a personal well-being plan and self-help resources looking beyond medication to enhance well-being, drawing on Deegan’s work on ‘personal medicine’³⁹ introduction to assertiveness how to access information about medication, including a talk by a National Health Service (NHS) trust mental health pharmacist, who was available for further discussion afterward supported ‘hands-on’ experience exploring relevant websites.

Besides the core content, the care coordinator training focused on adopting the role of a ‘shared decision-making coach’, supporting service users to play a more active part in the shared decision-making process³⁵ The programme for psychiatrists focused on competencies and resources that support embedding shared decision-making into routine clinical practice while acknowledging real-life challenges.

Training intervention: delivery

All training group participants were recruited from CPFT community mental health services: service users from the rehabilitation and recovery pathways; and professionals from these services and from assertive outreach teams. Service users were invited to participate by their care coordinators and psychiatrists and care coordinators were approached by team managers. In total, 47 service users, 12 psychiatrists and 35 care coordinators took part in the training.

Training was held in three different locations to reduce travelling for participants. Service users were reimbursed for travelling costs and received a fee (£40) for completing an evaluation before and after the programme.

The training was delivered in small group settings (2–12 participants), with each cohort completing their course of training together. An atmosphere of trust, acceptance and respect was encouraged. Participants had the opportunity for informal interaction before and after sessions as well as during breaks. Facilitators and project team members could be contacted between sessions for additional support.

Service user training groups were structured into four 2h sessions, meeting fortnightly After the training, two follow-up sessions were offered for ongoing support. Care coordinators met three times, at monthly intervals, for 1.5 h.

Psychiatrists had two 2 h sessions, one month apart, with an online self-study component. For organisational reasons one multidisciplinary team of clinicians received their training together in a single day.

Evaluation

The experience and impact of the training intervention was evaluated by collecting quantitative and qualitative data anonymously from participants at different stages of the project.

After providing baseline data, participants and facilitators completed a short questionnaire after each session, and participants completed a longer one immediately after the final training session. The questionnaires explored what the participants had hoped to learn from the programme, their views on its content and impact, and feedback on particular sessions, practical aspects, teaching methods and support materials.

Analysis of quantitative and qualitative data examining the impact of the intervention at a 12-month follow-up, as well as an economic analysis, will be reported on separately.

Results

Although care coordinators and psychiatrists were mostly trained in separate groups, their demographic and feedback data are reported as one group of clinicians. Demographic and attendance data for service users and clinicians are shown in *Table 1* and *Table 2*.

Demographic characteristics of participants

	Service users (<i>n</i> = 47) <i>n</i> (%)	Clinicians (<i>n</i> = 47) <i>n</i> (%)
Female	22 (47)	33 (70)
Male	25 (53)	14 (30)
Mean age, years	48	45
Ethnicity		
White	42 (89)	37 (79)
Black	1 (2)	1 (2)
Asian	0	4(9)
Other	3 (6)	2 (4)
No data	1 (2)	3 (6)
Education		
Tertiary/further	30 (64)	
Secondary	14 (30)	
Primary or less	1 (2)	
No data	2 (4)	
Employment ^a		
Paid/self-employed	3 (6)	
Voluntary employment	7 (14)	
Unemployed	25 (50)	
Student (including part-time)	4 (8)	
Age-related retirement	4 (8)	
Other	7 (14)	

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Table 14 – continued from previous page

	Service users (<i>n</i> = 47) <i>n</i> (%)	Clinicians (<i>n</i> = 47) <i>n</i> (%)
Professional background of clinicians		
CPN/nurse		11 (23)
Occupational therapist		9 (19)
Clinical psychologist		2 (4)
Social worker		2 (4)
Support time and recovery worker		6 (13)
Peer support worker		2 (4)
Team leader/deputy manager		3 (6)
Psychiatrist		12 (26)

CPN, community psychiatric nurse.

More than one answer possible.

Session attendance

	Patients	Care coordinators	Psychiatrists
Sessions offered	4 × 2 h	3 × 1.5 h	2 × 2 h
Cohorts training delivered to	6	2 + 1 (team training day)	2 + 1 (team training day)
Attendance	37 (79%) attended at least 3 sessions of 4	20 of 21 (95%) attended at least 2 sessions of 3 14 attended team training day	6 of 10 (60%) attended both training sessions 2 attended team training day

The mean length of contact with mental health services for service users was 17 years. The most common reported diagnoses were schizophrenia, schizoaffective disorder or psychosis (*n* = 28, 60%), followed by depression (*n* = 12, 26%), bipolar affective disorder (*n* = 9, 19%), personality disorder (*n* = 5, 11%), anxiety (*n* = 4, 9%) and post-traumatic stress disorder (*n* = 4, 9%). Some participants reported multiple diagnoses. The majority of service users received state benefits (*n* = 43, 92%), with *n* = 39 (83%) on a disability living allowance.

Immediate post-programme feedback was given by 61 (65%) participants: 33 (70%) service users and 28 (60%) clinicians, including 22 (63%) care coordinators and 6 (50%) psychiatrists. Before starting the programme, service users mostly hoped to learn about ways to cope with their symptoms not solely focused on medication, to understand their medication better and to negotiate decisions. Clinicians were particularly interested in improving their practice, learning about the model and process of shared decision-making, availability of support materials, and sharing experiences with colleagues.

Expectations of the programme were largely met in both groups, with the majority of participants expressing a positive view about its content. In all groups, the opportunity for discussion and exchange of views with peers was highlighted as the best aspect of the programme. In addition, service users valued the clarity of the information conveyed, access to resources and the prospect of greater collaboration in consultations. Clinicians also appreciated access to resources and the information given, as well as the opportunity to reflect on their own practice, particularly in the case of psychiatrists.

There was little negative feedback. Just over half of service users (*n* = 17, 52%) and the majority of clinicians (*n* = 20, 71%) did not identify any aspects of the programme as being 'least satisfactory'. Some service users mentioned dissatisfaction with practical aspects or teaching methods, and a few referred to difficulties reading all the paperwork/understanding everything. A small number of psychiatrists expressed concerns about a perceived bias against their profession. Most participants felt the training was pitched at the right level. Use of the project website was variable, with about half of service users visiting it outside sessions. Most psychiatrists visited the website, but only a few

care coordinators did. The online forum was not used by any of the groups.

Most clinicians rated the training programme as relevant to their clinical practice, but fewer expected that what they had learned would shape their future practice. Over half of service users expected or were at least hopeful that the programme would affect future practice.

A summary of the post-programme feedback is given in *Table 3*.

Summary of feedback

	Service users (<i>n</i> = 33)	Clinicians (<i>n</i> = 28)
Most important things participants hoped to learn	Lifestyle changes/coping with symptoms/alternatives to medication Understanding medication management/SDM/negotiating decisions Sharing experiences Understanding side-effects of medication Assertiveness/confidence with professionals Info about project/research Reducing/coming off medication	Improving practice Learning about SDM model and process Support materials/tools for SDM Sharing ideas and practice Information about medication, including side-effects and coming off Learning about the project Gaining confidence in discussions with service users Understanding service user perspective
Views on content of the programme	Positive views 28 (85%): interesting, helpful, informative, empowering, encouraging, learned a lot Other comments 4 (12%): SDM needs to be implemented from consultant psychiatrist downwards/did not learn that much concrete	Positive views 21 (75%) 18 (82%) care coordinators, 3 (50%) psychiatrists: very good, good, interesting, informative, well-balanced Other comments 4 (14%): repetitive, some prejudice against psychiatrists
Best aspects of programme	Meeting others, exchanging views and experiences, supportive environment Information conveyed, new ideas and access to resources Learning to be involved in my medication management, feeling confident my views will be listened to	Interaction with others, chance to discuss implementation of SDM Direction regarding resources/tools to support SDM, information Concept of SDM Gaining confidence in promoting SDM/putting SDM into practice Reflecting on own practice Getting service user perspective
Least satisfactory aspects	Practical aspects, teaching methods Not understanding everything, not able to read all paperwork Parts boring, same	Practical aspects, teaching methods Perceived bias against psychiatrists Did not improve personal knowledge of medication Content
Training pitch at right level	32 (97%)	20 (71%): 17 (77%) care coordinators, 3 (50%) psychiatrists
Use of project website	17 (52%)	11 (39%): 6 (27%) care coordinators, 5 (83%) psychiatrists
Relevance of training programme and impact on future practice	Expecting impact: 12 (36%) Hopeful of impact: 7 (21%) Doubtful/unsure: 5 (15%) Relevant for others: 2 (6%)	Relevant: 23 (82%) Impact on own practice in future: yes 16 (57%), no 1 (4%), hopeful/probably 2 (7%)

SDM, shared decision-making.

Listed in order of frequency.

Discussion

The ShIMME project was a small-scale exploratory project with an emphasis on service users co-leading in all aspects, while aiming to ensure the views of all key stakeholders were integrated into the development and delivery of the training intervention.

The training programme was well received overall, demonstrating the feasibility of providing group-based training in shared decision-making to service users and practitioners in NHS community settings. In this case, service user participants were drawn from the rehabilitation and recovery pathways which serve people with chronic and often severe mental health problems. Demographic data from participants indicated high levels of chronicity and disability. The positive feedback, good attendance and engagement from this group suggest that taking part in shared decision-making training is possible and worthwhile for people experiencing a range of mental health challenges.

Feedback indicated that service user participants were interested in being actively involved in managing their mental health, including gaining a better understanding of medication and exploring a range of other strategies to foster well-being. Clinicians showed an interest in improving their practice by learning about shared decision-making.

Members of all the stakeholder groups gave positive feedback about the group-based training, allowing for the exchange of ideas and experiences with peers. This was also reflected in facilitator comments about the supportive atmosphere and participants' enjoyment of meeting with each other in the service user groups. Interaction with peers seemed to be an important aspect of the whole programme.

There may also be advantages in service users and clinicians attending joint training groups, allowing participants from different backgrounds to work together on an equal basis and to gain a better understanding of others' perspectives without the pressures and structures of the clinical encounter. The involvement of carers and important others might bring further benefits.

The feedback about the content, approach and pitch of the teaching within the group of psychiatrists was not quite as positive as in the other groups. The reasons for this are likely to be multifaceted and would warrant further exploration, with possible adjustments of the programme. Away to enhance acceptability and engagement would be to encourage more psychiatrists to become involved in shared decision-making training and development of tools.²⁸ Use of the project website was limited, in particular by care coordinators and service users. Technical difficulties with the website might have contributed to this, but comments during sessions indicated that some participants, particularly service users, had low IT confidence and limited internet access outside the training sessions. Future training programmes will need to provide non-digital resources, as well as supporting access and use of IT resources.

The project team developed three paper-based tools to support the process of shared decision-making, which were trialled in training groups and repeatedly revised. Although useful, these would need to be integrated into the existing electronic records system to be truly effective in promoting, supporting and documenting the process of shared decision-making without significantly affecting consultation time. At present this remains a challenge, but there have been some promising recent developments.⁴⁰

Both groups of clinicians considered the training relevant to their clinical practice, although they appeared uncertain whether the programme would influence their future practice. This might be due to concerns about additional barriers to implementation or aspects of the training itself. Despite their positive feedback about the programme, service users were also cautious about its impact. This might reflect the perception that they have little influence in making significant changes to their healthcare delivery or doubts about positive initiatives being translated into clinical practice.

While this pilot programme had the limitations of a modest number of participants, not all of whom provided feedback, the consultation data from local stakeholders, the development of the training programme and the feedback from participants were all encouraging. Drawing on experiences from this project, CPFT has been working towards implementing shared decision-making across the trust by embedding shared decision-making into its procedures, raising awareness and offering training to practitioners across the trust (www.promise.global/sdm.html). The associated Recovery College (www.cpft.nhs.uk/about-us/recovery-college-east.htm), which is open to service users, family, friends and staff,

also included training in shared decision-making. The pilot project benefitted from a supportive environment within the trust, and the success of implementation in other organisations would depend on their own local conditions.

The complexity and difficulty of implementing shared decision-making in a mental health setting should not be underestimated.^{36,41} For it to truly become a routine part of clinical practice, changes in attitudes and behaviours are necessary among all parties involved, as well as the wider society.^{36,42} Psychiatrists are well placed to take on a leadership role in promoting shared decision-making within health services and should also be pivotal in explaining the benefits of increased patient autonomy and responsibility to the general community.

We thank all ShIMME project team members, service users and practitioners, as well as Dr Fiona Blake, Sheena Mooney, Mary Jane O'Sullivan and others for critically reviewing the manuscript. We are grateful to Prof. Matthew Large for his contributions as part of the *BJPsych Bulletin* Author Mentoring Scheme.

1.7.64 Trainee experiences of intellectual disability psychiatry and an innovative leaderless support group: a qualitative study

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Abstract

Aims and method There is very little research into the challenges of training in intellectual disability psychiatry or into interventions which may address these challenges. Using focus groups, we explored the experiences of intellectual disability psychiatry trainees, and evaluated a leaderless trainee support group developed in Bristol.

Results Five distinct themes were identified via framework analysis: that trainees felt unprepared for the difference from previous posts; the need for support; the value of the group; that trainees were concerned about judgement in supervision; that the group structure was valued.

Clinical implications Our findings highlight the support needs specific to intellectual disability psychiatry trainees. Leaderless peer support groups may be a valued resource to address such issues, and may be a useful model to be considered by other training schemes.

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Intellectual disability psychiatry (also known as learning disability psychiatry particularly in UK healthcare services) is a specialty in the UK involving the assessment and management of mental health problems in individuals with intellectual disability and other developmental disabilities. Trainees in intellectual disability psychiatry face specific challenges, including the need to acquire enhanced communication skills, understand a range of genetic, neuropsychiatric and neurodevelopmental conditions, and utilise knowledge of complex psychopharmacology.¹ They may also have to confront substantial existential and societal issues associated with caring for vulnerable individuals who face exclusion and disadvantage in many aspects of their lives.²

Although there is little published literature, one study exploring the experiences of intellectual disability psychiatry trainees described strong feelings of isolation, alienation, lack of skills and impotence, not unlike the feelings experienced by the patient groups the trainees worked with.² Prompted by these findings, trainees on the Bristol intellectual disability psychiatry training scheme developed an innovative, leaderless trainee support group (*Box 1*) after taking advice from a consultant psychotherapist. The group aimed to provide a forum for reflective peer support for core and advanced intellectual disability psychiatry trainees (doctors specialising in psychiatry, previously termed senior house officers and specialist registrars). It has continued since 2005, with individual membership varying from 6 months (core trainees) to 3 years (advanced trainees).

Here we report the findings of a qualitative study exploring the experiences of trainees in intellectual disability psychiatry who participated in this support group. The aims were to explore doctors' experiences of training in intellectual disability psychiatry, in particular the positive and negative aspects of working in this specialty, and the role of support and supervision; and to evaluate the model of a leaderless peer support group from the perspective of its participants.

Box 1 Trainee support group

- **Who:** All core and advanced trainees in intellectual disability psychiatry placements are invited. Typical attendance is 3–6 participants, dependent on need, leave or competing priorities. The group does not have a facilitator or leader, and was set up with an egalitarian structure.
- **When:** Fortnightly before the academic programme.
- **Where:** On the site of the academic meeting, central in the area between the different placements.
- **How long:** 90 min.
- **Structure:** 10 min of chat as people arrive, 70 min of focused support group. No fixed agenda, time used between trainees depending on needs that day.
- **Boundaries:** start and end time, confidentiality, respect.

Method

We approached this project using a qualitative design, as we were interested in exploring a variety of individuals' interpretations of their experiences.³ Although one-on-one interviews were an alternative, focus groups provided a time-efficient way to gather data, allowed discussion of the issues raised, and enabled researchers to gain a sense of whether the individuals identified with each other's experiences.⁴

Procedure

Two focus groups were held, one for each cohort, each lasting 90 min. Focus groups were facilitated by two of the researchers (J.N. and J.K. for the first cohort, and J.K. and D.R. for the second), who used a topic guide and encouraged free-floating discussion. The facilitators sought clarification when needed, and prompted the participants to move on to new areas when they started to repeat previously discussed issues, or after periods of prolonged silence. They also encouraged participants to share examples from their own work wherever possible. Recordings were transcribed, including spoken words, speech fillers and dysfluencies, by a medical secretary.⁵

The topic guide comprised four sections: experiences of working with people with intellectual disability; the role of support and supervision in training in intellectual disability psychiatry; reflections on the value and usefulness of the trainee support groups; specific consideration of the leaderless, egalitarian model of the trainee support group. The list was generated from data gathered via a previous semi-quantitative survey investigating perceptions of the trainee support group held by trainees and trainers in 2007.

Participants

All doctors who had been members of the trainee support group during the preceding year were invited to participate in each of the study's two focus groups. This process was performed twice, 4 years apart, sampling two non-overlapping cohorts. This was to allow exploration of whether experiences were cohort specific. Each focus group comprised five participants. The first included three core and two advanced trainees and the second two core and three advanced trainees. Each group was mixed gender and had trainees from different community learning disability teams (CLDTs) in the scheme. The ages of the participants were between 25 and 40 years.

Participation was voluntary, without incentive and occurred during work time. All participants consented to their comments being recorded and transcribed for analysis, with individual identities removed.

Ethical considerations

The regional training programme director reviewed the proposal, considered relevant ethical issues and gave approval for the study.

Analysis

Framework analysis was the most appropriate analytic method, given its relative simplicity and ease of use, and served the intended aims of seeking themes rather than generating explanations or new theories or concepts. A process similar to the framework analysis described in detail in Rabiee was followed.⁵

Stage 1

Two authors (J.K. and D.R. in the first and R.S. and H.T. in the second focus group) independently immersed themselves in the focus group transcript as a whole. The transcript was manually coded on paper, thus developing a 'thematic framework'.

Stage 2

Following this, quotes were highlighted, pasted into a separate document and arranged by broad themes.

Stage 3

The interpretation stage of the analysis was done jointly between each pair of authors and involved refining and condensing the themed quotations using suggested criteria of: attention to frequency; emotion/intensity; specificity (attention to actual personal experience over hypotheticals); and extensiveness. Internal consistency (reduced attention to views subsequently contradicted or changed) could not be reviewed as suggested by Rabiee,⁵ as individuals could not be consistently tracked throughout the transcript.

Stage 4

The final stage involved a review of the analysed and interpreted data to see whether they had resulted in significantly overlapping themes suggestive of an overarching or superordinate theme. Themes were named by a process of abstraction as described by Fade.⁶ A requirement for reflexivity was acknowledged from the outset. Thus, researchers' influence was viewed as a necessity for making sense of the richness of the data generated by group participants rather than as bias to be eliminated.⁷

Results**Results of thematic analysis**

Five distinct themes evident in both focus groups were identified. Owing to the anonymisation of participants during transcription, it was not possible to attribute quotes to specific participants. However, the quoted contributions incorporated a broad range of views arising in themes evident in both focus groups. Furthermore, it was evident in the transcript that they did not represent any one dominant voice.

Theme 1: unprepared for difference

Both groups perceived placements in intellectual disability psychiatry as being quite different to other psychiatry posts. This was viewed as having both positive and negative facets. Positive aspects included having more time allocated to conduct detailed assessments, and the potential to work jointly with colleagues from other professional groups. These were seen as enabling the doctor to assess the patient in a holistic manner and the overall experience was described as 'rewarding' by several trainees: "You don't just see the person in one dimension; you are seeing a holistic view. Working with people with disabilities ... can be very rewarding." A variety of negative issues were discussed, including problems associated with reliance on suboptimal collateral histories and doctors questioning their own abilities to provide adequate care to this patient group, particularly with respect to specialist skills such as epilepsy management: 'Suddenly you are asked to treat something you've probably not had a great deal of training for [epilepsy]... suddenly you are expected to already know about it.' Some trainees appeared to be aware of such differences prior to starting posts, which was sometimes a source of apprehension. However, for others it was more of a surprise: 'I think it is very

different to what one gets in general psychiatry and I think that is not clear at the outset and sometimes can come as a surprise.’

A sense of isolation while working in these posts was part of the discourse in both groups. The change from being in large mental health teams to smaller CLDTs, where the other professionals have limited psychiatry training, was noted. The low number of medical colleagues in the CLDTs also generated feelings of isolation, as did the geographical spread of posts: “The posts can be quite isolating ... there might be you and another doctor within the team. We are quite isolated, we are far and few. There is that huge geographical spread which means that you don’t tend to see people informally.”

Theme 2: need for support

The trainees described the need for help and support in coping with aspects of their work. For example, there were accounts of doctors struggling with the emotions evoked by working with a patient group with disabilities: “I think it is quite difficult to work with people with [intellectual disabilities]; especially people who are severely ... physically and mentally disabled, it can make [you] feel quite low if you see those people who are completely dependent on carers. If you work with someone who has so much pain and trouble, if you work with them and you don’t get any support, I think I would personally get depressed, just thinking about it. If you don’t actually discuss your feelings with someone else who understands where you are coming from, I think that can pile on and on and can actually start affecting you in your personal life too.” Some trainees also described being overwhelmed by the additive effect of numerous emotionally challenging encounters: ‘In a week you collect things in your head. If there were deaths you would have a formal debrief, but these things are not deaths. They are things that keep on happening, small things.’

Many of the participants also expressed feelings of impotence to ‘fix’ the underlying conditions of their patients with intellectual disability: ‘I’ve always been taught to diagnose a disorder and treat it... I felt powerless.’

The trainees described the trainee support group and consultant supervision as addressing different support needs: “I think they are quite separate things... they do quite different things. I think... supervision is about supporting your work and this [trainee support group] is a place that supports you.”

The trainee support group was also highlighted by several trainees as a useful place to talk about difficulties related to training and difficulties experienced within CLDTs.

Being a doctor who is newly working in learning disability and the emotions that generates and the challenges of training, I think you get more out of discussing that with a group of people who are going through the same thing.

Theme 3: value of the group

The trainees described finding the group a source of: “Genuine support and encouragement and reassurance. We talk, and when you talk it comes out, and you are able to share, and it is not so ... painful anymore.” Some participants also recalled specific clinical and nonclinical issues where the group had been helpful to them: ‘I was struggling ... the support was phenomenal.’ Trainees also stated that the group had a positive impact on their clinical work: ‘I think it does help us to become better clinicians in terms of how to deal with our emotions ... we do learn from each other a lot.’

Positive aspects to the structure of the group included: permission to discuss anything, the group being confidential, and the opportunity to be with peers who are experiencing similar challenges: “The openness and the fact that you feel a bit equal ... you can pretty much bring anything there. I can speak and no one will judge me.” Sessions that had been of most value were reported to be those that were best attended, and setting ground rules was considered helpful to the group. If the group discussion was solely focused on an informal chat or issues such as rota swaps, it then lost its supportive benefits: ‘Incredibly valuable [sessions] have been the ones where people, lots of people, have come and come on time, and other times they definitely have felt like a missed opportunity.’

Theme 4: judgement in supervision

Participants described finding it easier to talk about their feelings with peers in the group than in consultant supervision. In particular, worries were expressed regarding looking incompetent during supervision, as the consultant would need to sign off the trainee at the end of the placement.

I don't want to say something [in consultant supervision] that will make me look bad, that will go on my file.

I would probably be worried in supervision that I don't want to say that I felt unsure about myself.

I find the trainee support group is more about me and about how I am coping, whereas clinical supervision is everything about the client and getting my assessments and appraisal.

Part of the issue might be your unhappiness with your interaction with other members of the team or with your consultant, which ... you would find difficult to discuss in supervision.

However, consultant supervision sessions were deemed more appropriate for some other issues, which trainees said they would not discuss in a group setting: 'Certain personal and professional issues that you may want to discuss in a supervision environment I wouldn't do in a Balint group or here.'

Theme 5: group structure

The egalitarian model was described as enabling core and advanced trainees to express their opinions knowing trainees were viewed as of equal value to the group: 'My views were valued and ... I could also give advice to my senior colleagues, which is not always respected everywhere, so this was a major strength.'

It also allowed all members to talk about what they felt was important to them rather than to a facilitator. However, some noted a downside that a less confident member might not highlight their desire to bring a new topic to a session, and the group could be dominated by particular individuals: "There is a freedom in the group that comes from the fact that it's unstructured and doesn't particularly have an agenda. I think a chairman would be useful [...] in asking if particular quiet members would [...] like to say anything because there are some people who have attended and I haven't heard speak in 6 months." The lack of a leader was thought to promote a more lax view on attendance and punctuality, and some trainees and consultants were reported as giving the group a lower priority than other aspects of the trainees' work. Group members arriving late or leaving early was disruptive and disturbing: 'We value the group, we see it as valuable or we wouldn't come at all, but we don't value it as highly as other things in our timetable so it tends to be the first thing that gets bumped.'

Discussion

This study adds substantially to the very limited literature detailing the peculiarities and challenges of training in intellectual disability psychiatry.^{1,2} One strong theme that emerged from our results was how trainees considered training in intellectual disability to be different from other psychiatric posts and the degree to which they were prepared for this. The reasons cited were related to both the specifics of the work and the structure of teams. It is well known that psychiatric disorders in intellectual disability may be more complex to diagnose, particularly owing to difficulties in effective communication. A further contrast with many other areas of psychiatry is the degree to which healing or restoration to full function or participation is possible. In intellectual disability psychiatry, the primary disability is often the intellectual impairment or associated developmental disorder, thus treatment of any mental illness may restore the patient's previous level of functioning and quality of life, but no further. Despite epilepsy management being a common role for the intellectual disability psychiatrist,⁸ our findings suggest that many trainees felt apprehensive about their skills and confidence in this area.

Feelings of isolation were also highlighted. CLDTs in the area of the study are geographically spread out and based away from their mainstream psychiatric colleagues. Separation from peers has been noted as off-putting to foundation doctors,⁹ but few studies explore feelings of isolation among psychiatry trainees² It has been noted previously that

individuals who work with people with disabilities can feel stigmatised and isolated.^{10–12} Stigma by association is the process by which relatives, support staff, friends and associates feel stigmatised owing to their contact with a stigmatised group.^{13,14} This may also affect trainees working in this area and contribute to their feelings of isolation. We think that one reason the group was valued could be its ability both to reduce the feeling of isolation by bringing trainees together, and to mitigate some of the stigma felt by enabling the trainees to share difficult experiences. One could speculate that the group may have not just attenuated some potential negatives of the subspecialty training, but also contributed to the enjoyment and reward of it. If this were to be true, it would be interesting to study whether training schemes in areas with specialty-specific support or educational groups do better in relation to trainee retention or satisfaction than those without such structures.

It should be noted that despite the challenges, there was also a strong and pervasive feeling of positivity about training and working in intellectual disability psychiatry. Such experiences were startlingly absent in previous work,² but are important to note to reassure future recruits in the specialty. In particular, the trainees mentioned the term ‘rewarding’, a varied and complex concept.¹⁵ The view that community-based intellectual disability psychiatry would be rewarding was predicted some 30 years ago,¹⁶ although this is the first study as far as we are aware that affirms this view. Intellectual disability requires a particularly holistic approach, often not dissimilar to the approach of general practitioners (GPs). While there is an absence of published surveys or qualitative studies on what psychiatrists find rewarding, interpersonal relationships between doctor and patient have been found to be particularly satisfying for GPs.¹⁷ However, we are unaware of similar studies among psychiatrists.¹⁸

Both focus groups discussed how consultant supervision and the support group were different, but mutually supportive and compatible. When surveyed, UK trainees report they are mostly happy with supervision and find it useful.¹⁹ The Royal College of Psychiatrists recommends that supervision should enable ‘the development and assessment of clinical and personal skills under direct one-to-one supervision by an expert’ and should be ‘focused on discussion of individual training matters’.²⁰ The hierarchical nature of consultant supervision is both valued by trainees²¹ and necessary for valid competency assessments, but this can be a potential barrier to seeking support in some areas, particularly revealing vulnerabilities to a supervisor who is also an assessor. Personal upset and secondary grief relating to patients is considered by some supervisors and supervisees to be a boundary breach in supervision.²² The trainee support group is set up without hierarchy and this may have contributed to reducing boundaries around discussing vulnerabilities. Honest discussion about how trainees were ‘coping’ was easier in the trainee support group than supervision, despite the College suggesting consultant supervision should include this.²⁰ This study adds to previous work suggesting some mismatch between intent and what trainees feel comfortable discussing.²³ This space for honesty is a value of the group but it would be a concern if the availability of the trainee support group and its support acted as a colluder or barrier to honesty in consultant supervision.

Group peer support may be more beneficial than alternatives such as paired peer support. Several of the benefits described in both focus groups suggested similarities to Yalom’s therapeutic factors: universality, altruism, guidance, imparting of information, cohesion, and existential factors.²⁴ That senior trainees stayed in the group for up to 3 years may reinforce some of these factors, and their relative maturity and existing trust following a longer involvement in the group may provide additional support.²⁵ It also provides senior opinions, which have been found to be supportive when shared in other contexts.²⁶ A common concern when leaderless groups are used for supervision is a loss of focus on the task and drifting into support and advice-giving.^{27,28} As the model presented here is primarily for support, and advice is part of that, the lack of leader is not a concern in this context, although the results did suggest that some participants would have liked a facilitator role in encouraging quieter members to contribute.

As this is an analysis of a single group and the findings have not been replicated elsewhere, it is difficult to generalise the utility of such groups to other areas. However, we think similar models of egalitarian peer support that require limited resources for setting up may have the potential to benefit trainees in other, smaller or more challenging, specialties.

Strengths and limitations

The qualitative design and use of focus groups is appropriate to investigate attitudes and experiences of trainees. The training rotation is relatively small, with 7–9 core and advanced trainees available to attend the trainee support group in each 6-month period. ‘Group think and the articulation of group norms may have introduced a positive bias. However, the anonymity of participants in the transcript is likely to have mitigated self-censorship and there was evidence of a diversity of opinion, particularly illustrated by both praise and criticism of the trainee support group and highlighting a range of experiences in training. The anonymisation happened at transcription rather than at analysis stage. This precluded the ability of the authors analysing the data from tracking individuals’ comments or reviewing whether they were linked to particular posts or trainers. Generalisability is a concern in qualitative studies, and was also a concern in this particular training scheme. First, at the time of the focus groups, the Bristol scheme was performing above average on trainee satisfaction in GMC surveys.²⁹ Second, many of the CLDTs may be unusually isolating for trainees compared with elsewhere in the country by virtue of their geographic spread and relatively rural setting. Finally, in several CLDTs within the scheme, most team members, except psychiatrists, are employed by a different organisation and may have few psychiatric skills.

In conclusion, we have highlighted some of the challenges and rewards of training in intellectual disability psychiatry. Our evaluation of an egalitarian, trainee-led peer support group suggests that the model could be useful for other intellectual disability psychiatry training schemes. Whether this could be a support structure suitable for other specialties remains to be studied.

We thank Dr Andrew Clark, consultant psychotherapist, for help with setting up the group; Dr Kristina Bennert for recording equipment; Gill Wetherall for transcription of the tapes; Dr Helen Sharrard, training programme director, and all consultant trainers for supporting the groups; and importantly, all trainees who enthusiastically participated in them over the years.

1.7.65 Scottish independence: the view of psychiatry from Edinburgh

Julia Bland¹

date

2017-8

Contents

- *Scottish independence: the view of psychiatry from Edinburgh*
 - *The struggle for schizophrenia*
 - *Future hopes*

As a southerner and medical psychotherapist, it was with some trepidation that I ‘Ubered’ to Professor Eve Johnstone’s house in Edinburgh, which boasts over a hundred roses in her immaculate garden. After all, I was going to meet the

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woman whose research work had wrenched the pendulum radically in the direction of biological psychiatry, with her landmark *Lancet* paper¹ showing anatomical differences on CT scans between the brains of those with and without schizophrenia. I feared that she ate psychotherapists for breakfast, although she had sounded kind and friendly on the telephone. My anxiety was misplaced, since the person who emerged was a woman of fierce intelligence, with rigorous, idealistic, uncompromising and wholly admirable moral standards; compassionate and committed to patients and science, without any personal vanity, unless you include intellectual certainty.

Professor Johnstone is not a postmodern relativist: her life has indeed been a life scientific. For her this is seamless: the scientific truth is what leads to effective and therefore optimal treatment. She has never given interviews before, owing to a self-deprecating Scottish horror of self-publicity, but agreed to speak now as a retired professor.

Eve Cordelia Johnstone, ‘Scottish neuroscientist’, is the eighth generation of Glaswegian Presbyterian doctors, but the first woman doctor in her family. She laughed gently at my southern ignorance in asking about Catholicism in Glasgow: of course the Catholics were often of Irish origin, poor, poorly educated and discriminated against. No chance of eight generations of doctors then. (In fact, her father was a dentist because his serious deafness made medicine impossible.)

She remembered vividly the poverty and overcrowding in Glasgow, the worst in the UK at the time. One of her first patients on medical take was an exhausted woman presenting with open tuberculosis, a urinary tract infection and a haemoglobin of 8, who arrived late at night, after three jobs that day: scrubbing steps, cleaning offices, then washing dishes. ‘Had she ever been to the hospital before?’ I ask. ‘Yes, to be sterilised after having 13 children.’ The woman was 35 and looked 20 years older. Infant mortality was 28/1000 in Glasgow at this time, compared with about 6/1000 now.

Born in 1944, the young Eve was sent to an academic private Presbyterian girls’ school and was an obvious high flyer. This remained the case: she qualified in medicine in Glasgow in 1967. As a woman medical student, she was one of a 20% maximum quota. Most of her female contemporaries ended up doing a bit of part-time practice rather than working ‘in a serious capacity’, as she put it.

As a clinical researcher who looked after patients with scrupulous care, she is proud of having been supported by the Medical Research Council (MRC) continuously for 33 years, which is almost unprecedented. She did research at Northwick Park in Harrow from 1974 until 1989, and was Professor and Head of Department of Psychiatry at the University of Edinburgh from 1989 until 2010. She has a reputation in Edinburgh for supporting younger psychiatrists, although she has no time for slacking (or striking, as a doctor): ‘I worked 12 hours a day, it was what I expected’.

The struggle for schizophrenia

In 2016 it may be hard to remember the climate in which the 1976 *Lancet* paper landed.¹ Debate on the origin and meaning of mental illness was in the international public domain. The flamboyant R. D. Laing, a fellow Scot, was describing psychosis as a sane response to an insane society, chiming perfectly with the other social and sexual revolutions in progress.² Thomas Szasz published *The Myth of Mental Illness* in the same year, depicting psychiatrists (and all other doctors) as agents of social control.³ In 1975 Miloš Forman’s *One Flew over the Cuckoo’s Nest* portrayed the excesses of medicalisation, incarceration and psychosurgery.⁴ A famous study emerged in the USA in 1973, showing how journalists going to the emergency room complaining of ‘hearing’ three words in their heads attracted the diagnosis of schizophrenia.⁵ This massively discredited conventional psychiatric diagnosis. In the UK, David Cooper published *The Death of the Family* (1971), describing the family as the crucible of mental illness, and coined the term ‘anti-psychiatry’.⁶ The now discredited and mother-blaming notion of the ‘schizophrenogenic mother’ was widely held.

So just imagine the hostile reaction that a paper showing anatomical changes in schizophrenia would receive. As Professor Johnstone remembers: ‘There was all this anti-psychiatry stuff [...] People were saying schizophrenia didn’t exist [...] I had to prove my opponents wrong.’ As she reminisces today, it is not difficult to detect her contrarian relish for the battle: Professor Johnstone had no time for these theories. ‘There were 200 000 people in hospital with schizophrenia [...] what did they think they were there for?’ she asks incredulously. It was also the time that John Wing had written about the phenomenon of institutionalisation,^{7,8} although she points out ‘he never claimed that the institutions were the cause of the illness’.

In her own mind, Professor Johnstone was crystal clear: “‘I felt it had to be that this was a disease, but I couldn’t prove it [...] and then the non-invasive method of CT scanning came in. I was lucky. Before that people had to do

pneumoencephalography (injecting air into the ventricles and X-raying them, resulting in terrible headaches and worse), so there were no controls because of the dangers of the technique. The papers were all in Japanese or German.” This is a chilling moment: we are talking the Third Reich. ‘It sounds awful to admit’, she says ‘but the best papers [in support of the notion of schizophrenia as a disease originated in] the Third Reich. The Nazis wanted proof that schizophrenia was an inherited degenerative condition.’ When the 1976 study was published, even other neuroscientists objected, suggesting that the anatomical change could be secondary to drug treatment or encephalitis. ‘But I knew something was wrong with these people [...] When I was 21, I saw a 21-year-old woman, terribly distressed by paranoid delusions, who had been working in a bank 3 weeks earlier. It was ridiculous to say this was due to imperfect interpersonal reactions at home [...] just stupid.’

With iron determination, she then went on to refute all the challenges to the original paper with a study of 600 people with schizophrenia in Shenley hospital.⁹ They were followed up until death, and their brains at autopsy showed larger ventricles and smaller brains. However, there was no gliosis, suggesting that the pathology may be neurodevelopmental. Professor Johnstone, for all her modesty, cannot suppress an element of glee in having pipped to the post her American research competitors. Daniel Weinberger, backed by the enormous funds of the National Institute for Mental Health, confirmed her findings 2.5 years later.¹⁰ Not shirking controversy, she then ran a placebo-controlled trial of electroconvulsive therapy (ECT), which demonstrated ECT to be effective, albeit only for about 8 weeks, particularly in those depressed patients who experienced delusions and had intellectual disability.

Her next project, the Edinburgh High Risk Study,¹¹ was a prospective study of 16- to 22-year-olds, carefully comparing the incidence of developing schizophrenia in a cohort of people whose relatives had schizophrenia, the controls having no family history. Twenty-one of the high-risk group who then developed schizophrenia in fact had some anatomical differences in the brain when they were still well. The changes include smaller amygdala and hippocampus and hyperfolded gyration. Of course, this finding raises a host of ethical issues in relation to premorbid diagnosis and its implications.

I asked Professor Johnstone what she thought of the recovery model, and she was sceptical: “‘Seems to me a bit of a semantic issue [...] if it’s a dreadful illness, very hard for families, specially if you knew the people before they became ill [...] and people don’t want to say how bad it’s going to be. I don’t think the [Royal College of Psychiatrists] has emphasised psychopharmacology enough. We need much more individually tailored treatments, taking account of distinct side-effect profiles, not general algorithms. Unfortunately, it’s not true that the drugs we have now are vastly better, although it is better to have a wider range.’” She sees non-pharmacological treatment as ‘a bit better than nothing, if [the patient] will engage’, but her scrupulous honesty demands that we acknowledge that ‘a terrible thing has happened to them.’ Talking to her it was clear that she personally provided intensive clinical care to her patients and their families, and we could easily agree that continuity of care is crucial and dangerously eroded in many overstretched contemporary psychiatric services. She is unconvinced of the benefits of the newer antipsychotics: ‘It’s true the side-effects are different, but they hammer weight on to you, which is very distressing for young people.’ As for clozapine, the benefits have been ‘greatly exaggerated’.

Her academic success has been recognised. She received a CBE in 2002 for services to medicine, and a Lifetime Achievement Award of the European Psychiatric Association in 2009. She also had many senior roles in the MRC, including the chairing of the highly publicised inquiry into the disastrous linking of the MMR (measles, mumps and rubella) vaccine and autism. With the distressed parents of autistic children leading a class action against the government on the basis of the Wakefield paper,¹² she was truly in the eye of the storm. ‘I had to carry the parents with me.’ The disgraced Wakefield ‘got what he deserved’, she says.

In retirement Professor Johnstone has remained actively interested in the link between schizophrenia and cognitive impairment. She reminds me that there is a 3% point prevalence of schizophrenia in people with mild intellectual disability, three times higher than in the general population. The focus of understanding is in the area of overlap of schizotypal cognitions, molecular genetics and anomalies of brain structure, where ‘we are seeing a final common pathway that leads to schizophrenia.’ The large data-sets she has in this area fit well with the work of the Patrick Wild Centre, a charitable trust in Edinburgh set up for research into autism, fragile X syndrome and intellectual disability. Politically savvy and persuasive, she raised the funds for the centre, named after a person with severe autism.

Future hopes

In terms of the future, she told me about some hopeful developments in Edinburgh, which have potential for a personalised preventive psychiatry. Starting with a simple skin biopsy fibroblast, stem cells and then neurones can be grown, giving an opportunity to ‘develop drug treatments which basically work on an individual patient’s brain which has been developed in a dish’, as Professor Stephen Lawrie, her successor at the University of Edinburgh, put it. Roll on the day.

1.7.66 Handbook on Obsessive-Compulsive and Related Disorders

Lynne M. Drummond¹

date

2017-8

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- *Handbook on Obsessive-Compulsive and Related Disorders*

This multi-author book examines the disorders categorised in DSM-5 as obsessive-compulsive and related disorders (OCaRDs) and also covers two other related disorders: illness anxiety and obsessive-compulsive personality disorders. The text is written by experts in the field, many of whom were instrumental in developing the concept of OCaRDs in DSM-5. Unlike many multi-author publications, this is brief and to the point. Each of the chapters is arranged in a structured format which includes a general introduction; diagnostic criteria and symptomatology; epidemiology; comorbidity; course and prognosis; psychosocial impairment; developmental considerations; gender-related issues; cultural aspects of phenomenology; assessment and differential diagnosis; aetiology and pathophysiology; treatment (somatic as well as cognitive and behavioural) and a summary of key points at the end. Most chapters also contain illustrative case vignettes which demonstrate the disorders and their potential severity.

This excellent title should be on the bookshelf of every psychiatrist, whether working with adults or children. Mental health workers, managers and commissioners often overlook common conditions such as obsessive-compulsive disorder and body dysmorphic disorder, regarding them as less severe and important than conditions such as schizophrenia. This work describes the hugely detrimental effects these conditions can have on the individual’s mortality, morbidity and social functioning. It also considers newly defined disorders, such as hoarding and skin-picking disorders. These conditions are poorly understood and have generally not been researched extensively. They do, however, appear to be widespread and often have extreme consequences on the individual’s mental and physical well-being. For example, hoarding disorder, which was previously often classified as obsessive-compulsive disorder or else obsessive-compulsive personality disorder, may affect up to 6% of the adult population. Excessive hoarding can lead to death due to fire risk or the falling of large numbers of possessions resulting in an avalanche. It also frequently coexists with self-neglect and – owing to the extreme shame – social isolation. Nevertheless, few community mental health teams in the UK offer comprehensive treatment for hoarding disorders. Some enlightened councils have developed hoarding protocols incorporating housing agencies, social services, and mental and physical health services but overall these are patchy and rare.

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Hopefully, heightened awareness will lead to systematic research and a better understanding of the disorders and their treatment, as well as the development of effective services. This handbook would be a perfect introduction to these areas for a busy practitioner seeking brief but authoritative information.

1.7.67 Shrink Wrapped: Tales from Psychiatrists

Gary Cooney¹

date

2017-8

Contents

- *Shrink Wrapped: Tales from Psychiatrists*

There is something that feels a little otherworldly about *Shrink Wrapped*. As readers, we are invited to find our way into the psychiatrist's mind, to take our bearings from this anonymous collection of short anecdotes and reflections, written by psychiatrists, as a point of departure into understanding what it might mean to be a modern-day 'shrink'. We find warm, affectionate and humorous musings that are abruptly punctured by sharper observations, memories painful to revisit, self-doubt, recrimination and a sense of ever-questioned legitimacy. It is an honest, undiluted look into the experiences of eight psychiatrists, the whispered, confessional moments that blurred the boundaries of their personal and professional lives.

There is a strength of variety to the collection and, at its best, it draws us into questioning ourselves: what kind of a psychiatrist have I become and how did I get here? Does the voice I'm reading remind me of my own thoughts or my own journey? There are, however, one or two weaker moments alongside: in its editorial efforts to be snapshot-succinct, it can sometimes feel frustratingly whimsical and underdeveloped, like a string of highly promising film trailers. There are also passages that veer a little close to what might be found in the reflective practice section of an online portfolio.

Shrink Wrapped is as intimate and conversational as a cup of tea with a close colleague. It considers our own professional self-consciousness, 'the navel-gazing and self-doubt' that besiege our specialty, and takes a frank, unabashed look at the inevitable cross-pollination of our work and life experiences. The collection provides the reader with moments of piercing honesty, such as this summation from one particularly candid contributor, reflecting on what she, as a psychiatrist, might represent: 'I am very clearly a middle class professional White woman who is sitting here telling [the patient] what is happening.'

But who was this woman? Indeed, who were any of these interviewees? Their names are listed in the acknowledgements but not alongside any of their own contributions, an editorial device which purports to leave us free to explore the book in our own way. I found this troubling, untethering, as if I were experiencing these voices in an alternative space. It felt more in service to the interviewees, in defining the boundaries of the reader-writer relationship. It reminded me a little of the dynamic in clinic: you might be able to learn something about a psychiatrist, but not on your own terms. A lot will also be held back.

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1.7.68 Service user perspectives on coercion and restraint in mental health

Diana Rose Emma Perry Sarah Rae Naomi Good

date

2017-8-01

Abstract

Coercion remains a central aspect of many people's mental healthcare. It can include the use of legislation to restrict freedoms, the use of physical restraint, the restriction of freedom of movement and/or association, and the forced or covert administration of medication. There is good evidence that the use of such measures can traumatise service users. This article reports the findings of a survey of service users regarding their experiences of coercion and restraint and embeds this in the wider international and institutional environment.

Contents

- *Service user perspectives on coercion and restraint in mental health*
 - *The CRPD*
 - *Global South*
 - *Industrialised West*
 - *Conclusion: minimising coercion and restraint*

Most jurisdictions in the industrialised West promulgate mental health legislation which permits infringement of liberty and treatment against the will of the person detained. Increasingly, coercion in the community is also allowed. Partly at the behest of the World Health Organization, other countries are developing similar legislation. This ability to compel and coerce is unique in medicine and, from within psychiatry, has been called discriminatory (Dawson & Szmukler, 2006) and criticised for the focus on risk.

Dealing first with the United Nations' 2006 Convention on the Rights of Persons with Disabilities (CRPD) and its implications for coercion and compulsion globally, this article summarises what is known about service users' responses to coercion and compulsion, which includes chemical, physical and mechanical restraint. Responding to the paucity of studies focusing specifically on physical restraint (which is commonly followed by chemical restraint), this article reports on recent experiences of people subject to this practice in the UK while situating this in more general concerns.

The CRPD

The CRPD appears to be top of the agenda for service user movements everywhere except the UK. The European Network for (ex) Users and Survivors of Psychiatry (ENUSP) has provided a point-by-point explanation of how European human rights legislation is in breach of the CRPD and the World Network (WNUSP) was involved in drawing up the Convention itself. It is important as it is the first time that people 'with psychosocial disabilities' have been recognised as equal in law to other citizens in terms of rights.

But the Convention is controversial, particularly since the publication of the General Comment on Article 12, which states that all persons with disabilities must be deemed to have legal capacity all of the time. This intensifies the commitment in Article 14 to abolish compulsory detention and treatment by doing away with the last criterion on which it could be justified. The General Comment has drawn the ire of leading Western psychiatrists (Freeman *et al*, 2015). The debate is also not settled within service user circles, as shown by the different positions of Tina Minkowitz and Anne Plumb (see Spandler *et al*, 2015).

Global South

The CRPD language of ‘persons with psychosocial disabilities’ has also had important implications in the Global South. There is a move from the terms ‘user/survivor’ to ‘persons with psychosocial disabilities’. For example, the Pan African Network of Users and Survivors of Psychiatry is now the Pan African Network of Persons with Psychosocial Disabilities. A similar move has been counselled in India (Davar, 2013). This is not simply a change in language but a political position that states ‘we don’t have psychiatry and don’t want it’.

An Indonesian government programme, Aceh Free Pasung, intends to protect the human rights of people with severe mental illness by eliminating the practice of *pasung* from the province. *Pasung* means restraint by shackles, rope, wooden stocks and cages, and can cause death. Since the alternative was the building of a mental health hospital, the initiative has enabled access to free hospital treatment (Minas *et al*, 2011). Its replacement with neuroleptics, restraint and hospital confinement is nevertheless problematic.

Industrialised West

Decisions about coercion often hinge on the concept of risk. Recent evidence suggests that risk assessments exclude service users from the discussion and render invisible the fact that the assessments are more or less fictions in actuarial terms (Coffey *et al*, 2017).

How risk of harm within mental health settings is perceived and managed has received attention. However, harm in the context of restraint is mostly not recognised. Nonetheless, restraint-related deaths have been reported throughout the Western world, including in the UK, where 38 deaths have been recorded since 1988, 15 of people from Black and Minority Ethnic (BME) communities (Aiken *et al*, 2011). A qualitative study of in-patients showed that nurses and patients had very different accounts of both the determinants of and appropriate responses to violence and aggression (Rose *et al*, 2015).

Reviewing evidence of the effects of restraint, Cusack *et al* (2016) concluded that ‘restraint can be a form of abuse, its inappropriate use often being a consequence of fear, neglect and lack of using de-escalation techniques’.

A small pilot study by the National Survivor User Network (NSUN), as yet unpublished, surveyed 65 people about their experiences of restraint and recruited respondents mainly through the weekly e-bulletin. The findings align with Strout’s (2010) integrative review of the international qualitative literature on patient perspectives on the use of restraint. Strout identifies four categories: negative psychological impact, re-traumatisation, perceptions of unethical practices, and the broken spirit. Of the respondents surveyed in the NSUN study, 43% ($n = 28$) stated that their most recent experience of restraint had felt like an act of aggression ‘a great deal’, 12% ($n = 8$) ‘a lot’ and 15% ($n = 10$) ‘somewhat’. Although the number was small, all respondents from BME communities ($n = 5$) stated that their experience had felt like an act of aggression ‘a great deal’ or ‘a lot’. Respondents frequently cited the unnecessary use of physical force and the number of staff members who were involved in each incident of restraint. The most frequent reason for restraint given by respondents was the refusal to take medication, and physical restraint was routinely followed by a rapid tranquillising injection. This was often experienced as shaming and humiliating:

When I become agitated it is very obviously extreme fear and terror. On each occasion it is ALWAYS male staff pinning me down – always face down so [I] can’t breathe or move and who pull my underwear off/down to inject. They know the abuse history – it has been a police case. They never have talked to me afterwards. It is like being raped again.

One clear theme was the link between instances of physical restraint and tranquillisation with re-traumatisation. Consistent with studies of women’s experience of restraint representing an event that re-enacts the experience of trauma and sexual abuse, Gallop *et al* (1999) found that restraint and associated feelings of humiliation, punishment and powerlessness engendered traumatic emotional reactions such as fear, anxiety and rage.

Half of the respondents stated that experiencing physical restraint had affected their engagement with services ‘a great deal’. The majority reported a loss of trust in staff, and increased fear, suspicion and wariness. Others reported that they avoided services because of their experiences.

The Promise study (Wilson *et al.*, 2015), which informs the development of a proactive care framework to reduce the need for physical intervention, involved interviews with both staff and patients. The most dominant theme to emerge centred on staff–patient communication and relationships, with 11 patients and 19 staff members providing suggestions:

if you wish to reduce the number of restraints a high level of communication is needed whatever the issues of a particular patient, whatever their predisposition to violence or hatred of psychiatric staff, or factions within the resident group, or dislikes of a particular patient. In an ideal world there must be more verbal communication ... the culture is to encourage what Winston Churchill used to say was a 'jaw jaw rather than war war', to counsel and support a person onto a different state of thinking. (Wilson *et al.*, 2015)

Conclusion: minimising coercion and restraint

In the NSUN study, 94% ($n = 50$) of respondents reported that restraint could have been managed very differently, emphasising that if staff had taken the time to listen and to speak to them addressing fears, frustrations and concerns, the situation could have been avoided. Respondents said that staff needed better training and that service users should be involved in this.

No differences were found in the experiences of restraint occurring within the past 10 years compared with the past 2 years. Of the NSUN respondents, 40% ($n = 23$) reported incidents of restraint that occurred within the past 2 years, suggesting no recent improvement in experiences of restraint. These findings signal that the 2-year UK government programme 'Positive and Safe', launched in 2014 with the goal of reducing the need for physical restraint (Department of Health, 2014), has had no impact to date and that a fundamental culture change is needed. This directive was followed by an investigation involving the facedown restraint of a woman eight and a half months pregnant in July 2016 (*Mental Health Today*, 2016).

There are various arguments for reducing coercion and restraint and many different approaches that service users say they find more beneficial. Since 2007 the Mental Health Act in England has made it mandatory for advocacy to be practised by professionals alone, although the service user voice is not completely absent (Newbigging *et al.*, 2015). It will be important to regain and strengthen the user voice within peer and self-advocacy, as has happened in Africa (Kleintjes *et al.*, 2013).

Joint crisis plans or advance directives are counselled by many as a means of reducing incidents of restraint and of listening to the needs of service users (Papageorgiou *et al.*, 2002; Amering *et al.*, 2005). Approaches that include peer facilitators and improvements to the frequency and quality of communications are crucial. Some existing institutional systems make good communication a practical impossibility.

From the perspective of service users, coercion and restraint are mostly harmful and must stop being legitimised. There is an urgent need to challenge and address these practices as they represent gross human rights violations according to the stipulations of the CRPD. UK compliance with the legislation is due to be monitored in the next 2 years.

Conflict of interest. No authors have any conflicts of interest to declare.

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1.7.69 Patient safety and quality of care in mental health: a world of its own?

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date

2017-10

Abstract

Quality and safety in healthcare, as an academic discipline, has made significant progress over recent decades, and there is now an active and established community of researchers and practitioners. However, work has predominantly focused on physical health, despite broader controversy regarding the attention paid to, and significance attributed to, mental health. Work from both communities is required in order to ensure that quality and safety is actively embedded within mental health research and practice and that the academic discipline of quality and safety accurately represents the scientific knowledge that has been accumulated within the mental health community.

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- *Patient safety and quality of care in mental health: a world of its own?*

With repeated examples of failure across the healthcare system,^{1,2} there has long been a need to understand how we can better uphold and improve on the quality and safety of care that is being provided to our patients. There is a gap between the policy and guidelines generated from research evidence and the practice of medical, nursing and allied health professionals. This gap is at risk of increasing, owing to an under-appreciation of heterogeneity in local context³⁻⁵ and the ever-growing demands on the healthcare system, with fewer resources provided to manage them. As a result, quality and safety in healthcare, a discipline which aims to integrate scientific understanding with applied practice, has made significant progress over recent decades and is now regarded as an active and established community of researchers and practitioners alongside the fields of improvement and implementation science.⁶⁻⁸

Such growth has been reflected in the establishment of discipline-specific journals. For example, the BMJ launched *BMJ Quality and Safety* in 1992, and in 2006 a journal devoted purely to implementation science was introduced – *Implementation Science*. The evolution of the discipline has also included the development and refinement of a number of methodological tools, such as Plan, Do, Study, Act (PDSA) cycles and Driver Diagrams, which draw on the manufacturing industry to support individuals in applying continuous quality improvement (CQI) principles in healthcare practice.⁹

Despite the growing international interest in quality and safety in healthcare, its application to a mental health context has not been explored.¹⁰ It cannot be assumed that findings based on physical health in acute care hospitals can be automatically applied to mental health. This is because of the different challenges presented by patients and settings in this specialised area of care, including a greater emphasis on community-based care, greater use of Mental Health Act legislation and increased risk of self-harm.¹⁰ Mental health in general has been viewed as a neglected area and one in which patients may be less likely to have a voice when it comes to their care and safety.¹¹ It has also been suggested that

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the stigma surrounding mental health issues has the potential in itself to contribute to staff neglecting patient safety and quality of care.¹⁰ In order to deliver high-quality care to patients, it is essential that a firmer understanding of patient safety and quality of care in mental health is not only developed, but also disseminated appropriately to ensure that it has the greatest impact.

Key literature searches of high-profile quality and safety journals reveal that there is a lack of published literature under the umbrella term of mental health. For example, a high-level search conducted in *BMJ Quality and Safety* in July 2016 based on the search term 'mental health' appearing in the title or abstract returns just 56 hits across all archives. When restricted to 'mental health' appearing in the title only (and therefore indicating that it is the primary focus of the article), the search returns just 17 results. This is disappointing, especially when compared with similar searches on key search terms for other medical specialties, for example paediatrics (94 hits for title and abstract) and surgery (237 hits for title and abstract). These findings are also reflected in other notable quality and safety journals such as *Implementation Science* (30 hits for 'mental health' in a title-only search) and the *International Journal for Quality in Health Care* (15 hits for 'mental health' in a title-only search). We recognise that there are inherent challenges in these comparisons, including selection of terminology and disciplines; however, these searches are intended to be illustrative rather than exhaustive.

Even the small number of studies that are returned from these searches do not consistently focus on mental health as the primary setting of interest. Instead, mental health tends to form one component of a system-level study often associated with high-level quality improvement and quality of care structures in the healthcare system.¹²⁻¹⁴ In other instances, mental health is positioned as just one example or context alongside physical health settings and is therefore not the sole focus of the article or its key messages.¹⁵⁻¹⁷ Generally, the work being published in these quality and safety journals does not focus on aspects of safe care that may be of specific importance to a mental health setting or explore how established quality and safety metrics apply and translate to this unique context. However, searches do identify a systematic review on medication errors in mental health¹⁸ and some work around continuity of care and communication between in-patient and out-patient mental health settings, for example.¹⁹

Contrary to these findings, searches run across the broader medical and social science literature reveal that much has been published on the topic of quality and safety in mental health in other, more specialty-specific areas (e.g. psychiatric nursing journals). For example, academic teams in mental health led by Louis Appleby, Len Bowers and Joy Duxbury contributed a significant amount of work. Therefore, it seems that the issue is not necessarily a lack of work on quality and safety within a mental health context, but instead a lack of its representation as part of the stand-alone quality and safety discipline.

The specialty-specific literature succeeds at providing a significant amount of research into patient safety incidents that are more precisely related to a mental health setting. These include violence and aggression, patient victimisation, suicide and self-harm, seclusion and restraint, and absconding and missing patients.¹⁰ Other key areas that apply more broadly across all settings are falls and other patient accidents, adverse medication events and adverse diagnostic events such as misdiagnosis. This literature is not without its faults, however, as there is a tendency for it to focus on areas of safety that may be of greatest concern to the public rather than areas of quality that may contribute most to patient experience and clinical outcome effectiveness. It may also not be fully reflective of the vast developments that have been made in understanding quality and safety in healthcare more broadly.

There is a clear disparity between the two bodies of literature (i.e. work around mental health within the established quality and safety discipline and work around quality and safety of care within the broader and less defined mental health discipline). In recent years there has been a call for 'parity of esteem' between physical and mental health (i.e. recognition of mental health as an equally important discipline within medicine).^{20,21} The data that we have presented certainly suggest that there is no parity in the attention being paid to quality and safety, and this is an area that requires attention. The structure of the National Health Service (NHS) is guilty of fostering this separation, to some extent, through commissioning different organisations to provide physical and mental healthcare.²² However, Academic Health Science Networks are aiming to help break down historical barriers between acute care and mental health trusts.

Furthermore, the two bodies of literature appear to exist in silos and do not explicitly refer to or build on one another as a matter of course. Therefore, the core integration of the quality and safety discipline with the mental health setting is currently lacking and not fully reflective of the scientific understanding that has been incrementally built up via the specialty-specific journals. The opportunity has also been missed for the two bodies of work to effectively communicate, learn from each other's limitations and strengthen one another. For example, a more thorough integration could ensure

that quality and safety is explored across the board within the mental health setting in a way that is appropriately sensitive to the local context without being restrictive. This approach is likely to have the greatest direct benefit to mental health patients when such research translates into clinical practice.

It is important to discuss and reflect on the potential reasons for this disparity in order to understand how it might be rectified in the future. It is possible that academics focusing specifically on quality and safety as a research area (i.e. not wedded to any particular specialty) are not conducting a sufficient amount of research in a mental health context. Assuming that academics of this type are more likely to submit to quality and safety rather than specialty-specific journals, it is possible that the issue centres on a lack of work being completed in these settings by patient safety and quality improvement researchers.

A recent independent report into the quality of in-patient mental health services highlighted the need for further training and use of quality improvement in mental health services.²³ The Royal College of Psychiatrists also recognise this issue and have set up a working group to steer progress. The Institute for Healthcare Improvement (IHI) is working with a number of mental health trusts in the UK to build capacity and capability to implement quality improvement programming at scale. It is important to recognise the challenges in applying improvement science in different healthcare delivery models, targeting different health conditions that follow very different courses. For example, the challenge of adapting quality improvement methodology for long-term conditions (which is often the case in a mental health setting) as opposed to interventional healthcare where it is simpler to measure impact and change pre- and post-implementation.

We must also consider what drives authors to publish in specialty-specific rather than quality and safety journals. It may be the case that mental health professionals and academics are more motivated to do so. For example, they may have concerns about ensuring that their work has the greatest impact or be unaware of the alternative journals that are appropriate. If this is the case, then raising awareness across the scientific community will be vital for ensuring that authors submit their work to the most suitable outlet in terms of target audience and opportunities for translation. On a separate note, it is possible that work is already being submitted to quality and safety journals but is not being accepted. There may be factors around quality of work and acceptance processes that need to be considered. This could be due to differences in academic approach and levels of rigour across the disciplines.

These dilemmas have a number of potential implications for both research and practice, and recommendations for the future are required in order to increase and support integration between the two bodies of work. Both the quality and safety and mental health disciplines should be concerned by the clear disparities between their bodies of work. Existing in silos automatically forms a barrier to effective quality improvement and safer patient care. Mental health should form a core part of the quality and safety agenda and influence the ways in which it grows and develops as a discipline over time. The disparity may also prevent the academic expansion of the discipline as a science owing to a lack of incremental growth that is fully reflective of all relevant research on this complex topic area. It is also likely that the mental health community will miss out on full access to the knowledge that has been accumulated within the quality and safety discipline, which will therefore prevent optimal patient care.

Quality and safety journals should explicitly invite submissions from the mental health community in order to demonstrate their openness to work based in this setting. Simultaneously, mental health professionals and academics should be made aware of the different disciplines with which they could be integrating their work, and should not be penalised for publishing their work in quality and safety rather than specialty-specific journals. The long-term goal should be to normalise that quality and safety journals are a viable option for mental health professionals' academic work. This would involve incorporating and building on the present understanding of quality and safety that has already been developed more broadly, rather than scoping out a separate area of quality and safety that applies solely to the mental health setting. Patient safety and quality of care in mental health should not be existing in a world of its own but instead be a fully integrated component of the broader scientific discipline. It is the responsibility of members of both communities to ensure that this happens.

1.7.70 A Devil's dictionary for mental health

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2017-10

Abstract

Clinical psychiatry, for all its emphasis on scientific rigour, is mediated mainly by words rather than by numbers. As with other professional areas, it has developed its own set of jargon words and phrases. Many of these are not the technical terms traditionally seen as jargon, but standard English words and phrases used in an idiosyncratic way. They therefore go unnoticed as jargon, while enfeebling our communications. I have used the template of Ambrose Bierce's *The Devil's Dictionary* to highlight some examples, with the aim of helping us all to talk, write and, perhaps, think more clearly.

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 - *What is jargon?*
 - *My Devil's Dictionary*
 - *Casting out demons*

A review of health literacy suggests that patients often do not understand what doctors are trying to tell them – and, rather obviously, tells us that we should be more straightforward.¹ But it is not just us. The US boss of Pfizer has exasperated a British parliamentary committee with his obscure business jargon.² Farrington has highlighted the chasm between clinical and managerial language.³ Brian Lask pilloried the 'infestation' of family therapy publications with jargon, pomposity and impenetrability.⁴ And, although they were mainly addressing technical obfuscation, a pair of psychologists have trenchantly characterised much of the research communication in their field as 'bullshit'.⁵ They recommend translating 'others' procedures and outcomes in(to) ordinary language' to separate out any discernible content from the chaff of jargon.

But I am not here going to consider how we talk to patients or managers – or even researchers and academics. I have been thinking about how we talk to each other. It can be said that technical jargon does not matter inside a profession because each participant understands the words involved. It only becomes a problem when a professional tries to communicate with outsiders.⁶ But I think we may have a problem in day-to-day communication between those of us involved in mental health services. Over the past few years I have noticed the appearance of words and phrases which, because of their novelty and lack of definition, create real problems with communication. Many of these can be seen as 'weasel' words or phrases. They carry a covert meaning or overtones of meaning – or, sometimes, no meaning at all. They can be defined as 'something that someone says either to avoid answering a question clearly or to make someone believe something that is not true' (<http://dictionary.cambridge.org/dictionary/english/weasel-words>). Some are more technical, but all can be seen as forms of jargon owing to their characteristic use in medicine and psychiatry.

¹

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What is jargon?

But what is jargon? The current version of the online Oxford Dictionary defines it as ‘Special words or expressions used by a profession or group that are difficult for others to understand’. It also tells us that it been with us for nearly 400 years, being derived from Late Middle English, originally in the sense of ‘twittering, chattering’, later ‘gibberish’ (www.oxforddictionaries.com/definition/english/jargon). Earlier dictionaries are more robust: ‘Barbarous or debased language: gibberish: speech full of technical terms etc’.⁷ Synonyms include slang, cant, idiom, argot, patter and gobbledegook (www.thesaurus.com/browse/jargon). Nobody much likes jargon, even though we all seem driven to use it.

At first hearing, such language may not sound at all technical. The words or phrases are drawn from day-to-day English, but, as we use them, their meaning starts to dissolve. They become the aforementioned weasel words because they are either novel or of broad, inclusive meaning. Those inside a profession find that they can use such language in an idiosyncratic way to preserve professional authority and power.⁸ If you cannot understand a discussion, you cannot participate. The young may feel that they have to use this language to be an authentic part of professional life. The old, consciously or unconsciously, realise that it can be used to conceal, confuse, stonewall and neuter objections or criticism. Moreover, jargon is mostly categorical and conceptual, not concrete and specific. It can present an intimidating facade behind which, if one takes the trouble to look, there is little of substance. Although unsavoury, is it not a victimless crime? Not according to the House of Commons Public Administration Select Committee. They felt that ‘the use of inaccurate, confusing or misleading official language which results in tangible harm, such as preventing individuals from receiving benefits or public services, should be regarded as maladministration’ (p. 16).⁶ Perhaps, then, we should take this issue more seriously.

One might, in an uncharitable moment, single out managers as the main offenders. However, I have heard colleagues from our sister professions talking impenetrably, as well as my fellow psychiatrists and, regrettably, myself. We are all guilty. So, I decided to round up some words and phrases that seem, to me, to be misused in this way. Some of these are specific to psychiatry and mental health, some are used across medicine. Some remain a local coinage, others have attained a more universal currency. We hear some in the front line, in wards and community teams, and others in committee rooms and consultation papers. Ambrose Bierce was a 19th-century journalist who was similarly intrigued by the ways in which language can be misused. I have used the template of his *The Devil’s Dictionary*⁹ to produce my own, somewhat scattershot, rogue’s gallery.

My Devil’s Dictionary

Acting out: an analytical term provoked by extravagant behaviour. Example: ‘the patient acted out by shouting in the lounge’. We are thereby relieved from the burden of considering the matter further.

Adherence (to medication, advice, etc.): a delusion, held by all doctors, most strongly by enthusiastic pharmacologists. For us, a mainstay of treatment. For our patients, an irritation best neglected. They are reluctant to reveal their disinterest, not wishing to distress their psychiatrist.

Acuity: a snappy euphemism which removes to arms-length the stress and risk of our under-resourced and risky services. Essential to reduce the anxiety felt in higher echelons of management.

Behavioural: a term used by those of us with no behavioural training, to describe behaviour of which we disapprove (*see* ‘Acting out’). Commonly combined with ‘just’ – ‘It’s just behavioural’. Usually paired with the helpful conclusion: ‘he/she is not for our service’.

Best evidence: the cracked and misty lens with which the one-eyed man navigates the country of the blind.

Care pathway: a sequence of ideal interventions (*see* ‘Best evidence’) for a model patient. Lengthy and complicated, so best illustrated on a sheet of A3 paper. The dogged patient may be said to trudge, march or run the gauntlet on such a trek.

Challenge: the presentation of the impossible and implausible as a bold plan. Example: the NHS Challenge – save £20 billion in the next 3 years while improving quality. You can then, subsequent to the inevitable failure of the plan, pillory those involved as being old-fashioned, inflexible, not trying hard enough ... according to taste.

Clinician: a drone, a harmless drudge who sees patients. They can apparently perform audit, supervision and research simultaneously (*see* ‘Job description’). Their ability to be in two places at once (*see* ‘Job description’) suggests that they would have been burned as witches in less scrupulously rational times.

Consultation: the practice of gathering views about a proposed change in a service. To complain that such views are subsequently ignored would be both harsh and naive (*see* ‘Listening event’ and ‘Efficiency saving’).

Cover: an illusion of doubles. It suggests that an overworked colleague will also do your work in your absence. Essential to maintain the appearance of an adequately staffed service.

Cut: the Voldemort word that must never, ever, be uttered (*see* ‘Efficiency saving’). Sometimes linked with ‘Transformation’.

Distress: a catch-all for every experience from mild anxiety to raging psychosis. As one gently minimises the more extreme and intractable varieties of experience, one can slyly insinuate that psychiatry is just a way to medicalise normal experience.

Efficiency saving: as the wolf to Red Riding Hood’s grandmother. Cloaked in two benign words with which none can take issue, it stalks our services – and suddenly they disappear. *See also* ‘Challenge’ and ‘Cut’.

Evidence: the single academic paper that supports one’s proposed course of action.

Holistic: a synonym for comprehensive, originating from the word ‘whole’. But where did the ‘W’ go? The spelling generates a spurious overtone of spirituality. Clearly not intentional; evidence of unconscious processes at work.

Hypothesis: a simple idea that leaves port to the sound of marching bands, but then founders on the rocks of bureaucracy or upon the craggy island of sober reflection.

Integration: the unicorn of service provision. Often spoken of but rarely seen. Some say they have seen it in Birmingham. Others say it is a mirage, glimpsed by the desperate.

Innovation: a novelty that attracts money.

Inappropriate (behaviour): rational behaviour of which we disapprove. Studiously neutral, it is commonly used in close proximity to an emphatic font. Example: ‘patients must *not* use our accident and emergency department inappropriately’.

Job description: a work of fantasy that masquerades as a workaday agenda. As nectar to the bee, it attracts naive applicants to your service while obscuring the inquisitive gaze of our College. Any subsequent disaffection can be met with the phrase ‘caveat emptor’.

Just: an excellent way to deny complexity. One can avoid the trouble of biopsychosocial formulation without admitting to idleness, ignorance or indifference. Example: ‘It’s just... behavioural/social/drug-induced...’.

Liaison: the assurance that someone will, at some time, communicate something to someone. Example: ‘Community mental health team to liaise with primary care’. A common parasite of care plans and strategy documents. The phrase ‘liaison psychiatry’ can be honourably exempted.

Listening event: a talking shop.

Metric: a swaggering and self-confident synonym for ‘number’, ‘figure’ or ‘statistic’. It ballasts with false weight the inadequate and corrupted data that leak out of our struggling services.

Medical model: a synonym for the crudely biological. Essential if one has a sketchy acquaintance with medicine but a sincere desire to damn psychiatry. Best bolstered by a quote from an antique textbook which few have ever read – or even heard of.

Mission statement: a haiku of the obvious. A way for those remote from the front line to sincerely avow the commitments of an organisation. Only misfits and malcontents could assert that such statements are banal and platitudinous.

New ways of working: the promise that clinical drones (see above) can become queen bees. The admirable and novel element is that psychiatrists should, as far as possible, steer well clear of patients.

Ongoing: a way to communicate to the naive reader an impression of dogged and ceaseless activity.

Paradigm shift: a bit of a change. It proclaims how different (and how much better) your pet idea (*see* ‘Hypothesis’) is from everything that has gone before. Such shifts promise seismic change but most, mysteriously, register zero on the Richter scale of life.

Prioritisation: cutting one service to provide another. One service dies and another is born. Disney’s circle of life.

Quality indicator: an easily measurable irrelevance.

Quality improvement: an unarguable good. It marvellously exempts management from any responsibility for the lack of armaments or ammunition and ‘empowers’ frontline platoons to sort out the subsequent carnage.

Research: the selection of an unrepresentative group of people, the provision of an unsustainable intervention and the careful selection of a rating cut-off point to show your intervention to its best advantage.

Recovery: a two-edged sword. To Tweedledum, an essential reorientation of services to patient priorities. To Tweedledee, a pretext for culling rehabilitation services.

Reconfiguration: another attempt to rearrange the chairs on the deck of the Titanic (*see* ‘Transformation’).

Significance (statistical) (*see also* ‘Research’): a simple number that lends colossal weight to negligible differences.

Signposting: a respectable way to rebuff those seeking help from our service. We direct the patient towards another step on their therapeutic pilgrimage (*see* ‘Care pathway’), braced by the pious assurance that another will meet their need. Much loved by hard-pressed commissioners for whom distance from our services is by far the best medicine.

Target: a worthy aim, applauded by all. The resources marshalled to meet it hyperperfuse privileged parts of the organisation but induce gangrene and necrosis elsewhere.

Triage: a battlefield technique to sift the doomed from the salvageable. Applied to civilians in peacetime when the money runs out.

Transformation: an ‘abracadabra’ word, the promise to turn an ugly duckling into a swan. This powerful spell can reduce resistance to modish technology or to shedding staff. Memories mysteriously fail when the new swan proves to be just another maladroit fowl.

Vision(s): in a patient, evidence of brain dysfunction. In ourselves, evidence of foresight, imagination and understanding.

Work-life balance (*see* ‘Job description’): an excellent way to communicate an uncomfortable truth. Example: ‘We know you need to work X+1 sessions to do the job, but we will only pay you for X sessions’. Dissimulation is charmingly paired with an expression of concern for one’s welfare.

Casting out demons

The American edition of the online Oxford Dictionary, somewhat uncharitably, states that weasel words are ‘intentionally ambiguous or misleading’.⁷ I am less judgemental and would suggest that they have a less deceitful function. They help us to feel more at ease with difficult truths we have both to confront ourselves and to present to others. However, although we may feel more comfortable, we will not be communicating as well as we could – and not thinking as clearly as we should. I would not go as far as the Local Government Association which was widely reported to have published, for its members, a list of banned words and phrases.¹⁰ After all, context is everything and, in spite of my accusations, some of these words may be used quite helpfully from time to time. But an awareness of them can serve us as the canary once served the coal miner: as a sign that something may not be quite right, and that we need to keep our wits about us. To the charge that I am a cynic, I confess that I do not have the stomach for it. I still shrink from the uncomfortable and cling to desperate and unreasonable hopes. I have been unable to yet become that paragon described inimitably by Bierce⁹ (p. 34) as ‘A blackguard whose faulty vision sees things as they are, not as they ought to be’.

This list is not comprehensive and is certainly not static. New weasel words will emerge as others wither and perish. Each of us can identify our own offenders. To pay attention to how we talk (and write) is not self-indulgent. It can help us to think more clearly, to communicate more meaningfully and to engage with reality rather than self-serving fantasy.

1.7.71 Personality disorder services in England: findings from a national survey

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Abstract

Aims and method We aimed to evaluate the availability and nature of services for people affected by personality disorder in England by conducting a survey of English National Health Service (NHS) mental health trusts and independent organisations.

Results In England, 84% of organisations reported having at least one dedicated personality disorder service. This represents a fivefold increase compared with a 2002 survey. However, only 55% of organisations reported that patients had equal access across localities to these dedicated services. Dedicated services commonly had good levels of service use and carer involvement, and engagement in education, research and training. However, a wider multidisciplinary team and a greater number of biopsychosocial interventions were available through generic services.

Clinical implications There has been a substantial increase in service provision for people affected by personality disorder, but continued variability in the availability of services is apparent and it remains unclear whether quality of care has improved.

Contents

- *Personality disorder services in England: findings from a national survey*
 - *Aims*
 - *Method*
 - * *Survey design*
 - * *Sample*
 - * *Procedure*
 - * *Survey questionnaire*

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- * *Data analysis*
- *Results*
 - * *Respondents*
 - * *Primary study aim: availability of services for people with personality disorder*
 - * *Secondary study aims: quality indicators of available services*
- *Discussion*
 - * *Limitations*
 - * *Further developments*

Personality disorder is a serious mental health condition affecting up to 52% of psychiatric out-patients and 70% of in-patients and forensic patients.¹⁻⁴ Given the significant public health implications associated with the disorder – including extensive use of healthcare resources, high rates of suicide and reduced life expectancy – effective treatment is a priority.⁵⁻⁸

In 2003, the National Institute for Mental Health England (NIMHE) published *Personality Disorder: No Longer a Diagnosis of Exclusion*, challenging the healthcare community to address shortcomings in the treatment of people with personality disorders.⁹ Citing a survey of English mental health trusts conducted in 2002, the paper brought to attention the variability in practice and highlighted institutionalised stigmatisation which explicitly barred patients with personality disorder from mainstream services. At that time, only 17% of trusts had a dedicated personality disorder service, 40% provided some level of service, 28% had no identified service, and 25% did not respond.⁹

The 2003 NIMHE publication⁹ set out broad principles for how personality disorder services should be developed, stipulating that they should be multidisciplinary, follow a hub-and-spoke model, accept the management of risk, use the care programme approach (CPA),¹⁰ offer specialist biopsychosocial interventions, deliver training and consultation, and support the development of patient networks. Similarly, the 2009 guidance on borderline personality disorder from the National Institute for Health and Care Excellence (NICE) specified that mental health trusts should develop specialist multidisciplinary teams and/or services for people with personality disorders.^{11,12} In 2011, a preliminary investigation at a regional level found that specialist service capacity for those with personality disorder was inadequate.¹³ There have been no systematic attempts at a national scale aimed at understanding how the evidence for the management of personality disorder is being applied or whether service availability has become more uniform.

In 2014, the National Personality Disorder Service Review Group was formed to evaluate the extent to which variable service availability affects those with personality disorder. The group used the vision of *Personality Disorder: No Longer a Diagnosis of Exclusion* as its benchmark. Through this lens, we sought to map the availability and nature of dedicated personality disorder services, and to compare these to the care for clients with personality disorder available through generic services. The group drew on a wide range of evidence to define the concept of a ‘dedicated personality disorder service’. This included the Delphi study of the 11 pilot personality disorder projects within the National Personality Disorder Programme.¹⁴ We considered a dedicated service as one which is explicitly designed to manage the care of individuals affected by personality disorder, as opposed to a generic service which might be considered a typical community mental health service. *Table 1* displays the characteristics hypothesised by the group to distinguish dedicated from generic services.

Summary of service characteristics

Dedicated personality disorder services	Generic services
Personality disorder inclusion	No diagnostic inclusion/exclusion criteria
Variable service availability	Ubiquitous
Personality disorder-specific interventions	Offer range of biopsychosocial interventions
Specialist team	Mainstream multidisciplinary team
Local, regional and national catchment	Local catchment
Variable tiers (T1 to T6)	Locally focused tiers (T2 to T3)
Target complexity	Range of complexity
Treatment, consultation and training	Treatment orientation
Variable framework (includes CPA)	Operate under CPA framework

CPA, care programme approach.

Aims

The primary aim of this study was to describe a number of organisations which provided care for those affected by personality disorder and whether this care was delivered through dedicated personality disorder services, generic services or both.

The secondary aim was to evaluate the provision of services for personality disorder along key quality indicators outlined by NICE and NIMHE,^{9,11,12} and explore any differences between dedicated and generic services. The quality indicators evaluated were: Is there a multidisciplinary team available? Is care managed under the CPA process? Are patients offered specific interventions for personality disorder within a biopsychosocial approach? Are services involved in education, training and research? What level of patient and carer involvement do services employ? What exclusion criteria, if any, are applied by services?

Method

Survey design

We conducted a cross-sectional survey of mental health organisations in England using a questionnaire designed for this study. Data were collected between January and June 2015 using an online survey tool (www.surveymonkey.com).

Sample

The sample included any English mental health National Health Service (NHS) trust or independent provider of mental healthcare to adults or young people. In 2015 there were 57 relevant English mental health NHS trusts and 10 independent service providers, all of whom were approached to participate in the survey.

Procedure

Letters were sent to the medical directors of each NHS mental health trust and the CEOs of the independent providers informing them of the survey and requesting the name of the individual who they considered to have the requisite knowledge to complete the survey. Once details of these individuals were obtained, letters were sent inviting them to take part. Non-responders were followed up at least twice where necessary, offering further information or support to complete the survey questionnaire.

Survey questionnaire

Following an analysis of available literature, the electronic survey was structured to address the primary and secondary aims of the project. Participants were asked to briefly describe their organisation (e.g. NHS or independent provider, geographical remit) and their own professional role. They were then given a brief definition of a dedicated personality disorder service and of a generic service and asked to indicate whether their organisation had services of each type and detailed questions about its characteristics. We requested details of a maximum of five dedicated personality disorder services per organisation.

Questions relating to service characteristics included service leadership, team make-up, service access, inclusion and exclusion criteria, care management framework, intervention availability, patient and carer involvement, and training, education and research activity. The survey took up to 45 minutes to complete and could be conducted electronically or with telephone support.

Data analysis

Data were downloaded from Survey Monkey and entered initially into Excel for checking and data cleaning, and transferred to STATA (version 11) for statistical analysis. To address the primary aim of the survey, the characteristics of services were summarised descriptively in order to build a picture of service availability and characteristics. The availability of biopsychosocial interventions was assessed by generating a score ranging from 0 to 100 based on the number of available interventions of each type, weighted to give equal consideration to each of the three domains. The availability of personality disorder-specific interventions was assessed by determining whether services offered psychological therapies developed specifically for personality disorder.¹⁵ The level of perceived patient and carer involvement was similarly analysed and scored from 0 to 100 based on the number of involvement activities for each service, with paid involvement double weighted.

To address the secondary aims of the survey, logistic and linear regression was used to evaluate the effect of service type (dedicated or generic) on professional diversity, exclusion criteria, CPA usage, biopsychosocial provision, patient and carer involvement, and training, education and research activity. Multilevel models, with a random effect for organisation, were used to adjust for the potential higher similarity between services within the same organisation than between services from different organisations. Robust standard errors were used for linear variables that did not conform to a normal distribution. Where significant differences between dedicated and generic services were found, multivariate models were used to adjust for the influence of potentially confounding service characteristics.

Results

Respondents

Of the 57 relevant English mental health NHS trusts, 52 responded (response rate 91%) and of the 10 independent service providers approached 4 responded (response rate 40%).

Primary study aim: availability of services for people with personality disorder

Of the 56 organisations that responded to the survey, 47 (84%) reported having at least one dedicated personality disorder service and 43 (77%) reported having both generic and dedicated services. The remaining 4 organisations (7%) stated that they did not have any generic services and that all services were specialist; all offered dedicated personality disorder services. Nine organisations (16%) did not have any dedicated personality disorder services, and all of these stated that their generic services catered to personality disorder. Patients were reported to have equal access to dedicated personality disorder services in 31 (55%) of the organisations surveyed.

The number of dedicated personality disorder services per organisation ranged from 1 to 5 (mean 1.7, s.d. = 1.1). Across the 52 English mental health NHS trusts, 71 dedicated personality disorder services and 48 generic services were described, a mean of 1.37 dedicated service per organisation (range 0–5). The four independent service providers described ten dedicated personality disorder services; a mean of 2.50 dedicated service per organisation (range 1–5). *Figure 1* compares the findings with the survey of 2002. To aid comparison, the independent sector organisations have been removed from the 2015 results so that only English NHS mental health trusts are referred to. Tables 2, 3, 4, 5 and 6 summarise the characteristics of the dedicated and generic services across all domains surveyed.

Summary of service and team characteristics

	Dedicated <i>n</i> (%)	Generic <i>n</i> (%)
Tier 1	9 (11)	
Tier 2	43 (53)	
Tier 3	45 (56)	
Tier 4	17 (21)	
Tier 5	11 (14)	
Tier 6	1 (1)	
Service level leadership		
Consultant clinical psychologist	26 (32)	6 (12)
Consultant medical psychotherapist	21 (26)	2 (4)
Consultant psychiatrist	13 (16)	25 (49)
Consultant nurse	8 (10)	0 (0)
Clinical psychologist	4 (5)	1 (2)
Consultant adult psychotherapist	3 (4)	0 (0)
Non-medical psychotherapist	1 (1)	0 (0)
Undisclosed	3 (4)	16 (31)
Other	2 (2)	2 (4)
Team constitution		

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Table 15 – continued from previous page

	Dedicated <i>n</i> (%)	Generic <i>n</i> (%)
Nurse	56 (69)	45 (88)
Consultant clinical psychologist	41 (51)	29 (57)
Trainee psychologist	37 (46)	40 (78)
Consultant medical psychotherapist	36 (44)	18 (35)
Clinical psychologist	32 (40)	44 (86)
Occupational therapist	32 (40)	42 (82)
Social worker	31 (38)	38 (75)
Non-medical psychotherapist	30 (37)	25 (49)
Peer worker	26 (32)	26 (51)
Consultant adult psychiatrist	25 (31)	45 (88)
Trainee psychiatrist	24 (30)	37 (73)
Consultant nurse	20 (25)	21 (41)
Advocate	13 (16)	16 (31)
Consultant forensic psychiatrist	10 (12)	14 (27)
Pharmacist	10 (12)	25 (49)
Forensic psychologist	6 (7)	14 (27)
Trainee medical psychotherapist	4 (5)	13 (25)
Probation professional	4 (5)	5 (10)
Consultant forensic psychologist	3 (4)	11 (22)
Dual diagnosis professional	2 (2)	17 (33)
Clinical management framework		
Under CPA	64 (79)	47 (92)
Not under CPA	9 (11)	2 (4)
Not applicable	8 (10)	6 (12)

CPA, care programme approach.

Summary of interventions offered

	Dedicated service	Generic service
Biological interventions, <i>n</i> (%)		
Medication management	42 (52)	46 (90)
Organic investigations	28 (35)	42 (82)
Physical healthcare interventions	27 (33)	44 (86)
MUS management	23 (28)	27 (53)
Psychological interventions, <i>n</i> (%)		
Psychoeducation	44 (54)	40 (78)
DBT	40 (49)	29 (57)
MBT	35 (43)	21 (41)
Psychodynamic	30 (37)	27 (53)
CBT	27 (33)	42 (82)
CAT	26 (32)	35 (69)
Art therapies	22 (27)	25 (49)
Therapeutic community	19 (23)	9 (18)
Family therapy	14 (17)	26 (51)
Motivational interviewing	14 (17)	22 (43)
SFT	10 (12)	23 (45)
STEPPS	8 (10)	8 (16)

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Table 16 – continued from previous page

	Dedicated service	Generic service
Social interventions, <i>n</i> (%)		
Peer support	39 (48)	26 (51)
Vocational support	37 (46)	34 (67)
Occupational therapy	35 (43)	41 (80)
Social work	32 (40)	36 (71)
Housing support	31 (38)	37 (73)
Benefits advisory	28 (35)	28 (55)
Advocacy	25 (31)	31 (61)
Bio-psychosocial interventions rating, mean (s.d.)	3.4 (2.5)	6.3 (2.0)

CAT, cognitive–analytic therapy; CBT, cognitive–behavioural therapy; DBT, dialectical behaviour therapy; MBT, mentalisation-based therapy; MUS, medically unexplained symptoms; SFT, schema-focused therapy; STEPPS, systems training for emotional predictability and problem solving.

Summary of development activities

Integrated development activities	Dedicated <i>n</i> (%)	Generic <i>n</i> (%)
Training	75 (93)	27 (53)
Education	66 (81)	22 (43)
Research	56 (69)	18 (35)
Training + education + research	48 (59)	13 (25)

Summary of patient and carer involvement

	Paid, <i>n</i> (%)	Voluntary, <i>n</i> (%)		
Patient				
Service development	25 (31)	24 (47)	33 (41)	23 (45)
Education and training	25 (31)	19 (37)	26 (32)	20 (39)
Treatment	14 (17)	11 (19)	16 (20)	13 (25)
Service delivery	14 (17)	5 (10)	20 (25)	16 (31)
Leadership	11 (14)	11 (22)	14 (17)	10 (20)
Care planning	7 (9)	8 (16)	19 (23)	13 (25)
None	18 (22)	19 (37)	9 (11)	20 (39)
Carer				
Service development	1 (1)	1 (2)	11 (14)	11 (22)
Education and training	3 (4)	4 (8)	5 (6)	7 (14)
Service delivery	2 (2)	3 (6)	3 (4)	7 (14)
Care planning	0 (0)	3 (6)	10 (12)	9 (18)
Treatment	0 (0)	2 (4)	2 (2)	5 (10)
Leadership	3 (4)	2 (4)	2 (2)	3 (6)
None	14 (17)	39 (76)	9 (11)	32 (63)
	Dedicated	Generic		
Patient and carer involvement rating, mean (s.d.)	12.4 (12.3)	6.3 (5.6)		

Service level exclusion

Criteria	Dedicated <i>n</i> (%)	Generic <i>n</i> (%)
Uncontrolled substance misuse	43 (53)	10 (20)
Active risk to others	19 (23)	2 (4)
Ability to engage	16 (20)	4 (8)
Comorbid psychotic disorder	14 (17)	1 (2)
Developmental disorder	12 (15)	1 (2)
Gender	11 (14)	1 (2)
Forensic history	6 (7)	1 (2)
Comorbid affective disorder	6 (7)	1 (2)
Active risk to self	4 (5)	2 (4)
Past risk to others	2 (2)	0 (0)
Past risk to self	0 (0)	0 (0)
Prescribed medication	0 (0)	0 (0)
None	18 (22)	35 (69)
Others or not applicable	7 (9)	6 (12)

Secondary study aims: quality indicators of available services

1. Is there a multidisciplinary team available?

Across services, teams varied widely in their multi-disciplinary composition (*Table 2*). Within services, team make-up was significantly less diverse in dedicated than in generic services, with the latter utilising almost twice as many different types of professional on average (dedicated personality disorder services mean 5.7, s.d. = 3.0; generic services mean 10.5, s.d. = 5.1 ($= 4.85$, 95% CI 6.37 to 3.32, $P < 0.01$)). Dedicated services remained less professionally diverse than generic services after adjusting for the range of biopsychosocial interventions available, the provision of personality disorder-specific interventions, and the profession of the service lead ($= 3.14$, 95% CI 4.46 to 1.82, $P < 0.01$). This suggests that the less diverse workforce in dedicated services was not simply due to providing a more focused range of interventions.

2. Is care managed under the CPA process?

Almost all services used the CPA as their management framework. There was no difference between dedicated and generic services in CPA usage (odds ratio (OR) = 0.22, 95% CI 0.04 to 1.47, $P = 0.12$).

3. Are patients offered specific interventions for personality disorder within a biopsychosocial approach?

Across services, there was a fairly wide availability of a number of different biological, psychological and social interventions. *Table 3* includes the mean biopsychosocial ratings stratified by service type. Generic services had significantly higher biopsychosocial ratings than dedicated ones, indicating a greater availability and diversity of interventions ($= 3.02$, 95% CI 2.32 to 3.73, $P < 0.01$). However, services led by medics offered a greater range of interventions than those led by other professionals ($= 1.09$, 95% CI 0.97 to 2.84, $P < 0.01$), as did services with a more diverse professional make-up ($= 0.38$, 95% CI 0.32 to 0.45, $P < 0.01$). Biopsychosocial intervention provision did not differ between dedicated and generic services after adjusting for these factors ($= 0.69$, 95% CI 0.29 to 1.68, $P = 0.17$). Contrary to hypothesis, the availability of interventions developed specifically for personality disorder (such as dialectical behaviour therapy (DBT), mentalisation-based therapy (MBT), schema-focused therapy (SFT) and systems training for emotional predictability and problem solving (STEPPS)) did not differ significantly between dedicated and generic services (OR = 0.91, 95% CI 0.37 to 2.21, $P = 0.83$).

4. Are services involved in education, training and research?

Most services were involved in at least one of these activities (*Table 4*). The rates of participation in these activities for dedicated services were approximately twice those of generic services, and dedicated services were significantly more likely than generic services to be involved in all three of these activities (i.e. education, training and research) (OR = 6.18, 95% CI 2.29 to 16.69, $P < 0.01$). This difference remained significant after adjusting for the profession of the service lead and for the professional diversity of the team (OR = 31.67, 95% CI 4.26 to 235.5, $P < 0.01$).

5. What level of patient and carer involvement do services employ?

Table 5 contains the mean patient and carer ratings stratified by service type. Very few services had no patient or carer involvement, and the odds of having any involvement activity did not differ between dedicated and generic services (OR = 1.17, 95% CI 0.42 to 3.22, $P = 0.77$). However, dedicated services had significantly higher patient and carer involvement ratings than generic ones, indicating involvement in a greater number of service development, care planning, service delivery, training and leadership activities (= 6.29, 95% CI 3.03 to 9.55, $P < 0.01$). This difference remained significant after adjusting for the profession of the service lead and for the professional diversity of the team (= 9.76, 95% CI 3.90 to 15.62, $P < 0.01$).

6. What exclusion criteria, if any, are applied by services?

No services excluded individuals on the basis of a diagnosis of personality disorder. Across both dedicated and generic services, the most common exclusion criterion was uncontrolled substance misuse, followed by active risk to others (*Table 6*). Almost half of services (43%) had no exclusion criteria. Dedicated services were significantly more likely than generic ones to have exclusion criteria (OR = 10.95, 95% CI 3.31 to 36.19, $P < 0.01$). This difference remained significant after adjusting for the profession of the service lead and for the professional diversity of the team (OR = 5.02, 95% CI 1.24 to 20.35, $P = 0.02$).

Discussion

This national survey was the first of its kind and captured data provided by 56 relevant mental health organisations in England. With a response rate of 91% for English mental health NHS trusts, and a sample of independent service providers, we can be confident the survey is representative of personality disorder provision in England.

The majority of organisations described both dedicated personality disorder services (84%) and generic services (91%), and in organisations with no dedicated services all provision for personality disorder was through a generic service. This quantifies the progress made in this area since 2002 and points to a fivefold increase in organisations providing dedicated personality disorder services.⁹

This represents substantial progress in a decade in which the economic landscape has been challenging. Yet, while on this measure we can see substantial progress at an organisational level, the survey indicates a worrying level of variability at a local level, with only 55% ($n = 31$) of organisations indicating equal access to the dedicated services they provide.

The 2003 NIMHE publication formally introduced the concept of dedicated personality disorder service as distinguished from generic service, and this distinction has been further developed in the current paper.⁹ We had *a priori* assumptions about the nature of dedicated and generic services (*Table 1*), and this survey allows a more detailed conceptual analysis. The survey methodology steered respondents to consider the concept of dedicated *v.* generic services. Analysis of the descriptive and statistical differences between the 81 dedicated and 51 generic services allows us to draw some conclusions about these two types of service provision. For instance, we found that generic services draw from a wide range of professional disciplines, which is in line with their broader remit. Seemingly, dedicated services draw from a more restricted range of professional disciplines; this supports the notion that they are specialist, niche services.

Contrary to our *a priori* hypothesis, dedicated services were no more likely to provide personality disorder-specific interventions when compared with generic services. Furthermore, generic services provide a significantly wider range of biopsychosocial interventions than dedicated ones, although there was some suggestion that this was influenced by their employment of a significantly more diverse workforce and by their higher rates of medical professional leadership. The accessibility of these interventions and the quality of their delivery are unknown; however, NICE guidance stipulates that specialist interventions are best delivered by specialist services.¹¹

The delivery of developmental activities is a clear priority for dedicated services, with almost all involved in training, and significantly more dedicated than generic services involved, indicating that they deliver both training and education and research. This is in keeping with both the 2003 NIMHE publication and NICE guidance.^{9,11,12} Patient and carer involvement is also prioritised by dedicated services, with patients and carers involved in significantly more service development, management and delivery activities than those in generic services. Dedicated services appear to show greater selectivity in patient choice than generic ones, as significantly more operate with exclusion criteria. Given that impulsivity is a diagnostic criterion for borderline and dissocial personality disorder, it is noteworthy that active risk to others (23%) and substance misuse (53%) were so widely quoted as exclusion criteria for dedicated personality disorder services.

Limitations

The response rate for the independent providers should be treated with caution as it is subject to selection bias. Responses were self-reported and there may have been variation in the interpretation of what constituted a dedicated personality disorder service.

In the comparisons made with generic services, the respondents were asked to provide an overview of all of the generic services within their organisation. Although this was pragmatically necessary, given the large numbers of generic services within any organisation, this approach requires the reader to consider the comparisons with appropriate caution. In particular, the findings which relate to the personality disorder-specific interventions and range of staff within the multidisciplinary team will be skewed by this methodology.

While this survey is able to give a good organisational-level description of service availability, mapping the local provision is achieved to a limited degree. Perhaps the most important consideration is that the indicators used in this survey to consider the quality can only provide a broad brush-stroke indication, owing to necessary methodological trade-offs for pragmatic purposes.

Understanding the consistency with which individual patients and carers can expect adherence to best practice and the timeliness of the interventions offered is beyond the scope of this survey. We believe this body of work begins to elucidate the questions which need to be considered, but it is a long way from achieving that. Indeed, the largest limitation of this work is that at best it provides a broad overview of provision. To properly understand what is actually delivered to those in need will require a more systematic and sustained effort to describe quality standards and ensure, perhaps through accreditation, that best practice is being followed.

Further developments

This paper charts the most systematic attempt to date at mapping the provision of care across England for those affected by personality disorder. What is clear is that the past decade or so has seen considerable progress in providing a service for this range of disorders. Despite this progress, data presented here provide evidence that there remains continued exclusion, variability of practice and inconsistencies in the availability of services.

The current NICE guidance, in step with the evidence base, supports the provision of a range of cost-effective interventions and the establishment of specialist services from which to deliver them. The initial offering presented here lends weight to the call for the establishment of authoritative commissioning guidance and service standards to ensure that patients and carers have access to the care that they need.

The National Personality Disorder Service Review Group work stream was seeded by a small project funding initiative through the Royal College of Psychiatrists' Faculty of General Adult Psychiatry in 2014 and West London Mental

Health Trust Research and Development. A multidisciplinary group was formed with representations from psychiatry, psychology, psychotherapy and expertise through lived experience of personality disorder. At various stages through the project the affiliates included: the Faculty of General Adult Psychiatry, West London Mental Health Trust Research and Development, Informed Thinking, The Medway Engagement Group and Network (MEGAN) and the Imperial College Centre for Mental Health. The project was granted approval as a service evaluation through the audit department of West London Mental Health Trust.

1.7.72 Perceptions and knowledge of antipsychotics among mental health professionals and patients

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Abstract

Aims and method To assess the patients' most influential concerns regarding long-acting injectable antipsychotics (LAIs) and mental health professionals' preconceptions about these concerns. For both groups, to assess the level of knowledge about LAIs. This cross-sectional study used semi-structured interviews of patients with schizophrenia or schizoaffective disorder ($n = 164$), nurses ($n = 43$) and physicians ($n = 20$).

Results The mental health professionals overestimated many of the patients' fears of LAIs, and the expressed fears exceeded the actual experiences of patients already on LAIs. Acceptance to switch to LAIs was associated with shorter time from diagnosis. Nurses and patients disclosed limited knowledge of antipsychotics.

Clinical implications Physicians and nurses should aim to identify the individual patient's concerns about LAIs in the discussion about choice of antipsychotic treatment early in the course of illness.

Contents

- *Perceptions and knowledge of antipsychotics among mental health professionals and patients*
 - *Method*
 - * *Design*
 - * *Participants and setting*
 - * *Questionnaires*
 - * *Statistical analysis*

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- *Results*
 - * *Inclusion and exclusion of study participants*
 - * *Participant characteristics*
 - * *Perceptions of LAI antipsychotics*
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 - * *Clinical approach to LAIs among mental health professionals*
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Adherence to antipsychotic treatment is a major challenge and an important predictor of the outcome in patients with schizophrenia and schizoaffective disorder.¹ The risks of relapse and admission to hospital increase immediately after discontinuation, even with small treatment gaps.^{2–5} With oral antipsychotics, such gaps often go undetected until relapse – an issue that can be overcome by use of long-acting injectable antipsychotics (LAIs).⁵ There is growing evidence that, compared with oral treatment, LAIs reduce the risk of discontinuation, relapse and hospital admission.⁶ Furthermore, owing to superior pharmacokinetics, the use of LAIs is considered to increase the likelihood of finding the lowest effective dose, which subsequently reduces the risk of side-effects.^{7,8}

Despite the identified advantages, LAIs are not used as widely as might be expected. The prescription frequency varies greatly between countries,⁹ indicating that factors other than the patient's attitude influence the utilisation rate. While patients' attitudes towards LAIs become more positive with increased knowledge and experience of the treatment,¹⁰ clinicians often overestimate patients' resistance against LAIs, anticipating that they will be concerned about the injection procedure.^{10–12} This impedes so-called shared decision-making, an approach with the potential to increase adherence.¹³ Patients are frequently excluded from the discussion about the choice of antipsychotic formulation,¹⁴ and one reason may be resistance arising from mental health professionals' preconceptions.

We aimed to investigate the specific concerns that affect patients' perceptions of LAIs, and to what extent mental health professionals' preconceptions agree with these perceptions. Furthermore, we aimed to identify knowledge gaps about antipsychotic formulations among both patients and mental health professionals.

Method

Design

We conducted a cross-sectional study of mental health professionals' and patients' perceptions and knowledge regarding antipsychotic treatment in a psychiatry catchment area in Stockholm, Sweden, operated by PRIMA Adult Psychiatry. Data were collected in semi-structured interviews performed by a research nurse (L.C.) at the participant's home clinic between January and October 2015. The participants were enrolled upon giving written informed consent. The study was approved by the regional ethical review board in Stockholm (ref. 2015/47-31).

Participants and setting

We studied three categories of participants: (a) patients on LAIs; (b) patients on oral treatment; (c) mental health professionals, including physicians and nurses.

We identified all patients with schizophrenia or schizoaffective disorder. Patients with no medical treatment or with previous but discontinued LAIs, as well as patients who had been on LAIs >5 years were excluded. Other exclusion criteria were language barriers (i.e. need of interpreter in consultations), cognitive impairment and severe autism spectrum disorders. We collected information on patients' age, gender, years with diagnosis, marital status, number of children, highest achieved academic degree and occupation. The patients on oral medication were block randomised on diagnosis (schizophrenia/schizoaffective disorder), gender and age to two separate arms. The first group was included in this study to represent those on oral medication, while the second group did not participate and will act as controls in a future intervention study.

All physicians and nurses working in the psychosis sector of PRIMA were asked to participate. We recorded age, gender and extent of experience within the psychiatric field.

Questionnaires

We conducted semi-structured interviews based on different questionnaires specific to each participant category and designed for the present study. Participants graded their potential concerns with a mark on a continuous 100 mm scale ranging from 0 ('Does not affect at all') to 100 ('Decisive to decline LAIs'). Potential concerns included in the questionnaire were pain at administration, possible observation time of 3h, embarrassment at administration, restricted autonomy, feeling of being controlled, being obliged to show up at the clinic regularly, lack of ability to decide when medication is administered, and stigmatisation. The questions were designed to address the participant appropriately, for example, mental health professionals: 'To what extent do you think fear of pain affects the patients' perception?'; patients on oral medication: 'To what extent does fear of pain affect your perception?'; and patients on LAIs: 'To what extent does pain affect your perception?'. The investigated concerns were predefined based on a literature review and clinical experience.^{10,15,16}

Questions about knowledge of the differences between LAIs and oral treatment regarding achieved plasma concentration, side-effects and risk of readmission to hospital were identical for all participants and included pre-specified nominal options. In questions regarding clinical approach among mental health professionals, participants were asked to state items freely. Physicians stated their most common reasons for prescribing LAIs, and their strategies to encourage patients to consider LAIs. Furthermore, they were asked to speculate what the patients' key reasons for accepting LAIs are. These answers were assessed using thematic analysis after the study was complete.

Nurses were asked whether they tried to influence patients' and physicians' choice of formulation (yes/no). Patients on oral medication were asked whether they had previously been offered LAIs and whether they knew of the features of being on LAIs. Finally, at the end of the interview, all patients were asked about their perspective on switching formulation (positive/negative).

Statistical analysis

Anonymised data were analysed using Prism 5.03 for Windows. Sample comparisons were made using Fisher's exact test for categorical variables (gender, positive/negative towards switching to LAI). The Mann-Whitney [*U*-test or Wilcoxon matched-pairs test was used for continuous variables (age, illness duration, mental health professionals' experience and questionnaire responses on a 100 mm scale), where appropriate.

Results

Inclusion and exclusion of study participants

We identified 875 patients in the catchment area with a diagnosis of either schizophrenia or schizoaffective disorder; 341 patients were currently being treated with LAIs (39%). Of the 875 patients, 302 met our inclusion criteria. Finally, 101 patients on oral treatment and 63 on LAIs participated in the study. The reasons for not participating are presented in *Fig. 1*. All 21 physicians and 46 nurses working in the psychosis sector of PRIMA were asked to participate; 1 physician and 3 nurses declined owing to lack of time.

Participant characteristics

There were no statistical differences regarding characteristics between patients on LAIs and patients on oral medication, except that patients on oral medication were more likely to have achieved a higher academic degree (*Table 1*). The median age of the 20 physicians was 47 years (range 34–69) and 45% were women. The median number of completed years in the psychiatric field was 6.5 years (range 0–20). The 43 nurses had a median age of 51 years (range 27–67) and 81% were women. The median length of experience in the psychiatric field was 12 years (range 0–36), and 51% were specialists in psychiatric care.

Characteristics of interviewed patients

Characteristics	Patients on oral treatment (<i>n</i> = 101)	Patients on LAIs (<i>n</i> = 63)	<i>P</i>
Females, <i>n</i> (%)	46 (46)	26 (41)	n.s.
Age, years: median (range)	50 (21–84)	51 (24–74)	n.s.
Diagnosis, <i>n</i> (%)			
Schizophrenia	71 (70)	41 (65)	n.s.
Schizoaffective disorder	30 (30)	22 (35)	n.s.
Duration of illness, years: median (range)	21 (1–55)	18 (1–45)	n.s.
Highest education, <i>n</i> (%)			
Elementary school	21 (21)	24 (38)	0.020
High school	49 (49)	31 (49)	n.s.
University	31 (31)	8 (13)	0.0086
Employed, <i>n</i> (%)	19 (19)	7 (11)	n.s.
Marital status, <i>n</i> (%)			
Single	71 (70)	53 (84)	n.s.
Living independently	8 (8)	2 (3)	n.s.
Married/cohabiting	22 (22)	8 (13)	n.s.
Underage children living at home, <i>n</i> (%)	8 (8)	3 (5)	n.s.

LAIs, long-acting injectable antipsychotics; n.s., not significant.

Perceptions of LAI antipsychotics

Comparing patients on oral antipsychotics *v.* patients on LAIs, fears exceeded the actual experiences for all factors examined (Table 2, online Fig. DS1), but fear was only statistically significant for the concerns of being tied to the clinic (62 *v.* 28, $P = 0.018$) and loss of decision-making regarding when to take the medicine (45 *v.* 8, $P = 0.001$). Overall, patients' results tended to be polarised to either end of the 100 mm scale whereas the mental health professionals' results were more centred in their distribution.

Estimated and actual fears as well as experienced factors affecting the decision to decline long-acting injectable antipsychotics (LAIs)

Factors	Mental health professionals ($n = 63$)	Patients on oral treatment ($n = 101$)	P	Patients on LAIs ($n = 63$)	* P * a
Pain at the injection site	50.5 (11–95)	28 (0–100)	0.001	12 (0–100)	0.21
Being regularly tied to a clinic	49 (5–98)	62 (0–100)	0.24	28 (0–99)	0.018
Observation time at the clinic after one certain type of LAI	64 (4–98)	89 (0–100)	<0.0001	67 (3–98)	0.23
Embarrassment of having an injection	41 (1–93)	12 (0–98)	<0.0001	17 (0–100)	0.11
Reduction in autonomy	62 (5–93)	30 (0–98)	0.0025	10 (0–100)	0.18
Loss of ability to decide when to take the medication	56 (4–95)	45 (0–100)	0.13	8 (0–98)	0.001
Feeling of being controlled	56 (3–94)	25 (0–100)	0.013	13 (0–100)	0.58
Perceptions of stigma of being on LAI	51 (4–88)	17 (0–100)	0.0004	11 (0–100)	0.63

The questions were presented orally and adapted based on the participant category, *i.e.* mental health professionals, patients on oral treatment and patients on LAIs.

Patients on oral treatment *v.* patients on LAIs.

Only the 7 patients on long-acting injectable olanzapine who had experienced a 3 h observation time were included.

Patients on LAIs were asked to recall their fears before switching from oral treatment. They graded their recalled fears higher than the actual experiences regarding all factors except for observation time (online Table DS1). The differences were small, but reached statistical significance for pain (24 *v.* 12, $P < 0.0001$), embarrassment (9 *v.* 7, $P = 0.0006$), reduction in autonomy (13 *v.* 10, $P = 0.0027$) and loss of ability to decide when to take the medicine (14 *v.* 8, $P = 0.019$). Finally, there were no statistically significant differences between the graded fears of patients on oral treatment *v.* recalled fears in patients on LAIs (data not shown).

Mental health professionals overestimated the concerns of orally treated patients regarding feared pain (51 *v.* 28, $P = 0.001$), embarrassment (41 *v.* 12, $P < 0.0001$), reduction in autonomy (62 *v.* 30, $P = 0.0025$), feeling of being controlled (56 *v.* 25, $P = 0.013$), and stigma (51 *v.* 17, $P = 0.0004$; Table 2, online Fig. DS1). Conversely, they underestimated the patients' concerns regarding the 3h observation time required after injection of LAI olanzapine (64 *v.* 89, $P < 0.0001$).

Knowledge of oral and LAI antipsychotics

All physicians (100%) claimed that LAIs are associated with a more stable plasma concentration than oral treatment (Table 3). For nurses, patients on oral treatment and patients on LAIs, the corresponding proportions were 56%, 16% and 22%, respectively.

Mental health professionals' and patients' knowledge about oral v. long-acting injectable antipsychotics (LAIs) regarding plasma concentration, side-effects and frequency of readmission to hospital

Topic	Physicians (n = 20)	Nurses (n = 43)	Patients on oral treatment (n = 101)	Patients on LAIs (n = 63)
Plasma concentration, n (%)				
Lower/more stable with LAIs	20 (100)	24 (56)	16 (16)	14 (22)
Equal	0 (0)	11 (26)	23 (23)	20 (32)
Lower/more stable with oral	0 (0)	4 (9)	41 (41)	20 (32)
Don't know	0 (0)	4 (9)	21 (21)	9 (14)
Side-effects, n (%)				
Less with LAIs	15 (75)	12 (28)	18 (18)	27 (43)
Equal	3 (15)	17 (40)	25 (25)	19 (30)
Less with oral	1 (5)	11 (26)	45 (45)	11 (17)
Don't know	1 (5)	3 (7)	13 (13)	6 (10)
Risk of rehospitalisation, n (%)				
Less with LAIs	19 (95)	37 (86)	21 (21)	23 (36)
Equal	0 (0)	3 (7)	40 (40)	20 (32)
Less with oral	1 (5)	2 (5)	15 (15)	5 (8)
Don't know	0 (0)	1 (2)	25 (25)	15 (24)

Eligible answers were presented as pre-specified nominal options.

Of physicians, 90% stated that LAIs are superior or equal to oral treatment concerning side-effects. For nurses, patients on oral treatment and patients on LAIs, the corresponding proportions were 68%, 43% and 73%, respectively.

All physicians but one (95%) and 86% of nurses claimed that LAIs reduce the risk of readmission to hospital, while 21% of patients with oral treatment and 36% of patients on LAIs claimed LAIs to be superior in this matter.

Clinical approach to LAIs among mental health professionals

Poor adherence, limited insight and multiple relapses were the most common reasons for prescribing LAIs, mentioned by 80% of physicians. However, one-fourth considered LAIs an option even early in the disease course. Their strategies to encourage patients to consider LAIs were to inform them about the advantages of the formulation (65%) and about the risks and consequences of treatment discontinuation (40%). Exploring patients' fears was a strategy mentioned by 20% of physicians.

Half of physicians believed that not having to remember to take pills was the key reason for patients to accept LAIs. Other factors mentioned were good insight (40%) and that LAIs are associated with lower frequency of relapse (20%).

Of nurses, 31 (72%) replied that they actively tried to influence the patients' attitude towards one or the other formulation, and 29 (67%) actively tried to influence the physician's decision.

Patients' perspective on switching

Almost half of the patients on oral treatment (41%) declared that they had little or no knowledge of LAIs. At the end of the interview, they were asked whether they would switch to LAIs if offered by their treating physician. While 78 (77%) said no and three (3%) could not decide, 20 (20%) declared that they would agree to switch if offered such an option. The patients willing to switch had fewer years since diagnosis than those who were reluctant (12 v. 24, $P = 0.0013$; online Fig. DS2). Furthermore, the proportion of women was higher in the positive group (75% v. 44%, odds ratio (OR) = 3.9, $P = 0.023$). They considered pain (7 v. 40, $P = 0.020$), being tied to the clinic (26 v. 70, $P = 0.017$), reduction in autonomy (9 v. 30, $P = 0.034$) and stigma (6 v. 27, $P = 0.035$) to be less important issues than did the patients who were reluctant to switch to LAIs.

A total of 21 (33%) patients on LAIs would switch to oral treatment if they were offered it, 1 (1.6%) could not decide and 41 (65%) preferred to continue with LAIs. There were no statistically significant differences between patients who were positive v. patients who were negative about switching formulation with regard to age, number of years with diagnosis or gender. Those who opted to stay on LAIs were less concerned with the lack of autonomy (7 v. 40, $P = 0.015$) and the feeling of being controlled (9 v. 50, $P = 0.0011$). They also gave more correct answers regarding differences in side-effects between oral formulations and LAIs (85% v. 52%, OR = 5.3, $P = 0.012$).

Discussion

In this study, we found that patients' concerns with LAIs were minor except when considering observation time and being tied to the clinic, and that there was a mismatch in the assessment of specific concerns between the patients and the mental health professionals. We identified important knowledge gaps among patients and nurses. As many as one-fifth of the patients on oral medications were willing to switch to LAIs; these potential switchers were more recently diagnosed than those who were reluctant.

The patients on oral treatment were most concerned about observation time post-injection and about being tied to the clinic when asked about LAIs. This indicates that they valued their time and that practical issues surpassed in significance emotional ones such as stigma, a feeling of being controlled and embarrassment. All fears expressed by patients on oral treatment exceeded the actual experiences of patients on LAIs. This could be a result of selection bias, in that patients on LAIs were less concerned even before accepting LAI treatment. However, since patients on LAIs were speaking from experience, this difference may also reflect that these issues had a lower impact than expected once the patients had been started on LAIs. That the recalled concerns pre-LAIs were similar to the levels of concern among those still on oral treatment also supports this hypothesis.

Mental health professionals tended to answer questions by placing the indicator centrally on the 100 mm scale, which may reflect uncertainty as they were just estimating the patients' experiences. The patients' answers, on the other hand, were polarised, indicating that their opinions were more set. Patients also graded some factors distinctly low and others distinctly high. In light of this, physicians should be encouraged to learn more about the individual patient's concerns. Only 20% of physicians reported that they used this strategy when discussing treatment regimens.

According to previous studies, physicians' knowledge regarding antipsychotic formulations varies.^{16,17} Physicians in the current study showed very good knowledge. However, a significant proportion of the interviewed nurses had knowledge gaps concerning some of the advantages of LAIs. This could have a negative impact on the patient's attitude towards LAIs, especially as the majority of nurses claimed that they actively tried to influence both doctors and patients in the discussion on treatment choices. Patients already on LAIs had significantly better knowledge about the reduced side-effects with LAIs than patients on oral treatment. This most likely reflects their own experiences. It could also be an effect of information provided by mental health professionals – information many patients on oral treatment reported as lacking. This is of concern, as we know that patients' attitudes towards LAIs are likely to become more positive with increased knowledge and experience of the treatment.¹⁰ The physicians' observed reluctance to bring up the topic may be due to their anticipation that the patients are unlikely to accept the offered LAI. However, keeping the patients uninformed makes shared decision-making impossible.¹⁵

The majority of the patients on LAIs chose to keep this formulation and as many as 20% of the patients on oral treatment were willing to use LAIs. This is in line with a previous study in which 16% were positive towards a formulation

switch.¹⁴ This also supports the hypothesis that the use of LAIs could be limited by factors other than rejection by the patients.¹² Some physicians claimed that they offered LAIs early in the disease course, but their most common reasons for prescribing LAIs were poor adherence to oral medication and recurring relapses. Previous studies also report non-adherence^{16,17} and multiple relapses¹⁷ as key criteria for prescribing LAIs. This may be unfortunate as longer illness duration was associated with being reluctant to switch. Instead, this motivates a discussion of LAIs early on in the course of illness, especially as there is cumulative evidence that the use of LAIs as early as after the first admission to hospital decreases the risk of treatment discontinuation, relapse and readmission.^{4,5,18}

Limitations

Our study has several limitations. Not all patients in the targeted study population were included, and some patients could not be reached or were not present to complete the questionnaire. Some were only scheduled for visits once per calendar year, while the study was limited to 10 months. It is possible that patients were either too ill to present themselves or were stable enough to postpone yearly visits. The patients on LAIs were asked to declare their perceptions prior to starting on LAIs, which introduced recall bias. However, we excluded all patients on LAIs 5 years, reducing the effect of this bias. Finally, patients on LAIs are indisputably a selection of patients who have once accepted that formulation. However, the lack of significant differences between the graded fears of patients on oral treatment compared with recalled fears in patients with LAIs may indicate that this selection bias is of minor concern. A strength of this study was that all interviews were performed by the same person (L.C.), securing consistency across interviews.

Clinical implications

In conclusion, physicians should aim to set aside their own preconceptions and instead make time to identify the individual's specific fears regarding LAIs, preferably early in the course of the illness. In addition, there is room for improvement regarding patients' knowledge of antipsychotic formulations. Adequate education would be of value to strengthen nurses' knowledge about LAIs. Finally, there is room for improvement regarding patients' knowledge of antipsychotic formulations.

1.7.73 Mental capacity legislation in the UK: systematic review of the experiences of adults lacking capacity and their carers

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Abstract

Aims and method Capacity legislation in the UK allows substitute decision-making for adults lacking capacity. Research has explored the experiences of such adults and their carers in relation to the Adults with Incapacity (Scotland) Act 2000, and the Mental Capacity Act 2005 in England and Wales. A systematic review of the relevant research was performed using a framework method.

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Results The legislation provided mechanisms for substitute decision-making which were seen as useful, but there were negative experiences. Decision-making did not always seem to follow the legislative principles. Awareness of the legislation was limited. Most research was qualitative and some was of low methodological quality. Data were too heterogeneous to allow comparisons between English and Scottish law.

Clinical implications Capacity legislation was generally viewed positively. However, some experiences were perceived negatively, and the potential benefits of the legislation were not always utilised.

Contents

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In law, mental capacity is the ability to make decisions, and it relies on a number of attributes such as comprehension and reasoning.¹ Capacity legislation exists to allow legally valid decisions to be made about finances, welfare or medical treatment where the individual lacks mental capacity. In Scotland this legislation exists as the Adults with Incapacity (Scotland) Act 2000 (AWIA) and in England and Wales as the Mental Capacity Act 2005 (MCA). Northern Ireland has recently adopted the Mental Capacity Act (Northern Ireland) 2016.

Prior to the introduction of legislation, English capacity law was criticised by the Law Commission as being unsystematic and out of step with disability rights.² The Scottish Law Commission described Scottish capacity law as fragmented and archaic.³ The AWIA and the MCA were introduced to reform capacity law, and are similar in many respects. They set out principles which aim to promote the rights of adults who lack capacity, and create mechanisms to allow substitute decision-making, a process whereby another individual has the legal power to make decisions on the disabled adult's behalf. The MCA has a specific 'best interests' process, which allows some decisions to be made without court proceedings, whereas there is no equivalent process in the AWIA. The Northern Irish legislation mirrors the MCA in many regards. The terminology varies between jurisdictions, for example, guardianship in the AWIA is similar to deputyship in the MCA.

A number of studies have explored the experiences of adults lacking capacity and their carers in relation to the legislation, and this systematic review draws together findings from this area of research.

Method

This review systematically appraised the research evidence exploring how adults lacking capacity and their carers experienced capacity legislation. It followed the Centre for Reviews and Dissemination guideline.⁴ The process is summarised in *Fig. 1*. All experiences related to the AWIA and the MCA were considered of interest, from everyday decision-making to perceptions of court proceedings and their outcomes. There was no research relating to the Northern Irish legislation, because the review was undertaken prior to its adoption. In this review, ‘carers’ included family and professional carers who made substitute decisions in a day-to-day caring role.

Fig. 11: Flow chart of study selection process.

The primary research question was ‘What are the experiences and perceptions of adults lacking capacity, their carers and the general public in relation to capacity legislation in the UK?’ The secondary research question was whether such experiences varied between jurisdictions.

The published literature consisted of both quantitative and qualitative research. Studies were included if they were published after the year 2000 (the year of introduction of the AWIA) and consisted of quantitative or qualitative research about the experiences or perceptions of adults lacking capacity, their carers or members of the general public in relation to the MCA or AWIA. There was no restriction placed on diagnosis. Exclusion criteria included studies where the individuals were minors, studies of capacity to participate in research, and studies carried out prior to the implementation of whichever Act was relevant. Papers such as accounts of service development activities, assessments of educational interventions and legal commentaries were also excluded. Research publications from sources other than peer-reviewed journals were included, because it seemed likely that there would be a paucity of evidence in the peer-reviewed literature. Although this strategy increased the likelihood of low-quality evidence entering the review, this was addressed by consideration of quality in the synthesis of the results.

A literature search was performed during June 2015. The databases were Medline, PsycINFO, EMBASE, Web of Science, ESRC, Social Care Online, BAILII, HeinOnline and LexisLibrary. The search terms were the keywords ‘Mental Capacity Act’, ‘Adults with Incapacity Act’, and ‘Adults with Incapacity Scotland Act’. Each abstract was screened. Duplicate papers and papers originating outside the UK were not included. Additional papers were sought from reference lists, conference proceedings and contact with authors. The abstracts of the papers were compared with the exclusion criteria. The complete paper was read if it was unclear from the abstract whether the paper should be included. The remaining papers were read once to exclude irrelevant papers from the final sample.

Quality assessment was carried out using the Multi-Methods Appraisal Tool (MMAT),⁵ which was selected because it offered the ability to assess the quality of all the various types of studies in the sample. It consisted of screening questions followed by questions for quantitative, qualitative and mixed-methods studies. No studies were excluded from the final sample because of low quality.

This review followed guidance that items should be regarded as data for secondary research only if they were described as results or findings in the primary research.⁶ A data extraction form was developed during a reading of the final sample papers. The data extraction form consisted of headings taken from the results sections of the final sample papers. Results from each study were then extracted if they were relevant to any heading on the data extraction form. Analysis used a framework method⁷ with a matrix consisting of each study along the x-axis and each heading from the data extraction form along the y-axis.

Results

There were 11 papers in the final sample, containing 12 distinct studies. The type and quality of studies are summarised in *Table 1*. Most of the studies used qualitative or mixed methods. There was variation in the quality of studies; only 4 of the 12 studies were rated as having the highest methodological quality and had been published in peer-reviewed journals. The other eight studies presented their results clearly but failed to report important information.

Type and quality of studies in the final sample

Study	Act	Type	Peer-reviewed journal?	MMAT score
Badger (2009) ⁸	MCA	Multiple qualitative methods	No	3/4
Badger & Parnell (2009) ⁹	MCA	Multiple qualitative methods	No	2/4
Jevon (2014) ¹⁰	AWIA	Quantitative survey	No	2/4
Jingree (2015) ¹¹	MCA	Qualitative interviews	Yes	4/4
Killeen & Myers (2004) Ch. 4 ¹²	AWIA	Mixed-methods – quantitative survey and qualitative interviews	No	2/4
Killeen & Myers (2004) Ch. 5 ¹³	AWIA	Qualitative interviews	No	2/4
Manthorpe <i>et al</i> (2012) ¹⁴	MCA	Qualitative interviews	Yes	4/4
Mental Welfare Commission (2011) ¹⁵	AWIA	Qualitative interviews	No	2/4
Myron <i>et al</i> (2008) ¹⁶	MCA	Mixed-methods – questionnaires and qualitative interviews	No	1/4
Samsi & Manthorpe (2011) ¹⁷	MCA	Qualitative interviews	Yes	4/4
Samsi & Manthorpe (2013) ¹⁸	MCA	Qualitative interviews	Yes	4/4
Williams <i>et al</i> (2012) ¹⁹	MCA	Mixed-methods – quantitative survey and qualitative interviews	No	2/4

AWIA, Adults with Incapacity (Scotland) Act 2000; MCA, Mental Capacity Act 2005; MMAT, Multi-Methods Appraisal Tool.

Research aims and participants are summarised in *Table 2*. Although there were data related to experiences in courts in Scotland, there were no data related to the Court of Protection in England and Wales. The data about the AWIA related mainly to guardianship, and the data about the MCA related mainly to decision-making practices. Therefore, no direct comparison between specific elements of the AWIA and MCA could be made.

Aims and participants in studies in the final sample

Study	Act	Research aim	Population context	Participants
Badger (2009) ⁸	MCA	Explore decision-making	Intellectual disability	27 participants: 2 staff and 1 family member for each of 9 disabled adults in 3 settings (none of the 9 disabled adults directly involved)
Badger & Parnell (2009) ⁹	MCA	Explore decision-making	Not described	24 participants: 6 disabled adults with 2 staff and 1 family member for each
Jevon (2014) ¹⁰	AWIA	Assess experiences of guardians	Not described	193 welfare guardians (27% response rate)
Jingree (2015) ¹¹	MCA	Explore decision-making	Intellectual disability	15 support workers from a single service
Killeen & Myers (2004) Ch. 4 ¹²	AWIA	Explore power of attorney and intromission with funds	General public	3 individuals who had made a power of attorney and 5 individuals who had applied for intromission with funds (8% response rate)
Killeen & Myers (2004) Ch. 5 ¹³	AWIA	Understand the operation of guardianship	Mixed	58 professionals, carers, and adults with incapacity involved in 13 guardianship cases – exact composition not reported
Manthorpe <i>et al</i> (2012) ¹⁴	MCA	Assess links between personal and professional experiences of dementia	Dementia	123 professionals (70 of whom had experience as carers)
Mental Welfare Commission (2011) ¹⁵	AWIA	Assess experiences of guardians and supervisors	Not described	58 welfare guardians (family or carer)
Myron <i>et al</i> (2008) ¹⁶	MCA	Assess staff, family and patient knowledge of capacity	Mixed	73 staff, 20 disabled adults, and 6 carers
Samsi & Manthorpe (2011) ¹⁷	MCA	Understand how older people planned for their future	General public	37 self-identified ‘well’ people aged over 50 years
Samsi & Manthorpe (2013) ¹⁸	MCA	Explore decision-making	Dementia	12 dementia dyads (person with dementia plus their carer)
Williams <i>et al</i> (2012) ¹⁹	MCA	Explore decision-making	Mixed	385 participants, mostly professionals – 5 interviews from the perspective of carers

AWIA, Adults with Incapacity (Scotland) Act 2000; MCA, Mental Capacity Act 2005.

None of the four studies from Scotland had been published in peer-reviewed journals and none received the highest rating of methodological quality. Two of these studies were separate pieces of research in a single publication.^{12,13}

The findings are summarised in *Table 3*. For reasons of parsimony, the 15 items from the data extraction form were collapsed into four headings in the results, but all data were retained.

Summary of findings

Theme	Finding
Positive experiences	Having a legal basis for decision-making was recognised as useful Benefits such as increased safety and quality of life were sometimes described The ability to use the mechanisms of the Acts to plan for the future was seen as beneficial, although only a minority did this The legislation was sometimes perceived as empowering
Negative experiences	Court and other legal processes were seen as challenging and cumbersome, and costs may be off-putting Some participants had extremely negative experiences The legislation was sometimes perceived as disempowering
Decision making	Decisions were sometimes but not always made with the disabled adult's participation Carers sometimes struggled to make decisions in the best interests of the adult lacking capacity There could be conflicts of interest between the adult lacking capacity and the decision maker
Other issues	There were variable findings related to support and supervision There was a lack of understanding of the legislation on the part of the general public and carers A need for carers to be assertive was described The most common reason for applying for powers was because of a wish for a formal role in decision-making There were no findings about carers' abilities to assess capacity There were no findings about deprivation of liberty Data were mainly derived from carers

Positive experiences

One study from Scotland reported that family carers saw guardianship as positive because it offered them the ability to manage their relative's welfare and finances. Improved safety and quality of life were described in several cases. Half of the six adults with incapacity interviewed in this study described improvements in their quality of life.¹³ In a telephone survey, most guardians stated that guardianship was useful, but a minority reported that it made little difference, or found it a negative experience.¹⁵ In a postal survey of guardians, most of the participants described welfare guardianship as being useful, but the response rate (26.7%) in this study was low and the result may not represent the experience of carers.¹⁰ Those who had made a power of attorney or who had made a successful application for intromission with funds saw the process as a positive experience. However, there were only a total of eight participants in this mixed-methods study.¹²

Some older members of the general public in England saw potential benefits from making a power of attorney, but most described a disinclination to plan for the future. Any plans that were made were usually of a financial nature. Individuals living alone with no family described difficulty in appointing someone to look after their affairs.¹⁷ The finding of participants failing to make powers of attorney or advance decisions, despite believing in their utility, was repeated in a group of professionals who had personal experience as carers.¹⁴ Only a minority of elderly people made a power of attorney in another study by the same researchers.¹⁸

Negative experiences

One study involved 58 professionals, carers and adults with incapacity who had been involved in court proceedings for 13 guardianship cases in Scotland. The process was described as perplexing and inhibiting for carers, and confusing and stressful for adults who lacked capacity. The process made some carers feel 'isolated and under pressure' and was described in negative terms such as 'a nightmare' and 'an enormous waste of time'.¹³ By contrast, the instruments of the AWIA which did not require court proceedings were viewed generally positively.¹²

However, negative experiences were not just restricted to experiences in court. A minority of participants in the telephone survey of guardians found being a guardian to be a negative experience in general.¹⁵ One study of the MCA included five cases of best interests decision-making from the point of view of family carers, and the experience in each case was described as disempowering and distressing for the carers. No further details were given because the carers were not directly interviewed, but this finding contrasted markedly with the largely positive views of the MCA expressed by professional respondents in the same study.¹⁹

As well as the cases of carers appearing disempowered, some adults who lacked capacity were observed to resent the powers that others held over them.¹³ However, some carers in Scotland who had gone through processes to be formally appointed with decision-making powers saw themselves as empowered.^{12,13} In this review, the legislation was perceived as empowering' for some and disempowering for others.

Decision-making

A qualitative study of support workers found decision-making to be inconsistent with the MCA; there was no assumption of capacity, and decisions were rarely oriented towards best interests.¹¹ Other support workers described struggling to balance their duties under the MCA with duty of care and safeguarding obligations, and stated that limited resources restricted their ability to support decision-making in practice.⁹ Another group felt that organisational policies, the influences of others such as family and professionals, and their duty of care restricted their ability to engage the adults in best interests decision-making.⁸

Some decision-making was clearly compliant with the general principles of the legislation. All 12 carers for individuals with dementia described the importance of best interests decision-making. They stated that they attempted to maintain the autonomy of the adult who lacked capacity and took a decision-specific approach to each question. They described the use of strategies to enhance the disabled adult's participation in decision-making, and used their knowledge of the person's previous wishes. However, even these carers described conflicts of interest between their needs and those of the adult with incapacity, and admitted struggling to decide what constituted best interests.¹⁸ The situation was similar in Scotland, with carers reporting difficulties assessing the most beneficial course of action and understanding the views of the adult with incapacity.¹³

Overall, it appeared to be the case that immediate carers (whether family carers or support workers) sometimes found difficulty in making decisions which adhered to the principles of the legislation, and that there could be conflicts between the wishes of the adult lacking capacity and the priorities of the decision maker. Although the degree of engagement with the principles varied between studies, this finding was consistent in all the studies which examined this theme, including in two of the four highest-quality studies.^{11,18}

Other findings

Practical support

Older members of the public in England were generally unaware of potential resources to support making powers of attorney or advance decisions, and some suggested that this might be helpful.¹⁷ Carers described a lack of practical support for decision-making for the adult lacking capacity, and some would have liked more.¹⁸ In one study, carers could identify potential sources of support, but these were generic supports such as friends, relatives, general practitioners and social services.¹⁶ In Scotland, around 75% of guardians were satisfied with the level of supervision and support they had from their local authorities.¹⁵ Guardians in another study perceived that they received insufficient support but were subject to excessive scrutiny.¹³ The perception of excessive scrutiny was shared by holders of intromission with funds.¹²

Lack of knowledge of the legislation

There was a lack of awareness on the part of the general public about the legislation. None of the respondents in a study of older members of the public in England were aware of the MCA, or that it could potentially support their choices for the future, but a few understood the nature of a power of attorney.¹⁷ Only 3 of 12 ‘dementia dyads’ (consisting of a person with dementia and their carer) had heard of a power of attorney, and only a single pair had utilised one.¹⁸ This lack of understanding of the legislation was apparent even where carers had been trained or where they held specific powers. Support workers thought that they needed more training in using the MCA^{8,16} and were observed to be unclear about some of their duties under the MCA.⁹ Guardians in Scotland were ignorant of their responsibilities to document the use of powers, and were unaware that they could delegate them.¹⁵ Some respondents felt that improved sources of information were necessary.¹³ Organisations caring for disabled adults had policies about risk which needed to be revised to comply with the principles of the legislation, and education about the MCA was suggested not just for professionals, but for adults lacking capacity and family carers as well.⁸

Assertiveness of carers

Those professionals with personal experience of being family carers described a necessity for carers to be ‘assertive’ in using the MCA to compel health and social services to act in the best interests of the adult who lacked capacity.¹⁴ The need for guardians to be ‘assertive and articulate’ was also described in Scotland.¹³

Application for financial/welfare powers

Data about the reasons for making applications for formal financial or welfare powers were only found in studies from Scotland. In a survey of guardians, the most common reason described for applying for guardianship was a wish for a formal role in the care of the adult with incapacity.¹⁵ Carers applied for intromission with funds because they believed that they had no other means of managing the person's finances.¹²

Absent or limited data

There were no findings in relation to carers' abilities to assess capacity. No data in the sample related to experiences of formal legal proceedings under English law in the Court of Protection. There was no information about experiences of Deprivation of Liberty Safeguards. Although many adults lacking capacity participated in the studies in this review (*Table 1*), the experiences of carers dominated the findings (*Table 2*).

Discussion

Methods and limitations

This review offers a systematic appraisal of the empirical research literature exploring how adults lacking capacity and their carers experience capacity legislation in the UK. Both quantitative and qualitative data were sought in the process of this review, but most of the studies in the final sample used qualitative or mixed methods. The lack of quantitative studies presented difficulty in data synthesis, because methods for the systematic review of qualitative research are not well established.^{4,6} However, there were benefits from utilising qualitative data to answer this review's research questions. Qualitative methods were appropriate to answer the primary researchers' questions because they are concerned with experiences and perceptions,⁴ are not reliant on random sampling²⁰ and can draw conclusions from small sample sizes.²¹ However, this systematic review cannot make claims of generalisability because it is based mainly on qualitative data, and the prevalence of the experiences described in this review cannot be determined.

There are other limitations which mean that the findings of this review must be treated with caution. This review relied on a single researcher and therefore sampling of papers and quality assessment were carried out without independent checks to ensure consistency. Two-thirds of the studies had not been published in peer-reviewed journals and some were of low quality. Most of the data from England and Wales related to decision-making, and none related to aspects of English capacity law such as experiences in court. Some of the data from Scotland were more than 10 years old, and may not reflect current practices. Data were heterogeneous and the secondary research question could not be answered because direct comparisons between specific components of English and Scottish law were not possible. However, the data were not so heterogeneous as to prevent the use of framework analysis.

Findings

What does this systematic review say about the AWIA and the MCA from the perspectives of the people who are subject to these laws? This review found that the legislation provided family carers with the ability to manage decisions for adults lacking capacity on a legally valid basis, and the mechanisms to allow this were generally seen as satisfactory. There were reports of improved safety and quality of life in some cases, including from some adults who lacked capacity. The ability to make plans for future incapacity was seen as useful. These positive consequences of the AWIA and MCA suggest that the legislation has achieved its goals, at least judging by the standards set by the law reformers of the 1990s.^{2,3} However, although a detailed discussion of human rights is beyond the scope of this paper, it must be acknowledged that the paradigm of disability rights has changed since the drafting of these laws; for example, there is pressure from the United Nations' Committee on the Rights of Persons with Disabilities to replace existing capacity laws with alternative approaches which do not utilise substitute decision-making and which would allow legal capacity regardless of the level of mental impairment.²² These proposals are based on an interpretation of Article 12 of the UN Convention on the Rights of Person with Disabilities²³ which has excited controversy²⁴ and been criticised

as undermining rather than promoting the rights of people with mental illnesses.²⁵ However, if that interpretation of Article 12 is accepted as authoritative, then key areas of UK capacity legislation are incompatible with international law.²⁶

In this review, some positive consequences of the AWIA and the MCA were mitigated by other findings. Perhaps not unexpectedly, adults lacking capacity sometimes resented the powers held over them. There were experiences of both empowerment and disempowerment. Potential benefits such as advance planning were not always realised; for example, planning for the future was seen as potentially beneficial, but despite this few people made powers of attorney or advance decisions. This is an area of concern given the relative simplicity of such instruments compared with the cost and complexity of the legal proceedings which can become necessary when someone loses capacity. Awareness of the legislation seems to be lacking, and public education might increase the utilisation of advance planning. However, not everyone will have the desire or ability to nominate a suitable power of attorney.

Education about the legislation may also be beneficial. As well as a lack of knowledge about the legislation on the part of the general public, support workers and family carers who held specific powers were sometimes unaware of their responsibilities. Decision-making was not always fully compliant with the legislative principles. Although some of the studies with these findings were conducted shortly after the introduction of the legislation when knowledge might be expected to be limited,^{8,9,16} other studies continued to demonstrate this finding several years later.^{11,15}

Legislation could be experienced as either empowering or disempowering by carers. Although some adults lacking capacity described positive outcomes, others described concepts similar to disempowerment. The AWIA and the MCA have been lauded as progressive and empowering instruments.^{27,28} It is true that both are grounded in principles such as enablement, least restriction, and the participation of the adult who lacks capacity in decision-making. Nevertheless, these principles are only empowering in the sense that they return disabled people to the legal status of any other citizen, and do not give them any additional rights to allow them to overcome their impairments. Series²⁹ has observed that most of the mechanisms of the MCA have the effect of transferring power away from disabled adults, and for this reason disputes the claim that the MCA is empowering. The AWIA may be viewed as disempowering for the same reason.

In this review, negative experiences of the legislation related mainly to court proceedings, although data were lacking about the Court of Protection in England and Wales. The transfer of significant decision-making powers between individuals is always likely to require formal proceedings, which will often be perceived as challenging and costly by the applicants. What other options are there? Moving to a tribunal system could potentially decrease costs and reduce distress because the proceedings take place outside the courts. However, tribunals might prove more expensive because of the addition of an extra judicial tier,²⁷ and may not necessarily be experienced more positively than court proceedings.

The initial legislation did not deal with the provision of due legal process for adults without capacity who require restrictive care regimes but lack the ability to challenge their *de facto* detention (so-called 'Bournewood patients').³⁰ This gap in the law still exists in Scotland.³¹ In England and Wales, provisions to deal with this issue were made in the form of the Deprivation of Liberty Safeguards, but these were criticised by the House of Lords, which recommended the process be replaced.²⁷ Both the AWIA and the MCA are undergoing reform to deal with this issue. This review found no data about deprivation of liberty, and it is unfortunate that there are no perspectives from patients or their carers to inform the changes to this area of law.

Finally, the participation of disabled adults in research about capacity legislation needs to be improved. Most of the findings in this review were drawn from carers, despite many adults who lacked capacity having been recruited into the studies. It is disappointing if researchers have made efforts to include such participants, only for those voices to be lost, and future research should take care to avoid this.

This study formed part of an MSc in Mental Health and Law from Queen Mary University of London. Dr Erminia Colucci, Dr Ruth Fletcher and Dr Yasmin Khatib commented on the design of this study and drafts of the manuscript. Dr Lucy Series suggested additional papers for this review.

1.7.74 Does the cognitive therapy of depression rest on a mistake?

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Abstract

Cognitive therapy for depression is common practice in today's National Health Service, yet it does not work well. Aaron Beck developed it after becoming disillusioned with the psychoanalytic theory and therapy he espoused and practised. But Beck's understanding of psychoanalysis appears to have been seriously flawed. Understood rightly, the psychoanalytic approach offers a cogent theory and therapy for depression which, unlike the cognitive approach, takes us to its emotional-motivational roots. A clinically successful therapy can afford to eschew theory and rest on its pragmatic laurels. This is not the case for cognitive therapy. The time is right to re-examine the psychoanalytic theory and treatment of depression.

Contents

- *Does the cognitive therapy of depression rest on a mistake?*
 - *Psychopathological theory*
 - *Therapeutic practice*
 - *Implications*

Cognitive-behavioural therapy (CBT) is, alongside antidepressant medication and counselling, today's mainstay treatment for depression in the UK. Such treatments tend to work better than nothing at all,¹ yet in general fare little better than placebo,^{2,3} suffer relatively high relapse rates, and often struggle to provide a complete remission.^{4,5}

CBT treatments for anxiety disorders, by comparison, appear more successful.⁶ They work by helping the patient articulate, then transcend, their underlying inchoate fears, the transformative learning happening directly within action and experience. This bottom-up experiential focus contrasts with the cognitive treatment of depression, where the patient is more typically trained in an arduous top-down task of managing unhealthy habits of mind through attentional and behavioural training and rational self-management.⁷

One reason for the rather low remission and high relapse rates for CBT-treated depression may be that the treatment does not reach to the emotional roots of the problem. That CBT principally theorises and treats the maintaining, rather than identifies underlying, causes of depression was acknowledged by Aaron Beck, the American psychiatrist who developed the cognitive aspect of this pragmatic depression treatment in the 1950s.⁷

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The psychoanalytic psychology Beck displaced had a theory of the root cause of depression: avoidance of intolerable emotion blocks healthy emotional functioning, depletes uncontrived self-possession, and lowers self-esteem.⁸ But his clinical experience (as a psychoanalytic psychotherapist) and scientific research (on depression, anger and dreaming) led Beck to discount the significance of such unconscious emotion. Ever the pragmatist, he focused instead on treating the conscious assumptions and ruminations of the patient which, he proposed, were maintaining their depressive state.

This article argues that the versions of psychoanalytic theory and therapy Beck espoused, practised and then rejected were recondite and implausible. The claim is that Beck mistakenly threw out the psychoanalytic baby of a significant psychological understanding and treatment of depression with the bathwater of a rather idiosyncratic understanding of psychoanalytic theory and practice. The thesis offered is theoretical rather than scientific: it considers the fundamental conceptual matter of how that theory is itself to be understood, rather than the secondary empirical matter of evidence for or against hypotheses derived from particular interpretations of it. But given the availability of far more plausible versions of psychoanalytic theory and practice that outline and treat depression at its emotional roots, and given the relatively poor success of CBT for depression, the time is now right to put the psychoanalytic theory back on the table and test hypotheses and therapies derived from it.

Psychopathological theory

An important theme in psychoanalytic psychopathology has depression resulting from the avoidance of feelings of loss. When the acute sadness of letting go of a beloved or an aspiration is too painful, the patient may avoid it by shutting down and instead become flat and morose. This, however, prevents adaptation to loss, since sadness is simply the most fundamental form that our recognition of loss takes. Another especially significant theme has depression resulting from the unconscious avoidance of anger towards those to whom we are attached. Rather than risk the feared relational fallout from expressing anger, the patient unconsciously depletes herself, trading that sense of self-worth that would be provided by an angrily assertive sense of injustice for the stability of her relationship. A third theme has depression resulting from the unconscious avoidance of fear. Rather than face the vicissitudes of uncontrollable fate in one's love and work, the patient instead constructs and lives in a dismal and diminished version of himself, his situation and his future. Even if life thereby becomes grim, at least now it will not take him by surprise.

Such ideas form but three strands of a more complex psychoanalytic conceptualisation of depression,⁸⁻¹⁰ but are fairly widespread in both popular and clinical culture for good reason. For clinically what we discover, again and again in straightforward cases, is a depressed person who avoids sadness, fear and in particular anger by going flat, downgrading her sense of her own value, shutting down self-assertion, not allowing herself to get even reasonable hopes up, falsely characterising herself as perpetrator rather than victim of relational injustices, characterising herself as deserving of treatment which reasonable others would consider unjust, denying the significance of her unmet emotional needs, and envisaging a world in which the exercise of agency appears foolhardy. In more complex cases, however, we find masochistic self-abasement added to an anger-avoiding dynamic: unconscious hatred towards another breaks through the attempts at self-suppression and gives rise to intolerable guilt, and this in turn inspires self-punishment where the anger towards the other is 'retroflexed' (taken out on oneself), leading to further and darker melancholic misery.⁹

It was by way of a reaction against such psychoanalytic theory that a young, psychoanalytically minded American psychiatrist and dream researcher developed the theory and practice of cognitive therapy. Following a helpful personal experience of psychoanalysis, Aaron Beck treated several depressed patients using psychoanalytical methods, applied (albeit unsuccessfully) for membership of the American Institute of Psychoanalysis, and published a few papers on psychoanalytic psychotherapy and on the themes of his depressed patients' dreams.^{11,12} Reading these today we learn in particular of his scientific interest in the increased prevalence of thwarted, deprived, excluded, rejected, injured and ashamed themes in his patients' dreams, and of his clinical interpretation of these along psychoanalytic lines.

Already in these early papers, however, we find a curious feature which presages his later rejection of psychoanalysis: although most of the themes Beck describes (e.g. 'I was in a restaurant but the waiters would not serve me'; 'Everyone was invited to the party but me'; 'My fiancée married someone else') appear interpretable in terms of the simple hypothesis of motivated self-depletion, surprisingly he interprets them all in terms of the more complex dynamic of self-hatred: the depressed patient's misery is always seen as deliberately rather than incidentally self-inflicted, reflecting his 'need to suffer'.¹³ Dreams such as not getting food that is requested, or being rejected – which in themselves appear at most to indicate a need to safely anticipate setbacks or protect cherished others from one's resentment by portraying

life as hopeless and oneself as worthless – are instead counterintuitively read as ‘the representation of self-punitive tendencies ... the depressed person feels guilt about his ego-alien drives and punishes himself for them.’¹¹

The question naturally arises as to why Beck was so drawn to the masochism hypothesis. And this is particularly significant because it was when his later experimental and clinical investigations – including his patients’ appropriately negative reactions to interpretations overly organised by this hypothesis – rightly led him to doubt whether he really was meeting everywhere with self-hatred, that he threw out the entirety of the baby of the general psychoanalytic theory of depression along with the specific counterintuitive bathwater of an over-reaching application of the masochism hypothesis. Which is to say that the entire project of explaining why a patient may be unconsciously motivated to think and feel and act in depressive ways was abandoned; in Beck’s hands their condition now collapsed into a habitual rut of self-maintaining negative thought, feeling and behaviour.

One answer to why Beck was so compelled by the masochism hypothesis that it overrode his recognition of the frequent sufficiency of the simpler theory of motivated self-depletion is apparent in the early papers themselves. Beck somehow entirely forgets about the psychoanalytic ideas of depression as due either to thwarted mourning or to avoided fear, becoming solely preoccupied by the idea of it as due to suppressed anger. Such depression as did not appear to evince anger (since, one imagines, it was really due to suppressed sadness or fear) could then only be brought into line with the suppressed anger hypothesis by positing that such a patient was masochistically contriving to make herself depressed.

Another answer only becomes apparent in Beck’s later writings; it concerns the nature of dreaming. (Grasping this takes a little patience, but it is worth the effort.) In these later writings he tells us that what he was actually trying to do in his early research was to set the clinical psychoanalytic theory of depression as a function of suppressed anger on a firmer scientific basis by providing quantitative psychological evidence of unconscious anger in the dreams of his depressed patients.^{14,15} Although he did not report it at the time, what he later tells us he found is what has also been established since:¹⁶ that as a group people with depression have fewer themes of anger in their dreams than people who do not have depression. This puzzled him, as somehow he had understood the Freudian idea of dreams being the ‘royal road to the unconscious’¹⁷ to mean that feelings unacceptable to the waking patient ought to show up straightforwardly in their dreams.¹⁴ The finding of fewer angry themes in the dreams of patients with depression therefore appeared to contradict the psychoanalytic hypothesis of depression as resulting from suppressed anger. This troubled Beck, but – at least until he found independent evidence of the implausibility of this interpretation – he realised he could save the psychoanalytic theory by interpreting the very dreaming of such miserable dreams as masochistically motivated (‘he makes himself dream such miserable dreams because he hates himself’).

What is deeply unclear in all of this is why Beck thought that Freud’s theory posited that unconscious emotions ought to be directly manifest and countable in dreams. After all, Freud’s theory was that dreams serve to protect sleep by helping prevent the dreamer’s anxious recognition of emotions they find unacceptable, such as anger towards loved ones. In that theory dream construction involves the disguise – through displacement, condensation, reversal, negation and projection – of such impulses and emotions as threaten a comfortable sense of self–other relations. (Freud’s ‘royal road’ refers not to a direct, undisguised revelation of the unconscious, but rather to dreams offering particularly rich sites for interpreting the products of defences against intolerable feelings and motivations – by contrast with the myriad, emotionally irrelevant concerns of waking life.) In retrospect it seems at least possible that Beck’s enthusiasm to formulate and test a psychoanalytic hypothesis using the quantitative methods of empirical psychology ended up getting the better of his grasp of the psychoanalytic theory itself.

To sum up so far: a central plank of cognitive therapy’s origin myth has it that it developed out of an apparent scientific disconfirmation of the clinical psychoanalytic theory of depression as a motivationally explicable state.¹⁴ But in retrospect what seems more likely to have happened is that an inappropriate quantitative methodology deployed to provide support for an unlikely theory of depressive dreaming actually found against it; that an implausibly general theory of depressive masochism was developed to save the floundering analytic theory; and that when this overly general masochism theory was dropped for good reason, the whole idea of symptoms as motivated by the avoidance of intolerable feelings – i.e. the whole idea of a depth psychology – was jettisoned for no good reason at all.

Therapeutic practice

As described above, the development of cognitive therapy's psychopathological theory rests on its unwarranted rejection of the psychoanalytic notion of depression as unconsciously motivated. The development of cognitive therapy's psychotherapeutic technique, however, depends on its rejection of the centrality for psychotherapeutic practice of what psychoanalysis terms the 'transference relationship'.⁷ A curious aspect, then, of Beck's development of cognitive therapy is that it was actually inspired by his encounter with, and dawning realisation of the clinical significance of, what are clearly recognisable as his patients' transferences to him.

First, a note on 'transference'. A defining preoccupation of psychoanalysis is with how immersion in relationships which inspire concern and attachment – such as those with psychotherapists, partners, parents, employers, etc. – so readily elicits unrealistic fearful and idealising expectations concerning others' views of us. These relentlessly maintained, emotionally charged expectations are seen by psychoanalysis as being at the root of much psychopathology, and their manifestations inside and outside of therapy are known as negative and positive transferences. They can be easy to attend from, as it were, but powerfully difficult to attend to – i.e. they are often unconscious – and their patterns are typically transferred from one significant other to another over time.^{18,19} The task of psychoanalytic therapy is the patient's emancipation from distorting transference patterns, a task prosecuted by first facilitating the flourishing and then the subsequent experiential emancipation from the transferences between patient and psychotherapist, an experience that can then generalise to the transferences in the rest of the patient's life. Much of a psychoanalytical psychotherapist's training has to do with developing his ability to make room for and be emotionally touched, yet not inexorably swept along, by the patient's transference so he can think about, experience, describe, and help liberate the patient from her unconscious depressogenic emotional habits.

To return to cognitive therapy. As Beck¹⁵ tells the story, he had a patient who would lie on the couch each session and regale him with lurid tales of her sexual exploits, while he sat back and offered somewhat by-the-book psychoanalytic interpretations regarding the content of whatever it had occurred to her to say. At the end of one session, however, Beck asked his patient how she was feeling; she replied 'anxious'. Beck first suggested to her, in an interpretation focusing only on intra-psychic issues, that conflicts about sex were making her anxious. She cautiously responded, however, to the effect that her real worry was interpersonal: her worry was that he was bored by her. Beck then began to see 'that there's a whole stream of pre-conscious thinking that goes on that the patient doesn't normally communicate to the analyst'¹⁵ – especially pessimistic, biased, black-and-white, over-general irrational expectations concerning what the therapist thinks and feels about the patient. Beck came to call these transference expectations the patient's 'negative automatic thoughts' (NATs) and, drawing on the 'rational therapy' of Albert Ellis,²⁰ went on to develop a significant range of procedures to help the patient attend to and challenge their NATs.

There are several curious things about this and related narratives Beck offers.²¹ The first is that Beck the novice psychoanalyst started out (as one does) by naively listening to and interpreting the explicit content of what the patient freely said, rather than listening in with an analytic ear to what she was not saying, to the unconscious dimension of the transference (i.e. listening to how he featured latently in her mind), or listening in to his own countertransference (i.e. to the feelings provoked in him by, in particular, the performative rather than declarative aspect of her discourse). Thus, despite the patient's manifest lack of inhibition in talking about sex, Beck still interprets her anxiety as due to sexual conflict.

The second is that when Beck shows a real interest in his patient, asking her how she feels, she is able to acknowledge her transference to him, and they can understand it together to beneficial effect. We go on to hear that these worries (which, despite, or perhaps because of, being so very omnipresent in her mind she never discussed before) are actually common for her in other settings too. As the therapeutic relationship is strengthened (by Beck's concerned question about her actual feelings), the emotionally alive experience of the transference (her worries about Beck being bored by her) also begins to be acknowledged and worked through, and interpretative speculation about intra-psychic conflict is foregone.

The most striking thing about Beck's narrative, however, is that this therapy-potentiating emotional experience of the transference is set aside almost as soon as it is encountered. Anyone who has been in psychotherapy will know how replete it is with holding back acknowledgement, both to oneself and to the therapist, of one's thoughts and impulses for fear of encountering one's own or the therapist's disapproval, despite such fears speaking right to the heart of such emotional difficulties as brought one to therapy in the first place. Notwithstanding the simplicity of the 'fundamental

rule' of psychoanalysis – to 'free associate', i.e. say whatever is actually on your mind (which is not the same as saying whatever you feel like saying!) – the fact is that no one can truly follow it,^{21,22} since we naturally associate away from rather than towards conflictual emotional preoccupations.²³ This is why the therapist's job is often to listen not so much to the content of what is said as to performative matters of style, timing and omission. Beck, however, construes NATs as merely incidentally hard for the patient to articulate and challenge – due to a lack of training in attending to and reporting on them²¹ – rather than because of their emotional valence. This, I submit, is intuitively implausible. More consonant with everyday clinical and personal experience is the notion that his patient did not elaborate her actual worries because she feared they might not be disconfirmed – and chose instead to distract herself and please him with endless talk about sex, presumably since, as we all know, Freudians do have rather a reputation for being interested in such matters!

Cognitive therapists are often accused of ignoring the importance of the therapeutic relationship, but as Beck's daughter Judith Beck explains, this is false – cognitive therapy 'requires a good therapeutic relationship. Therapists do many things to build a strong alliance. For example, they work collaboratively with clients ... ask for feedback... and conduct themselves as genuine, warm, empathic, interested, caring human beings.'²⁴ However, as psychoanalytical psychotherapist Jonathan Shedler responds, 'This is the kind of relationship I would expect from my hair stylist or real estate broker. From a psychotherapist, I expect something else. [Beck appears] to have no concept that the therapy relationship provides a special window into the patient's inner world, or a relationship laboratory and sanctuary in which lifelong patterns can be recognized and understood, and new ones created.'²⁵ Shedler's optimism regarding his hair stylist and estate agent perhaps warrants some cognitive restructuring, but his point about the therapeutic relationship stands.

A relationship which is not merely instrumentally useful (as intended by cognitive therapy), but itself intended as the unique locus of change (as in psychoanalytic therapy), is one which both activates the patient's latent transference fears (that the therapist is untrustworthy, angry etc.) and simultaneously provides enough of a working alliance to enable such prototypical fears to be experienced, understood and worked through in real time. With a merely collaborative and empathic focus the opportunity is lost for the real-time eliciting and challenging of the patient's underlying emotional preoccupations. The result is somewhat like trying to conduct exposure therapy for a phobia without physically encountering the fearful stimulus, or like a chat between two adults about the difficulties of a child left waiting in the next room.

A popular canard has it that psychoanalytic psychotherapy is unhelpfully preoccupied with the past, whereas CBT is practically focused on the present. This ignores the way both therapies tend to formulate current disturbance in terms of childhood-acquired pathogenic beliefs. More importantly, it ignores the fact that, at the level of technique, CBT tends to focus on matters arising in the patient's past week, whereas a transference-focused psychotherapist hones in on uncomfortable transference feelings alive right now between patient and therapist. Rather than providing merely intellectual insight to further an ongoing project of dreary self-management, itself supplementing an already exhausting project of defensively managing intolerable feelings, psychoanalytic psychotherapy instead offers an intrinsically mutative emotional exchange which already constitutes a growth in self-possession and a change of heart, obviating the need for such self-management.

Implications

Work in the transference is designed to facilitate a patient's living exposure to their real underlying fears about how they would be seen if they were to allow themselves their own true feelings. The opportunity is thereby provided for a true change of heart – i.e. for emancipation from depressive cognition through an experiential recovery, acceptance and integration of hitherto unconscious emotional experience. Ideally, this would reduce the need to manage the dismal distal products of this emotional evasion with therapeutic techniques of behavioural activation, cognitive challenge or mindfulness. The result of such an effective therapy for depression would be akin to that sometimes achieved by CBT for anxiety conditions: a transformative learning, from the experiential ground up, that reinstates true self-possession.

The time is past for studies comparing outcomes of self-professed cognitive therapy/CBT and psychoanalytic practitioners. The apparent success of particular therapies in such trials is better predicted and explained not by therapeutic model²⁶ but by the theoretical orientation of the lead experimenter,²⁷ the personal qualities of the therapists,²⁸ or by theory drawn from quite different models.²⁹ Beck himself expressed the wish that cognitive therapy as a school die out,³⁰

the apt thought here being that what matters is not the treatment model but rather the particular treatment qualities which are individually worthy of study.

CBT treatments for depression often suffer high drop-out rates.³¹ One possible explanation for this is a lack of attention to transference. Sometimes this may be because negative transference undermines the therapeutic collaboration, although ideally CBT therapists are trained in recognising and managing this.⁷ At other times it may be because psychotherapeutic relationships that are merely collaborative, rather than offering experiential work in the transference, do not hit the therapeutic spot. Recently, however, there has been a resurgence in the general theory of,⁸ clinical practice and treatment manual for,³² and outcome studies supporting a transference-involving psychoanalytic approach to depression. With regard to outcome, outstanding results in helping patients with treatment-resistant depression which is not readily resolved by CBT have been obtained by particular practitioners of psychoanalytic psychotherapy³³ and somewhat optimistic results have been obtained with similar patients in the multi-practitioner Tavistock Adult Depression Study.³⁴

The present article has not been concerned to argue for a psychoanalytic approach to depression on the basis of empirical evidence. Instead, it noted that Beck's development of a cognitive approach to depression was predicated on his rejection of a psychoanalytic understanding of depression in particular, of the dynamic unconscious in general, and of psychoanalytic psychotherapeutic methods – and that his rationale for all this was flawed. What he developed in its stead does not stand or fall on this basis, and there are several benefits (especially clinical pragmatism and a strong research tradition) to the therapy he developed. But, given both the flawed rationale for rejecting a psychoanalytic approach which, rightly understood, possesses considerable clinical plausibility, and given the relatively poor results obtained by CBT for depression in much clinical practice, the time is surely right to revisit the psychoanalytic model.

1.7.75 The cognitive therapy of depression rests on substantial theoretical, empirical and clinical foundations: a reply to Dr Gipps

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Abstract

Dr Gipps claims that the cognitive therapy for depression rests on a mistake. But his anachronistic analysis of Beck's early research from the perspective of current psychoanalytic theory misses the point. The value of the research was not that it disproved psychoanalytic theory, but that it generated a model of depression that has revolutionised psychotherapy research. Psychoanalysts are belatedly adopting research methods that Beck pioneered half a century ago. The cognitive model of depression has explanatory power for both maintenance and vulnerability and has substantial research underpinning it. Cognitive therapy for depression has a larger body of evidence for its efficacy and relapse prevention effect than any other psychotherapy. Transference-focused approaches to depression have yet to establish themselves in the same way.

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 - *Psychopathological theory*
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Dr Gipps's polemic against Beck's cognitive therapy for depression rests on two assumptions. First, that cognitive therapy 'doesn't work very well' for the condition, and second, that the cognitive model is invalid because it is based on a flawed understanding of psychoanalysis. The first statement is misleading – cognitive-behavioural therapy (CBT) has the most comprehensive evidence base of all the psychological therapies. The second statement is largely irrelevant – the cognitive model of depression rests on a substantial body of research that is independent of the experiences that led to its original formulation. This reply will review the evidence for the effectiveness of psychological treatments for depression, highlighting the selectiveness of Dr Gipps's interpretation of the literature. It will then examine the cognitive model, demonstrating that it is far richer than he suggests, and has developed and changed in the light of extensive research. Finally, Gipps's caricature of CBT practice will be challenged: contemporary CBT does have something to say about experiential avoidance and interpersonal processes. It has the flexibility to address these as and when necessary without making them the sole vehicle for change. Gipps seems to believe that by denigrating Beck's psychoanalytic credentials and claiming his theory is based on a misunderstanding he can somehow erase nearly 60 years of research supporting the cognitive model. This is merely opinion, not reasoned scientific discourse.

Dr Gipps argues that current treatments for depression 'fare little better than placebo' so we should turn to psychoanalysis. He claims poor results for medication, counselling and CBT, but neglects to mention that trials of psychodynamic psychotherapy have not demonstrated it does better than CBT (the reverse may actually be the case).¹ If we take a non-partisan approach, the conclusion is that a number of treatments work for depression. For instance, a recent meta-analysis of randomised controlled trials (RCTs) reported effect sizes for CBT, counselling and short-term psychodynamic psychotherapy at 0.67, 0.57 and 0.69, respectively.² Dr Gipps, however, disingenuously selects a small uncontrolled trial of intensive short-term dynamic psychotherapy ($n = 10$) as his argument for the potential superiority of the psychodynamic approach.³ All these psychological treatments are as effective as antidepressants, but the superiority of all treatments over placebo may, as he suggests, be less than was once assumed.⁴ There is indeed a powerful placebo effect in mild depression, but this seems to lessen as severity of depression increases.⁵⁻⁹ It is also important to note that although placebo may do well in the short term, patients are more likely to relapse.¹⁰ Cognitive therapy still has the largest evidence base of all the psychotherapies for depression; not only is it effective in the acute phase, but it also reduces relapse.^{11,12} Its effects are not restricted to RCTs: in naturalistic settings 40% of patients recover and 64% show reliable improvement.¹³ The empirical data give us no reason to abandon CBT for depression.

Psychopathological theory

The implication of Dr Gipps's rather condescending analysis is that cognitive therapy would not have been created if Aaron Beck had been a better psychoanalyst (we are pointedly told that Beck failed entry to the American Institute of Psychoanalysis). According to Gipps, Beck got the wrong end of the stick, and his misunderstanding of theory led him to devise a set of experiments that set psychopathology off on the wrong track for the next half century. The problem here is that Beck's early work is scrutinised from the perspective of current psychoanalytic theory rather than seen in its historical context. It appears the 'mistake' Beck made was to be unaware of British psychoanalysis when he carried out his ground-breaking research in the late 1950s. Gipps's main reference is Trevor Lubbe's 2011 book written from the perspective of the British object relations school, which Beck is unlikely to have encountered in his analytic training in the USA – a training inclined towards instinctual and ego theories. Should we then abandon all Freud's work because his theories, originally framed in biological terms, were based on a misunderstanding of modern neurology?¹⁴ Gipps describes clearly what he sees as the current consensus of psychoanalytic thinking on depression which has unconscious avoidance of emotion at its centre: avoidance of feelings of loss, avoidance of anger towards those to whom we are

attached, and avoidance of fear. Rather than face these feelings the patient retreats into depression, preferring to live 'in a dismal and diminished version of himself, his situation and his future.' Beck's investigations tested one aspect of the anger-avoidance theory of depression: the masochism hypothesis. Anger towards another is repressed because it is unacceptable, but it breaks through and is then turned on the self. This internalised hostility leads to self-punishment, manifested in the self-criticism and self-abasement found in depression. Gipps wonders why Beck was drawn to the masochism hypothesis to the exclusion of others. The simple answer is that the introjected anger hypothesis was the prevailing theory of depression in American psychoanalysis at the time. Even in 1988 David Milrod could still write that 'the essential elements in a depression are the self-directed aggression and the mood state to which it leads'.¹⁵ In this context Beck's investigation of internalised hostility is very reasonable, and his research design perfectly acceptable for its time. But the significance of this research is not that it disproved psychoanalytic theory, but that it stimulated a powerful new theory. Whether one accepts the cognitive model or not, it has made an enormous contribution to the development of empirically based research in depression. Beck showed that it was possible to construct a theory that was refutable, and his steadfast focus on testing his theories has led to changes and modifications on the basis of research evidence. This is in contrast to psychoanalysis, which tends to change on the basis of new theoretical or clinical trends, but rarely in response to new research evidence. The first outcome study of cognitive therapy for depression, for instance, demonstrated that psychological therapy could be as effective as pharmacotherapy and showed that therapy could be operationalised and manualised.¹⁶ Even psychoanalysts now admit the value of treatment manuals!¹⁷ Any studies demonstrating the efficacy of psychoanalytic psychotherapy therefore owe a considerable methodological debt to Beck's pioneering work in outcome research.

So what is this mistaken cognitive model of depression? According to Beck, pervasive negative thinking is at the centre of depression: negative views of the self, the world and the future. These thoughts result from an information processing bias that selectively attends to negative events, negatively interprets situations, and encodes them as negative memories. These processes result from the activation of underlying cognitive structures or schemas, in the form of dysfunctional beliefs.^{18–20}

There is considerable evidence for this cross-sectional model: for a shift in information processing, for the reciprocal interaction between low mood and negative thinking, and for the presence of dysfunctional beliefs in depression.^{21,22} Beck also formulated a developmental model to explain vulnerability to depression. Negative events in childhood, for example loss of a parent, lead to negative beliefs which become activated when specific events impinge on these schemas. Beck revised this theory in the light of findings that severe life events are not always necessary to precipitate depression. An accumulation of milder stressful events can contribute, and with each successive episode the severity of event needed to trigger depression becomes lower (the kindling effect).²³ A further refinement of the model came with the discovery that when a depressed mood was evoked people prone to depression exhibited negative cognitive biases (cognitive reactivity).²⁴ These new findings were integrated into the theory using the concept of the depressive mode – a network of cognitive affective, motivational, behavioural and physiological schemas activated in depression. The mode is 'a complex neural network, including multiple relevant brain regions that are activated or deactivated during depression' (p. 971).¹⁹ With repeated depressive episodes the network of beliefs becomes stronger and relatively autonomous, so that minor stressors trigger the depressive mode. The cognitive model provides a comprehensive account of both vulnerability to and maintenance of depressive episodes. It does focus on unconscious processes, i.e. schemas and information processing biases, but these are unconscious because they are automatic, not because they are repressed. Regardless of its origins, the cognitive model stands on its own merits as an account of significant phenomena in depression.

Therapeutic practice

Dr Gipps's main criticism of CBT practice seems to be that it is not psychoanalysis. The collaborative, problem-solving relationship which is at the heart of good CBT is ridiculed as superficial because it apparently misses the opportunity to work with the transference. CBT, unlike psychoanalysis, is a problem-focused therapy, and one of its strengths lies in the way the problem is placed on the table and the therapist and patient work together to solve it. In depression this allows for a partnership in solving realistic problems and the identification of blocks to problem-solving arising from the patient's negative thought processes. For instance, negative predictions about being rejected may lead a patient to be socially avoidant, further reinforcing their depression. The therapist helps the patient test their beliefs by attending a social event and noting the outcome. This 'collaborative empiricism', together with the structure and focus

of therapy, engages the healthy adult functioning mode and minimises regressive transference so that the patient can learn strategies to help them out of their depression.²⁵ When negative interpretations of the therapist's behaviour arise these can be worked on together, for instance by noting how the patient's fear that the therapist may be cross with them is an example of a pattern of depressive misinterpretation that occurs outside the session with others. As the developmental conceptualisation is deepened over the course of therapy, the underlying assumptions that drive this reaction might be identified (e.g. 'If I make a mistake I'll be rejected'), their origins in parental criticism discussed, and the schemas modified. This is work with the transference but in the service of learning how to manage negative reactions activated when the person is depressed. With patients with personality disturbance the focus on the interpersonal relationship becomes more important and changing interpersonal schemas becomes one of the key goals of therapy. This is what Gipps calls the 'real-time eliciting and challenging of the patient's underlying emotional preoccupations.' However, CBT has the flexibility to work with the therapeutic process when necessary, but is not shackled to it as the only vehicle for change.

A second, more interesting, point made by Gipps concerns the role of experiential avoidance in depression. This is central to CBT for anxiety, where much of therapy focuses on identifying negative predictions and setting up behavioural experiments to test the fear. This is indeed often done in real time, through experiments in the session such as panic induction. This is of course very effective without any reference to transference. Recent developments in 'third-wave' CBT explicitly address emotional avoidance, and there is room for more attention to this within the standard cognitive model of depression. In mindfulness-based cognitive therapy, for instance, mindfulness meditation is taught as a skill to help patients practise moving from the ruminative depressive mode into a mode where they are present for whatever they are experiencing, approaching difficult feelings rather than moving away from them.²⁶ Although this concept of avoidance of emotions is similar to that in the psychoanalytic model, the significant differences are that it is not conceptualised as a motivated avoidance arising from a dynamic unconscious, and that it is perfectly possible to work with it outside the transference.

Dr Gipps's final criticism of CBT practice regards its project of 'dreary self-management'. Psychoanalytic psychotherapy, by contrast, 'offers an intrinsically mutative emotional exchange which . . . constitutes a growth in self-possession and a change of heart, obviating the need for such self-management.' This is wonderful news. Many of us would love to engage in a therapy that magically transforms us so that we do not have to pay attention to our habitual patterns that so frustratingly trip us up, but this is not what good psychodynamic psychotherapy is actually about. It involves noticing reactions outside the session as well as within, and considerable repetitive work on the self. Depression is a relapsing condition and it is patronising and misleading to imply that learning ways to manage it is unnecessary. Patients who successfully negotiate the vicissitudes of recurrent depression learn to identify risk factors that make them vulnerable, recognise how structuring their week helps to maintain positive mood, and how they can easily fall into negative thought patterns. Cognitive therapy gives them tools for doing this, but also changes underlying beliefs, to reduce vulnerability to depression.

Conclusions

Cognitive therapy is a tried and tested therapy for depression. It has a proven relapse prevention effect, but is not a panacea and is not the only effective treatment for depression. Most of these therapies do not work with the transference, and there is nothing to suggest that a transference-focused therapy will be hugely more effective or reduce dropout rates. The results from the two reported trials of psychoanalytic therapy are promising, but much more research is needed before they can be compared with the accumulated evidence for the effectiveness of CBT. Dr Gipps's article is based on a mistaken reading of the research into CBT as a therapy, and an anachronistic approach which judges Beck's evaluation of psychoanalytic theory in 1959 by the standards of 2016. What Beck developed stands not on this, but on almost 60 years of research. This has not only generated a robust theoretical model of depression, but has given psychoanalysts methodologies they now use to evaluate their own theories and therapies. The cognitive model of depression is likely to be around for another 60 years, but it will evolve and change on the basis of empirical research rather than theoretical whimsy.

1.7.76 Suicide patterns on the London Underground railway system, 2000–2010

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Abstract

Aims and Method Suicidal acts on underground railway networks are an area of public health concern. Our aim was to review recent epidemiological patterns of suicidal acts on the London Underground to inform future preventive interventions. Data from 2000 to 2010 were obtained from the British Transport Police via a Freedom of Information request.

Results The mean annual rate of suicidal acts from 2000 to 2010 was 5.8 per 100 million passenger journey stages. Of those who died by suicide, 77.3% were of White Northern European ethnicity. A fifth had a history of mental illness.

Clinical implications The widening gap between the number of recorded suicide attempts and completed suicides is encouraging. Further research is required regarding the role of drug and alcohol use, psychiatric history and area of residence. Installation of platform screen doors should be considered in future railway network expansion.

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 - * *Strengths and limitations*
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The London Underground was built in 1863 and was the world's first underground railway system.¹ Today it comprises 11 train lines serving a total of 270 stations across 402 km.¹ In 2015/16 it saw the completion of 1.34 billion journeys across its network.¹ Suicide on underground railway systems is a major cause for public health concern. Railway suicide can have a traumatic impact on both train drivers² and witnesses, and can lead to significant train delays, with substantial economic consequences.³

Between 1940–49 and 1980–89 the mean number of suicidal acts per year on the London Underground rose from 36.1 to 94.1.⁴ Previous studies have suggested an association between the rising number of suicidal acts across the national railway and increasing volumes of passengers across railway networks;^{5,6} however, this finding has been inconsistent across studies.⁷ Use of preventive measures to stop suicidal acts on railways has been the focus of several studies, for example, concentrating on changes to the immediate environment, media reporting and interagency collaborations.⁸

Our aim was to review recent epidemiological patterns of suicidal acts on the London Underground to better inform future preventive interventions.

Method

Data covering deaths by suicide between 2004 and 2010 and 'person under train' incidents between 2000 and 2010 were obtained by one of the authors (M.R.) on 7 October 2011 through a Freedom of Information request to the British Transport Police. Data covering completed suicides between 2000 and 2003 could not be provided owing to changes in coding. No further information in relation to this was provided by the British Transport Police.

The data provided by the British Transport Police included demographic information (age, gender, ethnicity) of suicide victims between 2004 and 2010. Age was categorised as: <15 years, 15–44 years, 45–74 years and > 75 years. The authors also received figures pertaining to all suicide attempts (which included incidents where individuals were prevented from jumping in front of a train or accessing the tracks) and all 'person under train' incidents (intentional and accidental) between 2000 and 2010.

Information regarding the total number of journeys completed on the London Underground was obtained from the publicly accessible Transport for London (TfL) 2011 *Travel in London* report.⁹ Passenger journeys were recorded as 'journey stages', where a journey stage represents a segment of a trip made on a particular mode of transport. For example, a journey made up of two stages could include a walking stage to the Underground station followed by a second stage on the Underground network.¹⁰

Results

Between 2000 and 2010 there were 644 recorded suicide attempts on the London Underground. The mean annual rate of suicide attempts during this period was 5.8 per 100 million journey stages (95% CI 5.0–6.5). Between 2004 and 2010 there were 132 deaths by suicide. The mean annual rate of individuals who died by suicide during this period was 1.8 per 100 million journey stages (95% CI 1.4–2.2). In addition, there were 38 deaths in which the coroner recorded an open verdict and 9 deaths in which the inquest had not yet taken place or in which the British Transport Police did not have access to the outcome of the verdict. The total number of 'person under train' incidents between 2000 and 2010, which included both intentional and accidental acts, was 433. The mean annual rate of 'person under train' incidents during this period was 3.9 per 100 million journey stages (95% CI 3.6–4.2).

Figure 1 shows an increase in the number of suicide attempts from 2004 to 2009, which is more marked than the increase in the number of incidents of death by suicide. The number of 'person under train' incidents, however, remained relatively constant. Our data revealed a small increase in the number of suicide attempts and 'person under train' incidents during May–August, with a peak in June, as illustrated in *Fig. 2*.

Fig. 12: Suicide attempts v. deaths by suicide, 2000–2010.

Tables 1 and 2 display the age and ethnicity distribution for males and females in incidents of deaths by suicide 2004–2010. Age at death was not available for two male individuals, and ethnicity data were not available for one

male individual. Of the deaths by suicide, two-thirds ($n = 88$) were male and a third ($n = 44$) were female. The average age at death was 40.7 years in males and 45.5 years in females.

Age and ethnicity in incidents of death by suicide in males, 2004–2010^a

	Age, y ears: n (%)		Ethni city, n (%)								
2004	0 (0.0)	66.7)	33.3)	0 (0.0)	12	50.0)	0 (0.0)	25.0)	25.0)	0 (0.0)	12
2005	0 (0.0)	66.7)	16.7)	16.7)	6	71.4)	0 (0.0)	0 (0.0)	28.6)	0 (0.0)	7
2006	0 (0.0)	69.2)	30.8)	0 (0.0)	13	11 (84.6)	0 (0.0)	1 (7.7)	0 (0.0)	1 (7.7)	13
2007	0 (0.0)	10 (76.9)	15.4)	1 (7.7)	13	12 (92.3)	0 (0.0)	1 (7.7)	0 (0.0)	0 (0.0)	13
2008	0 (0.0)	10 (76.9)	23.1)	0 (0.0)	13	69.2)	0 (0.0)	1 (7.7)	23.1)	0 (0.0)	13
2009	0 (0.0)	10 (62.5)	31.3)	1 (6.3)	16	12 (75.0)	0 (0.0)	18.8)	1 (6.3)	0 (0.0)	16
2010	0 (0.0)	46.2)	53.8)	0 (0.0)	13	10 (76.9)	0 (0.0)	0 (0.0)	23.1)	0 (0.0)	13
To- tal	0 (0.0)	57 (66.3)	26 (30.2)	3 (3.5)	86	65 (74.7)	0 (0.0)	10.3)	12 (13.8)	1 (1.1)	87

Age not available for one individual; ethnicity data not available for two individuals.

Age and ethnicity in incidents of death by suicide in females, 2004–2010

	Age, years: <i>n</i> (%)		Ethnicity, <i>n</i> (%)									
2004	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	1	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1	
2005	0 (0.0)	54.5	45.5	0 (0.0)	11	10 (90.9)	0 (0.0)	0 (0.0)	1 (0.1)	0 (0.0)	11	
2006	0 (0.0)	25.0	50.0	25.0	4	4 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	4	
2007	0 (0.0)	33.3	66.7	0 (0.0)	3	3 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	3	
2008	0 (0.0)	80.0	20.0	0 (0.0)	5	60.0	0 (0.0)	20.0	20.0	0 (0.0)	5	
2009	0 (0.0)	41.7	58.3	0 (0.0)	12	75.0	0 (0.0)	1 (8.3)	16.7	0 (0.0)	12	
2010	0 (0.0)	62.5	25.0	12.5	8	87.5	12.5	0 (0.0)	0 (0.0)	0 (0.0)	8	
Total	0 (0.0)	20 (50.0)	19 (43.2)	3 (6.8)	44	37 (84.1)	1 (2.3)	2 (4.5)	4 (9.1)	0 (0.0)	44	

Of the 132 individuals who completed suicide on the London Underground, 110 (83.3%) were resident in London at the time of the event. Information was unavailable for one individual. A history of mental illness was confirmed in 20.5% of individuals ($n = 27$).

The Northern Line had the greatest number of recorded suicide attempts ($n = 145$) between 2000 and 2010, followed by the Central Line ($n = 99$) and Piccadilly Line ($n = 92$). The lowest numbers of suicide attempts during that period were recorded on the Jubilee Line ($n = 27$) and Bakerloo Line ($n = 33$).

King's Cross St Pancras station saw the highest number of suicide attempts between 2000 and 2010 ($n = 18$), followed by Mile End ($n = 17$), Victoria ($n = 16$), Camden Town ($n = 15$), Archway ($n = 13$), Liverpool Street ($n = 13$), Oxford Circus ($n = 12$), Green Park ($n = 12$) and Earl's Court ($n = 11$). Suicide attempts led to delays in underground railway services; between 2000 and 2010 the Northern Line and Piccadilly Line experienced the greatest total delays (8484 min and 5521 min, respectively). The Jubilee Line recorded total delays of 2396 min and the Bakerloo Line 1911 min over the same period (*Fig. 3*).

Discussion

Suicide patterns over time

There was a marked increase in the number of suicide attempts across the London Underground from 2004 onwards, although this trend was beginning to reverse in 2009. Although there was also a rise in deaths by suicide during that period, this was of a lesser degree. In their 2016 paper looking at suicide trends across the entire England and Wales railway system, Taylor *et al* found that male suicide rates had increased from 6 to 8.4 per million from 2000 to 2013, with the greatest increase observed between 2010 and 2013, from 6.4 to 8.4 per million.¹¹ By contrast, female suicide rates remained relatively constant. Although previous studies looking at suicide attempts on underground railway systems have suggested a case fatality rate of 43 to 55%^{4,12,13} (compared with 90% on overground railways¹⁴), this does not fully

explain the extent of the difference observed. Increased reporting of suicide attempts by London Underground staff may be a factor, as well as the introduction of preventive interventions allowing for the early identification of persons at risk.

TfL has worked towards suicide prevention since the 1990s.¹⁵ This has included strategically placed Samaritans campaign posters and telephones within stations. More recently there has been further collaborative work with the Samaritans to train staff in identifying persons at risk, and giving them the confidence to intervene.¹⁶ Additional interventions have included platform-edge barriers on the Jubilee Line and gates to prevent passengers from entering tunnels at existing stations, as well as use of video surveillance and markings/warning signs to prevent individuals from approaching the platform edge.¹⁵ Presence of staff on platforms during rush-hour periods may also be helpful. The increase in the number of suicide attempts and deaths by suicide in 2008 and 2009 may in part be explained by the financial crisis of 2008.¹⁷

The number of journey stages made on the London Underground increased from 0.976 million in 2004 to 1.065 million in 2009.⁹ There have been several studies exploring a potential link between higher numbers of passenger journeys and the incidence of suicide, with variable findings. Sonneck *et al* found no such association on the Viennese subway,⁷ whereas in Stockholm, Sweden, and The Netherlands, authors noted a positive association.^{5,6} Although Waterloo station is the busiest in terms of passenger flow,¹⁸ it does not feature in the top 20 stations for suicide attempts on the London Underground in 2000–2010.

Our data did not reveal any marked variation in suicide attempts across the year, although there was a small increase in events during May to August, with a peak in June. Findings in other studies have been variable. Although Dinkel *et al* found no association between seasons of the year and suicide events,¹⁹ others have noted a small increase in suicide events during the summer months⁴ or during the months of April and September.²⁰ Even though summer months are associated with higher numbers of tourists in London, it is unclear whether this has had an effect on the number of suicide attempts during those months. Although a majority of those who died by suicide on the London Underground were mostly resident in the city, the time of year of their death was not available, nor was the proportion of London residents represented among those individuals who attempted suicide.

Demographics

The stark overrepresentation of men in the 15- to 44-year age group (61.4%, $n = 57$) among those who died by suicide was in keeping with national figures (England), where the proportion of males is approximately two-thirds.²¹ The overall gender distribution of suicide victims on the London Underground was very similar to that recorded nationally during the same period (2004–2010), with 66.9% of cases being male and 33.1% female. By contrast, the proportion of females aged over 75 years was almost double that of males (6.8% and 3.5% respectively), although the numbers were very small and therefore need to be interpreted with caution.

This is the first study looking at the ethnic distribution of suicide victims on the London Underground. The predominance of individuals of White Northern European background (>75%) is significant in a place like London where people of White ethnic background make up less than 60% of the total population,²² in particular since 83.3% of individuals who died by suicide on the London Underground were resident in the city. Moreover, use of the London Underground is evenly distributed across different ethnicities.²³ There are currently no data available on the ethnicity of individuals who die by suicide nationally, hence we do not know whether individuals of White Northern European ethnicity are also overrepresented relative to other ethnic groups. Similarly, we do not know whether individuals of White Northern European ethnicity are overrepresented in suicide incidents occurring across the rest of the national railway network or involving violent suicide methods.

In our sample a fifth of individuals had a history of mental illness. Unfortunately, no further data were available regarding their diagnosis, level of psychiatric care at the time of suicide or whether they were current or recent in-patients of a psychiatric unit. Proximity of stations or railway suicide ‘hot spots’ to psychiatric hospitals has been highlighted as a risk factor for suicide in several studies,^{4,5,12,24,25} although the result was not found to be significant across the Stockholm railway system.⁵ In their 1987 study of 100 individuals who had attempted suicide on the London Underground, Cocks found that 13 were current psychiatric in-patients, and 2 had been discharged within 48 h of the event.²⁶ Fifteen individuals had expressed suicidal ideation in the 24 h preceding the event. Although proximity to a

psychiatric hospital was not taken into account in this paper, the presence of a history of mental illness in a fifth of those who died by suicide highlights the need for staff working in psychiatric hospitals to be aware of the proximity of any nearby Underground stations in their assessment of risk in patients.

Additional risk factors

In Stockholm, authors found that the stations with the highest suicide rates were associated with higher levels of surrounding drug-related crime.²⁷ Previous studies have shown that consumption of alcohol or drugs was a characteristic of about 10 to 20% of individuals who had attempted or died by suicide on an underground railway system.^{12,28,29} In the UK National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, the authors noted that 54% of those who died by suicide and had been in contact with mental health services over the past year had a history of alcohol and/or drug misuse.³⁰ Intoxication with drugs or alcohol can increase the risk of impulsive and risk-taking behaviour and may have been a contributing factor in the incidents observed on the London Underground, including ‘person under train’ incidents of accidental cause. Unfortunately, the British Transport Police do not currently collect this information. Consumption of alcohol on the London Underground is forbidden; however, consideration must be given as to how to manage the risk of suicidal behaviour or accidental injury in intoxicated individuals.

Use of preventive measures

Several recent studies looking at suicide attempts on underground and overground railway systems have focused on the use of preventive measures. Diminishing ease of access to the track through barrier methods is suggested as an effective intervention, although Cox *et al* noted a lack of studies demonstrating this.³¹ In Seoul, the presence of platform screen doors (PSDs) reduced suicides on the underground network by 89%.³² PSDs are continuous panels that separate the platform from the train, only opening when the train is in the station. Half-length PSDs (1.6 m) were less effective than full-length PSDs; however, full-length PSDs were 120–150% more expensive to install.³² The effectiveness of PSDs was also noted in Hong Kong.³³ Portions of the Jubilee Line include the presence of PSDs, which may be a contributory factor to the lower number of suicide attempts observed on this line relative to the rest of the network. The presence of PSDs would also reduce the risk of accidental falls on to the railway tracks, thus reducing the number of ‘person under train’ incidents. Although the cost of installing these doors makes their presence across the railway network unlikely in the near future, their potential for significantly reducing the number of injuries or deaths on the tracks should be considered when planning future network renovation or expansion.

Other proposed interventions include increasing the presence of drainage pits, as mortality at London Underground stations that have a drainage pit was 44% v. 76% at those stations without, in incidents of individuals falling or jumping in front of trains.³⁴ These drainage pits were originally constructed to drain water between the tracks in deep-tunnel stations. Installation of blue lights at platforms was put forward as an effective measure by Matsubayashi *et al* in 2013³⁵ but this benefit was minimised by Ichikawa *et al* the following year.³⁶ Another suggested measure is reducing the average speed of trains entering the station at peak times.²⁹ In Vienna, changing the way in which media reported suicides on the underground by making it less dramatic was followed by a reduction in suicide.⁷

Strengths and limitations

This is the most recent study looking at patterns of suicide on the London Underground since 1994. It is also the first study looking at ethnicity within incidents of death by suicide on the Underground, and the findings raise new and important dimensions when seeking to introduce preventive measures.

There were several limitations to the study: no data were available for deaths by suicide between 2000 and 2003 owing to changes in coding, and death by suicide could not be confirmed in 47 cases owing to the recording of an open verdict or the outcome of the inquest not being available. Because of the relatively rare occurrence of deaths by suicide on the London Underground the numbers used in the study were small, leading to possible sample size bias. The limited breadth of information collected by the British Transport Police meant that certain risk factors (e.g. use of drugs/alcohol

or whether individuals were psychiatric in-patients at the time of the event) could not be adequately explored in our sample. The study is further limited by the absence of data beyond 2010.

Conclusions

Suicide on the London Underground railway system continues to be an important public health issue. The widening gap between the number of recorded suicide attempts and deaths by suicide is encouraging and may reflect the introduction of preventive measures. Use of PSDs has been proven to be effective for both suicidal acts and accidental ‘person under train’ incidents and needs to be considered when planning railway renovation or construction projects. The overrepresentation of people of White Northern European ethnicity among those who attempted suicide requires further exploration, as does the proportion of non-residents involved in suicide attempts on the London Underground across the year to better target preventive interventions. Finally, the collection of data on alcohol and drug use, as well as a more detailed psychiatric history, would help to inform further research and implementation of preventive measures for suicidal acts on the London Underground.

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1.7.77 Psychiatric neurosurgery in the 21st century: overview and the growth of deep brain stimulation

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Abstract

Ambulatory deep brain stimulation (DBS) became possible in the late 1980s and was initially used to treat people with movement disorders. Trials of DBS in people with treatment-resistant psychiatric disorder began in the late 1990s, initially focusing on obsessive–compulsive disorder, major depressive disorder and Tourette syndrome. Despite methodological issues, including small participant numbers and lack of consensus over brain targets, DBS is now being trialled in a wide range of psychiatric conditions. There has also been more modest increase in ablative procedures. This paper reviews these developments in the light of contemporary brain science, considers future directions and discusses why the approach has not been adopted more widely within psychiatry.

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- *Psychiatric neurosurgery in the 21st century: overview and the growth of deep brain stimulation*

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In 2014 the Mayo Clinic posted an online video in which a musician plays the violin while a neurosurgeon operates on his brain. Electrodes are being directed to an area of his thalamus with the aim of suppressing an essential tremor by electrical stimulation. Playing the violin during surgery was the best way to test whether the electrodes were in the right place. They were, and the operation was a success.¹

Deep brain stimulation (DBS) was first used to treat severe tremor in people with Parkinson's disease in 1987 and was subsequently found effective in severe dystonia.² Since then, tens of thousands of people have undergone the procedure for movement disorders and the technique has largely replaced earlier lesion-based methods. The most recent application, to 'benign' essential tremor, perhaps highlights its relatively low side-effect profile and patient acceptance. In 1999 a Belgian team used DBS in three people with treatment-resistant obsessive-compulsive disorder (OCD), with favourable results. There have since been DBS trials in a wide range of psychiatric conditions, and a more modest increase in ablative procedures.³ 2014 saw the publication of *Psychosurgery: New Techniques for Brain Disorders* by French neurosurgeon Marc Lévêque, the first 'state of the art' textbook to use that term in 40 years.⁴ It was a translation from the French; Anglophone practitioners in the field prefer a word with less toxic associations: neuromodulation.⁵

Whatever you call it, the use of DBS – and to a lesser extent lesion-based psychiatric neurosurgery – is on the rise, and this paper will review these developments. The aim is to inform rather than tilt opinion in a particular direction, but given the polarising nature of the subject it seems relevant to state the perspective from which it is written. The author is a retired neuropsychiatrist who formerly worked in a comprehensive service for working-age adults, within which the most frequent neurological diagnosis was acquired brain injury. While in training, he obtained a doctorate in electroencephalogram-based psychophysiology. A history project on psychiatric neurosurgery in the mid-20th century led to several outcomes, including an essay that prompted the Editor to commission this review.⁶

Background

Renewed interest in psychiatric neurosurgery has occurred against a background of major revisions in the way we think about the brain. At the beginning of the 20th century, anatomist Santiago y Cajal wrote: "Once brain development has ended the fount of growth and regeneration of axons and dendrites dries up irrevocably. In adult centres the nerve paths are something fixed, ended and immutable".⁷ That 'immutable' view of neurons held sway within brain science for much of the past century, although there were dissenting voices, particularly between the World Wars.⁸ The brain's capacity to structurally adapt and even regenerate was eventually demonstrated at the end of the century, by magnetic resonance imaging (MRI), functional MRI (fMRI) and other techniques. In addition, simplistic notions of functional localisation are being replaced by task-related and 'default' systems and networks.⁹ The past 25 years have also witnessed a transformation in our understanding of glial cells. Once viewed simply as the brain's scaffolding and housekeepers, they are now known to guide brain development, shape response to injury, modulate synaptic transmission, and operate an independent chemically based communication system.¹⁰ How all this produces mind remains a topic rich in speculation, with recent theories encompassing 'embodied' cognition and quantum biology.^{11,12} The implication of all this for psychiatry remains to be determined.

In the 1930s neurologist Egas Moniz speculated that in the brains of some people with chronic mental illness, 'the cellular bodies remain altogether normal ... but their multiple liaisons, very variable in normal people ... have arrangements that are more or less fixed'.¹³ He believed the most likely location for such an aberration was the pathway

between the prefrontal cortex and the thalamus. In 1935/6 he tested his theory by directing a surgeon to produce small lesions in that area, in 20 patients with mental illness – the first ‘prefrontal leucotomy’ series. Moniz’s targeted and theory-based approach was soon eclipsed by Freeman & Watts’ more destructive and indiscriminate procedure.¹⁴ The extensive damage that it produced often rendered behaviourally disturbed hospital patients with psychosis docile and, in some cases, dischargeable. The potential economic benefits of that were not lost on the architects of the UK’s National Health Service (NHS): in its first 5 years, there were more than 7000 leucotomies.¹⁵

Chlorpromazine rendered such destructive procedures in people with psychosis unnecessary and over the following 20 years psychosurgery teams – focusing on a narrower range of disorders – sought maximum benefit from minimum damage. Nonetheless, public distrust and dissenting voices increased, particularly in the USA, a trend fuelled by experiments on behaviourally disturbed children and aggressive prisoners.¹⁶ Beginning in 1974 a US Congressional Committee held hearings on psychosurgery, with a view to a possible ban. In the end, they recommended better regulation and, in any event, the number of operations fell dramatically over the next 30 years.¹⁴

Ambulatory DBS became possible in the 1980s because of technical developments (MRI, microprocessors, batteries, etc.) but also because the brain structures and pathways that produce movement had been mapped. Although the structures underlying emotion and behaviour, and the paths between them, have also been mapped, exactly how they produce the complexities of emotional life is much less clear. For that reason, a wide variety of brain areas have been targeted in this new wave of psychiatric neurosurgery. Despite the many theories as to how and why DBS and ablative procedures improve some psychiatric conditions, we do not actually know.

Technicalities: electrodes and procedures

All but two of the procedures in current use involve insertion of electrodes into the brain. The exceptions are vagus nerve stimulation (VNS) and gamma knife capsulotomy. Such surgery usually involves attaching a stereotactic cage to the head as a means of directing electrodes to brain locations mapped by MRI. VNS involves isolating the left vagus nerve in the carotid sheath in the neck and looping two electrodes around it. Electrodes in both cases are wired to a programmable stimulator placed subcutaneously in the upper chest wall (*Fig. 1*).¹⁷

Fig. 13: Illustration of an implanted deep brain stimulation system.

Each electrode includes an anode and a cathode. When an electrical current is applied the brain tissue between them joins the circuit. Three to five volts are usually applied in DBS at pulse frequencies above 100/s. At such frequencies brain tissue immediately surrounding the electrodes is deactivated/depolarised. However, just outside that area, volume conduction leads to electrical stimulation of axons, propagated upstream to cell bodies and downstream to synapses, interrupting local brain function while also producing effects more remotely. At frequencies below 100 – 15 pulses/s, for example, in VNS – stimulation is also produced in the tissue immediately surrounding the electrodes. Electrodes have been used experimentally to stimulate brain tissue in humans since the late 1940s.¹⁸ They have also been used to produce lesions, through thermocoagulation. In anterior cingulotomy, for example, a 10 mm exposed portion of the electrode is heated to 85°C for 60 s.

In gamma knife surgery, multiple narrow beams of gamma radiation intersect at a pre-mapped point in the brain, hence the skull is not opened.¹⁷

Brain targets and treatment rationales

Box 1 summarises the brain targets used in most psychiatric neurosurgery over the past 20 years, and the conditions treated in each case. The targets for current lesion surgery are those that have been found to produce the most benefit with the fewest adverse effects. The targets used for psychiatric DBS were chosen in four ways.

1. The first trial, in 1999, targeted the anterior limb of the internal capsule because lesion surgery to that area has been found in some cases to reduce the symptoms of severe OCD.³ The anterior cingulate and subcaudate areas, and the combination of the two, were chosen for similar reasons, in relation to major depressive disorder (MDD).
2. The subthalamic nucleus (STN) is the favoured target in Parkinson's disease. Following DBS, some patients with comorbid OCD experienced a reduction in the severity of those symptoms, hence its selection for trials in OCD.
3. fMRI has revealed increased metabolic activity in the subgenual cortex and habenula in some patients with MDD. Hence, those areas were targeted based on the hypothesis that such hyperactivity may be causal, rather than simply a manifestation of depression.
4. Tourette syndrome sits on the boundary between movement and compulsive disorder, which has contributed to the wide range of brain targets available, including the thalamus, STN, globus pallidum, nucleus accumbens and internal capsule.

Box 1 Brain targets used in psychiatric neurosurgery

Stimulation procedures

Deep brain

- Anterior limb internal capsule (obsessive-compulsive disorder (OCD), depression, anorexia nervosa)
- Nucleus accumbens (OCD, depression, anorexia nervosa, addictions)
- Subgenual cortex (depression)
- Globus pallidus (Tourette syndrome)
- Habenula (depression)
- Posterior hypothalamus (aggressive behaviour)
- Thalamus centromedian nucleus (Tourette syndrome)
- Subthalamic nucleus (OCD)
- Inferior thalamic peduncle (depression)
- Nucleus basalis (Alzheimer's disease)
- Fornix (Alzheimer's disease)
- Basolateral amygdala (post-traumatic stress disorder)

Cortical surface (epidural)

- Dorsolateral frontal (depression)
- Orbitofrontal (depression)

Vagus nerve (depression)

Ablative procedures

Thermocoagulation

- Anterior capsulotomy (OCD, depression)
- Cingulotomy (OCD, depression, addiction)
- Limbic leucotomy (OCD)
- Subcaudate tractotomy (depression, OCD)
- Nucleus accumbens (addiction)

radiosurgery ('gamma knife')

- Capsulotomy (OCD)

VNS was first used in the 1990s to treat some forms of refractory epilepsy. Improvement in the mood of some individuals was noticed, an effect that was independent of seizure response. Trials in treatment-resistant depression yielded positive outcomes, but a later study including a 'sham' surgery group suggested a significant placebo effect.¹⁹

Several authors have sought to explain the beneficial effects of stimulation-based procedures and lesion surgery on depressed mood and anxiety by reference to two cortico-striato-thalamocortical (CSTQ 'loops'.²⁰ Similar loops were previously identified in relation to movement, prior to the introduction of DBS, including inhibitory (GABA-based) and excitatory (glutamate-based) pathways.²¹ The CSTC loops, by contrast, involve a wider range of neurotransmitters, with complex interactions that are yet to be defined. Such 'circuits' may, however, explain the variety of targets that seem to produce at least some benefit in psychiatric DBS studies. It seems reasonable to speculate that tapping into and stimulating the loop at many points could influence and modify the whole network.

Protocols, conditions and outcomes

Lesion-based, ablative surgery continues to be available, including at two centres in the UK, but in most countries it is confined to a very small number of cases each year.^{22,23} The exceptions are Russia and China where it is now frequently used in the treatment of addiction.^{24,25} Radiosurgery has made lesion surgery possible without opening the skull and one report confirmed efficacy in OCD comparable to older techniques.²⁶ At the Editor's direction, the remainder of this review will focus on DBS.

The investigators who first applied DBS to the treatment of psychiatric disorders were aware of the legacy of past psychosurgical excesses and the ethical issues it raised. With that in mind a collaborative group drew up a list of research guidelines, published in 2002.²⁷ They include independent evaluation of potential participants according to strict diagnostic, severity and duration criteria; the need to ensure that individuals are able to give informed consent at the outset and for as long as the treatment continues; and ensuring DBS is never used for 'political, law enforcement or social purposes'.²⁷ Most investigators also use established severity ratings and response criteria based on them (such as a 35% or more reduction on the Yale-Brown Obsessive Compulsive Scale²⁸).

In the early years the focus of DBS studies was on people with treatment-resistant OCD, Tourette syndrome and MDD. The textbook cited at the beginning of this paper tabulates all such studies up to 2013 for each of these diagnoses, including patient numbers, brain targets, follow-up times and reported outcomes.²⁹ In summary: OCD: 11 studies involving 9 targets in a total of 86 patients followed up from 3 to 31 months; positive outcomes in 33–100% Tourette syndrome: 10 studies involving 7 targets in 40 patients followed up from 3 to 36 months; positive outcomes in 23–82% MDD: 6 studies involving 5 targets in 55 patients followed up from 12 to 36 months; positive outcomes in 30–75%.

The longer the duration of the follow-up overall, the better outcomes tended to be, but no one target appeared markedly superior. Whereas in movement disorder, and to an extent in Tourette syndrome, improvement occurred soon after stimulation commenced, in OCD and MDD improvement took many weeks to begin, symptoms diminishing further as time progressed. This perhaps indicates that rather than simply turning off ‘malfunctioning’ neurons, stimulation causes gradual beneficial change in the networks and systems it taps into. One exception to this delayed response was a study in which seven people with MDD received DBS to the medial forebrain bundle. The pulse frequency was lower than usual (see ‘Technicalities’ section) and at 1 year positive responses were reported in six people; all began to improve within a week of stimulation commencing.³⁰

Despite these apparently favourable outcomes, the small patient numbers, bewildering array of brain targets, variable follow-up times, and the impossibility of the double-blind placebo control methods, may lead many to conclude that the efficacy of this approach is far from proven. Although Lévêque considers the efficacy of DBS in OCD to be established, in relation to MDD he concedes that ‘although the benign nature of these techniques is in the process of being established, their efficacy remains difficult to demonstrate’.²⁹ Nonetheless, he and others offer several reasons why these outcomes should be taken seriously.

1. The patients treated have severe conditions that have failed to respond to all other treatments over a prolonged period.
2. Some studies target structures that had proved effective in lesion-based surgery (stimulation being used to simulate a lesion).
3. DBS allows for a form of ‘double blind’ methodology as the stimulating device may be turned on and off, the status at any point being kept from patient and assessor.
4. In some clinically improved cases temporary deterioration followed battery failure or inadvertent disconnection.^{30,31}

Although the reversible nature of DBS makes it more acceptable than lesion surgery, is it as effective in psychiatric applications, and does it result in fewer side-effects? The technique may only simulate a lesion, but if the patient requires that simulation to be in place for the rest of their life, what is the difference, apart from indefinite maintenance costs? A recent paper addressed that question by reviewing outcomes in 20 studies of treatment-resistant OCD.³² 108 patients who underwent capsulotomy were compared with 62 patients who received stimulation to the internal capsule or the nucleus accumbens. Of those undergoing capsulotomy 62% responded favourably, compared with 52% of those undergoing stimulation, but the difference was not statistically significant. Weight gain, which was common after lesion surgery, did not occur with stimulation. Apathy and disinhibition were also experienced by a small number of patients after lesion surgery but not during DBS.

Adverse effects reported after DBS include postoperative problems such as wound infection, haemorrhage (asymptomatic or resulting in transient motor signs), single seizures and syncopal episodes.³³ Additional undesirable effects develop when the stimulator is turned on but seem generally to disappear once the stimulation parameters are altered (voltage, frequency, etc.). These include physical symptoms such as paraesthesia, muscle contractions, dysarthria, diplopia and strabismus, and psychiatric features, particularly excitement, irritability and occasionally hypomania. Cognitive function is usually assessed before and during treatment and a recent review concluded that no adverse cognitive effects had occurred. In fact, as time progressed improvements in scores tended to occur, mirroring improvements in mental state.³⁴ The most common longer-term problems in psychiatric and movement disorder applications seem to be device-based. For example, one study of 84 patients with Parkinson’s disease recorded hardware-related complications in 8.4% of patients each year, including lead fractures, migrations and disconnections.³⁵ Technical improvements have doubtless occurred since that report, but the consequences of such mishaps in patients with severe psychiatric disorders may be grave, and are among the reasons that regular ongoing follow-up is deemed important.

A further stimulation technique that does not involve penetrating the brain has recently been tried in people with MDD.³⁶ Electrodes were placed in the epidural space over the dorsolateral frontal cortex in a single-blind study of 12 patients who were followed up for 2 years, with results comparable to the best DBS studies. A later paper discussed the combination of this technique with psychotherapy, a fascinating subject, sadly beyond the scope of this review.³⁷

The major advantage of DBS over lesion-based surgery is that if it does not work the hardware can be turned off and removed. In the longer term, stimulation could be stopped temporarily to assess whether it is still necessary. But as we now know, the brain is not 'immutable' and unresponsive to such challenge. It adjusts and adapts, chemically and structurally to changing circumstances and, in fact, the delayed onset of improvement in some of these applications seems to depend on such adaptation. The long-term implications of such changes are not clear.

In light of the relatively low side-effect profile of DBS in these early trials and apparently favourable outcomes, the technique has been extended to a number of other conditions including addiction,³⁸ eating disorder,³⁹ posttraumatic stress disorder (PTSD),⁴⁰ early Alzheimer's disease⁴¹ and, most controversially, aggressive behaviour disorder.⁴² Each of these has a defining clinical feature that suggests a particular brain target (in turn, nucleus accumbens, hypothalamus, amygdala, mammillary-fornix-hippocampal complex/nucleus basalis, hypothalamus). Although it is probably too early to comment on the outcome of this work, the target selections in two of these conditions are illustrative of the current approach and will be described briefly. The amygdala is being targeted in PTSD as a result of post brain-injury MRI and fMRI evidence (amygdala damage protecting against developing the condition and evidence of increased metabolic activity), and a positive response to amygdala stimulation in an animal model. The fornix is being targeted in early Alzheimer's disease as a way into the mammillary-fornix-hippocampal complex. This follows the serendipitous finding of improved memory and increased hippocampal volume following stimulation of the anterior hypothalamus undertaken for an unrelated condition, and animal studies showing stimulation-related neural growth.⁴³

The future

In 2013 President Obama launched a US\$100 million research programme with the acronym B.R.A.I.N (Brain Research through Advancing Innovative Neurotechnologies).⁴⁴ 'Emerging technologies' would be applied to the investigation of brain function and the treatment of disorders. This would include nanotechnology and, in relation to treatments, 'wireless fully implantable neural interface medical devices for human use ... closed loop systems able to deliver targeted neural stimulation'.⁴⁵ A patient group singled out for such innovative treatments was injured war-fighters, particularly those with treatment-resistant PTSD and memory problems due to acquired brain injury. This was a remarkable proposal, not least because at that point no 'wired' device-based treatments had been found useful or even trialled in either condition, and closed loop technology had only been used in cardiac dysrhythmia and epilepsy.⁴⁶

Closed loop technology has been more widely identified as important for the future of this work. In the context of epilepsy, implanted closed loop devices monitor an area where seizure originates, detect electrical activity that indicate a seizure is due, and respond with electrical stimulation or cooling to interrupt it.⁴⁶ In the psychiatric context, the possibilities of such devices include using nanotechnology to measure neurotransmitter levels and trigger therapeutic outputs.⁴⁷

Another development of possible importance is optogenetics. Light-sensitive ion channels that respond to different colours are delivered to and incorporated into individual neurons via a virus. Light channelled into the brain via fiberoptics can then be used to turn on and off such channels. Although this sounds the stuff of science fiction, a similar procedure has apparently succeeded in animal studies and trials in humans are expected in due course.^{48,49}

Conclusions

Given the torment of severe treatment-resistant depression, OCD and other psychiatric conditions, and the enthusiasm for DBS in relation to movement disorder, it is reasonable to ask why the technique has not been more widely adopted in psychiatry? A neurosurgeon recently addressed this question and identified a number of reasons: the legacy of ‘old-fashioned’ psychiatric surgery, the complexity and heterogeneity of psychiatric symptoms, and the multitude of brain circuits likely to be involved in them, ‘tricky ethical questions related to potential manipulation of the mind’, difficulty in conducting large trials in these conditions, and inconsistent results.⁵⁰ He might have added lack of consensus over targets in the conditions most often treated and the limited number of ‘placebo’ (sham treatment) controlled trials. Nonetheless, the US Food and Drug Administration gave approval for DBS in treatment-resistant OCD in 2009, albeit through a ‘humanitarian device exemption’.³³

In the UK, new medical procedures tend to be adopted and funded following pressure from patients and their interest groups, clinicians, medical Royal Colleges and the media. It is difficult to envisage such pressure for psychiatric DBS at the moment. The legacy of mid-20th century psychosurgery includes not only public and professional distrust (the charity OCD-UK ‘do not recommend DBS as a treatment for OCD *and remain concerned that the dangers associated with the procedure continue to be overlooked by the medical community*’⁵¹ – my italics) but also ethical and methodological rules that require complex, expensive, multiprofessional teams. In 2013 the NHS Commissioning Board published DBS guidelines for the treatment of movement disorders. They included an estimated cost of £26 070 for each procedure, but acknowledge that savings resulting from clinical and quality-of-life improvements offset ongoing maintenance costs.⁵²

In an afterword to the psychosurgery text mentioned at the beginning of this paper, and a related article, Marwan Hariz, a particularly cautious and thoughtful ‘functional’ neurosurgeon, warns that ‘hying’ DBS in psychiatry at this stage could lead to its demise.⁵⁰ He also expresses concern at recent suggestions that the technique could be used to enhance ‘normal’ functioning or even control antisocial behaviour. ‘Neuromodulation’ he concludes, ‘should not be allowed to become neuromanipulation’.⁵³ It remains to be seen whether a new generation of ‘millennial’ psychiatrists and neurosurgeons armed with these emerging technologies will follow his advice.

1.7.78 Teaching provision for old age psychiatry in medical schools in the UK and Ireland: a survey

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Abstract

Aims and method This work builds on a survey first done in 1999 to understand how old age psychiatry teaching is embedded in undergraduate medical schools in the UK and Ireland and the influence of academic old age psychiatrists on teaching processes. We invited deans of 31 medical schools in the UK and Ireland in 2015 to complete an online survey to reassess the situation 16 years later.

Results Response rate was 74%. As found in the original survey, there was variation across medical schools in how old age psychiatry is taught. Half of schools stated there was not enough space in the curriculum dedicated to old age psychiatry, and not all medical school curricula offered a clinical attachment. Medical schools that involved academic old age psychiatrists in teaching (59%) showed a greater diversity of teaching methods.

Clinical implications There is a need to recognise the importance of old age psychiatry teaching, with the consensus of opinion continuing to be that more curriculum space needs to be given to old age psychiatry. To achieve this we advocate increasing the number of old age psychiatrists with teaching roles, as relying on academics to teach and lead on curriculum development is challenging given their greater research pressures.

Contents

- *Teaching provision for old age psychiatry in medical schools in the UK and Ireland: a survey*
 - *Method*
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 - *Discussion*
 - * *Implications for recruitment*
 - * *Strengths and limitations*
 - * *Recommendations*

With the ageing population and high prevalence of mental health burden in the UK, it is becoming increasingly important that medical school undergraduate curricula for old age psychiatry advance in line with future demographic needs. This has been recognised by the General Medical Council (GMC) in *Tomorrow's Doctors*,¹ which stresses the importance of students learning about the special problems associated with older people's health. The Royal College of Psychiatrists has subsequently mapped the core undergraduate psychiatry curriculum outcomes² on to the competencies listed in *Tomorrow's Doctors*. Other UK national drivers, including the National Health Service (NHS) Outcomes Framework³ and the prime minister's dementia strategy,⁴ have highlighted the need for the future workforce to be competent in caring for the needs of the older person.

More broadly, there is also an increasing recognition that there is a shortage of old age psychiatrists, and recruitment of trainees is less than for other specialties (fill rate is 67% for training posts compared with 80% in psychiatry as a whole). The Centre for Workforce Intelligence (CfWI) in their in-depth review of the psychiatry workforce⁵ highlighted old age psychiatry as a particular concern, with the strongest risk of a larger demand–supply shortfall due to weak workforce growth. Currently, there are 1.1 full-time old age psychiatry certificate of completion of training (CCT) post holders per 100 000 population, but the workforce growth is not proportional to the growth in the older population, and baseline demand and supply projections anticipate a shortage of around 315 CCT holders in old age psychiatry by 2033.

In 2012, the Royal College of Psychiatrists published its recruitment strategy,⁶ with the primary aim of increasing recruitment into core psychiatry training, but the recommendations can be extended to old age psychiatry specialty training. Arguably, the concept of increased exposure to old age psychiatry and looking at the undergraduate experience

could be key to understanding why medical school graduates may or may not consider this specialty as an appealing career choice.

This study builds on a previous survey, carried out in 1999, which found that schools with established old age psychiatry academic departments devoted more time to undergraduate teaching of old age psychiatry, covered more topics and used a wider range of teaching methods.⁷ The aim of the current study was to determine how old age psychiatry teaching is embedded in undergraduate medical schools in the UK and Ireland. More than 15 years on from the original survey, we sought to demonstrate how undergraduate provision of old age psychiatry teaching has changed nationally and identify any ongoing gaps. Similar surveys have been carried out by other non-psychiatric specialties facing similar recruitment concerns, in particular geriatric medicine.^{8,9}

Method

The study took place between January and November 2015. A questionnaire (available in the *appendix*) was developed and published in electronic format using the Survey Monkey software (www.surveymonkey.com). It enquired about the teaching provision of undergraduate old age psychiatry, covering whether or not the curriculum included teaching of old age psychiatry; where in the curriculum this teaching took place; whether academic old age psychiatrists (i.e. person(s) working in old age psychiatry but with a significant aspect of their job plan including research and/or medical education) were involved in the organisation of teaching; the duration of attachment to the specialty; the form and content of the teaching; and the nature of the student assessment. There were free-text spaces for respondents to qualify their answers if necessary. The questionnaire was reviewed and the study endorsed by the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists.

The deans of all 31 UK medical schools were contacted by email and letter, asking them to identify a respondent with sufficient awareness of the undergraduate curriculum to allow completion of the survey, and requesting that the letter or email be forwarded to them. Where initial approaches and reminders were unsuccessful, members of the undergraduate leads forum were contacted through the Faculty of Old Age Psychiatry and invited to identify a respondent. As this was a survey requesting information already in the public domain, no formal consent procedure was undertaken and implied consent was assumed through participation.

The project met the Newcastle University preliminary ethical assessment guidelines, indicating that a full university ethics committee review was not required.

Results

Responses were received from 23 (74%) medical schools. No schools responded that they did not wish to participate but 8 did not respond to any form of communication (written, electronic and/or telephone). One (4%) response was from a dean, 9 (40%) from a senior lecturer, 5 (22%) from a consultant psychiatrist or programme director, 3 (13%) from a reader in old age psychiatry, 4 (17%) from a professor and 1 (4%) from a consultant physician.

Overall, 50% of respondents felt that there was not sufficient curriculum space designated to old age psychiatry; however, many appreciated the overlap with other specialties, including adult psychiatry, neurology and care of the elderly.

Staffing establishment of academic old age psychiatry

Figure 1 shows the current staffing establishment of academic old age psychiatry. More than half of schools (59%) reported that academic old age psychiatrists were involved in the organisation and delivery of undergraduate teaching, compared with 40% in the original survey. We found that 41% of schools have an academic old age psychiatrist represented on the board of studies or equivalent.

Fig. 14: Staffing establishment of academic old age psychiatrists.

Organisation and delivery of teaching

A designated clinical attachment in old age psychiatry was present in 86% of schools. Of those, in 13% the duration of the clinical attachment was dependent on individual student choice and in 41% there was the opportunity to spend more time in old age psychiatry. All respondents indicated that the majority of the teaching on cognitive assessment and dementia was delivered by an old age psychiatrist. There was no consistency between schools on when these topics were first covered, with 14% covering them in the first year, 23% in the second year, 36% in the third year, 23% in the fourth year and 5% in the fifth year.

With regard to time spent teaching old age psychiatry in the undergraduate curriculum, again there was no consistent standard, and reports ranged from a 1 h formal lecture to 25 days if the teaching on dementia/delirium covered by other specialties was included. This amount of time overlaps with that found in the original survey, in which time ranged from 1 to 40 days. Both the present and previous survey⁷ found that other, more informal/unstructured teaching was also given, but there was difficulty in quantifying the amount as this tends to depend on the clinical attachment. Some schools also offered self-directed teaching through podcasts or e-lectures (lectures delivered online), which depended on student interest and motivation.

A variety of teaching methods were used (*Table 1*), but with a large proportion primarily using lectures and tutorials as the main format of teaching (82% and 86%, respectively, v. 73% and 55% in the original survey). As with the original survey, schools where academic old age psychiatrists were involved in the organisation and delivery of teaching showed greater teaching method diversity and more use of innovative methods of teaching, such as interprofessional learning, e-learning and simulation, than those schools where there was no academic involvement. However, the overall figures were low (*Table 1*) and significance was only reached for simulation ($P = 0.03$) and home visits ($P = 0.02$). Of all schools, 50% responded that they involved carers or patients when delivering organised teaching sessions.

Method of teaching delivery

	<i>n</i> (%)		
Lectures	12 (92)	6 (60)	0.13
Tutorials	11 (85)	8 (80)	0.57
Bedside teaching	10 (77)	7 (70)	1.00
Problem-based learning	5 (38)	4 (40)	1.00
Interprofessional education	7 (54)	3 (30)	0.40
e-learning	8 (62)	2 (20)	0.09
Simulation	5 (38)	0 (0)	0.03*
Home visits	13 (100)	6 (60)	0.02*
Joint teaching	6 (46)	2 (20)	0.38
Other	0 (0)	1 (10)	0.43

Binomial probability $P = 0.03$ for all the teaching methods where there is academic involvement.

$P < 0.05$.

Content and assessment of old age psychiatry teaching

In 95% of schools the undergraduate curriculum contained specific old age psychiatry outcomes, compared with 100% of schools in the original survey, where the undergraduate curriculum contained some theoretical or clinical teaching of old age psychiatry. All schools were teaching cognitive assessment and dementia (95% in the original survey) but, as found in the original survey, fewer indicated that they covered affective disorders (82% v. 91%) or psychotic disorders (77% v. 82%). Even fewer covered service organisation (36% v. 59%) (*Table 2*). A variety of assessment methods are used (*Table 3*), with the most common (82%) being the observed structured clinical examination (OSCE). In the original survey, student assessment was most commonly by 'formal examination' (68%) and assessment of performance during the clinical attachment (64%).

Teaching content

Topic	Schools with academic old age psychiatrist involvement (<i>N</i> = 13)	Schools without academic old age psychiatrist involvement (<i>N</i> = 10)	χ^2 (<i>P</i>)
Cognitive assessment	13 (100)	10 (100)	1.00
Dementia	13 (100)	10 (100)	1.00
Delirium	10 (77)	10 (100)	0.23
Affective disorders	10 (77)	8 (80)	1.00
Psychotic disorders	9 (69)	8 (80)	0.66
Service organisation	4 (31)	4 (40)	0.69
Mental Health Act	11 (85)	7 (78)	0.62
Cultural issues	7 (54)	4 (44)	0.68
Other	2 (15)	0 (0)	0.49

Teaching and assessment methods in old age psychiatry

Assessment	Schools (<i>N</i> = 23) <i>n</i> (%)
Formal examination	11 (49)
OSCE	18 (82)
Long case	4 (18)
MCQ	14 (63)
Coursework	6 (27)
e-portfolio	3 (13)
Logbook	10 (45)
Essay	4 (18)

MCQ, multiple-choice questions; OSCE, observed structured clinical examination.

Table 2 also shows the content of teaching according to whether there is academic involvement which did not reach significance for any topic.

Discussion

Arguably, the most powerful message from this survey is that 50% of respondents did not feel that sufficient curriculum space is designated to old age psychiatry. This had been a concern in the original survey, in which 57% of schools had reported that there were significant obstacles to introducing and maintaining old age psychiatry teaching in the undergraduate curriculum. This raises the question of how much progress has been made over the past 15 years. Similar surveys done in elderly care medicine, a specialty facing a similar recruitment problem, have also found that inadequate time (<2 weeks) is spent teaching about subjects related to ageing, including dementia, which does not reflect the predominance of older patients in most doctors' workload.^{8,9,10}

The main finding in the original survey undertaken in 1999 had been that those medical schools with established academic old age psychiatry departments provided more teaching of old age psychiatry and are more likely to embrace new teaching methods.⁷ Our survey showed that 59% of schools have academic old age psychiatrists involved in the organisation and delivery of undergraduate teaching and 41% have an academic old age psychiatrist represented on the board of studies or equivalent. Similar to the original survey the main finding from the current survey is that schools where academic old age psychiatrists are involved in the organisation and delivery of teaching are more likely to use a greater diversity of teaching methods; however, only the use of simulation and home visits were found to be significant.

These results should be interpreted in the context that academics now may be less engaged in organising teaching (unless they are specifically medical educators) as they have predominantly research roles and greater research pressures. This highlights a need to drive up the number of other old age psychiatrists with teaching roles.

In the original survey all of the schools reported that the undergraduate curriculum contained some theoretical and/or clinical teaching of old age psychiatry and in our survey 95% of schools reported that their undergraduate curriculum contains specific old age psychiatry outcomes. Worryingly not all schools offer a clinical attachment in old age psychiatry (86%, slightly higher than in the original survey (82%)), and in those that did, the organisation of this is variable. As with the original survey, the amount of time offered varies considerably, and in some schools student exposure to old age psychiatry depends on individual clinical attachments. A wide range of teaching formats are reported, with the commonest methods being lectures and tutorials. Other methods, such as interprofessional teaching, e-learning and simulation, are less common (*Table 1*). Similarly, there was relatively low patient and carer involvement in teaching (50%).

Low use of interprofessional teaching and involvement of patients and carers in particular are missed opportunities, as evidence has shown that interprofessional education (IPE) can be used to significantly improve confidence and change attitudes in staff managing older patients with dementia or delirium.¹¹ This style of teaching delivery could therefore also be applied to undergraduates, especially at a time when the expectation from the GMC is for greater IPE within curricula to improve team-working skills.^{1,11} As such, teaching on topics relevant to old age psychiatry could be the hook through which it is possible to drive up the amount of IPE, and hence development of team-working skills within the broader medical curricula, as well as fostering more positive attitudes towards the older patient and improving recruitment into this specialty.

As regards the content of teaching, all schools are delivering teaching on dementia and cognitive assessment and the majority (91%) are teaching on delirium. It is concerning that not all schools cover affective and psychotic disorders (82% and 77%, respectively) in this age group as, unlike dementia and delirium, these topics are less likely to be covered by other specialties, and their presentation and management differ considerably compared with general adult psychiatry. As with the original survey,⁷ cultural issues were covered less (50%). Academic involvement in teaching did not lead to any significant difference in the content of teaching, which should be expected if medical schools are using a standard curriculum and is perhaps reassuring given that not all medical schools will have academic old age psychiatrists involved in the organisation of teaching.

In contrast to the original survey, where student assessment was most commonly by a 'formal examination', this survey showed that an OSCE was the most commonly used method of assessment, with other techniques, such as assessed

coursework and portfolios or logbooks, less frequently reported (*Table 3*). The need to ensure that teaching and assessment in medical schools is done to a high standard is crucial as assessment drives learning. However, we do not advocate a standardised assessment process as there are contextual variations in teaching nationally. What is important for educators is to understand what is being assessed and thereby select the correct assessment format as per the Millers Pyramid,¹² i.e. multiple choice questions to test knowledge, OSCEs to assess performance. This would enable assessment processes to be undertaken in an appropriate manner and for schools to demonstrate that learning outcomes have been achieved by students.

Implications for recruitment

Given the concerns about recruitment into old age psychiatry, it is important to consider the influence of the undergraduate curriculum experience of old age psychiatry on postgraduate career choice. A survey of graduates from Liverpool University 5 years post-qualification¹³ found that the majority felt their career choice was primarily dictated by their postgraduate experience rather than their undergraduate clinical attachments. However, in another survey of graduates, Goldacre *et al*^{14,15} found that factors during undergraduate experience significantly outweighed any inclinations before entry to medical school concerning the influence on career choice. They also found that career choices were greatly influenced by a particular teacher or department. The importance of a good role model has also been identified by surveys in other specialties,^{16–18} highlighting the importance of individuals in fostering enthusiasm and interest in a specialty.

Specialties with similar recruitment problems to old age psychiatry have found that the most significant factors influencing final-year medical students in their career choice were clinical mentors and specialty-themed, problem-based learning cases.¹⁸ However, for psychiatry as a whole, other studies have found that attitude changes towards considering a career in this specialty were similar whether students were taught with problem-based learning or with a more traditional curriculum.^{19,20}

In elderly care medicine, a study done at the University of Aberdeen²¹ found that an intensive 8-day programme increased the likelihood of fourth-year medical students considering this specialty as a career. Several US studies have shown that a positive attitude towards older people increases the likelihood of pursuing a career in care of the elderly and that increased exposure to this specialty during medical school has a positive influence on attitudes.^{22–24} This supports the view that the most effective interventions to increase recruitment of elderly care physicians should focus on positively influencing medical students' attitudes during medical school through meaningful experiences during clinical attachments, findings which could be extrapolated to include old age psychiatry. Indeed, US and Canadian surveys looking at factors that influence medical students choosing old age psychiatry as a career have found that one of the key factors is completing an old age psychiatry rotation alongside specific teacher attributes and training experiences.^{25,26} These findings support our key recommendations (*Box 1*).

Strengths and limitations

The response rate to this survey was good (74%), although it must be acknowledged that there may still have been a response bias, with a poorer return from the schools without a strong academic old age psychiatry department or representative for undergraduate teaching provision in old age psychiatry. Consequently, we may have underestimated the poorest end of the spectrum.

Box 1 Key recommendations

1. Old age psychiatry should be offered as a clinical attachment in all medical schools.
2. All schools should deliver specific old age psychiatry outcomes in the undergraduate curriculum including affective and psychotic disorders, legal and cultural issues.
3. A minimum time delivering formal teaching and time spent on clinical attachment should be agreed by the College with medical schools to ensure adequate exposure in old age psychiatry.
4. Schools should strive to drive up the number of old age psychiatrists with teaching roles and ensure they are supported in delivering a greater diversity of teaching methods and acting as positive role models.

5. There should be greater use of patients and carers in teaching to help foster positive attitudes.
6. The use of interprofessional learning should be recognised in driving up the status of old age psychiatry and ability to practise effectively in collaboration with other professions.
7. There is a need to ensure that schools teach and assess to a similar high standard in order to demonstrate that old age psychiatry outcomes have been addressed.
8. Future surveys should look at surveying medical students on their opinion and experience of old age psychiatry as well as career intentions.

Of the responding schools, data were collected from only one representative, with the hope that the respondent identified from each school would be whoever had suitable knowledge of the undergraduate curriculum. There is a possibility, however, that some of these representatives may have had an inadequate or biased overview of the undergraduate curriculum and that not all information was reported or accurate.

It was apparent through some of the free-text responses that some schools found it difficult to quantify the length of time spent teaching curriculum outcomes specific to old age psychiatry. For medical schools with an integrated curriculum, it may have been difficult to extract this information, as there is an overlap with other specialties who may have delivered this teaching.

It must be acknowledged that a limitation in the comparisons of academic old age psychiatrist involvement is that results reported were uncorrected and it is likely that there may have been no significant difference due to the overall numbers being low, and the number of comparisons being made. A further limitation was that the survey explores the taught curriculum and does not cover student-selected topics or the fact that some medical students may choose to do a research period in old age psychiatry. There are also no data regarding the opinion of medical students, and subsequently the influence of individual schools' undergraduate experience on career intention. Consequently, the assumption could not be made that medical schools with a mandatory clinical attachment in old age psychiatry and embracing more innovative methods of teaching delivery had a positive effect on intention to pursue old age psychiatry as a career. Further research is needed to explore the experience of the curriculum on paper and the 'hidden curriculum' experienced by the students by means of surveys and focus groups of undergraduate students as well as following up cohorts of students into their chosen career.

Recommendations

With the ageing population and increasing complexity of their needs, it is imperative that the future generations of doctors are suitably equipped with the knowledge, skills and attitudes for dealing with future challenges. It is especially important that the undergraduate experience fosters positive attitudes about old age psychiatry as a specialty and potential future career to try to address the workforce crisis we currently face. This survey of teacher practice has highlighted that there is still variation across medical schools in how old age psychiatry is taught, and made recommendations in how undergraduate experience of old age psychiatry can be enhanced. The value of interprofessional learning, as well as more involvement of patients and carers, should be recognised in improving the attractiveness and status of old age psychiatry. Although there may have been progress over the past 15 years in embedding old age-specific outcomes in the undergraduate curriculum, the consensus of opinion does continue to be that more curriculum space needs to be given to old age psychiatry.

1. Which medical school are you responding on behalf of? _____
2. What is your job title? _____
3. What is the current staffing establishment in academic old age psychiatry?
(number of posts 0 1 2 3 4 5 >5) (professor/reader/senior lecturer/lecturer/research fellow/research assistant)
4. Which of the following best describes the style of teaching at your medical school? (traditional (i.e. lectures and tutorials during years 2–3 followed by the clinical years), integrated (i.e. clinical attachments from year 1), problem-based (i.e. student-centred teaching), other.)
5. Does the undergraduate curriculum contain specific old age psychiatry outcomes? (yes/no/don't know)

6. Which topics are covered? Tick all that apply (cognitive assessment/dementia/delirium/affective disorders/psychotic disorders/depression/service organisation/Mental Health Act/cultural issues/other/none of the above)
7. How much time is spent teaching old age psychiatry in the undergraduate curriculum? (e.g. approximate number of days) _____
8. When is dementia and cognitive assessment first covered? (first year/second year/third year/fourth year/fifth year)
9. Are there plans to incorporate the recent Health Education England dementia curriculum into the teaching program? (yes/no/don't know)
10. Who delivers the majority of the teaching on cognitive assessment and dementia? (old age psychiatrist/other (please specify))
11. Is there a clinical attachment in old age psychiatry? (yes/no)
12. Is the duration of a clinical attachment in old age psychiatry dependent on individual student choice? (yes/no/compulsory attachment with opportunity to spend more time on old age psychiatry/compulsory attachment with no further opportunity to spend more time on old age psychiatry)
13. Which teaching methods are used for old age psychiatry teaching? Tick all that apply (lectures/tutorials/bedside teaching/problem-based learning/inter-professional/e-learning/simulation/home visits/joint teaching/other)
14. Are carers or patients involved in the delivery of teaching? (yes/no)
15. Which methods are used to examine students on old age psychiatry? (formal examination/OSCE/long case/MCQ/coursework/e-portfolio/logbook/essay/other)
16. Are academic old age psychiatrists involved in the organisation and delivery of undergraduate teaching of old age psychiatry? (yes/no/don't know)
17. Are academic old age psychiatrists represented on your board of studies or equivalent? (yes/no/don't know)
18. Do you think that there is sufficient curriculum space given to old age psychiatry? (yes/no)
19. Any other comments re: teaching of old age psychiatry? _____
20. Would you like a copy of the results? (yes/no)

1.7.79 Profile: Derek Summerfield – politics and psychiatry

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date

2017-10

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Preparing for this interview, I was aware of Dr Summerfield's political commitment. After all, he was the principal psychiatrist for Freedom from Torture (Medical Foundation for the Care of Victims of Torture) from 1991 until 2000. He is an outspoken critic of what he describes as the complicity of the Israeli Medical Association (IMA) and Israeli doctors posted to interrogation units in relation to the torture of Palestinian refugees, which has led to him receiving many accusations of anti-Semitism and becoming the subject of a libel suit by the President of the IMA. He is a member of the Critical Psychiatry Network. Before training in psychiatry, he worked as a government medical officer in Zimbabwe to 'repay his debt' to Africa. This was clearly going to be an encounter with a man of the left, passionate about social justice.

The personal and the political

I was curious about how Dr Summerfield sees the personal and the political. Can they ever be separated? What exactly is the role of the psychiatrist in relation to social justice? Should what I will call 'ethico-political awareness' be part of psychiatric training, given the huge relevance to mental health of the context in which our patients live?

If senior psychiatrists should be leading the profession, can this ethico-political thinking be encouraged by example only, or more explicitly within the syllabus? And how does Derek Summerfield see his role within the profession? Is he an individual firebrand, grit in the oyster, provocateur, thinking iconoclast, leading by example and seeking influence via publication, or does he have a more intergenerational mission? (It emerges that he has recently canvassed the juniors at the Maudsley Hospital and recommended they should not comply with trust training in relation to the controversial government Prevent strategy of 2015, intended to detect early radicalisation in pupils, students or patients, which he regards as outrageous state intrusion into clinical confidentiality and a form of McCarthyism.)

More widely, in the recent climate of junior doctor strikes, dire warnings from the British Medical Association, hot controversy over the National Health Service as a public service, what, if any, are the political obligations of (a) doctors in general and (b) psychiatrists in particular? I got my answer loud and clear in a note he sent me a few days after the interview: "There is the doctor as doctor, but also (ethically imperative) the doctor as sentient citizen . . . To do with a fundamental duty to attend not just to the particulars of the patient sitting in front of us, but also to the political and socioeconomic factors that produce distress and disease. Doctors have largely not done this. End of sermon . . ." Dr Summerfield is actually not preachy: he is amusing, not pompous, but self-deprecating – yet utterly (and perhaps unfashionably) serious. Of course he knows that not all doctors or psychiatrists share his views. Indeed, he is realistic: "With exceptions, doctors are not politically engaged. The average doctor doesn't have a social activist bone in his body. . . as a profession we are closer to those in power than those without it. . . medicine is basically an entrenched profession, and we behave like one . . . after the revolutions in places like Cuba, Mozambique, the vast majority of doctors left the country . . ." I wonder how he was viewed by the international and non-homogeneous group of South London and Maudsley NHS Foundation Trust (SLAM) junior psychiatrists when they received his open letter about the Prevent strategy training. Is he admired as a model of the thinking critical psychiatrist, or dismissed as eccentric or even dangerously insurrectionist?

Derek Summerfield was born 68 years ago in Cape Town, South Africa, into a non-medical family, but grew up in Bulawayo, the second city, after Harare, of Zimbabwe (then Rhodesia). He studied physics initially ('the headmaster persuaded bright White boys to do science'), then worked in a shipping company in Cape Town, and did some teaching. He always wanted to be a journalist (and now thinks he'd do law and anthropology if he was starting out again), but nevertheless began medicine, aged 24, at St Mary's Medical School in Paddington, London.

'I failed everything, and nearly left in the first year. I had no interest or feel for science in the preclinical years, but when I got onto the wards I felt an intellectual thrill at last.'

He did house jobs (i.e. FY1) in Oxford and Cambridge, and went on to become a medical registrar with MRCP Part 1. During this period he did several stints in Zimbabwe during and after the civil war, no walk in the park. In Chiredzi, in the war-ravaged rural south-east, there were 200 beds and 2 doctors. He was the paediatrician, 'with 50 desperately sick kids at any one time ... 5 of whom died each day'. He saw up close and personal the effect of poverty on health: 'even measles was 80–100 times more fatal in these malnourished kids'.

He finally decided on psychiatry in 1982, now aged 34, and went to St George's Hospital. While working there he met a beautiful and much younger woman, now a consultant clinical psychologist and psychoanalyst at the Tavistock, Francesca Huhne. They have a 20-year-old daughter, who is reading History at university. He and Francesca subsequently studied war-wounded men from both sides of the civil war in Nicaragua together. He has been a consultant to Oxfam, and for many years was a research associate at the Refugee Studies Centre, University of Oxford.

He joined Freedom from Torture (Medical Foundation for the Care of Victims of Torture) full-time in 1991, where he treated around 800 patients, often seeking asylum in the UK: Bosnians, Sri Lankans, Iraqis, Turkish Kurds, Africans and Palestinians, with 95% of consultations requiring interpreters. But with his lifetime history of independent thinking and acting on principle, this appointment did not end amicably: he was 'asked to leave' Freedom from Torture in 2000 because the organisation was concerned that his widely published questioning of the category of posttraumatic stress disorder (PTSD) might deter funders.¹ He sees the diagnosis of PTSD in the context of refugees as the 'pseudo-scientific pathologising of people affected by war ... the medicalisation of their situation diminishes the importance of work and the rebuilding of social networks ... the broken social world is the lot of the asylum seeker'.²

After leaving Freedom from Torture, he contacted Dr Maurice Lipsedge, who suggested that he should consider applying for his job in SLAM, from which he was retiring. This was in the HIV mental health team, initially part time, then full time.

The HIV team at its zenith had four psychologists and acted as a community mental health team with an HIV focus. He enjoyed the interest of the 'two different groups of patients ... African women and British gay men'. The service was greatly reduced in 2016, owing to both financial constraints and the mainstreaming of HIV. He accepts this process as reasonable, given the changes in HIV treatment and prognosis, with life expectancy being almost normal now, if the medicines are taken reliably. (And many African women don't always do this, and he would like to understand why.)

He has no immediate plans to retire and is busy with a variety of work outside the 'day job'. He's involved with the new medical school in Bulawayo, his home town, helping with the undergraduate curriculum, and will teach there: 'I still feel a debt to Africa'. He advises Oxfam: In the 80s they suddenly got very interested in the mental health of victims of war'. Derek Summerfield helped evaluate their projects in Bosnia, and steered Oxfam away from a PTSD-centred approach to victims of that war: 'I persuaded them not to go down the counselling route ... if you ask Muslim adolescents in Tuzla what they want, they want a bit of normality. They actually requested some fabric so they could put on a fashion show'.

Problem with the concept of global mental health

He has published widely from the standpoint of a fundamental opposition to the medicalisation of human distress and the assumption that Western psychiatry is universally valid, which he sees as a kind of cultural imperialism.^{3,4}

He offers a critique and deconstruction of international attitudes to the mental health of victims of war.² He stresses how the global effects of wars are largely experienced by people living in poverty, and he sees the danger of the PTSD diagnosis as pathologising of the individual rather than attending to the effects of poverty and the need for reconstruction of the social fabric.²

He makes a more general critique of the concept of 'global mental health', highly critical of 'taking depression into a country which has no such concept, followed by the marketing of antidepressants ... Western cultural values parading as medical facts'.^{3,4} His critique extends to the cultural relativism of psychiatric diagnoses in general: as if disease had an objective existence, independent of the gaze of the diagnostician.

The origin of PTSD as a diagnosis was for disturbed Vietnam war veterans in the USA with the benign intention of lobbying to get decent care for them by emphasising the traumatogenic nature of war, thus legitimising a position of victimhood, moral exculpation and receipt of disability pensions. In Summerfield's view, the development of this concept of PTSD needs to be understood in the wider social context of the 'rise of expressive psychologically minded individualism, personal rights, entitlement and grievance,' as opposed to the previously socially sanctioned stiff upper lip self-management of trauma. Now PTSD has become a 'certificate of impairment'. It is the only diagnosis which contains its aetiology within itself, while in fact, he claims, premorbid factors such as psychiatric history or a negative thinking style are more important than the actual event itself in the aetiology of symptoms.¹

Conflating normality and pathology 'devalues the currency of true illness'.

He is an old fighter, brave and almost proud of his battle scars: 'No-one has been called an anti-Semite in the medical press more than me'. He feels the campaign he convened against medical complicity with torture in Israel is the 'best thing I've done in my career'. So the life and views of Derek Summerfield are a challenge to all doctors, even those with different political views: is it acceptable for doctors to absent themselves from political engagement as being outside their remit, or are we ethically obliged to be properly aware of the sociopolitical context of our work? People with unflinching integrity have always made others uncomfortable: consider the unpopularity of Jesus overturning stalls in the temple market.

If we take our ethical obligations as doctors seriously, we need intellectually rigorous and dogged colleagues like Derek Summerfield to point up our innate conservatism and political passivity.

1.7.80 Paul Haydon Rogers FRCP FRCPsych

: Formerly Consultant Psychiatrist and Medical Director, St Crispin Hospital, Northampton

Don Williams

date

2017-10

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- *Paul Haydon Rogers FRCP FRCPsych*
– : *Formerly Consultant Psychiatrist and Medical Director, St Crispin Hospital, Northampton*

Paul Rogers died on 11 February 2016, aged 96, after a short illness. For the last 10 years of his life he lived independently and happily in a support and care complex in the grounds of St Crispin hospital (now converted into apartments) where he had worked from 1955 to 1979. During his time at St Crispin, where he established community-based services, he was responsible for the introduction of new treatments, particularly the newly developed psychotropic drugs. He developed child guidance clinics in the area and was also involved in the planning of Princess Marina Hospital for people with learning difficulties. After retirement from the National Health Service (NHS) he worked with the Health Advisory Service and as a member of the Mental Health Review Tribunal dealing with difficult issues at Broadmoor and Rampton high-security hospitals. In Northampton, he pioneered the recognition of stress at work and helped to create a local charity to advise employers and provide counselling for employees.

A son of the manse, he was born in Cardiff in 1919 and from an early age wanted to be a doctor. After attending Caterham School and Christ's College Cambridge, he qualified in 1943 at the London Hospital, now The Royal London Hospital. Shortly afterwards, he served as captain in the Royal Army Medical Corps in Normandy, Egypt and Palestine. On demobilisation in 1947 he returned to the London Hospital to pursue his ambition to become a consultant physician. Unfortunately, at this time, there was ferocious competition for promotion because of the high number of doctors returning from the forces after the Second World War. So, instead, he retrained at the Maudsley Hospital to become a psychiatrist. Nevertheless, he remained a physician at heart, adopting a medical approach and placing great emphasis

on diagnosis and the use of physical methods of treatment. Although he was insistent that he did not do psychotherapy, he had all the personal qualities of an excellent psychotherapist: empathy, non-possessive warmth, genuineness and a supportive non-judgemental approach.

Paul was a consummate professional dedicated to his work and the NHS, and as a role model he influenced several younger colleagues to take up psychiatry. He had no time for private practice or medical politics. His focus was the care and management of his patients. They loved him and on the rare occasions I took his clinic their disappointment was palpable. Modest, unassuming, understated and unassertive, he combined the qualities of an English gentleman with attributes of Welsh nonconformity and liberalism, reflecting his deep roots in west Wales. Basic Christian values guided his life and he had no regard for social class – a good example of this was his lifelong friendship with his batman, the only link he maintained with his time in the army. The Guardian was his newspaper and he espoused its core values.

He was devoted to his family and only looked for the good in everyone. He supported many charities and was pre-occupied with people, who, as he put it, were ‘less fortunate than I am through no fault of their own’. In retirement, activities linked to psychiatry gradually declined and were replaced by his only hobby – gardening. He enjoyed growing food for the house and his garden was always a pleasure to see. Over the years and into advanced old age he enjoyed excellent health; so much so that his close relatives were lulled into thinking that he would always be around and that his support, consideration and wise advice would always be available. He grew old gracefully in every way, retaining his core liberal values to the end.

Marjorie, his wife, and his younger daughter, Helen, predeceased him. He is survived by his sister, daughter and son.

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1.7.81 Costas Stefanis MD

: Formerly Professor of Psychiatry and Head, Department of Psychiatry, University of Athens Medical School; Director, Eginition University Psychiatric Hospital, Athens

Nick Bouras

date

2017-10

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- *Costas Stefanis MD*
 - : *Formerly Professor of Psychiatry and Head, Department of Psychiatry, University of Athens Medical School; Director, Eginition University Psychiatric Hospital, Athens*

Costas Stefanis, who died recently at the age of 88, was the leading figure in psychiatry in Greece for 30 years, from the time of his appointment as professor of psychiatry in 1970. In collaboration with British-trained colleagues he transformed Greek psychiatry and mental health services, steering away from a previously narrow traditional psychoanalytic approach towards a much broader biopsychosocial direction. He expanded the provision of generic and

specialist mental health services and was quick to adopt the new emerging trends of community care by developing the first community mental health centre in Greece. He developed a strong research programme, having himself – early in his career, while in the USA and Canada – carried out pioneering work on the functional role of pyramidal neurons in the sensorimotor cortex. He had an international reputation as an expert on the mode of action of neurotransmitters functioning on central nervous system synapses.

Several generations of Greek psychiatrists and allied professionals were trained by him, including me. Many became his associates and were inspired to go on to acquire international recognition and reputation. In 1989, in Athens, he founded the University Mental Health Research Institute – which undertook much neurobiological and psychosocial research into mental disorders – and remained president and director until his death.

He also played a major part in international psychiatry. As president of the World Psychiatric Association (WPA) from 1983 to 1990, he was responsible for an organisation in crisis. The political use of psychiatry in the Soviet Union to incarcerate political dissidents on the grounds of mental illness led to an explosive climate within the WPA. In 1983, after major criticism from societies in other countries – which made it likely that it was facing expulsion – the All-Union Society of Psychiatrists and Neuropathologists of the USSR withdrew from the WPA. Years later, at the WPA congress held in Athens in 1989, the general secretary of that Society publicly acknowledged that political abuse of psychiatry had indeed taken place and the organisation was reinstated as a member. This by no means ended the unhappy situation in the Soviet Union, which to some extent continues to this day, but a greater degree of openness was achieved. Costas Stefanis was among those responsible for reaching a conciliatory approach on issues with significant ethical and political dimensions.

Costas Stefanis became active in the political life of his country. Between 1996 and 2000 he served as honorary member of the Greek Parliament in the reformist social-democratic government and was Minister of Health and Welfare from 2002 to 2004. During his ministerial tenure, he was president of the Council of Ministers of Health of the European Union and succeeded in achieving approval for anti-stigma legislation regarding mental illness. On behalf of the EU member states, he signed the World Health Organization's International Treaty on Tobacco Advertising. In Greece, he was responsible for four major bills passed by Parliament – on public health; reform and decentralisation of health services; the organisation of primary health care and provisions for prevention and social reintegration. Unfortunately, most of them are still awaiting implementation.

He received numerous distinctions and awards. In 1994 he was elected life member of the Athens Academy of Sciences and Arts – the highest level of scientific recognition in Greece – and served as its president in 2006. He was awarded the Medal of the Cross of the President of the Hellenic Republic in recognition of his distinguished service to the country. In acknowledgement of his contribution to psychiatry, the World Federation of Societies of Biological Psychiatry and International Neuropsychiatric Association established an international prize: the Costas Stefanis Award for Excellence in Psychiatry and the Neurosciences. He was elected honorary member and fellow of several scientific associations and he authored numerous peer-reviewed articles as well as books and articles in the lay press.

Costas Stefanis was born in Greece in 1928 and graduated from the Medical School of Athens University in 1953. He trained in neurology and psychiatry in Athens and subsequently served as a fellow in basic neurophysiology at McGill University, Montreal, and as a research scientist at the National Institute of Mental Health and Saint Elizabeth Mental Hospital (Bethesda, Maryland and Washington, DC).

He was a highly intelligent, conscientious professional who, during difficult times, strove to improve psychiatric and mental health service provision not only in Greece but worldwide, thus improving the lives of thousands of people. He died on 29 October 2016 after a long illness stoically borne, remaining active in offering advice and ideas to the end. He was devoted to his family and is survived by his wife Adela, two sons – Nicos, professor of psychiatry, and Leonidas, professor of neurology – his daughter Evanthia, a film maker, and four grandchildren.

The death of Costas Stefanis will be felt as a great loss to psychiatry by many clinical, academic and international colleagues who had the privilege of knowing and working with him.

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1.7.82 Kurt Schapira MD FRCP FRCPsych DPM

: Formerly Consultant Psychiatrist, Newcastle Health Authority, Honorary Lecturer in Psychiatry, University of Newcastle

Kenneth Davison Hamish McClelland Alan Kerr Martin Schapira

date

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- *Kurt Schapira MD FRCP FRCPsych DPM*
 - : *Formerly Consultant Psychiatrist, Newcastle Health Authority, Honorary Lecturer in Psychiatry, University of Newcastle*

Shortly after completing his house officer posts and national service in the Royal Army Medical Corps, Kurt Schapira, who died recently aged 87, was appointed a research fellow to the eminent neurologist Henry Miller. More than 1150 patients with multiple sclerosis resident in Northumberland and Durham on 1 January 1958 were reviewed by Dr Schapira. Using this material, he jointly wrote 16 scientific articles on various aspects of multiple sclerosis – including its epidemiology and clinical features – many of which are still cited today. The study made a major contribution to knowledge of this condition.¹ Subsequently, fascinated by the emotional effects of multiple sclerosis on the patients, Dr Schapira decided to switch to psychiatry. He participated in Martin Roth's landmark studies on anxiety and depression and undertook his own research into suicide and attempted suicide, as well as on the treatment of anorexia nervosa. His longitudinal studies relating suicide rates to social factors and the availability of lethal methods were influential in demonstrating the importance of a public health preventive approach to suicide.² He published several articles on these and other topics, including, with others, a much-quoted paper on the influence of tablet colour in the treatment of anxiety and depressive states.³

Born in Vienna to orthodox Jewish parents, Kurt's childhood was disrupted by the death of his mother when he was aged 7 years. This was followed by the incarceration of his father by the Nazis in Dachau and then Buchenwald concentration camps. Fortunately, his father was released from Buchenwald and allowed to travel to England before the Second World War. Kurt lived in Berlin with a maternal aunt until the age of 10, when he obtained a place on a Kindertransport train to England. Having successfully negotiated a path through the British educational system, Kurt was admitted to medical school in Newcastle – then part of the University of Durham – and qualified as a doctor in 1952.

He trained in psychiatry in the university department of psychiatry in Newcastle, headed at that time by Martin Roth and James Gibbons. Within the department he was promoted to first assistant and then senior lecturer. In 1974 he became consultant psychiatrist to the Newcastle Health Authority while retaining his university connection as an honorary lecturer. He continued in this position until his retirement from the NHS in 1989.

He lectured widely both in the UK and abroad, as far afield as Brisbane, Minnesota, Montreal and Jerusalem. During his retirement he remained active in research, especially into factors influencing the incidence of suicide in Newcastle over three decades. His last published article on the subject⁴ – in collaboration with others, including his son Martin – appeared as recently as June 2016.

He undertook many responsibilities in both National Health Service and university administration and was a member of several university committees. Within the Royal College of Psychiatrists, he was a member of Council (1979–82), the Education Committee (1979–82) and the Board of Assessors of the *British Journal of Psychiatry* (1970–75), as well as examiner for the membership and various other psychiatry-related degrees at home and abroad. He was also elected President of the Section of Psychiatry, Royal Society of Medicine (1980) and President of the North of England Medico-Legal Society (1982).

Kurt enjoyed teaching and regularly topped the students' ratings for the quality of his lectures, which were notable for their combination of wit and erudition. These attributes rendered him a popular speaker to non-medical audiences, especially on the art of Chagall, Salvador Dali and Van Gogh, and the artistic portrayal of doctors and lawyers. He was a connoisseur of opera and classical music, particularly Verdi and Mozart.

He was generous with his time in acceding to invitations to speak about his childhood experiences to a variety of audiences, from schoolchildren to prisoners, and was proud to meet Prince Charles recently at a reception for Kindertransport survivors. A genial extrovert and renowned raconteur, whose personality raised the spirits of his friends and colleagues, he had a fund of humorous anecdotes, enhanced in the telling by a trace of a Viennese accent. He often expressed his indebtedness to England for accepting him as a refugee. Considering his many contributions to the sum of human health and happiness, any debt has been more than repaid.

He leaves Eva, his wife of 51 years, 3 children, 5 grandchildren, 4 great grandchildren and an older sister.

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1.7.83 Women in Academic Psychiatry: A Mind to Succeed

Linda Gask¹

date

2017-10

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- *Women in Academic Psychiatry: A Mind to Succeed*

As a female academic psychiatrist I asked two questions of myself about this book. Did I identify with the problems described here? And second, would I have found it valuable to read at an earlier stage in my career? The answer to both of these is a (qualified) yes.

¹

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The book is in two parts. The first consists of 16 interviews with eminent female psychiatrists and psychologists, which were almost certainly conducted by email. The questions are standardised, the responses polished and there is no in-depth probing of replies – which as a qualitative researcher I would have found more revealing. The second part of the book is a series of rather brief chapters which provide a helpful template for recognising the barriers and considering how to overcome them. These include putting yourself first, projecting confidence even if you don't feel it, being memorable, persistent and something I've found to be particularly important – networking.

The problems described are all too familiar – I've been subjected to mansplaining, '*a man compelled to explain, especially to a woman, something that she already knows better than him.*' I've held back in conversation, fearful of asking questions. I've been the only woman in a committee room except for the person taking the minutes. Yet, all of these very talented women demonstrate how a combination of real passion for what you are interested in and the ambition to push yourself forwards, even when times are challenging, has resulted in outstanding academic success.

Almost all the interviewees are now at the pinnacle of their careers. Many came from similar professional families and more than a few acknowledge the role played by a supportive partner with the kind of job that made it easier to be both an academic clinician and a mother. There is no one still 'finding their way' that a younger me might have identified with and the majority work in biological psychiatry – the editors' own field – in the USA. I might have found it helpful to read their stories when I was younger, but on the other hand, I might have been more than a little intimidated too.

1.7.84 Mental health law across the UK†

Tony Zigmond

Correspondence

Tony Zigmond (aszigmond@me.com)¹

date

2017-12

Abstract

The criteria governing medical treatment without consent in the three legal jurisdictions of the UK – England and Wales, Scotland and Northern Ireland – is discussed.

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- *Mental health law across the UK†*

'A doctor is not that sinister figure which in former times he was represented to be, anxious simply to confine a man in a dungeon for life. He is treating mental disorder in exactly the same way as he treats any other disease.'

Lord Russell 1928¹

Nearly 20 years ago I wrote an editorial in this journal that there should be a medical incapacity act to 'provide for the medical treatment, both mental and physical, of those who lack capacity from whatever cause. It would establish a statutory framework offering the same protections to all patients who are unable to consent to medical intervention, from both physical and psychiatric conditions, and permit investigation and treatment of both the physical and mental

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Tony Zigmond, retired consultant psychiatrist, UK.

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illnesses of such patients'.² Szmuckler & Holloway have not just argued for a single piece of legislation for all nonconsensual care and treatment saying that a mental health act is harmful,³ they have written a draft act under the heading of 'Fusion Law'.⁴ We may soon know whether we were right.

There are three distinct legal jurisdictions within the UK: England and Wales, Northern Ireland and Scotland. Until recently all had a mental health act to regulate the care and treatment of people with a mental illness while relying on common law to do the same for the physically ill. The powers given to doctors and other healthcare professionals by the two regimes was very different.

Within a year or two either side of the turn of this century, all the jurisdictions started to review their relevant legislation, not only their mental health law but also the necessity for replacing common law with statutory provision for the non-consensual treatment of physical illness, not least to ensure compliance with the European Convention on Human Rights as required by the Human Rights Act 1998. Scotland passed its Adults with Incapacity (Scotland) Act 2000, England and Wales its Mental Capacity Act 2005, Northern Ireland its Mental Capacity Act (Northern Ireland) 2016. For their mental health acts, each started with a review: Richardson for England and Wales published in 1999,⁵ Millan for Scotland in 2001⁶ and Bamford for Northern Ireland in 2007.⁷ Each considered whether or not their mental health act should include a 'capacity' criterion for medical treatment without consent.

The courts have been consistent about the role of capacity when adults make a decision about medical treatment. Lord Reid in 1972 said: "There is no doubt that a person of full age and capacity cannot be ordered to undergo a blood test against his will. ... the real reason is that English law goes to great lengths to protect a person of full age and capacity from interference with his personal liberty. We have too often seen freedom disappear in other countries not only by coups d'état but by gradual erosion: and often it is the first step that counts. So it would be unwise to make even minor concessions".⁸ Lord Donaldson, then Master of the Rolls, in 1992 said: "Prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even lead to premature death".⁹ Ten years later Dame Butler-Sloss said the same: "A competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even when that decision may lead to his or her death".¹⁰ They all emphasised the importance of autonomy. Although common law has now been replaced by statute law, the provisions of capacity legislation fully reflect these sentiments. I note that all the Judges were, of course, incorrect. A competent person with a mental illness may have no right to refuse treatment.

To return to the reviews. The first principle of Recommendation 3.3 in the Millan report is 'Non discrimination – People with mental disorder should whenever possible retain the same rights and entitlements as those with other health needs' (p. 23).⁶ So, should capacity be a criterion as it is for those with other health needs? The report sets out the arguments against the capacity criterion including that there were difficulties assessing capacity, particularly in patients with mood disorders, obsessive-compulsive disorders and eating disorders; 'Such patients might retain legal capacity but be at such risk as to justify intervention' (p.55).⁶ The committee was also told by some psychiatrists that "incapacity was a concept which they would find difficult to measure and apply. The British Medical Association (BMA) suggested that a capacity test would make it harder for GPs and doctors in, for example, Accident and Emergency Departments to come to a decision, and might lead to a reluctance to use the Act. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), while in favour of making the justification for non-consensual interventions more explicit, suggested that professionals were not equipped to apply sophisticated tests of capacity fairly' (p.55).⁶ These comments about difficulties assessing capacity are noteworthy because no individual or organisation said they could not operate or abide by the provisions of that country's incapacity act which, of course, requires assessment of capacity.

The Millan committee advised "that it should not be possible for a compulsory intervention to be made under mental health law unless there is evidence that the person's judgement is significantly impaired, as a result of mental disorder, so as to justify the intervention. This expresses a broadly similar concept to incapacity, but is felt to be a less legalistic formulation, and one which may be easier to apply in practice' (p. 57).⁶ Significantly impaired decision-making as a result of the mental disorder (SIDMA) is a criterion for compulsion in the Mental Health (Care and Treatment) (Scotland) Act 2005. Millan had asked the question as to whether a mental health act was necessary and decided it was. Richardson also considered the question of capacity. Similar to Millan, 'The principles governing mental health care should be the same as those which govern physical health' (p. 21)⁵ wherever possible. Although deciding that incapacity should not be a criterion because 'Mental disorder unlike most physical health problems may occasionally

have wider consequences for the individual's family and carer, and very occasionally for unconnected members of the public' (p. 19),⁵ the report suggested a form of words which would require the assessment of, and taking into account, the patient's capacity. Patients with capacity could only be detained if they presented a higher degree of risk compared with patients who lacked capacity. The government rejected this proposal. That a distinct mental health act was required was not questioned. There is no 'capacity' or 'SIDMA' criterion, nor a distinction between patients who retain capacity and those who do not, in the Mental Health Act 1983 (amended in 2007). To have such a criterion would have meant, according to Lord Hunt during the debate on the 2007 Bill, 'abandoning one of the most fundamental objectives of the Act, namely that compulsory intervention should be based on need and risk'.¹¹ To spell it out, in England and Wales a person can be forced to accept treatment for their mental illness if there is a health risk to themselves or others despite retaining full decision-making capacity. The equivalent law for physical illness, the Mental Capacity Act 2005, only applies if the person cannot consent because they lack capacity to do so. Patients with capacity who refuse consent cannot be forced to accept treatment no matter what the risks.

Northern Ireland has taken rather longer to determine their way forward. The outcome of the Bamford review and the provisions of their new act are detailed by Lynch *et al.*¹² There is to be no mental health act. The Mental Capacity Act (Northern Ireland) 2016 gives exactly the same legal framework for the non-consensual medical treatment of all citizens no matter what their illness.

Parity of esteem, a flagship policy of the Royal College of Psychiatrists, is best described, according to the College, as: 'Valuing mental health equally with physical health' (p. 3).¹³ The College has described a range of equalities which need to be achieved although, perhaps surprisingly, there is no mention of equality under the law. Northern Ireland now has equality under the law. The day after the judgment in the case of Ms B,¹⁰ *The Independent* newspaper wrote 'Never again may a clinician administer treatment against the will of a mentally competent patient'.¹⁴ In Northern Ireland that will soon be true.

Earl Howe, in his closing statement during the passage of the Mental Health Bill 2007 (England and Wales), quoted the Millan committee, 'It should not be the function of mental health law to impose treatment on those who are clearly able to make decisions for themselves' and then continued, 'As it is we are, in a real sense, back in the world of Enoch Powell and 1959. Patient empowerment and respect for the wishes of the patient are acknowledged features of good clinical practice in all other areas of healthcare – but not, it seems, in mental health'.¹⁵ The Mental Health (Northern Ireland) Act 2016 gives psychiatrists the same legal powers as all other doctors, and psychiatric patients the same autonomy and respect as all other patients. Where Northern Ireland has led surely other UK jurisdictions, and countries across the world, will follow.

1.7.85 Newspaper depictions of mental and physical health

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Abstract

Aims and method Media portrayals of mental illness have long been recognised as being misleading and stigmatising. Following the campaigns of several advocacy groups to address this issue, we aimed

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to evaluate the impact on mental health reporting over time. We repeated a survey we did 15 years ago using the same methods. Nine UK daily newspapers were surveyed over a 4-week period and coded with a schema to analyse the reporting of mental health compared with physical health.

Results In total, 963 articles – 200 on mental health and 763 on physical health – were identified. Over half of the articles on mental health were negative in tone: 18.5% indicated an association with violence compared with 0.3% of articles on physical health. However, there were more quotes from patients with mental disorders than physical disorders (22.5% v. 19.7%) and an equal mention of treatment and rehabilitation.

Clinical implications Mental health in print media remains tainted by themes of violence, however some improvement in reporting in recent years is evident, in particular by providing a voice for people with mental illness.

Contents

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Newspapers and other forms of mass media are influential in transmitting key information and ideas, including social commentary.^{1,2} Consequently, their role in reporting on mental illness is seen as one of the main conduits through which the public, especially those without personal exposure to mental illness, learn and come into contact with issues surrounding mental health.^{3,4}

For many years it has been recognised that media reporting of mental illness is heavily biased in representing a misleading link between mental illness and violence, with preferential reporting for sensationalist stories depicting individuals with mental disorders as being aggressive, dangerous and unpredictable.^{1,4-7} Such widespread negative portrayals have reinforced the continued stigmatisation and lack of acceptance among those with psychiatric diagnoses, possibly increasing social distance and contributing to morbidity and distress. Of particular concern is the potential ‘internalisation’ of prejudices portrayed by the media, such that people with mental illnesses also begin to take on the view that they are dangerous and unstable.⁸ Furthermore, there is a corresponding lack of voice for people of mental illness,^{6,8} with few personal accounts of their burden of disease and similarly little representation from qualified healthcare professionals.^{6,9} All of this contributes to creating a stereotyped, isolated group without social status and acceptance.¹⁰

In a similar vein, there is a disappointing lack of coverage of stories on recovery and rehabilitation following mental illness.^{5,6} This potentially leads both the public and policy makers to erroneously believe that recovery is rare. We highlighted this in a newspaper survey 15 years ago in which we found that the reporting of mental illness and people with mental illness tended to be negative, whereas that of physical illness was much more likely to be positive in tone.¹¹ This may even influence health resource allocations to conditions that have a higher perceived chance of cure.⁴

As far back as the 1960s, Nunally noted that mental health representations in media were few and distorted, limited to ‘neurotic behaviour’ in evening dramas where ‘the afflicted person often enters the scene staring glassy-eyed, with his mouth widely agape, mumbling incoherent phrases or laughing uncontrollably’.¹² Steadman & Coccozza¹³ also showed

that media depictions are often skewed towards extremes. Their findings on public perception of the ‘criminally insane’ (mentally disordered offenders) are salient, with 61% of the public surveyed responding that they feared former mentally disordered offenders ‘a lot’.¹³ However, as the authors noted, the mentally disordered offenders named by the public following intensive coverage tend not to have any legal claim to be ‘criminally insane’, and are merely assumed to be as such by the media.

Although those with mental illness are reportedly 2–6 times more likely to commit violence than matched controls,^{5,14} the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness¹⁵ found that only 5% of the homicides carried out in the general population between 2001 and 2011 were by those with an abnormal mental state ($n = 52$). However, an additional 14% had been in contact with mental health services in the preceding 12 months. Therefore, the vast majority of perpetrators of homicide do not have a mental illness at the time of the offence ($n = 951$). Contrast this with the statistics for suicide in the same report: 30% of all completed suicides in the 10-year period analysed were by patients already known to mental health services ($n = 2678$). The figures identified are 14 times higher than for homicide. From this, it is reasonable to infer that an individual with a mental health disorder is far more likely to self-harm than harm others. This important point is also often missing from media reports seeking to capitalise on the sensationalist angle and, by doing so, dehumanise the patient to the extent that they are defined by their illness. Similarly, it is clear that people with mental illness are much more likely to be ‘victims’ of crime than perpetrators.^{16,17} This discrepancy in public perception between perpetrator and victim among those with mental illness has also been highlighted in other studies,^{18,19} acknowledging the need to shift attention away from the perceived threat to the public, to providing support and protection for the truly vulnerable. In this regard, the media has been counterproductive in reinforcing misleading stereotypes about public safety while simultaneously underreporting key statistics on mental health.

Although viral campaigns such as Rethink Mental Illness’ ‘Find Mike’²⁰ have been highly successful in bringing mental illness to some public attention, it is difficult to assess their impact. Based on our previous survey,¹¹ we hypothesised that: mental health reporting would still be consistently more negative in tone compared with reporting of physical health issues, and patients would be consistently underrepresented in media depictions compared with physical health reports. Additionally, regarding the link with violence and criminality, we further hypothesised that the association between mental illness and violence would continue to pervade mental health reporting.

Method

The method followed that of Lawrie.¹¹ Nine weekday UK daily newspapers (Scottish editions) were surveyed over a period of 4 weeks between 4 March and 4 April 2014. The papers chosen represent a selection of popular broadsheet (*The Times*, *The Telegraph*, *The Independent*, *The Guardian*, *The Scotsman*, *The Herald*) and tabloid (*Daily Mail*, *The Sun*, *Daily Record*) publications in the UK, with a reported range in circulation of between 64 279 (*The Independent*) and 2 048 977 (*The Sun*) in February 2014.²¹ Only national newspapers were included in this analysis, as they have the widest distribution.

Print copies of the newspapers were obtained from the Reference Library of Edinburgh on the day of publication and manually screened for headlines relating to mental health or psychiatry and general health issues. Two tabloids, *The Sun* and *Daily Record*, were purchased each day, as they were not subscribed to by library services, yet have the highest circulation figures in the UK.

Articles relating to mental health and physical health were identified initially through headline screening. The main body of text was then read and coded as positive, negative or neutral, if the article was mainly stating facts or had mixed elements. As such, it is possible to have a disparity between tone of headline and article. Each article was then analysed and coded to a schema with eight variables, which noted key themes (*Table 1*).

Coding schema for newspaper articles

Variable	Description
Quote from patient, relative or charity	Direct or paraphrased quote from a patient with the illness in question, relative or advocacy organisation
Quote from professional	Quote from a healthcare professional in charge of the patient's care or spokesperson for government organisations, etc.
Association with violence	Any article where a person portrayed as having a mental illness or under the influence of drugs/alcohol engages in criminal or dangerous activity where others are put at risk or harmed. Suicide or self-harm is not included in this category
Mention of treatment/rehabilitation	Either specific (e.g. Prozac), general (anti-depressants, cognitive-behavioural therapy), alternative (mindfulness, yoga) or relating to the Mental Health Act 1983 where treatment is noted under a compulsory treatment order
Substance misuse	Articles relating to addiction, overdose or psychiatric effects of substance misuse were classified as relating to mental health. Physical effects of drug usage, including side-effects, were classified under physical health
System failure/negligence	Any article where substandard care is delivered by a single person or on an organisational level, resulting in adverse outcomes. Shortcomings range from IT failures and changes in social policy to deliberate mistreatment
Innovations in research	Articles where a new diagnostic method, treatment or better understanding of a named disease is reached
Medical advocacy/raising awareness	Where the primary purpose of the article is to transmit information about a particular disease profile or set of symptoms or charity efforts. For example Autism Awareness Week, United Nations World Down Syndrome Day, 'Check 'Em Tuesday' – a campaign run by <i>The Sun</i> to increase uptake of self-screening for breast cancer

Inclusion and exclusion criteria

The sports and business sections were surveyed, however property and automobile inserts were excluded due to likely lack of relevance. Primary newspaper articles, editorials and opinion pieces were included in the data collection. Advertisements, letters to the editor, film and entertainment reviews and obituaries were omitted. Articles with only a passing or chance reference to mental or physical health were also omitted.

All articles concerning mental disorders recognised by the DSM-5,²² psychiatry or psychiatrists were included, as well as generic, undefined mental conditions with the exception of paedophilia and the paraphilias, as their classification as a mental illness in DSM-5 is controversial. For physical health, all articles relating to other general medical issues were collected. Articles concerning the National Health Service (NHS) or other organisational bodies were included only if there was a demonstrable mention of impact on patient health and safety.

Results

In total, 963 health-related articles were collected during the 4-week period. Of these, 763 (79.2%) concerned physical health, whereas 200 (20.8%) were about mental health. Although there was a slight preponderance towards neutral pieces (38.0%) in the physical health category, compared with positive (28.6%) and negative (32.9%) reporting, the majority of articles concerning mental health were negative in tone (50.5%), with only a small number of positive (22.0%) or neutral articles (27.5%) (*Box 1*). This striking disparity between mental and physical health reporting underscores a key finding that mental health reporting remains consistently more negative than physical health, which is in line with the results from Lawrie's¹¹ study over a decade previously (ratio of positive to negative articles for physical health: 218/251; and for mental health: 44/101; odds ratio (OR) 1.99, 95% confidence interval (CI) 1.34–2.97). In addition, we found a prominent and stigmatising association between mental illness and violence as 18.5% of mental health articles featured violence as a major theme, compared with 0.3% of physical health articles (OR = 86.37, 95% CI 20.60–362.1) (*Table 2*).

Comparison of variables between physical and mental health reporting

Variable	Physical health, <i>n</i> (%)	Mental health, <i>n</i> (%)
Total number of articles	763	200
Positive	218 (28.6)	44 (22.0)
Negative	251 (32.9)	101 (50.5)
Neutral	290 (38.0)	55 (27.5)
Quote from patient/charity	150 (19.7)	45 (22.5)
Quote from professional	285 (37.4)	58 (29.0)
Association with violence	2 (0.3)	37 (18.5)
Mention of treatment/rehabilitation	217 (28.4)	48 (24.0)
Substance misuse	31 (4.1)	22 (11.0)
Medical advocacy/raising awareness	131 (17.2)	26 (13.0)
System failure/negligence	118 (15.5)	25 (12.5)
Innovations in research	184 (24.1)	22 (11.0)

Although previous studies have shown that patients with mental illness are underrepresented in newspaper articles,^{6,8} we found this not to be the case, with a higher proportion of quotes from patients with mental illness, their relatives or mental health charities (22.5%) compared with physical health (19.7%) (ratio of quotes in physical health: 150/613; mental health: 45/155; OR=0.84, 95% CI 0.58–1.23). There appears to be comparatively fewer quotes from professionals in relation to mental health however, highlighting the need of the psychiatric profession to make a conscious effort to engage with the media, and vice versa.²³ Interestingly, whereas previous studies have highlighted a lack of reporting on treatment and rehabilitation for mental health,^{4–6} here we found the rates to be comparable to that of physical health articles (24.0% v. 28.4% respectively) and previous reports.⁶

Box 1 Examples of positive, negative and neutral headlines for mental and physical health

Physical health

Positive

‘US Aids baby may be cured’

‘Cholesterol drugs may slow MS, study shows’

Negative

‘Three-year old died after hospital delay’

‘“Sickness culture” claim as 1 in 3 has long-term illness’

Neutral

‘Statins have no side-effects, study finds’

‘Smoking link to breast cancer in older women’

Mental health

Positive

‘Depression and self-harming are taboo ... that’s why I’m determined to speak out’

‘Ketamine trial provides fresh hope for long-term depressed’

Negative

‘Mentally ill man in bus knife attack’

‘School accused of excluding girl with anorexia to avoid copycats’

Neutral

‘Give dementia patients trial drugs en masse’

‘Depression must be seen as a societal disorder’

The disorders most commonly associated with violence were personality disorders as well as undefined ‘mental illnesses’ and post-traumatic stress disorder, which make up 13.5% of all articles pertaining to mental health. Surprisingly, sensationalist stories about schizophrenia were minimal and comparable to reporting on other mental disorders, whereas dementia and eating disorders were least likely to be reported as associated with violence (*Table 3*).

A breakdown of newspaper articles according to diagnosis and association with violence

Diagnosis	Articles <i>n</i> (%)	Association with violence, <i>n</i> (%)
Suicide	31 (15.5)	0
Mood disorder	26 (13)	2 (1.0)
Dementia	32 (16)	0
Eating disorder	12 (6)	0
Developmental disorder	17 (8.5)	3 (1.5)
Substance misuse	13 (6.5)	2 (1.0)
Personality disorder	11 (5.5)	14 (7.0)
Schizophrenia/psychosis	10 (5)	3 (1.5)
Other ^a	49 (24.5)	13 (6.5)

Includes multiple disorders, undefined and post-traumatic stress disorder.

Based on the previous data that show people with mental illnesses are more likely to be victims of crime rather than perpetrators, we were interested to see whether this correlated with media reports. We found that people with mental illness are twice as likely to be portrayed as a perpetrator (34/200) compared with a victim (17/200), in direct contrast to the available data.^{16,18,19,24}

Given that 18.5% of articles on mental health concern violent acts and are seen as a threat to the public, we asked what made up the rest of the negative reporting. On further analysis, it appears that a significant proportion of the negative articles pertain to the stigmatisation and abuse of people with mental health within society, as well as lack of funding and adequate care provision. Examples include headlines such as: ‘The great mental health betrayal’ (*The Independent*, 13 March 2014), an article about the unlawful detaining of people with mental health illnesses in care homes and hospitals, and ‘Mental health and race – the blight of dual discrimination’ (*The Guardian*, 26 March 2014), which highlights the additional burden of being an ethnic minority with mental illness. The remainder of the negative articles are reports on suicide (15.5%).

Overall, there was no significant difference between mental health reporting in broadsheets compared with tabloids.

Discussion

We found that mental health reporting makes up a fifth of all articles concerning health in a selection of UK print media over the course of a month. This is lower than found in a similar study by Pieters *et al*²⁵ in Belgium but comparable to the figures obtained by Lawrie in the UK¹¹ over a decade ago, reflecting little change in the frequency of reporting on mental health. Half of all articles on mental health are negative in tone, which is a much greater proportion than for physical health, but nonetheless represents a small reduction compared with Lawrie's study. On the other hand, the association with violence remains prominent, with 18.5% of articles carrying a theme of danger or criminality.

In the intervening 15 years, several campaigns by mental health charities both in the UK and abroad have sought to lessen the stigma attached to mental illness and encourage open dialogue about mental health. Media coverage is important to the success of such campaigns in influencing public opinion and increasing exposure. In light of this, we asked whether there is any evidence that media reporting on mental illness is improving (see below). Although previous studies have commented on the lack of voice for people with mental illness, we have found this not to be the case with a higher proportion of quotes from patients with mental illnesses compared with physical health. Although there are fewer representations of healthcare professionals in psychiatry, this may reflect reluctance among the profession as a whole to engage with the media, as psychiatrists too are affected by stigma.^{26,27}

Mental illness and violence

The link between mental illness and violence is unfortunately still pervasively reported – being part of about a fifth of all articles on mental health. The figure obtained in this study (18.5%) is lower than previous reports of association with violence.⁶ However, other studies have utilised more restricted search criteria, only using specific keywords such as 'schizo', 'mental', 'deranged' and 'psycho', which does not encompass the whole spectrum of mental illnesses.^{5,6,28,29} As most studies also used a computerised database programme (such as the LexisNexis) to generate articles, limiting the search criteria to only the above keywords will bias the results to find articles on schizophrenia or those that include derogatory terms such as 'psycho' or 'deranged', which are inherently stigmatic and more likely to be associated with violence.²⁹ In contrast, mental illnesses not usually considered violent, such as eating and mood disorders, would be excluded from the analysis.

In our study we found that schizophrenia and psychotic disorders make up a minority (5%) of reporting on mental illness and only 1.5% of these articles featured violence. Although there is little contention that mental disorders are disproportionately associated with violence in the media, one possible explanation for the strength of the association between the two is that it is an artefact created by selective searching among newspaper databases. We suggest the effect would be diluted if all articles on psychiatry, including conditions such as mood and anxiety disorders, were incorporated in the analysis.^{30,31}

In this study, we also found that people with mental disorders are twice as likely to be portrayed as a perpetrator of crime compared with a victim. This is another illustration of how the media can be misleading on key facts. Education for journalists and guidance on the reporting of mental health issues is central to bringing about a change in reporting trends. However, this may be easier said than done. One study attempted to correct journalists' erroneous views about mental illness with a short presentation on schizophrenia prior to a press conference regarding a high-profile assault carried out by a man with a serious mental illness. Although they found that journalists had a good recall for the details several weeks later, the presentation did not ultimately affect the writing of the article.³² This suggests that collaborations with the media will have a greater chance of success and change in reporting if they are mutually beneficial and desired. One example of this is UK mental health charity, Mind, which has set up a series of media awards for responsible and ethical reporting of mental health issues (www.mind.org.uk/news-campaigns/mind-media-awards), as well as reporting guidelines for different conditions.^{33,34}

Strengths and limitations

The main strength of the study is that all papers were hand-searched according to the criteria set out in the Method. This abolishes the need to search based on keywords, potentially increasing the yield of articles. Similarly, the scope and definition of 'mental illness' is wider than in previous studies, allowing for a greater overview of the subject in media. In the current study, the use of one investigator to locate and rate the articles, is both a potential advantage – in reducing interrater variability – but also a disadvantage in that no interrater reliability could be established (although we did discuss and resolve any uncertainties between the authors). The main limitation is that the coding schema used is a relatively blunt tool and cannot convey the complexity or depth of a newspaper story. Second, the categorisation of articles into mental and physical health does not allow for overlap in coverage, although that only occurred in a small minority of articles. Furthermore, the short time frame of the study means it can only provide a snapshot of mental health reporting in the UK. Last, there were two mental health stories that garnered a considerable amount of media attention in this time period and subsequently have the ability to bias the data. One was the suicide of a famous fashion designer and another, the death of a woman who had murdered her three children and was subsequently labelled as having a personality disorder. Both stories were extensively reported on over multiple days. However, they were included in the analysis as this study was designed to encompass all the news on mental health over 4 consecutive weeks, rather than the sampling of random time points, and different reports had different foci as new information about the cases came to light.

Conclusions

Despite several prominent government-led and charity campaigns, mental illness and individuals with mental illness continue to experience stigmatisation and stereotyping. Although it is encouraging that people with mental disorders are being increasingly represented in print media, and there appears to be an overall increase in non-stigmatising articles,³⁵ much remains to be done to address the inaccurate and stigmatising association with violence, and raise the profile of mental illness as a whole.

The particular reasons for the ongoing negative headlines about mental illness, and what could or should be done about them, are beyond the scope of this study. Our results do however indicate that there is a clear need for more reporting about mental health in general, and for more accurate reporting about violence and for more accounts of innovative research developments in particular. We therefore suggest that there is much to be gained from further ongoing engagement between patients and psychiatrists and the media, with an emphasis on realistic depictions of the lives patients lead and of recent research advances.

Many thanks to the staff at the Reference Library of Edinburgh for meticulously collating the newspapers used each day.

1.7.86 Implementation of a novel primary care pathway for patients with severe and enduring mental illness

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Abstract

Aims and method New collaborative care models with an emphasis on primary care are required for long-term management of patients with severe and enduring mental illness (SMI). We conducted a descriptive evaluation of clinical outcomes of the first 3 years of a novel enhanced primary care (EPC) service. Data from 2818 patients and staff survey results were analysed.

Results 2310 patients were discharged to EPC (508 not assessed as clinically suitable or patients/general practitioners declined the transfer); mean length of stay with secondary care service of the cohort was 9.8 years (range 0–24). 717 patients (31%) have been discharged to primary care only out of the EPC services and 233 patients (10%) have been transferred back to secondary care. Patient and staff satisfaction with the new EPC model was high. No severe untoward incidents were recorded.

Clinical implications The data suggest that EPC can be safely provided for a significant proportion of patients with SMI, who traditionally received long-term secondary care support. The novel EPC model can be utilised as a template for the provision of cost-effective, recovery-oriented and non-stigmatising care in the community.

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 - *Discussion*

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* *Limitations and outlook*

Mental healthcare for the majority of patients with severe and enduring mental illness (SMI) was historically provided predominantly by specialist secondary care services in the UK. Hereby, most patients with long-term chronic conditions received open-ended health and social care support and relatively few were discharged back to primary care for ongoing case management. More recently, patients with SMI are increasingly considered for clinical management by less specialised, generic primary healthcare services and in collaborative care models.¹⁻³ Most of these schemes have not been robustly evaluated through clinical and controlled trials. There is however good evidence to suggest that collaborative chronic care models foster patient self-management and can improve mental and physical outcomes for patients with mental health problems.³

In England, the introduction of clinical commissioning groups (CCGs) in 2013⁴ and the significant public spending savings plan with annual targets for all National Health Service (NHS) provider organisations⁵ resulted in a nationwide review of mental healthcare provisions and piloting of novel care pathways. Secondary mental healthcare providers have started to reduce the number of cases held by specialist community mental health teams, including assertive outreach and community rehabilitation teams. The NHS policy paper *No Health Without Mental Health*⁶ emphasised the need for integration of care for physical and mental health needs; provider and commissioner organisations therefore started to engage in various local service redesign projects. In East London, enhanced primary care (EPC) services for patients with SMI were developed and implemented in 2012, following a whole system review which attempted to address the issue of plateauing resources. The overall aim of the EPC service is to foster recovery of patients with SMI, to safely discharge them to primary care settings that attend to their mental healthcare needs. Three years after its launch, clinical outcomes of the novel care pathway for patients with SMI, patient/staff satisfaction were evaluated and are reported in this paper.

Method

Data collection and analysis

This evaluation is based on a retrospective data analysis of routinely collected data on all the patients referred to and/or fully discharged from secondary care to the EPC service since its inception (reporting period from 1 August 2012 to 31 July 2015). Electronic clinical data-sets included: total number of identified/discharged patients; number of patients who refused to be transferred to the new service and where either general practitioners (GPs) or consultant psychiatrists assessed patients as not suitable; diagnoses and ICD-10⁷ codes, gender, ethnicity, duration of service provided by secondary care, number of admissions to hospital; number of patients re-referred to secondary care or readmitted/relapsed analysis of main characteristics of this subgroup of patients.

In addition we conducted an analysis of available information collected regarding staff satisfaction (semi-structured interviews and questionnaires) and summarised data from a patient satisfaction survey (Client's Assessment of Treatment Scale⁸) for the new service from one of the three localities (Newham).

Description of the new EPC service

The model was developed in partnership between East London NHS Foundation Trust and the three East London CCGs (Newham, City & Hackney, Tower Hamlets) across primary/secondary care teams by interdisciplinary working groups; those involved were people participation leads, GPs, consultant psychiatrists, senior community psychiatry nurses, psychologists and social work leads. The initial target was defined as 300 patients per year per locality. The EPC care pathway allows providing mental healthcare flexibly according to patients' needs and to step up (secondary mental health services) or step down (generic primary care) in a seamless way without administrative hurdles.

EPC care pathway elements

Elements of the EPC care pathway were as follows: Regular GP reviews (in addition to quality and outcome requirements), the development of a recovery care plan, practice nurse administration of depot medication, and specific assessment of risk factors for physical illness, signposting into healthy lifestyle services. Enhanced support to primary care from consultant psychiatrists with regular practice-based mental health multidisciplinary review meetings. Training and education to GPs on managing SMI in primary care, and for practice nurses on psychopharmacology and therapeutic depot administration. EPC mental health teams consisting of registered mental nurses, employed by East London NHS Foundation Trust but working within general practice, to support discharge into the EPC and provide recovery-oriented support to patients on an ongoing basis.

The philosophy of the service operationally distinguishes clearly between: specialist acute and rehabilitation treatment for patients with severe or complex needs and/or those identified as presenting with significant risks to self or others associated with their illness (continued to be provided by secondary care services); and long-term condition management aiming to provide monitoring and maintenance support for patients with stable chronic SMI (provided by the new EPC teams). Inclusion criteria for the EPC transfer were defined as follows: Aged 18 years or older, resident in one of the three East London boroughs and currently under the care of secondary care services. Established diagnosis of an SMI that would warrant their inclusion on the practice severe and enduring mental illness (SEMI) register. Identified care needs above those that would ordinarily be provided for under normal primary care, either medical or social needs, that require additional support. Patient agrees to the support offered via the EPC clinic. Sustained clinical progress with less frequent support from secondary care and no identified need for specialist interventions and treatments. Last acute psychiatric hospital admission more than 12 months ago, no current risks to self or others identified; patient is well-established on a medication regime and requires minimal assistance with concordance, but does require regular monitoring and review. Patient has settled accommodation, is able to meet their own basic living needs. Patients requiring lithium prescribing or depot injections in primary care are included.

Teaching, training and supervision

Primary care liaison nurses (PCLNs) of the EPC teams were recruited from secondary care services and all had experience in providing mental healthcare to patients with SMI. A list of essential competencies, skills and experiences were identified as significant requirements for the recruitment of the EPC workforce and included the following areas: history taking/mental state examination, engagement skills and basic knowledge of principles pertaining to a positive therapeutic relationship, risk assessment and management, recovery care and social psychiatry, and psychiatric emergencies. Additional training was offered to PCLNs.

The provision of the EPC service is supported through weekly team meetings, monthly supervision sessions, and six monthly appraisal/reviews, aiming to maintain and update knowledge and skills.

The three localities agreed on mandatory training requirements for primary care staff as part of the EPC contract with their primary care practices and the EPC team provided training for staff in GP practices including mental health awareness training for practice reception staff and depot training for nurses.

Subsequently, in 2015 a website with a wide range of teaching and self-learning materials for all primary care staff was developed with funding from Health Education England North Central and East London, launched into public domain in 2016 (<http://primary-mentalhealth-care.elft.nhs.uk>).

Service aims and expected outcomes

- To support patients to achieve their recovery goals through a process of joint planning that places patients at the centre.
- To empower people to self-manage their own recovery journey and reach a position where they can reduce their contact with mental health services.
- To mark the recovery journey by recognising achievements while being transferred to receive care in EPC and at the point of discharge from EPC.
- To improve the patient experience and outcomes through enhanced multidisciplinary team working that addresses mental health, physical health and social need as part of an integrated approach.
- To improve patient experience and outcomes through the provision of care in a normalised setting, close to home and to assist the navigation of patients towards resources that supports their recovery.
- To enable the development of capacity, confidence and competence in relation to mental health treatment and care in the primary care workforce.

The service elements were developed accordingly, centred on a 'My Recovery Plan' and associated 'My Safety Plan' documents for time-limited EPC interventions according to recovery goals set by the patient (with a recommended duration of up to a year after which the patient is supposed to be discharged into generic primary care services). The time-limited nature of the service was to be made clear to the patients at the outset and the service provides a fast-track option back to secondary care services if needs change.

Team composition

The service is predominantly delivered by psychiatric PCLNs. The three localities agreed on different staffing compositions according to local variations of service needs and/or perceived requirements in respect of multidisciplinary inputs from health professionals.

In Newham, psychiatrist input is provided by one consultant with protected time in the job plan and by catchment area consultants as required based on a sectorised/practice-aligned service model; in Tower Hamlets consultants with a primary base in general practice deliver psychiatric expertise; and in City & Hackney a model with a dedicated EPC service consultant was established.

Following a 12-month review the team of healthcare professionals was complemented by a group of peer support workers, who provide patients with emotional and practical support as they approach discharge from secondary care services. All the peer supporters have personal experience of in-patient and community mental healthcare and support patients flexibly based on their own experiences of recovery. A summary of the current team structures and allocated posts is provided in *Table 1*.

Staffing composition in enhanced primary care (EPC) teams in each locality *a*

Directorate	Total WTE per team	Admin Band 4	Occupational therapist	Clinical psychologist	Nurse Band 6	Nurse Band 7	Consultant	Peer/supervisor Band 3/4	Service manager Band 8a	Team case-load capacity
CH original	10.6					8.0	1.6		1.0	300
CH current	16.3	1.0	0.2	0.2		6.0	1.0 <i>b</i>	7.0	1.0	720
NH original	9.1				4.0		0.1	4.0	1.0	300
NH current	14.0				4.0		0.5 <i>c</i>	8.0	1.0	600
TH original	6.4				6.0		0.4			250
TH current	18.0	1.0			6.0	4.0	1.5 <i>d</i>	4.0	1.0	700
Trust total current	48.3	2.0	0.2	0.2	10	10	3.0	19.0	3.0	2020

CH, City & Hackney; NH, Newham; TH, Tower Hamlets; WTE, whole time equivalent.

Original and current from 2016. Phased increase in size of service with new investment following a service review in 2014–2015.

Consisting of each of the four current primary care consultants devoting 2.5 sessions a week to the EPC service and primary care liaison.

Consisting of time dedicated to EPC and primary care liaison by the four assessment and brief treatment consultants providing support to practices and one consultant with 0.1 WTE leading on EPC.

Consisting of a dedicated consultant providing two sessions a week to provide clinical support to the EPC team and the Compass Primary Care Psychology service, and each of the community mental health team consultants providing one session a fortnight to supporting the primary care practices to which they are aligned.

EPC provides an open general advice service to GPs to assist in the treatment of patients that have been discharged from EPC and secondary care. The arrangements vary between the three East London boroughs but all include case-based discussions between GPs and consultant psychiatrists during regular multidisciplinary clinical meetings at primary care level.

Results

Service activity summary

As per 31 July 2015, the three East London EPC teams provided care for 1370 patients. Since August 2012 the services considered in total 2810 patients, of which 480 were not proceeded with because the patients declined transfer ($n = 149$), the GP declined the transfer ($n = 90$) or the secondary care eventually decided the transfer was not clinically appropriate ($n = 241$). Therefore, 2330 patients have received an active service from EPC services since their inception. In total, 717 patients were transferred to primary care only from EPC with variations across teams. The total number of patients discharged from EPC to primary care alone has significantly increased beyond the reporting period of this service evaluation due to changes in operational policy and as a result of the teaching and training efforts to upskill GPs, resulting in increased throughput.

All referral and case-load data with developments to 30 October 2016 are summarised in *Table 2*.

Total referral and case-load activity for enhanced primary care (EPC)

	At 31 July 2015	At 29 February 2016	At 30 October 2016
Active case-load, <i>n</i>			
City & Hackney	510	547	633
Newham	485	557	610
Tower Hamlets	375	473	618
Total <i>n</i>	1370	1577	1861
Referrals considered, total <i>n</i>			
EPC – Trust wide	2810	4082	5286
Refused/not suitable, <i>n</i>			
EPC – Trust wide	480	576	633
Received EPC service, <i>n</i>			
City & Hackney	955	1317	1635
Newham	787	1186	1448
Tower Hamlets	588	1003	1570
Total <i>n</i>	2330	3506	4653
EPC transfer to primary care, <i>n</i>			
City & Hackney	384	675	939
Newham	184	465	705
Tower Hamlets	149	385	594
Total <i>n</i>	717	1525	2238
Transfer back to secondary care, <i>n</i>			
City & Hackney	65	95	177
Newham	124	164	227
Tower Hamlets	48	94	160
Total <i>n</i>	233	353	564

Patient characteristics

The majority of patients referred to EPC had a significant history of SMI with an average (mean) duration of care provided under care programme approach (CPA) standards by secondary care services (community mental health teams) of 9.7 years (range 0–24). The mean age of patients was 45.7 years (range 18–65; 12.1% 18–30 years and 77.3% 30–60 years); 54% of patients were female and 46% were male. Overall, 47.4% were single/living alone, 26.3% were married/civil partner and 11.6% were separated/divorced/widowed/surviving civil partner. Given the high percentage of Black and ethnic minorities living in East London, the distribution of ethnicity across the sample reflects the diversity: Asian or Asian British 24%, Black or Black British/African–Caribbean 19.8%, White British or other White 38.5%, other ethnic groups 17.8%.

The main diagnoses of patients were: schizophreniform or other psychotic disorders (ICD-10 codes F20–29) 37.2%, mood (affective) disorders (F30–39) 32.1%, anxiety/stress-related/somatoform and other non-psychotic mental disorders (F40–48) 11% and disorders of adult personality and behaviour (F60–69) 4.1%.

According to Department of Health guidance⁹ the main cluster codes on transfer to EPC were: cluster 10–13: 48.9% (11: 19.4%; 12: 21.5%; 13: 7.1%); cluster 4–7: 26.1%. The number of patients referred back to secondary care due to clinical issues (relapse concerns) was 237 (City & Hackney $n = 65$, Newham $n = 124$, Tower Hamlets $n = 48$).

Feedback from patients

Both EPC staff reports and results from questionnaire surveys suggest that the vast majority of patients regarded the new service arrangements as both helpful and adequate according to their needs. We conducted a more detailed survey in one of the three localities (Newham), using the structured Client's Assessment of Treatment Scale. Results from 126 patients who completed the survey (mean age 49.2 years, range 26–71; 66 female, 60 male) are indicative of comparatively high levels of patient satisfaction (most scores across the group rated with a mean of 8–9 out of 10) (*Table 3*).

Results from 126 patients who completed the Client's Assessment of Treatment Scale

	Mean	Range	s.d.
Do you believe you are receiving the right treatment/care for you here?	8.8	4–10	1.6
Does your general practitioner understand you and is she/he engaged in your treatment/care?	8.4	1–10	1.9
Does your named nurse understand you and is she/he engaged in your treatment/care?	9.0	2–10	1.5
Are relations with other staff members here pleasant or unpleasant for you?	8.5	0–10	2.0
Do you believe you are receiving the right medication for you?	8.9	0–10	1.7
Do you believe the other elements of treatment/care here are right for you?	9.4	4–10	1.3
Do you feel respected and regarded well here?	9.0	4–10	1.5
Has treatment/care here been helpful for you?	9.0	4–10	1.4

Feedback from GPs

GPs across all three localities engaged very well with the three EPC teams and expressed high levels of satisfaction; they acknowledged that the EPC service improved care for their patients. A brief survey questionnaire distributed to 61 GP surgeries in Newham was returned by 52 GPs. All but two GPs stated that the EPC helped to change their perception of/and relationship with mental health services.

Another GP survey was conducted in Tower Hamlets and revealed the following feedback (first figure 6 months after service implementation based on 61 responses (from 36 surgeries), second figure 1 year later based on 23 responses); this survey indicates that the EPC model contributed to developing GP's skills and knowledge of psychotropic prescribing (Very confident 3.3/13%, Confident 44.3/47.8%, Neutral 33.4/34.8%, Not confident 18.0/4.4%). In addition, satisfaction rates with practice-based multi-disciplinary meetings as well as the network-linked PCLNs was largely positive and increased over time.

We conducted a subgroup analysis of patients from Newham EPC who were re-referred to secondary care from EPC due to a relapse (significant increase in symptoms) of their mental disorder or other reasons; $n = 124$ out of 787, 15.8%.

Relapse due to a range of stressors (iatrogenic, non-adherence, etc.) was $n = 69$; relapse with acute admission to hospital, $n = 8$; and non-engagement and requests to be discharged from GP, $n = 9$. Requests for medication review by secondary services/GP referred back: $n = 26$; social circumstances: $n = 4$; and patient demanding to be referred back to consultant: $n = 3$.

Only for 3 out of 124 re-referred patients with a change in prescribed dose of medication were identified, all others had been on stable medication as per discharge plan from secondary care. The number of EPC face-to-face contacts for this group varied from 0 to 8, most patients had been seen on 1–3 occasions by their PCLN. The diagnostic codes, PCLN clinics and GP surgeries were equally distributed across this group.

Discussion

The data-set considered for this service evaluation comprised of a large sample of over 2000 patients with predominantly chronic severe mental illness (schizophreniform, psychotic or severe affective disorder, care clusters 10–13 and 4–7) and the observation period of 3 years seems adequate to allow for a critical appraisal of performance data. The overall results from this service evaluation suggest that a significant proportion of patients with SMI, who were traditionally seen long term with open-ended care plans in secondary care, can be successfully discharged to enhanced primary mental healthcare services. This is even more so significant given the fact that prior to transfer of care, patients had been receiving specialist mental health services for on average of nearly 10 years. The number of relapses and referrals to secondary care services has been low, even though the overall referral rate to EPC has risen. A significant number of patients who received EPC services are now supported by primary care alone.

The success of this novel care pathway is based on very close collaboration between primary and secondary care health professionals and service characteristics that provide seamless care across boundaries: all PCLNs were employed through secondary mental health services and mostly recruited from existing mental health teams, which enabled them to provide clinical expertise into the new service – quick access to secondary care for crisis management was built into the service structure.

Only about 14% of patients were not taken into EPC clinic care following the initial referral and this is indicative of a carefully conducted and initially conservative selection process, also taking patient preferences into account. Patient feedback was very positive and no severe untoward incidents occurred during the observational period.

Although mental healthcare services for patients with SMI have traditionally been regarded as too specialised for primary care, most patients regard primary care provisions as a significant milestone in their recovery journey.¹⁰ The care pathway development was conducted based on a much clearer distinction between elements focusing on supporting people to maintain stability and monitor symptoms versus elements providing active recovery-oriented treatment. This allowed refocusing of specialist services and deconstructing the 'shifted out-patient clinic' model,¹¹ essentially a replacement model, which does not provide opportunities for enhanced linkage and face-to-face consultations between

the primary care physician and the psychiatrist.¹² By contrast, the consultation-liaison collaboration model provides regular face-to-face contact between the psychiatrist or mental health worker and the GP.¹³

The survey results suggest that the support primary care doctors receive from consultant psychiatrists is a vital part of the scheme. The precise arrangements vary across the three boroughs but each primary care practice has an aligned consultant who visits the surgery regularly, is available for advice especially on potential referrals to secondary care and who assists the surgeries to become more mental health sensitive and informed.

The main difficulties with the new care pathway identified in the context of this service evaluation are related to the wider context of recovery-focused care with an emphasis on integration with mainstream community services, such as employment, training and leisure activities. Depending on pre-existing skill and knowledge base within each of the participating GP surgeries, the quality of mental state monitoring and therapeutic engagement is likely to vary significantly. More emphasis must therefore be given towards developing robust and ongoing teaching and training curricula for primary care practitioners. Another significant challenge is the variation in access to psychological therapy services and social care from locality to locality depending on the level and specification of integrated care pathways. This is a crucially important issue for the success of EPC services, safeguarding against compromising the quality of care.

A further significant increase of the number of people who experience a mental health problem in England has been predicted (i.e. 14.2%, from 8.65 million in 2007 to 9.88 million in 2026) as a result of population growth.¹⁴ More research of innovative and collaborative schemes for high-quality cost-effective mental healthcare is required, assessing the impact of working across primary and secondary care.¹⁵

The promotion of psychological resources and capabilities at a family and community level to support people experiencing mental ill health appears to be a promising complementary strategy for both primary and secondary prevention. Last but not least there seems to be a real case to extend the role of district nurses, to strengthen the role of GP champions in mental healthcare¹⁶ and to involve patients as teachers in interprofessional learning as already pointed out by Lester *et al*¹⁷ in their discussion paper on integrated primary mental healthcare more than 10 years ago.

Limitations and outlook

This is a retrospective analysis of routinely collected data for service evaluation, not a formal research study. Patients were identified by their secondary care clinicians as potentially suitable for transfer to the EPC clinic and there was no control condition. The Client's Assessment of Treatment Scale satisfaction scores and relapse indicator analysis was only available for one of the three localities and only a subgroup of about 25% of patients open to the EPC service completed the survey.

Empirical research is needed to establish detailed patient characteristics as predictors for successful transfer of care. Longer-term and controlled follow-up studies are required to establish care quality and effectiveness issues across various components of the health and social care pathway (e.g. social inclusion, subjective quality of life, psychopathological symptom levels) following discharge from secondary care services, compared with continuing specialist treatment. It will be important to assess differences between inner-city and more rural areas to establish as to whether the claim, that the delivery of mental healthcare in primary settings is 'more accessible, affordable and acceptable for the population'¹⁸ can be substantiated.

1.7.87 National survey of training of psychiatrists on advance directives to refuse treatment in bipolar disorder

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Abstract

Aims and method To determine features associated with better perceived quality of training for psychiatrists on advance decision-making in the Mental Capacity Act 2005 (MCA), and whether the quality or amount of training were associated with positive attitudes or use of advance decisions to refuse treatment (ADRTs) by psychiatrists in people with bipolar disorder. An anonymised national survey of 650 trainee and consultant psychiatrists in England and Wales was performed.

Results Good or better quality of training was associated with use of case summaries, role-play, ADRTs, assessment of mental capacity and its fluctuation. Good or better quality and two or more sessions of MCA training were associated with more positive attitudes and reported use of ADRTs, although many psychiatrists would never discuss them clinically with people with bipolar disorder.

Clinical implications Consistent delivery of better-quality training is required for all psychiatrists to increase use of ADRTs in people with bipolar disorder.

Contents

- *National survey of training of psychiatrists on advance directives to refuse treatment in bipolar disorder*
 - *Method*
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 - * *Analysis*
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 - *Discussion*

The Mental Capacity Act 2005 (MCA) in England and Wales provides a legal framework for personal welfare and financial decisions to be made in advance by individuals, who later due to an impairment or disturbance of functioning in the mind or brain, may be unable to make these decisions for themselves. If capacity is not present, a decision can be made on behalf of the person based on what is in their best interests taking consideration of their wishes using three specific provisions of the MCA for advance decision-making: advance decision to refuse treatment (ADRT), a legally binding provision preventing specific treatment; advance statement of wishes and feelings, a non-legally binding statement of preferences for treatment, and/or personal and financial affairs; lasting power of attorney, a legally binding direction identifying who will look after the person's personal and financial affairs. Clinicians and their employers, especially psychiatrists, are legally required to 'have regard to' MCA guidance and, if later asked, prove that they did.

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¹ Therefore there is an expectation that psychiatrists receive training in the MCA. However, the methods and amount of training that psychiatrists should receive are not specified, nor has the quality or amount of training been related to attitudes or use of ADRTs in practice. We chose to examine the attitudes to and use of ADRTs by psychiatrists as these may be seen as restrictive in terms of treatment offered by psychiatrists to people with bipolar disorder. In a national survey of general adult and old age psychiatrists in England and Wales, we wished to explore how the quality and amount of training they have received may be associated with their implementation of ADRTs in people where capacity is lost (e.g. mania, severe depression) and regained (e.g. bipolar disorder) to complement a survey of patient experience in bipolar disorder. ²

Method

Objectives and design

Our objectives were: to determine what aspects of training in the MCA were associated with higher or lower perceived quality of training in the view of psychiatrists; and to examine whether the quality and amount of training were associated with reported attitudes or use of ADRT in people with bipolar disorder. We anticipated that high-quality training may be required to overcome professional resistance to the use of ADRTs should any be present.

Participants

Inclusion/exclusion criteria were: participants practice within England and Wales, i.e. the jurisdiction of the MCA specialise in either general adult or old age psychiatry they were consultant psychiatrists or in training grades (CT1-CT3, ST4-ST6).

Procedure

We aimed to recruit a national sample of 500 psychiatrists in a 12-month period for the survey. No data were available for a formal power calculation. The study was advertised with the help of the National Institute of Health Research-funded Mental Health Research Network (MHRN) and the Royal College of Psychiatrists. The College agreed to publicise the study by tweeting the link to the survey and the study team also attended a national conference organised by the College to publicise the study. Consultants, senior and junior trainees in general adult and old age psychiatry were selected from different regions to ensure maximum variance of practical clinical experience. To maximise the participation rate of psychiatrists and the frankness of their responses, we anonymised the survey, not asking for personal information such as age, gender or workplace, and placed it online or if they preferred we administered it face to face, by telephone or posted it.

Measures

The survey was divided into nine sections that addressed the following topics: Section A: Preliminary information – position, years since qualification, place of work (e.g. in-patient, crisis team), geographic location. Section B: MCA training – how many sessions attended, whether mandatory, how recent, whether training considered advance decision-making that included ADRTs, nature of training, quality of training (e.g. in your opinion how much of the training focused on advance decision-making (including ADRTs) – a significant amount, a reasonable amount, a minimal amount, none?). Section C: ADRTs and bipolar disorder – whether psychiatrists had experience of patients making ADRTs, whether they had advised on making ADRTs, content of ADRTs, factors influencing their decision to advise regarding ADRTs. Section D: ADRTs and other conditions – content of ADRTs. Section E: ADRTs and the Mental Health Act 1983 – whether psychiatrists had encountered ADRTs in context of patients admitted to psychiatric units or sectioned under the Mental Health Act. Section F: ADRTs in clinical practice – how often should they be discussed (e.g. in your opinion how often do you feel that discussion of ADRTs should take place – at every consultation, every 6 months, at care programme approach meetings, only when I think I might be relevant, only when another health or

social care professional raises the topic, only if the patient or carer raises the topic or never?). Section G: Advance statement of wishes and feelings – whether psychiatrists had experience of patients using these; what was contained, whether the frequency was changing among people with bipolar disorder. Section H: ADRTs and implementation of the MCA – whether psychiatrists had experience of patients using ADRTs and their contents. Section I: Lasting power of attorney – whether psychiatrists had experience of patients making lasting powers of attorney, who advised on these.

Analysis

Descriptive statistics were employed in the survey to explore the professional characteristics of psychiatrists and their experience of training. Univariate analysis indicated that several demographic or service provision factors may be associated with the use of the MCA. Binary logistic regression was applied to three separate analyses: the quality of training (dependent variable) perceived by psychiatrists was explored in relation to the methods, site and content of training the quality of training (dependent variable) was then related to attitudes and experiences of psychiatrists to implementing ADRTs in their clinical practice the amount of training (dependent variable) was related to their attitudes and experiences of implementing ADRTs. Checks for collinearity were applied by exploring the Spearman correlations between the independent variables that might enter the logistic regression. None of the independent variables were excluded because of collinearity. Odds ratios (ORs) and 95% confidence intervals (CIs) are presented for any significant variables.

Results

A total of 650 psychiatrists were recruited for the survey. *Table 1* shows the grade, work setting, country of medical training and duration of time since medical qualification of this sample. Within the sample, there were 374 (57.5%) consultants in general adult or old age psychiatry, and the remainder were trainees, with a slight majority qualified in medicine outside the UK. Psychiatrists were recruited for the study between May 2011 and June 2012. Of 607 respondents who identified the geographic location of their work, 133 (21.9%) were from the West Midlands, 116 (19.1%) from the East Midlands, 80 (13.2%) from the South West, 116 (19.1%) from the South East, 74 (12.2%) from the East of England, 46 (7.6%) from London and 10 (1.6%) from the North West of England.

Professional characteristics and nature of Mental Capacity Act 2005 training of psychiatrists ($n = 650$)

Work characteristic	<i>n</i>	%
Grade		
Consultant general adult psychiatry	283	43.5
Consultant old age psychiatry	91	14.0
ST4–6 trainee	111	17.1
CT1–3 trainee	130	20.0
Missing	35	5.4
Main work setting		
Community mental health team	349	53.7
In-patient	216	33.3
Crisis team/EIP/ACT	77	11.9
Missing	8	1.2
Years since medical qualification		
0–10	210	32.3
11–20	241	37.1
21–30	146	22.5
30+	51	7.8
Missing	2	0.3

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Table 17 – continued from previous page

Work characteristic	<i>n</i>	%
Country of medical qualification		
UK	306	47.1
European Union	51	7.8
Outside European Union	288	44.3
Missing	5	0.8
Number of training sessions		
0	55	8.5
1	128	19.7
2	183	28.2
3	113	17.4
>3	169	26.0
Trained but missing data	2	0.3
Method of training <i>a</i>		
Case examples	491	75.5
Role-play	82	12.6
Watch video	44	6.8
None of these	86	13.2
Source of training <i>a</i>		
Local NHS trust	489	75.2
Royal College of Psychiatrists	133	20.5
Legal or solicitor	48	7.4
Pharmaceutical company	35	5.4
Other	89	13.7
Perceived quality of training		
Excellent	24	4.0
Very good	153	25.7
Good	269	45.2
Average	134	22.5
Below average	12	2.0
Missing	58	8.9
Primary reason for attending		
Mandatory NHS trust training	172	28.9
Approved clinician training	194	32.6
Educational event	128	71.5
Personal interest	79	13.3
Other	22	3.7
Missing	55	8.4

ACT, assertive community treatment; EIP, early intervention in psychosis; NHS, National Health Service.

Categories are not mutually exclusive.

Table 1 shows the number of training sessions, methods used for training, source of the training, quality of training and reasons for attending the training: 595 (91.5%) had attended at least one training session on the MCA; 465 (71.5%) had attended two or more sessions; and 326 (50.1%) had been to a training session in the previous year. Of the 595

psychiatrists trained in the MCA 489 (75.2%) had been trained by their local National Health Service (NHS) trust. The quality of the training was perceived to be high, with 446 (75.0% receiving training) rating it as good, very good or excellent (Table 1). However, 209 (35.1% receiving training) psychiatrists stated that either minimal or no attention was paid to ADRTs in the training sessions.

Table 2 examines the binary multiple logistic regression associations between the quality of training and the methods of training, the site of training, the number of training sessions and topics covered in the training. Compared with average or poor training, good or better (very good or excellent) training was associated positively with the use of case summaries, role play, coverage of advance decision-making (including ADRTs) and assessment of capacity. Video feedback was only carried out in good or better quality of training (44 or 9.9%, Fisher's exact 2-tailed test $P < 0.001$). Average or poor training was associated with training in their own NHS trust compared with good or better training (Table 2). In relation to the specific use of advance decision-making including ADRTs and the need to be able to assess fluctuating capacity in conditions such as bipolar disorder with highly variable severity and therefore capacity, it is notable that even good or better-quality training covered these issues in only just over 45% and 37% of cases respectively.

Content and method of training related to perceived quality of training in the Mental Capacity Act 2005 a ($n=588$)

	Q uality of tr aining						
Used rol e-play	76	17.1	26 6	4.1	3.32	1.3 7–8.07	0.008
Tr aining in a dvance dec ision- making ` b <#TF N5>`__	203	45.6	26	17.8	2.58	1.5 4–4.31	<0.001
Ca pacity asse ssment	410	92.3	107	74.3	2.80	1.5 6–5.02	0.001
Tr aining in their NHS trust	355	80.0	132	91.7	0.39	0.2 0–0.77	0.007

NHS, National Health Service.

55 psychiatrists received no Mental Capacity Act training, 7 missing responses.

Including advance decision to refuse treatment.

Only 94 (14.5%) of surveyed psychiatrists had encountered a patient with bipolar disorder who had made an ADRT; 136 (20.9%) had encountered a patient with bipolar disorder who had made an oral or written statement of wishes and feelings; and 91 (14.0%) had encountered a patient with bipolar disorder who had made a lasting power of attorney relating to health or personal welfare. Of the 259 psychiatrists expressing an opinion, 208 (80.3%) considered that the number of people with bipolar disorder making ADRTs had remained the same since the implementation of the MCA in 2007, and 41 (15.8%) considered that it had increased by less than 10%. Of the 252 psychiatrists expressing a view regarding statements of wishes and feelings by people with bipolar disorder, 187 (74.2%) thought that the frequency remained the same since the MCA came into force, and 46 (18.3%) that it had increased by less than 10%.

Table 3 displays the binary multiple logistic regression associations between the quality of training and the discussion of ADRT with patients with bipolar disorder or other patients who may lose mental capacity but then regain it. Compared with average or poor training, good or better training was associated with fewer psychiatrists who never discuss ADRTs with patients, and fewer psychiatrists who believed that they had insufficient time to discuss ADRTs with patients. Table 4 shows that compared with only receiving one training session on the MCA receiving two or more training sessions was associated with more psychiatrists discussing ADRTs at care programme approach meetings and fewer psychiatrists who believed that they had insufficient training to discuss ADRTs with patients. There were no other associations between the quality of MCA training or number of MCA training sessions and reported practice or beliefs about implementing ADRTs.

Relationship between quality of training in the Mental Capacity Act 2005 and barriers to implementing ADRTs *a*

	Q uality of tr aining						
Never d iscuss ADRTs	96	21.5	48	32.9	0.53	0.3 5–0.79	0.010
Insuff icient time to do ADRTs	177	39.7	79	54.1	0.57	0.3 7–0.88	0.002

ADRTs, advance decisions to refuse treatment.

55 psychiatrists received no Mental Capacity Act training, 7 missing responses on quality of training and 3 missing responses on amount of training.

Relationship between amount of training in the Mental Capacity Act 2005 and barriers to implementing ADRTs *a*

	A mount of tra ining	Mu ltiva riate stati stics					
Di scuss ADRTs rout inely at care prog ramme app roach mee tings	77	16.6	11	8.7	2.372	1.17 –4.83	0.017
In suff icient tra ining to do ADRTs	178	38.3	80	63.8	0.41	0.27 –0.63	< 0.001

ADRTs, advance decisions to refuse treatment.

55 psychiatrists received no Mental Capacity Act training, 7 missing responses on quality of training and 3 missing responses on amount of training.

However, 206 (46.3%) psychiatrists would not discuss ADRTs even if the person with bipolar disorder or carer raised it, and even after good or better training 96 (21.5%) would never discuss ADRTs. Furthermore, 177 (39.7%) and 178 (38.3%) of psychiatrists still believed they had insufficient training and time to discuss ADRTs in clinical practice despite good or better training and two or more training sessions respectively.

Discussion

Although the need for training of psychiatrists and other clinical health staff in the MCA is often recommended or even required,^{1,3,4} and clinical guidelines also support the importance of considering the MCA in people with bipolar disorder,⁵ there is an assumption that all training is likely to help clinicians become more familiar with the MCA and that such training will improve attitudes and use in practice of the MCA by psychiatrists. We found that there was plenty of training in the MCA being offered to and taken up by psychiatrists at trainee and consultant level; 92% of trainee and consultant psychiatrists had received at least one training session on the MCA, with 50% receiving the training in the past year. Although 75% of psychiatrists rated their training in the MCA as good or better, ADRTs were only covered in 65% of the MCA training.

Psychiatrists preferred MCA training that was not didactic and merely information giving, rating training as good or better that utilised discussion of the MCA in relation to case summaries, used role-play, and covered topics such as ADRT, the assessment of capacity and the assessment of fluctuating capacity. Although the assessment of mental capacity was usually covered in MCA training, the topic of fluctuating capacity was rarely discussed, whereas the potentially challenging issue of ADRTs was discussed in only 39% of MCA training attended by psychiatrists. Therefore in the view of the authors, training of psychiatrists was rarely of sufficient quality to meet the needs of people with bipolar disorder under the MCA Training arranged by NHS trust was not perceived to be as good as training provided by the Royal College of Psychiatrists, law firms or other external agencies. The reasons for this view are unclear.

There was some evidence that good- or better-quality MCA training received by psychiatrists was associated with fewer psychiatrists reporting that they would never discuss ADRTs under any circumstances. Receipt of two or more sessions of MCA training was associated with an increased likelihood that ADRTs would be discussed routinely in

multidisciplinary care programme approach meetings. Both better quality and more training sessions were associated with a reduced likelihood that psychiatrists had insufficient time to address ADRTs. Although these data are associations and not a comparison of interventions delivered in a randomised controlled trial, there was some evidence that higher-quality training and more than one training session may be helpful in both improving the attitudes to and use in clinical practice of ADRTs by psychiatrists in patients with bipolar disorder or other patients who lose and then regain mental capacity. Another alternative explanation is that psychiatrists who are interested in helping people with bipolar disorder through the MCA attend more than one session of training and find better-quality training.

Nevertheless offering training in the MCA that psychiatrists perceive as good or better quality seems insufficient to improving their attitudes to ADRTs and their use in practice in people with bipolar disorder. Even after good or better training, 22% of psychiatrists would never discuss ADRTs under any circumstances, 46% would not discuss ADRTs even if the person with bipolar disorder or carer raised it, and 39% believed they had insufficient training and time to discuss ADRTs in clinical practice. These findings chime with the experience of people with bipolar disorder in a national survey we carried out² where neither knowledge nor use of ADRTs were associated with seeing a psychiatrist, although knowledge and use of ADRTs were associated with seeing other mental health professionals and attendance at peer support groups.

A strength of the survey was that to our knowledge it is the first of its sort inquiring into quality of training of psychiatrists and relating it to their attitudes and use of ADRTs with people with bipolar disorder. The survey was large, national and deliberately anonymised so that psychiatrists would feel able to comment frankly without any possible constraint. We judged that this advantage of the methodology outweighed the disadvantage that we do not know how many psychiatrists had the opportunity to take part in the survey but decided not to. We also do not know much about the characteristics of psychiatrists in terms of the demographic characteristics of who did or did not take part in the survey. A further limitation was that this survey was completed 4 years ago so the quality of training and use of ADRTs in clinical practice may have improved. Furthermore, by concentrating on MCA training in relation to ADRTs in bipolar disorder, we cannot comment on other aspects of MCA training on other forms of advance decision-making, application of ADRTs in people who are less likely to regain mental capacity and deprivation of liberty.

The findings confirm those of a 4-year re-audit study where increases in MCA training and improved documentation had a minimal impact on the recording of the MCA by psychiatrists in patient records.⁶ There seems to be some consistency in studies of advance planning that the therapeutic relationship between mental health professionals, including psychiatrists, and their patients is improved with advance planning.^{7,8} The House of Lords heard much evidence that the implementation of the MCA had failed to make much of an impact on clinical practice in the way that was intended, and made 39 recommendations to improve the implementation of the MCA.³ We have not had the opportunity to study the effects of these recommendations but note that none of these relate to the quality or amount of training that psychiatrists or other health professionals receive in relation to the MCA. The Academy of Royal Medical Colleges were asked to report on measures to improve the uptake of the MCA.^{3,4} So far it has organised educational events on the MCA but has not made recommendations on the content, form or amount or frequency of training that psychiatrists or other health professionals should receive in relation to the MCA.⁹

Therefore we conclude that there is a need to improve the quality of training that psychiatrists receive on the MCA so that fluctuating capacity and ADRTs are covered, and that techniques such as case summaries and role-play are employed to improve confidence and competencies of psychiatrists in its use. There may be a case for adding training in the MCA to mandatory training under the Mental Health Act section 22 training regulations. There is a need for further implementation research on ways to improve the knowledge and use of the MCA including ADRTs, by people with bipolar disorder or other conditions where capacity is lost and then regained, and also on how to improve the attitudes of psychiatrists and assist them further to discuss ADRTs with people who have bipolar disorder or similar conditions.

1.7.88 Assessing the second-hand effects of a new no-smoking policy in an acute mental health trust

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Abstract

Aims and method To examine whether a new no-smoking policy in an in-patient mental health setting had any effects outside of smoking cessation. Our hypothesis stated that a forced smoking ban for in-patients may result in an increased susceptibility for clinical incidents, aggression and lower admission rates. All patients admitted to adult in-patient mental health services in Coventry and Warwickshire Partnership NHS Trust were included in the analysis. Data 6 months post-implementation of the smoking policy (1 July 2015 to 1 January 2016) were compared with the same period 1 year prior (1 July 2014 to 1 January 2015). Patient demographics, admission rates, ward occupancy, average lengths of stay, numbers of reported incidents and use of the Mental Health Act 1983 (MHA) were compared.

Results We analysed 4223 admissions. We found a significantly increased number of admissions under the MHA ($P = 0.007$), a significantly greater number of reported smoking-related incidents ($P < 0.001$) and aggression-related incidents in the psychiatric intensive care unit ($P < 0.001$). However, we found no significant difference in capacity of in-patient wards ($P = 0.39$), admission length ($P = 0.34$) or total aggression-related incidents ($P = 0.86$).

Clinical implications Although further comparisons over longer time periods are necessary, our results suggest that enforced smoking cessation on acutely unwell psychiatric patients admitted to the most restricted environments may have some negative effects. Nicotine replacement therapy should be offered to all patients to minimise the risk of clinical incident.

Contents

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 - *Aims and objectives*
 - *Method*
 - * *Study location and Trust smoking policy*
 - * *Inclusion and exclusion criteria*

1

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Smoking rates among those with a mental illness are 70% higher than in the general population.¹ In fact, although the prevalence of smoking in the general population has decreased, this has not occurred for those with a mental illness.² In particular, the highest smoking rates are found in those acutely unwell with a psychiatric illness, in in-patient units.³⁻⁶

Multiple explanations for such high smoking rates within the mental health sector have been put forward, including symptom control and amelioration,⁷ boredom or loneliness,^{8,9} an increased propensity to experience more severe nicotine withdrawal symptoms than the general population,^{10,11} for relaxation in a stressful environment,^{9,12} a common genetic vulnerability⁵ or that people with a mental illness are less susceptible to anti-smoking messages.¹³

As a result of relatively higher smoking rates, people with a mental illness also have higher mortality rates than the general population. Tobacco use contributes significantly to causes of ill health and mortality in those with mental health disorders.¹¹ Individuals at particular risk are patients with schizophrenia, who have a life expectancy 20% shorter than the general population.^{14,15} Tobacco use can also affect the effectiveness of some psychiatric medication, necessitating increased dosages and therefore purporting a higher chance of side-effects.¹⁶

The UK government implemented its smoke-free policy in July 2007, which extended to all ‘substantially enclosed’ public and work places. This included hospitals, with the aim of reducing the impact of second-hand smoke on patients and staff.¹⁷ This was extended to all types of in-patient units from 2008.

Guidance from the National Institute for Health and Care Excellence (NICE), published in 2013, aims to support smoking cessation, temporary abstinence from smoking and smoke-free policies in all secondary care settings.¹⁸ In this guidance, ‘secondary care’ refers to all publicly funded secondary and tertiary care facilities, including buildings, grounds and vehicles. It covers in-patient, residential and long-term care for severe mental illness in hospitals, psychiatric settings, specialist and secure units.

Prior to the introduction of the legislation, a relatively large survey of National Health Service (NHS) staff found that a third of psychiatric staff disagreed with smoke-free legislation compared with only one in ten of general staff.¹⁹ A survey of mental health units in England in January 2007 found that the vast majority (91%) believed mental health premises faced particular challenges due to the high smoking prevalence among patients, associated safety risks, and potential interactions with antipsychotic medication.²⁰ However, despite the challenges, the smoke-free policy has been rated positive overall. Cited advantages include a reduced exposure of patients and staff to second-hand smoke, an enhancement and support in patients’ motivation to stop smoking, improved sleeping patterns among patients, and the conversion of former smoking rooms into new recreational spaces.²⁰

Since the development of non-smoking policies within the NHS, debate has evolved around any potential infringement this might have on a patient's human rights. A patient at one of Scotland's high-security forensic hospitals recently won a court ruling that a blanket ban on smoking breached his human rights.²¹ According to Article 8 of the Human Rights Act 1998, everyone has the right to respect for his private life and his home. With regard to mental health units, lengthy hospital admissions may qualify as breach of one's private and home life.

The introduction of a non-smoking policy to mental health services remains a relatively novel practice. We are yet to fully appreciate its impact on in-patient services. Coventry and Warwickshire Partnership NHS Trust in the UK introduced a no-smoking policy within its mental health units on 1 July 2015. The Trust is one of the first to implement this policy following the growing evidence of high smoking rates and adverse health implications within the mental health population. Although the benefits of smoking cessation are widely acknowledged, there exists an assumption that enforcing smoking cessation on unwilling patients results in increased stress levels and therefore higher rates of aggression-related incidents.

Voluntary admission to an in-patient mental health ward requires the patient to agree to certain ward policies and procedures explained by the clinician. Within the Trust it is standard procedure to explain the non-smoking policy for both voluntary and involuntary admissions. The impacts outside of smoking cessation caused by a forced no-smoking policy has previously been analysed in a medium secure unit, finding no significant difficulties and that the widely anticipated problems did not materialise.²² We have been unable to find another study analysing similar changes in a typical psychiatric unit (mixed voluntary and involuntary patients).

Aims and objectives

The aim of the study was to examine whether a newly implemented no-smoking policy for patients in a typical in-patient mental health setting had any effects outside of smoking cessation. The objectives were first to compare admission rates and bed occupancy/capacity levels at comparable time periods pre- and post-implementation of the new no-smoking policy in a specified mental health trust. We also sought to compare the numbers of reported incidents occurring on the wards at comparable time periods pre- and post-implementation, focusing particularly on aggression-related and smoking-related incidents. In addition, we wanted to ascertain whether there was any significant difference in the use of the Mental Health Act 1983 at comparable time periods pre- and post-implementation of the new policy, and whether this was related to the change in smoking policy.

Method

Study location and Trust smoking policy

Data were collected from all patients admitted to mental health beds in Coventry and Warwickshire Partnership NHS Trust during the 12 months before and 6 months after implementation of the smoking ban. The change in policy was implemented on 1 July 2015, therefore data were collected between 1 July 2014 and 1 January 2016. The Trust smoking ban states that 'all staff, patients and visitors are not able to smoke tobacco products in Trust buildings or on Trust land.'²³ The Trust maintains a policy of offering nicotine replacement therapy to admitted patients, comprising of either an e-cigarette or nicotine transdermal patch.

Adult in-patient mental health services in the Trust comprise of three acute psychiatric units: the Caludon Centre in Coventry (112 beds), St Michael's Hospital in Warwick (41 beds) and the Pembleton Unit in Nuneaton (12 beds), with adult rehabilitation services provided at multiple sites (40 beds), for a catchment area of around 850 000 people.

Inclusion and exclusion criteria

All patients admitted to adult in-patient mental health services, both acute and rehabilitation, in Coventry and Warwickshire Partnership NHS Trust were included in analysis. To account for seasonal variation, data 6 months post-implementation of the smoking policy (1 July 2015 to 1 January 2016) were compared with the same 6 months the year prior to implementation of the smoking policy (1 July 2014 to 1 January 2015). There were no specific inclusion criteria for diagnosis or length of admission to help prevent selection bias. All sites within the Trust were included in the analysis.

Ethics

The study was approved by Coventry and Warwickshire Partnership NHS Trust as a service evaluation and as such did not need formal ethical approval from an NHS research ethics committee. Data were collated in an anonymised format from routine clinical records, by the authors.

Data collection

First, basic demographic data such as mean age and gender were obtained. Second, monthly admission rates and ward occupancy levels between the dates were collected. Third, monthly total numbers of reported incidents were obtained. All data were collected by data analysts within the Trust.

Statistical analysis

For the count data (number of admissions under the MELA, total incidents, aggression-related incidents, psychiatric intensive care unit (PICU) incidents and smoking incidents), Poisson regression was used to generate a significance value. Where data were provided as percentages (i.e. capacity), we converted to mean n based on the total Trust capacity ($n = 205$). The Shapiro-Wilk test for normality allowed a decision as to whether to use parametric or non-parametric statistical comparisons. All statistical comparisons were made using IBM SPSS Statistics 24.

Since we were measuring six outcomes in our analysis, a Bonferroni correction was applied. The α -value (0.05) was therefore adjusted to a significance value of $P = 0.008$.

Results

Demographic data

Table 1 outlines the demographic data comparisons during our two selected periods of analysis. *Table 2* outlines the findings from our other objectives.

Demographic differences

	Pre-implementation	Post-implementation
n	2124	2099
Male, %	60.2	59.9
Age, years: mean	29.56	29.39

Data outlining differences before/after implementation of no-smoking policy

	Jul	Aug	Sep	Oct	Nov	Dec	Mean
Number of admissions under Mental Health Act 1983, <i>n</i>							
Before	143	144	145	171	169	173	157.5
After	207	184	141	174	188	169	177.2
In-patient ward capacity, %							
Before	101	102	100	101	104	104	102.0
After	104	101	102	104	98	101	101.7
In-patient ward capacity, mean <i>n</i>							
Before	207.5	209.1	205	207.5	213.2	213.2	209.3
After	217.2	207.5	209.1	213.2	200.9	207.5	209.2
Mean duration of stay, days							
Before	38.1	38.8	40.6	44.3	55.7	36.6	42.4
After	44.7	37.0	37.2	37.8	41.9	36.3	45.4
Total aggression-related incidents, <i>n</i>							
Before	105	87	59	48	82	88	78.2
After	76	92	51	93	79	90	80.2
Aggression-related incidents on PICU, <i>n</i>							
Before	24	16	16	22	21	13	18.6
After	32	20	35	25	37	29	29.6
Smoking-related incidents, <i>n</i>							
Before	9	7	9	7	2	5	6.5
After	38	19	17	12	9	26	20.2

PICU, psychiatric intensive care unit.

Number of patients admitted under the Mental Health Act 1983

Poisson regression found that the number of admissions under the MHA increased (1.13, 95% CI 1.03–1.23) at the boundary of our corrected α -value, $P = 0.007$, in the same 6 months the year following the introduction of the new smoking policy.

In-patient ward capacity

Our findings show that the bed capacity was at maximum or over-maximum at each month studied. Using the data adjusted into mean capacity, the Shapiro-Wilk test for normality ($P = 0.306$) allowed us to proceed with an unpaired t -test, which showed no significant difference ($P = 0.99$).

Average duration of in-patient admission in days

The Shapiro-Wilk test for normality ($P = 0.068$) allowed us to proceed with an unpaired t -test, which showed no significant difference ($P = 0.34$).

Total number of in-patient aggression-related incidents

Poisson regression revealed no significant difference in total aggression-related incidents following the introduction of the new smoking policy (1.02, 95% CI 0.90–1.12; $P = 0.70$).

Aggression-related incidents (PICU only)

Poisson regression revealed a significant increase in aggression-related incidents in PICU following the introduction of the new smoking policy (1.59, 95% CI 1.26–2.01; $P < 0.001$).

Smoking-related incidents

Poisson regression revealed a significant increase in smoking-related incidents following the introduction of the new smoking policy (3.10, 95% CI 2.55–4.46; $P < 0.001$).

Discussion

Main findings

We aimed to ascertain whether a new no-smoking policy for in-patients at a specified mental health trust might result in any less favourable effects outside of smoking cessation. We found a statistically significant increase in the number of admissions under the MHA, total number of reported aggression-related incidents on PICU, and a statistically significant increase in the number of reported smoking-related incidents. The majority of these findings may be expected. In consideration with our finding that in-patient bed capacity was at or over 100% for each of the months studied (potentially due to patients being ‘on leave’ from hospital but still named in beds), one might argue that the acutely stressed state necessary to be granted an admission into bedspace at a premium would have been of considerable severity. Such patients may also have been admitted against their will, further heightening stress levels. One may therefore consider that immediately and forcefully removing the right to smoking, a past-time that can bring comfort, reduce stress, ameliorate psychiatric symptoms and help to fight boredom, may be poorly timed.

Perhaps a more surprising finding is the statistically significant increase in patients admitted under the MHA. This was included as an outcome measure as it was hypothesised that patients may refuse informal admission based on the no-smoking policy. Although patient refusal for informal admission may have contributed to the effect, it is likely not the whole story, as that hypothesis relies on the provision of adequate information to patients, i.e. the new smoking policy is explained prior to admission. Other work²⁴ has shown that this is not always the case. It is also well known that detentions under the MHA have been on the rise across the UK over the past 10 years,²⁵ due to a multitude of factors (not smoking related) which we were unable to analyse in this study. In-depth case-note analysis may have allowed us to qualitatively ascertain whether the smoking policy played a part in this significant finding, and future research analysing this perhaps legitimate question could take this into account.

We found no significant difference in the total number of reported aggression-related incidents. At face value, this finding suggests that in an open-ward environment, the new smoking policy did not cause an increase in agitation or aggression, which contradicts the finding we obtained from PICU only. There are several possible explanations for this. First, the patients that are admitted to PICU are likely to be more acutely stressed than those admitted to an open ward and therefore the potential to cause an ‘incident’ might be increased. Second, the more strictly controlled environment in PICU may lend itself to better adherence of the smoking policy than for informal patients on an open ward (who may

be allowed out for ‘grounds leave’ each hour, or more), thus the new smoking policy may be felt more among patients on PICU. Third, there is the very likely possibility that not all incidents are reported. Incident reporting can sometimes be viewed as an arduous process, especially for staff with busy in-patient ward roles. Although this could affect the results both in the open-ward environment and on PICU, one could suggest that staff on PICU might be more familiar with and better trained to deal with incidents, thus incident reporting might be better adhered to.

We also found no significant difference in patients’ length of admission, suggesting that the new no-smoking policy did not positively or negatively affect the patient journey through mental health services. This might be an expected finding as the benefits of smoking cessation are known for long-term rather than short-term health. However, it is useful to address this result in light of our findings of increased smoking-related and aggression-related incidents, as it suggests that the new policy’s potential to predispose to aggression or agitation does not necessarily result in prolonged in-patient stay. We also found no significant difference in in-patient ward capacity, which could be expected considering capacity was at maximum or above maximum for each month studied.

Strategies and limitations

We believe this study is one of the first to assess the effects of a new no-smoking policy of psychiatric in-patients in the UK, in an age where the importance of physical health in psychiatric patients is becoming increasingly recognised, such that many more healthcare trusts may in future choose to adopt a similar policy. In using the entire sampling frame over a 6-month period, we have ensured a large sample size which may help to reduce the potential for type I or II statistical errors. We have reduced the impact of seasonal variation by comparing the same 6 months both in the year of introduction of the new no-smoking policy and the year preceding it. In comparing data across time, we can demonstrate a temporal association with the positive findings. Furthermore, regarding the new no-smoking policy being more strictly enforced on PICU, a dose-response relationship may be observed when comparing the non-significant open ward aggression-related findings with those obtained from PICU. In addition, we have included a range of measures that were chosen prior to commencing data collection.

There are however a number of limiting factors that should be taken into consideration. First and most importantly, we cannot show that the new no-smoking policy is causal to the positive findings. There could be many other causes for increased aggression-related incidents on PICU and it is therefore not clear how much (if at all) the change in smoking policy contributed. It is however less probable to consider reverse causality as a factor in this study, as it is unlikely that the no-smoking policy was enacted because of significant aggression-related incidents.

In addition, we are unable to determine the effect of any poor reporting practice on our findings. We have mentioned that reporting might be better in certain areas of in-patient psychiatric care than others which may skew our results and invalidate comparisons. Despite our efforts, we were unable to obtain a comparison of total number of reported incidents between the two time periods. This would have better highlighted the reporting practices in the Trust across the two time periods and may be useful for future work.

It may also be possible that the timing of our data collection may have affected the validity of our results. We chose to measure the 6 months immediately following the introduction of the new no-smoking policy. It is likely that group practice takes time to adapt and this may be an explanation for some of the negative findings in our results. It may have been more appropriate to choose a length of inclusion greater than 6 months to better visualise this, however we were limited by time and resources. Both adherence to the Trust smoking policy and the reporting of incidents (if common) may improve over time, and it therefore may be useful to repeat this study in the future to compare the results.

Finally, since our study only measured outcomes during in-patient stay, we were unable to ascertain any longer-term effects of the new smoking policy, such as the increased achievement of smoking cessation among patients admitted under the new no-smoking policy. Further work might seek to establish the longer-term effects of such a policy.

Other research has been carried out on this topic internationally, which correlates partially with our results. A 2002 systematic review²⁶ including studies from several countries found no significant behavioural effects when smoking bans were enacted in psychiatric units, although the review also notes that in the included studies, smoking bans were not associated with long-term smoking cessation among patients. More recently, a 2005 study²⁷ from the USA found no significant increase in aggression with the introduction of a new smoking ban. Furthermore, a survey²⁸ of mental health staff working at an Australian healthcare trust in 2013 found that although most staff preferred to work in a

smoke-free environment, around half of survey respondents found the smoking ban to be detrimental to acute patient care, which may give the impression of increased agitation or behavioural problems among patients involved.

Our results are therefore broadly in line with the findings of others. However, it is notable that we have shown a potential difference in the effects of a smoking ban on different patient groups across different settings. Further work might seek to clarify and further examine the reasons behind this finding.

Overall, the reasoning behind a smoke-free hospital environment is clear. The long-term health benefits of smoking cessation are numerous and well documented, and other work has shown staff to prefer a smoke-free working environment. However, there is the legitimate debate as to whether the acutely stressed state is the right time to impose this lifestyle change, and whether it is even ethical to do so. Our results show that, in general, a new smoke-free policy did not result in significant changes of reported aggressive behaviour or incidents, and did not affect the patient journey through mental health services. However, we found significantly increased smoking- and aggression-related incidents in more restricted environments. It is possible that the most highly agitated psychiatric patients are most susceptible to cause incidents with this enforced lifestyle change. Our finding of significantly increased use of the MHA may be explained by other factors, but also may warrant further research. Therefore, to reduce the impact this may have on both patients and staff tasked with dealing with any resultant incident, nicotine replacement therapy should be considered for all relevant patients.

The authors would like to extend their thanks to the data analysts of Coventry and Warwickshire Partnership NHS Trust for their support in obtaining the data used in this study, and to Pascal Perry-Cheung for his kind assistance.

1.7.89 A service evaluation of outcomes in two in-patient recovery units

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date

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Abstract

Aims and method To evaluate outcomes for patients during their admission or in the first year of treatment in two in-patient recovery units. Changes in health and social functioning, service use and need (rated by patients and staff) were evaluated.

Results In 43 patients treated, there was a large (30%) increase in patients discharged to their own tenancies, rather than supported accommodation. There was minimal change in Health of the Nation Outcome Scales (HoNOS) scores in the course of the admission but staff- and patient-rated unmet needs reduced and met needs increased. Needs changed mainly in domains relating to social functioning. Reductions in risk to self and others were rated by staff but not patients. There were no cases of patients being readmitted to acute hospital during the study period.

Clinical implications Although these results offer some support to the treatment approach described in these in-patient recovery units, further research in larger samples is needed to identify how these

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services can best be deployed to help individuals with severe mental illness and complex needs.

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 - * *Results and limitations of research*
 - * *Consideration of findings against previous research*

From the start of 2011 it was decided to develop greater understanding of the outcomes of the work of our two 2gether Foundation National Health Service (NHS) Trust recovery in-patient units, by evaluating outcomes assessed by staff and patients at admission, mid-point and discharge from the units. These services have in the past decade adopted a strong recovery-based model of practice, in line with the UK government policy *No Health Without Mental Health*.¹ A major strategic aim in this policy is for more people with mental health problems to recover, defined as: ‘a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live’.¹ The literature on personal recovery emphasises the individual journey in recovery, in which regaining hope, taking back control and finding new opportunities are key processes.² It has been argued that a transformation of mental health services is required for this to occur;³ mental health professionals recognising patients’ strengths and expertise as experts in their own health and acknowledging the importance of personal narratives, alongside other forms of evidence. The increasing focus in UK and international healthcare policy on recovery has occurred at a time of generally increasing personal autonomy in wider society while health services have shifted their focus towards helping every individual to make the most of their health, rather than relating mainly to those with illness.⁴

The recovery units studied provide active rehabilitation for 10 and 13 residents respectively. The units are remote from the main psychiatric hospital services but provide full in-patient support and are registered to take detained patients. The focus of the work in the units is with patients who have complex, severe mental illness, predominantly psychosis, characterised by treatment resistance and other complications. Treatment is provided through a full multi-disciplinary team and includes approaches to optimise health through use of medication, talking therapies including family work, guidance on healthy living, and treatment and support for substance use problems. A wide range of social approaches include help with daily living skills including budgeting, self-care, shopping and cooking, help with finances, benefits and accommodation, and support to develop interests and activity such as sport, leisure activities and work. The work in these units differs from acute in-patient work in focusing more on treating long-term, disabling mental health problems and impaired social functioning over longer time periods, rather than dealing with brief, episodic illness. Typical admissions last approximately 9 months, rather than just over 1 month in acute units (based on November 2016 2gether Foundation NHS Trust data).

The original model of the recovery units described was developed to help patients in their rehabilitation from long-stay hospitals,⁵ aiming to support patients with complex illness to reintegrate into the community. They have subsequently evolved to work mainly with patients who need longer-term rehabilitation after acute psychiatric admission or any

patients who have developed disability due to severe mental illness. Over the past 20 years in the UK, in association with NHS and local authority funding changes, there has been a disinvestment in these services,⁶ despite recognition in recent commissioning guidance⁷ that this form of treatment is needed as part of a spectrum of care provision in each district.

The evidence from research in this field has previously been reviewed,⁸ showing that in-patient recovery units can effectively support most patients accepted by them, the majority of whom can be resettled to less dependent community placements over a period of months or years. The research indicates that treatment in recovery units is associated with improvement in social functioning and social networks and reduced levels of negative symptoms in schizophrenia. Placements are associated with relatively few long-term readmissions. These findings have been replicated in other countries such as Australia, the USA Northern Ireland, Norway and Italy.⁹ The quality of the research evidence is however variable and there has been very little formal research carried out in this area.⁵ A recent study of outcomes 5 years after in-patient rehabilitation¹⁰ found that around 40% of patients had remained in stable accommodation or moved to independent placement and sustained this.

Although UK commissioning frameworks have consistently argued the need for services of this type to help patients with complex needs in their pathway from acute or secure hospital to the community, there still seems to be a shortage of appropriate residential places in some areas, particularly for those with the most severe and enduring mental health problems. A study of hospital services in Birmingham, UK,¹¹ showed that long-stay (more than 6 months) patients were consistently found to occupy 20% of acute beds. The authors noted that where staff made recommendations for community placements, 'by far the majority' required 24-hour residential care, suggesting a need to improve access to this sort of provision. A recent paper¹² noted that problems may arise from the fragmentation due to use of private sector psychiatry and made a strong case for local, well-organised, NHS rehabilitation services. A survey¹³ of English rehabilitation services showed that despite closures of nearly all NHS long-stay hospital beds, most areas still had active rehabilitation units available to help people with complex, treatment-resistant illness. In 93 local authority regions, most (77%) had short-term (up to 12 months) rehabilitation units, with an average of 13 beds. It appears that although services are available in most areas, the level of provision is variable and patchy. Hospital services in the UK continue to be under pressure and there are often suggestions of a need for more beds. However, it has been argued¹⁴ that alternatives to acute in-patient admission could reduce this pressure and that around one in four cases in acute units could be managed in a unit run by nurses or care workers.

Aims of the evaluation

This service evaluation aimed to describe, prospectively, aggregated outcomes for new residents over the duration of their admission or in the first year of treatment. The evaluation considered changes in health and social circumstances from admission to the units, to discharge or 1 year after admission. Utilisation of acute hospital treatment was monitored before and during treatment in the recovery units.

Method

This project was carried out as a service evaluation with a formal protocol and a project steering group which met regularly during the project's work. The County Research and Development Support Unit assessed and gave written agreement for the project, prior to commencement. The use of aggregated data was preferred to other methods, such as the use of within-participant findings. This was a pragmatic decision, as the introduction of routine outcome monitoring was hoped to improve and make more systematic individual care planning, as well as to enable individual and service-level evaluation of outcome. The measures used in the project were selected to support the new way of working.

Participants

At the point of admission to the unit, demographic and health-related data were collected for all patients, on a specially designed form. The patient's key worker rated the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) ¹⁵ and Health of the Nation Outcome Scales (HoNOS) ¹⁶ scores at the time of admission. CANSAS forms were given by key workers to patients for self-completion, with an explanation about how to complete them. Key workers were instructed to ensure that patient rating of need was independent of their own rating and access to support from local advocacy services was offered if this was considered helpful. Where a carer had a significant role with the patient, this individual was also approached to assess the needs of the patient (with consent, following the usual clinical permissions pathway).

To be included in the evaluation, patients were required to have continuous treatment for a minimum of 3 months in one of the units. This was to ensure that patients who were occasionally admitted briefly from the acute ward, due largely to problems such as homelessness leading to delays in discharge, but were not assessed to require the therapeutic approach of the recovery unit, did not bias the sample. It was also felt that patients discharged before 3 months would not have had time to engage meaningfully with the therapeutic work of these services.

The same ratings were repeated 6 months after admission and at discharge, or at the end of the first year of treatment. Demographic and health-related data were collected at the point of discharge from the unit or at the end of the first year of admission.

Measures

The CANSAS ¹⁵ rates need as 'absent' (no problem), 'met' (problem addressed by services) or 'unmet' (significant, ongoing problem) across 22 social and healthcare domains. The HoNOS ¹⁶ is a 12-item scale that rates various aspects of health and social functioning on a 5-point Likert scale to measure levels of problem severity.

Data management

At admission, patients were allocated a number for identification purposes and from this time all data were held anonymously, with the identification number only used on forms, held securely by the unit administration lead, who managed the data collection processes. Data sheets were held in a locked office in secure filing cabinets or on a password-protected Trust PC.

Statistical analysis

C.F. advised on the use of descriptive, demographic and illness-related information and the analysis of change scores from admission to discharge using aggregated HoNOS scores and CANSAS total, met and unmet need total scores. Data were entered into SPSS for analysis (SPSS version 18 for Windows). Non-parametric Wilcoxon matched pairs signed ranks tests were used to assess changes in mean HoNOS and CANSAS ratings.

Ethical consideration

This work was an attempt to evaluate whether the recovery units were effective in their intended work. It was a service evaluation and did not have a randomised controlled design. Information was collected as part of the work of the units and it was used at an individual level to more systematically understand patient need and plan treatment. There was no intention to use experimental tools or to compare units or employ a control group. As a result of the design it was noted that results would not be generalisable, although it was hoped that they may be of value at a time of greater attention to treatment outcomes and considering issues of service quality and innovation. Patient consent was not formally taken but was considered to be given by participation, where patients gave individual ratings of need and this was always explained to be optional and unrelated to the rest of the patient's treatment. Prior to starting the project, the need for

formal ethics committee submission was considered by our County Research Support Unit, which advised that this was not required and gave written approval for the project.

Results

Data collection was carried out in the two units from April 2011 to June 2014. During that time a total of 43 patients were admitted for a period of at least 3 months. Data were collected on the patients over this period, the gaps in data being largely due to the challenges of managing data collection within a standard clinical setting, rather than (with the infrastructure permitted by research funding) as a research project. Gaps in the data-set are reported within the results presented below. These related often to patient choice and willingness to participate in routine data collection. Although access to advocacy was freely available and advocates were working regularly in both units through the project, we do not know how often they provided specific support to patients in completing outcome measures. We believe this was rare and in the great majority of cases patients completed forms independently or with minor support from staff.

The study group of 43 patients included 28 (65%) male patients, aged 18–62 years (mean 36.5, s.d. = 10.3); 39 (91%) were single, 2 (5%) married and 2 (5%) divorced. Most patients ($n = 23$, 53%) were admitted from an acute psychiatric ward, the remainder ($n = 20$, 47%) direct from the community. In the year prior to the recovery unit admission, patients had spent a mean of 20.7 weeks (range 0–52, s.d. = 24.5) in a psychiatric hospital. Patients had experienced a mean of 1.0 admissions in the year before entering the recovery unit (range 0–4, s.d. = 0.55).

At the time of admission all patients were unemployed, and 23 (53%) lived in supported accommodation, 19 (44%) in their own tenancy and 1 (2%) with family. Overall, 27 (63%) were under an assertive outreach team, 11 (26%) under a community recovery team (community mental health team) and 5 (12%) under early intervention services.

Patients spent a mean of 380 days (s.d. = 177) in the recovery units; there were no recorded episodes of acute psychiatric readmission during this time. In total, 38 of discharges (74%) were planned and 5 patients (12%) were discharged for other reasons.

At the time of discharge, 42 (98%) were unemployed, 1 patient being a part-time student. Overall, 32 (74%) had their own tenancy, 4 (9%) were living in supported accommodation and 2 (5%) were living with family. In total, 29 (67%) were under an assertive outreach team, 11 (26%) under a community recovery team and 3 (7%) were under early intervention services.

The main changes over the course of this evaluation were: there was a small increase in employment following treatment in the units; there was a 30% increase in patients living in their own tenancy; and some patients were taken over by assertive outreach teams during their admission, mostly moving from early intervention teams.

No individuals were readmitted to acute in-patient care during their recovery in-patient admission.

Baseline and final mean HoNOS and CANSAS met/unmet need scores are presented in *Table 1*.

Mean HoNOS and CANSAS ratings at baseline and discharge/12-month follow-up

	Baseline rating Mean (s.d.)	Discharge/12-month rating Mean (s.d.)	Wilcoxon signed ranks 2-tailed test
HoNOS	19.9 (8.2)	18.5 (9.0)	Z= 1.46, P>0.05
Staff-rated CANSAS met need	7.2 (4.3)	7.3 (3.9)	Z= 0.41, P>0.05
Staff-rated CANSAS unmet need	3.7 (3.6)	3.4 (3.0)	Z= 0.76, P>0.05
Patient-rated CANSAS met need	3.9 (4.5)	4.8 (4.4)	Z= 1.39, P>0.05
Patient-rated CANSAS unmet need	2.8 (3.3)	2.2 (2.5)	Z= 1.32, P>0.05

HoNOS, Health of the Nation Outcome Scales; CANSAS, Camberwell Assessment of Need Short Appraisal Schedule. CANSAS scores by domain at baseline and discharge/12 months are represented in *Table 2* for patient ratings and *Table 3* for staff ratings.

Patient CANSAS ratings of met, unmet and no needs by domain at baseline and discharge/12 months

	Met need	Unmet need	No need	Total completed CANSAS ratings			
Social life	5	13	8 (28)	13	10	3 (10)	11
Psychological distress	7	12	5 (17)	10	6	4 (13)	13
Physical health	10	12	2 (7)	6	5	1 (3)	15
Intimate relationships	5	3	2 (7)	9	14	5 (17)	16
Daytime activities	10	16	6 (21)	10	4	6 (21)	9
Sexual expression	3	4	1 (3)	10	10	0 (0)	16
Accommodation	9	19	10 (33)	8	1	7 (23)	13
Psychotic symptoms	11	14	3 (10)	11	7	4 (13)	9
Safety to self	9	6	3 (10)	4	2	2 (7)	18
Information on treatment	18	23	5 (16)	2	2	0 (0)	11
Enough food	14	18	4 (13)	2	3	1 (3)	15
Use of public transport	7	3	4 (13)	4	7	3 (10)	19
Basic education	2	8	6 (19)	2	0	2 (7)	27
Budgeting	8	8	0 (0)	5	10	5 (16)	18

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Table 18 – continued from previous page

	Met need	Unmet need	No need	Total completed CANSAS ratings			
Safety to others	3	1	2 (7)	0	1	1 (3)	27
Care of home	8	15	7 (23)	3	3	0 (0)	12
Self-care	11	10	1 (3)	3	2	1 (3)	17
Non-prescribed drugs	4	2	2 (7)	2	1	1 (3)	25
Benefits taken up	9	10	1 (4)	1	4	3 (12)	16
Use of telephone	4	5	1 (3)	0	0	0 (0)	27
Alcohol problems	2	4	2 (7)	4	1	3 (10)	25
Childcare	2	1	1 (3)	1	0	1 (3)	27

CANSAS, Camberwell Assessment of Need Short Appraisal Schedule.

Staff CANSAS ratings of met, unmet and no needs by domain at baseline and discharge/12 months

	Met need	Unmet need	No need	Total completed CANSAS ratings			
Social life	12	18	6 (15)	18	16	2 (5)	10
Psychological distress	19	21	2 (5)	11	8	3 (8)	8
Physical health	18	20	2 (5)	7	7	0 (0)	14
Intimate relationships	7	3	4 (13)	13	16	3 (9)	12
Daytime activities	22	23	1 (3)	16	13	3 (8)	2
Sexual expression	8	3	5 (18)	10	13	3 (11)	10
Accommodation	12	21	9 (23)	13	9	4 (10)	15
Psychotic symptoms	20	23	3 (8)	18	14	4 (10)	1
Safety to self	19	10	9 (23)	4	4	0 (0)	16
Information on treatment	27	33	6 (15)	2	0	2 (5)	12
Enough food	20	22	2 (5)	3	2	1 (3)	17
Use of public transport	7	4	3 (8)	6	7	1 (3)	24
Basic education	7	11	4 (10)	1	0	1 (2)	33
Budgeting	17	13	4 (10)	9	13	4 (10)	13

conti

Table 19 – continued from previous page

	Met need	Unmet need	No need	Total completed CANSAS ratings			
Safety to others	17	7	10 (25)	2	2	0 (0)	21
Care of home	11	15	4 (11)	12	10	2 (6)	13
Self-care	19	17	2 (5)	6	7	1 (2)	16
Non-prescribed drugs	14	5	9 (23)	2	3	1 (3)	24
Benefits taken up	20	22	2 (6)	1	0	1 (3)	13
Use of telephone	5	7	2 (5)	0	0	0 (0)	36
Alcohol problems	15	13	2 (5)	6	4	2 (5)	20
Childcare	3	4	1 (3)	1	1	0 (0)	35

CANSAS, Camberwell Assessment of Need Short Appraisal Schedule.

There were improvements in patient-rated met needs in domains relating to accommodation, social life, care of the home and daytime activity, most other domains showing no change or minor increases and decreases. There were reductions in patient-rated unmet needs in accommodation, daytime activity budgeting and intimate relationships, with about half the domains showing minimal change. It can be seen that the main changes in patient-rated need were in domains relating to social functioning.

There were increases in staff-rated met needs in domains relating to accommodation, social life and information about treatment. Apparent reductions in staff-rated met need in the domains safety to others, safety to self and use of non-prescribed drugs appeared to be explained by comparable increases in levels of 'no need' in these domains. Staff-rated unmet needs showed smaller levels of change, the domains which reduced most being accommodation, daytime activities and psychotic symptoms.

Discussion

We have shown that it is possible as part of routine clinical outcome measurement to assess longitudinal outcomes in a standard recovery in-patient setting, using staff- and patient-rated measures. The results included some gaps in data which were due largely to patients declining to complete CANSAS ratings of need or incomplete participation by staff members. However, the results seem likely to be reasonably representative of the patients admitted to the units over this time, other than those patients who were admitted and then discharged or readmitted to the acute ward within a short time (these patients were excluded from the study population).

Results and limitations of research

We found minimal change in HoNOS scores in the course of the recovery unit admission but overall staff and patient assessed unmet needs tended to reduce and met needs tended to increase, although not at a statistically significant level. This may have related to the relatively small sample size. The main changes in need found over the study period rated by staff and patients related to improved social functioning, a finding which accords with the primary clinical aims of these services; to help individuals to regain life skills lost through periods of severe illness and ideally to try to achieve the most independent living situation possible. Our evaluation included patient and staff evaluations of need, both being included as the research indicates that they differ, and that the patient's perspective may be particularly important.¹⁷ The reduction in staff-assessed risk to self and others was encouraging and may have linked to reduced substance misuse, as these units have a strict drug-free policy and during admission patients are supported to remain drug free. A recent survey¹⁸ of in-patient rehabilitation units in Birmingham, UK, found chronically high levels of

problematic and socially inappropriate behaviours and suggested that new approaches, focusing on engagement and the management of challenging behaviour, may be helpful.

A number of limitations result from the method of this service evaluation. There was no control group and, as a result, the findings cannot be generalised. We are only aware of the existence of one, small, randomised controlled trial in this area,¹⁹ and arguably this type of research is not really feasible in this setting,⁵ although it remains vital to learn more about outcomes in these important and relatively expensive services. The numbers in our study group were small and it would be helpful to compare our results with studies using similar outcome measures in other settings, ideally with larger patient groups. Further limitations arise from the lack of data relating to progress at different time points during the treatment in the recovery units: it is possible that greater benefits occur early or later in the treatment process, which we were unable to evaluate. The scales used allow limited understanding of the patient experience, which could be more fully accessed through the use of qualitative studies and a number of tools assessing aspects of patient-rated recovery are now available.²⁰ Qualitative studies in this area have emphasised the importance of choice and autonomy for many patients²¹ and have shown the potential for personal recovery to be facilitated through appropriate supported living accommodation.²²

Of interest, poorer outcomes were associated with non-adherence to medication and our finding that most patients were discharged to assertive outreach teams suggests that many patients will continue to need a high level of support following treatment in recovery units. A recent study using retrospective care records⁹ found significantly reduced hospital admission 2 years after in-patient rehabilitation and that a substantial proportion of the sample went into more independent living. We found a large increase (30%) in the number of patients discharged to their own tenancies, rather than supported accommodation.

Consideration of findings against previous research

At a time of increasing pressure on in-patient services, our findings accord with previous research²³ suggesting that alternatives to acute in-patient care could reduce this pressure and that many cases could be managed in facilities such as recovery units. More than half the admissions to our in-patient recovery units were from acute wards and their ability to manage cases effectively without return to hospital and, most importantly, achieve clinical improvements, emphasises the importance of having these services available in each region/district where acute units operate. Our findings were in line with previous research¹⁴ showing improved outcomes in terms of accommodation and stable social functioning following treatment in recovery units. It is important to have a long-term perspective due to the ongoing, high levels of chronic morbidity in this population.¹⁰ There is a continuing need for different types of supported accommodation, although in our study a substantial number progressed to fully independent living.

Research in supported accommodation has been classified⁵ into three domains: quality of care; external evaluation and quality of life; and subjective satisfaction by the resident. In terms of quality of care, the most important factors appear to be the effectiveness of an individually centred, targeted programme of care and the quality of the physical environment. A systematic review of the quality of care in longer-term mental healthcare settings²³ found eight domains of institutional care that were key to recovery: living conditions, interventions for schizophrenia, physical health, restraint and seclusion, staff training and support, therapeutic relationship, autonomy and patient involvement. The two units investigated have both embraced the recovery approach, working alongside patients in pursuit of their goals and promoting autonomy and empowerment of the individual. Previous research²⁴ has shown that quality of care is heavily determined by the personality and orientation of project leaders and staff working in these units drew on extensive experience of local rehabilitation/recovery work, which has resulted in three major reviews and redevelopment of services and extensive staff training in recovery methods. The units were both accredited as 'excellent' in 2016 within the rehab-AIMS national benchmarking of rehabilitation units.²⁵ However, the results in our study show that the patient population is highly disabled with high levels of need and high usage of hospital care. Our results, showing clinical stability alongside progress in personal and social domains, was encouraging and hopeful. These units support many patients who due to their illness have difficulty creating their own structure, with consequent loss of internal security and often associated fears of losing control. The provision of support, treatment and therapeutic approaches available 24 hours provides an important support²⁶ which enables patients to feel stable, secure and then able to progress with rebuilding their lives. It is however important to consider differences between professional and patient preferences. When asked their view, patients have tended to prefer the option of their own, independent accommodation²⁷ over

rehabilitation or supported accommodation. Family members tend to align with the professional view and prefer their relatives being cared for in staffed environments.²⁸ An important criticism of staffed settings is the potential for institutional regimes and a poor rehabilitative culture, which could impede independence and autonomy.²⁹ Conversely, some patients and family members have reported that independent tenancies can be socially isolating²⁷ and it seems that many patients benefit from treatment in these units, particularly if they maintain a collaborative approach and provide a wide range of therapeutic options.

We would like to thank the recovery units' staff and patients for their support with this project and for completing the necessary rating scales required. We thank Natasha Wallace for her administration and support more widely for the project.

1.7.90 Weekend new patient reviews in psychiatry: evaluation of activity over 3 months

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date

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Abstract

Aims and method South West London and St George's Mental Health NHS Trust developed a system of weekend new patient reviews by higher trainees to provide senior medical input 7 days a week. To evaluate the effectiveness of these reviews, the notes for all patients admitted over 3 months were examined. The mean length of stay for patients before and after the introduction of the weekend new patient reviews were compared via unpaired *t*-test.

Results A total of 88 patients were seen: 84.4% of patients were seen within 24 h of admission. Higher trainees instituted some changes in 78.9% of patients. The most frequent action was to modify medication, in 47.8%. The average length of stay after the introduction of weekend reviews was not significantly different.

Clinical implications Weekend reviews of newly admitted patients by higher trainees is a feasible method for providing senior input to patients admitted out of hours.

Contents

- *Weekend new patient reviews in psychiatry: evaluation of activity over 3 months*
 - *Method*
 - *Results*

1

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– Discussion

* Conclusions

Medical specialties of various types are increasingly being requested to deliver senior-led care throughout weekends and bank holidays. This 7-day working is felt to be potentially beneficial for patient care and has been started by many acute specialties. The Academy of Medical Royal Colleges released a report in 2013 outlining how this could be achieved for different specialties, including psychiatry.¹ They recommended that 21–30% of psychiatric in-patients would benefit from a daily consultant-led review; mainly those who have been newly admitted or are clinically unstable. They stated that all new admissions, especially those under the Mental Health Act 1983, should receive a review the following day to initiate a treatment plan, including medication, observation levels, physical and psychosocial investigations and referrals.

The Academy of Medical Royal Colleges also advised that their recommendations were considered in light of the requirements of the local organisation as practice is likely to vary depending on geographic location, organisation size, on-call staffing and number of in-patient units. They also acknowledged that to achieve these outcomes, certain interventions and investigations would need to be available, such as pathology access.

Method

South West London and St George's Mental Health NHS Trust developed a system of weekend ward reviews led by higher trainees with consultant advice. The higher trainees in the Trust were on a full-shift on-call rota with 09:00 h to 21:00 h shifts on weekends and bank holidays. Patients admitted out of hours on Fridays, Saturdays or up to 09:00 h on Sunday morning are reviewed by the on-call higher trainee the next day. Patients admitted after 09:00 h on Sunday are reviewed on Monday by the ward team, unless it is a bank holiday, in which case they are reviewed by the higher trainee on call that day. After the higher trainee has completed their reviews for a given site, they contact the on-call consultant to discuss the cases and ensure the management plans instituted are appropriate. This occasionally led to changes in treatment plan. This provides an opportunity for supervision and training and ensures consultant input. The role of the reviews was to ensure that the patients received prompt assessment by a senior clinician and a comprehensive management plan could be instituted. They were not intended to facilitate immediate discharge, although it was hoped that earlier treatment would reduce the time patients had to spend on the ward.

To evaluate the activity involved in the weekend new patient reviews, the notes for all patients admitted between 17:00 h on Friday and 09:00 h on Sunday between 1 January 2016 and 31 March 2016 were identified via the RiO system used by the Trust. This provided information regarding the timing of their admission. The clinical notes of each of these patients were examined to determine the reason for their admission, when they were seen by the on-call higher trainee, the diagnosis made and any actions taken as a result of the weekend review. The mean length of stay for patients admitted between 17:00 h on Friday and 09:00 h on Sunday and 1 January 2015 to 31 March 2015 were also compared via unpaired *t*-test. The number of serious untoward incidents in each time period was also compared via Mann–Whitney *U*-test.

Results

A total of 88 patients were seen over the 3-month period. This equates to 6.8 patients appropriate for senior review each weekend.

Of those admitted, 46 (52.3%) were male. The average age was 41.9 years (range 18–84, s.d. = 17.8). For males the average age was 41.4 years (range 18–84, s.d. = 19.6) and for females it was 42.5 years (range 19–83, s.d. = 15.9). These differences were not significant on *t*-test.

The time from admission to senior review is indicated in *Table 1*. A total of 11 patients were not seen at all. Of these, 4 were admitted via the 136 Suite in the Trust.

Time from admission to senior review

Review within	Number of patients	Cumulative number	Cumulative percentage of patients seen
12 hours	17	17	22.1
24 hours	48	65	84.4
36 hours	8	73	94.8
48 hours	4	77	100

Diagnoses were made by the higher trainee in 73 patients. The other 15 patients were diagnosed during later assessments. These diagnoses are shown in *Table 2*. There were no significant differences between patients diagnosed by the higher trainee or at a later point on two-tailed *z*-tests.

Diagnoses made by higher trainees, the diagnoses of patients not seen or not diagnosed by the higher trainee

	Diagnosed by higher trainee	Diagnosed subsequently	Total diagnoses			
Psychosis	31	42.5	8	53.3	39	44.3
Depression	17	23.3	7	46.7	24	27.2
Mania/hypomania	7	9.6	1	6.7	8	9.1
Alcohol or substance misuse	7	15.6	1	6.7	8	9.1
Personality disorder	12	2.6	3	20	15	17
Anxiety and stress-related disorders	2	1.3	2	13.3	4	4.5
Eating disorder	1	5.2	1	6.7	2	2.3
Developmental disorders	4	1	2	13.3	6	6.8
Physical illness	1	1.3	0	0	1	1.1
Unclear	1	1.3	1	6.7	2	2.3

The interventions made or recommended by higher trainees for the 77 patients reviewed during weekends are shown in *Table 3*. This does not include them indicating their agreement with actions made by clinicians who saw the patients before them. Again, the number of interventions shown exceeds the number of patients.

Interventions made or recommended by higher trainees as a result of weekend new patient reviews

Intervention	Total, <i>n</i>	%
Start medication		

continues on next page

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Intervention	Total, <i>n</i>	%
Regular antipsychotic	8	10.4
As required antipsychotic	2	2.6
Mood stabiliser	1	1.3
Antidepressant	8	10.4
Sedation	5	6.5
Hypnotic	3	3.9
Physical medication	3	3.9
Nicotine replacement	1	1.3
Total in which medication started	24	31.2
Increase medication		
Regular antipsychotic	1	1.3
Antidepressant	2	2.6
Sedation	3	3.9
Other psychotropics	1	1.3
Stop medication		
Antipsychotic	1	1.3
Sedation	1	1.3
Opiate replacement	1	1.3
All	2	2.6
Total medication changes	37	47.8
Recommended interventions		
Regular antipsychotic	2	2.6
Psychotherapy	3	3.9
Electroconvulsive therapy	1	1.3
Social interventions	1	1.3
Leave	1	1.3
Transfer	1	1.3
Other specific assessments	3	3.9
Discharge	2	2.6
Recommendation for Mental Health Act assessment	2	2.6
Physical investigations	8	10.4
Physical monitoring or treatments	8	10.4
Total physical health interventions	11	14.3
Transfer to psychiatric intensive care unit	3	3.9
Change in observations	3	3.9
Urine drug screen	3	3.9

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Intervention	Total, <i>n</i>	%
Specific advice or information	3	3.9
Obtained collateral information	2	2.6
No action	17	22.1

The length of stay for patients admitted between Friday 17:00 h and Sunday 09:00 h between 1 January and 31 March in 2015 was 26 days (s.d. = 37) and for the same period of time in 2016 the length of stay was 28 days (s.d. = 43). This was not significant.

The number of serious untoward incidents between January and March 2015 was 13, and during the same period in 2016 it was 28; this was significant ($P = 0.0652$). However, when serious untoward incidents were limited to those occurring in acute services and out of hours, there was 1 incident between January and March 2015 and 3 incidents in the same time period in 2016; these numbers were too low to be analysed and so did not reach significance.

Discussion

A substantial number of patients, 88 in total, were eligible for weekend review over the 3 months covered by the service evaluation and 77 of these were actually seen. A substantial minority of those not seen were admitted through the Trust's dedicated 136 Suite. This mode of admission may be a weak point in the current system, possibly as a patient detained to the suite could be viewed as having been admitted at that point, despite still awaiting formal assessment and possible admission. Patients admitted via the 136 Suite should still have been reviewed the following day.

Of those patients seen by the higher trainees, the vast majority (84.4%) were seen within 24 h and most of the rest, up to 94.8%, were seen within 36 h. Many of those seen between 24 and 36 h had been admitted during the morning on a Saturday and the higher trainee was unable to see them until the afternoon on Sunday. A small number (5.2%) were seen after 36 h had elapsed. The reasons for this are unclear but could be as a result of temporary limited provision of higher trainee cover due to illness.

The characteristics of the patients admitted do not appear to be remarkable, although it would have been useful to have a comparison group of patients admitted during the week to determine whether there were significant differences between the two, in terms of demographics, admission reason and diagnosis. It is unclear why some higher trainees did not formulate diagnoses for the patients they reviewed, but there appears to be no significant differences between those diagnosed during the weekend or following later assessments.

Higher trainees performed or recommended a wide variety of interventions for patients, instituting some changes in 78.9% of cases. The most frequent action was to start some form of medication; this was done for 31.2% of patients. If increasing and stopping medication is also considered, then medication changes were performed in 47.8% of cases seen by the higher trainees. These were in addition to prescriptions made by admitting core trainees.

The next largest group of interventions were recommended physical investigations and interventions, again, which had not been instituted on admission. This occurred in 14.3% of patients reviewed. These varied from instituting monitoring of fluid and food intake to obtaining specific investigations, such as lithium levels.

A variety of other interventions were performed. It is reassuring that only 2 patients needed to have a recommendation for detention under the Mental Health Act completed. The others appear to be appropriately informally or already detained under the Mental Health Act. The limited number of discharges would be at least partially explained by this not being the proposed aim of the weekend reviews.

In 22.1% of patients seen over the weekends no action was taken by the higher trainee. This could be due to all reasonable interventions already having been performed by an experienced core trainee or patients requiring a period of observation before any definitive management plans are made.

Despite these interventions being initiated earlier than expected, there was no change in the average length of stay for patients who were eligible for new patient reviews. This could be explained by the interventions only being delivered

24–48 h earlier than they otherwise would have been. The reviews were also not intended to facilitate immediate discharge. A greater focus on expediting discharge over the weekend may have led to a reduced length of stay.

Although the overall number of serious untoward incidents was significantly higher in 2016 than 2015, there was no significant difference when they were restricted to those associated with acute out-of-hours services which would appear most clearly related to the introduction of weekend new patient reviews. The overall increase in incidents may be due to a continuing Trust drive to improve reporting with a view to improving services, rather than a true increase and so the figures are difficult to interpret accurately in this context.

This system did not require any changes in rota patterns for higher trainees. The system was such that the reviews were carried out during the scheduled 09:00 h to 21:00 h shift, with reviews ceasing at 21:00 h so that patients could rest adequately without their evening or night being disrupted. On rare occasions when all the planned reviews could not be completed, they were postponed until the next day. Furthermore, as mentioned above, the focus of the reviews was not discharge; this prevented difficulties in coordinating with social care and other agencies during the weekend. The system used by the Trust enabled it to provide senior medical input 7 days a week in acute services without disrupting weekday working or leading to any of the other concerns raised by some authors.²

Conclusions

There has been increasing emphasis on providing more senior weekend medical input across all specialties.¹ In psychiatry, the recommendations were mainly in terms of newly admitted patients.

Weekend reviews of newly admitted patients by higher trainees, with consultant support, is a feasible and appropriate method for providing senior input to these patients who could potentially remain on a ward for more than 48 h without being seen by any clinician more senior than a core trainee. This would not be considered appropriate in any other medical specialty. If we are to be committed to parity of esteem in healthcare, then it is reasonable for patients admitted to psychiatric wards to be reviewed by a senior clinician within 24 h, as they would in any other hospital.³ This is particularly pertinent as the higher trainees provided some intervention in most patients, modifying medications in just under half of those admitted. It may be valuable to determine how this compares with patients reviewed during medical or surgical post-take rounds.

1.7.91 New models of care: a liaison psychiatry service for medically unexplained symptoms and frequent attenders in primary care

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date

2017-12

Abstract

Aims and method This paper describes the process of setting up and the early results from a new liaison psychiatry service in primary care for people identified as frequent general practice attenders with long-term conditions or medically unexplained symptoms. Using a rapid evidence synthesis, we identified existing service models, mechanisms to identify and refer patients, and outcomes for the service. Considering this evidence, with local contingencies we defined options and resources. We agreed a model to set up a service in three diverse general practices. An evaluation explored the feasibility of the service and of collecting data for clinical, service and economic outcomes.

Results High levels of patient and staff satisfaction, and reductions in the utilisation of primary and secondary healthcare, with associated cost savings are reported.

Clinical implications A multidisciplinary liaison psychiatry service integrated in primary care is feasible and may be evaluated using routinely collected data.

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 - *Future proposals*

Medically unexplained symptoms (MUS) and comorbid physical and mental health conditions place a significant burden on individuals and the economy.^{1,2} Annual costs of MUS have been estimated at £3.1 billion³ and of comorbid conditions at £18 billion.⁴ Policy makers suggest innovative approaches be deployed to improve care for patients and make savings across the system.⁵

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These patients frequently return to general practitioners (GPs) with unresolved and new complaints. Despite being referred to specialist services their problems remain, which is demoralising for all. Current primary care configurations do not adequately provide for this population. Standard secondary care mental health services rarely have staff with relevant expertise and are insufficiently close to primary care services to influence presentations. Improving Access to Psychological Therapies (IAPT) services are unsuitable due to these patients' high level of medical complexity. Access problems are further compounded by patients not meeting the referral criteria for specialist mental health services.

The skill base in liaison psychiatry services renders them an ideal source of expertise. Until recently such services were hospital-based but they can be integrated within primary care services.⁶⁻⁸ We report a novel pilot primary care liaison psychiatry service – the Primary Care Wellbeing Service (PCWS) in Bradford and Airedale, West Yorkshire. The service was targeted to frequent attenders with MUS or psychological difficulties associated with their underlying long-term conditions. This report is a description of the planning, set up and evaluation and feasibility of the preliminary project.

Method

A partnership board of clinical experts, academics and commissioners met monthly to develop and have oversight of the service; the original impetus came from local Clinical Commissioning Groups (CCGs).

A rapid evidence review helped identify service models, staffing and skill mix, patient selection and outcome measures for the service. Review findings in the context of local practitioner preferences and resources were used to agree the service configuration. The Project Board secured 15 months' funding for the preliminary project. An evaluation by the Commissioning Support Unit (CSU) assessed the feasibility of service design, implementation, collecting the data and effectiveness.

Data collection

Electronic patient health records (primary and secondary care and mental health) and measures of patient-reported outcomes, experience, and staff experience, were collected as follows: Healthcare utilisation: defined as any patient event recorded in the electronic record system; a specific Read code for the service was applied to the patient record at each practice and anonymised data extracted for 12 months prior to and 9 months following referral for secondary care data, and 11 months following referral for primary care and mental health data, providing healthcare activity and costs. Clinical effectiveness: at referral and then every 2 months during follow-up using the 9-item Patient Health Questionnaire (PHQ-9),⁹ 15-item Patient Health Questionnaire (PHQ-15),¹⁰ 7-item Generalised Anxiety Disorder scale (GAD-7)¹¹ and the EuroQol 5-dimension, 5-level health status measure (EQ-5D-5L).¹² A clinician-reported outcome measure assessed perceived improvement in the patient's condition by referring clinician. Staff experience: a referrer satisfaction scale, 6 months after the referral or at patient's discharge from the PCWS; and a survey administered at the end of the pilot. Patient experience: a brief patient-reported measure at discharge comprising (a) patient satisfaction with the service; (b) two questions asking what was good about the service and what could be improved; and (c) would they recommend the service? Case studies were used to illustrate individual formulations and negotiations that took place.

Data analysis

Feasibility of data collection was judged by the completeness of measures, using summary descriptive statistics. For healthcare utilisation and costs, a before-and-after 'time series' approach provided an indication of service effectiveness. Data points were taken from the 12-month period prior to the start of the PCWS and were truncated at 9 months post intervention for secondary care data, giving data points for months 1–21 and 11 months post intervention for primary care and mental health service data at months 1–23. Qualitative data were collated and themes reported.

The service

The literature review confirmed there was no ‘off the peg’ solution, providing information about key issues to consider when designing the service.

Service model and setting

An integrated service with specialist mental health professionals based in and collaborating with three GP practices was established. Practices were selected on the basis of expressions of interest, willingness to commit time and resources. Practices were of average size and served areas of high socioeconomic deprivation. One practice also had a high minority ethnic population.

Staffing

The team comprised a team manager, mental health occupational therapist, physiotherapist, psychology assistant, consultant psychiatrist, consultant psychologist, psychologist and administrator. Specialist advice was provided by the consultants. GP practices contributed both GP and practice nurse time.

Patient selection and referral

Most studies in the published literature used some combination of case-finding measures for mental disorder alongside frequency or cost of healthcare to identify the target population. A preliminary study in a local practice used the PHQ-9 and a search of GP electronic databases to identify distressed patients and frequent attenders. Of the 100 patients assessed with the PHQ-9, only 6 were identified who were not already in contact with services and who also had significant mood symptoms. They all declined referral. Using standardised case-finding measures failed to identify relevant candidates for this service.

Instead, GPs identified patients using a combination of their own knowledge of patients alongside a risk stratification tool. They focused on those who had a presumed diagnosis of MUS or patients with long-term conditions experiencing significant psychological difficulties, and who were also frequent attenders in primary and secondary care. Attendance was considered to be frequent when a patient had more than the average number of primary care consultations or hospital admissions and when patients’ problems remained unresolved and were escalating in cost. A discussion of potential candidates helped achieve consensus about appropriate referrals and practices were then asked to refer ten patients each, providing information on goals for referral and a summary of the patient’s health record.

Outcomes

Organisational level outcomes (health service use, healthcare costs, medication use) and patient-level outcomes (mental and physical health, physical functioning, and quality of life).

Results

In total, 28 patients were referred, with 27 appropriate referrals. One was unsuitable due to alcohol dependency and substance misuse. There was a delay of 6 months in receiving referrals from one practice, as the GP lead for the pilot left the practice. Complete data for healthcare utilisation and cost were available for 19/21 patients in 2 practices.

Health issues

A range of difficulties were identified including neuro-developmental problems; undiagnosed autism; significant health anxieties or preoccupation with illness; chronic pain and overuse of opioids; non-epileptic attacks and medically unexplained loss of movement and pain; and other maladaptive behaviours (e.g. misuse of insulin). Most patients had significant psychosocial difficulties including relationship problems, recent and past life adversity. High levels of physical morbidity such as ischaemic heart disease, chronic obstructive pulmonary disease, arthritis and head injury were also found.

Patient engagement

Patients were offered an initial joint assessment by two team members; the choice of health professionals took account of referral information about the presentation and degree of readiness to engage. For example, patients reluctant to see a mental health specialist were contacted first by the physiotherapist or occupational therapist. A flexible approach to timing and location of appointments was taken. We were able to engage with 22 of 27 patients either fully or partly with the service.

Interventions

Initial formulation developed for each patient was reviewed iteratively as alternative interventions were trialed, focused on referral goals. There were four components to interventions as follows: Taking stock and formulating the problem: review of medical notes to reconsider evidence for established diagnoses and medication reviews. Developing a function-based approach, occupationally oriented and focused on improving activities of daily living by accessing community resources; adaptations to home and mobility; introducing non-medical ways of managing pain. Psychological approaches included negotiation of a shared formulation and approach to management, with basic stress and anxiety management. Where indicated, specific therapies such as mindfulness, eye movement desensitisation and reprocessing (EMDR), trauma-focused work and acceptance commitment therapy (ACT). Service-level approaches included non-contingent access to practice staff to manage escalating demands and avoid unscheduled hospital and Accident and Emergency attendance; liaison with GPs and other specialists to agree a consistent approach.

Feasibility of data collection

Of the 19 patients for whom data could be collected there were only 8 complete data-sets for EQ-5D-5L, GAD-7 and PHQ-9, and 7 complete data-sets for PHQ-15 and EQ-5D-5L.

Healthcare utilisation data from the clinical system were readily available, although it was not possible to collect out-of-hours data. However, gathering information on prescriptions and costs of medication was prohibitively resource intensive.

Feasibility and effectiveness of the service

Across the whole patient cohort, secondary care activity reduced by an average of nine events per month. In the 9 months after the implementation of the PCWS, 177 fewer events occurred in secondary care (*Fig. 1*).

Nine months after implementation the total cost of activity was £63 950 less than the previous year (*Fig. 1*). The cost of secondary care activity reduced by an average of £3702 per month after the implementation of the PCWS (*Fig. 2*). Primary care activity had also reduced across the whole patient cohort by an average of 11 events per month.

Primary care

Time spent delivering care reduced by an average of 7 min per month. A substitution effect was observed in primary care with GPs delivering an average of 12 appointments and 127 min less to the patient cohort since the implementation of the PCWS. In contrast, other clinical staff delivered one additional appointment and 120 min more to the patient cohort.

Primary care costs were reduced across the whole scheme by an average of £171 per month for the cohort of 19 patients. In some cases, interventions led to significant changes in symptoms and health-seeking behaviours (*Box 1*). In others, work is still ongoing and longer-term intervention will be needed.

Discussion

What works in a research study does not easily translate into routine clinical practice in the National Health Service (NHS). In this study, academics and GP commissioners worked with specialist mental health providers to consider the evidence and identify local resources to design the best service configuration for patients with MUS, long-term conditions and frequent attenders in primary care. There is no short-term solution for these complex patients but a liaison psychiatry service based within primary care and as part of a long-term care plan shows great promise.

Identifying the patient group for the service and managing complexity

The service presented here addresses a common problem for GPs, which traditional diagnostic categories do not describe well and standard mental health services do not currently manage well. This is not the first attempt at establishing primary care-based liaison services. The service described, however, is unique because it eschews traditional collaborative care approaches¹³ and screening for anxiety and depression widely described in the research literature.^{13,14} In clinical practice that type of screening does not identify the right candidates to work with. The GPs and practice staff identified patients for this study by focusing on those patients with MUS or long-term conditions who were struggling to cope and that were returning with unresolved physical and emotional problems with rising healthcare costs. This was facilitated by a discussion of the case and the development of the vignette prior to referral to the PCWS. There was a level of detail in identifying this type of patient that required consideration and scrutiny by practice staff which could not be picked up by electronic systems or case-finding measures alone.

Patients with such complex conditions cannot be managed in standard ways following a protocol. They require a creative approach to person-centred care that supports their identification and management. In almost all cases the GPs were correct in identifying the right patients for the service via their clinical presentation, the exception being someone who required support from specialist addiction services.

Box 1 Case study

Patient A was a frequent attender at Accident and Emergency, the GP practice and mental health services, with a range of physical and non-psychotic mental health symptoms. She had a suprapubic catheter due to incomplete bladder emptying and detrusor overactivity; she found it too distressing to self-catheterise using a urethral catheter because of a history of sexual abuse. As she was struggling with the suprapubic catheter, an operation was planned to create a conduit between the skin and bladder to make catheterisation easier. However, there was concern that this would not address the underlying reasons for her frequent presentations, and would in fact increase her physical health problems, for example,

increasing her risk of urinary infection. Following referral to the Primary Care Wellbeing Service (PCWS), a review of her case notes revealed that her urodynamic studies had been normal. The team liaised with the surgeon, who agreed to a trial of bladder retraining. The team worked to engage patient A and to develop a shared formulation with her about the reasons for her urological difficulties and accept that her physical health difficulties could be managed in a non-operative way. We recognised the importance that all staff conveyed the same message to the patient and that care did not suddenly decrease while other changes in care took place. With input from the practice nurse and the PCWS team, she was able to start passing urine again without the catheter.

Challenges to service delivery and data collection

Our findings suggest that such services are feasible to deliver but that practices can struggle without sufficient staff to deliver the service. This accords with the literature¹⁵ which suggests an assessment of practice readiness be performed but this might not account for unexpected changes in practice staffing and infrastructure. Patients and staff that completed satisfaction measures were satisfied with the service, although it is possible that those that did not complete measures did not have such a positive experience. Further, it was not possible to routinely collect self-reported outcome measures in routine practice for this service. Given that these practices were highly motivated to take part, it is unlikely that collecting self-report measures, as part of an evaluation package, would be feasible in less motivated practices. Feedback from staff suggested that they were not able to collect this additional data. Any additional work to use self-report measures in practice needs to consider the burden of additional work for practice staff against the need to collect this information. However, routinely collected data on service use and cost proved to be feasible to collect as this is already part of the existing monitoring systems. Again, out-of-hours information was not collected as part of this. Case studies enabled practitioners to consider how well the patient progressed helping to sustain the service in its early phases using cases as a feedback loop as proposed in the literature.¹⁵

Implementing new service models requires a long-term view

There are challenges in setting up and maintaining such services, however. We cannot be sure that they will be cost-effective in the longer term, as the full costs of the service were not examined here only salary costs. This type of analysis would need to be evaluated in a larger study of effectiveness taking account of the commissioning cycle and utilising an economic evaluation. This pilot was only conducted in one metropolitan district in England. Population demographics, health service configurations and commissioning arrangements vary across the UK, and our findings and experience may not be generalisable. Moreover, GP practices taking part were selected for their willingness to engage with the pilot, with one out of the three being unable to launch the proposed service within the project time frame.

Findings from the evaluation are not definitive, but rather provide important data to inform the next stages of service development and evaluation. This pilot demonstrates that service developments can be implemented using NHS resources and commissioning processes, and evaluated using routinely collected data. However, including patient self-report and staff measures, which are not part of usual care, requires additional resources. Administering and collecting paper-based measures for patients and staff proved onerous, with incomplete data collection from all practices despite concerted efforts to collect these by the team.

Questions of sustainability and scaling up need to be considered. In this feasibility study, there were significant reductions in secondary care activity and cost. If such a service could be extended then a further study including full economic costs would be of interest. Such transformation requires commissioners to take a long-term view and to accept that cost savings may be negative or neutral in the first year or more.

Future proposals

To maintain the momentum and build on this project and other innovative pilots in the UK,^{6,7} we propose setting up a network of interested colleagues to critically consider the future development of primary care liaison psychiatry services. The purpose would be to share experience and to inform further implementation projects and design approaches to the particular problems of scaling up and managing the needs of patients with complex problems who are prone to relapse and likely to require repeated specialist help or longer-term care plans.

The Clinical Commissioning Groups of NHS Airedale, Wharfedale & Craven and NHS Bradford Districts commissioned the Health Economics, Evidence and Evaluation Service (HEEES) of Yorkshire and Humber Commissioning Support to evaluate the Primary Care Wellbeing Service pilot.

1.7.92 Systematic review into factors associated with the recruitment crisis in psychiatry in the UK: students', trainees' and consultants' views

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Abstract

Aims and method To review the literature to examine the factors that may be affecting recruitment into psychiatry in the UK. We systematically searched four databases to identify studies from 1974 to 2016 and identified 27 papers that met the specified inclusion criteria.

Results Most papers ($n = 24$) were based on questionnaire surveys. The population in all studies comprised of 1879 psychiatrists, 6733 students and 220 746 trainees. About 4–7% of students opt for a career in psychiatry. Enrichment activities helped to attract students more towards psychiatry than just total time spent in the specialty. Job content in terms of the lack of scientific basis, poor prognosis and stigma towards psychiatry, work-related stress and problems with training jobs were common barriers highlighted among students and trainees, affecting recruitment. Job satisfaction and family-friendly status of psychiatry was rated highly by students, with lifestyle factors appearing to be important for trainees who tend to choose psychiatry.

Clinical implications Negative attitudes and stigma towards psychiatry continue to persist. Teaching and training in psychiatry needs rethinking to improve student experience and recruitment into the specialty.

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Psychiatry as a career has been negatively regarded and unpopular among medical students. About 3.6% of British graduates decide on a career in psychiatry whereas about 6% are needed.¹ From 2000 to 2011, the absolute number of consultant psychiatrists in England rose from 2904 to 4394 (an increase of 51%), with similar increases in Scotland and Wales, in line with the expansion of the consultant workforce in most secondary care specialties.¹ A need for more psychiatric consultant posts has been predicted based on projections of increasing workloads due to the increased population needs.² A perceived fall in the proportion of UK medical school graduates choosing a postgraduate career in psychiatry, and low competition ratios for first-year core specialist training (CT1) posts in psychiatry,³⁻⁵ has led to many questions about the way in which psychiatry is taught at medical school and how psychiatry could be made as an attractive career option.⁶⁻⁸

Low recruitment in psychiatry is a global issue, highlighted in a number of publications.^{9,10} However, the problem also has country-specific dimensions, as each country has different factors such as the pay scale for the specialty, medical education system and training programmes, which may attract or dissuade medical students from a career in psychiatry. The subject has not been reviewed systematically especially in the context of recruitment in the UK. The review question was: what are the factors that influence recruitment to psychiatry as a career choice and how can this be improved? The aim of this paper is to systematically review the literature from the UK on psychiatry as a career choice. We are specifically interested in identifying the factors that influence the recruitment into psychiatry with emphasis on barriers and facilitators affecting recruitment. A greater understanding of the views ranging from medical students to trainees and consultants working in the UK may enable curriculum developers and recruitment leads to design programmes that attract students and trainees to psychiatry as a career and improve students' attitudes towards psychiatry in the long term.

Method

We followed the PRISMA statement¹¹ as a guide for conducting the systematic review. The following electronic databases were searched from 1974 onwards: Medline, EMBASE, CINAHL, PsycINFO. These databases were selected in view of the fact that almost all the literature published from the UK would be covered in these databases. Keywords used in the searches included: medical students, trainees, doctors, consultant, attitudes, psychiatry, career, undergraduate psychiatry. Boolean operations and truncations were added to allow for alternative endings in the keyword searches. The search was last updated in August 2016.

We included studies that described a UK sample, were published in English in a peer-reviewed journal and provided original data on careers in psychiatry or factors affecting recruitment in psychiatry. We excluded studies that had the primary objective of addressing other issues that were not directly relevant to recruitment in psychiatry but only mentioned their effects on career choice as a secondary effect. Studies which provided data on medical careers in general were included if these provided data relevant to psychiatric careers or recruitment.

The electronic search returned 601 relevant abstracts and titles. We screened the titles and abstracts and excluded the studies that were not directly relevant to the objectives of the review. Therefore we excluded the studies that did not describe a UK sample or did not provide the original data. We also excluded the studies that described the recruitment to certain subspecialties and therefore not relevant to the recruitment to psychiatry in general. After screening these titles and abstracts we decided to examine 56 full text papers. Finally, we included 27 papers in the review. Further details are provided in *Fig. 1*. The studies were conducted in a number of different populations, settings and periods, and also used diverse methodologies varying from surveys to statistics derived from databases. The 30-item Attitudes Towards Psychiatry (ATP-30),¹² a validated tool used to assess attitudes of students towards psychiatry, was used in four papers; other papers used different questionnaires to assess attitudes. Due to the diverse methodologies it was inappropriate to pool the data to produce a statistical summary. We therefore describe the main findings and produce a narrative summary of results.

Results

Characteristics of included studies

Table 1 shows the characteristics of the 27 studies included in the review. The majority of studies ($n = 24$) were surveys and questionnaire-based studies. The other studies included one database study of doctors entering training posts and two retrospective cohort studies, which looked at which medical school psychiatrists had attended. These reported on medical students ($n = 12$), trainees ($n = 10$), medical students and trainees ($n = 1$), trainees and consultants ($n = 1$) and consultants ($n = 3$). One of these studies looked at data from postgraduate departments in different medical schools, and one study reported on the database of applicants to MMC (Modernising Medical Careers) for training posts.

Study characteristics

Author/year	Population	Method/design	T
Brook, 1976 ¹⁹	Medical school of origin for psychiatrists	Retrospective cohort	5
Brook, 1983 ²¹	Medical school of origin for psychiatrists	Retrospective cohort	1
Levine <i>et al</i> , 1983 ²⁴	Medical students	Survey	3
Brook <i>et al</i> , 1986 ²⁰	Medical students	Survey	4
Calvert <i>et al</i> , 1999 ³³	Medical students	Survey	3
Mcparland <i>et al</i> , 2003 ³⁰	Medical students	Cohort study – survey	3

Table 21 – continued from pre

Author/year	Population	Method/design	T
Maidment <i>et al</i> , 2003 ³¹	Medical students	Survey	8
Petrides & McManus, 2004 ²³	Medical students	Cohort study – survey	8
Rajagopal <i>et al</i> , 2004 ³⁵	Medical students	Survey	3
Curtis-Barton & Eagles, 2011 ²⁵	Medical students	Survey	4
Budd <i>et al</i> , 2011 ²⁶	Medical students at 4 different medical schools	Survey	9
Archdall <i>et al</i> , 2013 ³⁴	Medical students	Survey	1
Halder <i>et al</i> , 2013 ²⁸	Medical students – 18 UK medical schools	Survey	4
Farooq <i>et al</i> , 2014 ²⁷	Medical students (only UK data used)	Survey	2
Maidment <i>et al</i> , 2004 ³¹	Trainee doctors	Survey	2
Goldacre <i>et al</i> , 2005 ¹⁴	Trainee doctors (graduates from 1974 to 2000, UK medical schools)	Survey	2
Lambert <i>et al</i> , 2006 ¹⁵	Trainee doctors	Survey	5
Fazel <i>et al</i> , 2009 ¹³	Trainee doctors (all applicants to MMC for training posts)	Database analysis	3
Barras & Harris, 2012 ³⁸	Trainee doctors	Survey	3
Goldacre <i>et al</i> , 2012 ¹⁶	Trainee doctors who had qualified in 2002, 2005, 2008	Survey	9
Goldacre <i>et al</i> , 2013 ¹⁷	Trainee doctors who qualified between 1974 and 2009	Survey	3
Svirko <i>et al</i> , 2013 ¹⁸	Trainee doctors who qualified 2005, 2008, 2009	Survey	9
Collier & Moreton, 2013 ²²	Hospital postgraduate departments of 19 medical schools	Survey	1
Woolf <i>et al</i> , 2015 ³⁷	Medical students and trainee doctors	Cohort study – survey	1
Korszun <i>et al</i> , 2011 ³⁶	Trainee doctors, academics, trust clinicians	Survey	3
Dein <i>et al</i> , 2007 ³⁹	Consultants	Survey	7
Denman <i>et al</i> , 2016 ³²	Consultants and trainees	Survey	C

M, male; F, female; MMC, Modernising Medical Careers.

Data not used from this paper just broad findings in review.

In survey-based studies response rates varied from 16% to 100%. Mean response rate from the papers which had figures available ($n = 20$) was 63.3%. The population in all studies comprised of 1879 psychiatrists, 6733 students and 220 746 trainees. One database study¹³ looked at 31 434 trainee doctors, and studies by Goldacre *et al* were aimed at all doctors in training, accounting for large numbers of respondents in the trainee subcategory.^{14–18}

The influence of the medical school and teaching practices

Most of the research addressing the influence of the medical school and teaching practices on selecting psychiatry as a career was carried out in the 1970's and 1980's. Two studies by Brook *et al*^{19,20} looked at the medical school of origin for 531 psychiatrists between 1961 and 1970 and reported no significant relationship between schools that had a professional unit or specific teaching programme and students pursuing psychiatry in the long term. However, it was noted that those schools that produced fewer psychiatrists tended to have either a recently established professional unit or none.¹⁹

No clear pattern emerged in terms of the type of teaching offered at each university and the impact this had on choice of psychiatry as a career in the long term.¹⁹ All four Scottish schools, and Cambridge and Oxford were noted to be higher in terms of producing psychiatrists, attributed possibly to the well-established professional units such as the Maudsley and Bethlem Royal hospitals.¹⁹ The personality, charisma and enthusiasm of teachers were associated with an increase in the uptake of psychiatry in the long term.^{19,21}

Brook *et al*²¹ found that the effectiveness of teaching rather than the amount of teaching had an effect on student attitudes and recruitment into psychiatry. The attitude of non-psychiatric teachers appeared to be influential with doctors experiencing negative attitudes of other doctors towards psychiatry.²¹ The two hospitals which ranked top in terms of producing psychiatrists had changed their teaching model. One stressed the importance of psychiatry as being part of general medicine, emphasising the effectiveness of physical therapy, whereas the other placed emphasis on liaison psychiatry and psychotherapy.²¹

More recent work by Collier *et al*²² looked into the teaching time allocated for psychiatry in foundation programmes across the country. They found that only 2.3% of teaching was dedicated to psychiatry compared with 44.1% to medical and surgical topics.²² Exposure to psychiatry remained limited with 4 out of 17 hospitals in the survey not having any teaching on psychiatry for medical students.²² Doctors generally led a higher proportion of medicine and surgery teaching sessions (63%) compared with psychiatry (48%).²²

Medical students' views of psychiatry and factors affecting career choice

Twelve studies examined the factors affecting medical students' career choice and one study looked at both medical students and trainees. Petrides *et al*²³ studied the theoretical understanding of how different medical specialties are perceived and how choices are made. Psychiatrists were found to have a more artistic approach to medicine, seeing interpreting and responding imaginatively to a range of medical, social, ethical and other problems. This is in keeping with early work by Levine *et al*²⁴ who also found that there was a group of students who were 'psychologically minded' and they could be identified and encouraged to make psychiatry as career choice.

Budd *et al*²⁶ found that job satisfaction (98%, $n = 128$) and family-friendly status of psychiatry (79%, $n = 103$) were important for students who rated psychiatry as one of their top three choices.²⁶ The academic status was significantly less important (48%) for students who placed psychiatry as their top three specialty schools v. 63% for those who did not place psychiatry in their top three choice.²⁶

Choice of psychiatry as a career among medical and sixth form students

The number of students choosing psychiatry has remained fairly stable at around 4–7%.^{25–27} Three per cent of students from six medical schools placed psychiatry as their first choice, with 18% seriously considering it.²⁰ Halder *et al*²⁸ found similar results in 18 medical schools; 16% chose psychiatry as a future career on entering medical school but by the final year only 3% had decided to pursue a career in the subject. These results were replicated by Farooq *et al*²⁷ In a survey of sixth form students, Maidment *et al*²⁹ reported that 60.9% ($n = 363$) indicated that it would be very likely or they would definitely want to pursue psychiatry as a career. In terms of overall intentions to pursue a career in a specialty, the ratings for psychiatry was similar to general medicine at 12.4% ($n = 72$) v. 12.2% ($n = 69$) respectively.²⁹

Effect of undergraduate attachment and education on choosing psychiatry as a career

Positive attitudes towards psychiatry and the influence by a teacher during the attachment correlated with an intention to pursue psychiatry as a career in the long term.²⁹⁻³¹ Three studies highlighted the importance of psychiatric attachment. Student attitudes improved as the attachment progressed.^{26,30,31} Maidment *et al*²⁹ found 1.4% of fourth-year medical students expressed a definite intention to pursue which rose to 4.7% after their attachment.²⁹ McParland *et al*³⁰ reported that 19% ($n = 58/309$) of students were very attracted to psychiatry or had a definite intention to pursue psychiatry at the start of the placement, which increased to 27% ($n = 101/373$) of students at the end of the attachment. The importance of the undergraduate experience was highlighted by a recent study showing 50% of consultants and 37% of trainees surveyed decided on a career in psychiatry while still at medical school.³²

Calvert *et al*³³ looked into the attitudes of medical students towards psychiatry and psychiatric patients at year 1, 3 and 5 in medical school. First-year medical students were more likely to have stereotypical views compared with third- and fifth-year students, and were more likely to agree with statements such as 'Psychiatry deals with imaginary illness' (mean 1.4, s.d. = 0.9, $P < 0.5$).³³ Fifth-year students (mean 3.2, s.d. = 1.4) showed lower agreement than third-year medical students (mean 3.6, s.d. = 1.2, $P < 0.5$) with the statement 'Psychiatry is as a challenging career'.³³ As they progressed through medical school, students recognised that mental illness has serious morbidity and that people do recover from mental illness,³³ showing that attitudes towards psychiatric patients improved with greater clinical experience but possibly became more negative towards psychiatry as a career.

Other factors that appeared to affect students positively included enrichment activities, i.e. activities beyond standard teaching and clinical placements led to a significantly increased interest in psychiatry.²⁸ These included research experience in psychiatry (13% v. 4% in those not interested in psychiatry, $P = 0.001$), university psychiatry clubs (38% v. 11%, $P < 0.001$), psychiatry electives (14% v. 1%, $P < 0.001$) and psychiatry special study modules (38% v. 16%, $P < 0.001$).²⁸

McParland *et al*³⁰ identified factors which increased interest in psychiatry, including: influence or encouragement by someone during the attachment (74%, $n = 282$), particularly the influence by consultants (43%, $n = 163$), exposure to interesting and stimulating ideas (29%, $n = 110$), liking someone's approach (27%, $n = 103$), feeling someone believed in their ability (11%, $n = 41$) and having formed close working relationships (9%, $n = 33$).³⁰ Other factors that had a significant impact were: receiving encouragement from the consultants ($n = 374$, $P < 0.001$, $r = 0.26$), seeing patients respond to treatment ($n = 374$, $P < 0.001$, $r = 0.20$) and having a direct role in the involvement of patient care ($n = 374$, $P < 0.001$, $r = 0.26$).³⁰

Factors which did not affect career choice of medical students

Seeing patients in different settings or different phases of the illness had no effect on career choice of medical students when deciding their career intentions.²⁸ Interestingly, one study found that the earning potential and status of psychiatry had no effect on selecting psychiatry as a career choice.²⁶ Other factors related to teaching such as quality of rating of small group teaching and lectures,²⁸ the curriculum type used^{30,31} and performance at viva examinations and multiple choice questions also had no effect on the career choice.³¹

Factors discouraging medical students to choose psychiatry as a career

Curtis-Barton *et al*²⁵ in their survey ($n = 467$) found that the factors discouraging students to pursue a career in psychiatry included: prognosis of patients (62%), perception that there is a lack of evidence in diagnosis (51%), lack of scientific basis (53%) and the amount of bureaucracy and paperwork in the specialty (48%). Other discouraging factors included the stigma towards psychiatry (30%), the standing of the profession among medical colleagues (31%) and comments by other specialists (26%).^{25,34} Psychiatry scored the lowest among the specialties as a career choice. Students described psychiatry as boring, unscientific, depressing, stressful, frustrating and 'not enjoying the rotation'.³⁵

Many students experienced psychiatry as being different to other specialties. For some this was a reason not to pursue psychiatry as a career but for others it was a positive aspect of the specialty. Students felt ward rounds focused on 'social

issues' rather than medical conditions. Some found it an 'emotional burden' and others felt that psychiatry could not 'fix' people and no one is being cured.³⁴

A survey by Korszun *et al*³⁶ examined the views of trainee, academics and clinicians on students not taking up psychiatry. The following factors were identified as deterring the students from psychiatry: negative attitudes towards psychiatrists from other doctors and health professionals (57%), stigmatisation of psychiatry (40%), stigma associated with mental health disorders (39%), poor teaching and role modelling from psychiatrists (37%), psychiatry not seen as medical or scientific enough (26%) and poor morale among psychiatrists (26%).³⁶

Factors affecting trainees' and consultants' choice of psychiatry

Fazel *et al*¹³ found that psychiatry was the sixth most popular specialty out of ten specialty groups for trainees applying for training places. A higher proportion of female graduates were shown to choose psychiatry between 1974 (32%) and 1999 (59%).¹³ However, a more recent survey showed a slight decline in the number of women choosing psychiatry over the last decade, 4.9% (1999) v. 4.6% (2009).¹⁷

Goldacre *et al*¹⁴ examined career choices for medical students over the past 40 years. The number of doctors choosing psychiatry as a career has hardly changed and remains around 4–5%, which is similar to figures from 1975.¹⁴ It was noted that students who went on to work in psychiatry 10 years after graduation, 52% (224 out of 428) had chosen psychiatry in the first year after graduation and 71% (308 out of 434) had chosen it in year 3.¹⁴

In common with the factors attracting students towards psychiatry, numerous studies identified factors that appear to attract trainees towards psychiatry. The major attractions for choosing psychiatry are listed in *Box 1*. Denman *et al*³² found that the most common factor influencing core trainees' (60%) and consultants' (70%) decisions to specialise in psychiatry was emphasis on the patient as a whole.³² Trainees highlighted that mental health was an area of need (53%) and empathy and concerns for people with mental illness (53%) were important reasons for choosing psychiatry.³²

Box 1 Factors attracting medical students and trainees in pursuing psychiatry as a career

Medical students

- Encouragement by colleagues^{24,26,30,31}
- Influence by someone during the placement^{24,30}
- Females are more likely to favour a career in psychiatry^{24,27,30}
- Family history of mental illness was associated with choosing psychiatry²⁴
- Quality of experience^{26,27,30,33}
- Role models can have a positive impact on students pursuing a career in psychiatry^{28,30,33}
- Enrichment activities^{27,28}

Trainees

- Hours and conditions of work^{17,31,32}
- The doctor's personal assessment of their aptitudes and skills,^{17,31,32} for example recognising factors such as using one's intellect to help others³⁷
- Experience of the subject as a student^{17,31}
- Inclinations before medical school and a positive student experience^{17,37}
- Attitudes and inclination to psychiatry as a medical student^{24,31,37}

- Lifestyle factors ^{32,37}
- Encouragement from consultants and senior doctors ³¹
- Emphasis on the patient as a whole person and empathy/concern for mentally ill people ³²

Barriers associated with not choosing psychiatry as a long-term career choice for trainees

Barras & Harris ³⁸ explored trainee's experiences ($n = 359$) within psychiatry. Trainee attitudes were grouped into different categories. The attitudes towards psychiatry (12.6%), professional role (12%) and day-to-day working (11.3%) were identified as the main negative factors. Trainees raised concerns with the training programmes in psychiatry, such as problems with the rota and not having enough time with patients. ³⁸ Many trainees felt frustrated with the Annual Review of Competence Progression (ARCP) process and workplace-based assessments, as well as the duplication of paperwork being a constant frustration. ³⁸

The studies identified a number of barriers against choosing psychiatry as a career (*Box 2*).

Trainees felt improvements were needed in terms of training opportunities and felt this could be enhanced by providing a variety of jobs, increasing research opportunities and increasing medical aspects of training. ³⁸

Work looking into consultant psychiatrists' views into why they chose psychiatry was limited to two papers. ^{32,39} Dein *et al* ³⁹ found that the majority of consultants (46%) chose psychiatry as a career soon after leaving medical school, and a recent study surveying consultants in the West Midlands found that 50% had made their choice by graduation from medical school. ³² The main reasons cited by consultants for choosing psychiatry as a career included: empathy for those with a mental disorder (36.1%), interface with neuroscience (25%), expectation of better working conditions in psychiatry (20%) and influence of teaching at medical school (19.4%). ³⁹ Denman *et al* ³² highlighted several 'very important' reasons for consultants choosing psychiatry including: career in psychiatry would be intellectually challenging (60%), sense of fulfilment expected from seeing patients improve (47%) and enjoyment of problem-solving (47%). Lifestyle factors such as salary, better working conditions and quality of life were shown to be more important reasons for choosing psychiatry for trainees compared with consultants. ³²

Box 2 Barriers associated with not choosing psychiatry as a career

- Job content (71.7%) ($n = 71$) (including the lack of scientific basis, job not being clinical, poor prognosis) ^{15,17,25,35,36,38}
- Poor public image of psychiatry ^{15,25,36}
- Lack of respect towards psychiatry as a specialty by other specialties ^{15,25,36}
- Work-related stress cited by (49%) ¹⁵ trainees in psychiatry ³⁸
- 25–50% of trainees leaving psychiatry as a specialty cited lack of resources as one of the main reasons which was significantly more than those rejecting general practice and trauma and orthopaedics ^{15,38}
- 25–50% of trainees leaving psychiatry ^{15,16,38} highlighted:
 - a. lack of adequately supervised training
 - b. lack of evidence base to diagnosis and treatment
 - c. lack of improvement in patients
 - d. work-life balance
 - e. work not clinical enough
- Physical risks involved in the job ¹⁵
- Sense of eroded professionalism ^{36,38}
- Too much paperwork and duplication ^{25,36,38}

- Problems with rota and not enough time with patients ³⁸
- Trainees leaving the scheme felt frustrated with workplace-based assessments ³⁸
- Low morale among workforce ³³
- Future role of psychiatrists being eroded ³³

Discussion

This is the first systematic review of literature which examined factors that influence the choice of psychiatry as a career in the UK. The main findings are that enrichment activities help to attract students more towards psychiatry than just total time spent in the specialty. Job satisfaction and family-friendly status of psychiatry was rated highly by students who tend to choose psychiatry. Role models and encouragement from consultants may increase the number of students who want to pursue psychiatry as a career. The major factors that appeared to dissuade medical students/trainees from pursuing psychiatry as a career included: an apparent lack of scientific basis of psychiatry and work not being clinical enough, perception that psychiatry is more concerned about social issues, the bureaucracy, paperwork, apparent poor prognosis of patients, stigma towards psychiatry as a specialty, low morale, and onerous workloads as a consultant.

We are aware of one previous systematic review that examined medical students' attitudes towards psychiatry internationally. ⁴⁰ In common with our study this systematic review alongside another survey of psychiatrists ³⁶ highlighted the stigma towards mental illness as a major barrier influencing negative medical views towards psychiatry. ⁴⁰ Stigma towards psychiatry as a specialty arises from a variety of sources, notably from medical students themselves. In addition, this stigma could arise from ward staff attitudes towards patients and from other doctors in other specialties, which detract students. ^{13,25,34}

Other reviews have looked at one aspect such as the effect of clinical experience of psychiatry on medical students' attitudes towards the specialty. ⁴¹ Lyons ⁴⁰ highlighted the impact of poor-quality teaching leading to negative attitudes towards psychiatry and highlighted the need to address psychiatry curricula and introduce novel teaching strategies. ⁴⁰ El-Sayeh *et al* ⁴² have previously highlighted the importance of teaching and the various methods which could be utilised to try to improve the student experience and in turn help attract students towards psychiatry. The recent survey by Korszun *et al* ³⁶ highlighted that the number of clinicians compared with academics and trainees agreed that they did not have time to teach medical students ($P < 0.001$). Both clinicians (42%) and academics (47%) felt that teaching medical students did not contribute to their future career prospects compared with 21% of trainees ($P < 0.001$) ³⁶ Fewer clinicians considered teaching to be a significant component of their appraisal compared with trainees and academics. ³⁶ The combination of poor teaching practices due to lack of resources or commitment and the stigma reinforce the poor image of psychiatry.

We feel that the findings of our study support the recommendations made by Mukherjee *et al* ⁴³ which identify a number of steps to address the crisis in psychiatry recruitment at different nodal points in a medical career, i.e. prior to entry to medical school, during medical education and after graduation.

Improving recruitment

This study highlights the need to change the experience of psychiatry at undergraduate and postgraduate level in keeping with work by Shah *et al* ⁴⁴ who highlighted early medical experience, influence of seniors and the aspects related to working environment as areas that could be affected positively which in turn could have a positive effect on choosing psychiatry as a career. Kelley *et al* ⁴⁵ highlighted the impact of foundation programme experience in psychiatry, with a significantly higher proportion of trainees pursuing a career in psychiatry compared with those without any exposure to psychiatry (14.9% v. 1.8%). This correlates with earlier findings by Shah *et al* ⁴⁴ that found a significant correlation between those Scottish students considering psychiatry as a career and having held a psychiatry post. ⁴³ A recent survey by Denman *et al* ³² showed that 43% of psychiatry trainees made their decision to specialise in psychiatry during the foundation years, correlating with increased exposure to psychiatry during the foundation years with 80% of trainees in this survey completing a post in psychiatry during the foundation years. Specific enrichment activities beyond standard teaching and clinical placements such as research experience in psychiatry, university psychiatry clubs, summer schools,

⁴⁶ psychiatry electives and psychiatry special study modules appear to be a way in which medical students will gain invaluable experiences and improve their attitudes to psychiatry. These need to be adopted and evaluated in future programmes to enhance recruitment in psychiatry Collier *et al* ²² found that only 2.3% of teaching was dedicated to psychiatry compared with 44.1% to medical and surgical topics, which does not help the poor image of psychiatry. This and similar issues need to be addressed at institutional level.

A number of studies found that psychiatry has a perception that it is not a 'scientific' or 'medical' discipline. ^{15,36,38} Medical students and trainees expressed the views about the weakened medical identity of psychiatry. The erosion of the role of the psychiatrist was cited by some psychiatry trainees as a potential factor that would make them consider leaving psychiatry training. ³⁸ This unfortunately is not helped by negative comments or 'bad-mouthing' of psychiatry. ^{36,47}

Interventions such as anti-stigma films and Medfest ⁴⁸ have been shown to improve medical students' attitudes to psychiatrists, serious mental illness and psychiatry, at least in the short term. ^{48,49} However, it appears that there is need to reconsider the content of psychiatric training and the undergraduate curriculum. It has been suggested that moving undergraduate teaching from in-patient to general hospital settings such as liaison psychiatry will allow students to see patients with problems that are relevant to medical practice. ⁴⁷ Setting up and evaluating such programmes that have the potential to offer a different and enjoyable experience for medical students and foundation doctors should be a priority to improve the image of and recruitment into psychiatry.

Limitations

A limitation of the study is that almost all data are based on surveys and databases. This represents a cross-sectional view on the subject. The lack of any comparisons with other specialties, which may have similar recruitment rates, is particularly concerning. The focus on UK studies is also a limitation but was necessary to understand the factors affecting recruitment in this country. We noted with some concern that there are only a few studies that address the positive aspects of psychiatry, ^{26–28,30–33} which may attract students and trainees towards psychiatry, and how these can be used for improving the recruitment. Future studies need to address this gap in the literature. Finally, we feel that the problems underlying the recruitment in psychiatry perhaps also reflect the lack of parity of esteem. Unless mental health is valued equally with physical health, the misconceptions and distorted perceptions about psychiatry as a discipline in which a medical career can be fruitfully pursued will linger on and will hinder aspiring physicians from considering psychiatry as a career option.

1.7.93 Mental Capacity Act (Northern Ireland) 2016 †

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Abstract

Mental health legislation in Northern Ireland has always been separate from legislation in the rest of the UK; the Mental Health (Northern Ireland) Order (MHO) had been in place since 1986. In common with other jurisdictions, this legislation utilises the presence of mental disorder and risk as criteria for detention and involuntary treatment. The MHO has been replaced by the Mental Capacity Act (Northern Ireland) 2016 (MCA), an example of ‘fusion’ legislation in which impairment of decision-making capacity and best interests are the only criteria to be used when making decisions across health and social care. In this paper, we outline the development of the MCA to date, and discuss its potential to improve mental healthcare by placing the treatment of mental illness within the same legislative framework as physical illnesses.

Contents

- *Mental Capacity Act (Northern Ireland) 2016 †*
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 - *Conclusions*

The Mental Capacity Act (Northern Ireland) 2016 (MCA) is an example of a ‘fusion’ legislation – a generic law applicable across all medical specialties and social care where an intervention is proposed and the person has impaired decision-making capacity.

The MCA was enacted in May 2016. Since then, the Department of Health has completed phase 1 of the implementation work; creating a first working draft of a code of practice, and working on forms and draft regulations associated with the Act. This work has been shared with a ‘virtual’ MCA Reference Group, composed of a wide range of stakeholders. The first full draft of the code of practice, forms and regulations have recently been circulated to the MCA Reference Group and the second phase, a pre-consultation phase on the full draft, has just begun.

Background

The Bamford review of mental health and learning disability, established in 2002, was a wide-ranging examination of the delivery of mental health and learning disability services in Northern Ireland.

In addition to the examination of service delivery, the review also undertook a review of the mental health legislation, the Mental Health (Northern Ireland) Order (MHO), which had been on the statute books since 1986. Criteria for involuntary treatment of mental illness under the MHO were based on diagnosis and risk; the presence of mental illness or severe mental impairment, and failure to detain leading to a substantial risk of serious physical harm to self or others. In addition, certain conditions were specifically excluded – no person could be detained solely on the grounds of personality disorder, dependence on alcohol or other drugs, or sexual deviancy.

There was no specific or separate mental capacity legislation in Northern Ireland. Decisions on the treatment of incapacitous patients are taken under common law, with decisions based on a presumption of capacity and the doctrine of necessity (best interests).

The Bamford review decided that the legislation was not compliant with essential principles (autonomy, justice, benefit and least harm). In 2007, it recommended that: ¹ There should be a single comprehensive legislative framework for the reform of mental health legislation and the introduction of capacity. The framework should be based on agreed principles. These principles should apply to all healthcare decisions, as well as welfare and financial needs. Impairment of decision-making capacity should be a mandatory prerequisite for any interference with a person's autonomy without their consent. Individuals who are subject to the criminal justice system should have access to assessment, treatment and care which is equivalent to that available to other people.

A public consultation was held in 2011. There was strong support for the proposal of a single legislative framework. It was therefore decided to fuse mental capacity and mental health law into a single bill. The resulting draft bill was the subject of another consultation in 2014, followed by its introduction to the Stormont Assembly. There, it underwent further consideration and amendment, and was passed as the Mental Capacity Act (Northern Ireland), receiving Royal Assent in May 2016.

Aims and principles

Fusion legislation provides equally for all circumstances in which a person's autonomy might be compromised on health grounds. It puts impaired decision-making capacity at the heart of all non-consensual interventions. By treating mental and physical illnesses equally under the law, it reduces stigma associated with separate mental health legislation, and is respectful of a person's autonomy and decision-making capacity whether they have a mental or a physical illness.

Compatibility with international statements on human rights, particularly the European Convention on Human Rights (ECHR) ² and the United Nation's Convention on the Rights of Persons with Disabilities (CRPD), ³ is an issue for any legislation dealing with involuntary treatment. Conventional mental health legislation, which uses a diagnostic test for involuntary treatment, could be regarded as being incompatible with Article 14 (1) (b) of the CRPD – 'the existence of a disability shall in no case justify a deprivation of liberty'. No UK mental health legislation is currently compliant with the CRPD.

Proponents of fusion legislation argue that capacity, as the test for involuntary treatment, is a functional test, i.e. a particular ability at a particular time, and therefore not directly linked to diagnosis or disability. However, the MCA retains a 'diagnostic' element; the person is unable to make a decision because of an impairment of, or a disturbance in, the functioning of the mind or brain. It therefore arguably still fails to satisfy Article 14 (1) (b) of the CRPD. Nevertheless, the MCA is fully compliant with the ECHR, and its strong rights- and principles-based ethos moves the legislation significantly towards CRPD compliance.

Content of the MCA

The MCA revokes the MHO for those aged 16 and over and puts common law into statute.

Capacity test

Statutory decision-making will come into play when a person lacks capacity. There is a presumption that the person has capacity, there must be no unjustified assumptions based on age, appearance or condition, there must be a respect for decisions even if unwise, the person must be given all practical help and support, and the act must always be in the person's best interests.

There are two tests to be satisfied in reaching a decision about a person's decision-making capacity: a diagnostic test – there must be an impairment of, or a disturbance in, the functioning of the mind or brain, and; a functional test – the person is unable to understand the information relevant to the decision, to retain the information long enough to make the decision, to appreciate the relevance of that information and use or weigh the information as part of the process of making that decision, and communicate the decision. There must be a causal link between the two tests – the person is unable to make a decision because of impairment or disturbance in the brain or mind.

Looking at the functional test, the specific difference between this and other definitions of lack of capacity is the use of the word 'appreciate'. The consultation document ⁴ emphasises the importance of the inclusion of the appreciation element: its inclusion moves a decision about capacity from a purely cognitive test (p. 13, para. 2.22). The consultation document gives as an example: 'A person whose insight is distorted by their illness or a person suffering from delusional thinking as a result of their illness may not, therefore, meet this element of the test' (p. 13, para. 2.22). ⁴

Protection from liability

The legislation puts into statute the common-law definition of necessity and protects the person (D) doing the act from liability if D takes reasonable steps to establish whether the person (P) lacks capacity in relation to the matter in question and D reasonably believes that it is in P's best interests for the act to be done. There is therefore a shift in emphasis from the MHO, which confers statutory powers, to a situation where non-consensual intervention is predicated on protection from liability for D.

Future decision-making

The Act includes a robust lasting powers of attorney system. A lasting powers of attorney must be registered with the Office of Public Guardian before being activated and extends to health and welfare decisions, when the attorney reasonable believes that the person lacks capacity and must always act in the person's best interests.

In addition, advance decisions to refuse treatment must be complied with, if valid and applicable under common law. This means that an effective advance decision to refuse treatment for a mental disorder (or indeed any disorder) cannot be overridden, if made when P had capacity. However, the Act allows that, if there is doubt, D will be protected from liability if he or she gives life-sustaining treatment or treatment required to prevent a serious deterioration in P's condition. Advance decisions were not put into statute in order for the courts to continue to develop the law in the light of the MCA.

Safeguards

The Act provides for a proportionate increase in the number of safeguards that must be met if D is to be protected from liability as the seriousness of the interventions or acts being done to P increases. These additional safeguards must be met in addition to the general safeguards.

- For acts of restraint, D must reasonably believe that there is a risk of harm to P, and that the act of restraint is proportionate to the likelihood and seriousness of that harm.
- For serious interventions or treatment with serious consequences, there must be a formal assessment of capacity and a written statement of incapacity by a suitably qualified person, and a nominated person must be in place, who should be consulted and whose views should be taken into account. Serious interventions include, but are not limited to, serious treatment for physical illness, any intervention that causes the person serious distress or serious side-effects, affects seriously the options that will be available to P in the future or has a serious effect on his/her day-to-day life. The decision whether or not an act is a serious intervention or treatment with serious consequences rests with D. However, some acts are always serious interventions. These are: (a) deprivation of liberty, (b) attendance for certain treatments requirement and (c) community residence requirement.
- Certain serious interventions must be authorised by a trust panel. These include acts (a), (b) and (c) above, or the act is the provision of treatment with serious consequences and the nominated person objects, P resists or it is being done while the person is being deprived of their liberty.
- For attendance for certain treatment requirements, D must reasonably believe that failure to impose the requirement would be more likely than not to result in P not receiving the treatment.
- For community residence requirements, the prevention of harm condition must be met.

The trust panel will be made up of three persons with relevant expertise. The application will be made by a 'prescribed person' and must include a medical report and a care plan. The statutory criteria will differ depending on the measure for which authorisation is being sought.

- For treatment with serious consequences when the act amounts to a deprivation of liberty, the 'prevention of serious harm' condition must be met. D must reasonably believe that failure to detain P in circumstances amounting to a deprivation of liberty would create a risk of serious harm to P or serious physical harm to others, and the detention of P is a proportionate response to the likelihood of harm and the seriousness of the harm concerned.
- For attendance for certain treatment requirements, D must reasonably believe that failure to impose the requirement would be more likely than not to result in the person not receiving the treatment.
- For community residence requirements, the 'prevention of harm' condition must be met.
- For compulsory treatment with serious consequences against the wishes of the nominated person, the 'prevention of serious harm' condition must be met.

A second opinion is required when the act is the provision of electroconvulsive therapy or is a treatment with serious consequences where the question of best interests is finely balanced, or is the continuation of medication beyond 3 months (if the medication is treatment with serious consequences) when the person is an in-patient or in a care home, or is subject to requirements to attend for treatment in the community.

The Act provides for the provision of an independent mental capacity advocate (IMCA). An IMCA must be in place when the Act requires an act to be authorised or, although not requiring authorisation, is a serious compulsory intervention. The role of the IMCA is to support and represent P; the IMCA must be consulted but is not a decision maker.

Where an authorisation has been granted, an application can be made to a review tribunal in respect of the authorisation. This provides a judicial review of the decision to ensure that it has been made in accordance with the law and that the criteria for the authorisation have been met. Applications to the tribunal can be made by P and the nominated person. Cases may also be referred to the tribunal by the Department of Health, the Attorney General or the High Court. The trust must refer to tribunals when authorisation has been extended for 1 year (for those aged 16–17) or 2 years (for those aged 18 or over).

The clauses describing the additional safeguards to be put in place do not apply when the situation is an emergency. D is protected from liability if there is a reasonable belief that delay would create an unacceptable risk of harm to P. However, D is expected to take reasonable steps to ensure that the safeguard is met by the relevant time.

Children and young people

The Act cannot be applied to children under the age of 16 because it puts into statute the common law presumption of capacity. For those aged 16–17, the MCA will operate alongside the Children (Northern Ireland) Order 1995, and additional safeguards will be put in place. The original MHO will continue to be in place for the small number of under-16s who require compulsory assessment/treatment in hospital for mental disorder. This has been the subject of some controversy; if the current legislation is discriminatory and stigmatising, it is difficult to argue for its continued use in one particular group. It has been argued that a legislative framework for those under 16 must be brought forward. This will be a difficult task, not least because a capacity-based framework will have to grapple with the complex question of emerging capacity in young people. The government has indicated that their intention is that there will eventually be legislation for those under 16, but at present, this is some way off.

Criminal justice provisions

There are new disposal options following a finding of unfitness to plead or insanity, including public protection orders (PPOs) and supervision and assessment orders. There are powers to remand an accused person to hospital, to transfer prisoners to hospital for treatment, for interim detention orders and for immediate hospital direction on conviction. Although the MCA contains powers for involuntary admission to hospital in various circumstances, treatment decisions are based on capacity to consent and subject to the core provisions of the Act. This means that there are circumstances under which a person can be admitted to hospital against their capacitous wishes; however, they cannot be treated against their capacitous wishes.

New criteria form the basis for entry into the criminal justice provisions. A ‘disorder’, a ‘disorder requiring treatment’ and ‘an impairment of, or disturbance in, the functioning of the offender’s mind or brain’ replace mental illness and severe mental impairment. A disorder is broadly defined to include any disorder or disability, whether mental or physical: a disorder requires treatment if any of its symptoms or manifestations could be alleviated or prevented from worsening by treatment.

A person can be remanded to hospital if the medical report condition or the treatment condition are met. The medical report condition is that the person has or may have a disorder, that a report should be made into that person’s condition, that an assessment would be impracticable in custody, and that it would be practicable to assess the person in hospital. The treatment condition is that the person has a disorder requiring treatment, that failure to provide in-patient treatment would ‘more likely than not’ result in serious physical or psychological harm to the accused person or serious physical harm to others, and that remanding the person to hospital would be likely to result in significantly better clinical outcomes.

PPOs replace hospital orders. A PPO can be made when detention conditions are met. These are that: ‘there is an impairment of, or a disturbance in, the offender’s mind or brain’, that ‘appropriate care and treatment is available’, that dealing with the person without detention ‘would create a risk, linked to the impairment or disturbance, of serious physical or psychological harm to others’ and that depriving the person of their liberty would be a proportionate response to the likelihood and seriousness of that harm. Restrictions may be added where the restriction conditions are met.

A prisoner can be transferred to hospital where they have a disorder requiring treatment, failure to provide treatment would be ‘more likely than not’ to result in serious harm to the person or serious physical harm to others, and appropriate treatment is available.

Patients admitted to hospital under the MCA criminal justice provisions will remain there following tribunal only if the ‘prevention of serious harm’ condition is met. The criteria for the ‘prevention of serious harm’ condition differ for those subject to PPO and for transferred prisoners or those subject to hospital direction. The criteria for those subject to PPO are: the person has ‘an impairment of, or a disturbance in, the functioning of the mind or brain’; releasing the

person would create a risk of serious harm to others; and depriving the person of their liberty is proportionate to the likelihood and seriousness of the risk.

The criteria for transferred prisoners or those subject to hospital direction are: the person has the disorder for which they were transferred; effective treatment can be given; and it is 'more likely than not' that discharging the person to prison would result in serious harm to the person or serious physical harm to others.

Discussion

The MCA is unique in that it repeals separate mental health legislation, replacing it with a single piece of legislation applicable across all medical specialisms and social care, whereby involuntary treatment is only permitted when the person (a) has impairment of decision-making capacity and (b) the intervention proposed is in the person's best interests.

The arguments for and against replacing conventional mental health legislation with a law based on capacity have been well rehearsed in a recent debate.⁵

The removal of mental health legislation that makes decisions about involuntary treatment based on diagnosis and risk will require a significant change in practice for professionals working in mental health in Northern Ireland. It is somewhat ironic that such a radical piece of legislation, based on non-discrimination, is being introduced in a jurisdiction that spends the lowest proportion of its health budget on mental health of any UK nation.⁶

The Act must work across a wide and diverse range of settings – care homes, mental health services (both in-patient and community) and general hospitals. It will affect staff who have little previous knowledge or experience of the principles behind capacity assessment. It is therefore imperative that a comprehensive training and supervision programme is put in place, which will have considerable resource implications.

The inclusion of the 'appreciation' element introduces a difference in the definition of capacity in the MCA compared with that used in other jurisdictions. The addition of the 'appreciation' element moves the definition of capacity away from purely cognitive terms towards the concept of capacity being affected by factors such as emotional colouring, delusions and lack of insight.⁷ Because of this difference, it cannot be assumed that studies that have demonstrated the reliability of capacity assessments⁸ will automatically apply in the case of the MCA. The reliability of the use of capacity assessments using this definition of capacity in routine clinical mental health practice requires to be evaluated.

The shift away from compulsory intervention based on in-patient treatment when a particular threshold of risk is reached may facilitate earlier intervention and allow for a proportionate response across a wide range of treatment and care settings. On the other hand, there is a more widely expressed concern that capacity legislation may delay appropriate treatment.

Trust panels can authorise a very wide range of interventions. As health and social care professionals work under the principle of beneficence, there is a risk of 'slippage', with staff making decisions about impaired capacity based on a person making foolish or unwise choices. This could lead to the unintended consequence of the Act leading to a greater rather than a lesser restriction of a person's autonomy and self-determination.

There is a plethora of issues that could potentially affect clinical practice; for example, exactly what constitutes serious interventions, how to manage fluctuating capacity, the question of decision-making capacity in patients with personality disorder, patients who retain capacity but present a risk to self or others, and the potential conflict between human rights (especially the right to life) and autonomy. Some of these issues may be addressed by the code of practice, others may be left to clinicians or courts.

Conclusions

Fusion legislation (of which the MCA is an example) is a radical change in the approach to involuntary psychiatric treatment. It is an exciting and innovative development and there are substantial potential benefits, including the reduction of stigma, the protection of patient autonomy, and the removal of confusing parallel mental health and mental capacity legislation. It is also more compliant with CRPD and ECHR. Much of the practical impact of the MCA depends on the development of a comprehensive code of practice and the provision of a comprehensive training and supervision programme. In addition, as Szmukler & Kelly have pointed out,⁵ the gathering of data on its implementation is vital and the MCA must be subject to a rigorous and comprehensive evaluation.

1.7.94 Measuring relational security in forensic mental health services

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Abstract

Aims and method Relational security is an important component of care and risk assessment in mental health services, but the utility of available measures remains under-researched. This study analysed the psychometric properties of two relational security tools, the See Think Act (STA) scale and the Relational Security Explorer (RSE).

Results The STA scale had good internal consistency and could highlight differences between occupational groups, whereas the RSE did not perform well as a psychometric measure.

Clinical implications The measures provide unique and complimentary perspectives on the quality of relational security within secure services, but have some limitations. Use of the RSE should be restricted to its intended purpose; to guide team discussions about relational security, and services should refrain from collecting and aggregating this data. Until further research validates their use, relational security measurement should be multidimensional and form part of a wider process of service quality assessment.

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Serious incident investigations in forensic mental health services have been linked to relational security breakdowns. ¹ However, relational security has been described as the ‘poor relation’ ² when compared with physical or procedural security. This is most likely due to definition difficulties. Chester & Morgan ³ noted that numerous conceptualisations of relational security exist, all referencing different phenomena, such as ‘therapeutic relationships’ and ‘boundaries’, without describing how such concepts can affect security. ³ The authors noted that the most practically useful definitions emphasise exactly how relational issues affect security, in two stages: (1) staff knowledge of patients and therapeutic relationships; and (2) how patient knowledge and therapeutic relationships are used to foresee potential and manage actual security incidents, for example: ‘The professional relationships between staff and patients so that ... the staff to get to know ... their patients, their moods and problems, to facilitate interventions before these become major problems, or lead to incidents of a security nature’ (p. 171). ⁴ As such, relational security is intrinsically linked to short- and long-term assessment and management of risk in mental health and forensic services.

Relational security is therefore a service quality indicator of interest within forensic and general mental health services. Its measurement should allow practitioners to explore background causes and respond accordingly with appropriate interventions. Due to the definitional complexities, there are subsequent challenges to measurement. Previously available tools only measure partial aspects of relational security or individual patient needs. ³ However, two tools have been developed in recent years, the Relational Security Explorer ⁵ and the See Think Act scale. ² As limited research has examined the clinical utility of these measures, the present study examines their psychometric properties to support the aim of relational security measurement.

Method

Design

The study employed a within-participants (reliability testing) and between-participants (assessing the measures’ ability to identify differences between occupational groups according to the variables level of security, ward gender and length of experience working in secure services) cross-sectional questionnaire design.

Participants

Participants were recruited from a forensic service for people with intellectual disability. As guidance recommends that relational security implementation should involve all occupational groups working within secure services,⁶ the study invited all staff who have contact with patients as part of their role to take part in the study ($n = 216$), and of these 41% ($n = 89$) responded. The majority of the participants were female (63%), and the average length of service working in secure services was 6 years (range 0.12–20). The majority of participants were from the nursing department (57%), followed by occupational therapy (16%), psychology (9%), social work (6%), psychiatry (2%) and housekeeping (8%), and two participants identified their occupation as ‘other’. The level of security in which respondents worked in at the time of the study was medium (23.6%), low (27%) and locked rehabilitation (16.9%). There are no national data available which describe the demographics of the forensic mental health workforce, although the reported characteristics reflected the socio-demographic and occupational breakdown of the study service and the broader mental health workforce as a whole,⁷ being predominantly female and with nursing staff comprising the largest department followed by other members of the multidisciplinary team. As participants responded anonymously, it was not possible to undertake any analyses comparing participants with non-responders.

Measures

See Think Act (STA) scale²

The STA scale is the first attempt to create a direct measure of relational security. The 28 items were developed from the Department of Health conceptualisation of relational security,⁶ and reflect relational security scenarios (e.g. ‘We speak up if we think we can see that a colleague has been put in a difficult position that could weaken security’). Individual staff members complete the questionnaire in relation to the ward they work on, and select how closely their ward team resembles provided statements on a 4-point Likert scale, with scores of 3 ‘Just like our team’, 2 ‘Quite like our team’, 1 ‘A little like our team’ and 0 ‘Not like our team’. A principal components analysis confirmed a four-component structure of the measure: Therapeutic Risk Management, Pro-Social Team Culture, Boundaries and Patient Focus.² Initial examinations indicated good convergent validity with related measures (e.g. EssenCES⁸), and internally consistent subscales.² There is currently no normative data available for the STA scale.

The Relational Security Explorer (RSE)⁵

The RSE is a tool designed to help clinical teams working within secure settings to communicate and assess their competence in relational security. The tool requires users to provide a numerical score of their team’s confidence in eight areas of relational security: Therapy, Boundaries, Patient Mix, Patient Dynamic, Personal World, Physical Environment, Visitors and Outward Connections on a scale ranging from 1 (no confidence) to 10 (extremely confident). The RSE was not developed as a psychometric measure; however, the tool requests clinical teams to provide a numerical score of their confidence in each of the eight areas. In doing so, the tool lends itself for use as an outcomes measure and, anecdotally, the authors are aware of service’s collecting and analysing this data, despite it not being validated for this purpose. This is in line with the suggestion that when numerical indices and cut-off points are available, clinical decisions tend to be reduced to those numbers.⁹ Participants were asked to complete the RSE on an individual, rather than a team basis, to investigate the tool performance as an outcomes measure.

Procedure

The researcher arranged one-to-one meetings with staff eligible for the research, at which informed consent was sought. Once obtained, staff members were asked to complete and return the questionnaires. A debrief form was provided for participants, which detailed further information about the study.

Ethics

Ethical approval was obtained from the London Metropolitan University Research Ethics Review Panel. The National Research Ethics Service Committee for the East of England – Norfolk was also approached for ethical review of the project, who advised that as the relational security measures were being used in routine clinical practice within the study service, the study does not require National Health Service ethical approval.^{10,11}

Data analysis

Prior to analysis, assumption testing for parametric tests was completed. The assumption of homogeneity of variance was violated, and the data were negatively skewed, violating the assumption of normal distribution. Transformations of the data were attempted, but this did not reduce the skew. A number of cases appeared as outliers for all outcome variables, and notably, these cases were all from the housekeeping department. Data were therefore examined using non-parametric methods. This point was discussed with our statistician, who assured us that the loss of power associated with the non-parametric tests was small.

Therefore, internal consistency was examined using Spearman's Rho correlation to calculate the Corrected Item-Total Correlation (CITC) coefficient values for subscales of the STA and the RSE. Convergent validity was analysed by correlating subscales of the STA scale and the RSE using Spearman's Rho. The Sidak adjustment was used to adjust for multiple comparisons.

Non-parametric statistical tests were used to examine the association between scores on the STA and the RSE, and the variables requested in the demographic questionnaire (length of experience working in secure services, the ward and level of security worked on, the gender of the patients on their ward, and staff department/occupational discipline). Analysis between individual wards and staff occupational discipline could not be completed due to small and unequal numbers between the groups. To examine the association between level of security and the subscales of the two measures, the Kruskal-Wallis test was used. The Wilcoxon Mann-Whitney *U*-test was used to examine the association between gender of patients and the subscales. To examine the association between length of experience working in secure services and the subscales, Spearman's Rho correlation was used.

Results

Internal consistency

Internal consistency was assessed using CITC coefficients. A CITC value above 0.5 is considered high, but if less than 0.3, items within a subscale may be measuring more than one construct. All RSE subscales exceeded the CITC 0.30 cut-off, although there was some variation, with the Personal World subscale having the highest internal consistency at 0.80, and the Physical Environment subscale the lowest at 0.49. All the STA subscales had CITC scores over 0.9. *Table 1* displays the CITC coefficient values for each subscale of the two measures.

Corrected Item-Total Correlation (CITC)

Measure	CITC
Relational Security Explorer	
Therapy	0.66
Boundaries	0.61
Patient Mix	0.57
Patient Dynamic	0.65
Personal World	0.80
Physical Environment	0.49
Visitors	0.62
Outward Connections	0.68
See Think Act scale	
Therapeutic Risk Management	0.90
Pro-Social Team Culture	0.96
Boundaries	0.92
Patient Focus	0.92

Convergent validity between measures

There was little convergent validity between the subscales of the two measures. All four subscales of the STA scale correlated significantly with each other, whereas subscales of the RSE did not. The Spearman's Rho values are detailed in *Table 2*.

Correlations matrix of the subscales of See Think Act scale and Relational Security Explorer

	See Think Act scale	Relational Security Explorer											
See Think Act scale													
Therapeutic Risk Management	1												
Pro Social Team Culture	0.808` ** <#TFN 1>`__	1											
Boundaries	0.780` ** <#TFN 1>`__	0.878` ** <#TFN 1>`__	1										
Patient Focus	0.812` ** <#TFN 1>`__	0.846` ** <#TFN 1>`__	0.795` ** <#TFN 1>`__	1									
Relational Security Explorer													
Therapy	0.424	0.436	0.344	0.413	1								
Boundaries	0.470	0.411	0.367	0.341	0.469` ** <#TFN 1>`__	1							
Patient Mix	0.444	0.468	0.582` ** <#TFN 1>`__	0.401	0.338	0.293	1						
Patient Dynamic	0.453	0.482	0.457	0.401	0.515` ** <#TFN 1>`__	0.300	0.668` ** <#TFN 1>`__	1					
Personal World	0.485	0.487	0.391	0.465	0.588` ** <#TFN 1>`__	0.439` ** <#TFN 1>`__	0.319	0.447` ** <#TFN 1>`__	1				
Physical Environment	0.091	0.182	0.247	0.246	0.251	0.249	0.110	0.173	0.239	1			
Outward Connections	0.320	0.236	0.171	0.278	0.273	0.266	0.297	0.300	0.556` ** <#TFN 1>`__	0.186	1		

Correlation is significant at the 0.01 level.

Between-groups analysis

Level of security

Significant differences in scores on the two measures were found between staff working in different levels of security. Staff working on medium secure wards tended to have the lowest scores on both measures, followed by staff on low secure wards, with the highest scores on rehabilitation wards. On the STA scale, this reached statistical significance on the Therapeutic Risk Management ($P < 0.001$), Boundaries ($P = 0.012$) and Patient Focus ($P = 0.034$) subscales. There were also significant differences on the RSE, on the Patient Mix ($P < 0.001$), Patient Dynamic ($P = 0.008$) and Personal World ($P = 0.011$) subscales. Descriptive data for this variable are presented in *Table 3*.

Descriptive statistics for level of security on the See Think Act scale and Relational Security Explorer

	Level of security, mean (s.d.)		
See Think Act scale <i>a</i>			
Therapeutic Risk Management	2.34 (0.44)	2.54 (0.39)	2.8 (0.25)
Pro-Social Team Culture	2.34 (0.49)	2.52 (0.48)	2.68 (0.41)
Boundaries	2.5 (0.43)	2.64 (0.41)	2.83 (0.31)
Patient Focus	2.5 (0.45)	2.76 (0.49)	2.76 (0.34)
Relational Security Explorer <i>b</i>			
Therapy	7.46 (1.61)	7.47 (0.26)	8.07 (1.61)
Boundaries	7.85 (1.21)	8.3 (0.26)	8.3 (1.21)
Patient Mix	7.54 (0.97)	7.1 (1.56)	8.71 (0.61)
Patient Dynamic	7.15 (1.34)	7.1 (1.34)	8.3 (0.83)
Personal World	7.31 (1.7)	7.41 (1.18)	8.5 (1.09)
Physical Environment	7.23 (1.7)	7.88 (1.4)	8.07 (1.33)
Visitors	7.0 (1.09)	7.0 (1.12)	7.64 (1.98)
Outward Connections	7.23 (1.36)	7.17 (1.74)	8.07 (1.59)

The scale for the See Think Act scale is 0–3.

The scale for the Relational Security Explorer is 1–9.

Ward gender

There were no differences in STA scale scores between staff working on wards caring for male patients, as compared to female patients. However, on the RSE, staff working with male patients reported higher scores on the Patient Dynamic ($P = 0.024$) subscale, compared with staff working with female patients.

Length of experience working in secure services

There was no correlation between the number of years staff had been working in secure services, and their confidence in relational security, on the STA scale or the RSE.

Discussion

Serious incidents within forensic mental health services can be linked to breakdowns of relational security.¹ Available measures should therefore provide insight into the quality of relational security within services, direct exploration of strengths and weaknesses, and prompt timely, appropriate interventions before an incident occurs. Furthermore, tools should be accessible to all occupation groups.⁶ This study therefore evaluated the psychometric properties of the STA and the RSE, including internal consistency, convergent validity and their ability to highlight differences between groups.

Study limitations include a relatively small sample size, and participants being drawn from a single service, which limit generalisability. It is categorised as a preliminary study for these reasons. However, the study reports interesting findings in relation to the specific tools examined and the wider task of measuring relational security by investigating the perspectives of staff members across occupational professions and levels of security. The study setting, a secure intellectual disability service, may be viewed as a strength, as previous studies have been completed only within generic forensic psychiatric services, and as a weakness, due to the extent of the study findings generalising to non-intellectual disability services. Research comparing patient characteristics between mainstream forensic and specialist intellectual disability services is scarce, however there are a number of notable differences between the two populations which may have an effect on relational security. These include communication difficulties which could affect the development of therapeutic relationships, increased levels of behavioural incidents,¹² and higher assessed risk on structured clinical judgement tools.^{13–15} That said, the present research reports many findings which echo those of previous research.²

Test–re–test reliability was not examined in the present research, although it may be an interesting area for further study. At present, the stability of relational security levels are unclear, and it may not be realistic or relevant to expect stability over time, as relational security is a fundamentally a dynamic concept.

The internal consistency aspect of reliability was examined, with the STA scale demonstrating high levels in accordance with previous research.² Its subscales correlated significantly, suggesting they are statistically related concepts. Internal consistency for the RSE was adequate but its subscales did not all correlate significantly, possibly indicating that some of the concepts measured are statistically unrelated. Although the RSE and the STA both aim to measure relational security, convergent validity was low. Collectively, these findings suggest that the RSE does not perform as well as the STA as a psychometric outcome measure. This raises questions regarding the practice of collecting and analysing data from the RSE, despite not being validated for this purpose. Lodewijks *et al*⁹ explicitly advise against the use of numerical indices and cut-off points, due to clinicians' tendency to reduce clinical decisions to numbers if they are available.

Particular subscales of the two measures were able to detect differences between groups in relational security confidence, thus facilitating the comparison of wards and staff disciplines within a service, potentially between services comparisons, and directing intervention as necessary. Significant findings were reported between wards of different levels of security, with relational security confidence lowest on medium secure wards, increasing on low secure wards, and highest on rehabilitation wards. Tighe & Gudjonsson² also reported this effect, as well as authors investigating social climate in secure settings.^{16,17} A possible explanation for this is that medium secure wards represent the beginning of the care pathway accepting newly admitted patients and, as such, staff have had less opportunity to develop the knowledge of patients and therapeutic relationships necessary to achieve good relational security. As patients progress

through the low secure and rehabilitation stages of the care pathway, this provides an opportunity for the components necessary to relational security to develop.

The study also compared relational security confidence between staff working with male and female patients. This was examined as authors have documented difficulties in building therapeutic relationships with women, due to their clinical complexity.^{18,19} However, there were few differences between these two groups on the subscales of the two measures, although staff working with male patients reported higher scores on the Patient Dynamic ($P = 0.024$) subscale of the RSE.⁵

It was expected that staff with more experience working within secure services would be more confident in their judgements of relational security, but there were no significant associations. However, relational security relies on knowledge of patients and therapeutic relationships, within a dynamic environment. For example, if a new patient is admitted to a ward, all staff, regardless of experience will begin to develop their knowledge and their therapeutic relationships with this patient at the same time. Furthermore, if an experienced staff member is asked to move onto a different ward, they will know little about the patients on that ward and have to develop new knowledge and therapeutic relationships. In this sense, all staff members, regardless of experience, are repeatedly beginning and developing their knowledge of individual patients and new therapeutic relationships.

Housekeeping staff felt less confident in relational security, as compared to all other departments. This is probably due to the measures tapping into areas of clinical practice that housekeeping staff would not be involved in, and the comparable lack of training offered to this group. However, guidance recommends that relational security implementation should involve all occupational groups working within secure services.⁶ As housekeeping staff are a daily presence on forensic wards, they are equally as vulnerable to relational security issues and in a position to witness threats to security. Further research should investigate ways to support all occupational groups with relational security.

Measuring relational security: further considerations

Some points are of note when interpreting data obtained from relational security measures. Initial assumption testing indicated negatively skewed data, suggesting that most participants rated their confidence in relational security at the top end of each measures' respective scale. This could indicate that staff working in this particular service are highly confident in their relational security practice. However, it is unclear how confidence scores relate to the actual quality of relational security within a ward, for example is a highly confident team an experienced team or a complacent team? It could also indicate positive responding, as essentially, measures are asking individuals to rate themselves in an aspect of their role in which they are expected to be competent. Introducing some negatively worded items could improve this.

High scoring may also be due to the way the two tools conceptualise relational security. Both measures are based on the STA conceptualisation of relational security,⁶ which places much of the responsibility onto staff and teams, thus neglecting the 'quantitative' aspects of relational security, for example 'staff-to-patient ratio and amount of time spent in face-to-face contact' (p. 434)²⁰ and the supportive role and responsibility of service management. For example, to achieve quality therapeutic relationships with patients, ward staff and teams need to be stable, with minimum staff ward moves, turnover and absenteeism,³ factors outside of staff members' control. Incorporating items reflecting such aspects of relational security could provide a more comprehensive picture.

Normative data are not currently available for either of the two measures, which limits the interpretability of the results. Both measures are designed to be used by staff members in relation to one specific ward. However, many employees work across multiple wards in secure services, with 27% respondents in this sample working across wards. These participants were typically from occupational departments other than nursing, such as psychology, psychiatry, social work and occupational therapy.

Conclusions

The increased attention relational security is receiving within the forensic field is a welcome advance. There is growing awareness around the importance of this concept, and resources aiming to raise awareness and support the implementation of relational security are widely available.²¹ However, until recently there have been few mechanisms to assess the quality of relational security within services. The results of this study suggest that the STA scale and the RSE hold unique and complimentary roles attempting to support relational security. The RSE did not perform well as a psychometric measure, and therefore its use should be limited to its intended purpose – as a tool to guide team discussions about relational security – and services should refrain from using the RSE as an outcomes measure. However, deciding on a numerical score of relational security confidence may serve a function within the context of a team discussion, for example, if one team member feels the ward should score highly, whereas another member feels the ward should be given a lower score, this could suggest team splitting and form a basis for discussion. At present, the STA scale is best placed to provide insight into the quality of their relational security, while taking into account the aforementioned issues when interpreting the data.

Further research is needed in all areas of relational security: definition, implementation and measurement. This research should examine the relationship between relational security and negative outcomes, such as institutional aggression or serious incidents. Future studies should evaluate the clinical utility of the RSE, examine the psychometric properties and provide normative data for the STA. Until more is known about relational security, the approach to implementing and measuring it should be multidimensional,²² i.e. incorporating staff, patient and service management perspectives.

The authors are grateful to Paul Bassett for his help with statistical analysis.

1.7.95 Profile. The constant psychiatrist: an interview with Michael Kopelman

Norman Poole¹

date

2017-12

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- *Profile. The constant psychiatrist: an interview with Michael Kopelman*

From his journal-lined office in St Thomas' Hospital Professor Michael Kopelman could quietly yet assiduously observe the powerful in their Palace of Westminster just across the Thames. Following retirement in 2015 he has become ever more alarmed by the spectacle: “Our society, in my view, is becoming more and more authoritarian. It's very worrying the direction we are moving in. Even within our university system and the NHS things have become much less democratic than they used to be, and much more authoritarian. It's both sad and frightening.” A perpetually crumpled mac under his arm, the Professor appears much like an MI6 officer in a le Carré novel grown disillusioned with the culture of edicts, diktats and target-driven performance for the workers while those in positions of power sit removed and aloof.

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‘Now it’s really the chief executive and his executive team who run things. With no disrespect to any particular individual, some of whom are very good, I can’t see that they have proper accountability. We doctors have accountability. We can be hauled before the GMC. But managers and commissioners, who are changing the healthcare environment, often for the worse, are not held to account in the same way.’

The Professor’s comportment is at one with his assertion, ‘These are matters I feel strongly about.’

Indeed. For just as the anti-heroes in le Carré’s novels battle with the bureaucracies in which they work, Professor Kopelman is exasperated by perceived wisdom, particularly with regard to a matter close to his professional heart, the modern memory clinic. ‘The memory clinics that are being set up under the Dementia Strategy are not what I would advocate.’ A Fellow of the Academy of Medical Sciences and founding member of the Memory Disorders Research Society, Professor Kopelman appreciates the diversity of problems that have an impact on cognition.

‘There is a wide range of memory disorders to be diagnosed, and the early diagnosis of dementia, even by the very experienced, is difficult. There are very sad implications if you get it wrong. The earlier we go for diagnosis the more likely we are to get it wrong, whatever the clinical/genetic/biomarker tools that we have.’

Criticising the consensus again, he says: “‘I think, and I’m not popular for saying this, that nurse-led diagnostic teams making early diagnosis is not the direction to go in. The direction to go is better care for those with established diagnoses of dementia. What we have at present is shameful, and in my view it’s actually now worse than in the 1980s.’” Professor Michael Kopelman. It is perhaps this disillusionment that partly drives his medico-legal work, in which he is fearless in tackling injustice head-on. On many occasions he has been involved in headline-grabbing courtroom dramas that could themselves be the stuff of fiction. Interestingly, he highlights a radical human rights lawyer as the anti-establishment role model for his own legal work.

‘Gareth Peirce is superb at using the legal rules to beat authoritarians and government. She plays within the system, but she does it better than the government lawyers and beats them. That fits my temperament. Not shouting or protesting on the streets, but playing the system to get justice for people.’

Clashes with the establishment have seen Professor Kopelman fight for the falsely convicted and for Guantánamo detainees. He said: “‘I got into false confession cases, which I see as a form of memory disorder, and was involved in overturning convictions; one from 50 years ago, another after 25 years, and a delusional memory case at 26 years.’” He added: “‘Then with two others – a therapist and a GP – I wrote a report in 2010 on people who had come back from Guantánamo, including some prominent names, and this resulted in them getting substantial amounts of compensation. Ken Clarke announcing this in Parliament made the somewhat ambiguous statement, “We must never let this happen again.” I feel in some ways I have done more good from this sort of work than anything else, and that’s what I’m going to do in my retirement.’” His colleagues obviously agree as Professor Kopelman has previously been elected to serve as president of the British Academy of Forensic Sciences.

This ability to perform scalpel-sharp analyses of intricate legal cases and their relation to esoteric psycho-pathology originates in his wide-ranging reading list at medical school and a first degree in psychology. ‘I had gone into psychology and enjoyed it, and before that – oh I hate to say the cliché – I was interested in people, and enjoyed literature from the psychological angle. So this is what I was curious about.’ Upon gaining a place studying medicine at Middlesex University, he was not your typical medical student: ‘I read Luria quite early on, when I should have been reading anatomy textbooks!’

Paradoxically, a contemporary model of memory claims that it evolved to enable planning for the future, or mental time travel.¹ Professor Kopelman’s forays into the science of memory were thus doubly prescient: “‘I’d been interested in the neuropsychology of memory, which was just developing at the end of the 60s and 70s. I was reading quite a lot of the amnesia stuff at an early stage and I was interested in the more biological aspects of psychology. I knew I would either do neurology with an interest in cognitive neurology or psychiatry with an interest in neuropsychiatry, and I’ve ended up in the middle discipline.’” That’s rather too modestly put given that Professor Kopelman actually ended up as president of both the British Neuropsychological Society and the International Neuropsychiatric Association, and is currently Presiding President of the International Neuropsychological Society.

The influence of psychology so early in his academic career may well contribute to his continued aversion to reductive thinking about mental disorder: ‘I get a bit anxious about what I call naive reductionism, the kind of approach that

thinks that all PTSD and depression are just disorders of the hippocampi or the frontal lobes or whatever. I think that is very simplistic.’ Adding, ‘We have to remember the brain is operating within a social context and not to underplay the importance of our social context.’ It is to his own social context that his mind now turns. Between confrontations with government barristers and completing research programmes at St Thomas’, where he can still be found a few days of the week, Professor Kopelman divides his time between a beautiful 18th-century home in Surrey and a cottage in Norfolk. It is apparent that similarities to le Carré’s heroes don’t just end with the raincoat.

1.7.96 Handbook of Secure Care

Lindsay Thomson¹

date

2017-12

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- *Handbook of Secure Care*

The *Handbook of Secure Care* is a useful book for those new to the field of forensic mental health and is most relevant to those practising in England and Wales. It examines the relationship between mental disorder and offending, with individual chapters on personality disorder, intellectual disability, autism spectrum disorder and acquired brain injury. Strangely, there is little on psychosis which is the fundamental diagnosis within secure care.

The work considers the needs of specific populations such as women, young and older people, and outlines the provision of secure psychiatric services for these groups. It focuses on the basic components of secure care and includes information on risk assessment and management, and on recovery. The latter chapter is of particular use in defining the challenges we face in secure care and ways to redefine our conventional thinking. The fundamentals of psychological treatment in secure care are clearly set out and there is a helpful description of the role of nursing within that setting.

There is discussion in the first chapter on the evolution of secure and forensic mental healthcare, as well as information on the number of secure beds, but I would have welcomed an analysis of the overall estate, the needs for planning and the methods of provision. Similarly, details on pathways into or out of secure care, or on the legislation that allows us to detain people within these settings would have been valuable.

Notably, there is a good chapter by Penny & Exworthy on human rights in secure psychiatric care – the Human Rights Act 1998 underpins much of what we do in secure care, making this especially relevant. It is followed by a chapter on quality assurance and clinical audit. It is my view that the human rights considerations and the quality improvement agenda are so crucial to our work that it would have been beneficial to place these chapters near the beginning of the book to emphasise their importance.

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1.8 2015

1.8.1 Severn School of Psychiatry education fellowships: a new way to promote educational practice and research

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date

2015-4

Abstract

This paper describes a model of training in leadership and project management skills for advanced trainees, using educational projects within the Severn School of Psychiatry. Fellowships lasting 1 year have been developed to enable trainees, working with a senior consultant trainer associated with the School of Psychiatry, to support important new educational initiatives. Linkage with the local university training and learning for health professionals research module has provided academic support for the trainees and the projects. Four examples for the first year of the programme are described and feedback from structured interviews with participants is presented. The development of the fellowships appears to have had wider benefits, in developing educational faculty in the School of Psychiatry and the trainees involved have had opportunities to extend their project management and leadership skills. The fellowship programme is continuing to develop, based on feedback from its first successful year.

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- *Severn School of Psychiatry education fellowships: a new way to promote educational practice and research*
– *Background*

1

Rob Macpherson is a consultant psychiatrist and head of School of Psychiatry, Health Education England, Cheltenham. **Sherlie Arulanandam**, is an Advanced Trainee in the Department of Liaison Psychiatry at Bristol Royal Infirmary. **Guy Undrill** is a consultant psychiatrist for the Crisis Resolution and Home Treatment Team South West area, 2Gether Trust, Cheltenham and a regional advisor in Psychiatry, South West Region. **Simon Atkinson** is the director at Teaching Learning for Health Professionals at Bristol University. **Steve Arnott** is the director of medical education at the AWP NHS Trust, Bristol. **Sian Hughes** is a consultant in the crisis team at Bybrook Lodge, Blackberry Hill Hospital, Avon and Wiltshire Partnership Trust, Bristol. **Hannah Toogood** is a specialty registrar in learning disability psychiatry at New Friends Hall, Bristol. **Karl Scheeres** is a clinical teaching fellow at AWP NHS Trust, Bristol. **Luciana Matone** is a child and adolescent psychiatrist at Melksham Community Hospital, Oxford Health NHS Foundation Trust.

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 - * *Developing knowledge and skills among core trainees*
- *Results*
 - * *Feedback from educational fellows*
 - * *Feedback from the consultant leads*
- *Discussion*
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Background

To increase the range of opportunities and quality of education within the Severn School of Psychiatry, we have in recent years developed a range of projects across the School. Although there is a strong group of trainers, training programme directors, tutors and directors of medical education (DME) who provide leadership, there is limited time within job planned allowances across the senior trainer group to permit extensive work within projects. Advanced trainees need to develop leadership skills and we felt an obvious vehicle to promote this was through co-leadership of educational projects. There are opportunities across the School for projects in areas of educational theory, quality assurance, review of educational processes, innovation and new methods of training/assessment. The Royal College of Psychiatrists' curricula for advanced training in each specialty contain specific leadership domains and recommendations for training in this area, but a survey of advanced trainees¹ showed that many questioned how prepared they felt for the role of consultant. The survey indicated they felt well prepared for the clinical role, but less prepared for leading, designing and changing services. There was felt to be a need for higher training to engage with the entirety of the new consultant role.

A business internship model, which now operates across all areas of the Severn School of Psychiatry, has provided opportunities for project-based management training. Similar to the paired learning initiative described elsewhere,² this has had wider benefits for the trainee population and also to the organisations where trainees have had opportunities to work on important trust management projects. We noted that as well as preparing trainees for the management aspects of their new consultant roles, it is important to prepare them fully for the educational role as the majority will become trainers. A smaller group will go on to develop higher-level training responsibilities, such as tutor, training programme directors, DME or head of school role. Project management has the potential to facilitate development across a wide range of areas because of its multifaceted nature and the requirement to work across a variety of interfaces.

Programme description

The project aimed to offer four educational fellowships over 1 year, allocated through competition. A number of senior faculty members took a lead role in overseeing the programme: the head of the School of Psychiatry (R.M.); the lead for the local MRCPsych core course (S.H.); the regional advisor (G.U.); the lead from the local university training and learning for healthcare professionals department (S.Atk.); and a local director of medical education (S.Arn.). The fellowships were made available by email invitation to all advanced trainees (approximately 50). Trainees were invited to submit an application to undertake a fellowship, through writing a 500-word statement, expressing their interest in this and their key relevant background skills. An assessment framework was developed to rank submissions to decide on appointment and fellows were appointed in the spring 2012, to start their fellowship from August of that year.

Fellowships lasted a minimum of 1 year, with the fellows meeting monthly for peer support, together with project leads and with educational supervision from the teaching and learning for healthcare professionals (TLHP) team. It was expected that trainees use non-clinical special interest time for the project. Each project was overseen and co-led by a consultant with a specific, related educational role. We suggested that the educational fellow worked with a core trainee in his or her trust, aiming to involve a wider number of trainees, to provide an interesting and attractive opportunity for the core trainee and also to give opportunities for the fellows to give academic/project supervision, viewing the core trainee as a research assistant in this context. Depending on commitments, core trainees were welcome to attend the fellowship supervision sessions.

The work required was expected to vary across the different projects, but some common requirements were set out: literature review and summary of relevant evidence; liaison with key stakeholders including service user and carer groups; liaison with the trainee group; development of option appraisals; preparation of reports; presentation of material to the wider educational community; and dissemination through deanery and regional/national training forums.

The fellows were automatically enrolled on the TLHP research methods module, with an expectation that each fellow attend two study days and complete assignments, based on their fellowship project. On successful completion of the course they would be awarded 20 credits at Masters level (approximately one-third of the Masters course) and were able to take this credit into any further work in this area. The costs of the module (approximately £1200) were supported by the Deanery, other than for one fellow who was funded directly by the DME. Meetings of the project group were held in the Deanery and any costs for specific activities related to projects were considered by the head of School, in collaboration with the school of psychiatry manager in the Deanery. The programme was managed through the School of Psychiatry and issues arising reported to the board and wider deanery colleagues as necessary. Further governance support was obtained as needed through the Severn Deanery Executive team, who supported the project.

Projects overview

Training across boundaries (TAB)

This project, led by R.M. and S.Aru., explored the development of training links between core psychiatry and medical/general practice posts. It aimed to provide opportunities for exposure to different medical specialties. Although this has been recommended in the psychiatry training literature, there were no examples in the literature that we could find to describe this. The project focused on core training years two and three across two mental health trusts. The project was carried out in a single 6-month period from February to July 2013. Trainees were encouraged to maintain a reflective log and ideally complete a workplace-based assessment in their project. Up to six TAB sessions were encouraged during the 6-month placement. The project was relatively successful, 12 trainees undertaking a TAB placement in the time specified. Placements included general practice, neurology, paediatrics, endocrinology, emergency medicine and neuroimaging. The programme was more trainee-led than expected. Feedback suggested trainees had a range of valued, positive training experiences and this project will be written up elsewhere.

Supervision project

This project, led by S.Aru. and L.M., focused on exploration of educational supervision. It was noted that despite supervision being a central aspect of psychiatric training, the literature was limited regarding the activity occurring within supervision sessions. Nine structured interviews of advanced trainees were carried out by L.M. These focused on experiences of supervision and were transcribed, then subjected to thematic analysis, with the expectation of disseminating the results.

Communication skills training project

This project was led by G.U. and H.T. The project noted a paucity of literature relating to the evidence around communication skills appropriate to basic psychiatric training. A programme of development of the communication skills training within the core psychiatric trainees' course was undertaken. This included use of videos and more systematic, structured feedback. This was developed into more refined skills assessment using simulation and is now being further developed with the use of a software package to formally rate aspects of communication skills and provide structured feedback to the interviewer.

Developing knowledge and skills among core trainees

This project was led by S.H. and K.S. The project started from an awareness of local and national difficulties in knowledge, skills and competence within the core psychiatric trainee group. It was noted that many trainees had problems passing the College clinical exam, despite successful completion of clinical competence requirements in placements. The project identified a range of different interventions potentially of use to help core trainees. These included a mock clinical assessment of skills and competencies (CASC) exam, additional communication skills training, cultural awareness training, cognitive assessment and targeted skills development. The project is being further developed in a second round of educational fellowships.

Results

In the first year of the fellowship there were 12 supervision sessions. Trainee attendance ranged from 5 to 11, in total 34 attendances across the year. Consultant attendance ranged from 9 to 11, total 40 attendances across the year.

Feedback from educational fellows

The educational fellows reported that the administration of the programme was effective and they felt well engaged in their projects and the supervision programme. There was some concern about the way trainees were linked to individual projects and the potential for trainee choice about projects undertaken. However, it was noted that within the projects there was substantial choice and multiple opportunities for individual development. Supervision was found to be helpful, particularly with regards to the attendance by the TLHP team. The network of supervision provided a useful prompt to ensure that projects did not stagnate and was found to be interesting, although in some cases the individual's supervision with project supervisors was felt to be more helpful in terms of project design and problem-solving.

Communication outside supervision ranged from two to four times per month, with trainees feeling they had appropriate levels of support. In terms of challenges encountered during the project, the fellows reported some difficulties in managing the project within time restraints and in two cases a risk of the project escalating into an unmanageable, larger scale research project. The trainees felt that more specific input from an educational specialist could have been valuable across the programme and that greater attention could have been paid to educational and management theory alongside the practical experiences gained. The two trainees who completed the TLHP research module found it helpful and highly relevant to their involvement in the fellowship. One trainee planned to attend the course at a later stage.

Trainees reported a range of different opportunities arising from their involvement. These included the development of teaching, mentoring and education research skills, as well as softer benefits such as increased confidence and networking with research experts. Trainees also gained understanding of the challenges of project management and dealing with resistance. Issues around data protection and consent were sometimes difficult and required negotiation with senior colleagues in the Deanery. Liaison across different disciplines was valued and one trainee reported that using formal project management systems such as a Gantt chart had been valuable. Two of the trainees reported that the fellowship had a significant impact in the development of leadership skills and enabling reflection on leadership style. A range of different skills including transactional, participative approaches were required and it was noted that developing a non-hierarchical, inclusive style of working with trainees and others had been important. It was felt that attention to the development of leadership skills could be helpful in future fellowship programmes. All four trainees recommended

the fellowship programme to other trainees and there were a range of other comments including the suggestion that this was the most helpful leadership/management training experience obtained so far.

Feedback from the consultant leads

This was obtained through a similar format. Advice from other consultant colleagues and the TLHP team within supervision sessions was found to be helpful, as was group support and input from trainees. It was noted that working with bright trainees who were highly motivated and interested in education enabled the development of a wider educational faculty. The consultant group noted that there had been some specific problems around transcription and information technology that had hindered the completion of some projects. It was noted that in some cases there was a process of continuing improvement/development, meaning that the completion of one aspect of a project would open up further developments. The consultants particularly valued the opportunity to work closely with senior trainees and to develop a major project. It was noted that issues around leadership and project management were centrally involved throughout the project and this provided many opportunities for training and learning. The fellowships also provided opportunities for creative development that was not constrained by bureaucracy and seemed to develop the skills of trainees who were likely to become the senior trainers of the future. There was significant learning around the area of leadership and project management in the consultant group also, particularly around the balance between guidance and instruction/direct facilitation. It was felt that ideally trainees should be allowed to develop their skills by testing their own ideas out. It was noted that coaching skills, rather than supervision or line management was most helpful in this context. The consultants all recommended the fellowship programme to other trainees and to other consultant colleagues, particularly those involved in a senior educational role.

Discussion

This paper presents a model for training advanced trainees in leadership, education and management through co-development of educational projects with senior educationalists in a school of psychiatry. It was apparent that, as reported in other educational literature,³ effective leadership of the projects was associated with being proactive and fully engaged with the group affected by the project. The educational fellow and paired consultant needed to integrate a clear project focus and vision, with effective implementation, for projects to progress effectively. Five factors have been associated with effective leadership⁴ (*Box 1*) and recognition of these featured frequently in feedback from consultants and educational fellows.

Box 1 Factors associated with effective leadership⁴

Modelling the way – leading by example in a manner that is consistent with leader’s stated values. Inspiring a shared vision – developing a compelling vision of the future and enlisting the commitment of others. Challenging the process – being on the look-out for opportunities to improve the organisation and being prepared to experiment. Enabling others to act – promoting collaborative working; empowering others; building trust. Encouraging the heart – recognising individuals’ contributions; celebrating accomplishments.

Other feedback noted that a key process in this project was the development of senior educational faculty (including the advanced trainees) and the development of a collegiate culture based on the principles of coaching and mentoring, which can have benefits for educational satisfaction, academic and personal development.⁵ There were obvious benefits for senior faculty in participation in this work and an aim of this project was to facilitate project management across the School, giving opportunities for the consultants to complete work that otherwise may not have been feasible. For the trainees, the project enabled holistic development, encompassing academic learning and the development of skills such as problem-solving and analysis. There is a need for training organisations to provide a portfolio of learning opportunities and resources, to facilitate the development of management and leadership skills among senior trainees.

The joint supervision sessions were valued by all participants. Others have noted⁶ that it is the process of bringing many constituencies into debates that facilitates transformation, rather than restricting the process to a small number of consensual voices. Such ideas fit naturally with theory around ‘sense making’, which emphasises the role, after the initial impetus has been set by leaders, of inclusive and widespread conversations and reflection, to explore new possibilities and the emerging pattern of changes.

Future plans

It is hoped that a number of this first phase of projects will produce publications and be presented at regional and College forums. The fellowship programme is now in its second year and has recruited four new trainees into new projects, with two new consultant leaders. The fellows from year one are invited to continue to attend supervision sessions as are the two consultants no longer actively working on projects. Feedback from year one was used to plan for greater choice of projects for trainees, increased academic and theory input to supervision sessions and the involvement in the TLHP module has been timed to fit better with the project timeline.

Work carried out in The Severn School of Psychiatry, Health Education England SW.

1.8.2 Advance care planning and palliative medicine in advanced dementia: a literature review

Ketan Dipak Jethwa Oluwademilade Onalaja

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date

2015-4

Abstract

Aims and method To assess the factors that affect the clinical use of advanced care planning and palliative care interventions in patients with dementia. A literature search of Medline, Embase and PsycINFO was performed to identify themes in advanced care planning and palliative care in dementia.

Results In total, 64 articles were found, including 12 reviews, and three key areas emerged: barriers to advanced care planning, raising awareness and fostering communication between professionals and patients, and disease-specific interventions.

Clinical implications Most of the studies analysed were carried out in the USA or Continental Europe. This narrative review aims to help guide future primary research, systematic reviews and service development in the UK.

Contents

- *Advance care planning and palliative medicine in advanced dementia: a literature review*
- *Method*

1

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 - * *Barriers to advanced care planning*
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 - * *Management issues specific to patients with dementia*
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 - * *Limitations*

Advance care planning is a targeted intervention that promotes autonomy for end-of-life decisions. It is particularly important in dementia where the illness impairs individuals' decision-making abilities. Patients with advancing dementia experience significant comorbidities such as malnutrition and dehydration. They may have no advance care plan (ACP) in place and this can pose difficult management questions for their families and attending physicians concerning palliation and end-of-life care.

Method

A search of Medline, Embase and PsycINFO was performed to investigate the current literature on ACP and palliative care in dementia. The following search protocol was used: ([‘advance care plan*’] AND [‘palliat*’ OR ‘palliative care’ OR ‘end of life’] AND [‘dementia’ OR ‘Alzheimer’s’]).

Results

The search produced 64 journal articles, including 12 reviews. The titles and abstracts of these articles were reviewed. Those published in English and pertaining explicitly to palliative interventions or advance care planning in dementia were looked at more thoroughly.

The majority of the studies found were conducted in the USA or Continental Europe. This limits the generalisability of study findings to practice in the UK. For example, in the USA artificial nutrition is commonly used, whereas in the UK the National Institute for Health and Care Excellence (NICE) guidelines for dementia ¹ state that artificial nutrition should not commence if there is resistance to eating or difficulties in swallowing, related to progression of the disease. Differences in service configuration between countries also limit the generalisability of these studies, especially when considering the role of different agencies in delivering care. Assertive outreach in general psychiatry clearly demonstrates this. In the USA it is associated with improved outcomes and cost-effectiveness; however, these findings have not been replicated in Europe because of differences in the way services are organised. ²

The purpose of this literature review was to identify key themes for future research and development and how they may relate to practice in the UK.

Discussion

Our review of the relevant papers identified the following themes:

barriers to advanced care planning raising awareness and fostering communication between families and health professionals management issues specific to patients with dementia.

Barriers to advanced care planning

Patient-centred care involves the assessment of physical illness and its functional impact with consideration of the patient's preferences, needs and values, whereas ACP is a tool that aims to enhance individual autonomy in addressing end-of-life care. This approach becomes challenging when patients lack capacity to make their own decisions. At present, relatively few patients have such care plans in place. The reasons for this are multifactorial and are likely to represent both patient- and health professional-specific barriers.

In a Spanish study, a cohort of patients with mild Alzheimer's disease and 'proven decision-making capacity' were supported by a multidisciplinary team (MDT) to draw up an ACP.³ Of the 15 patients recruited only 1 drafted a plan. Psychiatric comorbidities (depression and anosognosia), complex family dynamics and a reluctance to engage with the process were cited as patient factors contributing to poor uptake. This initial study highlights the importance of identifying and managing psychiatric disorders in patients with cognitive impairment. This is especially important as improvement in affective symptoms may also result in some improvement in cognitive function, especially in the early stages of dementia.

Delivering advanced care planning and palliative care in acute general hospitals has also been investigated. An intervention, supporting carers, was delivered when a patient with severe dementia was admitted to hospital.⁴ A designated team discussed the various advanced care planning and palliative care options available and supported the formulation of an ACP. Thirty-three patients were recruited and even though discussions were well received only 7 eventually wrote an ACP. The poor uptake in this study may be related to the reluctance of carers to engage with the process because of the distress associated with the hospital admission of a relative. In addition, there is the possibility that once a patient has been admitted to hospital a carer may feel compelled to continue with management of the acute medical problem. In a cross-sectional survey of patients and their spouses it was found that there was moderate agreement between patients and their spouses when considering end-of-life care.⁵ However, if there was discord, spouses were more likely to ask for treatment. Despite this ambivalence, advanced care planning is important. Nursing models that emphasise advanced care planning, communication and comfort are associated with higher levels of satisfaction among family members when they are asked to reflect on their experience of the end-of-life care given to their relative.⁶

In this category, the following areas for service development and medical education were noted:

identification and management of psychiatric comorbidity
 identification of appropriate settings for the delivery of ACP interventions
 exploration of the patients' and families' ideas, concerns and expectations.

Raising awareness and fostering communication between families and health professionals

In a Dutch post-mortem chart review of 198 patients, advanced care planning and palliative care were discussed with 11% of patients.⁷ In this study, 62% of patients had palliative care records, 49% of cases were discussed at an MDT meeting and 76% of patients had a physician order limiting life-sustaining treatment. The current paucity of ACP and targeted palliative care interventions in dementia may relate to a poor understanding of the condition and its natural history. Dementia is a progressive and terminal disease. In a multi-site observational study, 94% of physicians thought of dementia as 'a disease you can die from' compared with 43% of families.⁸ However, in another study,⁹ 19% of the physicians questioned stated that they did not discuss ACP options with patients with mild to moderate Alzheimer's disease. Of the 81% who did discuss advanced care planning, 47% addressed end-of-life care specifically. In families where dementia was understood as a terminal condition, patient comfort was rated more highly than in those where dementia was not viewed as terminal. This may reflect acceptance of the diagnosis and an understanding of the natural course of the condition, thus giving families the opportunity to prepare both materially and psychologically.

The physician plays a key role in ensuring patients receive appropriate palliation and end-of-life care. In a multicentre cross-sectional survey of 594 nursing homes in Belgium, it was found that patients were more likely to receive palliative care if they had input from a general practitioner (a doctor who may initiate palliative care).¹⁰

However, more often than not, these decisions are taken when patients are very dependent and have lost capacity.¹¹ This may be following admission to an acute hospital. In a small survey of health professionals ($n = 16$), including physicians and specialist nurses, respondents reported feeling most confident in managing pain.¹² There was, however, significant variation in the knowledge of opioid dosing, management of constipation and artificial nutrition in patients

with advanced dementia. Given that these patients may not be able to articulate their discomfort, which may only manifest as increasing agitation, it is important that clinicians recognise and manage reversible causes of distress. The complexity of the illness and non-specific presentations mean the medical team may feel ill prepared to deal with specific end-of-life issues. This uneasiness is also present among nursing staff and can result in poor communication between staff and patients/carers.¹³ To tackle this, a role-play-based teaching package was delivered to palliative medicine fellows¹⁴ who afterwards felt more able to discuss ACP and identify caregiver burden. This type of teaching is effective but labour intensive. A 2-day residential course, the 'Dementia Difference Workshop', has been developed in Canada. At a focus group 1 year after the initial training session respondents reported feeling more confident in communicating with patients about ACP and that the course had led to a change in their practice.¹⁵ Internet-based e-learning is another alternative.¹⁶ However, although online courses are effective at delivering information, they may not directly help improve learners' communication skills. Both role-play and internet-based teaching methods are used in UK medical education and provide a key opportunity for raising awareness.

Advanced care planning discussions are associated with an increased rate of plan formulation.¹⁷ It is important that such discussions are undertaken in a supportive manner/setting to ensure understanding and involvement. Patients' educational level also seems to be an important factor, affecting understanding and uptake.¹⁸ The use of audiovisual media can help overcome this and make the material more readily accessible. Lack of communication and support are frequently cited as sources of stress for caregivers, especially when patients are admitted to nursing homes.¹⁹

It is important to clearly and accessibly document the capacity assessment, patients' preferences and their proxy (if appropriate). This is important for medico-legal reasons, as patients' wishes may also change. A retrospective chart review of 93 US patients²⁰ enrolled in a 'program of all-inclusive care for the elderly' found that patients had on average two (range 0–4) documented discussions per year considering end-of-life issues. It was found that, after adjusting for the number of medical comorbidities, including dementia, the longer the patient was enrolled the less aggressive they wanted their medical care to be. At enrolment 34.4% of patients requested full medical treatment while shortly before death this figure was much lower at 6.5%. The enrolment period ranged from 1.0 to 6.4 years with 46% enrolled for more than 3 years. It is, however, unclear whether this change was related to perceived or actual deterioration in health, reduced quality of life or awareness of the natural history of dementia. The recommendations of the Nuffield Dementia Report 2009, which propose a form of proxy decision-making in collaboration with the family, have been suggested as an alternative to legally binding advance decisions which may not be flexible enough to allow for changes in patients' preferences.²¹

Key areas for service development and medical education in this category were:

educational interventions for doctors and other health professionals to raise awareness of ACP and palliative care in dementia improving access to advance care planning and palliative care information for patients standardising documentation and ensuring services are dynamic to follow changes in patients' wishes.

Management issues specific to patients with dementia

The timing and triggers for palliative intervention remain unclear. It may be instigated in a number of settings including nursing homes, hospices or acute hospitals. In a sample of 198 patients, identified in a post-mortem study, 54% had dementia and 95% experienced one or more 'sentinel events' before the initiation of palliative care.⁷ These included febrile illness, pain or behavioural disturbance.

In the UK, the majority of patients with dementia are admitted to hospital. Lack of clinical improvement or worsening clinical biochemistry are common indications for palliation. This may include discussions with families about 'do not resuscitate' (DNR) orders, the cessation of active treatment and initiation of symptom control. End-of-life care is initiated by senior physicians. In addition, junior doctors need to be supported in managing acute behavioural disturbance and general deterioration. There is scope to develop a targeted management framework that takes into account the benefits and side-effects of treatment.²²

The acute hospital plays a key role in the palliative care delivered to patients. Hospital admissions are related to an excess of sentinel events in the community. The capacity of hospices and nursing homes to instigate supportive or palliative measures is currently limited. In the USA, a retrospective cohort study²³ of 240 patients investigating 'do not hospitalise orders' (DNHOs) discovered that 83.8% of patients had a DNHO in place and 24.6% of patients

had a hospital transfer in the 6 months preceding death. Factors found to be independently associated with DNHO were: aged older than 92 years, nursing home stay of more than 2 years, eating problems and the surrogate decision maker not being the patient's child. A qualitative study in the north-east of England, using semi-structured interviews and including representatives from community, hospital and ambulance services,²⁴ found uncertainty among staff about whether current services could meet patients' wishes. The main concerns highlighted included: responsibilities of different groups, aspects of ACP that are legally binding and inconsistencies between the forms used by different agencies. Clarification of roles, standardisation of documentation and shared care between primary and secondary care are organisational and legal issues that need to be addressed to facilitate continuity of care.

Intervention offered by special care units is a relatively under-researched area. A post-mortem review of the care of 422 nursing home residents (263 had dementia) by semi-structured interviews with care staff and 293 family caregivers found that patients with dementia had less shortness of breath, but required more physical restraint or sedative medication for behavioural disturbance.²⁵ Patients in residential care had more skin ulcers, poorer hygiene, less use of restraint and higher use of emergency medical services. This study was performed in the USA and no difference was found between patients with or without dementia in terms of pain, ACP, life-prolonging interventions or hospice use.

A further longitudinal study of 323 patients in 22 nursing homes in Boston, USA was performed.²⁶ It revealed that 43.7% of patients were cared for in a special care unit where they were more likely to receive treatment for dyspnoea, had fewer hospitalisations and were less likely to be fed via a nasogastric tube. Special care units are nursing homes where the structural design, training and activity programmes provide a supportive social environment for patients with dementia. Patients in standard nursing homes were more likely to receive analgesia, had fewer pressure ulcers, and antipsychotics were less frequently used. Staff in special care units reported higher levels of satisfaction.²⁷ Staff in special care units may have more experience in managing patients' personal care needs and behaviours, whereas those in nursing homes may have more experience in assessing and managing pain and pressure sores. A probable confounder in this study is the possibility that patients with more behavioural disturbance and higher care needs are more likely to be cared for in special units. The primary care physician may be in the best position to recognise when referral to a hospice or specialist unit is required.²⁸

Key areas for service development and medical education in this category are:

integration of dementia and pre-existing palliative care services
 integration of dementia and general medical services
 identification and management of causes of behavioural disturbance in dementia
 facilitating transfer of information and patient records between primary and secondary care
 legal issues surrounding the use of ACPs.

Advanced care planning and palliative care in UK dementia services

The 2008 *End of Life Care Strategy* published by the UK Department of Health was the first comprehensive strategy for dying people.²⁹ There have subsequently been a number of initiatives to improve advanced care planning and end-of-life care for patients with dementia, cancer and other chronic conditions.

The National Council for Palliative Care (www.ncpc.org.uk) has a section charged specifically with improving the provision of end-of-life care in dementia. In particular they are working on strengthening ties with pre-existing dementia services and palliative care services to ensure access and coordination between services. In some areas they are working closely with Admiral Nurses (www.dementiauk.org/what-we-do/admiral-nurses), specialist mental health nurses with additional training in dementia care. Given the unpredictability of the illness and questions over the timing and triggers for palliative intervention, integration of these two services will be invaluable in ensuring ACPs are drawn up and that appropriate end-of-life care is available when patients require it.

In 2012, the prime minister announced that dementia is now a national priority.³⁰ A Challenge on Dementia scheme was set up to raise awareness and improve services. One of its key aims is advanced care planning. The scheme highlights the following as examples of good practice that should be replicated across the country: a community-based approach using dementia-friendly environmental design and non-invasive assistive technology to help people remain in the community, and a psychiatry and general practice intervention to facilitate end-of-life care in the community. At a time of financial constraint and increasing demand for already stretched accident and emergency services, these interventions have been welcomed as means of reducing costs.

The experience of dementia special care units can offer insights that may be transferable to general hospital or nursing home settings. Patients in special care units experience greater comfort, treatment for dyspnoea and are less likely to be fed by a nasogastric tube. Having ‘dementia wards’ in general hospitals staffed by physicians, psychiatrists and specially trained nursing staff will help ensure patients receive appropriate medical care and pastoral support. In the community, ensuring nurses have generic medical skills, such as setting up subcutaneous fluids, will reduce the requirement for hospital admissions and will increase the nurses’ experience and confidence in delivering complex palliative interventions.

Limitations

The heterogeneity of study methodology, setting, reported outcome measures and small sample sizes reduce the generalisability of our findings. For example, end-of-life care discussions in out-patient and in-patient settings have different confounders, which will affect responses and outcomes. The majority of the studies are also retrospective or use post-mortem data that are open to recall bias and/or have incomplete/inconsistent data collection. More studies need to be undertaken in the UK, with larger sample sizes and standardised methods of reporting outcomes, to ensure applicability in the UK and comparison between studies.

This review has focused on the organisational factors associated with advanced care planning and palliative care in dementia. However, the disconnect between the willingness of carers and health professionals to discuss these issues,³¹ and the low levels of uptake and engagement reported in the studies reviewed, call for more exploration. This would require a wider review incorporating psychosocial literature exploring personal, cultural and other influences that shape people’s expectations towards death and end-of-life care. The role played by a lack of information, misperceptions about the course of the illness and the setting in which advanced care planning interventions are delivered have been cited in the studies reviewed as possible contributing factors.

1.8.3 Venous thromboembolism prophylaxis in mental healthcare: do the benefits outweigh the risks?

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date

2015-4

Abstract

Venous thromboembolism is an important cause of morbidity and mortality. In recent years, growing awareness has led to the development of strategies to prevent venous thromboembolism in individuals admitted to hospital who are deemed to be at high risk. However, there remains a considerable degree of uncertainty over whether these strategies are of overall benefit and there are few published studies on people who are admitted to psychiatric hospitals. In this editorial I review current clinical practice and areas of uncertainty with respect to venous thromboembolism prophylaxis and its implementation in mental healthcare settings.

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 - *Areas of uncertainty*
 - *Do people who develop venous thromboembolism always need treatment with anticoagulants?*
 - *Benefits and risks of venous thromboembolism prophylaxis in mental healthcare settings*
 - *Discussion*

Previous estimates have suggested that venous thromboembolism is responsible for around 60 000 deaths in the UK each year.¹ It is thought that individuals admitted to hospital may be at increased risk of developing deep vein thrombosis and/or pulmonary embolism as a result of reduced mobility or intercurrent illness. Other important risk factors include older age (over 60 years), active malignancy, dehydration, inherited or acquired thrombophilia, obesity, previous venous thromboembolism or family history of venous thromboembolism, oral contraceptive pill use, hormone replacement therapy, pregnancy and varicose veins with phlebitis.^{2,3} These risk factors may be applicable to individuals admitted to hospital for medical, surgical or psychiatric care. For these reasons, current clinical guidelines recommend a risk assessment for all people who are admitted to hospital and prescription of a low-dose anticoagulant such as low molecular weight heparin (LMWH) and/or mechanical prophylaxis for those thought to be at high risk.² The decision as to whether to offer venous thromboembolism prophylaxis should be balanced against potential risks, particularly the risk of bleeding with LMWH.

Evidence base for venous thromboembolism prophylaxis in acute general hospitals

Numerous interventional studies have investigated the role of mechanical and pharmacological prophylaxis in reducing the risk of venous thromboembolism among those admitted to an acute general hospital. Studies have principally focused on patients undergoing orthopaedic surgery, non-orthopaedic surgery or no surgery. Interventional studies have demonstrated a reduction in symptomatic deep vein thrombosis among patients undergoing orthopaedic surgery who receive LMWH (relative risk (RR) = 0.50, 95% CI 0.43–0.59⁴). The use of LMWH in this group is not associated with a significant increase in major bleeding (RR = 0.81, 95% CI 0.38–1.72⁴). Prophylactic LMWH is also associated with a reduction in non-fatal symptomatic venous thromboembolism in patients who are undergoing non-orthopaedic surgery (RR = 0.31, 95% CI 0.12–0.81⁵) and possibly a reduction in symptomatic deep vein thrombosis (RR = 0.47, 95% CI 0.22–1.00⁶) and pulmonary embolism (odds ratio (OR) = 0.70, 95% CI 0.56–0.87⁷) in patients who are not undergoing surgery. However, this is balanced with a significantly increased risk of major bleeding (OR = 1.28, 1.05–1.56⁷). Furthermore, when considering fatal pulmonary embolism or overall mortality, prophylactic LMWH is not associated with significant benefit in any group.^{4–7}

Evidence base for venous thromboembolism prophylaxis in mental healthcare settings

In contrast to studies in acute general hospitals, there is relatively little published evidence investigating venous thromboembolism incidence and the role of pharmacological or mechanical prophylaxis in mental healthcare settings. A recent observational study that included systematic venous ultrasonography identified deep vein thrombosis in 10 out of 449 participants (2.2%) following 10 days of admission to a psychiatric hospital.⁸ A total of 16 out of 458 (3.5%) had experienced an episode of venous thromboembolism by 90 days following admission. Of these, three had a non-fatal pulmonary embolism. The study also showed that venous thromboembolism was more likely in older people (8.6% of those aged over 75 years), which may relate to greater exposure to risk factors such as immobility. Another study based on a review of hospital records revealed 17 confirmed cases of venous thromboembolism among 1495 people (1.1%) admitted to an in-patient mental health service for older people.⁹ This contrasts with an incidence of 2.4%

within 91 days among people undergoing total hip arthroplasty surgery¹⁰ and 1.45 per 1000 person years in the general population.¹¹

There is growing evidence from observational studies that suggests a possible association between antipsychotic medications and venous thromboembolism, particularly for clozapine and first-generation antipsychotics.¹² However, it has been difficult to establish whether this association could be a direct pharmacological consequence of antipsychotics (leading to a prothrombotic state) or if it is mediated through other risk factors that are consequences of antipsychotics, such as obesity or sedation leading to reduced mobility.¹³ Some studies have also pointed towards physical restraint as a potential risk factor for venous thromboembolism in mental healthcare settings.^{14–16}

Areas of uncertainty

A recent meta-analysis has led to increasing controversy over the potential benefits of pharmacological or mechanical measures to prevent venous thromboembolism among hospital patients who are not undergoing surgery.⁷ Although a reduction in non-fatal symptomatic venous thromboembolism was seen with LMWH prophylaxis, this is balanced with an increased risk of bleeding and no overall benefit in terms of reduced mortality. Furthermore, the relative benefit of prophylaxis only translates to a modest reduction in absolute risk; for every 1000 in-patients treated with LMWH, only three cases of pulmonary embolism are prevented balanced with four additional cases of major bleeding.⁷

There is also continued uncertainty about the true incidence of clinically significant venous thromboembolism.¹⁷ Although data from epidemiological modelling suggests that venous thromboembolism is responsible for around 60 000 deaths each year in the UK,¹ data from postmortem studies suggest a much lower rate of around 5680 per year.¹⁸ Whether pharmacological and mechanical prophylaxis could prevent all deaths from venous thromboembolism is also unclear.

Do people who develop venous thromboembolism always need treatment with anticoagulants?

Some observational studies have employed systematic ultrasound screening to identify asymptomatic as well as symptomatic deep vein thrombosis. Although deep vein thrombosis was identified in 10 out of 449 participants following admission to a psychiatric hospital, seven cases were of distal deep vein thrombosis of which only one case was symptomatic.⁸ The extent to which asymptomatic deep vein thrombosis predisposes an individual to increased risk of mortality remains uncertain, particularly with respect to asymptomatic distal deep vein thrombosis.¹⁹

The advent of computed tomography pulmonary angiography (CTPA) has led to a substantial increase in the radiological diagnosis of pulmonary embolism.²⁰ However, uncertainty is growing over the optimum treatment particularly with respect to whether all those with a radiological diagnosis of pulmonary embolism would benefit from anticoagulation.²¹ It is thought that small subsegmental emboli may not necessarily be associated with adverse clinical outcomes and that the risks of bleeding from treatment with anticoagulants may outweigh any benefits within this group.²²

Benefits and risks of venous thromboembolism prophylaxis in mental healthcare settings

There are no published interventional studies that have investigated the potential benefits of venous thromboembolism prophylaxis in mental healthcare in-patient settings. Despite this, there is ongoing interest in developing and utilising risk-screening tools to identify individuals at increased risk of venous thromboembolism for prophylaxis.²³ Furthermore, there is no published evidence that has investigated the potential harms of venous thromboembolism prophylaxis in this setting. Although risks of bleeding have been well characterised for people admitted to acute general hospitals, it is not clear whether the same risks apply elsewhere. In particular, prolonged use of LMWH can predispose to thrombocytopenia leading to an increased risk of bleeding.²⁴ The mean length of stay in an in-patient mental healthcare setting (adult: 52.1 days, older people: 93.2 days) is substantially greater than that of an acute medical unit (5.5 days).²⁵ With the exception of those taking clozapine, full blood count monitoring is not routinely performed in the mental healthcare in-patient setting. The extent to which staff in mental healthcare settings are trained to administer prophylaxis and recognise potential adverse complications is also unclear.³ For these reasons, it is possible that the risk of

thrombocytopenia from LMWH may be greater for those who receive it for venous thromboembolism prophylaxis in the mental healthcare setting.

Balancing the potential risks of bleeding and the potential benefits of preventing venous thromboembolism with pharmacological prophylaxis is problematic. Cost–utility analysis is a method by which the benefits and risks of an intervention may be balanced with respect to quality of life measures. A study investigating the application of cost–utility analysis to venous thromboembolism found that there was a wide degree of variation in individual estimates of cost–utility of both acute venous thromboembolism and bleeding complications from pharmacological prophylaxis.²⁶ However, in the mental healthcare in-patient setting, it is sometimes not possible for patients to weigh up benefits and risks of an intervention because of lack of mental capacity. Furthermore, there is little evidence to estimate the potential benefits and risks of venous thromboembolism prophylaxis among individuals who lack capacity as randomised controlled trials have excluded these individuals.¹⁷

Discussion

Venous thromboembolism remains an important cause of mortality in people who are admitted to hospital. However, in recent years, there has been ongoing uncertainty over the efficacy and risks of prophylaxis among in-patients who are not undergoing surgery^{6,7} and whether everyone with established venous thromboembolism would benefit from anticoagulant treatment.^{21,22} Although prophylaxis appears to reduce the incidence of non-fatal venous thromboembolism, there is no robust evidence that supports a reduction in mortality.^{4–7} This may be because of the balance with risk of bleeding for pharmacological prophylaxis.^{7,24} There is even less evidence to support its use in mental healthcare in-patient settings where no interventional studies have been published.

Despite this, substantial resources (over £30 million per year in England) have been invested into venous thromboembolism prevention programmes that claim to ‘save lives’.²⁷ Although it is claimed these investments have resulted in a modest overall saving (a yield of 2.7%²⁸), it is possible that there is a greater opportunity cost in mental healthcare settings where there is currently no evidence for the cost-effectiveness of venous thromboembolism prophylaxis.

It is clear that there is an ongoing need to improve the overall physical health of individuals with mental illness, particularly those with severe mental illness who have been shown to have a substantially lower life expectancy than the general population.²⁹ Although venous thromboembolism is an important cause of mortality, a greater degree of impact could be achieved by investing resources into improving detection and treatment of new cases³ as well as preventative strategies in mental healthcare for cardiovascular disease in general.³⁰ In summary, there is little evidence to support current strategies for venous thromboembolism prophylaxis in mental healthcare settings. Further study to develop and evaluate the effectiveness of novel venous thromboembolism prevention and early detection strategies is therefore warranted.

1.8.4 Psychiatry: Past, Present and Prospect

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date

2015-4

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- *Psychiatry: Past, Present and Prospect*

The editors of this prodigiously ambitious collection of personal essays hint that they strived with some difficulty to extract from their distinguished authors personal views of how psychiatry has developed during the course of the past 50 years. The editors did not want a series of academic reviews but more the experience and wisdom gleaned during successful careers. This is history but as reminiscence, memoir as well as critical scientific review. The editors have achieved magnificently what they set out to do and nearly all the individual essays are worth spending time absorbing. The book is quite simply the best account, a searingly honest one, of the progress we have made over the working lifetime of the internationally renowned authors of the essays, nearly all like your reviewer at the tail end of their careers.

Every practising psychiatrist and trainee should read this book. I did not just read it, I devoured it, but readers beware, I put down the finished book with a disturbing sense of disappointment. Have we really changed the prospects for our patients' lives so little in 50 years? Has so much neuroscientific research, psychopharmacology, sociology and changing political environments produced so little? I fear so. 'What's past is prologue', as pronounced by Shakespeare in *The Tempest*. The real story is yet to be revealed.

The perennial indecisiveness about the boundaries of psychiatry's responsibilities, the repeated creation of social movements that ultimately fail to shift patients' life chances, the deficiency in translating what we know from social psychiatric studies into practical treatment modalities, the ever-shifting ethical sands of risk and restraint and the almost total lack of significant improvement in medications after imipramine in 1940 and clozapine in the 1960s, all this makes disturbing reading. Yet many essays contain scholarly reviews of fruitful paths of research that have not quite yielded success yet, such as Peter McGuffin on genetics, Steven Hyman on neuroscience, Edwin Harari on personality disorders. We are always on the brink, looking upwards but not quite over the brow of the hill just yet. Inevitably, the reader is drawn to areas of one's own personal interest. This reviewer turned straight away to George Szumukler's entertaining review of the vicissitudes of legal controls versus professional judgement, Paul Mullen and Danny Sullivan's pithy and sceptical account of the development of forensic psychiatry and Julian Leff's *cri de coeur* bemoaning the loss of social psychiatry developments from its exciting origins. Why have we not implemented what we know from social skills training and education for patients with schizophrenia, for example? I fear the answer is that mental health services have plenty of doctors and nurses but insufficient numbers of educationalists, social work interventionists and behavioural trainers. The administrative context in which psychiatry is practised has remained almost unchanged in the past 50 years, asylums are gone but the care and treatment has barely changed. Scientific endeavour plods on, our understanding of aetiology makes modest progress, but clinical practitioners must do the best they can with inadequate tools, today just as our colleagues did 50 years ago.

I have one criticism and this is not of the authors or editors. Oxford University Press should surely have produced this book in a better-quality format. It is printed in a small font (although not as small as this journal!) and the cover is somewhere between dull and unfathomable; it looks cheap. A tome so rich in content deserves a more sumptuous coat.

1.8.5 Neglect of the complex: why psychotherapy for post-traumatic clinical presentations is often ineffective†

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Abstract

Evidence of efficacy in studies of post-traumatic conditions is largely derived from studies in which variables are kept to a minimum. Extrapolation of treatments from uncomplicated disorders to complex conditions may therefore be called evidence-based without being evidenced. Complex conditions with polysymptomatic presentations and extensive comorbidity are being denied proper evaluation, and patients most severely traumatised from the early stages of their development are not provided with rigorously evaluated psychotherapies because they are more difficult to study in the manner approved by research protocols. Such evidence as there is suggests that the simple extension of treatments for uncomplicated disorders is seriously inadequate. This has significant implications for health services responsible for the provision of the most efficacious treatments to those whose disorders arise from severe trauma, often very early in their life.

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- *Neglect of the complex: why psychotherapy for post-traumatic clinical presentations is often ineffective†*
 - *Evidence-based and evidenced are not necessarily the same*
 - *Limitations of the evidence base for the treatment of complex PTSD*
 - *Consequences of accepting ‘evidence-based’ as ‘evidenced’*
 - *Dropouts from DBT*
 - *Prevalence of dissociative disorders*
 - *Therapy for severe complex PTSD and dissociative disorders*
 - *Conclusions*

Evidence-based and evidenced are not necessarily the same

Psychotherapy for post-traumatic clinical presentations is often restricted by the lack of evidence in support of approaches other than those validated for non-complex post-traumatic stress disorder (PTSD), such as cognitive-behavioural therapy (CBT)¹ and eye movement desensitisation and reprocessing (EMDR).^{2,3} Complex PTSD has different definitions but is essentially a multifaceted presentation arising from extreme stress, usually at an early developmental level. This leads to difficulty in regulating affective arousal; alterations in attention and consciousness such as amnesia and dissociation; somatisation; chronic characterological changes; and alterations in systems of meaning.⁴ The variability in the syndromes that result means that inexact use of terminology bedevils this clinical and research area. While PTSD is a theoretical umbrella term,⁵ we use ‘complex PTSD’ in this paper to refer to complex reactions to multiple traumatic stressor exposures and experiences, usually against a background of severe disturbances in primary caregiving relationships.

Complex presentations are often excluded from studies because they do not fit neatly into the simple nosological categorisations required for research power. This means that the most severe disorders are not studied adequately and

See *Bulletin* comment, p. 100, this issue.

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patients most affected by early trauma are often not recognised by services. Both historically and currently, at the individual as well as the societal level, dissociation from the acknowledgement of the severe impact of childhood abuse on the developing brain leads to inadequate provision of services. Assimilation into treatment models of the emerging affective neuroscience of adverse experience could help to redress the balance by shifting the focus from top-down regulation to bottom-up, body-based processing.

At present there is little regard for the subcortical generators of distress and an overemphasis on the cognitive strategies needed to manage the resulting emotions. At the institutional level this translates to a preoccupation with therapist supervision; attainment of symptom-reduction goals; invalidation of the importance of affective experience; and intolerance of clinical complexity. There are then imposed limitations on psychotherapy sessions and inadequate time and emphasis on therapeutic engagement. The concept of evidence needs to be expanded to include neuroscientific plausibility. The collection of outcome data needs to include biological data such as changes in functional imaging responses to trauma-related and apparently innocuous interpersonal stimuli. Neuroscientific plausibility can be a source of indirect evidence and affective neuroscience can be included in the rationale for novel treatments in complex PTSD. We explore this elsewhere (details available from the authors on request). However, acknowledgement of the magnitude of the problem would have severe financial implications for mental health services.

Limitations of the evidence base for the treatment of complex PTSD

Evidence-based therapy for mental disorders is often considered to be CBT as it has been shown to be of value in reducing symptoms in many disorders. CBT has been able to accumulate evidence in part through the readiness of funding bodies to provide for research when there is likely to be some observable and measurable benefit, however clinically relevant – in terms of symptoms or functioning. If research funding is not readily accessible for complex and prolonged interventions that are clinically applied in the phase-based treatment of complex PTSD, it is easy to arrive at the false conclusion that a lack of evidence for a particular therapy indicates that it is not effective. There is not, to our knowledge, any register of projects which have been refused financial support or discouraged from making a full application on the basis of cost. One example is sensorimotor psychotherapy,⁶ which has as yet little supporting evidence but is endorsed by leading international experts and is neuroscientifically credible. The costs of carrying out an outcome study of sensorimotor psychotherapy with current methodological constraints would be prohibitive. Somatic experiencing⁷ preceded sensorimotor psychotherapy as a body-based therapy for the resolution of traumatic experience and is widely used throughout the world. It also lacks the evidence base deemed necessary in those services for which rapid symptom reduction is the economically derived priority.

Both the National Institute for Health and Care Excellence (NICE) guidelines⁸ and a Cochrane review of psychological therapies for chronic PTSD in adults⁹ concluded that EMDR and trauma-focused CBT are effective in clinician-rated symptom reduction, although there was evidence of greater dropout in active treatment groups. The authors of both also considered the evidence available to them to be of low quality. A Cochrane review of psychological therapies for people with borderline personality disorder¹⁰ concluded that dialectical behaviour therapy (DBT) was effective in reducing anger and parasuicidality and in improving general mental health, but it did not appear to be more likely than treatment as usual to keep people in therapy. The authors considered that none of the treatments they studied for borderline personality disorder had ‘a very robust evidence base’.

Consequences of accepting ‘evidence-based’ as ‘evidenced’

If CBT and/or DBT were effective for 100% of patients with complex trauma sequelae there would be no need for additional therapeutic approaches. To illustrate our contention that this may not be the case, a relevant paper¹¹ recommended to us as methodologically sound has been selected. This helps to clarify the answer to the 100% resolution question in regard to CBT. In this paper by McDonagh and colleagues,¹¹ exclusion criteria were: use of medication with significant autonomic nervous system effects; dissociative identity disorder; current alcohol or drug misuse; presence of active suicidality or a history of two or more suicide gestures or attempts in the preceding year. Women were also excluded from the study if they were in a relationship with an abusive partner, a situation unfortunately all too common in this clinical population. Although the eventual study group had experienced multiple traumas, those who completed treatment were middle-aged, well educated and in employment. Many of the patients encountered in general psychiatric practice do not fit this profile. Many of those who present clinically with a history of complex PTSD have

been attempting to manage their distress through one – or more likely a combination – coping strategies, for instance self-harm, alcohol/drug misuse, eating disorders, or other behaviours designed to limit their sudden shifts out of the ‘window of tolerance’.¹² The efforts to achieve physiological regulation themselves then lead to further difficulties. Because treatment studies in general dislike comorbidity, the evidence on treatment approaches to multiple, coexisting and complex problems is limited.

As well as the exclusion of people who need therapy – such as those who are chronically suicidal as a result of early trauma – there was evidence of a problem with dropouts from the study. This was most evident with CBT (41%) and required the discharge of the random assignment process to get sufficient numbers into the CBT group. The post-treatment analysis applying intention-to-treat showed no significant difference in the numbers no longer meeting PTSD criteria: 28% for CBT ($n = 8$); 32% for present-centred therapy ($n = 7$); 17% for the waiting list ($n = 4$). So of the 200+ patients who met the criteria for complex PTSD following childhood sexual abuse, 74 were included in the study and 8 got better with CBT compared with 4 on the waiting list. This falls well short of a 100% recovery criterion which would support the restriction of training to CBT, and raises serious questions about CBT being the core treatment modality provided for complex post-traumatic presentations.

For the completers only (i.e. ignoring those who dropped out) both treatment groups improved significantly compared with the waiting list and both showed sustained improvements at 6 months. CBT therefore had clear and demonstrable benefits for some female childhood sexual abuse survivors. However, patients were more likely to stay in present-centred therapy, in which the therapists were required to be genuine, empathic and non-judgemental.

This is only one methodologically sound study of a selected population but it is of interest that the problem with the dropout rate has been previously observed for clinical practice in the ‘real world’,¹³ in which many psychologists trained in CBT were found to be reluctant to use imaginal exposure.¹⁴ There is a striking discrepancy between recommended best evidence-based practice for PTSD and actual clinical practice.¹⁵ The underlying reasons for this discrepancy are likely to be complex but may reflect the clinician’s view of the tolerability of the therapy for both patient and practitioner. Prolonged exposure may be necessary for some who prefer to spend the hours on slow adaptation rather than to go with the rapid information processing available in non-exposure treatment protocols such as EMDR.² However, EMDR cannot be applied in complex PTSD with strict adherence to the standard protocol used in non-complex PTSD without a high risk of increasing dysregulation. For the multiple traumatic events and experiences of the kind commonly encountered by victims of child sexual abuse, prolonged exposure is unlikely to work in the lifetime of the patient.

The context-dependent unhitching of stimulus and response can occur without any impact on the stored representation of the unconditioned stimulus.¹⁶ If the unconditioned stimulus involves a body memory from being raped at 3 years old, it may be possible to reduce the distress related to adult sexual activity without having any impact on the stored and readily triggered pain, rage, terror, shame, abandonment, isolation, worthlessness, hopelessness, helplessness or survival terror. Also unaffected will be the dissociative defences which helped the child to survive and continue with life, apparently unscathed. The therapeutic gains are therefore helpful, but limited.

Therapists engaged in the provision of prolonged exposure may be troubled by ‘feelings of helplessness’.¹⁷ So if the therapists feel helpless, they then need to spend more time in supervision, being exposed to their helplessness with a supervisor who presumably feels less helpless because he or she is supervising rather than treating. Subsequently, within systems there is then less time available to treat those patients who are willing and able to participate in the exposure therapy that even those supplying it dislike and prefer to avoid. It may also be the personal preference of clinical researchers to focus on the cognitive, as in restructuring, rather than be exposed to the realms of horror and terror, intense isolation and abandonment, excruciating pain and despair of the complex trauma survivor. If the therapist has unresolved residues of traumatic experience himself, the ability to convey the psychotherapy may be even more challenging; it is then much easier to focus on reappraisal and the reassurance that all present have survived and prospered.

Dropouts from DBT

Dialectical behaviour therapy provides techniques for safety and stabilisation of borderline personality disorders¹⁸ and some of its elements have been adapted for dissociative disorders.¹⁹ In DBT emotions are recognised as an important part of human experience and there is considerable emphasis on their regulation to reduce distress. So it is interesting to see that dropout rates from DBT in the UK can increase, from an already high 52% to 88% in those with more complex presentations.²⁰ Of course, not all patients with borderline personality disorder have a history of trauma or unresolved attachment and genetic and other factors may be present in some.²¹ However, between 40 and 70% of those with borderline personality disorder would also meet criteria for one of the major dissociative disorders in which trauma histories and disorganised attachment are major aetiological factors.²¹ It is surprising, but perhaps a reflection of what is considered treatable, that attachment trauma is often ignored, despite research specifying feelings of emptiness and problems in coping with abandonment as key features of borderline personality disorder.¹⁰ Treatment continuity may be interfered with by the behaviourist management of dissociation as a problem behaviour, which can be approached through desensitisation of present cues to past traumatic experiences.²¹ The structural dissociation model of van der Hart *et al*²² sees self-states that interfere with therapy as nevertheless based in the defence from the overwhelming effects of trauma. Therapists working with an ego state model in which the cooperation of aggressive protector parts is a prerequisite for continuing treatment (e.g. Paulsen²³) have identified and delineated strategies for achieving this. It would be interesting to know whether the disregard for the original survival functions of peritraumatic and structural dissociation contributes to the high dropout from DBT. A very testable hypothesis is that people who drop out from DBT are primarily those with significant but unrecognised dissociative disorders.

Prevalence of dissociative disorders

There is evidence that some of the complex post-traumatic disorders – including dissociative disorders – can have an impact on functioning equivalent at least to major psychotic disorders, and should be considered to be ‘serious mental illness’.²⁴ Studies of the general population find a prevalence rate for dissociative identity disorder at 1–3%, whereas in psychiatric patient populations the figure is 1–5%.²⁵ Those individuals are often not diagnosed as having dissociative identity disorder but receive treatment according to the most prominent signs and symptoms, and their response to treatment for depression, anxiety, panic disorder, eating disorder, substance misuse or somatoform disorders will inevitably be incomplete. Moreover, unreported or unrecognised trauma is common in psychiatric patients (details available from the authors on request). Unfortunately, in controlled trials in groups of patients presenting with these symptoms and syndromes the diagnosis of those who drop out is not reassessed. Ethical constraints would prevent attempts to acquire this information after a patient has dropped out, so there is a need to assess for the sequelae of complex trauma at recruitment. It could be predicted that some will have unrecognised major dissociative disorders, or significant secondary or tertiary dissociative symptoms. Treatment of comorbid conditions – or concomitant symptoms – is an inadequate response to a range of complex presentations aetiologically related to early trauma.

Therapy for severe complex PTSD and dissociative disorders

It could be argued that psychotherapy for the residual effects of trauma should start with the aim of helping those most severely affected. Chu *et al*²⁵ reviewed the treatment of the major dissociative disorders which are recognised to result from early attachment trauma often compounded by later sexual and/or physical abuse. The review argued that the economic cost of dissociative disorders was considerable and highlighted the priority needed for the development of effective treatments. However, dissociative disorders were frequently unrecognised as such, perhaps because of their polysymptomatic presentations, and therefore appropriate services were not provided. When treatment was adapted to address the consequences of dissociative defences to complex trauma, even those with severe disorders could improve. The lack of controlled or randomised outcomes studies for the psychotherapy of dissociative disorders is an effect of the complexity of the presentations and of the level of funding that would be required to properly evaluate treatment. The lack of evidence is not an indicator that particular approaches do not work – only that they have not been rigorously tested. Testing procedures understandably but unhelpfully prefer simple, measurable attributes for economy of scale.

Conclusions

Patients with many trauma-based disorders are not well served by existing therapies: they will often drop out of treatment at an early stage. PTSD is an inclusive term⁵ which has precipitated much research and clinical interest. However, this categorisation has dominated research and clinical services to the detriment of the range of disorders occurring after traumatic experience.²⁶ Disorders arising from extreme stress during the brain's development and maturation need a prolonged period for recovery. The first requirement is therefore to adopt an approach which will retain patients in therapy long enough for the therapist and patient to form a shared understanding of what is happening and to find a way of working together. This way must be found to be beneficial for the patient and sufficiently tolerable for the therapist so that the therapist does not avoid it.

We are grateful to Janina Fisher and Ron Schwenkler for comments on early drafts.

1.8.6 London's liaison psychiatry services: survey of service provision

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Abstract

Aims and method To describe the liaison psychiatry services of all 30 general hospitals in Greater London and to determine whether services met national recommendations. The results were compared with a similar survey conducted 8 years previously to determine whether there had been significant service development.

Results We identified wide variations in service provision across London. Fifteen hospitals (50%) had 24-hour services and one had no service. There had been a significant increase in services that assessed older adults. Increases in the size of teams and consultant psychiatry staff were not significant.

Clinical implications Despite an increasing emphasis on the effectiveness of liaison psychiatry services, no London hospital had staffing levels consistent with national recommendations. Recent evidence for the cost-effectiveness of liaison psychiatry and an emphasis on parity between physical and mental health in National Health Service policy may provide further impetus for growth.

Contents

- *London's liaison psychiatry services: survey of service provision*
 - *Method*
 - *Results*
 - * *Hospitals*
 - * *Bed numbers*
 - * *Working hours*

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- * *Patient groups*
- * *Staffing*
- * *Funding and management*
- *Discussion*
 - * *Limitations*
 - * *Implications*

Liaison psychiatry is concerned with the management of mental disorder in general medical settings where there are high rates of mental health problems. Mental disorder accounts for 5% of emergency department attendances; 30% of hospital in-patients have comorbid mental illness.¹

A comprehensive liaison psychiatry service will address the following clinical needs:¹

patients presenting at the emergency department with mental health needs; comorbid mental and physical disorders; patients being treated for the physical complications of alcohol and substance misuse; where physical illness and its treatment is causing mental health problems; medically unexplained physical symptoms.

In addition, liaison psychiatry services have a role in the training of general medical staff in the recognition and basic management of common mental health problems.²

The benefits of a comprehensive liaison psychiatry service for a general hospital fall into four key domains:³

improved psychiatric and medical outcomes of patients
enhanced patient experience of medical care
increased patient safety
greater cost-effectiveness of medical services.

The National Health Service (NHS) Confederation highlighted the economic benefits of liaison psychiatry services, which are primarily achieved by decreasing the length of hospital stays and reducing the frequencies of reattendance and readmission.⁴ A subsequent economic analysis of a 24-hour liaison psychiatry service found that it generated considerable cost savings for the health economy, with a cost–benefit ratio of 4:1.⁵ The greatest cost benefit was found in service provision for older adults.

Following increased recognition of the clinical and economic benefits of liaison psychiatry services, the Academy of Medical Royal Colleges recommended the provision of 24-hour multidisciplinary liaison psychiatry services for emergency departments and in-patient wards.⁶ In addition, the need for specific liaison psychiatry service provision for older adults has been emphasised.^{7,8}

To meet a need for more explicit guidance on the provision of services for patients with mental health problems in general hospital settings, the Royal College of Psychiatrists⁹ updated its recommendations for the staffing of liaison psychiatry services (*Table 1*). These were reiterated in national commissioning guidelines.¹ The need for this guidance arose, in part, from the recognition of the wide variability in service provision.

In 2004, a survey of liaison psychiatry services in 29 general hospitals across Greater London identified wide variations in staffing, working hours and patient groups seen.¹⁰ Although half of services worked over 24 hours, all except one service fell short of national recommendations for service provision. Similar deficits have been identified in other areas of the UK.^{11–13}

Following a national focus on emergency care, there had been an expansion in liaison psychiatry services serving emergency departments. However, there was concern that *Table 1* Summary of liaison psychiatry staffing recommendations⁹, a Role Whole time equivalents Consultant psychiatrist 1.0 Trust grade doctor 1.0 Nurses 5.0 Clinical health psychologist 1.0 Administrator 1.5² services for other general hospital patients might be neglected as a result.

2

These recommendations are for a service operating from Monday to Friday, 09.00 h to 17.00 h, assessing and managing adults of all ages in a 650-bed general hospital. Psychiatric training posts are not included and are in addition to the staff above.

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In light of recent recommendations for the establishment of robust liaison psychiatry services, this survey aimed to identify changes in service provision across London over the 8 years up to mid-2012, and to audit the staffing of these services against national standards.

Method

Greater London comprises 32 London boroughs and the City of London, and has 30 general hospitals with emergency departments. Information on bed numbers was obtained from hospital websites.

An email and telephone survey of liaison psychiatry services was carried out over the first 6 months of 2012. A senior clinician from each of the services was asked a list of predetermined questions. We enquired about the number and professions of clinical team members. Higher specialist trainees in psychiatry were not included in these figures as such posts are often supernumerary and may not continue beyond the current post-holder's attachment.

We established details of service delivery. Hours of work were categorised into services operating within core 'working hours' (09.00 h to 17.00 h, Monday to Friday), those delivering an extended-hours service and those operating 24 hours per day.

Comparison of the 2004 and 2012 profiles of the directly comparable liaison psychiatry services ($n = 27$)

Service variable	2004	2012	2004 v. 2012 <i>P</i>
Number of in-patient beds, mean (s.d.)	638 (232)	530 (242)	0.001
Number of whole time equivalent staff, mean (s.d.)	8.4 (6.0)	9.0 (5.7)	0.63
Hours of service, <i>n</i> (%)			
No service	0 (0.0)	1 (3.7)	
Working hours (09.00 h to 17.00 h)	5 (18.5)	6 (22.2)	
Extended hours	9 (33.3)	6 (22.2)	
24 hours	13 (48.1)	14 (51.9)	0.80
Staffing, <i>n</i> (%)			
Dedicated medical psychiatry staff	19 (70.4)	23 (85.2)	0.06
Dedicated consultant psychiatry staff	19 (70.4)	23 (85.2)	0.06
Patient groups seen, <i>n</i> (%)			
Older adults	17 (63.0)	26 (96.3)	0.01
Alcohol and substance misuse	21 (77.8)	23 (85.2)	0.55

The survey enquired about service provision for the following specific patient groups:

those presenting to the emergency department in-patients out-patients older adults those with alcohol and/or substance misuse those with perinatal mental health problems.

These groups were selected as being those most commonly served by a comprehensive liaison psychiatry service. Where specialist liaison teams existed to manage specific patient groups (e.g. older adults), these were included within the data collected for the overall liaison psychiatry service. Information was also collected on the organisations responsible for the funding and management of services.

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The results of the survey were analysed using the Statistical Package for the Social Sciences, Release 19.0 (on IBM). Staffing levels were compared with the Royal College of Psychiatrists' recommendations (*Table 1*). Following reconfiguration of acute hospital services between 2004 and 2012, we judged that differences between liaison psychiatry staffing and service provision in these 2 years could be compared at 27 sites.¹⁰ Data from the two surveys were compared using the Wilcoxon Signed-Rank Tests for continuous variables and the McNemar (mid-*p*) test for categorical variables, which is appropriate for binary matched pairs data with small and moderate sample sizes.¹⁴ The criterion for statistical significance was set at $P < 0.05$.

Results

Hospitals

Information was collected from all 30 hospitals, of which 29 had a liaison psychiatry service. Between 2004 and 2012, 2 hospitals had closed and 3 new sites had opened; 27 hospitals were common to both surveys.

A comparison of the profiles of the 27 directly comparable services is given in *Table 2*.

Bed numbers

The mean number of in-patient beds for the 30 hospitals was 535 (range 200–1200, s.d. = 235). For the 27 comparable sites there was a significant decrease in bed numbers of 17% over the previous 8 years ($P = 0.001$).

Working hours

Six (20%) hospitals had services operating in core working hours (09.00 h to 17.00 h, Monday to Friday). Eight (27%) hospitals had extended-hours services and 15 (50%) had 24-hour services. At the 27 comparable sites, there was no significant change in the hours of work between 2004 and 2012 ($P = 0.80$).

In the 15 hospitals with either no liaison psychiatry service or where the service operated for less than 24 hours, out-of-hours cover by community mental health services was available at 13 sites (87%).

Patient groups

Table 3 describes the patient groups assessed by services and indicates where a particular group was managed by a specific specialist team within the overall liaison psychiatry service.

All of the 29 services assessed patients in the hospital's emergency department. One service only assessed patients of 65 years of age or over; younger adults were referred to community mental health services.

All of the liaison teams accepted referrals for older adults and 14 (48%) had a specific specialist older adults service. For the 27 comparable sites there was a significant increase in liaison psychiatry service provision for older adults between 2004 and 2012 ($P = 0.006$), but not for patients with alcohol and substance misuse ($P = 0.55$).

Staffing

The mean number of whole time equivalent clinical staff for all 29 teams was 8.7 (range 1–22, s.d. = 5.5). The mean numbers of staff for the various hours of service are given in *Table 4*.

With respect to the 27 directly comparable sites, there had not been a statistically significant increase in the mean size of teams ($P = 0.63$).

Three teams (10%) consisted solely of nursing staff, but had access to senior medical staff if required. Fourteen teams (48%) had at least one whole time equivalent consultant psychiatrist. Two teams (7%) had a whole time Table 3 Patient groups managed by liaison psychiatry services in London's general hospitals ($n = 30$) Patient groups Liaison psychiatry

service

n (%) Specialist service

provision within

the liaison service

n (%) Emergency department 29 (97) 0 (0) In-patients 28 (93) 2 (7) Out-patients 16 (53) 1 (3) Older adults 29 (97) 14

(48) Alcohol and substance

misuse 26 (87) 10 (33) Perinatal 26 (87) 9 (30) Table 4 Staffing of London's liaison psychiatry services ($n = 29$) Whole

time equivalent number of staff, mean (s.d.) Hours of service Consultant

psychiatrist Other

medical Nursing Psychology Other Working hours ($n = 6$) 0.8 (0.5) 0.8 (0.7) 1.8 (1.0) 0.0 (0.0) 0.0 (0.0) Extended hours ($n = 8$) 0.5 (0.4) 1.3 (1.0) 5.1 (4.7) 0.3 (0.4) 0.2 (0.5) 24 hours ($n = 15$) 0.9 (0.7) 1.5 (1.4) 8.4 (2.4) 0.1 (0.2) 0.4 (1.1) equivalent psychologist and five more (17%) had regular psychology sessions.

At the directly comparable sites there had been an increase in the number of teams with dedicated medical psychiatry staff and specifically consultant psychiatry staff, but the differences were not statistically significant (both $P = 0.06$).

National staffing recommendations for liaison psychiatry services (*Table 1*) are for a working-hours service, although it is noted that an extended-hours service with additional staffing should be provided where there is local need. It is difficult to compare the services surveyed against these recommendations, because of the range of different hours of work. However, none of the services employed all of the recommended staff.

Funding and management

In total, 16 liaison psychiatry services (55%) were funded via a mental health trust, 6 (21%) via an acute trust and 7 (24%) were jointly funded. All services were managed by mental health trusts.

Discussion

This survey of London's general hospitals describes the level of liaison psychiatry service provision in 2012 and compares this with 8 years previously. As in 2004, the survey found a wide variation in staffing and hours of work. No hospitals had staffing levels consistent with national recommendations. Between 2004 and 2012 there was a significant increase in service provision for older adults. There was a non-significant increase in the number of liaison psychiatry teams with dedicated medical staff and consultant psychiatrists.

There continued to be considerable gaps in service provision, with one hospital having no liaison psychiatry service. Although community mental health services often provide psychiatric input where no liaison psychiatry service exists, this is likely to be a less clinically and cost-effective model of care.

The variation in service provision between hospitals has been found in surveys of other areas of the UK.^{11–13} As service provision in London has previously been found to be more extensive than elsewhere, this survey indicates that considerable development is required across the UK to fulfil national recommendations and achieve potential cost savings for the wider health economy.⁵

The increase in specific service provision for older adults might reflect the emphasis on providing such services following the previous survey.⁷ Subsequent evidence of their cost-effectiveness may provide further impetus for the growth of such services.⁵

There was an indication that psychiatric expertise within liaison psychiatry services may be increasing, including a growth in consultant numbers, although these findings did not reach statistical significance. This potential increase may reflect recognition of the need for robust clinical leadership and management, and of the specific expertise that psychiatry can bring to the management of complex cases.¹⁵

The decrease in mean bed numbers for London's hospitals may reflect the emphasis in health service policy for England and Wales on providing more services in the community. If this trend continues, it could have a significant impact on how liaison psychiatry services are delivered. One potential area of service development is the extension of liaison psychiatry expertise into primary care to support the management of patients with comorbid physical and mental illness and those with medically unexplained symptoms.^{15,16}

At the time of this survey, the principle of 'parity of esteem' between mental and physical health services was stated in England's NHS Mandate.¹⁷ NHS England's objective is to close the health gap between people with mental health problems and the population as a whole. The potential impact of this on liaison psychiatry has been articulated in a subsequent report, which recommends that commissioners need to regard liaison services as a necessity rather than an optional luxury, in order to provide an integrated approach to healthcare in acute settings.¹⁸

Potential changes in the funding and commissioning of liaison psychiatry services may also provide an impetus for service development. As indicated by this survey, most services in England and Wales are currently paid for from a mental health block contract.¹⁹ Separate funding of physical and mental health services is inappropriate for liaison psychiatry, which bridges the two areas.³ Work is underway to devise a sustainable model of funding that will provide more incentive for commissioners and providers of healthcare to establish comprehensive liaison psychiatry services.

Limitations

The survey was conducted in 2012, and several respondents indicated that local commissioners were considering an increase in liaison psychiatry service provision, often on a trial basis. Hence, although at the time of publication there may have already been an increase service provision in London, it will be several years before it can be determined whether this has been sustained. We anticipate that this survey will provide a baseline for a future survey to identify the effect of an increased focus on liaison psychiatry service provision in commissioning guidance.

The survey is likely to underestimate overall mental health service provision for adults in general hospitals. We did not include stand-alone specialist services that operated separately from the main liaison psychiatry service (e.g. neuropsychiatry, psycho-oncology, clinical health psychology). Also, we did not enquire about child and adolescent liaison psychiatry services, which usually operate separately from adult services.

Implications

The survey describes the persistent variation in liaison psychiatry service provision to London's general hospitals, with services universally falling below recommended standards. Since the survey was undertaken, a number of national reports have highlighted the clinical and economic benefits of liaison psychiatry and emphasised the importance of parity between physical and mental health services. As well as describing recent changes in services, the survey provides a basis for future research to determine whether current recommendations are translated into the commissioning of comprehensive liaison psychiatry services for all of London's general hospitals.

1.8.7 Children and Young People's Improving Access to Psychological Therapies: inspiring innovation or more of the same?†

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Abstract

In 2007 the UK Government announced a substantial expansion of funding for psychological therapies for those presenting with common mental health problems. This 'Improving Access to Psychological Therapies' (IAPT) project was widely welcomed, however, evidence backed, economic, and conceptual critiques were voiced from the start and the project remains controversial. In 2011, the UK government announced it was extending the IAPT project to encompass services for children and young people with the aim of 'transforming' the way mental health services are delivered to them. Here I critically reflect on the problems associated first with IAPT and then with CYP-IAPT and ponder whether CYP-IAPT is significantly different to the problematic adult IAPT project or more of the same.

Contents

- *Children and Young People's Improving Access to Psychological Therapies: inspiring innovation or more of the same?†*
 - *Improving Access to Psychological Therapies (IAPT)*
 - *Children and Young People's IAPT (CYP-IAPT)*
 - * *Did the above findings have an impact on the design of the CYP-IAPT project?*
 - *Conclusion*

Improving Access to Psychological Therapies (IAPT)

For those who believe that psychological therapies help people, there was much to celebrate in a plan to dramatically increase access to these therapies and decrease waiting times, allowing more people with common mental health problems, such as anxiety and depression, to recover. However, from the start IAPT has had a mixed reputation in professional circles, although this has not yet affected its continued expansion. Why did it become so controversial? One of the main reasons has been the 'fetishisation' of certain therapeutic modalities (particularly cognitive-behavioural therapy (CBT)) resulting from an adherence to a primarily technical understanding of the nature of mental health problems and their solutions. This stance marginalises the evidence base that points to the limitations of the technical paradigm, sets up an artificial hierarchy of desirability and efficacy for psychotherapies (and therefore psychotherapists), encourages medicalisation and leads to claims about efficiency that has not been matched by the available evidence.

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² See *Bulletin* comment, p. 100, this issue.

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The technical model assumes that: mental health problems arise from faulty mechanisms or processes of some sort involving abnormal physiological or psychological events occurring within the individual; that these mechanisms or processes can be modelled in causal terms and are not context-dependent; and that treatments can be designed and delivered in a manner that is independent of relationships, contexts and values.¹ Thus, like National Institute for Health and Care Excellence (NICE) guidelines, IAPT's foundational paradigm follows a pathway that assumes that a correct diagnosis (of mild to moderate depression for example) will enable the correct choice of a technical intervention to be made. In this linear formatting, process-driven protocols are central and relational and other contextual issues are of secondary importance – issues to be negotiated to enable satisfactory adherence with the required 'correct' treatment.

From a purely evidence-based point of view, this technical model for delivering mental healthcare has little to support it. Whereas factors outside of therapy (the real-life challenges and histories) have by far the biggest impact on outcomes, within treatment, the factor that has the biggest impact on outcomes is the therapeutic alliance (as rated by the patient) with matching treatment model to diagnosis having a small to insignificant impact.^{2,3} This relationship between the alliance and outcome seems remarkably robust across treatment modalities and clinical presentations.⁴ The search for the 'active ingredients' of a psychological therapy is anyway likely to be doomed to failure because it depends upon the false assumption that such ingredients are delivered by therapists in a uniform manner regardless of the state, requirements and input of the patient.⁵ After all, although the utterances of a patient may not have a direct impact on the chemical activity of a drug, they will in the two-way process of a well-delivered talking therapy. Thus we should not be surprised that attempts to find the active ingredients of, for example, CBT have failed, as studies have shown that most of the specific features of CBT can be dispensed with, without adversely affecting outcomes.^{6,7} Countless reviews and meta-analyses have found that no clear pattern of superiority for any one treatment model has emerged,^{8,9} a finding that extends into evaluations of NHS psychotherapy services, where non-specific factors such as the therapeutic relationship accounts for the variance in outcomes rather than the therapeutic model used.¹⁰

As a result, the IAPT process, which insists on one or two modalities, ends up limiting choice for patients, despite the lack of evidence supporting such a stance. It is possible, of course, that choice had to be sacrificed to maximise the efficiency that may come from standardisation, but the evidence here provides no encouragement either.

Not surprisingly, the IAPT project leaders have reported favourable results being delivered by their services;^{11,12} however, their reports do not include comparisons with the costs and outcomes achieved by non-IAPT services. The first independent evaluation of the initial IAPT pilot sites found little difference between the IAPT sites and comparator services. What differences there were in outcomes were not significant 4 months after treatment and had disappeared at 8 months, but IAPT treatments had cost more per patient, than those provided in neighbouring boroughs.¹³ According to reports compiled by the Artemis Trust,^{14,15} which evaluated data from the subsequent national roll out, the average number of patients achieving recovery for a fixed expenditure of £100 000, when treated by an IAPT service was far lower (49) than for pre-IAPT primary care counselling services (115) or voluntary sector counselling services (78). In addition recovery rates, as a percentage of patients referred, was lower for IAPT services than comparable services (pre-IAPT primary care therapy services, university counselling services and employee assistance programme counselling services).

This is a truly remarkable achievement. The government have spent large amounts of taxpayers' money creating an expensive service that provides little choice and has poorer outcomes than cheaper alternatives that were already in existence before IAPT. In terms of efficiency this has parallels with many large-scale government contracts, whether in information technology (we all know about the billions wasted trying to link up NHS information technology systems for example), building or procurement, where large amounts are put into monopoly contracts, that overcharge and deliver poor quality products that never quite work the way they were meant to.

Perhaps IAPT has helped reduce medicalisation? Again the answer is No. Prescriptions for antidepressants have continued to rise with little evidence that introducing IAPT has had any meaningful impact on these trajectories. Numbers of people claiming disability living allowance in the UK for a mental health problem has also continued to rise with psychiatric disorders as the reason for receiving disability benefits rising from 30.9% of claimants in 2000 to 44.8% in 2013, with the biggest subcategory (over 50%) being for people given a diagnosis of depression (information retrieved from <http://tabulation-tool.dwp.gov.uk>). If current national models of mental health service delivery were effective, we would not see this picture of steadily worsening long-term outcomes in parallel with steadily increasing expenditure.

We should again not be surprised by these findings. The technical model locates the challenges and dilemmas that people face in late capitalist neoliberal cultures as happening in people's heads rather than in the wider contexts of

their lived experience. The task of therapies such as CBT is that of helping the person adjust and learn to deal with the pessimistic thoughts that have come to dominate their life. Although I have no problem appreciating the usefulness of this approach for many people, the fetishisation and commodification of ‘suffering’ at the cultural/political level acts to create new markets for ‘treatment’ while simultaneously obscuring the brutal nature of our winner/loser culture through individualising people’s problems. An approach that fails to appreciate the social, cultural and political dimension of distress is thus unlikely to address the problem of the expanding medicalisation of suffering.

Children and Young People’s IAPT (CYP-IAPT)

As with the adult outcome literature, there is little evidence to support that matching a treatment model to a diagnosis differentiates which treatment is more likely to work and which is not in children and young people.^{16,17} It seems that ‘evidence-based’ treatments for youth tend to come out as superior to usual care, only if the ‘evidence-based’ treatment was developed by the researcher.¹⁸ Technical factors appear irrelevant. Thus, a meta-analysis of component studies found that the theoretically purported critical ingredients of CBT are not specifically ameliorative for child and adolescent depression and anxiety as full CBT treatments offered no significant benefit over treatments with only components of the full model.¹⁹

When real-life clinical outcomes from Child and Adolescent Mental Health Services (CAMHS) are examined the picture is even less encouraging. Research has found that 40–60% of youth who begin treatment drop out against advice.²⁰ Furthermore, although the effect size for outcomes in controlled studies is large, in traditional treatment in community CAMHS effect sizes are close to zero²¹ with little difference found in outcome between treated and untreated children.^{22,23}

Other evidence finds that service transformation projects including allocating extra resources have a negligible impact on outcomes. The Fort Bragg evaluation described the implementation, quality, costs, and outcomes of a \$94 million demonstration project designed to improve mental health outcomes for children and adolescents who were referred for mental health treatment. Outcomes in the experimental service were no better than those in the treatment as usual group, despite the considerable extra costs incurred.^{24,25} This finding was then replicated in the Stark County evaluation study where again there were no differences in outcomes when compared with care received outside the new system, despite the extra expenditure.²⁶

These are sobering findings suggesting that, just as with adults, traditional, medical/technical model approaches do not appear to provide much ‘added value’ in terms of improving the outcomes and efficiency of services.

Did the above findings have an impact on the design of the CYP-IAPT project?

In 2011 IAPT gave birth to the CYP-IAPT project. This upstart announced it was going to strike out in a new direction. But like many children who criticise their parents, the values they carry was already part of their histories, and the bold new direction they boasted about amounted to new directions in the scope of implementation without any recognisable change in the underlying paradigm. Indeed, CYP-IAPT decided to start by focusing on improving the skills of the existing CAMHS workforce and to achieve this by training staff in the manualised implementation of CBT or parenting management treatment (in phase 1). As far as the basics go CYP-IAPT was, therefore, no different to its parent IAPT project. However, another and more interesting objective of the CYP-IAPT project was that of ‘service transformation’. Here the plan was to influence the whole CAMHS team to use more feedback-informed approaches including use of session-by-session outcome ratings. Having been involved in a successful ‘service transformation’ project with my own team involving implementing session-by-session outcome monitoring and developing an outcomes database for the team, I was flattered to be invited to join the CYP-IAPT steering group. Perhaps CYP-IAPT was going to go in a new exciting direction after all. My resulting flirtation with CYP-IAPT proved to be a short lived, but fascinating, insight into how bureaucratisation happens when large monolithic programmes are attempted.

Instead of building on existing and successful service transformation projects that have been developed in other countries and in the UK¹⁶ (and I must declare a potential conflict of interest here – at present ideological rather than financial), the service transformation CYP-IAPT aimed for used the same expensive technological paradigm adhered to by the inefficient IAPT project. The millions given to this programme is being spent on sending CAMHS clinicians to train

in the delivery of manualised treatments (such as CBT or parent management). These clinicians' time then needs to be backfilled, and once trained they are to come back and deliver these therapies in diagnostic-based pathways. A course for managers and extensive implementation checklists have been developed adding greater complexity to service transformation while missing out on learning from whole service projects that have already demonstrated how you might achieve improved outcomes and efficiency. This choking bureaucratisation seems to happen whenever such national projects are attempted in CAMHS.

For example, the CAMHS Outcomes Research Consortium (CORC) has been operating as a UK national project since 2004 with the aim of instituting a common model of routine outcome evaluation and data analysis. However, return rates for second scores on the main patient-rated outcome measure have run at 10–25% or lower for years, thus no reliable and therefore valid outcome data has, at any point, been produced. No matter what they did they could not improve the return rate because the project failed to connect with the reality that front-line clinicians' face. Such national projects are at constant risk of morphing into ever more complex systems that offer little to help the daily practice of hard-pressed clinicians and therefore little to offer patients.

In my own service we have continued to develop an 'outcome orientated' approach¹⁶ drawing on the successful American 'Partners for Change Outcome Management Systems' (PCOMS) model.²⁷ Indeed, PCOMS is recognised as an evidence-based model by the USA 'Substance Abuse and Mental Health Services Administration' (SAMHSA) National Registry of Evidence-based Programs and Practices on the basis of sufficient randomised controlled trial research. Although it would be insulting and disrespectful to the diversity of opinions in our CAMHS service to claim our project has been a runaway success without immense and problematic aspects, what I can, I believe, claim is that drawing on and building on models that have already demonstrated improved outcomes, improved efficiency, improved recovery rates and decreased medicalisation; has engaged clinicians, proved cheap and efficient and built a database of outcomes for the whole service in under a year. I can tell you my own outcome data for open and discharged cases as well as the outcomes for the team I work with and our service as a whole. We have simple formats that provide our commissioners with the sort of whole-service outcome data they have never previously had. We did not need expensive formulaic trainings, just building on the existing skills of the workforce and providing a feedback mechanism that helps us focus on recovery and enhancing reflective practice.

Conclusion

The evidence from a variety of outcome studies provides important pointers for how we should design our services. Extra-therapeutic factors are by far the biggest factor influencing outcomes, which should help us have a little more humility about the task of helping people experiencing mental distress. When we deliver services, matching model of treatment to diagnosis is not only a waste of time (given its clinically insignificant impact on outcomes), but fetishising approaches denies patients choice and flexibility, leading to more potential for disengaging from treatment if the model used is not connecting meaningfully for them (a major problem in delivering our Western psychotherapies with marginalised groups such as ethnic minorities). It is clear to me, and an increasing number of psychiatrists, psychologists and researchers that our allegiance to the technical model for understanding mental distress and behavioural deviance is a big mistake. Meaningful transformations in mental healthcare are unlikely to come through projects like IAPT and CYP-IAPT that can not see this. Instead what we get when we go down the technical route is reduced potential patient choice, poor value for money, increasing medicalisation and bureaucracies that alienate clinicians.

I realise that in the face of powerful well-funded organisations, I am powerless to influence meaningful change. But given the overwhelming evidence and so many critics, perhaps together we can foment enough momentum to make possible a more informed national debate to take place that would lead to a more evidence-based approach and future reform of well-intentioned but misguided projects like CYP-IAPT.

1.8.8 Recognition of the neurobiological insults imposed by complex trauma and the implications for psychotherapeutic interventions†

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Abstract

Considerable research has been conducted on particular approaches to the psychotherapy of post-traumatic stress disorder (PTSD). However, the evidence indicates that modalities tested in randomised controlled trials (RCTs) are far from 100% applicable and effective and the RCT model itself is inadequate for evaluating treatments of conditions with complex presentations and frequently multiple comorbidities. Evidence at levels 2 and 3 cannot be ignored. Expert-led interventions consistent with the emerging understanding of affective neuroscience are needed and not the unthinking application of a dominant therapeutic paradigm with evidence for PTSD but not complex PTSD. The over-optimistic claims for the effectiveness of cognitive-behavioural therapy (CBT) and misrepresentation of other approaches do not best serve a group of patients greatly in need of help; excluding individuals with such disorders as untreatable or treatment-resistant when viable alternatives exist is not acceptable.

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 - *Brain stem responses to traumatic experience may be stored and lead to dysfunction*
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See *Bulletin* comment, p. 100, this issue.

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- * *The understanding of dissociation as essentially neurobiological*
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The healing of emotional wounds is an endogenous, dynamic process which, fortunately, occurs spontaneously in most people whose traumatic experiences resolve over time. Just as the pain of grief diminishes as the body feelings become less insistent and perspectives change, so other adverse events can be processed naturally and emotional healing can occur. When a bereavement is traumatic, for whatever reason, the natural healing process may be blocked and the pain fails to resolve. This is echoed after other adversity: the distress and its associated body feeling, however subtle, continue to intrude on awareness and impair the capacity for positive affects. A failure to recognise the intrinsic homeostatic, emotional healing potential of the brain/mind leads to an overemphasis on techniques for regulation of distress and a denial of opportunity for resolution.

Simple protocols for PTSD, complex post-traumatic presentations and help-seeking

There are interventions available to treat established post-traumatic stress disorder (PTSD) that have been shown to be effective. Reviews of the literature and expert consensus have supported the use of trauma-focused cognitive-behavioural therapy (TF-CBT; especially treatment programmes involving imaginal and *in vivo* exposure), and eye movement desensitisation and reprocessing (EMDR).^{1,2} Moreover, the National Institute for Health and Care Excellence (NICE) guidelines on PTSD recommend that all individuals with PTSD should be offered TF-CBT or EMDR.³ However, psychotherapy studies for PTSD typically exclude for comorbidity and complexity and do not report adverse effects: it should not be assumed that therapy is either positive or, at worst, neutral. The wrong therapy, by the wrong therapist or with the wrong timing (or a combination thereof) may be psychotoxic. Reviews and guidelines present the evidence base for PTSD, but rarely overtly identify the dichotomy between the patients seen in research studies and those with the range of clinical presentations encountered after traumatic experiences, even though the evidence indicates that modalities tested in randomised controlled trials (RCTs) are far from 100% applicable and effective.⁴ The guidelines also do not readily apply to the nature and challenges of treating someone with complex PTSD, as opposed to single-event-related PTSD. The oversimplified misrepresentation of the evidence base leads to a constricted provision of services.

In most areas of medicine it is seen that the most severe damage can present the greatest challenges to the intrinsic healing potential of the body. The complexity of the wounding requires an integration of approaches from different specialties and disciplines. This applies not only to the acute interventions but to the painstaking rehabilitation work that may be required over many years to achieve optimal, if still less than full, functioning.

A pain clinic which ignored a history of severe body injuries with functional consequences – and the associated emotional factors – and offered only paracetamol on the grounds that there was good-quality evidence for its analgesic efficacy in many conditions, would fail to treat much intense and prolonged suffering. The psychotherapy often provided for complex PTSD includes no multi-modal approach and those who fail to benefit may then be considered to be treatment-resistant. For patients with complex PTSD the ineffectiveness of psychiatric treatment and subsequent labelling as treatment resistance can then be attributed to an underlying personality disorder, often without adequate assessment or corroboration. Patients who are told that their lack of response to treatment is due to long-standing differences in one or more of the following: their thinking, their emotional regulation, their behaviour, and/or their

interpersonal relationships, will feel further invalidation that confirms their inseparable differences from the rest of humanity. If everyone else can learn top-down regulation of distress in response to triggers, the failure to acquire these skills is held to imply deep-seated personality pathology.

Help-seeking: incentives and disincentives in asking for treatment

There is evidence that even those with non-complex post-traumatic disorders may be reluctant to seek treatment for their condition.⁵ Rates of help-seeking for PTSD are lower than for similar mental disorders such as depression⁵ and studies both internationally and in Northern Ireland have shown extended time to seeking treatment (12–22 years).^{6,7} Reasons given in the USA by those not in treatment who nevertheless recognised that they needed help included a perceived lack of effectiveness (it would not help or did not help in the past), dissatisfaction with services, stigma or fear of forced hospitalisation.⁵ If the wrong treatment paradigm has been offered or the individuals have felt labelled as treatment-resistant or as having a personality disorder, they will be less likely to present again for help and will either not seek any treatment or seek it elsewhere. A narrow approach focused on effortful regulation of distress will deter from contacting services those who believe they have been doing their best to manage their condition themselves.

Brain stem responses to traumatic experience may be stored and lead to dysfunction

The body awareness of defence responses

Trauma involving threat, whether physical or social, instigates impulses to defend oneself arising in the midbrain.^{8–10} These impulses may be aborted at an early stage or become active only to be ineffective. They may also be subject to top-down control through the ventromedial prefrontal cortex,¹¹ at which level the regulation may also be involuntary. The sequences of movement impulses associated with these responses can be stored ‘in the body’ to the extent that they are outside the ready awareness of working memory and unavailable to access through word-based interventions. Fight, flight, freeze, hide, avoid, attack, submit, despair and uncontrolled activation states have autonomic and motor accompaniments which can be triggered many years after the traumatic episode.¹² Striatal memory activated preferentially under stress is one mechanism implicating the basal ganglia¹³ in procedural (motor) rather than hippocampal (episodic) memory. Animal studies stress the role of the midbrain periaqueductal gray (PAG) and its connections with the hypothalamus for the full motor and autonomic components of the basic defence responses.^{14,15} It is often through specific motor tension patterns that trauma memories are accessed in body-based psychotherapy: these are the route to healing in somatic experiencing and sensorimotor psychotherapy. This suggests that the midbrain and the basal ganglia loops engaged by defensive movements, actual or thwarted, are instrumental in what is stored in the body following unresolved trauma. The profound impact of sensorimotor psychotherapy and somatic experiencing in survivors of trauma is a source of empirical data which demand thorough evaluation. Rigorous level 2 (case controlled trials, non-randomised) or level 3 (observational studies including surveys) evidence is frequently accepted in medicine when it would be difficult to apply RCT methods, either because of unrealistic statistical power demands or because of a likelihood of harm to patients assigned to a cohort which did not receive the active treatment; for example, the acceptance of psychological first aid after disasters where denying core elements of the approach would be unethical.

The body awareness of emotions

The animal work of Jaak Panksepp (e.g. Panksepp & Biven¹⁶) has accumulated over decades into a fundamental realisation that there are basic emotional systems in the mammalian brain. The seven basic emotional systems are: SEEKING/desire; RAGE/anger; FEAR/anxiety; LUST/sexual urges; CARE/maternal nurturance; PANIC/GRIEF/separation distress; and PLAY/physical social-engagement. The midbrain areas involved are the ventral tegmental area for SEEKING and PLAY; the dorsal PAG for RAGE and GRIEF/PANIC; the ventral and dorsal PAG for FEAR and LUST; and the ventral PAG for CARE. All of these basic affective systems are active in humans and are a fundamental part of being human. Many clinical researchers would add shame as a basic affect but the possibility of this being generated in the midbrain is difficult to study in laboratory animals (as discussed in Corrigan¹⁷). The emotional systems experienced as negative are all activated in various ways by traumatic experience. The aloneness, abandonment and shame

of GRIEF/PANIC/separation distress; the terror and dread of FEAR; the explosive energy of anger and RAGE: all of these are commonly encountered in treating PTSD. To treat them as only subcortical disturbances which must be properly managed by the re-trained cortex – or as manifestations of amygdala activation which can be re-learned through prolonged exposure – is to ignore the fundamental role of emotional response in a person's interaction with the environment. When the environment is hostile these responses facilitate survival: they are adaptive and based in trends that go far back in brain evolution. In therapy it can be through emotions that healing and lasting transformation are achieved.¹⁸

The understanding of the 'reptilian' brain as essential for human emotional life

The MacLean description of the triune brain¹⁹ provides a neat guide to the different levels of the central nervous system in relation to their evolution from organisms more primitive than humans. It is important, however, to appreciate that the 'reptilian' brain has evolved in humans to participate in complex functions that would not be available to reptiles. A human may not have as fast a tongue-flick as a lizard, but the human brainstem is supporting behavioural programmes with much greater autonomic and motor variability. A review of neuroimaging studies of the human PAG confirms the involvement of the PAG in many pain syndromes, including fibromyalgia and migraine, and during electroacupuncture.²⁰ There are demonstrable PAG responses during emotional experiences such as fear and dread, disappointment, social rejection, hearing aversive sounds, and stressful cognitive tasks. The imaging studies of the human PAG confirm much of what has been found in animal studies.

What is missing from evidence-based treatments that are not effective?

Patients with complex PTSD who cannot be held in a compassionate and non-judgemental therapeutic relationship will quickly revert to the survival behaviours which have kept them alive. They will default from a therapeutic interaction which carries some of the more threatening features of the ambivalent or disorganised attachment styles to which they may have been exposed from birth. These non-secure relationship templates amplify the impact of later traumatic experiences. Such patients are often exquisitely sensitive at an unconscious level to attachment conflicts. While craving normal attachments, like most humans, any ambivalence or disorganisation in the interactions can lead to an activation of defence response sequences established in early life. The associated survival behaviours will then interfere with the capacity to engage wholeheartedly with the treatments offered. Patients who understand and know the rules to abusive or traumatising interpersonal interaction need to be presented with contingencies to allow them to experience and learn how to have normal, non-traumatising interactions. The attunement with a therapist aware of the importance of attachment in early life experience is essential for the processing of early attachment disruption. The first opportunity some complex trauma patients will have for a stable and non-abusive relationship will be with the therapist. A non-challenging, validating and bounded therapeutic relationship may be able, eventually, to facilitate the feeling of safety and trust which has been lacking through most, if not all, of the patient's life.

The awareness of the body

Those who have disturbing body reactions to triggers reminiscent in some way of the original adverse/traumatic experience will have tried to think their way out of the problem themselves. They may also have been the recipients of common-sense solutions from friends and family. They will have almost certainly discovered the inability to influence through thinking the body sensations of traumatic experience: working memory and cognitive solution areas of the neo-cortex fail to influence the sensorimotor sequences programmed by the trauma. *Body-Centered Psychotherapy: The Hakomi Method*,²¹ first published in 1990, described mindful body awareness for the elicitation of core material, not necessarily of traumatic origin. This influenced the development of sensorimotor psychotherapy in which the mindful attention to somatic residues of traumatic experience promotes the resolution of these for clinical recovery.²² Somatic experiencing was developed by Peter Levine,²³ whose recent book carries the subtitle 'How the body releases trauma and restores goodness'.²⁴

The extant neurobiology also focuses on the body. For example, van der Kolk,²⁵ writing on approaches to the psychobiology of PTSD, included in the title of his chapter the evocative words: 'the body keeps the score'. Scaer, with

a perspective derived from an extensive experience in neurology, concluded that trauma, including preverbal trauma, could leave residues in the body to manifest in later years as clinical syndromes.²⁶ Patients with dissociative disorders have difficulty in being in the body experience and becoming safely embodied is a challenge for many.²⁷

The gulf between the body-based psychobiology and the talking treatments, evidence-based for PTSD but not for complex PTSD, has been bridged by sensorimotor psychotherapy, somatic experiencing, the Comprehensive Resource Model (CRM),²⁸ and other formalised approaches which provide extensive modality-specific training for trauma psychotherapists. Although these are widely used, the lack of RCT data means that they can be readily dismissed if authorities wish to do so: collation of level 2/level 3 evidence would cost much less and set standards for trainers and therapists in the promotion of safe practice. Anecdotally, dropout rate might be the first outcome criterion to employ when empirical studies do evaluate these psychotherapies. Patients who continue to attend because they find sessions helpful and relevant, especially when they have dropped out of other approaches, can provide naturalistic data of empirical value to a caring service.

The body awareness of safety

The 'safe place' is used in the preparation for EMDR to provide an imaginal resource for stabilisation if processing becomes too distressing.²⁹ It is also used as a screening tool for EMDR – a patient who cannot access an imaginal place of safety will not readily be offered active reprocessing. This is regarded as an important safeguard as those who have never felt safe have almost certainly suffered from attachment and other trauma from birth, and are likely to be highly dissociative. Calm or peaceful imagery may be used for those who cannot tolerate even the word 'safe', but this is fraught with difficulty as the lowering of vigilance may trigger switching to protective ego states or activate trauma-burdened memories. When hypervigilance has long been a default setting, the potential pursuit or creation of a 'safe place' or 'calm place' may be rejected as too triggering or activating, and alternative creative language will be required. In sensorimotor psychotherapy the attainment of a sense of safety in the body is considered of great importance for stabilisation. This leads to the proposition that it is only when the safe place is sufficiently strong to be experienced at a somatic level that it can be considered to be fully present. Safety resources that do not extend below the cortex are unlikely to have the required depth when processing becomes difficult. Conversely, being able to find the feeling of safety in the body²⁷ provides an anchor for processing material which would otherwise be overwhelming. Innovative approaches such as the CRM provide therapists with strategies to build internal resources; thus patients who would otherwise be rejected due to an inability to imagine a safe place can be resourced in alternative ways.²⁸

The understanding of dissociation as essentially neurobiological

Dissociation helps the individual experiencing trauma to survive by compartmentalising the responses to the event. It is then not overwhelming, either neurochemically or physiologically. Peritraumatic dissociation is probably best understood through animal models of stress-induced analgesia to which many neurochemicals contribute (e.g. Ford & Finn³⁰). However, it is clear from animal models that, when the trauma involves intense fear, endocannabinoids are released to prevent the overwhelming terror associated with unopposed glutamate, dopamine or acetylcholine transmission in the fear circuits. Riebe *et al*³¹ describe a spill-over effect which triggers the synthesis and release of endogenous cannabinoids. These then bind to presynaptic cannabinoid receptors to down-regulate the release of the fear-promoting neurotransmitters. The endocannabinoid system is active in the fear circuitry of the amygdala, hippocampus and prefrontal cortex, but also in the midbrain PAG where it mediates non-opioid analgesia.⁸ There is evidence that the learning of emotional responses is not confined to the corticolimbic system but occurs also in the midbrain – as would be expected from clinical observations in the treatment of PTSD, such as the resistance of the exaggerated startle response to extinction.

Endogenous opioids promote the analgesia accompanying the passive defence responses mediated by the ventral PAG;⁸ and modulation of these opioids can be used to study behaviour suggestive of terror in laboratory rats.³² Lanius³³ considers endogenous opioids to have a foundational role in dissociative responses to trauma. Whichever chemicals are primarily involved, peritraumatic neurochemical change may contribute longer-term to structural dissociation of the personality.

The awareness in the body of the level of activation related to trauma

Orientation to the occurrence of a traumatic event precipitates an immediate shift in the body's level of arousal. For example, being exposed to a direct gaze activates the midbrain in those who are suffering from the after-effects of complex trauma but induces a response at a primarily cortical level in a non-traumatised control group.³⁴ This activation readily precipitates a generalised arousal through brainstem nuclei for the release of monoamines and other neurochemicals. From brainstem structures such as the locus coeruleus there are ascending noradrenergic projections to the thalamus and cortex for general arousal as well as downward projections to the spinal cord. Ascending dopaminergic projections from the ventral tegmental area activate the ventral striatum and the substantia nigra. There are major ascending cholinergic and serotonergic projections from the brainstem. So alerting, arousing, activating stimuli – often involving different appreciation of pain levels – are exerting their influence through deeply subcortical structures.

The awareness in the body of the residues of attachment response patterns established in infancy

It is particularly easy for those working in the 'here and now' to scoff at the idea of working with body feelings left over from experiences of attachment disruption in early life. This is despite there being much description of the relevance of attachment in the development of affect regulation capacities (e.g. Schore³⁵) and evidence of the relevance of disorganised caregiving in the development of clinical syndromes (e.g. Lyons-Ruth *et al.*,³⁶ Hesse *et al.*³⁷). Attachment disorders can be dismissed as an easy default explanation when there is little evidence of other trauma to explain difficult-to-treat syndromes. However, if the conflicts are approached through body activations brought into awareness while grounded in the experience of specific situations, the patient, rather than the therapist's model, is leading the enquiry; the body's response will ground the experience in the 'here and now' (Schwenkler, May 2014, personal communication). If there are clear patterns of body response to the present-day relationship conflicts, these are the foundation for identification of cycles of obstruction of the attachment urge, followed by protest, despair, detachment, dissociation and sequences of defence responses. A simple here-and-now trigger, such as disproportionate rage to a partner's temporary absence, can reveal patterns established in early life. Scaer²⁶ sets out the arguments for procedural memory based in brainstem centres being established in infants with preverbal capacities for emotion and sensation. These action tendencies based in procedural memory manifest later as proximity-seeking, social engagement and defensive behaviours,³⁷ which may appear at odds with the here-and-now context.

Healing has no territory

We have argued that the evidence for particular approaches to the psychotherapy of complex PTSD indicates that so-called 'evidence-based' modalities – defined as much by those clinical cases excluded as those included – are far from 100% applicable and effective.⁴ Instead, we consider that psychotherapies which acknowledge the role of the somatic residues of traumatic experiences – provide techniques for their resolution – are necessary for the healing of the range of clinical disorders arising from severe and complex traumatic experiences during the brain's early development. Safety, compassion and patience are needed to counteract the long-term hypervigilance and other threat-based responses, so that the patient is internally resourced and treatment is not quickly rejected. Recognition, and evaluation, of non-RCT but still empirical data from widely used psychotherapies such as sensorimotor psychotherapy and somatic experiencing could widen the evidence base, guiding service development for those suffering in a way which cannot be treated by standard talking therapy.

A willingness to explore other/additional pathways to healing

Given the limitations of RCT-evidence-based CBT for complex post-traumatic conditions,⁴ it is essential to investigate other approaches consistent with the evolving understanding of the neurobiological underpinnings of traumatic experiences and reactions. In its standard format, EMDR cannot be readily applied in complex post-traumatic disorders but it can have adaptations for use in structural dissociative conditions (e.g. Paulsen³⁸). These modifications are often influenced by the many publications (over decades) of hypnotherapy experience of treating complex trauma disorders (e.g. Frederick & McNeal³⁹). Moreover, advances in psychotherapy such as Brainspotting⁴⁰ and the CRM²⁸ may be effective at a deep level of the psyche because they necessarily involve the midbrain.⁴¹ Psychotherapies such as sensorimotor psychotherapy and somatic experiencing, which work with emotions and defence responses and access these through awareness of the body and the sensations, movement tendencies and motor impulses ‘remembered’ from the time of the trauma, also work at multiple brain levels. Trauma release exercises⁴² for the discharge of muscular energy residual from adverse events will certainly recruit subcortical areas, as the intrinsic generators of tremor – central oscillators – are not in the neocortex.⁴³ Body-oriented breathing exercises stemming from the CRM²⁸ and yoga breathing cycles (e.g. Brown & Gebarg⁴⁴), based in the respiratory central pattern generators of the brainstem,⁴⁵ can be used clinically to augment affect regulation.

Russell,⁴⁶ asking why EMDR was not more available to US service personnel, explored the reasons for the dominant treatment paradigms being exclusive. Some of these were financial; some were theoretical or belief-based. Grand⁴⁰ advocates the view that ‘healing has no territory’: developments in therapy should always be encouraged and embraced, although it will inevitably mean that the techniques pioneered will be replaced. For example, the CRM has evolved from resource brainspotting to meet the needs of those individuals with complex trauma and dissociative disorders who require more resourcing than is provided by the safe, attentive and attuned presence of the brainspotting therapist working in a dual attunement frame.⁴⁰ Any important advance will change the field so much that other breakthroughs will follow; each is a temporary way station. No therapeutic paradigm should be allowed to become so dominant that it stifles clinical innovation, especially in the absence of compelling evidence of efficacy for complex disorders.

Implications for mental health services of fully engaging with the treatment of complex trauma, and research challenges

The high prevalence of trauma exposure and trauma-based disorders with severe consequences for physical and mental health raises the possibility of significant unmet need. Adults who have been exposed to four or more defined categories of adverse childhood experiences have higher risks for alcohol and substance misuse, depression, suicidality and poor physical health.⁴⁷ Childhood sexual abuse increases the risks in adulthood of depression, anxiety, suicidality, alcohol and illicit drug dependence, PTSD symptoms and poor physical health.⁴⁸ The lifetime prevalence of traumatic events and PTSD is high in those with severe mental illness⁴⁹ and there is evidence that trauma therapy can be effective even in this group.⁵⁰ The service implications of the epidemiological findings are that the provision of long-term trauma psychotherapy may be required, and this is expensive. It is considerably cheaper to downplay or ignore the role of trauma and constantly question any psychotherapy methods which have not yet acquired a gold standard RCT evidence base, even if they are expert led or neurobiologically informed. Indeed, services driven by waiting list targets have a disincentive to explore training in, and use of, psychotherapy interventions which require longer therapeutic contact. For dissociative disorders the treatment may require years, even with the best psychotherapy available,⁵¹ rather than the maximum of 20 sessions currently offered by many services.

If there is no cultural dissociation from the reality of the need for treatment of complex post-traumatic conditions, the consequence would be a caring health service providing treatment for a large number of patients who are only in ill health because they suffered trauma, loss or abuse at an early and critical age. If health service providers recognised the limitations of the RCT evidence base, they could promote training in internationally recognised models and conduct clinical research on those particular psychotherapeutic approaches. Moreover, psychotherapists who are better acquainted with the neurobiological underpinnings of psychological conditions and their implications for treatment and outcomes, may be less affected themselves by feelings of hopelessness in their long-term clinical endeavours.

NICE³ recommended chronic disease management strategies if trials of evidence-based therapies (TF-CBT or EMDR) were ineffective for PTSD; the guidelines did not differentiate the evidence base for PTSD from that for complex PTSD. As we have suggested, these treatments are likely to have been found ineffective for complex PTSD. A focus on sleep

hygiene, structured and supported activities as well as coping strategies for chronic problems will neither greatly assist the patient nor allow their therapist the satisfaction of seeing benefits from their skilled and compassionate intervention. Nothing else will be offered if services or systems continue to affectively dissociate from the clinical reality through the blinkered insistence that it is not really happening and that ‘apparently normal’ and ‘getting on with life’ perspectives are the only possible vision.

Research challenges

For clinical trial research to demonstrate real-world effectiveness of treatments for the range of post-traumatic conditions, the exclusion criteria need to be reduced. Comorbidity with PTSD is the norm, not the exception, yet trials do not reflect this. The measurement of treatment outcomes also needs to reflect more than just any change in PTSD symptoms and to include general functioning, intra- and inter-personal issues, and quality of life. Funding for complex interventions is expensive and a research programme is needed which does not rely on the single intervention for single outcome measure model: this would pose immediate difficulties within a phase-oriented structure for treatment. One intriguing question within the treatment of complex trauma is whether the resourcing required to allow re-processing of trauma experience and memory needs to be provided as a specific phase of treatment prior to any re-processing or whether it can be integral to each therapy session and therefore specific to the issue being reprocessed (as is suggested in the CRM²⁸). While discussions about the provision of expensive, innovative medical treatments have occurred, often in public, we are unaware of discussions justifying and limiting the access to long-term psychotherapy for complex disorders.

Education challenges

The need for outreach and education of referrers should not be underestimated. Evidence from a novel ‘screen and treat’ model after a high-profile terrorist incident showed that despite widespread advertising of the services, general practitioners (GPs) were found to refer few patients to trauma services specifically tasked with assessing and treating individuals in the aftermath of the incident.⁵² There is perhaps even less reason to expect referrals from GPs of individuals with complex post-trauma reactions originating in early development. Within general adult psychiatry the role of trauma may or may not be recognised, largely dependent on the clinician’s interest, knowledge or conceptualisation of cases; it may also perhaps reflect their pessimism about the availability of effective treatment. Potentially significant post-traumatic psychopathology in psychiatric patients⁴⁹ can go unrecognised when there is a failure to include trauma experience in treatment formulations. When this applies to the so-called ‘large T’ trauma causes, there is even less likelihood of the significant attachment disruptions inherent in developmental trauma being identified.

Conclusions

Within psychological services, the general public have been greatly served by improving access to psychological therapies (IAPT) in England and Wales and similar initiatives elsewhere. However, limited session provision and a dominant therapeutic paradigm that does not approach the needs of patients with chronic, comorbid and complex post-traumatic reactions, leaves those with the most severe symptoms without effective treatment. Patients unable to make use of time-limited cognitive-behavioural strategies may face rejection and labelling, feeling blamed for their non-improvement. In fact, they are victims again, this time of therapists trying to deliver a therapy for a quite different disorder, with managers who expect them to demonstrate consistently improving rating scale scores.

The strategy for the provision of psychological therapies needs to ensure that the most ill are not sidelined and blamed. Current drivers such as waiting list targets are vital to drive access to therapy. However, quality must also be brought to the fore: clinical governance demands the establishment of an environment that allows clinical excellence to thrive; excellence demands that the therapy provided is evidenced for the disorder being treated. In Scotland, there is a strategy for trauma-sensitive services including certain ‘at risk’ groups such as veterans of the armed forces. This is to be applauded. However, clinicians and managers should be educated to clinical need at all points on the trauma spectrum, not just those potentially responsive to CBT or those with combat-related disorders.

Systems that allow long-term trauma psychotherapy rather than time-limited, defined sessional input are needed. Treatment should be influenced by the major developments in affective neuroscience to proceed in a direction that is not affect-phobic. Individuals with highly polysymptomatic post-traumatic conditions, often with more Schneiderian first-rank symptoms than individuals with schizophrenia,⁵³ pose major difficulties when monitoring clinical trials. However, the inherent difficulties do not then demand an acceptance – as clinically sufficient – of those techniques validated for the reduction of particular symptoms or symptom clusters within non-complex PTSD. The search for the best treatments for the most traumatised individuals is being hampered by the exclusive acceptance of conditioning, cognitive or emotional learning models which dismiss the fundamental role of affective experience in response to the environment and are, therefore, dehumanising.

We are grateful to Janina Fisher, Ron Schwenkler and Catherine Shea for comments on earlier drafts of this paper and to the anonymous reviewer who made very helpful criticisms and comments.

1.8.9 Panic Disorder and Agoraphobia

Emma Barrow¹

date

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Contents

- *Panic Disorder and Agoraphobia*

This text is part of the Oxford Psychiatry Library series and at about 80 pages there is nothing anxiety-provoking about its length. The authors make clear from the outset that this is a book designed to be user friendly in its approach and, with four independently referenced chapters, the reader instantly feels it will live up to this claim.

Published in the USA, the opening chapter on diagnosis refers to the (at the time of print) current DSM-IV and new DSM-5 diagnostic criteria. The main focus of diagnosis is, however, referencing the complex interplay between patients with panic disorder who frequently present with multiple and varied somatic complaints to a wide range of medical, surgical and psychiatric specialties. Of particular interest to this reader was the comprehensive table of medical conditions that can mimic panic attacks. Concise text is interspersed with useful boxes and tables, drawing the reader's eye to the key points and considerations. Three further chapters on aetiology, pharmacological treatment and non-pharmacological treatment follow a similarly structured pattern.

For those who are looking for a summary of the current research into these disorders the 'aetiology' section on neurochemistry will not disappoint. For those, perhaps from non-psychiatry-based disciplines, looking to jump to more practical management advice, the section on 'pharmacological treatment' contains a handy FAQ list.

This book is by no means exhaustive, but what it quite cleverly manages to do is educate and interest the reader while guiding them through the practicalities of treating patients with panic disorder and agoraphobia in clinical practice. The section on pharmacological treatments is not as detailed as, say, the NICE or Maudsley guidelines, but its handy

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‘pocket’ size means it is a worthy supplement and far more likely to be carried around. I have already found it useful, not only in my out-patient clinics but also in the acute care setting while on call – where it is important to bear in mind the reminder that appropriately placed psychoeducation can go a long way.

1.8.10 Lessons from export to New Zealand of the second opinion appointed doctor scheme

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Abstract

Aims and method We compared findings of an audit of New Zealand’s version of the second opinion appointed doctor (SOAD) scheme with published information on the equivalent scheme for England and Wales, to consider what might be learnt from the different jurisdictions’ experience.

Results Strong similarities exist between the two schemes in the demographic profile of individuals subject to the SOAD process and rates of approval of compulsory treatment. The clearer legal framework for the English scheme and its supervision by an independent national agency may offer significant advantages in terms of consistency and transparency, compared with the informal, decentralised structure of New Zealand’s scheme.

Clinical implications Clinicians may not always favour greater formality or elaborate national structures for administering the Mental Health Act, but there are advantages in promoting clarity and consistency in a mandatory statutory process designed to protect compulsory patients’ rights.

Contents

- *Lessons from export to New Zealand of the second opinion appointed doctor scheme*
 - *Method*
 - *Results*
 - * *Comparisons between the New Zealand and English SOAD schemes*
 - * *Lack of consistency between New Zealand centres*
 - * *No clear process where impasse*
 - *Discussion*

1

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- * *Main findings*
- * *Lessons learnt*
- * *Limitations*
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In 1992, New Zealand adopted a modified version of the second opinion appointed doctor (SOAD) scheme into its mental health law. That scheme was first enacted for England (and Wales) by the Mental Health Act 1983 (UK). As in England, New Zealand law requires the proposals of the treating clinician to be approved by a second psychiatrist in two main situations – for longer-term use of medication, and for electroconvulsive therapy (ECT) – where a compulsory patient does not consent.¹ In England, this mandatory second opinion scheme has been managed, funded and periodically reviewed by a national agency, firstly by the Mental Health Act Commission (MHAC), then by the Care Quality Commission (CQC). In New Zealand, no equivalent national agency has existed to manage the scheme. Its administration has fallen on regional officials (usually senior psychiatrists) who manage the statutory process in the nation's 20 district health boards. Moreover, New Zealand's national guidelines on the Mental Health Act^{2,3} contain nothing like the detail of the English Code of Practice⁴ regarding conduct of the scheme. Instead, each local district health board uses its own systems and forms.

The English rules require SOADs to check the patient's legal status, speak to the patient in private, consult the treating clinician, consult two other professionals involved in the patient's care and provide written reasons for the decision. A national system of online forms is also used for SOADs to document these steps, state whether they approve the treatment in changed or unchanged form and specify the agreed treatment regime.⁵ No such prescriptive rules govern the New Zealand process. This paper compares the role performed by second opinion psychiatrists in New Zealand with that of SOADs in England and Wales. The term SOADs will be used to refer to the second opinion psychiatrists, of both jurisdictions.

Method

We audited the New Zealand scheme, for the first time, at three different centres. We reviewed documentation concerning SOADs' conduct of the treatment approval process, for both medication and ECT.⁶ We matched SOAD reviews of ECT with the two medication reviews nearest in time (ECT, $n = 146$; medication, $n = 292$; total, $n = 438$). Then we studied the progress in the following year of 11 patients at one centre whose treatment had not been fully approved by the SOAD.⁷ Finally, we compared our findings with published information and guidelines concerning the equivalent English scheme. The study was approved by New Zealand's Multi-Region Ethics Committee.

Results

Comparisons between the New Zealand and English SOAD schemes

We found intriguing similarities and important differences between the operation of the New Zealand and English schemes. There were strong similarities in the demographic profile of patients for whom treatment approval was sought for medication and ECT respectively. In both jurisdictions, in medication reviews, males outnumbered females by approximately 2:1, whereas that gender ratio was reversed for ECT; the mean age of patients undergoing medication review was significantly younger than for ECT; and the mean age of female patients under review was significantly older than males, for both medication and ECT.

These features seem to be associated with the different diagnostic profile of patients undergoing the different forms of treatment. In New Zealand, we found patients undergoing medication review tended to be male (62%), younger (mean age 44.8 years) and had a diagnosis of schizophrenia or schizoaffective disorder (64%), whereas patients being considered for ECT tended to be female (70%), older (mean age 56.9 years) and had a diagnosis of affective disorder (68%).⁶ Interestingly, Māori patients tended to be underrepresented in figures for ECT (6%) compared with their proportion in the general New Zealand population (approximately 15%).

In both jurisdictions, ECT reviews generally occur at an early stage in the Mental Health Act process. In England, Fennell, in a study conducted some years ago, found 60% of ECT approvals occurred within 7 days of the patient's detention under the Act, 18% on the very first day.⁸ In New Zealand, we found 60% occurred during the initial month's compulsory assessment under the Act.⁶ Medication reviews are only required by the legislation, of both jurisdictions, after the patient has been detained for a longer period of time.

In both jurisdictions, SOADs overwhelmingly approved the treatment sought, especially ECT. Non-approval, or significant change in the proposed treatment, was rare (*Fig. 1*).^{6,9–11} In England, there has been a recent trend towards less frequent full (or 'unchanged') approval of treatment plans for medication (81% in 2002–2007, falling to 68% in 2011–2012), though not for ECT.^{9,11}

Lack of consistency between New Zealand centres

In our New Zealand audit, we found little consistency in the conduct of the SOAD process at the different centres.⁶ There were marked differences in how SOADs were designated to review the treatment of individual patients; the number of clinicians who performed the SOAD role; their degree of independence from treating clinicians; the forms they completed; and the steps they took during the approval process, as documented in local forms or the patient's clinical record in the week before or after treatment was reviewed.

In New Zealand, the Mental Health Act authorises the Mental Health Review Tribunal to appoint qualified psychiatrists as SOADs, but there is no national agency managing the scheme.¹ Different methods are then used in the various regional district health boards to designate the particular SOAD who will review an individual patient's treatment. These methods include an administrator approaching SOADs on a roster system; the treating clinician sending an email request to all local SOADs, to see who responds; and the treating clinician directly approaching a SOAD with specialised knowledge in treating the particular patient's condition. In some services, treating clinicians personally decide which SOAD to approach.

At one centre, only a small number of appointed SOADs actually performed the task. At another, the work was shared widely among consultant psychiatrists. At a third, a single specialist considered almost all proposals for approval of ECT, then administered the course of treatment, if approved. The SOADs invariably worked in the same region as the treating clinician. They were not paid more to perform the SOAD role than their usual salary or given any particular relief from their usual workload.

Each district health board used different forms and systems for recording the SOADs' written opinions on treatment. The text of these opinions was remarkable in its diversity, ranging from a single word (the name of an alternative medication) to a three-page formal report. The depth of scrutiny given by SOADs to the treatment is indicated in part by this written record. It revealed great variation between New Zealand centres in the extent to which SOADs recorded having reviewed the patient's clinical notes, diagnosis or treatment plan, or recorded the patient's views on treatment. There was similar variation in the extent to which there was any record that SOADs had spoken to the treating clinician or provided a written *Fig. 1* Extent of approval of (a) medication and (b) electroconvulsive therapy (ECT) by second opinion appointed doctors (SOADs) in New Zealand (2003–2011) and England and Wales (2002–2012). Data from Dawson *et al* (2013),⁶ Mental Health Act Commission (2008),⁹ Care Quality Commission (2013).¹¹ Terms used in New Zealand: 'approved unchanged', 'partially approved' and 'not approved'. Terms used in England and Wales for both periods of time: 'approved unchanged', 'slight change' and 'significant change'. There were missing data for second opinions on medication (New Zealand 2003–2011, 2.4%, England and Wales 2002–2007, 7.6% and 2011–2012, 3.5%) and ECT (New Zealand 2003–2011, 0%, England and Wales 2002–2007, 8.2% and 2011–2012, 8.3%). justification for their decision. This diversity is illustrated in *Fig. 2*.

In short, there seems little consistency in SOADs' conduct of the process at different New Zealand centres. Moreover, different methods were used to store information generated during the process, and generally no adequate method was adopted for linking the information SOADs provided on the forms with any comments they made in the patient's notes, so the two could be read together.

No clear process where impasse

At one centre we evaluated the files of 11 patients whose treatment had not been approved, or only partially approved, by the SOAD,⁷ trying to determine how the disagreement had been resolved. We found that when the SOAD did not approve, or qualified, the treatment plan, intensive consultation usually occurred between the treating clinician, the SOAD and the regional administrator of the Act. Cases generating most correspondence concerned non-approval of ECT. In some cases, these written exchanges revealed significant dissatisfaction or disagreement on the part of the clinicians.

In England, the Mental Health Act Code of Practice says (para 24.67) there is 'no appeal' from the SOAD's decision to approve treatment or not.⁴ In New Zealand, the Act simply says that, for the proposed treatment to proceed, it must be approved by 'a' SOAD. This rule does not say the SOAD can veto the treatment proposed. Instead, it opens the possibility that another SOAD might approve the treatment, if the first SOAD does not. So it might be said that there is an appeal.

In 2 (of 11) cases of non-approval we followed, further second opinions were sought when the first SOAD declined. Nevertheless, some disagreement arose in these cases between the clinicians as to whether the initial SOAD's refusal to approve treatment was final. No clearly established process seemed to exist for resolving such disagreements, and no clear 'appeal' process was specified by the Mental Health Act guidelines² during the period studied.

Discussion

Main findings

Our findings show some clear similarities in the conduct of the SOAD schemes in England and New Zealand, although there is considerable inconsistency in the process followed at different New Zealand centres, along with uncertainties arising from the absence of a clear rule in New Zealand regarding the finality of a SOAD's decision not to approve treatment.

There are similarities in the characteristics of patients subject to medication and ECT reviews, in the stage patients have reached in the civil commitment process when undergoing these reviews and in the high rates at which SOADs approve the treating clinicians' plans. In sum, under the two schemes, SOADs seem to review similar patients, at similar stages in the Mental Health Act process, with similar results.

One can debate whether high rates of approval of treatment by SOADs are a good or a bad thing. Psychiatrists exercise considerable discretion in selecting appropriate treatment and, in doing so, must take many factors into account. Complete agreement between treating clinicians and SOADs on all occasions is therefore improbable. If it occurred, it would suggest 'rubber-stamping' and no exercise of independent judgement on the part of SOADs. That would seem to rob the process of any value. Yet high levels of disagreement between the two clinicians would also be a concern. It would seem to call into question the competence of SOADs, or the competence of treating clinicians whose plans would be regularly overruled. Alternatively, it would call into question the reliability of treatment decisions in psychiatry, if the two clinicians could rarely agree on a treatment plan.

A high but not complete level of agreement therefore seems satisfactory. It suggests that independent judgement is exercised by SOADs, but the two clinicians can usually agree on a treatment plan. The rates of approval, in both New Zealand and England, fit that pattern, even though the rates are not exactly the same.

Lessons learnt

At the New Zealand centres studied, there were notable inconsistencies in how SOADs were designated to review individual patients' treatment and in the degree of independence evident between SOADs and treating clinicians. There also seemed to be little consistency in the range of people SOADs consulted or in the information they considered (including the frequency with which they consulted the treating clinician, considered the patient's views about treatment and provided a written justification for their decision) – as judged from their written comments on the forms or in patients' notes. Likely explanations for this diversity include the lack of detailed national guidelines stipulating a process to follow, lack of specific training or funding for SOADs who perform the role, and absence of decisions of New Zealand courts reviewing the SOADs' conduct against legal standards of procedural fairness.

A notable feature of the New Zealand situation is the absence of a 'no appeal' rule. In cases where SOADs declined to approve treatment, intense consultation usually occurred, but this did not always produce agreement between the SOAD and treating clinician on an amended treatment plan. Approval from another SOAD might then be sought, on the premise that treatment could proceed if 'a' positive opinion was obtained.

The 'no appeal' rule in England is more final and certain. It may encourage SOADs and treating clinicians to negotiate an amended treatment plan to permit some form of agreed treatment to proceed, when the patient is detained for treatment under the Act. It is interesting that the MHAC and CQC publish no figures on cases in which SOAD approval is declined. They report only cases in which the treating clinician's plan was approved 'unchanged', 'slightly changed', or 'significantly changed'. There is in fact no space on the current CQC form for English SOADs to say they decline. Presumably they could simply decline to sign the form and – if there was 'no appeal' – that would seem to mean the treatment could not proceed.

This does not mean that all disagreements in England between treating clinicians and SOADs are happily resolved. The 'no appeal' rule may confer sufficient authority on SOADs to secure amendment of the treatment plan, in most cases, and conferring such authority on SOADs may be more readily justified where – as in England, but not New Zealand – senior psychiatrists are selected, trained, funded and supervised by an independent national agency to perform the task. But it is not wholly obvious why one SOAD should have final authority to approve the treatment or not, and some treating clinicians are no doubt left aggrieved by the SOAD's decision. The SOAD does not carry continuing responsibility for the patient's care, and the treating clinician may have far more knowledge of the patient and be a specialist in treatment of the patient's particular condition. So why should the treating clinician be overruled by another clinician, with no right of appeal?

Greater knowledge on the part of the treating clinician should, of course, be taken into account by the SOAD when making their decision. But a case can be made for the New Zealand position: that treatment should be permitted provided 'a' SOAD approves. This produces something like an appeal from the first SOAD's decision. Any appeal process should be clearly specified, however, and should not be capable of manipulation by the treating clinician.

The new New Zealand guidelines regarding the Mental Health Act, issued in 2012³ after closure of the period we studied, address the matter more fully. They suggest (at para 10.2.2) that, where the first SOAD declines to approve, the regional administrator of the Mental Health Act (although not the treating clinician) may 'direct that another approved psychiatrist provide a second opinion'. So the process of obtaining another SOAD's opinion is to be managed by a senior psychiatric administrator, not by the treating clinician. One can imagine such a process being managed in England by the CQC.

Nevertheless, through this 'appeal' process the first SOAD's view can be trumped. So then we may ask: why should the second SOAD's view be preferred to the first, and will 'shopping around' for opinions somehow occur? In the end one might conclude that the practical advantages of finality justify accepting the first SOAD's view, and support the 'no appeal' rule.

Other changes to the New Zealand scheme might be made to try to capture some advantages of the English superstructure. The new guidelines in New Zealand suggest SOADs should consider, before approving treatment: the history of the patient's illness and prior pharmaceutical regime; the risks and benefits of potential treatment approaches; the patient's views, as far as they can be ascertained; and whether the treatment is of maximal benefit to the patient and appropriate to their condition.³ This provides some guidance on the process to follow. But the guidelines could go further, to specify clearly the degree of independence required between SOADs and treating clinicians, and the information

SOADs should record. The Ministry could promulgate a system of online forms to be used nationally. Completion of the forms would confirm the necessary steps have been taken, and the forms could be used to collate data, publish statistics and make the process more transparent, as has occurred in England with reports from the MHAC and CQC.^{9–11}

Limitations

The shortcomings of this study must be acknowledged. The retrospective data collection for our audit was based on written forms and clinical notes. It is a study of documented steps and is likely to underestimate the intensity of treatment review SOADs conducted. Our general audit only covered the process at 3 New Zealand district health boards (out of 20) and our substudy covered a small number of non-approved cases at a single board. The audit discovered significant diversity in practice between district health boards, so generalising to other boards may be inappropriate.

Implications

In our audit, 438 examples of the SOAD process were studied at the three sites. These related to both medication and ECT, and the results show clear parallels between the operation of the New Zealand and English schemes. Our substudy of non-approved cases is, we believe, the first of its kind. In conclusion, the inconsistencies revealed in the conduct of the process at different New Zealand centres should encourage clinicians in England and Wales to value their clear national guidelines and forms. It shows the benefits of the structure, training, funding and reporting provided by the MHAC and CQC. Clinicians may not always value greater formality or elaborate structures for administration of the Mental Health Act. But, in light of New Zealand's experience, we suggest that central administration of a SOAD scheme can confer advantages in terms of clarity and consistency that are particularly desirable in a mandatory process designed to protect compulsory patients' rights.

1.8.11 Age inclusive services or separate old age and working age services? A historical analysis from the formative years of old age psychiatry c.1940–1989

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Abstract

The Equality Act 2010 made it unlawful to discriminate in the provision of services on the grounds of age. This legislation is open to interpretation, but it is affecting the way older people's services are defined and provided. Historical evidence indicates that, since the 1940s, apart from psychiatrists working in dedicated old age services, most were unenthusiastic about working with mentally unwell older people and unsupportive of those who chose to do so. A historical analysis might shed light on current dilemmas about 'all age' or 'old age' services and inform decision-making on future mental health services.

1

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The Equality Act 2010¹ made it unlawful to discriminate in the provision of services on the grounds of chronological age, but precisely how the Act can be brought into effect to produce appropriate services for older people is unclear. The Act has led to reconsideration of whether dedicated services for older people, or ‘all age’ services, are clinically most appropriate and legal, and to the Royal College of Psychiatrists Old Age Faculty proposing new criteria to define their specialty.² Key themes in public health policy and practice recur and are re-addressed by each generation.³ Some reiteration of themes is inevitable and sensible in the context of material changes in society and new medical discoveries. But attitudes in society can be slow to change and some deep-seated cultural beliefs endure, which, although not reproduced identically at different times, provide antecedents of public resistance to health innovation. Historical analysis can help clarify this process⁴ and may facilitate rational decision-making. This is particularly important for new policies as ‘policy makers are constrained from behaving rationally in many ways’: they, like the rest of society, are not value-free and they are faced with influences of past policy that may restrict options.⁵ This paper derives from a historical study concerning the formative years of the specialty of old age psychiatry until it was recognised by the Department of Health in 1989. It would be difficult to undertake a reflective historical analysis of the years 1990–2014, partly because of its recency and also because of methodological difficulties such as accessing government documents under the ‘30 year rule’. Historical evidence from the formative years may nevertheless help inform current decision-making on planning mental health services for older people.

The very beginning: the 1940s

There was little enthusiasm for working specifically with older mentally ill people in the 1940s: ‘After all, they had to consider the medical personnel as well as the patients’⁶ one psychiatrist commented at a psychiatry conference. Geriatric medicine was new, and contrary to cultural beliefs that emphasised inevitable decline in old age, the early geriatricians demonstrated that age-appropriate specialist treatment could reverse much physical impairment.⁷ Birth rates had been falling and infant mortality increased at the beginning of the Second World War.⁸ Population projections were that one in six of the population would be of pensionable age by 1961. Welfare planners were not to know that this was a significant overestimate. The government prioritised supporting families and young children and William Beveridge’s plan for the welfare state gave older people less priority.⁹

Joseph Sheldon’s study of older people noted their ‘mental vigour and “guts”’, and concluded that ‘living in the environment they are used to, of having something to do, and of being still able to feel necessary to the world’ were important for their well-being.¹⁰ This was an innovative message for health and social care authorities, who tended to focus on the minority who needed intense support, rather than the well majority. Such evidence challenged widespread negative assumptions,¹¹ including in the medical profession that tended to neglect mentally ill older people.¹²

The first old age psychiatry services c.1950–c.1970

In the 1950s, dedicated old age services were almost nonexistent. A report in the *Guardian* commented that mental hospitals ‘should be regarded as treatment centres for the mentally ill and not as depositing grounds for the senile for whom nothing can be done’.¹³ The very presence of older people in mental hospitals was deemed, by some psychiatrists, to undermine care for those ‘more in need of active treatment, having to be denied admission’,¹⁴ i.e. younger people. Brice Pitt (later professor of old age psychiatry) said: ‘The hospital... was like a castle, a good registrar would fend off the elderly, as those who got in were bound to stay, bound to be dumped by their family’.¹⁵

Once admitted, older people mainly by-passed the assessment wards and were admitted directly to long-stay back wards.¹⁶ Potentially reversible physical and psychiatric disorders often remained undiagnosed.¹⁷ Grudging medical attention given to older people¹⁸ contrasted with that given to younger people on forward-looking wards that became hotbeds of intervention with new treatments¹⁹ and rehabilitation.²⁰ Emil Kraepelin’s influential opinion prevailed: most old age psychiatric disorder was irreversible senile dementia,^{21,22} the ‘result of the natural wear and tear of the body’.²³ This stereotypical view of the inevitability of decline undermined proactive approaches to treatment. Evidence from geriatric medicine about treatment, rehabilitation and support for families²⁴ had not permeated mental hospital practice. Psychiatrists working across all ages offered little to older people.

In the early 1950s, at Crichton Royal Hospital, Dumfries, rather than admitting older people directly to back wards, in order to improve outcome, all patients regardless of age began to be admitted to acute admission wards. This all age approach failed: the admission wards filled with older people. Their needs were different: different presentations of the same illnesses, different sensitivities to medication, slower rehabilitation and negative staff expectations of recovery could undermine treatment. Also, mixing older, frail, restless and confused people with acutely disturbed younger people was not conducive to safety or well-being.^{16,25} In response, at Crichton Royal in 1958, Ronald (Sam) Robinson established a dedicated comprehensive old age psychiatry service, a successful prototype for others to emulate.²⁶

In 1959, the medical committee at the Bethlem-Maudsley psychiatric teaching hospital in south London analysed recent publications about the needs of older people (see, for example, National Old People’s Welfare Council²⁷). Several consultants were consulted in this analysis, but Felix Post, the only consultant working specifically with older people, was not.²⁸ Reasons were not given, but perhaps an old age psychiatrist’s opinion was not considered relevant, implying that the really important clinicians worked with younger people. This mirrored leaving out geriatricians from a British Medical Association committee in 1954 when planning geriatric services²⁹ and later events at the Royal College of Psychiatrists.³⁰ The Bethlem-Maudsley committee concluded that better services for older people would relieve ‘pressure caused by aged and infirm people’ in mental hospitals: this would give more scope for treating younger patients. Post repeatedly tried to improve services for his patients during the 1950s and 1960s, an impossible challenge for a lone psychiatrist advocating for older people. The Bethlem-Maudsley’s prioritisation of younger people and ambivalence towards older people persisted. It included proposals to reduce beds in the old age wards and re-designate them to other departments,³¹ and seemed to perpetuate an inferior share of resources for older people.

Elsewhere, there was also ambivalence among general psychiatrists towards treating older people. At Claybury Hospital, Essex, in 1966, some general consultants wanted to keep their older patients with treatable conditions, but hand over those thought to be incurable: ‘the general psychiatrists were dead keen to get us to take their old schizophrenics’ recollected Pitt. Others wanted to keep their caseload of older people perceived as needing little clinical input: it conveniently boosted their numbers.

In all age services, where no old age psychiatrist effectively advocated for older people, they were treated inequitably; similar happened at policy level. For example, the Worcester Development Project, a feasibility study of comprehensive community and district general hospital mental health services to replace a local psychiatric hospital, did not automatically include older people.³² In Northern Ireland, in 1970, the Ministry commented that older people ‘often have to go through the general admission unit, to the distress of younger patients and the detriment of the service’.³³ It did not mention that older people might be distressed by younger patients, or that the NHS was meant to be universal.

Old age services begin to increase: 1970s

In the 1970s, there was a tendency to plan for younger before older mentally ill people. *Hospital Services for the Mentally Ill*, in 1971, mentioned ‘psycho-geriatric’ assessment but did ‘not deal with services for elderly patients whose mental illness symptoms are the result of ageing or physical disease or both’. It promised further guidance.³⁴ The mental health charity MIND and the Royal College of Psychiatrists were disappointed by the exclusion.^{35,36} Not mentioning older people did not necessarily exclude them, but left ambiguities rather than a sense of direction and responsibility for provision. It conveyed that their particular needs were unimportant and discouraged the development of specific services, despite increasing clinical evidence of benefits from active interventions.^{37,38}

A geriatrician noted that psychiatric hospitals were becoming ‘silted up’ with older mentally ill people, at least partly because psychiatrists ‘do not wish to treat’ them.³⁹ Tony Whitehead, an old age psychiatrist, commented that psychiatrists should stop ‘pretending that the old were not their concern’.⁴⁰ The logical course to avoid competing with younger people was to provide dedicated, resourced services.⁴¹ In 1972, the Department of Health and Social Security’s (DHSS) *Services for Mental Illness Related to Old Age*, based on recent clinical experience in a few places, recommended appointing a psychiatrist with ‘special responsibility’ for older people in each health authority catchment area.⁴² Progress was slow.⁴³ The DHSS acknowledged that ‘old people are almost inevitably neglected among the competing demands of acute work with younger people’^{44,45} and, in 1976, reiterated the need for ‘at least one consultant in each district’ to lead clinically and to develop services for older people.⁴⁶

The Royal College of Physicians of London suggested reasons for underprovision of dedicated services for geriatric medicine that were equally applicable to old age psychiatry. They included the need for adequate resources and ‘fundamental changes in society’s attitude to old people’.⁴⁷ The general psychiatric leadership of the Royal College of Psychiatrists made disparaging comments about old age psychiatry: it might create ‘a vacuum for unsuitably qualified people’ and ‘It was necessary to preserve standards and maintain some unity’.⁴⁸ These comments implied their view that ‘psychogeriatrics is a dead end job for which no psychiatrist in his right mind applies’.⁴⁹ Their stereotypical attitudes revealed prejudices about working with older people.

Older people accumulated in mental hospitals. In 1978, in England and Wales, people over 75 years old occupied 20 000 mental hospital beds (25%),⁵⁰ but that age group accounted for only 5.6% of the total population.⁵¹ To some degree, the need for institutional care reflected age-related degenerative disorders and the needs of ageing long-stay patients with illnesses dating back many years. Other factors affecting bed use were less justifiable: clinically unnecessary admissions; low expectations of recovery; patients remaining in hospital when they no longer required treatment and they could have been better supported elsewhere; limited provision of domiciliary services and community residential care; unsupported families being unable to cope with the care of older people;⁵² and potentially curable conditions such as depression remaining undiagnosed.⁵³ In addition, they were given less opportunity than younger people for community and rehabilitation services, probably at least partly related to their perceived low economic value,⁵⁴ a yardstick of success in Western society.

Into the 1980s

Attitudes to illness and disability in old age did not generally improve, at least not sufficiently to influence service provision widely. A joint geriatric, psychiatric and nursing report in 1987 noted that ‘the low worth of old people and their therapeutic potential still persist despite the dramatic evidence to the contrary’.⁵⁵ Attitudes outside old age specialties were often derisory, in contrast to the rewarding nature of the work experienced by staff doing the job.^{56,57} A lecturer at a nursing conference in 1982 commented: ‘the thought of being permanently posted to a psychogeriatric ward fills newly qualified nurses with dread’.⁵⁸ The president of the Royal College of Psychiatrists, Thomas Bewley, commented: ‘it was quite difficult to discover what percentage of a psychiatrist’s sessions were spent on caring for old people, part of the problem being that the general psychiatrist might have fears about being labelled as a psychogeriatrician’.⁵⁹

In some places, general psychiatrists were unwilling to share resources with those taking responsibility for older people;⁶⁰ resources might have been even less for older people if no one was specifically advocating for them. For example, the admired old age psychiatric service at Redruth, Cornwall, which hosted numerous visiting dignitaries, including Prime Minister Edward Heath and teams from abroad, consistently faced ‘half-hearted understanding rather than fervent support’ from the local general psychiatrists.⁶¹ The precise level of resources was probably less important

than local colleagues' willingness to offer a commensurate share of existing resources. The problem of providing adequately for older people meant that old age psychiatrists' roles included: 'occasional militancy... to gain a fair share of scant resources, to put them to best use, to make do with too little while wheeling, dealing, and fighting for more'.⁶² As in earlier decades, meetings about old age psychiatry service development took place without old age psychiatrists and risked overlooking older people's mental illnesses.^{63,64}

There were few formal studies comparing clinical effectiveness of old age and all age psychiatric services. One study conducted in 1985/6 compared 'specialised' and 'non-specialised' services treating older people with mental illness. Despite difficulties in the sampling method, which were likely to minimise differences, it indicated outcomes 'in favour of the specialised services', such as for teaching, research and having beds in general hospitals rather than in psychiatric hospitals,⁶⁵ suggesting that dedicated services provided more forward-thinking services. Methodologically ideal randomised studies were lacking, and even well-designed studies risked creating artificial environments of case selection, staffing levels and case-load.⁶⁶ Comparative studies often did not state clinical outcomes,⁶⁷ although some noted better outcomes for depression treated by old age services.⁶⁸ Better outcomes could irritate colleagues of equal status who do not like to be told by others that they can do the job better: challenges to professional skills are linked with ambivalence towards emerging new specialties,⁶⁹ risking undermining developments.

General practitioners (GPs) mentioned advantages of having old age psychiatric services 'closely allied' to primary healthcare, but this was sometimes almost synonymous with shortage of resources.⁷⁰ Where dedicated old age mental health services existed, GP referral rates of older people increased significantly: at Crichton Royal, between 1974 and 1984, a 16% increase in the population over 65 was associated with a 150% increase in referrals,⁷¹ suggesting that GPs valued the interventions provided.

Discussion

'Age' can be measured in different ways.⁷² Usually in health service planning, 'chronological age' was used. A 'chronological' retirement age is arbitrary, but men's retirement and pension age, 65 years, was socially acceptable to define and establish services for older people.⁷³ In clinical work, staff knew the limits of their responsibilities and it could constructively guide GPs to refer patients to the appropriate psychiatric team. Chronological age cut-offs remain inseparable from certain services. They are used at both ends of life for administrative matters such as for leaving school or receiving a state pension or to enable population needs to be estimated and plans implemented. Age-related physiological and social factors affect illness in old age and may interact, requiring a distinct body of clinical knowledge and skills to permit optimum treatment. Illnesses in childhood and adolescence also present differently from in adulthood with different diagnostic and treatment implications. Not all adolescents reach 'maturity' at the same chronological age, and not all older people age at the same rate. In childhood and adolescence, separate services based on chronological age are acceptable. Similarly, old age services may be necessarily and appropriately different, rather than bearing overtones of negative discrimination.

An alternative definition of age is 'cultural age', combining chronological age with aspects of function ('functional age'), degree of independence and capacity for self-care, coupled with the understanding of old age within a community's value system.⁷⁴ It relates to society's expectations of outcome of treatment and priorities about providing health services. Those factors are not neutral and might affect providing and planning services for older people.

How best to ensure non-discriminatory services for older people remains unclear. In line with their understanding of the Equality Act, the Royal College of Psychiatrists' Old Age Faculty has proposed criteria for services based on 'cultural', rather than 'chronological', age.² This might, however, be discriminatory, given the subjective implications of the former, and since it raises issues of whether it could reliably provide appropriate services for people who need them. Who would decide on robust clinical grounds, for example, which patients should be referred to which service? Ambiguous lines of responsibility for older patients might contribute to undermining treatment for them.

Negative attitudes towards treating older people persist widely in the NHS and there is evidence that older people are still unwelcome in hospitals.⁷⁵⁻⁷⁷ Times have changed, legislation has changed, but attitudes appear similar. The World Psychiatric Association recently noted that combating ageism was part of the remit of services for older people;⁷⁸ taking that perspective might be difficult for those also advocating for younger people, especially where there are resource constraints. This reflects the historical evidence that services improved where dedicated old age psychiatrists advocated for their patients and were listened to.

General psychiatrists have repeatedly demonstrated a lack of interest and desire to work with older people and excessively low expectations of health improvement for them. Clinicians, managers and NHS planners overlooked their needs when creating services and allocating resources. A survey of health service commissioners in 2010 identified a disconcerting pattern of government response: ‘Governments and commissioners have shown a surprising failure to realise the significance of the ageing population, adopt best practice and make service development for older people a national priority’.⁷⁹

Services for older people lag behind those for younger people (see, for example, Hilton⁸⁰). Since the 1970s, policies for older people have appeared after those for younger people, reinforcing the idea that the needs of older people are less pressing. The National Service Frameworks for mental health in 1999 and for older people in 2001⁸¹ are more recent examples. Two years might seem little, but in the context of this being a repeated pattern, with reluctance to provide for older people, and in the context of economic downturns, including the financial crisis beginning in 2008, this has probably cumulatively undermined service development. A recent government strategy for mental health stated: ‘we will use the word “people” to encompass infants, children, young people, working-age adults and older people’.⁸² Age-equality is welcome, but has the anti-discrimination agenda become so all-encompassing and the policies so inclusive and watered down as to be meaningless? Will this pattern prevent real differences from being recognised? All age government strategies, however, have the potential to enhance equality in terms of planning services and allocating resources to all age groups simultaneously. By contrast, evidence of negativity towards older people by general and all age psychiatrists reinforces the importance and appropriateness of clearly defined, chronologically age-based, separate services to ensure reliable, dynamic, enthusiastic and effective psychiatric provision in old age.

Thanks to Tom Arie, Dave Jolley and Pat Thane for their comments.

1.8.12 Understanding Medical Education: Evidence, Theory and Practice (2nd edn)

Brian Lunn¹

date

2015-4

Contents

- *Understanding Medical Education: Evidence, Theory and Practice (2nd edn)*

Why should a jobbing psychiatrist be interested in a medical education textbook? Simply put, it is that we have shifted from an era of ‘See one, do one, teach one’ to one where an evidence base is available for education, not just for treatments. This is particularly the case for medical education, where the need to evidence pedagogic practice for regulators has been a priority for many years and has driven research to support and drive practice. This is an increasingly important issue. The General Medical Council, in *Recognition and Approval of Trainers*, has set out the standards it requires for clinicians to be trainers, with an implementation date of 31 July 2016, and a similar standardised approval process is well underway for undergraduate teaching.

¹

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Understanding Medical Education is a good place to start for those wishing to build their knowledge of the evidence base to inform their teaching. With a strong cast of the ‘usual suspects’ in the field, it delivers a broad range of chapters covering the breadth of educational topics. The book is set out in themed sections allowing selection of topics of interest. For the determined reader, read sequentially they build from basic foundations through strategy and assessment to research and finally, a ‘Staff and Students’ section that covers issues related to learners and teachers. This all finishes with an excellent chapter on educational leadership.

This should not be seen as a book targeted at the academic community. Even though one or two chapters may not affect most doctors’ teaching practice (e.g. the chapter on curriculum design), they will nonetheless enhance understanding of the choices that went into learning and teaching strategies.

So at the end of this, a reasonable question might be, ‘Is it worth my time buying/borrowing this book?’ If you already have a strong background in pedagogic theory, then it gives up-to-date monographs collected together in one place but perhaps nothing new, so it may be one you borrow rather than buy (and this is not a criticism). If you are developing your knowledge or wish a reference to support your teaching, whether undergraduate or postgraduate, then the answer is indubitably ‘Yes.’

1.8.13 *Bulletin* comment: Ever-expanding empires†

date

2015-4

Contents

- *Bulletin comment: Ever-expanding empires†*

The development of policy and governmental decisions at the highest level ought to be based on sound information, research or expert advice. Further, once change has been implemented and new practices set up there needs to be ongoing assessment, monitoring and reflection on the relative merits of the situation. Depending on the findings it might be necessary to make further changes: sometimes these alterations may even result in a complete reversal of the newly implemented practice.

The plan to increase the availability of psychological therapy for individuals with the more common mental disorders was clearly a good one. However, in practice the evidence for its effectiveness failed to materialise; research originating from two pilot sites was flawed giving an unbelievable impression of it doing good. Hopes of returning thousands of people with mental health issues to full-time employment were also unmet. Incredibly, the response to such an unconvincing success has been the further expansion of the service into the provision of talking treatments for children and young people experiencing a wide range of psychological problems.

No one can argue against the expansion of psychological services so that much needed appropriate treatment can be given to people with genuine problems. However, any plan consuming millions of public money ought to show convincing effectiveness on all fronts before it is blindly expanded.

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1.8.14 Skydiving for Beginners: A Journey of Recovery and Hope

Femi Oyebode¹

date

2015-6

Contents

- *Skydiving for Beginners: A Journey of Recovery and Hope*

This book will surprise you, shock you, and intrigue you but ultimately it will fill you with admiration and respect for the author. It is the personal memoir of Jo McFarlane, a woman who was born into adversity but who has triumphed, very much against the odds. She is that rare human being: sensitive, thoughtful, positive, driven and without bitterness. A living example of what resilience means in practice.

Her life started in ‘virtual squalor with dry rot and gaping holes in the floor’. She goes on: ‘Ours was a dirty, freezing home infested with vermin’. As if the utter material deprivation was not enough she experienced sexual abuse at the hand of both her father and brother and the circumstances were unspeakable: ‘The politics of my parents’ sex life was played out openly among the children. We knew that he wanted it all the time and that she hated it. This was an enduring source of tension in their marriage and they often embroiled us in the drama [...] One of her avoidance strategies was to have me sleep in their bed between them. I soon became an outlet for his sexual frustration’. The whole family were subjected to her father’s unpredictable moods which ‘like flames could blaze at the slightest provocation and burn for hours; at other times they were extinguished in a breath [...] So unpredictable were his rages that the atmosphere was like a bomb ticking towards its inevitable climax’.

This deprived and abusive childhood formed the backdrop of her psychiatric history in adulthood. Her account of her many admissions, treatments, suicide attempts, and relationships with psychiatrists, nurses and social workers is written with candour. It is an unsparing honesty with which she describes her own behaviour with unswerving clarity and objectivity. There is no sentimentality, self-pity or excuses here. It is an analytic mind that is on display, one that is eloquent and self-assured in how it handles language and ideas. She says of one of her depressive spells: ‘A military metaphor is the most apt I can think of to describe the war zone in my head. It was not a benign melancholy but a splintering of faculties, a torture even to exist. The rapid gunfire of destructive thoughts supplanted my will to survive’. Again, ‘I was so paranoid I thought Kathryn had hidden cameras in my flat, that they were all watching and laughing at my distress, that they could hear what the voices were saying to me and were using them to drive me to suicide. I felt I had to get away from the Royal Edinburgh as far as possible and I boarded a night bus for London. The journey was hell because of my mental state’.

The depiction of life on psychiatric wards, of good relationships with psychiatrists, of the exemplary quality of the interactions with some nurses, and of the kindness and generosity of many people underlines what is admirable and exceptional in mental health services. But, sadly, there are many examples of abuse, of disinterest, of perfunctory interactions, of gross neglect and of errors of judgement. What is impressive is that Jo McFarlane takes the good and the ugly in her stride and she emerges as an astonishing human being.

1

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This memoir stands alongside the great memoirs of Daniel Schreber, Janet Frame, William Styron and Kay Redfield Jamison. It sheds light on the intersections of disrupted attachment in early life, of traumatising abuse and of biological vulnerability to psychosis. It reveals the unheard but real voice of a fragile self that is masked by serious illness. And McFarlane's own ambition in writing this book is to be 'an invitation to others, through encouragement and example, to embrace their talents with pride and joy'. I think she has succeeded marvellously.

1.8.15 Clinical Guide to Obsessive Compulsive and Related Disorders

Ijeoma E. Onuba¹

date

2015-6

Contents

- *Clinical Guide to Obsessive Compulsive and Related Disorders*

This book gives an overview of obsessive–compulsive disorder (OCD), hoarding disorder, body dysmorphic disorder, excoriation (skin picking) and trichotillomania, all listed in DSM-5 under 'obsessive–compulsive and related disorders'. The authors have also included hypochondriasis and tic disorder as some of the related disorders.

The book is divided into three parts. The first part gives a general overview and evaluation of the disorders. The second part discusses each disorder in detail, focusing on the clinical description, diagnosis, comorbidity, course and prognosis, differential diagnosis and treatment. Scales that can be used in monitoring treatment are included in the appendix at the end of the book. The final part is titled 'special clinical considerations' and addresses areas such as treatment resistance, treatment of children and people with intellectual disability, and alternative treatments. This part also mentions neurosurgery for OCD and the ethical dilemmas associated with this approach. The appendices have a list of suggested further reading and contact details of organisations and treatment centres.

A useful resource for trainees and students is a table in the first chapter, which shows types of obsessions and compulsions with good examples. I also like the way the authors describe how to differentiate the symptoms associated with each disorder and normal behaviour. The book also gives practical advice on how to screen for these disorders. The response rates to treatments are discussed and some chapters also mention research work.

There is a table summarising pharmacological treatment for each disorder when managing children and I wished a similar table was done at the end of part two, which could be used as a quick reference guide. The book's title may mislead readers who are looking for information on hypochondriasis and tic disorder.

I would recommend this book for health professionals, students and even patients and their carers. It is well written, concise and easy to follow.

¹

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1.8.16 Gregory O'Brien MB ChB MA MD FRCPsych FRCPCH FRANZCP

Tom Berney

date

2015-6

Contents

- *Gregory O'Brien MB ChB MA MD FRCPsych FRCPCH FRANZCP*

Formerly Professor of Developmental Psychiatry, Northumbria University and the University of Queensland; Consultant Psychiatrist and Associate Medical Director, Northumberland, Tyne and Wear NHS Foundation Trust; Senior Psychiatrist with the Queensland Mental Health Assessment and Outreach Team of Disability Services.

Greg O'Brien, who died recently aged 59 years, played a major part in developing the character of the speciality of the psychiatry of intellectual disability, first in the UK and then in Australia.

Greg entered intellectual disability psychiatry in the 1980s at a time when its role and future were being questioned. Over the next 30 years, he helped develop its clinical and academic character. Within the Royal College of Psychiatrists, he was elected Chair of the Faculty of Psychiatry of Intellectual Disability in 2002 and appointed Associate Dean in 2006, an office that gave him a wider opportunity to develop psychiatric education. He was appointed to the academic chair in Developmental Psychiatry at Northumbria University in 2004. Martin Bax drew him into the Society for the Study of Behavioural Phenotypes and the Ronnie MacKeith group where he was able to focus on autism and epilepsy. These various worlds had in common a clannish, crusading nature, which Greg explored with energy and ebullience, fermenting ideas through encounters that included long journeys, long lunches, research meetings and conferences. His numerous publications reflect a wide range of concepts and approaches to clinical practice. In particular, he was the senior editor of *Behavioural Phenotypes*, the first textbook published on this subject.

The College gave Greg a further forum which he relished, enjoying its influence on psychiatric training and service development. Like others, he had set out to be a child psychiatrist, only to be drawn into the fast-changing, multi-disciplinary adventure of intellectual disability. Both locally as a medical director and nationally as the faculty chair, he was effective in steering professional and service development through the surf of repetitive reconfiguration that characterises the NHS. His apparent confidence in doing this was achieved only by careful preparation.

An unfashionable speciality, Greg made sure the Faculty of Psychiatry of Intellectual Disability would be a significant source of support for many isolated members. Its growth inevitably brought some loss of informality and intimacy. Greg's antidote was to foster the inclusive, all-are-welcome ethos that was the Faculty's hallmark. He started the tradition of after-dinner music at Faculty meetings, the sessions extending through the night and becoming, for some, the highlight of the programme.

While still at the height of this career, he left the UK in 2010 to move to Queensland, where he succeeded in recapturing the pioneering spirit that had inspired him in the UK, developing a new service and its academic base. Appointed Senior Staff Specialist on the Mental Assessment and Outreach Team of Disability Services and to the chair in Developmental Psychiatry at Griffith University, he set about a similar campaign to convince the Royal Australian and New Zealand College of Psychiatrists not only that there were powerful intellectual challenges in neurodevelopmental psychiatry but also that this could become the most human and clubbable of the psychiatric specialties.

Greg grew up in Paisley, where his family and school (St Aloysius College) left him with the strong sense of social justice that would underpin his life. His father, Jack O'Brien, was a Glasgow trade unionist. After graduating from Aberdeen Medical School, Greg entered psychiatry in Newcastle. There he met Barbara, who was to become a specialist in paediatric intensive care, and whom he later married. The O'Briens moved to Cambridge in 1986, where Greg took up a post as lecturer in the Department of Psychiatry, specialising in intellectual disability. In 1991, he returned to Newcastle to become a consultant at Northgate Hospital. There, with Ken Day as his mentor, he focused on forensic psychiatry and medical management. At the same time, he completed his MD and set about fostering academic development in

his specialty, directing the regional training programme, organising research, editing a series of books and managing the politics of a professorial chair.

Throughout his career, Greg remained a clinician, seeing, treating and learning from individuals, their families, friends and carers. He had an intense enthusiasm combined with the strong sense of humour that carried him through his career. Behind the jollity and extravagance of manner was a keen awareness that he was lucky to have such congenial employment. He was always ready to help colleagues with advice that was not only intelligible but also constructive. He was a great confidant, recognising the normality of imperfection. For Greg, however, the real world was rooted in his family and friends whose own lives were shaped by his warmth and humanity.

His illustrated life on Facebook, written from Australia, was about fun, friends and family (blithely ignoring the cancer that developed a year after his arrival) and he lived life to the full, right up to the point when he wrote a dignified letter of farewell to the Australian College (<https://www.ranzcp.org/Membership/Subspecialty-groups/Interest-Groups/Intellectual-Developmental-Disabilities/SIGPIDD-Newsletter-May-2014.aspx>). He returned to Newcastle and made arrangements for his disposal (a funeral mass at the cathedral, a crowded wake and then, on the following day, a more private cremation).

Greg O'Brien died of cancer on 13 July 2014 at his home in Newcastle upon Tyne. He is survived by his wife, Barbara, and their children, Áine and Daniel.

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1.8.17 Quality assurance of approved out of programme psychiatry training and research over the past 5 years

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Dr Victoria Osman-Hicks was a Royal College of Psychiatrists Quality Assurance Committee member and was secretary to the Royal College of Psychiatrists Trainees Committee 2012-13. She is a higher trainee in old age psychiatry and Wessex Quality Improvement Fellow on out of programme training alumni in Wessex Deanery. **Hannah Graham** is a Royal College of Psychiatrists Quality Assurance Committee member and curriculum manager at the Royal College of Psychiatrists. **Peter Leadbetter** is a Royal College of Psychiatrists Quality Assurance Committee member and senior lecturer in applied health and social care, Edge Hill University, Liverpool. **Dr Andrew Brittlebank** is the Chair of the Royal College of Psychiatrists Quality Assurance Committee member, consultant general adult psychiatrist and deputy medical director at Northumberland, Tyne and Wear NHS Foundation Trust.

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2015-6

Abstract

Aims and method This paper intends to analyse the number of applications, trainee demographic and approval rate of those applying for out of programme training (OOPT) or out of programme research (OOPR) between January 2008 and April 2013 using the committee's anonymised database. We also describe the process of application and approval by the Quality Assurance Committee.

Results There were 90 applications, including 10 resubmissions during the 64-month period. Most applicants (77%) were higher trainees; 53% of applicants were from the London deanery; 60% of applications were for research posts and higher degrees (OOPR). Overall, 64% were approved by the committee: 70% for OOPRs and 53% for OOPTs.

Clinical implications This paper shows with transparency the breakdown of applications to the Quality Assurance Committee. Around two-thirds of applications to the committee are supported (64%). Relatively few psychiatry trainees (2.5%) have applied for an OOPT or an OOPR over the past 5 years.

Contents

- *Quality assurance of approved out of programme psychiatry training and research over the past 5 years*
 - *Method*
 - *Results*
 - * *The Applicants*
 - *Discussion*
 - * *Implications*

The Quality Assurance Committee at the Royal College of Psychiatrists includes a group of consultants across all specialities, a lay member, carer and trainee representative. The committee leads on the review and college approval of trainee's out of programme training (OOPT) or research (OOPR). Trainees seeking for their OOPT or OOPR to count towards part of their psychiatric training and therefore certificate in clinical training (CCT) apply prospectively to the committee via a structured application form. In this article we will review the process of applying, the outcomes of those that apply, the common pitfalls and problems for those that are unsuccessful and review the demographics of applicants.

Method

We analysed the numbers of applications, trainee deanery and ethnicity and approval rate of those applying for OOPT or OOPR between January 2008 and April 2013 using the Quality Assurance committee's anonymised database. We also describe the process of application (see *Box 1*) and approval by the Quality Assurance Committee.

Results

The Applicants

There were 90 applications to the Quality Assurance Committee between January 2008 and April 2013, a 64-month period. This included 10 resubmissions. The descriptive data on core and higher trainees; approval rates; and applications by deanery is described in *Table 1*.

Approval v. non-approval

Of the 90 applications, 58 (64%) were approved and 32 (36%) not approved on the first application. Of the 32 applications not approved, 10 (31%) trainees resubmitted additional evidence or information with 8 (80%) successful in gaining approval. Of the 10 resubmitted, 1 application required minor changes and was approved after personal correspondence between committee members between meetings. Nine (90%) were reviewed at the subsequent committee meeting following resubmission.

Core v. higher trainee applicants

Overall most applications were from higher trainees; 77% (70/90). Core trainees included those who were core trainees at the time of applying. These trainees may be applying for OOPT or OOPR in their next post, which may be a higher training post. This may have had an impact on the actual proportion taking OOPT or OOPR in their higher training.

Box 1 The application process

Trainee applies for a specific training or research opportunity not part of their programme. Trainee starts deanery/LETB process for applying for local approvals; leading to signed LETB form usually by educational supervisor, training programme director and dean or head of school. Trainee looks at website: <http://www.rcpsych.ac.uk/training/qualityassurance.aspx> for timeline of next quality assurance committee meeting. If trainee does not want to have OOPT/OOPR to count towards CCT, the trainee need not apply to the Quality Assurance Committee at the College. If trainee wants some or all of the OOPT/OOPR to count towards their CCT they then apply to the Quality Assurance Committee using the structured application form on the website in the area on quality assurance of training (<http://www.rcpsych.ac.uk/training/qualityassurance.aspx>) before starting the new post (i.e. prospectively). The trainee includes a covering letter, copy of the signed local approval, the Quality Assurance Committee application form and all the recommended supporting evidence. The Committee meet quarterly and review all of the applications. The applications are not anonymised so any members who know the trainee or have a conflict of interest leaves the room. The Committee then recommend approval, request for further information or non-approval by letter to the applicant. This includes the number of weeks to months to count towards CCT. Those that are not approved are given the reasons for the decision. The approved applications are then forwarded to the General Medical Council for final approval and a letter is sent to the applicant with their amended CCT date. Applications that required minor further information are usually reviewed in between meetings online. Applications that require resubmission or are less minor are reviewed at the following quarterly meeting. A letter to the applicant, advising the result, is sent by email and post within 1–2 weeks of the quarterly meeting.

The numbers and success rate of core and higher trainees applying for out of programme training (OOPT) and out of programme research (OOPR) by deanery (local education training board)

Deanery	Total applications, <i>n</i>	Applications by core trainee, <i>n</i>	Application by higher trainee, <i>n</i>	Number
East Midlands	5	0	5	3
East of England	8	2	6	6
Kent, Surrey, Sussex	4	0	4	2

Table 22 – continued from previous page

Deanery	Total applications, <i>n</i>	Applications by core trainee, <i>n</i>	Application by higher trainee, <i>n</i>	Number
London	48	12	36	28
Mersey	2	0	2	2
North Western	4	3	1	3
Northern	3	1	2	3
Oxford	3	1	2	0
Northern Scotland	1	0	1	1
Severn	1	0	1	1
South-East Scotland	2	0	2	2
South-West	1	0	1	1
Wales	2	0	2	1
Wessex	3	0	3	3
West Midlands	1	0	1	1
West of Scotland	1	0	1	0
Yorkshire and Humber	0	0	0	0
Unclear	1	<i>a</i>	<i>a</i>	1
Total	90	19	70	58

Not able to say from College data.

Applications by deanery or local education training board

We analysed the 90 applications across deaneries, now local education training boards (LETBs). The largest deanery in the UK is London in terms of psychiatry trainee numbers. The London deanery applicants made up 53% of applicants (48/90) with the other deaneries making up the remaining. We found that OOPT and OOPR applications were at the same rate in the London deanery (2.5%) as in the overall trainee sample (2.5%); during 2008–2013 the London deanery had 1918 trainees. As a result of the relatively small numbers applying from deaneries outside London, data from all other deaneries was combined for statistical analysis. These data were compared with data from the London deanery. Results from chi-squared analysis ($\chi^2(1, n = 89) = 0.94, P = 0.33$) indicates that there was no significant difference in the likelihood of success on an application based on deanery location (London *v.* outside London). This supports the transparency of the application process by deanery.

The diversity data

The Quality Assurance Committee reviewed trainee's ethnicity against application approval for all declared ethnic groups. This was as part of the committee's process to ensure there was no discrimination as part of the approval process. Declared ethnicity is available for all applications since January 2009. The database includes 76 applications; 95% ($n = 72$) of trainees declared their ethnicity on the OOP application. *Table 2* shows that across trainees that declare their ethnicity, 33% (19/57) of White trainees did not have their applications supported v. 40% (6/15) of Black and minority ethnic trainees. Data was statistically analysed to see if self-declared ethnic group (White or non-White) was significantly related to the likelihood of success for OOPT and OOPR applications. Chi-squared analysis ($\chi^2(1, n = 72) = 0.23, P = 0.63$) indicates that there was no significant difference in the likelihood of success based on ethnicity. This supports the transparency of the application process by ethnicity.

OOPT v. OOPR

The majority of trainee applications 60% (54/90) were for OOPR. The remaining were for OOPT 36% (32/90) and 4% (4/90) were unclear from College databases. A total of 16 of the 54 (30%) OOPR applications were not approved to count towards training or CCT (this included resubmissions). Of the OOPR applications, the majority were for research posts, PhDs and research fellowships. Some diverse applications were approved including a 12-week research post in Ghana and an MSc that counted towards CCT.

Of the 32 OOPT applications to the College, 15 (47%) were unsuccessful in gaining college support towards a CCT. Of the successful 17 applications, 4 (24%) were for forensic training including 3 forensic child and adolescent *Table 2* Applications for out of programme training (OOPT) and out of programme research (OOPR) by ethnicity (White and Black and minority ethnic) Ethnicity Groups Core trainee, n Higher Trainee, n Applied for OOPT or OOPR, n Supported OOPT or OOPR, n Unsupported OOPT or OOPR, n White (any origin) 907563573819 Black and minority ethnic (any origin) 12768051596 Total 21831368724725 psychiatry and a medium secure forensic training post. A total of five (29%) posts were approved for work overseas including South Africa (one), Ghana (two) and Australia (two). Five (29%) fellowship posts were approved in areas as diverse as medical education, quality improvement, healthcare policy and practice fellowships. The remaining posts included working in London at the Maldives High Commission Drugs Policy Unit, clinical lecturer and clinical posts in the UK.

Reasons for non-approval

For the 16 OOPR applications not approved, 8 (50%) required further necessary information. For example not including the requested supporting information, not stating how psychotherapy competencies in core training would be met as part of the post or not including previous information on posts. For the remaining rejected applications, reasons for non-approval of core trainees related to issues such as taking OOP too early in core training (contrary to *The Gold Guide*¹) (one); taking additional OOPS in core training when already on an academic clinical fellow (ACF) scheme with a 75% clinical post (one). Pitfalls for higher trainees included requesting multiple OOPT or OOPRs to count towards training (three), clinical lecturer posts whose timetables did not meet the clinical training requirements (one), overseas posts that did not meet the curriculum, or trainees who had already completed 24 or more months training at the time of application (two).

For 15 OOPT applications not approved, 6 (40%) were posts in Australia. The main reasons for unsuccessful applications included a lack of evidence particularly around work-based assessments or documenting how assessments would take place. Other reasons for non-approved applications included the following.

Retrospective and did demonstrate coverage of the curriculum. One was for an infant mental health post (children aged 0–3), which is not part of the UK higher training child and adolescent mental health services (CAMHS) curriculum. One

was for a post at a House of Commons Committee that did not map to the curriculum. One was for a post overseas where the duties appeared too junior for equivalence of a higher trainee. One post overseas did not demonstrate how the curriculum competencies would be met. One had an incorrectly completed application form. One was a core trainee before core trainee year 3 (CT3) who had not completed 2 years of core training prior to an OOPT as recommended by the Gold Guide. The remaining two required further information to support their application.

Trainee psychiatrists v. other colleges trainees

Of the current psychiatry trainees 90 out of 3606 (2.5%) core and higher trainees in psychiatry have applied for OOPT or OOPR. Following request to the other Royal Colleges for comparative data, we have three returns with some information. The responses were from the Royal College of General Practitioners (RCGP), the Royal College of Obstetrics and Gynaecology (RCOG) and The Royal College of Pathologists (RCPath).

The RCGP confirmed that they have no OOPT or OOPR approved to their knowledge. They report that as general practice is a short training programme of 3 years, which includes a mix of training opportunities there is no need to do OOPT. Of those that take time out, for example to work overseas, it is usually recorded as a career break (OOPC) and therefore is dealt with at deanery/LETB level. In terms of OOPR, GP trainees have the opportunity to apply for an academic clinical fellow (ACF) scheme and therefore do not require OOPR during the training period.

The RCOG report that, in 2012, 26 of their trainees had OOPR or OOPT and 62 in 2011. The RCPath report that since 2003, 20 trainees have applied for OOPRs and 7 trainees applied for OOPT and 100% of trainees were approved to count towards training and their CCT. Both colleges did not supply the numbers of trainees in total to compare the rates of OOPT and OOPR with psychiatry

Discussion

Out of programme training and research remains a fairly uncommon experience with just 2.5% of psychiatry trainees applying for a training or research experience outside of their programme to count towards their CCT. The reasons for this may be that relatively few trainees spend time in out of programme experiences (OOPEs) outside of their programme in psychiatry. However, it may be that, similar to the GP vocational training scheme (VTS) programme, many trainees take time but do not apply for their OOPE to count towards their CCT. Reasons may be that the training programme is relatively short (6–7 years depending on endorsements). It is noted that there are relatively low competition ratios in psychiatry at CT1 and specialty trainee year 4 (ST4) entry over the period analysed. It may be that many trainees do not feel the need to develop their curriculum vitae in this way through research and OOPT. Qualitative analysis could explore the reasons why in future studies.

A further possible explanation is that trainees do not have an awareness of the process and role of Royal College of Psychiatrists in signposting and supporting applications for OOPT or OOPR. It may be that on a practical level out of programme opportunities and processes within the college and deaneries need to be more actively promoted.

The analysis shows that about two-thirds of trainees (64%) who apply for OOPT or OOPR are successful in getting approval by the Quality Assurance Committee. The Committee noted that a proportion of approvals were incomplete and required further information or evidence of mapping to the curriculum or training programme. We have simplified the application system by creating a form that prompts trainees to complete all of the required information. This went live in October 2012 on the College website. The updated guidance document is available on the College website.

There are relatively low numbers of OOPR applications (54 over 64 months). This suggests that there is a relatively low interest in research opportunities outside of the academic clinical fellow scheme; just 1.5% (54/3606) trainees have had the opportunity to be actively involved in a full-time research opportunity as OOPR. This suggests that relatively few trainees will have exposure to practical research experience, which may be of some concern to academics and the profession. Medicine and allied health sciences is based on the principles of evidence-based practice, where current best evidence is utilised in making decisions about the care of individual patients, therefore research is critical to developing psychiatry's evidence base and practice.²

It is noted there are relatively high numbers of applications from the London deanery (53%), compared with all of the other deaneries. The data demonstrate that London, compared with the UK as a whole, has the same rate of uptake of OOPT and OOPR, when taking into account the total number of psychiatry trainees in the deaneries. Despite a large number of applications from London, applications were not significantly more or less likely to be approved. This supports the transparency of the application and review process. This was also found for ethnicity supporting issues around equal opportunities and diversity. The larger number (not rate) of OOPTs and OOPRs in London suggests that there may be a culture there that encourages trainees to develop their expertise through OOPTs or OOPRs, which is not the case in other regions to the same extent. However, it may be because a large proportion of the research and training opportunities available out of programme are in London as a result of the high number of expert centres and universities. It may be that there is a supportive 'hidden curriculum' in London; led by supervisors with explicit links to these centres in signposting, promoting and supporting trainees in research and additional training.

Implications

Overall, although only a small proportion of trainees apply for OOPT or OOPR. Our analysis indicates that the process of its quality assurance is transparent in terms of applicants by ethnicity or deanery. The majority of applications overall are successful. Future research should examine how psychiatry compares with other specialisms in more detail and the reasons why low percentages of psychiatry trainees are applying for OOPT or OOPR. However, there is a lack of easily accessible comparative data making generalisations across specialisms difficult.

We wish to thank the Quality Assurance Committee for their input.

1.8.18 Investigating the usefulness of a metacognitive training group programme for schizophrenia

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Abstract

Aims and method To examine the usefulness of a cognitive-behavioural therapy-based group intervention, metacognitive training for schizophrenia (MCT), in a 'real-world' clinical setting. In total, 164 participants completed 327 questionnaires at the end of MCT group sessions; rating the perceived usefulness, helpfulness to recovery, change in knowledge and anxiety. Non-parametric statistical tests were used to analyse the data.

Results Participants indicated positive responses in terms of perceived usefulness, helpfulness to recovery and increased knowledge following group attendance. Significant positive correlations were found between: (a) usefulness and helpfulness to recovery, and (b) helpfulness to recovery and change in knowledge. There were significant negative correlations between: (a) usefulness and anxiety, and (b) helpfulness to recovery and anxiety.

Clinical implications The results suggest that MCT is a useful and effective evidence-based psychological intervention. It supports the use of cognitive-behavioural interventions in the treatment of individuals experiencing psychosis, although further evaluation is needed.

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The need for psychological interventions for psychosis is increasingly recognised¹ and cognitive-behavioural interventions have emerged as potentially effective approaches that should be considered in the treatment of schizophrenia.² The rationale for such approaches stems from mounting evidence that cognitive biases may trigger or maintain symptoms in schizophrenia, especially rigidly held unusual beliefs, frequently described as delusions within the literature.³ Individuals with the diagnosis may show evidence of attributional biases, jumping to conclusions, bias against disconfirmatory evidence, overconfidence in errors and problems with theory of mind.⁴ In light of these findings, an evidence-based group cognitive training programme has been developed called metacognitive training for schizophrenia (MCT)⁵ (metacognitive can be defined as thinking about one's own thinking). The programme aims to provide psychoeducation on cognitive biases to help alter individual's current problem-solving repertoire and prevent relapse.^{5,6} Research has confirmed the feasibility of MCT and provided support for its efficacy in reducing positive symptoms and cognitive biases related to schizophrenia in 29 countries including Germany^{7,8} and Switzerland.^{9,10}

However, although there is already support for the efficacy of MCT^{7,8} exploring its effectiveness within the local service was deemed important and, if necessary, adapting the service on the basis of feedback. This was reinforced by a health trust-wide initiative to promote clinical effectiveness through service-user feedback. It was considered important to examine individual sessions/modules as well as the broader programme experience (collapsing across attended modules). The open nature of the programme was such that participants could enter the programme at different points in the cycle: comparison of individual modules would show whether different entry-points to the programme were seen to be similarly useful/effective and identify particular foci for improvement. Three specific aims emerged from local service needs: to (a) explore the perceived utility and effectiveness of each MCT module, (b) explore the overall perceived utility and effectiveness of MCT group attendance (collapsing across sessions attended), and (c) examine the interrelationships between post-session ratings of perceived group utility, effectiveness and self-reported anxiety.

Method

Participants

Flyers inviting individuals to attend MCT sessions were disseminated to potentially suitable participants through professionals within the local community mental health team and acute in-patient ward. There were 164 participants; 105 attended only one session and 59 attended multiple sessions (mean 3.8 sessions, range 2–17). The mean age of participants was 42.7 (range 16–85); excluding 18 participants who did not give their age. Seventy respondents indicated they were male (43%) and 82 female (50%). Participants were not asked for details of their diagnosis in order to ensure the sessions were as non-invasive as possible.

Procedure

At the end of each session, participants were given a questionnaire to rate the utility and effectiveness of the programme. Throughout eight cycles (64 sessions) of the group, 327 questionnaires were completed.

Measures

The questionnaire was developed by the group facilitator (a clinical psychologist) based on the questionnaire used by the authors of MCT.⁵ It took approximately 5 min to complete and covered demographic information, questions that created a unique anonymised code to track participants through the programme and questions providing quantitative data on either a five-point or ten-point Likert scale (*Appendix*).

Description of the programme

The MCT programme consisted of eight sessions on a weekly basis lasting approximately 45 min, facilitated by a clinical psychologist. There were different modules each week, which consisted of familiarising participants with the Table 1 Programme content¹¹

Module title Target domain Overview of exercises

Module 1a & 1b: Attribution – blaming and taking credit

Self-serving bias v.

depressive attributional bias Different reasons for positive and negative events are contemplated.

Explanations that account for various causes are preferred to single

explanations

Module 2a & 2b:

Jumping to conclusions

Jumping to conclusions/ liberal acceptance/bias

against disconfirmatory evidence Situations leading to rash decisions are discussed and disadvantages are emphasised. Disjointed pictures are shown that ultimately display objects

Module 3a & 3b: Changing beliefs

Bias against disconfirmatory evidence Cartoon sequences are shown in backward order. Individuals learn to

withhold strong judgements until adequate evidence has been collected

Module 4a & 4b: To empathise

Theory of mind Incomplete cartoon strips and pictures of human faces are presented, and participants are asked how the people depicted might feel. The first

intuition is often wrong, showing that relying solely on facial expression

can be misleading and multiple cues should be used

Module 5a & 5b: Memory Overconfidence in errors Factors that may promote or impair memory acquisition are discussed.

Complex scenes are displayed with two typical elements each removed.

Participants learn to differentiate between false and correct memories

by their vividness Module 6a & 6b:

To empathise II Theory of mind/need for

closure Different features guiding theory of mind are discussed. Cartoon sequences are presented, and the perspective of one of the characters is considered Module 7a & 7b:

Jumping to conclusions II Jumping to conclusions/

liberal acceptance Similar to module 2, the disadvantages of hasty decisions are outlined.

Paintings are also displayed, and the correct title must be inferred from

four options Module 8a & 8b:

Self-esteem and mood Mood and self-esteem Causes, symptoms, and treatment of depression are discussed. Typical depressive cognitive patterns are presented. Strategies to help enhance

self-esteem and improve mood are also discussed target domain (for example jumping to conclusions, attributional style), using everyday examples and illustrations projected from a computer screen. Two cycles of the programme were available; each cycle involved the same targets but with different group exercises. It was an open group that individuals could join at any time. The manual, modules and other resources were downloaded cost-free from www.uke.de/mct. Table 1 outlines the content of the group programme.¹¹

Results

Data was not normally distributed, therefore, non-parametric tests were used and the median and interquartile ranges (IQR) are reported throughout.

Utility and effectiveness of each module

Table 2 shows the descriptive statistics for each module of the group programme; 266 out of 327 participants' completed questionnaires were included; 61 were excluded because of missing data. Mann–Whitney *U*-tests were used to compare differences between ratings given for parallel sessions within each module. No significant differences were found; therefore, the two cycles of the programme were considered equivalent and the data was pooled.

As Table 2 shows, ratings for each module seemed fairly positive in terms of usefulness, change in knowledge and helpfulness to recovery. A Kruskal–Wallis test was conducted to investigate whether there were any significant differences in perceived utility and effectiveness between Table 2 Median (interquartile range) ratings by module *a*

Median (IQR) Module *n* Usefulness Knowledge – prior Knowledge – post Change in knowledge Helpfulness

to recovery Anxiety

(session-end) 13 14.0 (3.0–5.0) 4.0 (1.0–6.0) 7.0 (4.0–9.0) 2.0 (0.0–4.0) 5.0 (3.0–10.0) 4.0 (1.0–6.0) 23 54.0 (3.0–5.0) 5.0

(3.0–7.0) 6.0 (5.0–8.0) 1.0 (0.0–3.0) 5.0 (3.0–9.0) 5.0 (1.0–7.0) 33 34.0 (3.5–4.5) 4.0 (1.0–6.0) 6.0 (5.0–8.0) 2.0

(0.5–4.0) 6.0 (4.5–9.5) 4.0 (1.0–6.0) 43 54.0 (3.0–4.0) 4.0 (1.0–5.0) 6.0 (5.0–8.0) 3.0 (1.0–4.0) 6.0 (4.0–7.0) 4.0

(1.0–8.0) 53 44.0 (3.0–4.25) 3.0 (1.0–6.25) 7.0 (4.0–7.0) 2.0 (1.0–3.88) 5.0 (2.0–7.0) 4.5 (1.0–6.25) 63 64.0 (3.25–5.0) 4.0

(1.25–7.0) 7.0 (5.0–9.0) 2.0 (1.0–4.0) 6.0 (3.0–7.0) 4.0 (1.0–6.0) 72 84.0 (3.0–4.0) 4.0 (1.0–7.75) 7.0 (4.25–8.75) 2.0

(1.0–3.75) 5.0 (4.0–7.0) 3.5 (1.0–5.0) 83 44.0 (3.0–5.0) 4.5 (2.0–6.25) 7.0 (3.75–9.25) 1.0 (0.0–3.0) 4.5 (2.0–8.0) 5.0

(1.75–8.0)² modules. No significant differences were found on usefulness ($H(n = 154) = 2.738, P = 0.908$), change in

2

n represents the number of participants providing ratings for each module. Usefulness was rated on a five-point scale anchored at: 1, 'unhelpful' and 5, 'very helpful'; knowledge, helpfulness to recovery and anxiety were all rated on a ten-point scale anchored at 1, 'none at all' and 10, 'a great deal'.

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knowledge ($H(n = 157) = 11.558, P = 0.116$), and helpfulness to recovery ($H(n = 154) = 5.057, P = 0.653$). To ensure that each rating was independent, only the first observation from each of the 59 individuals who attended more than one session was taken, and some individuals were excluded because of missing data. This suggested that ratings for each module were comparable and it was concluded that evaluating the group as a whole to evaluate the remaining aims of this paper was justifiable.

Overall utility and effectiveness of group attendance

Subsequent analyses collapsed data across sessions to produce individual-level summaries. Thus, each unit of observation represents a separate individual, and each data-value represents the average score for that individual, across the sessions that they attended. In this way, all observations are independent and comparable, facilitating descriptive and inferential analyses of aggregated individual-level data that reflect the overall impact of group attendance.

On average, participants reported that sessions were fairly useful (median 4) and helped towards their recovery somewhat (median 4.5). Wilcoxon Signed Ranks tests were conducted for individual-average ratings of change in knowledge. Participants reported a highly significant increase in knowledge from pre-group (median 4.5) to post-group (median 5.5), $z = -5.79, P < 0.001$.

Although there were overall (sample-level) changes in knowledge, inspection of individual change-scores seemed Table 3 Spearman's rho correlations for overall group ratings ($n = 150$) Helpfulness to recovery Change in knowledge Anxiety $rPrPrPU$ Usefulness $0.288 < 0.001 - 0.0530.514 - 0.301 < 0.001$ Helpfulness to recovery $0.2060.010 - 0.1940.018$ Change in knowledge $-0.0400.625$ to show that some individuals reported no change or negative change between pre- and post-group. Specifically, 20% (32/159) reported zero or negative changes in knowledge. It was not possible to compute accurate reliable change estimates¹² for knowledge items, as available estimates of test-retest reliability are conflated with intervention effects. Those who showed zero and negative changes would not be able to demonstrate reliable improvement in any analysis of reliable change.

Interrelationships between group utility, effectiveness and self-reported anxiety

The Spearman's rank order correlation coefficient (i.e. Spearman's rho) was performed to explore the interrelationships between group ratings (Table 3). The Spearman's rho revealed significant positive correlations between (a) usefulness and helpfulness to recovery and (b) helpfulness to recovery and change in knowledge. Furthermore, there were significant negative correlations between (a) usefulness and anxiety and (b) helpfulness to recovery and anxiety.

Discussion

Participants indicated positive responses towards MCT in terms of perceived usefulness and helpfulness to recovery. Changes in outcome measures revealed an overall increase in knowledge following group attendance, although at an individual level some individuals did not report any increase in knowledge (this is discussed further in the Limitations section).

No particular sessions were perceived as more useful or effective than others. This supports the clinical application of all components of the programme and could be seen to support the open format of the group, since all entry-points are generally comparable in terms of utility.

It seems that the more useful participants found the group, the more they found it helpful towards their recovery – and vice versa. In keeping with the aims of the group, helpfulness to recovery was also positively correlated with change in knowledge. By increasing an individual's awareness of cognitive biases and providing corrective experiences, it could be expected that an individual would report an increase in knowledge and related recovery (in terms

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of decreased symptoms).⁵ However, it is acknowledged that ‘recovery’ is a complex term and, although recovery from clinical symptoms can be seen as an outcome, individuals may continue to experience psychological distress while achieving ‘personal’ and ‘social’ recovery.^{13,14}

Interestingly, self-reported anxiety was negatively correlated with perceived usefulness and helpfulness to recovery. This suggests that the more anxious participants were, the less useful and helpful towards their recovery the group was – and vice versa. This may have important clinical implications for future practice, which are discussed below.

Limitations

Despite participants’ responses supporting the utility and effectiveness of MCT, which met various criteria for statistical significance, a number of limitations must be noted. The frequency of zero and negative individual-level change-scores suggests that some participants did not demonstrate knowledge improvements. From the available data it is unclear why this may be. It could be hypothesised that because the programme was an open group, establishing group cohesion was difficult. Therefore, although some individuals may have benefitted from the social processes of the group, some may have found the situation unhelpful and possibly anxiety-provoking. This may have had an impact on their ability to process and retain the information.

As participants were not specifically asked about their diagnosis, individuals who did not experience psychosis may have been included. As such, the programme content may not be suitable for those individuals and they may not have benefited from the group. Nevertheless, it is suggested that individuals with various mental health difficulties may benefit from MCT as the focus is on providing a neutral ‘common ground’ for discussing thinking styles, rather than individual symptoms.¹¹ However, this remains to be investigated and was beyond the scope of this paper.

It is also noted that some participants only attended the group once or a few times. This may be a behavioural indication that the intervention was not working. On the other hand, it may indicate that individuals were in the process of recovery and felt they no longer needed MCT. There are also contextual issues to consider; for instance, those participants who were in-patients may have been discharged and reluctant to return to the group because they were feeling better or a desire to disassociate with the hospital environment.

The service-developed questionnaire also had a number of shortcomings that may have affected the results. Change-scores were based on retrospective measures that may have resulted in inaccurate estimates, or participants may have felt obliged to respond in accordance with perceived demand characteristics. Furthermore, the items do not map onto the specific targets of MCT, including the expected reduction of positive symptoms and cognitive biases. In addition, it was difficult to establish what ‘recovery’ meant to respondents and how they evaluated this. As mentioned above, recovery is a very complex and individual experience and the quantitative data did not capture this.

Clinical implications

Despite the limitations, the results address the aims of the paper and suggest that MCT can provide a useful and effective evidence-based psychological intervention to participants within a local service. In addition to meeting local service needs, this paper contributes to the broader evidence base for MCT and supports the use of cognitive-behavioural interventions in the treatment of individuals experiencing psychosis.^{2,7,8}

The results have provided some important insights that may help to inform future clinical practice. Correlations suggested that individuals may need support to manage their anxiety in order to facilitate the processing of programme content (for example using relaxation and ‘ice-breaker’ exercises at the beginning of sessions). It may also be useful for the group facilitator to have an open dialogue with participants about the effects of the group and recognise that not everyone may benefit from MCT. Furthermore, as some individuals did not appear to benefit from the group, more selective inclusion criteria may be needed (for example ensuring only individuals with a diagnosis of schizophrenia/psychosis are included). It may also be useful to implement the recently developed individualised MCT programme on a one-to-one basis with some clients who may not benefit from a group format.¹⁵

The MCT programme showed promising results in promoting knowledge and was helpful for recovery and therefore further evaluation of the MCT group programme is needed in the future. There were various design limitations of the

questionnaire that would need to be addressed in order to improve future evaluation: (a) some participant demographics should be collected, including diagnosis, (b) measures of change should be taken before and after sessions in order to overcome problems with retrospective accounts, (c) items should map more tightly to the theoretical targets of MCT and could include objective tests (for example multiple-choice questions) v. subjective items that are more open to bias, (c) space for qualitative data should be provided under each question – particularly in relation to ‘recovery’ and what participants found helpful/unhelpful, and (d) questions about the impact of the facilitator’s style of delivery. This would allow exploration of what influences on outcomes relate to programme content or facilitator’s presentation skills.

Questions on the evaluation form

How much knowledge did you have on the topic being covered prior to this session?									
1	2	3	4	5	6	7	8	9	10
None at all									A great deal
How much knowledge do you feel you have now on this topic?									
1	2	3	4	5	6	7	8	9	10
None at all									A great deal
How much do you think today’s session has helped your recovery?									
1	2	3	4	5	6	7	8	9	10
None at all									A great deal
Overall how useful did you find the session?									
Un helpful		Fairly un helpful	Un-sure		Fairly helpful	Very helpful			
How anxious do you feel?									
1	2	3	4	5	6	7	8	9	10
None at all									A great deal

1.8.19 Learning about Emotions in Illness: Integrating Psychotherapeutic Teaching into Medical Education

Paramabandhu Groves¹

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- *Learning about Emotions in Illness: Integrating Psychotherapeutic Teaching into Medical Education*

Reading *Learning about Emotions in Illness*, I found myself reflecting on my emotional response to the book – I was moved, and surprised at being moved. Partly, it reminded me of my own time as a medical student participating in the student psychotherapy scheme, which gave me my first opportunity of being useful as a trainee doctor, as opposed to being someone in the way. The supervision group was a wonderful and constant haven in which to reflect within the busyness and ever-changing landscape of medical training. Partly, I was simply moved by some of the accounts of people who as students had participated in either of the schemes described in the book, as they grappled with their own and their patients' emotional responses, especially to physical illness.

The book describes two approaches aimed at helping students learn how psychotherapeutic understanding can help them with their patients: the student psychotherapy scheme and student Balint groups. There are accounts of the scheme both from its supervisors and from participants, and there is also a chapter on research into the two schemes. The University College London student psychotherapy scheme has a long pedigree, having run for over 50 years and surviving various organisational changes. It has spawned other schemes such as in Bristol and Heidelberg. The scheme allows medical students to take on a patient for psychotherapy for a period of about a year. At its inception, allowing untrained students to practise psychotherapy was an audacious move. However, patients are carefully selected and the process is well supervised, and studies seem to indicate that patients have a good outcome. For students, the scheme often leaves an indelible mark, with a number of people citing it as a highlight of their medical training.

By its nature the psychotherapy scheme can only take on a limited number of students, and numbers wanting to participate outstrip the available places. Modified student Balint groups were introduced at University College London as an alternative. These meet in small groups for a period of 11 weeks and are used to reflect on students' emotional responses to patients they have seen, to help foster, in Balint's terms, a patient-centred rather than an illness-centred approach.

Participants in the scheme seem more likely to become psychiatrists – a point to be noted given the recruitment shortage. However, the real value of these schemes is in helping to develop doctors who can tolerate difficult emotions that arise in patient–doctor interactions and to be alive to the often unspoken emotions that our patients communicate. In other words, regardless of specialty, to make better doctors.

1.8.20 Testimony of Experience: Docta Ignorantia and the Philadelphia Association Communities

Duncan Double¹

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- *Testimony of Experience: Docta Ignorantia and the Philadelphia Association Communities*

R. D. Laing and others founded the Philadelphia Association (PA) in 1965. The PA provides community households where people with emotional difficulties can live with others. The first ‘official’ community was the infamous Kingsley Hall, a ‘counterculture’ centre in the East End of London, which after 5 years was largely trashed and uninhabitable. In retrospect, Laing admitted that it was not a ‘roaring success’ (*Conversations with R. D. Laing*, B. Mullan). Nonetheless, despite the commonly perceived demise of ‘anti-psychiatry’, with which Laing was associated, the PA has survived nearly 50 years and still runs two community houses. In this book, Bruce Scott, a member of the PA, where he did his psychoanalytic psychotherapy training, offers the testimonies of 14 people who have lived in a PA household. These were obtained mostly by face-to-face interviews or by questionnaire.

Scott sees the PA communities as providing true asylum, in the sense of an ‘inviolable place’. There is no discussion, however, about whether such asylum is possible if the person is detained under the Mental Health Act 1983. My guess is Scott would say not. He makes a case for *docta ignorantia* or the doctrine of learned ignorance, a concept used by Nicolas Cusanus in the 15th century to recognise the limits of knowledge. For Scott, this is a path to health practised by the PA communities. However, there is little discussion about whether such neutrality is attainable. I am uncertain whether Scott’s search for an ‘anti-method’ is anything more than being pragmatic. The testimonies commonly mention the lack of structure in the households. I have no problem with mystery and perplexity and I totally agree with an anti-materialistic stance for dealing with mental distress. The PA rightly wants to avoid the objectification of people with mental health problems. Helping them find their own way is not easy.

This book describes the tension between ‘going to pieces’ and being helped to ‘come back together again’. Regression and psychosis can be mechanisms of healing and re-adaptation, as noted by Donald Winnicott among others. The PA continues to explore these areas, as does this book, but it may be increasingly difficult to find space for them in a bureaucratic society.

1.8.21 Services for adults with ADHD: work in progress†

: Commentary on ... Specialist adult ADHD clinics in East Anglia

David Coghill

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2015-6

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² See pp. 136–40, this issue.

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Abstract

Magon and colleagues highlight a number of relative strengths and weaknesses very reminiscent of those we have seen over the years in the development of similar services for children and adolescents. It is clear that we all have a lot of work to do to improve our approach to the transition from child to adult services. There was clear evidence that adult services can adapt to manage ADHD, but there is also a clear need for increased upskilling of clinicians in the practical management of medication and other treatments. I disagree with Magon and colleagues about the role of primary care and believe that treatment initiation and ongoing monitoring should, for the time being, remain in secondary care and that, because of the volume of work that will come our way, this will need to become a core rather than specialist task. As with other aspects of psychiatric care, there is a clear role for specialist nurses in delivering a significant proportion of the core care.

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- *Services for adults with ADHD: work in progress†*
 - : *Commentary on ... Specialist adult ADHD clinics in East Anglia*
 - * *ADHD diagnosis rates in the UK*
 - * *Guidelines for service transition*
 - * *ADHD pharmacological treatment: competence issues*
 - * *A new way of delivering services*

Magon and colleagues ¹ are to be congratulated for conducting what I believe is the first evaluation of the National Institute for Health and Care Excellence (NICE) recommendations on services for adults with attention-deficit hyperactivity disorder (ADHD). Their audit highlights several of the important, and sometimes controversial, issues that face commissioners, practitioners and patients.

This is a field of clinical work that is constantly evolving. Many of the changes that we are seeing mirror those that have taken place over the past two decades within child and adolescent mental health services (CAMHS). It will therefore be important that the lessons learnt there are not ignored. However, there are also many differences between the needs of people still experiencing ADHD and its related impairments as adults and those that they had while growing up and these too need to be respected. It is an important starting point to acknowledge that ADHD does not arise *de novo* in adulthood. There are of course some individuals with ADHD who were provided with ample scaffolding and support at home and school during childhood and adolescence and whose ADHD-related impairments may only have become clear when they left home and/or moved to less supported educational or work situations in early adulthood. But for most, their ADHD will have been causing significant problems throughout life and will have had an impact throughout their lives on their educational achievements, ability to form and sustain relationships, personality development and mental well-being.

ADHD diagnosis rates in the UK

Unfortunately, in the UK at least, many of those with ADHD will not have received a diagnosis or any treatment during childhood or adolescence. Recent figures from Scotland suggest that despite increases in recognition over the past 20 years ADHD is still significantly under-diagnosed. Even in the regions with the highest rates of recognition only around one in five of those with ADHD are currently being diagnosed. ² There is also very significant variation between regions and in the most densely populated areas of Scotland the rates of recognition are even lower, with diagnosis and treatment rates running between 6 and 13% of the epidemiological prevalence. ² This same situation, both with respect to under-recognition and regional variability, is almost certainly replicated across the rest of the UK.

As a consequence, it seems very likely that those individuals who are being identified, diagnosed and treated are those with the most severe symptoms and impairments. They are also the group that is most likely to need continuing services

and the greatest support during transition. It comes as no surprise to me to hear that transition was generally not well managed in either of the services covered in the audit and I recognise many of the comments in the discussion about the problems of transition only too well from my own clinical experience. From the CAMHS perspective it is often difficult to have the conversation about what the young person should expect from adult services when you are fully aware that in reality this depends a great deal on who picks up the case. It is much easier to hold on to cases well past the official transition date but this is neither good clinical practice – the needs of young adults are different and deserve to be treated by adult-oriented services – nor a good way to develop these much needed services.

Guidelines for service transition

Acknowledging the challenges of developing these, essentially new, services, we have produced guidance for the establishment of transition services.³ These built on NICE recommendations⁴ and include suggestions that:

a planned transfer to an appropriate adult service should be made if the young person continues to have significant symptoms of ADHD or other coexisting conditions that require treatment; transition should be planned in advance by both referring and receiving services; transition between teams should be a gradual process, e.g. lasting a minimum of 6 months; clear transition protocols should be developed jointly by commissioners, CAMHS/paediatric services, adult mental health services (AMHS) and primary care to facilitate transition and ensure that standards of care are maintained during the transition period; pre-transition: young people with ADHD should be reassessed at school-leaving age by the service managing their care; they should be informed of the outcome of this assessment and transitioned according to need; during transition, child and adult services should ideally have a joint transition appointment; during these meetings both services must ensure the needs of the young person will be appropriately met, which may involve further discussion and collaboration with educational and/or occupational agencies; post-transition: a comprehensive assessment should be carried out by the receiving service and this should include a reassessment for comorbid conditions; shared-care arrangements between primary and secondary care services for the prescription and monitoring of ADHD medications should be continued into adulthood.

Admittedly, these may seem to be relatively demanding recommendations, but the ongoing burden will be considerably lessened if they are underpinned by good-quality commissioning and planning. Getting the transition arrangements right should help to set the right tone for broader service planning. It should also strengthen the relationships between the child and adult services and facilitate joint learning, protocol development and planning.

ADHD pharmacological treatment: competence issues

In contrast to the clear issues hindering transition, it was very encouraging to see that both audited services were generally doing very well with respect to the assessment of not only the core ADHD symptoms but also the physical needs and coexisting conditions as well as in the initiation of medication treatment. This clearly indicates that it is possible for adult services to develop the required skills and integrate them into day-to-day practice. Although I do not believe this was ever in doubt, it is not uncommon to hear colleagues say that they feel out of their depth when dealing with these patients. There are now increasing opportunities for training in the assessment and management of adults with ADHD. In particular, the UK Adult ADHD Network (UKAAN; www.ukaan.org) has developed, and can deliver, high-quality training within the UK and has produced a helpful handbook for clinicians.⁵ There are also recently updated guidelines from the British Association of Psychopharmacology.⁶

It has become clear in recent years that the pharmacological management of ADHD is a skilled task and that whereas the basic principles of treatment are relatively simple, it is not so easy to ensure that treatment is first optimised and then continues to work well over time.^{7,8}

Primary- v. secondary-care management

Various opinions have been proposed about why it is difficult to maintain treatment results over time, but it would seem that continuing to provide ongoing high-quality care may be one important part of the puzzle (e.g. see Langley *et al*⁹). This certainly seems to be the case in our own clinic and has led to us developing a nurse-led clinical pathway that focuses on providing high-volume, high-quality continuing care.¹⁰ This highlights the one area where I think I may disagree with Magon *et al*. I do not believe that primary care services in the UK have yet acquired the skills to manage ADHD independently of specialist services. I certainly fully support the use of shared-care arrangements whereby (post-stabilisation) prescribing and possibly some physical monitoring is managed in primary care. I strongly believe, however, that symptom monitoring, monitoring of impairment and functioning and monitoring of comorbid conditions should at present remain within secondary care. These are skilled tasks and take time to do properly, and even if general practitioners (GPs) acquire the skills they are unlikely to be able to spend enough time to ensure outcomes are optimised.

Specialist ADHD management teams: (not) a perfect approach?

Although I do not currently support primary care-led services, it is still an open question as to which secondary care service model is best suited to the delivery of services for adults with ADHD in the National Health Service (NHS). Several different models have been put forward, ranging from all-age specialist teams, through specialist services limited to adults (such as those described in Magon *et al*'s audit), to services using a standardised protocol to deliver care via general AMHS. It is easy to see the allure of specialist teams, whether they be all-age or separate teams for children and adolescents and adults. There are, however, risks with this specialist team model. These include continued marginalisation of ADHD with specialist teams being seen as elitist and allowing those who are sceptical about ADHD to continue to ignore it as a valid clinical entity. Indeed, within such a model even those who may be somewhat interested but have not been placed on the team will often feel deskilled and left out.

Specialist teams often depend on a small group of individuals often centred around a charismatic and motivated leader. This makes them vulnerable when someone retires or leaves for another post. If successful, such teams will need to either become very big or only manage a small area. If they are large they can be very difficult to manage, if small one often gets postcode prescribing. On the other hand, expecting all adult psychiatrists to accept and manage ADHD alongside their other duties from the outset is almost certainly unrealistic and would be very likely to result in a huge variability in services. It would therefore seem parsimonious to accept that, as recommended by NICE, specialist services for adults with ADHD should be encouraged in the short to medium term, but that in the longer term it should be expected that managing ADHD will become a core skill for adult psychiatry, as it has over the past 20 years for child and adolescent psychiatry.

A new way of delivering services

While the optimal configuration of services is still being debated, I strongly support the use of multidisciplinary skills in the delivery of care. It is certainly not the case that all clinical care needs to be delivered by a doctor. In Dundee we have successfully developed a pathway that is primarily delivered by trained nursing staff, most of whom are not prescribers. These skilled nurses run parallel clinics, often as many as five at a time, supported by a senior medical staff member (usually a consultant), who works as a 'floating doctor' across the clinics providing support as required and overseeing changes in medication. I am aware that several adult services have also been successful in adopting a similar nurse-led service model and believe this is the way forward for ADHD services across the age range. Clinical psychologists, occupational therapists, dieticians, a range of psychological therapists and voluntary sector staff can also play a very important role in providing holistic care and their involvement should be encouraged wherever possible. It is not essential, or often desirable, for everyone to be part of a physical team and there can be great benefits from adopting a 'virtual team' approach with a clear and shared clinical pathway.

Another important point raised by the audit is the current difficulty accessing non-pharmacological treatments. It is true that we do not yet have a solid evidence base for non-pharmacological approaches to the management of ADHD in adults, nevertheless I believe that NICE was correct to highlight the potential importance of broader approaches to

treatment. As pointed out by Magon and colleagues, there are now a range of psychological therapies, most of which use a cognitive-behavioural therapy (CBT) approach. The problem seems to be getting those with the skills to deliver such programmes actually interested in doing so. Similar problems have arisen in effectively delivering behavioural parenting approaches. Here one solution has been to engage partners from outside the healthcare spectrum, often third-sector voluntary agencies, in delivery. It is not yet clear how this will work out for adult services. It may be the case that we have to wait until more clinical psychologists and/or appropriately trained nurse practitioners are ready to step up to the plate and start to provide a sound base of practice skills from which work can expand. Or it may be that, as suggested by Magon and colleagues, opportunities will arrive through the development of stronger and more active local ADHD support groups working in partnership with the voluntary sector.

The last point I would like to pick up on is that there were quite a few instances where the practice of the two audited services differed considerably. This is in line with the clear geographic differences in provision of services to children and young people. However, even though some degree of variability between services is of course inevitable, in ADHD very high levels seem to be the norm. Some of this variability will represent historical differences based on individual or service-level beliefs about the validity of ADHD and the use of medication to treat it and will have predated the provision of clear clinical guidelines. However, the introduction of guidelines does not seem to have led to increased uniformity in service delivery for child services^{2,11} and I suspect it will take a lot of hard work to ensure greater uniformity in the development of services for adults. Audits such as this are a good starting point and I again thank Magon and colleagues for getting the ball rolling.

1.8.22 Profile: Morgan David Enoch

Roxanne Keynejad¹²

date

2015-6

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 - *Waziristan*
 - *Medical training*
 - * *Uncommon Psychiatric Syndromes*
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A benchmark of fame in the modern world, a quick Google search for Dr Morgan David Enoch brings up an intriguing set of results. These range from a BBC article, ‘Spotting the Royal stalkers’,¹ a *BMJ* case report on ‘Exorcism for

¹ Dr Morgan David Enoch discusses his uncommon life in an interview with **Roxanne Keynejad**.

²

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schizophrenia’² and Ian McEwan’s *Enduring Love*,³ to Mersey Regional Health Authority’s implementation of care in the community and books, including *I Want a Christian Psychiatrist*⁴ and *Uncommon Psychiatric Syndromes*:⁵ now out of print, the paperback fourth edition is currently available from online sellers, second-hand, for over £1000.

The spectrum of today’s search results for this 88-year-old emeritus consultant psychiatrist of Royal Liverpool University Hospital, fellow of the Royal College of Psychiatrists, member of its Council for over 20 years and Court of Electors for 8, due shortly to publish his autobiography, offers just a glimpse of the diverse tales Dr Enoch might relate, should you be lucky enough to meet him.

Waziristan

With a surname meaning ‘he who walks with God’, Morgan David Enoch was a sixth-form student due to read theology at the end of World War II. David’s mother, who worried about his sister attending a hairdressing course in Swansea, 8 miles from the family home, was shocked when, after a letter from the King of England, he was soon serving with the British army in India’s north-west frontier, ‘facing the forces of the Faqir of Ipi at the very place where fighting has been heaviest for the [past] 10 years’, aged 18. Later, following a War Office Selection Board, he trained at the Indian Military Academy, ‘the Sandhurst of India’ at Dehra Dun, was commissioned into the Royal Artillery and posted to the second Indian (Sikhs) Field Regiment in 1947.

During this time, he says ‘while angry with God for obstructing my chosen path, I had four exciting years in India. I heard Jawaharlal Nehru and Mohammed Ali Jinnah address vast crowds: I witnessed the birth of two great nations and the process of India’s violent partition’. Playing rugby for the British Army in India, David returned to Woolwich Arsenal on leave, expecting to continue playing but was indignant to be ordered back to India to complete his outstanding months’ National Service. He says the physical and mental suffering he observed during his army career is what called him to medicine. After eventual military discharge, he ‘went around the London teaching hospitals and liked St Thomas’ Medical School. I think the uniform helped at interview’.

Medical training

Qualifying in 1954, following house jobs Dr Enoch returned to Wales to work at St David’s Mental Hospital, Carmarthen, as his father, ‘a hewer of coal in 2 feet 9 inches’ was dying of silicosis. Of his first years in psychiatry, he recalls the routine use of the hypnotic paraldehyde at night, prescribing ‘quite effective’ Drinamyl (amobarbital and dextroamphetamine, later known as ‘purple hearts’), deep insulin coma therapy and, for the first time, an antipsychotic: chlorpromazine.

Following his father’s death in 1958, he returned to London, then ‘the supreme place to train’, obtaining a medical registrar post at University College Hospital, working for Professor Baron Max Leonard Rosenheim, Dr Roger Tredgold and Dr Desmond Pond, later president of the Royal College of Psychiatrists. In the mid-fifties, after the Institute of Psychiatry course and obtaining his Diploma in Psychological Medicine, Dr Enoch witnessed the introduction of antidepressants, beginning with imipramine and amitriptyline. He later obtained a senior registrar post divided between the London Hospital (now the Royal London Hospital) and Runwell Mental Hospital, Essex, which opened after World War II in response to shell shock – the last mental hospital built in Britain.⁶

Dr Enoch recalls Runwell’s physician superintendent, Dr Rolf Ström-Olsen, as ‘one of the best physicians I ever met. He was Norwegian, abrupt and highly intelligent’. He recollects Runwell’s units divided into neurosis and psychosis, conferences clouded in cigarette smoke, treating patients for the first time with out-patient electroconvulsive therapy and the introduction of newer antipsychotics, like haloperidol. This dynamic clinical, educational and research environment was to prove instrumental in inspiring his future writing, yielding a lifelong dedication to evidence-based improvement in clinical practice.

Uncommon Psychiatric Syndromes

Dr Enoch recalls presenting a patient at Runwell Hospital, whose complaint was that ‘my wife’s an impostor’. Phrases began to occur to him describing the psychodynamic processes at work: ‘His wife was “the fallen idol”, hence the delusion of doubles. How do you resolve loving and hating someone at the same time? By splitting. Is apperception not a wonderful word? To perceive with feeling. That is the essence of Capgras psychopathology.’

After further research, Dr Enoch’s paper on Capgras syndrome won the bronze medal and prize of the Royal Medico-Psychological Association in 1962 and was published in *Acta Psychiatrica Scandinavica* in 1963,⁷ the same year he won the Gaskell Prize. He developed an increasing interest in rare presentations, from De Clérambault’s syndrome, to folie à deux, Tourette’s and more, which yielded his first book. The first edition of *Some Uncommon Psychiatric Syndromes*, a bestseller, was published in 1967, with further editions in 1979, 1991 and 2001. Dr John Pollitt, President of the Section of Psychiatry of the Royal Society of Medicine, predicted that it ‘well deserves to be placed as a classic’;⁸ it has been translated into French, German, Turkish and Japanese.

Dr Enoch expected his ‘uncommon syndromes’ to remain rare and was surprised by their later *cause célèbre* status. ‘I never thought, for example, that patients with Munchausen syndrome by proxy would become so important. They became huge’. The diagnosis was questioned publicly, after several child killing convictions were overturned, including that of lawyer Sally Clark. In these cases, the diagnosis was used inappropriately for paediatric assessment, without involvement of a psychiatrist. By contrast, high-profile cases incorporating psychiatrist assessment, such as that of nurse Beverley Allitt, now detained at Rampton Secure Hospital, demonstrated the contemporary relevance of the diagnosis.

To this day, Dr Enoch receives telephone calls from readers of *Uncommon Psychiatric Syndromes* from around the world; he remains fascinated by delusional disorders. ‘I’d like to know far more about emotions. How can feelings affect thought? Psychodynamics remain all important. This book has been lived’. Although he never met Ian McEwan, who referenced the text in *Enduring Love*, Dr Enoch ‘approved’ of the novel, unlike the film *Fatal Attraction* (1987, director A. Lyne), which did not depict true De Clérambault’s syndrome, because ‘the protagonists had an initial affair: usually there is no contact’.

After the success of *Uncommon Psychiatric Syndromes*, Dr Enoch wrote other well-received books, including *Healing the Hurt Mind: Christian Faith and Psychiatry*.⁹ Now in its 11th edition, its title was inspired by a patient’s letter, kept to this day, stating that ‘Dr Enoch was the first person who listened to me and asked me how I am. Healing began for me today’. In the most recent, *I Want a Christian Psychiatrist*,⁴ he returns to his theological roots. ‘You don’t necessarily need a Christian psychiatrist: you need a competent psychiatrist who must respect your faith’.

Clinical career

Dr Enoch recalls obtaining his first consultant post at Shelton Hospital, Shrewsbury, after debating Ganser syndrome with Professor Sir William Trethowan, foundation chair of psychiatry at the University of Birmingham, at interview. He would later invite Trethowan to contribute to the chapter on Ganser syndrome and Dr John C. Barker that on Munchausen syndrome, in the first edition of *Uncommon Psychiatric Syndromes*.

It was at Shelton Hospital that Dr Enoch introduced regular teaching, therapeutic communities and care in the community. He recalls meeting Enoch Powell, then expounding de-institutionalisation as minister of health. He worked with Barbara Robb on a national campaign for elderly care in hospitals, contributing a chapter to her book, *Sans Everything: A Case to Answer*.¹⁰ He remembers ‘feeling encouraged’ at the time by the *Sunday Times*’ article series on care in the community by Marjorie Wallace, who later founded the mental health charity SANE, with telling photographs by Lord Snowden.

Dr Enoch was later head-hunted to take on the new post of consultant psychiatrist and senior clinical lecturer at the new Royal Liverpool University Hospital’s ‘superb’ department of psychiatry, later including beds at Rainhill Mental Hospital. He is still remembered as a dynamic and enthusiastic teacher, as evidenced by Dr Gamal Hammad’s description of him as ‘a charismatic guru, a wonderful mentor and a visionary’.¹¹

Fig. 15: Dr Enoch at his home in Cardiff, March 2014.

He always enjoyed encouraging the next generation of psychiatrists and made a point of involving students and nurses in ward rounds: 'I wanted the doctors and students to see the full range of psychiatric disorders. I used to remind them, "Rare things rarely occur".' At the opening of Shelton Hospital's replacement, the Redwoods Centre, in 2011, his second wife, Anne, a retired headmistress, recalls him being treated 'like a celebrity... they'd all read his book'.

Above all, Dr Enoch strove to teach and practise psychiatry as a holistic discipline, examining each and every patient: 'I liked psychiatry because it deals with the whole person: their body, mind and spirit. I wanted to do something exciting while staying true to my faith. A good psychiatrist is prepared to listen, know their stuff and gather it all together into a diagnostic formulation. It doesn't mean you have all the answers, but the diagnosis is the first step to management and treatment.'

On psychiatry

Dr Enoch is a staunch supporter and advocate of psychiatry as a compelling specialty with much still to be discovered: 'It's a new frontier of medicine... We know so little about the human brain: the heart is a pump, but you love with the hypothalamus. We thought that scans would give us clear-cut answers but they have not. What is consciousness? I have thirty books on it but no one can say where, how, what. It is remarkable what can arise from the unconscious. I thought that fMRI would locate jealousy, De Clérembault, because those syndromes are so specific: monomanias with one delusion. The fact that we cannot locate them suggests that the brain's connections hold the answers. But can this brain really have the capacity to understand itself?'

The specialty remains compelling for Dr Enoch, even after more than 50 years; he continues to advocate keeping psychiatric wards within medical hospitals: 'Psychiatry is the most intriguing of all specialties: you deal with the whole Meeting the Royal College of Psychiatrists' Pathfinder Fellows, January 2014. person. You must be a first-class physician: I have picked up lung cancer, brain tumours, pernicious anaemia, cardiac lesions, thyrotoxicosis. We are physicians of psychological medicine. Recalcitrant cases not medically understood are referred to us. You listen and discover things other doctors miss.

Patients come to you broken psychologically and emotionally, intent on suicide, and get better. Is there anything more helpful in society than to heal pain: physical and psychological? Psychiatric illness is an illness like any other: treatable and curable despite what even doctors may think. You need maturity to choose something so difficult, though. You will need hope, positivity and graciousness.'

On reflection

Having seen his last patient on 31 December 2012 and survived a coronary artery occlusion of '99%', Dr Enoch remains active, lecturing at Cardiff University Medical School until recently. In addition to his forthcoming autobiography, a book of Welsh essays is due for publication in 2014, with several exploring the relevance of the Ten Commandments today. Although he never did complete that theology degree, he has continued to preach from age 16 until today, in between spending time with his wife, son and four grandchildren. Considering his rather uncommon life, he reflects that: 'I have been greatly blessed. I am very grateful for a very exciting life; it's still exciting. I have enjoyed psychiatry's riches in helping people in great depth.'

When we last met, Dr Enoch was looking forward to meeting recipients of the Royal College of Psychiatrists' Pathfinder Fellowships, considering the next generation with excitement – and a little envy: 'this is going to be the century of the brain'. Above all, it is the pursuit of learning which he most fervently advocates for us all: 'I spent 65 years in the game, to realise how little I know. I would love to be starting again, with the knowledge I have now'. His wife adds, 'He is as enthusiastic today as when he was twenty'. All taught by Dr Enoch, exposed to this enthusiasm, may count themselves truly fortunate. His last piece of advice? 'Gather your materials from everywhere, but be your own architect.'

1.8.23 Mental health clustering and diagnosis in psychiatric in-patients

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date

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Abstract

Aims and method This paper investigates the relationship between cluster (Mental Health Clustering Tool, MHCT) and diagnosis in an in-patient population. We analysed the diagnostic make-up of each cluster and the clinical utility of the diagnostic advice in the Department of Health's *Mental Health Clustering Booklet*. In-patients discharged from working-age adult and older people's services of a National Health Service trust over 1 year were included. Cluster on admission was compared with primary diagnosis on discharge.

Results Organic, schizophreniform, anxiety disorder and personality disorders aligned to one superclass cluster. Alcohol and substance misuse, and mood disorders distributed evenly across psychosis and non-psychosis superclass clusters. Two-thirds of diagnoses fell within the MHCT 'likely' group and a tenth into the 'unlikely' group.

Clinical implications Cluster and diagnosis are best viewed as complimentary systems to describe an individual's needs. Improvements are suggested to the MHCT diagnostic advice in in-patient settings. Substance misuse and affective disorders have a more complex distribution between superclass clusters than all other broad diagnostic groups.

Contents

- *Mental health clustering and diagnosis in psychiatric in-patients*
 - *Aims*
 - *Method*
 - *Results*
 - *Discussion*
 - * *Limitations*

A set of needs-based clusters were originally developed as a classification system to aid service improvement in secondary care mental health services.¹ There are a total of 21 clusters grouped into three superclasses: non-psychosis, psychosis and organic. Each cluster describes a particular type, combination and severity of needs. This Care Pathways and Packages approach (www.cppconsortium.nhs.uk) was subsequently adopted as the heart of a move away from block contracts towards a new mental health payment system.

¹

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The first 12 scales of the Mental Health Clustering Tool (MHCT) are Health of the Nation Outcome Scales (HoNOS) items.² The HoNOS tool was originally developed by the Royal College of Psychiatrists' Research Unit as an outcome measure. The Care Pathways and Packages Project developed the remaining six MHCT scales to support the classification of patients based on their level of need.¹ The *Mental Health Clustering Booklet* provides likely diagnoses for each cluster. Added to version 3.0 of the booklet were unlikely diagnoses for each cluster based on the ICD-10 classification system used in the National Health Service (NHS).^{3,4}

Aims

The study had two aims. The first was to analyse the diagnostic make-up of each cluster from an in-patient population and to investigate the clinical utility of the advice in the MHCT booklet regarding likely and unlikely diagnoses. The second aim was to investigate the distribution of diagnoses across both superclass cluster groups and individual clusters.

Method

All discharges from working-age adult or older people's in-patient services in Northumberland, Tyne and Wear NHS Foundation Trust (NTW) between 1 April 2012 and 31 March 2013 were included in the study (each discharge refers to one treatment episode rather than one patient). Working-age adult services included psychiatric intensive care units (PICUs), acute adult and rehabilitation wards. Older people's wards included functional, organic and long-term/complex need wards.

The cluster on admission was taken as cluster assigned on date of admission or up to 3 days after admission, or nearest cluster prior to admission. Cluster superclass groups used are those given in the MHCT booklet: non-psychosis clusters 1–8; psychosis clusters 10–17; and organic clusters 18–21. Patients were assigned to cluster 0 if they were not adequately described by another cluster but required secondary care services.

We considered the diagnosis on discharge because diagnosis is more likely to be recorded on discharge and is more likely to be related to the current episode than diagnosis on or prior to admission. The ICD-10 code was sourced from electronic patient records. The broad diagnostic groups used were F00–09 (organic and dementia), F10–19 (substance misuse), F20–29 (schizophrenia and related disorders), F30–39 (affective disorders), F40–48 (neurotic, stress-related and somatoform disorders), F60–69 (personality and behaviour disorders), and 'other' diagnoses. 'Other' diagnoses included F50–59 (behavioural syndromes associated with physiological disturbances and physical factors), F70–79 (mental retardation), F80–89 (disorders of psychological development), other developmental disorders, G00–99, H00–95, R00–99, S00–T98 and Z00–99. The next diagnostic level used to analyse the data was at the 'three character' level, for example F32 depressive episode or F33 recurrent depressive disorder. Within affective disorder the four-character level was used to distinguish conditions with and without psychosis.

To empirically validate the MHCT 'likely' and 'unlikely' advice, a threshold of 65% was set for the cumulative proportion of discharges in a cluster which were attributed to the 'likely' diagnoses. In other words, all of the 'likely' diagnoses for a cluster should account for 65% or more of discharges. An acceptable threshold of 10% was set for the 'unlikely' diagnoses, meaning that all 'unlikely' diagnoses for a cluster should not account for more than 10% of discharges. Diagnoses not in the likely or unlikely groups were put in the 'other' group.

All analysis of the data was performed using SPSS version 19 for Windows and Microsoft Excel.

This study was part of a service evaluation of clinical activity in NTW which focused on the use of in-patient services across the trust. This was within the Transforming Services Programme which had approval of the trust board and included ongoing work to evaluate the use of MHCT within the trust. Data were provided by the trust informatics department. We used routinely collected data for this study.

Results

In total, there were 2830 discharges between 1 April 2012 and 31 May 2013. Primary discharge diagnosis was available for three-quarters of these ($n = 2094$): half were accounted for by affective disorders ($n = 552$, 26%) and schizophrenia and related disorders ($n = 533$, 25%). The remaining diagnostic groups were: personality disorders ($n = 283$, 14%); alcohol and substance misuse ($n = 260$, 12%); neurotic, stress-related and somatoform disorders ($n = 253$, 12%); dementia and organic disorders ($n = 131$, 6%); other ($n = 82$, 4%).

Over 90% of discharges ($n = 2570$) had an admission cluster. Of those, almost half (45%, $n = 1145$) were non-psychosis clusters 1–8, 42% ($n = 1091$) were psychosis clusters 10–17, 11% ($n = 287$) were organic clusters 18–21 and 2% ($n = 47$) were cluster 0.

There were 1937 discharges with both a cluster on admission and diagnosis on discharge. The diagnostic make-up of clusters 1, 2 and 21 was not analysed due to low numbers. In 11 of the remaining 17 clusters, the likely diagnoses made up more than 65% of the cases. This figure was highest for clusters 13, 16 and 17 where the likely diagnoses accounted for more than 80% of the cases. In 6 of the 17 clusters the likely diagnoses accounted for less than 65% of the cases and made up half or less of cases in clusters 3, 4, 10, 15 and 18. These same five clusters had high rates of ‘other’ diagnoses.

In the majority of clusters the ‘unlikely’ diagnoses made up around 10% of cases. In four of the clusters in the psychosis superclass (clusters 11, 12, 15 and 16) the ‘unlikely’ diagnoses accounted for between 11 and 17%.

Highlighted in *Table 1* are five clusters which have low numbers of ‘likely’ diagnoses and relatively high numbers of ‘other’ diagnoses. There were a number of unexpected diagnoses for some clusters, particularly within non-psychosis clusters. Alcohol misuse was the primary diagnosis in more than 10% of those in clusters 3, 4 and 5. Personality disorder was the primary diagnosis in more than 10% of cluster 3; similar figures were found for recurrent depression in clusters 6 and 15, and organic disorders (F04–09) in clusters 18 and 19. More than a third of those in cluster 15 had an F20–29 diagnosis. Alcohol and substance misuse was the primary diagnosis for a fifth of cluster 10, whereas depression accounted for 10%.

Table 2 shows the distributions of broad diagnostic groupings among the cluster superclasses. There was a significant relationship between cluster and diagnosis: F00–09 largely falling within the organic superclass; F20–29 largely falling within the psychosis superclass; F40–48 and F60–69 largely falling within the non-psychosis superclass.

Substance misuse and affective disorders were split between the psychosis and non-psychosis superclass clusters. *Table 3* shows a significant relationship between different types of substance misuse and superclass. Two-thirds of F10 diagnoses fell in the non-psychosis supercluster and nearly half were classified as having alcohol dependence (F10.2). In contrast, 67% of the F11–18 diagnoses fell within the psychosis supercluster. Multiple substance misuse diagnoses were equally split between these two superclass clusters.

A marked distinction between mania and bipolar disorders and the remaining affective disorders was observed (*Table 3*). There was a non-significant trend towards clustering bipolar disorder in the psychosis clusters, regardless of whether the patient exhibited psychotic symptoms or not. Patients with depression were significantly more likely to be assigned to non-psychosis clusters than to psychosis clusters. The only exception to this was depression with psychosis (*Table 3*).

Discussion

The results show that the diagnostic advice in the clustering booklet holds true for ‘likely’ diagnoses in 11 of the 17 clusters analysed and in 13 clusters for ‘unlikely’ diagnoses. In five clusters (3, 4, 10, 15 and 18) the ‘likely’ diagnoses accounted for half or less of discharges from hospital and there were particularly high rates of other diagnoses.

Discharges from each cluster and the percentage in the likely, unlikely and other diagnoses from the Mental Health Clustering Tool advice. Individual clusters with low rates of ‘likely’ diagnosis and high rates of ‘other’ diagnoses in bold

		Diagnoses, %		
Non-psychosis (1–8)	896	59	9	32
1	4	N/A	N/A	N/A
2	17	N/A	N/A	N/A
3	72	46	7	47
4	189	49	9	42
5	151	68	7	25
6	67	75	9	16
7	157	65	10	25
8	239	62	10	28
Psychosis (10–17)	899	73	10	17
10	133	52	0	48
11	111	74	17	9
12	169	76	15	9
13	102	83	6	11
14	220	74	10	16
15	28	29	11	60
16	80	81	15	4
17	56	93	4	3
Organic (18–21)	113	66	3	31
18	21	52	5	43
19	50	68	0	32
20	32	78	0	22
21	10	N/A	N/A	N/A
Total	1908	66	9	25

Broad ICD-10 diagnostic groups at discharge and superclass cluster group at admission

	Superclass cluster groups				
F00–09 Dementia and organic disorders	5 (4)	10 (8)	14 (12)	92 (76)	121 (100)
F10–19 Substance misuse	3 (1)	128 (56)	93 (40)	6 (3)	230 (100)
F20–29 Schizophrenia and related disorders	6 (1)	31 (6)	445 (92)	2 (0)	484 (100)
F30–39 Affective disorders	7 (1)	255 (49)	254 (49)	1 (0)	517 (100)
F40–48 Neurotic, stress-related and somatoform disorders	3 (1)	199 (82)	40 (17)	0 (0)	242 (100)
F60–69 Personality and behaviour disorders	2 (1)	235 (87)	34 (13)	0 (0)	271 (100)
Other diagnoses	2 (3)	39 (54)	19 (26)	12 (17)	72 (100)
Missing diagnostic data	19 (3)	248 (39)	192 (30)	174 (27)	633 (100)
Total	47 (2)	1145 (45)	1091 (42)	287 (11)	2570 (100)
	$\chi^2 = 1622.7$, d.f. = 14, $n = 2523$, $P < 0.001$				

Caution must be taken when interpreting some of these findings due to low sample numbers in some of the clusters. Further analysis in both in-patient and out-patient populations is necessary. Our findings indicate that the diagnostic advice holds true for the majority of clusters. However, the low rates of ‘likely’ diagnoses among a few clusters suggest that the current advice for those clusters does not hold true for a subsection of the in-patient population. These findings are supported by previous research which found high rates of mismatch between ICD-10 diagnoses and clusters 3, 4, 15 and 18.⁵

Clinical practice issues could partly explain these findings, but if further in-depth analysis in other trusts reveals similar trends, then changing the ‘likely’ diagnosis advice will increase the MHCT booklet’ clinical usefulness. Our results indicate that the following diagnoses could be added to the ‘likely’ diagnoses group: alcohol misuse for clusters 3 to 5; recurrent depression for cluster 6 and 15; Table 3The distribution of F10–19 substance misuse and F30–39 affective disorder diagnoses across the non-psychosis and psychosis superclass groups. Cluster 0 and organic superclass are not shown separately, but are included in total numbersMHCT groupsICD-10 diagnostic groupTotal cluster 1–8Total cluster 10–17TotalF10–19 alcohol and substance misuse128 (56%)93 (40%)230 (100%) F10 alcohol80 (67%)31 (26%)119 (100%) F11–18 opioids, cannabinoids, sedatives, stimulants etc.7 (29%)16 (67%)24 (100%) F19 multiple drug use41 (47%)46 (53%)87 (100%)² = 20.41, d.f. = 2, $n = 221$, $P < 0.001$ F30–39 affective disorder255 (49%)254 (49%)517 (100%) F30–31 mania and bipolar disorder49 (20%)192 (78%)245 (100%) F32–33 depression196 (76%)59 (23%)259 (100%) F34–39 persistent mood disorders, other mood disorders and mood disorders unspecified10 (77%)3 (23%)13 (100%)² = 162.22, d.f. = 2, $n = 509$, $P < 0.001$ F31 bipolar

disorder with psychotic symptoms 8 (19%) 34 (79%) 43 (100%) without psychotic symptoms 20 (29%) 48 (69%) 70 (100%) mixed episode 2 (15%) 11 (85%) 13 (100%) unspecified 16 (14%) 97 (85%) 114 (100%)² = 6.46, d.f. = 2, $n = 236$, $P = 0.09$ F32 and F33 depression with psychotic symptoms 22 (38%) 35 (60%) 58 (100%) without psychotic symptoms 93 (86%) 13 (12%) 108 (100%) unspecified 81 (88%) 11 (12%) 92 (100%)² = 60.45, d.f. = 2, $n = 255$, $P < 0.001$ schizophrenia and related disorders to cluster 15; organic conditions (F04–09) to clusters 18 to 21.

There were two diagnostic areas that are worth discussing further. The first was personality disorder. A number of diagnoses of personality disorder were found in cluster 8. However, there were also some found in other non-psychosis clusters including clusters 3 and 4. It may be that these were incorrectly diagnosed or clustered. Alternatively, it may be that those with complex and severe personality disorders are allocated to cluster 8 whereas those with simple personality disorders are clustered lower down within the non-psychosis superclass.⁶

A further area of concern was the high proportion of ‘other’ diagnoses in cluster 10, a substantial proportion of which were alcohol and substance misuse diagnoses. This is at odds with the finding that the prevalence of drug-induced psychosis is relatively low in England.⁷ It may reflect a reluctance of some early intervention psychosis services to give a formal diagnosis early on in an individual’s contact with services.⁸

Whereas dementia and organic disorders, neurotic and stress-related and somatoform disorders, and schizophrenia and related disorders aligned to one superclass cluster group, affective disorders and substance misuse disorders did not. At one diagnostic level down, depression mainly fell within the non-psychosis superclass while mania and bipolar disorder fell within the psychosis superclass. The only exception to this was the diagnosis of psychotic depression. Local trust policy, in line with Royal College of Psychiatrists advice, was to cluster patients with bipolar disorder to the psychosis clusters, regardless of whether psychotic symptoms were present.⁹

Department of Health guidance currently being drafted suggests that patients with bipolar disorder diagnoses may be allocated to either psychotic or non-psychotic clusters depending on presenting needs,¹⁰ supporting the view that cluster and diagnosis should best be viewed as complementary. These findings also have implications for the proposed reorganisation of services. If there is to be a division between psychosis and non-psychosis, it is evident that both teams will require expertise in the management of affective disorders.

Further analysis showed that F10–19 alcohol/substance misuse accounted for 14% of all clusters 2–8 and was largely uniform across each cluster individually. This highlights that patients with a primary diagnosis of alcohol/substance misuse experience a wide range of problems and have varying levels of need. This can be seen as supporting the previous decision to disaggregate the original generic substance misuse cluster 9.¹¹

Limitations

There are a number of limitations of this research which need to be highlighted. First, the accepted thresholds used for ‘likely’ and ‘unlikely’ diagnoses were set by the research team. No previous research was available in which to benchmark against. Second, only in-patient discharges were included, but the MHCT was developed for use in both community and in-patient services. To acquire a fuller understanding of the cluster–diagnosis relationship, the research should be extended to community patients. Third, for low-need non-psychosis and organic clusters in particular, there were low numbers, meaning that reliable and valid conclusions could not be drawn. Fourth, it is important to note that during the first analysis, we grouped together all ‘likely’ diagnoses and did not separate out the relative contributions of each diagnosis. It is possible that a ‘likely’ diagnosis occurred rarely and was offset by a more frequent one. Fifth, audits established that cluster accuracy for the period from January to June 2012 was at 68% (CAPITA, personal communication, 2013). However, assignment to superclass cluster was highly accurate; only one service user (2%) was assigned to the wrong supercluster. It is important to note that this audit was conducted using 63 patients who had been clustered to a psychosis cluster only. This suggests that findings of associations at the superclass level are likely to be more robust than at the individual cluster level. Finally, we used clinical diagnoses and due to the nature of the study it was not possible to check accuracy or interrater reliability.

This paper provides further information on the relationship between cluster and diagnosis in an in-patient setting. It supports the notion that cluster and diagnosis are best seen as complementary systems to describe an individual’s needs,

rather than there being a 1:1 relationship. This particularly applies to affective and substance misuse disorders. The data identified different skill sets required for the management of in-patients in the psychosis, non-psychosis and organic clusters if services are to further specialise in these areas. Results suggest some of the interventions that would need to be delivered within these services. Future work should extend this research into community teams.

1.8.24 The neurology–psychiatry divide: a thought experiment†

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Abstract

Diseases of the brain are generally classified as either neurological or psychiatric. However, these two groups of illnesses cannot be readily separated on the basis of pathophysiology or symptomatology. It is difficult to rationally explain to someone with no prior frame of reference why we have the split between neurological and psychiatric illness. This demonstrates that the division is untenable, which has implications for training in both psychiatry and neurology.

Contents

- *The neurology–psychiatry divide: a thought experiment†*
 - *Convention*
 - *Neuropathology*
 - *Symptomatology*
 - * *The biopsychosocial approach*
 - *Conclusion*

Can the distinction between psychiatric and neurological illness be explained to a Martian? This hypothetical Martian has come down to Earth and wants to know about our classification of diseases pertaining to the brain. Let us suppose our Martian has similar anatomy and biology to humans, except he has no concept of illnesses relating to the central nervous system; he does not experience psychiatric or neurological disease. The Martian is curious as to why most organs (such as lungs, kidneys, hearts and eyes) are treated by a single medical specialty, whereas the brain is divided between neurologists and psychiatrists.

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²

See pp. 105–7, this issue.

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Convention

Perhaps a reasonable place to start would be to define neurological illnesses as those treated by neurologists and psychiatric illnesses as those treated by psychiatrists. You might take the Martian to a neurology ward and declare that all patients here have neurological illnesses. Or explain that the people seen by community psychiatric nurses are those with psychiatric illness. Of course, this is circular reasoning and does not stand up to much scrutiny. The Martian would surely not be satisfied by this explanation; he has no prior knowledge of the history, development or social implications of psychiatry *v.* neurological disease. Therefore, to him, the division is not self-evident.

Neuropathology

You might, therefore, go a little deeper and start to think about what characterises each type of illness. The Martian recognises the notion of pathology and can relate this to other aspects of disease – for example, pulmonary fibrosis causing restrictive lung disease, which we categorise as a respiratory disease. By comparison, you might argue that neuropathological lesions cause neurological disease, whereas psychiatric illness is more to do with abnormal function of the brain. This seems sensible and certainly holds for well-characterised neurological disease such as multiple sclerosis. Demyelination of neuronal axons is the neuropathology, which results in a patient's symptoms. However, it becomes less tenable as the underlying disease processes are less well characterised. Epilepsy was once regarded as a psychiatric disease. As its neuropathology was better understood, we now regard it as a neurological illness.¹ Similarly, we now know of pathological processes in diseases such as schizophrenia. These processes, while not localised lesions, are evident when comparing brain imaging of people with schizophrenia to healthy controls and are present before the illness manifests clinically.²

The final nail in the coffin of classifying brain diseases by their pathology is the case of conversion disorder, or neurologically unexplained symptoms. By definition, this disorder cannot be explained by underlying neuropathology.³ It is, presumably, a result of psychological and social factors and is more a 'functional' disorder of the central nervous system. And yet it is not treated by psychiatrists but by neurologists. Attempting to categorise brain disease by pathology is clearly troublesome so perhaps we should focus on dividing illnesses based on their symptoms.

Symptomatology

You could try explaining to the Martian that there are 'neurological symptoms', weakness, tingling and seizures, for example. By contrast, 'psychiatric symptoms' would generally be regarded as dysfunction of higher functions of the nervous system, disturbance in mood, delusions, hallucinations and so forth. Of course, there is some overlap but neurological symptoms would generally signify neurological disease which would interest a neurologist more than a psychiatrist. This holds true for conversion disorder which, although not involving lesions of the nervous system, certainly presents with symptoms more familiar to neurologists.

Unfortunately, it would take little time for our Martian friend to pick holes in this argument. He could point to anti-*N*-methyl-*D*-aspartate receptor encephalitis, which can be clinically indistinguishable from the first episode of schizophrenia, though it has a well-defined 'neurological' pathophysiology.⁴ This disease was only recently discovered, making it difficult to estimate how many patients presenting with psychiatric symptoms actually have neurological diseases. Similarly, psychiatric symptoms are common in traditionally neurological disorders: hallucinations in Parkinson's disease⁵ and depression in multiple sclerosis⁶ are just two examples.

The biopsychosocial approach

It could be argued that psychiatrists are specifically trained to have a biopsychosocial approach to disease, paying more attention to psychological and social aspects.⁷ This is important, as these factors influence the presentation and course of psychiatric illness. However, as previously stated, psychological and social factors also underpin traditionally neurological conditions such as unexplained neurological symptoms and non-epileptic attacks. Indeed, there is a spectrum of psychosocial components to all diseases. Having a biopsychosocial approach to illness is required not just for psychiatrists and neurologists but for all doctors. In an ideal world, our approach to all illness would include consideration of psychological and social factors, and would be indistinguishable between neurologists and psychiatrists.

Conclusion

There is no defining line between neurology and psychiatry. Furthermore, I contest that it is impossible to justify the separation of neurological and psychiatric illness on a rational basis. To a Martian, or anyone looking at the situation with a fresh pair of eyes, it is impossible to explain how we put brain disorders into either neurological or psychiatric boxes. This is because current classification is based on convention, tradition and quirks of history.

To our Martian, it would probably seem rational to have a degree of overlap in training between neurologists and psychiatrists. It would seem desirable that neurologists be competent in the management of psychiatric disorders, and *vice versa*. Unfortunately, this is not the case. In the UK, it is perfectly normal to train in one of these specialties with no exposure to the other, unlike in other European countries.⁸ Nature does not respect our arbitrary categorisations and neither do our patients. It would surely benefit both specialties to integrate training pathways, as has been suggested by others.⁹

1.8.25 *Bulletin* comment: What is wrong with the likes of Rolf Harris?

date

2015-6

Contents

- *Bulletin comment: What is wrong with the likes of Rolf Harris?*

The revelations about the perverse activities of high-profile celebrities such as Rolf Harris, Jimmy Savile and Max Clifford continue to cause shock, bewilderment and voyeuristic intrigue. It seems the scourge of abuse is so prevalent that it extends into all institutions previously held in high regard; from the county councils, to the Catholic Church, and further to the Houses of Parliament.

For mental health professionals (as well as any other keen observer of human behaviours), such disturbing disclosures often lead to discussions about why any individual might act this way: considerations of personality disorders may be had. The extreme arrogance, the lack of regret and absence of profound feelings of guilt, in the context of lifelong careers in the media or entertainment industries or positions of importance in society, point towards cluster B difficulties, with elements of both antisocial and histrionic disorders.

News reports inevitably pay most attention to the wrongdoer and the calls for enquiries into the institutions, organisations or official bodies that have essentially been supportive or at least responsible for passively allowing the abuse to continue.

Ultimately, the revelations lead to thoughts about the trail of destruction left in the wake of such behaviours. Extensive research has repeatedly linked child sexual abuse with mental health difficulties of later life. Severe depression, anxiety problems, post-traumatic stress disorder and long-term inability to adjust to adult life: some studies have found life prevalence rates of up to 80% in victims of sexual abuse.

Although the media focus is on the activities of celebrities or society leaders, they are clearly responsible for only a tiny fraction of all childhood and adult sexual abuse cases. This high prevalence in the community setting places the problem fairly and squarely in the realm of public health. And as such, it should be the focus of effective education programmes and community-based treatments for sex offenders. The instruction of children and adolescents on human sexuality and the importance of interpersonal skills needed to build satisfying and healthy intimate relationships needs to be emphasised and funded.

Incarcerating the likes of Rolf Harris might satisfy the public's desire for justice or their need for prurient stimulation, but in reality it does little for primary prevention of a continuing societal scourge.

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1.8.26 Relationship between timeliness of contact and length of stay in older and younger patients of a consultation-liaison psychiatry service

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Abstract

Aim and methods The aims were to determine whether the timeliness of contact with a consultation-liaison psychiatry (CLP) service is associated with shorter lengths of stay (LOS), whether this relationship persists for stays greater than 4 days and whether this association varies with age. The length of stay was correlated with the time from admission to contact with the service (the referral lag (REFLAG)), and the REFLAG's proportion of length of stay (REFLAG/LOS) for all 140 in-patients, those with stays greater than 4 days, and for those under and over 65 years.

Results The length of stay was significantly correlated with referral lag and logREFLAG/logLOS for all patients and for patients with stays greater than 4 days. The correlations remained significant for both age groups, but were stronger in the younger group.

Clinical implications Timeliness of contact with CLP was associated with shorter length of stay, particularly in younger patients. Psychiatric factors influencing length of stay in older patients should be studied by CLP services.

Contents

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- *Relationship between timeliness of contact and length of stay in older and younger patients of a consultation-liaison psychiatry service*
 - *Method*
 - * *Participants*
 - * *Data collection*
 - * *Statistical analysis*
 - *Results*
 - *Discussion*
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 - * *Limitations*
 - *Implications*

Consultation-liaison psychiatry (CLP) has not consistently demonstrated evidence of cost-effectiveness, which is partly related to the difficulty of conducting studies with robust methodology that reflect the real-life operation of CLP services.¹ Some recent studies have demonstrated the effectiveness of intensive psychiatric consultation services with the specific brief of reducing length of stay (LOS).^{2,3} In contrast, studies of services with a traditional model of accepting referrals from a treating team, have found that earlier contact with CLP is associated with reduced lengths of stay.⁴⁻¹¹ Most of these studies have compared length of stay with the proportion of the referral lag (i.e. REFLAG: the time from admission to patient contact with the CLP service) of the length of stay (i.e. REFLAG/LOS).^{4-7,10} This avoids directly comparing lengths of stay with the referral lag, as these are related variables. In support of this, REFLAG/LOS has been found to be independent of length of stay, if the stay is longer than 4 days.¹⁰ The primary aim of this study was to examine if the timing of contact is associated with length of stay for all patients referred to a CLP service, particularly when those with a stay less than 4 days were excluded. Furthermore, CLP services see many frail and complex older patients who utilise proportionally greater resources.¹² Older in-patients with, or who develop, mental conditions while in hospital have been found to have longer lengths of stay.¹³ A secondary aim of this study was to compare the relationship of timeliness of referral and length of stay for patients under and over 65 years old.

Method

Participants

The study was conducted at a 215-bed acute metropolitan general hospital in Sydney, Australia. The CLP service at this hospital consisted of a part-time staff specialist psychiatrist (0.6 full-time equivalent) and a full-time psychiatry trainee. The hospital also employs mental health liaison nurses (0.9 full-time equivalent) who directly manage some ward referrals instead of the CLP service. The CLP service was referred 1.03% of all hospital in-patients during 2012, which is in keeping with previous studies.¹⁴ All consecutive in-patients referred to the CLP service, excluding those referred from the obstetrics and gynaecology department, from 1 January to 31 December, 2012, were included in the study. This exclusion was made because of a difference in referral pathway, as these patients had usually been seen on an ongoing basis during their out-patient antenatal care.

Data collection

Data were collected for patients referred to the CLP service from the routinely used service referral forms and the medical record. Data collected included demographic information, admission date, date of first contact with CLP and number of contacts, length of stay, referring team, referral reason, medical diagnosis, psychiatric diagnosis, Karnofsky score on contact with the CLP service and at discharge. The Karnofsky score was recorded by the CLP team at initial contact and on discharge. This score was devised to quantify ability to carry out normal activities and self-care, and is rated from 0 (dead) to 100 (normal, no complaints, no evidence of disease) and has been established as a valid and reliable score of global functioning.¹⁵

Length of stay was calculated as the whole number of days from admission to the day of discharge from the hospital and if these were the same day this was counted as a length of stay of 1 day. The psychiatric diagnosis was made using the DSM-IV-TR criteria,¹⁶ and multiple psychiatric diagnoses were recorded with identification of the primary diagnosis relevant to the episode of care. This study was approved by the Human Ethics Committee for Sydney Local Health District (RPAH zone).

Statistical analysis

Distributions were described as mean, standard deviation and range. The referral lag was calculated as the whole number of days between admission and first contact by the CLP service and this parameter was used to calculate the proportion of referral lag over length of stay (REFLAG/LOS). Thus, a REFLAG/LOS of 0.5 indicated that a patient was referred halfway through their admission and a REFLAG/LOS of 0.25, at the first quartile of the admission. Logarithmic transformations ($\log\text{REFLAG}/\log\text{LOS}$) were required because the data were positively skewed and logging the values made the data more normally distributed, consistent with previous studies.⁴⁻⁷ These variables were compared with the lengths of stay for all in-patient referrals, and then specifically in groups according to age ('younger' – defined as under 65 and 'older' – 65 years or more). Group differences were determined using one-way ANOVAs and Spearman's correlations were used to assess associations between variables if any of the variables were not normally distributed. All data analyses were performed using SPSS version 17 for Windows. All *P*-values were two-tailed and significant differences between groups were determined using $P < 0.05$.

Results

There were 174 in-patient referrals to the CLP service in 2012. Of these, 34 were in-patients of the obstetrics service who were excluded from the analysis. The demographic profile, referring team, Karnofsky score and number of contacts by the CLP service of the remaining 140 patients are presented in *Table 1*. Patients 65 years and older were more likely to be born overseas, require an interpreter and have more contacts (reviews during admission) than younger patients. In total, seven (5%) in-patients died; four of these were less than 65 years old.

The most common referral reasons for all referrals were depression (45, 32%) and self-poisoning (18, 13%), followed by confusion (16, 11%) and medication review/past psychiatric history (14, 10%). For the two most common referral reasons, there was the greatest discrepancy in the age groups. There was a greater proportion of patients 65 years and older referred for depression (37, 41%) compared with those under 65 years of age (8, 16%); and a greater proportion of those with self-poisoning in the younger group (13, 26%) than the older group (5, 6%).

The most common medical diagnostic categories for all referrals were respiratory (21, 15%), oncological (18, 13%), related to self-poisoning (16, 11%) and neurological (15, 11%) conditions. Between the age groups the largest differences in percentage terms were for self-poisoning (12, 24% for the younger group and 4, 4% for the older group) and urosepsis (0, 0% v. 13, 14%).

The psychiatric diagnoses for both age groups are also presented in *Table 1*. There was a significant association between psychiatric diagnoses and age groups ($\chi^2 = 14.804$ (d.f. = 4), $P < 0.005$). When the four diagnostic groups were assessed individually, it was noted that patients 65 years and over were more likely to have a diagnosis of a mood disorder than younger patients ($\chi^2 = 5.20$ (d.f. = 1), $P = 0.23$), whereas younger patients were more likely to have other diagnoses (*n*

= 14, 28%), such as anxiety or adjustment disorders ($\chi^2 = 7.59$ (d.f. = 1) $P = 0.006$) compared with older patients ($n = 9$, 10%).

The average length of stay for all patients was 19.6 days, whereas the average hospital in-patient stay over the same time period was 3.5 days. The length of stay, referral lag and related parameters are detailed in *Table 2*. The lengths of stay for older patients was significantly longer than those patients who were under 65 years old ($F(1,138) = 6.17$, $P = 0.014$). There was also a significant age group difference for referral lag ($F(1,138) = 4.80$, $P = 0.030$) and logREFLAG/logLOS ($F(1,124) = 4.41$, $P = 0.038$).

When contact with the CLP service occurred during a 1-day admission (LOS = 1) or on day 1 of a longer admission (REFLAG = 0), this introduced a mathematical error in calculating the REFLAG/LOS and the logarithmic transformation of REFLAG/LOS. As the logarithm of zero is undefined and the logarithm of one is zero, these cases resulted in an undefined value for logREFLAG/logLOS. Therefore, these patients ($n = 14$) were not included in some analyses. There were no significant differences between the older and younger groups of patients in terms of the number of these cases.

The correlations between length of stay and the parameters related to referral lag are shown in *Table 3*. There were significant correlations between length of stay and all the referral lag parameters for all patients, which included the correlation between length of stay and referral lag when the values were logarithmically transformed (logREFLAG/logLOS, $r = 0.38$, $P = 0.001$). These relationships were more strongly correlated in patients under 65 years old. A total of 38 patients had a lengths of stay of 1-4 days. The positive correlation of the timeliness of referral and length of stay was only maintained for the REFLAG/LOS with logarithmic transformation ($r = 0.242$, $P = 0.02$) and the referral lag itself ($r = 0.547$, $P = 0.001$) when the 38 patients with a shorter length of stay were removed (*Table 4*).

Demographic variables by age group

	Age 64 or younger ($n = 50$)	Age 65 or older ($n = 90$)	Total ($n = 140$)	P
Age, mean (s.d.)	43.6 (15.8)	79.2 (7.8)		
Women, n (%)	27 (54)	57 (63)	84 (60)	NS
Born overseas	21 (42)	62 (69)	83 (59)	0.0
Interpreter used	4 (8)	37 (41)	41 (29)	0.0
Department referred from, n (%)				
General medical	23 (46)	36 (40)	59 (42)	
Aged care and re habilitation	1	32 (36)	33 (24)	
Intensive care unit	16 (32)	4 (4)	20 (14)	
Palliative care	4 (8)	9 (10)	13 (9)	
Emergency department	4 (8)	4 (4)	8 (6)	
Surgery	1 (2)	5 (6)	6 (4)	
Paediatrics	1 (2)	0	1 (0.7)	
Karnofsky score on admission, mean (s.d.)	24.8 (5.0)	25.1 (5.4)	25.0 (5.3)	NS
Karnofsky score on discharge, mean (s.d.)	61.4 (28)	54.1 (23)	57 (25)	NS
Contacts, mean (s.d.) range	4.4 (3.6) 1-18	7.6 (6.3) 1-41	6.4 (5.7)	0.0
Contacts per day after first contact, mean (s.d.)	1.24 (0.89)	0.95 (0.93)	1.05 (0.92)	NS
Psychiatric diagnosis, n (%)				
Organic brain disorder	12 (24)	35 (39)	47 (33.6)	NS

continues on next page

Table 23 – continued from previous page

	Age 64 or younger (<i>n</i> = 50)	Age 65 or older (<i>n</i> = 90)	Total (<i>n</i> = 140)	<i>P</i>
Mood disorder	6 (12)	26 (29)	32 (22.9)	0.0
No psychiatric diagnosis	10 (20)	12 (13)	22 (16)	NS
Psychotic disorder	8 (16)	8 (9)	16 (11)	NS
Other diagnoses` b <#TFN3>` __	14 (28)	9 (10)	23 (16)	0.0
Multiple psychiatric diagnoses, <i>n</i> (%)	9 (18)	22 (24)	31 (22)	NS

NS, not significant.

Chi-square, $\chi^2 = 14.804$ (d.f. = 4), $P < 0.005$.

Other diagnoses included: anxiety disorders, adjustment disorder, borderline personality disorder, somatoform disorders, substance misuse disorders, eating disorders and bereavement.

Discussion

It is acknowledged that the average length of stay of patients with psychological comorbidity is much longer than the overall average length of stay.¹⁷ This is consistent with the results of this study where CLP-referred patients had a greater mean length of stay compared with the length for all patients at the studied hospital. It is therefore important to investigate factors that may relate to this disparity in stay length, which could then become targets of interventions to reduce healthcare costs. In this study, there is a significant association between early contact with CLP services and shortened stays for all patients referred to the CLP service. The association was strongest for patients under 65 years of age. The relationship was maintained for those patients with stays greater than 4 days.

The results regarding timeliness of contact with CLP services are in keeping with most previous studies.⁴⁻¹¹ Only one study, which focused on patients with organic brain disorder referred to a CLP service, did not find that earlier referral predicted a shorter length of stay.¹⁸ Only two previous studies have separated out those patients with stays greater than 4 days.^{3,10} It could be argued that in a hospital stay less than 4 days, the impact of a CLP service is likely to be minimal given the frequently delayed response to psychiatric interventions, both pharmacological and psychological, and the multiple other factors that are involved in a patient's readiness for discharge. Furthermore, it is particularly important for CLP services to demonstrate reduction in lengths of admissions in more complex long-term patients; where there is greater potential cost saving through shorter hospital stays.

None of the studies that have previously examined the impact on the length of stay of the proportion of the referral lag of the length of stay have specified the number of cases that have not been calculated because of the mathematical errors in those cases with a stay of 1 day, or who are referred on the same day of admission.⁴⁻⁷ This is not as important for those cases with a 1-day stay as there is no possibility that a CLP service could reduce this further. However, the necessity to not include those cases that are referred as early as possible does potentially reduce any positive effect demonstrated by CLP services using this measure. Thus, the number of cases that result in mathematical error should be reported in future studies.

Differences between the two groups

There was a significant but comparatively weaker correlation between length of stay and timing of referral in older patients compared with the younger group, which was a disappointing finding as this is a large and important target group for CLP services. This result is in contrast to the study of the rapid assessment, interface and discharge integrated model (RAID), which found that most of the service's cost savings were achieved through reduced lengths of stay and fewer readmissions in the geriatric wards.² The authors suggested these outcomes were related to educating general hospital staff about mental health problems and efforts to link patients to appropriate pathways for community care.² The difference in strength of correlation of the association found in the study presented here may be because of the inherent differences Table 2 Comparison of length of stay (LOS) and referral lag (REFLAG) related parameters by age group Mean (s.d.) rangenAge 64 or younger

(*n* = 50) Age 65 or older

(*n* = 90) Total

(*n* = 140) *P* Length of stay, days 10.4 (10.2) 1–4224.6 (39.5) 1–33719.6 (32.9) 0.014 Referral lag 1403.9 (5.0) 8.5

(14.5) 6.9 (12.2) 0.03 REFLAG/LOS 133a 0.498 (0.288) 0.408 (0.274) 0.441 (0.281) NS log REFLAG/log

LOS 126b 0.4050.5330.4900.038^{2,3,4} Table 3 Spearman's correlations between referral lag related parameters and length of stay (LOS) by age group

Length of stay,

Spearman's rho Patients, 64 years and under Patients 65, years and over All patients Variable *r* *P* *n* *r* *P* *n* Referral lag (RE-FLAG) 0.6940.001500.6440.001900.6970.001140 REFLAG/LOS –0.5300.00148–0.2770.01085–0.3780.001133a Log(REFLAG)/log(LO

between the two age groups, including the need for an interpreter. The study hospital serves an ethnically diverse population with 48.1% of the hospital's catchment population born overseas, which explains the high level of utilisation of interpreters by this CLP service.¹⁹

The higher number of contacts with the CLP service received by the older group is likely reflective of the longer length of admission. This correlation has been found previously.¹⁰ It is unsurprising that patients who are in hospital longer will see CLP services on a greater number of occasions. In support of this, there was no significant difference between the two age groups in the average number of contacts/day after initial contact with CLP services, despite the greater need for interpreters in the older age group.

Surprisingly, the Karnofsky scores were not significantly different between the older and younger groups of patients, which would suggest that disparity in functional status does not account for the difference in the correlation results. This may reflect the limitations of this scale as it is most applicable to non-hospital-based supportive care settings, such as palliative care, rather than acute in-patient treatment.²⁰

Previous studies have found factors that predict later referral to CLP services, such as higher social vulnerability,¹² referral for depression and psychiatric diagnoses of adjustment disorder and delirium and no psychiatric diagnosis.⁵ Therefore, the profile of psychiatric diagnosis between the younger and older patients may also have contributed to the difference in impact of CLP on length of stay between the two groups. The older patients were more likely to be diagnosed with a mood disorder but, Table 4 Spearman's correlations between referral lag (REFLAG) related parameters and length of stay (LOS) when patients with a length of stay <4 days (*n* = 38) were excluded

Variable *n* Length of stay, *r* *P* Age 1020.090 NS Referral lag (REFLAG) 1020.5470.001 REFLAG/LOS 97a –0.087 NS Log(REFLAG)/log(LOS) 97a 0.2420.02^{7,8} unexpectedly, there was no difference for the diagnoses related to organic brain disorders between the two age groups. There are two possible explanations for the relatively low frequency of referred patients diagnosed with cognitive disorders. First, the study hospital has been found to have low rates of recognition of cognitive disorders by referring teams.²¹ Second, a concurrent delirium-prevention study took place at this hospital that improved staff knowledge and confidence and reduced the occurrence of delirium, which may have reduced the overall number of individuals with cognitive disorders referred.²²

² NS, not significant.

³ Data for seven patients could not be calculated because of consultation on day of admission (REFLAG = 0).

⁴ Data for 14 patients could not be calculated because of a REFLAG = 0 (*n* = 7) or LOS = 1 (*n* = 7).

⁵ Data for seven patients could not be calculated because of consultation on day of admission (REFLAG = 0).

⁶ Data for 14 patients could not be calculated because of a REFLAG = 0 (*n* = 7) or LOS = 1 (*n* = 7).

⁷ NS, not significant.

⁸

Data for five patients could not be calculated because of consultation on day of admission (REFLAG = 0).

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There was a greater proportion of patients referred for, and diagnosed with, self-poisoning in the younger group of patients compared with the older group, which may have influenced the difference seen in the two age groups. Psychiatric input is almost universal in patients who are admitted with self-harm as the reason for the consultation is immediately obvious and this may be reflected in earlier referral of these patients by the treating team⁵ and arguably therefore, greater influence of the CLP team on management and discharge planning.

There were other significant differences in the older group of patients in this sample in terms of length of stay and referral lag. The fact that there was a longer length of stay in older patients referred to CLP is not surprising and is in keeping with previous reports.¹³ Three in-patients, all older than 65 years of age, had stays greater than 100 days. These outliers were included in the final statistical analysis but did not significantly influence results when removed. The longer admissions may have been because of factors such as waiting for residential care placement or rehabilitation, and greater medical comorbidity, which are less common in younger patients. Arguably, there is limited scope for CLP to influence lengths of stay when these factors are active.

The longer referral lag for the older patients is somewhat surprising for this service, which has a liaison attachment with the aged care and rehabilitation department. This department referred only 24% of all older (65) CLP patients; a greater proportion of older patients were referred instead by general medical teams (40%), which carry a larger total patient load. However, the longer referral lag in the older patients may also reflect other differences between the younger and older patient groups that influence timing of the referral from the teams. For example, proportionally more older patients were born overseas and required an interpreter. It is possible that delays in accessing interpreters precluded early referral to CLP.

Limitations

This study was conducted in a district hospital with a representative sample of CLP patients. It did not involve alterations to the established CLP service or its referral patterns and was conducted retrospectively, which eliminated the possibility of the Hawthorne effect. Therefore, although based on small numbers, the results are generalisable to most CLP services, which are not designed as specialised acute intervention teams focused upon reducing lengths of stay.

The data collected included many of the parameters that may have contributed to the differences in effect of CLP contact on length of stay of the two groups. However, the re-admission rates of the two groups were not known and this has been suggested as an important potential consequence of reducing length of stay, although this is contested by some studies.²³ No other study that has examined the timeliness of CLP contact has included this parameter,^{4-7,10} but it has been included in other cost-effectiveness studies with different methodology.² This would be an important point for inclusion in future studies of timeliness of CLP contact and lengths of stay.

The limits of interpretation previously discussed regarding the association of timeliness of referral with lengths of stay also apply to this study. The demonstrated relationship between the time to referral and stay length cannot be assumed to be causal and it remains possible that the association is a result of unmeasured factors. These factors may include those associated with the request for consultation or also that the direction of the inference may be reversed.²⁴ Thus, it is not possible to state that this CLP service directly shortens lengths of stay if there is greater proportional involvement in a patient's admission, except to state that a positive association between these two variables has been demonstrated.

Implications

Timeliness of referral was associated with shorter lengths of stay, including for those with stays of more than 4 days. This correlation was weaker for older than for younger patients. There are multiple and complex factors that likely lead to this result, particularly the greater likelihood of the older patients requiring an interpreter and being born overseas, as well as a greater delay in contact with CLP services and a longer length of stay when compared with younger patients. Given the ageing population, further exploration of these factors should be a priority for CLP services, as this is a group where CLP could have a considerable impact and cost-benefit. It is important to evaluate whether better outcomes achieved through hospital-wide education about mental health problems and emphasising clear pathways for community care can be replicated.²

1.8.27 Black Rainbow: How Words Healed Me – My Journey Through Depression

Rebecca J. Lawrence¹

date

2015-6

Contents

- *Black Rainbow: How Words Healed Me – My Journey Through Depression*

Black Rainbow is Rachel Kelly's story of depression and recovery. It is an eloquent description of her experience of two severe depressive episodes, both with marked anxiety symptoms, and with a strong emphasis on the 'striking physicality of the illness'.

During her first episode, she focuses on the biological nature of her illness, becoming frighteningly dependent on her husband and mother and an attentive psychiatrist, and obsessively preoccupied with her medication. Although this persists in the second episode, she develops a wider interest in factors that may have contributed to her illness, and seeks lifestyle changes and therapy to reduce her vulnerability. She recognises in particular her traits of sensitivity and perfectionism, and the difficulties inherent in combining motherhood with a high-achieving career.

Kelly gains much solace from words, including poetry and prayer, during her prolonged recoveries. Her familiarity with poetry from childhood may underlie this and her accounts of her life when depressed describe a return to a childlike state, where she is cared for by her devoted husband and mother. Her own role as a mother is temporarily lost, something she reflects on later with a sense of shame and failure.

Although she does not spare herself, it must be acknowledged that her experiences are different from most, given her level of privilege. A full-time nanny cares for her children, her psychiatrist visits her at home every couple of days, and she gives up work without obvious financial pressure, assuming a prolonged sick role. Interestingly, she herself questions the value of this and explores the difficulty of needing to be seen as either fully ill or well, and the possibility, often denied, of secondary gain. But her recovery is allowed to be unusually gentle, with a gradual and vividly recounted reawakening of senses dulled by depression, something not always possible for those less fortunate.

More personally, having also experienced depression, I found this a beautiful book. I remain unconvinced that poetry can cure depression (Kelly does not claim this), but it can provide much needed comfort and sets it within the human experience. In W.H. Auden's words from *Musée des Beaux Arts*, 'About suffering they were never wrong, The Old Masters'.

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1.8.28 Do psychiatry and neurology need a close partnership or a merger?†

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2015-6

Abstract

Advances in neuroscience in recent years have blurred the boundaries between psychiatry and neurology. They now have more in common than what divides them and this signals a return to their origins. Many have called for a merger of the two disciplines, which would offer a more holistic approach, whereas others vigorously reject such a move. Limiting neurology to the study of the nervous system and psychiatry to the social brain or affect and its disorders is no longer sustainable. The ongoing separation of the disciplines has had an impact on diagnosis and treatment, on professional isolation and on funding psychiatric research.

Contents

- *Do psychiatry and neurology need a close partnership or a merger?†*
 - *History of the relationship between neurology and psychiatry*
 - *Why are psychiatry and neurology separate?*
 - *Why bring neurology and psychiatry together?*
 - *Professional isolation from medicine*

The relationship between psychiatry and neurology remains a controversial topic, with strong voices opposing a merger, whereas others point out that the future lies with the neurologist/psychiatrist or neuropsychiatrist. ¹ Either way, it highlights the growing disparity in how the disciplines are currently defined and the many areas of overlap.

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See pp. 134–5, this issue.

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History of the relationship between neurology and psychiatry

The term ‘neurology’ originated with English physician Thomas Willis following his study of brain anatomy in the 1660s, according to Millon.² Subsequently in 1808, Johann Christian Reil, a German physician and philosopher, gave us the term ‘psychiatrie’. However, the two disciplines had common origins. Krishnamoorthy³ points out that the ancients, including Hippocrates, believed that all psychopathology arose in the brain and that this is clearly reflected in writings well into the nineteenth century. On the other hand, this was not a universally held view and some of the ancients believed that hysteria was because of a wandering womb. Even so, the 1845 seminal work on mental illness by Wilhelm Griesinger in *Mental Pathology and Therapeutics* still has a modern ‘ring’ to it in the 21st century. He was a major clinical and academic researcher in a number of hospitals in Europe at the time. The one-time unity of the disciplines was also reflected in the title of the journal Griesinger founded in 1867, *Archives of Psychiatry and Neurology*. For Griesinger, mental diseases were essentially brain diseases, according to Millon.

Over the years there has been considerable opposition to Griesinger. In an interview with Poole,⁴ William Alywn Lishman was severely critical of Griesinger because he ‘tried to make the whole of psychiatry brain science’. I would concur with Lishman that Griesinger went too far and especially ignored environmental influences. I believe the biopsychosocial model of psychiatry can only operate via the brain and Johansson⁵ is correct in his assertion that all mental life will eventually be mapped onto ‘a neuronal substrate’. The split between medicine and psychiatry was lamented by Silas Weir Mitchell as early as 1894. He expressed the view that when the ‘treatment of the insane’ passed completely out of the hands of the profession at large and ‘into those group of physicians (psychiatrists) who constitute a sect apart... what evil this has wrought, what harm it has done to us’, as noted by Andreason.⁶ This split became even more pronounced in the USA between 1935 and 1975, when psychoanalysis largely took over psychiatry there, further increasing the gap between neurology and medicine generally. Ironically, psychoanalysts are now trying to reconnect with neurology through neuropsychology, according to Solms.⁷

The advent of diagnostic imaging has brought a certain degree of clarity to the field. Kandel points out that had imaging been available in 1895 when Freud wrote *Project for a Scientific Psychology* he might have directed psychoanalysis along very different lines, keeping it ‘in close relationship with biology as outlined in that essay’.⁸ It is worth noting that Freud was a superb neuropathologist and neurological scientist, as evidenced in the very ambitious but highly relevant *Project for a Scientific Psychology*.⁹ However, the work also signalled his subsequent move away from traditional science.

Why are psychiatry and neurology separate?

Many views have been expressed on why psychiatry and neurology are separate. In response to White *et al*’s¹⁰ assertion that it is time to end the distinction between mental and neurological illnesses, Ikkos points out that neurology’s expertise is the nervous system and its disorders, whereas psychiatry’s expertise is affect and its disorders.¹¹ Furthermore, he argues that, conceptually, neurology is necessarily at a different level of abstraction from the nervous system. This argument, however, is not the least bit persuasive to me. Miller notes that ‘psychiatry was neurology without physical signs’,¹² whereas Holmes points out that ‘only psychiatry can encompass the social brain’.¹³ There is absolutely no reason why neurologists cannot embrace the social brain and indeed many do today. I believe the split between neurology and psychiatry is in fact artificial.

The chorus of disapproval against neuropsychiatry has certainly grown. Pies argues that psychiatry and neurology cannot simply merge because they use ‘significantly different narratives or... discourses’.¹⁴ He also claims that psychiatry is grounded in human subjectivity and existential concerns and is a ‘discourse of interlacing and multi-layered meanings’ and a ‘narrative about narratives’. Neurology, on the other hand, he believes is fundamentally ‘a discourse of neuroanatomical and neurophysiological relationships’. When a neurologist examines a patient with symptoms not corresponding to known neurological pathways, which Pies sees as ‘functional, supratentorial or psychogenic’, then the patient should be deferred or referred to the psychiatrist. Essentially, Pies’ description of psychiatry has echoes of psychoanalysis. For example, he asserts that psychiatry’s discourses should be understood as a dialectic between a text and a presumed subtext – ‘not unlike the dialectic between *p’shat* and *d’rash* in Talmudic exegesis. That is, beneath the literal words or surface meaning of a biblical text (*p’shat*), there lies a realm of figurative, allegorical, and mystical meanings that must be explicated (*d’rash*)’.¹⁴ Indeed, his description of psychiatry relates to that of the mid-nineteenth century, in my view.

An editorial by Baker *et al* in the *BMJ* in 2012 stated that it is time to tear down the wall between neurology and psychiatry advances in neuroscience.¹⁵ In response to this editorial, Bailey *et al* presented the orthodox psychiatric reaction. They point out that most mental disorders, given our current state of knowledge, have no unequivocal biomarkers and classification has to rely, however imperfectly, on clinical signs and symptoms.¹⁶ They were against a merger of neurology and psychiatry, but in favour of a close working relationship.

The advances in neuroscience prompted Stone & Sharpe to pose a key question: will greater understanding of neuroscience mean that psychiatry will simply follow neurology in abandoning the patients that fail to fit into a reductionistic paradigm?¹⁷ However, I believe that if there were a merger, patients would be less likely to fall through the ‘cracks’. Excessive specialisation is the greatest reason for bringing neurology and psychiatry together. Indeed, even at a research level progress is more likely to occur at the interfaces between specialties and subspecialties. One reason for the lack of progress in psychiatric research in recent years has been because of the excessive specialisation and subspecialisation.

Why bring neurology and psychiatry together?

One of the most compelling arguments for bringing the two disciplines together is that their boundaries are becoming increasingly blurred. Ramachandran observed this fact and declared it was only a matter of time before psychiatry becomes just another branch of neurology.¹⁸ I would dispute that aspect of the argument; there is no question of one discipline ‘swallowing’ up the other. Instead it would be a merger of two equal partners: neurology and psychiatry. If it were to occur, both disciplines would enrich each other enormously.

The separation of the two disciplines has had a somewhat negative impact on diagnosis and treatment. Kanner points out that, in neurology, the separation from psychiatry has led to comorbid disorders being underrecognised and undertreated.¹⁹ In effect, the separation of neurology from psychiatry has led to a separation of the brain from the mind – the physical from the mental – which has been unhelpful for both disciplines. If a merger did occur, the neuropsychiatrist could provide a more holistic approach to the diagnosis and treatment of a patient. In fact, all neurologists and psychiatrists practise basic counselling and brief therapy to varying degrees. It is noteworthy that there are similar brain changes after the treatment of obsessive-compulsive disorder with either medication or behaviour therapy. This increases the link somewhat between neurology and psychiatry.

Aarli points out that psychiatry and neurology have a common route and both share a common basis in neuroscience.²⁰ He also notes that there is much more that unites neurology and psychiatry than divides them. Neurobiological conditions like epilepsy, autism, dementia, delirium, Tourette syndrome, intellectual disability, dyspraxia, speech and language problems are all overlapping. Between neurology and psychiatry Henningsen favours overcoming ‘dualistic’ and often ‘irrational splits’ in the classification and in the practice of medicine.²¹ He agrees with the idea of subsuming mental disorders under ‘disorders of the brain’ because this gives greater clarity and simplicity. Kandel finds it useful to consider that psychiatry and psychoanalysis work at the level of individual nerve cells and their synaptic connections.⁸ Neurology and psychiatry are simply two ‘sides of the same coin’. Certainly in the area of neural plasticity, neurology and psychiatry overlap.

The overlap is also evident in medical journals relevant to the disciplines. In a study of papers published in *Neurology* and the *American Journal of Psychiatry*, Price²² found that less than 5% of papers in the *American Journal of Psychiatry* were on meningitis, epilepsy and headache and that less than 5% of papers in *Neurology* focused on schizophrenia, panic and mania. The proportions for attention-deficit hyperactivity disorder were 23% in *Neurology* and 77% in the *American Journal of Psychiatry*; for autism 30% in *Neurology* and 70% in the *American Journal of Psychiatry*; for ‘mental retardation’ 70% in *Neurology* and 30% in the *American Journal of Psychiatry*. As one can see, there is considerable overlap. Similarly, Raja showed that neurological disease affected 13.05% of acute and 68.9% of chronic psychiatric patients.²³

Professional isolation from medicine

The question of professional isolation has also emerged. The separation of psychiatry from neurology has led Levine to comment that, over the past 30 years, psychiatry has become professionally, geographically and managerially separate from the rest of medicine.²⁴ In many places this isolation has seriously damaged psychiatry and caused major recruitment and funding problems.

In a paper entitled 'Wake-up Call for British Psychiatry', Craddock *et al* were concerned about the evolution of unclear responsibility in psychiatry, which reduces medical student interest because of not being 'proper doctors', and modern psychiatry, diminishing the value of careful diagnosis and reducing psychiatry to a 'nonspecific psychological support'.²⁵ Combining neurology and psychiatry would reduce these problems. It is well-known that medicine and psychiatric illness are closely allied. The merger of neurologists and psychiatrists would improve the care of the patient at the interface and moreover may reduce stigma. Bullmore *et al*²⁶ believe that the merger would reduce stigma, however Jorm & Oh²⁷ did not find that brain *v.* social aetiology affected stigma in their formal study. Read *et al*,²⁸ in their review paper, said that biological psychiatry increases stigma, whereas Bullmore *et al*²⁶ suggested the opposite. This issue remains controversial and opinions as described vary.

There is a great deal of similarity in the training of neurologists and psychiatrists from medical school onwards. At the present time, all psychiatrists are required to spend a minimum of 6 months to a year working in neurology and vice versa. Joint training in neurology and psychiatry would be helpful. These individuals would be dual trained and would require both Royal Colleges to come together to produce this dual-trained neurologist/psychiatrist, as happens in the USA and Germany. Indeed, it may be easier to recruit this neurologist/psychiatrist in the future. In a study of trainers and trainees in psychiatry/neurology, Schon *et al*²⁹ found that psychiatrists were even keener on links between neurology and psychiatry training than neurologists, with psychiatric specialist registrars significantly more in favour.

In conclusion, psychiatrists should return home to neurology and medicine and leave non-medical interventions to non-medical practitioners, for example in relation to specialist or long-term psychotherapy. Neurologists and psychiatrists need to merge into neuropsychiatry or some acceptable title. The merger would admittedly not be easy, but it would be beneficial to both fields in the long term and to patients at a clinical level.

1.8.29 Specialist adult ADHD clinics in East Anglia: service evaluation and audit of NICE guideline compliance†

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Abstract

Aims and method To measure compliance with National Institute for Health and Care Excellence (NICE) recommendations in two adult attention-deficit hyperactivity disorder (ADHD) clinics and to guide further service development. We audited the case notes of 150 patients referred to adult ADHD clinics in East Anglia in 2010-2011 against NICE standards using an adapted version of the ADHD audit support tool.

Results We found good compliance with NICE standards for diagnosis, assessment and pharmacological treatment of adult ADHD. There was a failure in smooth transitional arrangements from child

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² See invited commentary, pp. 140-3, this issue.

and adolescent mental health to adult ADHD services. Comprehensive treatment programmes addressing psychological, behavioural, educational and occupational needs were not well developed. Deficiencies were observed in conducting recommended physical examinations. Substance use was prevalent in almost half of ADHD patients.

Clinical implications Greater attention is needed in delivering better transitional arrangements and comprehensive treatment programmes for adult ADHD. More structured training with emphasis on ADHD-specific psychological interventions, physical examination and treatment of complex cases, especially with comorbid substance misuse, should be offered to clinicians.

Contents

- *Specialist adult ADHD clinics in East Anglia: service evaluation and audit of NICE guideline compliance†*
 - *Method*
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 - * *Diagnosis and treatment*
 - * *Psychological intervention*
 - * *Alcohol and substance misuse*
 - * *Person-centred care*
 - * *Organisational service*
 - *Discussion*

Attention-deficit hyperactivity disorder (ADHD) is the most common neurodevelopmental disorder. Symptoms of ADHD persist into adulthood and 10-20% of children with a diagnosis of ADHD still meet diagnostic criteria in adulthood. ¹ The National Institute for Health and Care Excellence (NICE) guideline makes clear recommendations for assessment and management of ADHD in adulthood. ² An increasing number of mental health trusts in the UK are implementing this guideline and offer services for adults with ADHD. ³

The Adult ADHD Research Clinic in Cambridge (with a satellite clinic in Peterborough) is a joint venture between the Department of Psychiatry at the University of Cambridge and Cambridgeshire and Peterborough NHS Foundation Trust (CPFT); this tertiary referral centre provided a diagnostic and treatment advice service for East Anglia until it was temporarily suspended in August 2011. In January 2013, a new National Health Service (NHS)-funded adult ADHD service was started by CPFT. Adult ADHD clinics of the Hertfordshire Partnership NHS Foundation Trust (HPFT) are part of secondary mental health services for adults in Hertfordshire providing comprehensive assessment, diagnosis and treatment. Patients stabilised with drug therapy are referred back to their respective general practitioner (GP) through a shared care agreement.

Method

The study was conducted to measure compliance of current practice in two adult ADHD centres with recommendations in the NICE guideline and to further inform service development.

We audited the case notes of 150 patients who were referred to our adult ADHD clinics in Cambridgeshire and Hertfordshire in 2010–2011 against NICE standards using an adapted version of the ADHD (adult) audit support tool.⁴ The percentage of patients was calculated for whom selected relevant NICE standards were met. As a part of the audit, data on patterns of substance use in the ADHD population were also collected. The project had formal approval from both participating trusts.

Results

There were a total of 150 ADHD adult patients selected consecutively for this audit from the two trusts (CPFT $n = 100$, HPFT $n = 50$).

Demographics

The study sample (*Table 1*) was predominantly male (77%), young (66% were 18–30 years old) and White (84%). Ethnicity was not recorded in the case notes of 64 adult ADHD patients. Less than a third of the sample ($n = 46$) was in regular employment, with 51 patients in the unemployed category; the rest were in education ($n = 41$). Employment status was unknown for 12 patients. Fifty-seven ADHD patients had a forensic history.

Transitional arrangements

There was failure in transition to adult ADHD services in 34 out of 53 (64%) cases known to child and adolescent mental health services (CAMHS) with an established ADHD diagnosis (*Table 2*). The reason quoted for non-transition in some cases was receiving treatment from abroad (6 cases); one patient did not want to continue the drug treatment and one patient was having difficulty with the drug treatment. The reason for non-transition in the remaining 26 patients was not known.

Diagnosis and treatment

Good compliance was observed in using (and documenting) diagnostic criteria (DSM-IV and/or ICD-10)^{5,6} across both trusts (89% at CPFT and 100% at HPFT) and assessing psychosocial impairment along with patients' needs, physical health history and coexisting conditions.

Drug treatment was the first line of treatment recommended for 80% (80/100) of the patients at CPFT and 94% (47/50) at HPFT. In HPFT, methylphenidate was the first drug tried in 79% (37/47) of cases and there was 100% compliance in initiation and titration of the methylphenidate and monitoring of side-effects. Before starting the drug treatment, a full mental health and social assessment was carried out for all patients. However, a full physical assessment prior to drug treatment was performed only in 11% of cases (5/47); some physical examination was carried out in 72% (34/47). Risk assessment for substance misuse and drug diversion was performed in the majority of cases (HPFT 94%; CPFT 100%). Of the patients taking methylphenidate, 10% (4/47) received routine blood tests. Antipsychotic use was observed in 3% of patients (5/150); none of these patients carried a diagnosis of psychotic disorder; one patient suffered with a comorbid tic disorder and indication of antipsychotic use in four other patients was not documented in case notes.

A medical or family history of serious cardiac disease, a history of sudden death in young family members or abnormal findings on cardiac examination was reported in only 7 patients, but an electrocardiogram (ECG) recording was performed for 14 patients.

A comprehensive treatment programme including drug treatment and addressing patients' psychological, behavioural, educational or occupational needs was recommended by CPFT for 95% of adults with ADHD. However, drug treatment formed a part of comprehensive treatment programme in only 25% (12/47) of adults receiving treatment in HPFT, where a diagnostic and treatment service is established.

Psychological intervention

Group or individual cognitive-behavioural therapy (CBT) to address the person's functional impairment was considered Table 1 Study sample demographics Age group, years 18–30 31–65 Female 21 13 Male 78 38 Ethnicity White British 72 Other White and Black background 9 Other mixed background 1 Asian 2 Other ethnic background 2 Unknown 64 Employment status Regular employment 46 Unemployed 51 Student 41 Unknown category and other 12 for 15% (15/100) of the service users attending CPFT and 10% (5/50) of service users in HPFT. Psychological treatment was considered in the context of persisting functional impairment or patients' choice as an alternative to drug treatment.

Alcohol and substance misuse

Almost half of the sample diagnosed with ADHD used illicit or licit substances (45%; 67/150). Alcohol (19%; 28/150) and nicotine (17%; 26/150) were the most commonly used drugs. Patients also used caffeine (13%; 19/150); cocaine (10%; 15/150); cannabis (7%; 11/150); amphetamine (4%; 6/150); ecstasy (3%; 5/150); hallucinogens (0.6%; 1/150) and heroin (0.6%; 1/150). All adults with ADHD and comorbid substance use received treatment by clinicians with expertise in both ADHD and substance misuse management (HPFT) or were referred to the drug and alcohol team with a recommendation for starting ADHD drug treatment after the substance misuse management (CPFT). Overall, 85% (57/67) of patients using substances were offered drug treatment for ADHD and 15% (10/67) were referred or signposted to the drugs and alcohol team for treatment of alcohol dependence ($n = 9$) and opiate dependence ($n = 1$).

Person-centred care

Written information about the illness and on the treatment and care was given, along with information on the availability of NICE guidance to the majority of patients (148/150).

Organisational service

Organisational support in terms of training programmes covering diagnosis and management was present at both trusts. Local shared care arrangement between primary and secondary care was present at HPFT only. Under the shared care arrangement, a range of responsibilities from drug prescription to physical health monitoring and annual reviews is transferred when the specialist and the GP agree that the patient's condition is reasonably predictable and the treatment regime has been specified. If the GP is not confident about undertaking this role, then they are under no obligation to do so. In such an event, the total Table 2 Audit standards based on the NICE guideline and trust compliance Compliance with standards % Standards HPFT CPFT Smooth transition for young people with ADHD receiving treatment and care from CAMHS 67 **24*** Diagnosis should meet the diagnostic criteria in DSM-IV or ICD-10 100 89 Diagnosis process should include an assessment of the person's needs, coexisting conditions, social, family and educational or occupational circumstances and physical health 100 100 Drug treatment should be the first-line treatment 94 80 Drug treatment should be started only under the guidance of a psychiatrist, nurse prescriber specialising in ADHD, or other clinical prescriber with training in the diagnosis and management of ADHD 100 * Before starting drug treatment for adults with ADHD: 100 100 • A full mental health and social assessment should be performed • ECG if there is medical or family history of serious cardiac disease, a history of sudden

death in young family members or abnormal findings on cardiac examination 100 (overused in 7 cases) * • Risk assessment for substance misuse and drug diversion should be performed 94 100 • All recommended physical examination **11** (34 received some physical examination) * Drug treatment for adults with ADHD should always form part of a comprehensive treatment programme that includes psychological, behavioural and occupational needs **25 95** (standard recommended on assessment*) Antipsychotics should not be used for the treatment of ADHD in adults 90 100 Methylphenidate should be the first drug tried in adults with ADHD 78 * People taking methylphenidate should not have: * • Routine blood tests 90 • ECG 100 During the titration phase, symptoms and side-effects should be recorded at each dose change by the prescriber 100 * Adherence to NICE guidelines on methylphenidate use 100 * Group or individual CBT to address the person's functional impairment should be considered **10 15** Drug treatment for adults with ADHD who also misuse substances should only be prescribed by an appropriately qualified healthcare professional with expertise in managing both ADHD and substance misuse 100 * Specialist ADHD teams should jointly develop training programmes for the diagnosis and management of ADHD for mental health, social care, forensic and primary care providers and other professionals who have contact with people with ADHD 100 100 Are there local shared care arrangements in place between primary and secondary care? 100 *³⁴⁵ clinical responsibility for the patient remains with the specialist in secondary care.

Discussion

Overall, this first audit of adult ADHD services in East Anglia established good compliance with NICE guidance for assessment and treatment. This confirms that the implementation of NICE guideline recommendations for adults with ADHD is feasible and should therefore be rolled out and evaluated on a broader scale.

There was a failure in smooth transitional arrangements from CAMHS to adult ADHD services. Different reasons were quoted for non-transition in some cases, but for most patients the reasons were not known. The 2010 TRACK study, which looked into the transition policies, procedures and outcomes in Greater London,⁷ found that neurodevelopmental disorders such as ADHD did not come under the eligibility criteria for transfer from CAMHS to adult mental health services. These young people are either retained at CAMHS or referred to GPs or voluntary organisations. For patients with a childhood diagnosis of ADHD there should be a clear transitional arrangement that takes into account the fact that adolescents are the most critical group of patients and that lack of treatment during the transitional period typically results in increased morbidity in adulthood.⁸ Clear communication and transitional pathways between specialist adult ADHD services, CAMHS, community paediatricians and GPs are essential to ensure continuity of care for individuals with ADHD from adolescence to adulthood. Currently, HPFT has a policy and CPFT is developing a transitional pathway, with the aim of improving transitional arrangements.

NICE has explicitly expressed the need for full mental health and social assessment and full history and physical exami-

³ ADHD, attention-deficit hyperactivity disorder; CAMHS, child and adolescent mental health services; CBT, cognitive-behavioural therapy; CPFT, Cambridgeshire and Peterborough NHS Foundation Trust; ECG, electrocardiogram; HPFT, Hertfordshire Partnership University NHS Foundation Trust; NICE, National Institute for Health and Care Excellence.

⁴ Standards for recommended therapeutic interventions were not applicable due to the limited service model (assessment and treatment advice only) at the time of the audit.

⁵ Highlighted low compliances (in bold) are discussed in the paper in detail.

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nation prior to the drug treatment.² In our study good compliance was observed in using (and documenting) diagnostic criteria (DSM-IV and/or ICD-10) and assessing psychosocial impairment. A full mental and social assessment prior to starting the ADHD drug was carried out, but deficiencies were observed in conducting (or delegating) recommended physical examination. Interestingly, there was an overuse of ECG investigations. Such discrepancy in practice can be overcome by structured training on adult ADHD with emphasis on physical examination and the use of ECG. This can be complimented by filing a physical examination checklist in the patient file and developing a local protocol for the indication of ECG use in adult ADHD patients with a history (or family history) of cardiovascular problems.

Drug treatment was the first line of treatment in the majority of cases. However, attention is needed in delivering more comprehensive treatment programmes addressing psychological, behavioural, educational and occupational needs. Adult ADHD patients are commonly referred to existing psychological services embedded in local community mental health teams or Improving Access to Psychological Therapies (IAPT) services, which have limited expertise in managing ADHD symptoms and associated impairments. The main issues that affect adults with ADHD include poor skills in prioritising and organising workloads in the workplace and home environment, occupational and educational underachievement, poor interpersonal and social skills and low self-esteem.⁹ Although good evidence of the effects of psychotherapy in adulthood is sparse,¹⁰ new research supports the use of CBT programmes in adults with ADHD.^{11–13} In the UK, the Young–Bramham Programme¹¹ provides an integrated approach for understanding ADHD, adjusting modules to the diagnosis and developing skills to cope with symptoms and associated impairments. The programme offers techniques based on psychoeducation, motivational interviewing, cognitive remediation and CBT.¹¹

Use of antipsychotics was seen in 3% (5/150) of patients referred for ADHD assessment, despite the fact that NICE has ruled out the use of antipsychotic drugs in treatment of core symptoms of ADHD.² The finding highlights the need for more effort in educating clinicians about safety and effectiveness of antipsychotics in ADHD. More comprehensive treatment programmes that address psychological, behavioural, educational and occupational needs should be established and encouraged through the development of local ADHD support groups and in partnership with the voluntary sector. These include anger management, occupational therapy, ADHD life coaching, inter-agency liaison and working with voluntary sector providing employment support and counselling services.

Several longitudinal studies of children and adolescents with ADHD have demonstrated an increased risk of developing substance use disorder compared with matched controls.^{14,15} Factors such as novelty-seeking personality traits, increased impulsivity, self-medication for ADHD symptoms¹⁶ and comorbid disorders such as conduct disorder^{14,17} and bipolar disorder¹⁸ increase the risk of developing substance use disorder in this population. Adults with ADHD are more likely to be past or current users of substances and use these substances in greater amounts. They are also more likely to receive treatment for previous alcohol and drug use disorders.¹⁹

In our sample, substance use was prevalent in almost half (45%) of the ADHD patients. Patients with substance use disorder were appropriately referred to the addiction team and/or managed by clinicians with expertise in treating both ADHD and substance misuse as per the NICE guideline. It is important that mental health professionals receive appropriate training in assessment and management of ADHD with comorbid substance use disorder. Magon & Müller²⁰ discuss treatment studies in this area and provide a treatment algorithm to guide clinicians in the management of adult ADHD comorbid with different forms and severities of substance use disorders.

The national Prescribing Observatory for Mental Health (POMH-UK) launched a new Quality Improvement Programme (QIP) in 2013 focusing on prescribing for ADHD in children, adolescents and adults (www.rcpsych.ac.uk/pomh). The baseline audit on prescribing for ADHD was concluded and results published in a report in September 2013; the report is not available externally, but more information can be obtained by contacting POMH at pomh-uk@rcpsych.ac.uk. The QIP project will generate UK-wide data on prescribing for adults with ADHD and help to identify gaps in service provision.

1.8.30 The borderline of bipolar: opinions of patients and lessons for clinicians on the diagnostic conflict

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Abstract

Aims and method It has been observed that some individuals self-diagnose with a bipolar affective disorder and many are later diagnosed with a borderline personality disorder. There is a background context of clinical and neurobiological overlap between these conditions, and fundamental debates on the validity of current diagnostic systems. This qualitative study is the first work to explore the views of patients caught at this diagnostic interface. We predicted that media exposure, stigma and attribution of responsibility would be key factors affecting patient understanding and opinion.

Results Six core illness-differentiating themes emerged: public information, diagnosis delivery, illness causes, illness management, stigma, and relationship with others. Individuals did not ‘want’ to be diagnosed with a bipolar disorder, but wished for informed care.

Clinical implications Understanding patient perspectives will allow clinical staff to better appreciate the difficulties faced by those we seek to help, identify gaps in care provision, and should stimulate thought on our attitudes to care and how we facilitate provision of information, including information about diagnosis.

Contents

- *The borderline of bipolar: opinions of patients and lessons for clinicians on the diagnostic conflict*
 - *Method*
 - * *Participants*
 - * *Materials*
 - * *Procedure*
 - *Results*
 - * *Public information on the illness*
 - * *Delivery of the diagnosis*
 - * *Illness causes*

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- * *Illness management*
- * *Stigma and blame*
- * *Relationships with others*
- *Discussion*
- * *Study limitations*
- * *Implications*

‘Someone call the doctor,
Got a case of a love bipolar’
– Katy Perry, ‘Hot N Cold’

Diagnosing mental illness can be clinically challenging. The publication of DSM-5¹ and the surrounding debates have raised long-standing arguments about the fundamental validity of classification systems and their potential to variously stigmatise and disempower, or clarify and facilitate treatment and research.² In parallel, neuroscientific research is increasingly moving towards the concept of ‘pathway’ illnesses³ with complex interactions between many risk genes and the environment, and fuzzier boundaries between conditions lying on a spectrum of phenotypes.^{4,5}

Given the difficulties that trained professionals can experience, it is scarcely surprising that patients can have problems self-identifying psychiatric phenomenology and diagnostic labels, and indeed seeking expert help to establish a diagnosis has always been an important part of all healthcare. It has been noted recently that a growing number of individuals are presenting to mental health services having self-diagnosed with bipolar affective disorder (BPAD).⁶ In our experience, many are ultimately diagnosed with a borderline personality disorder (BPD).

Although there are obvious clinical similarities between the two conditions, notably mood cycling between pathological extremes, and a growing literature comparing them, to the best of our knowledge no one has previously tried to explore the opinions of those caught in this diagnostic dilemma. We hypothesised, fitting with the discussion piece by Chan & Sireling,⁶ that a complex combination of factors including stigma, causality and blame, celebrity culture, treatment (and treatability) and perception of staff attitudes would influence patient thinking regarding diagnosis. Furthermore, we anticipated that a better understanding of these issues would afford us greater insight into those we treat, with reflection for how this might positively affect our clinical practice in better communication, making and discussing diagnoses, and developing rational care plans.

Method

Participants

The study recruited eight individuals over a 3-month period in the London Borough of Bromley. All had self-diagnosed with BPAD, but were subsequently diagnosed with BPD. Four had no previous contact with mental health services and had been referred by their general practitioner (GP) to secondary mental health services for assessment due to their concerns that they had BPAD. Four had been within mental health services for varying periods of time (3-32 years): differing diagnoses had been suggested to them at different times, but a diagnosis of BPD had only been made for the first time in the month prior to interview and in the context of the patient having advocated for a diagnostic review in the belief they had BPAD. All participants were White women (7 British, 1 American), although this was not intended through study design, and were aged between 27 and 56 years old (median 35).

Materials

A semi-structured interview was designed following a narrative review of the literature on the presentation and treatments of both BPAD and BPD. This was used to explore participants' opinions on the similarities and differences between the two disorders in six areas: symptoms; the cause of the difficulties; public understanding; availability of clinical information; treatment; and stigma and attitudes. Participants were encouraged to express their thoughts on any topic they felt was important, including any not covered, or not fully covered, by the semi-structured interview.

Procedure

The study received ethical approval through Oxleas NHS Foundation Trust. The London Borough of Bromley's primary care liaison 'intake' team and the home and day treatment services were approached to identify eligible individuals. A letter of introduction outlining the study rationale was sent to 15 potential participants: 8 responded, were screened and deemed eligible, and provided informed consent to take part. All interviews were conducted jointly by both researchers and lasted between 36 and 75 minutes. They were transcribed verbatim (by E.R.) and processed Table 1 The major themes for both diagnoses identified by participants Theme Bipolar affective disorder (BPAD) Borderline personality disorder (BPD) Public information on the illnesses Highs and lows; euphoria; more predictable;

public awareness; positive celebrity exposure;

more internet resources and support groups Quicker mood changes, more exhausting; highs 'not really enjoyable'; unknown to the public; harder to

diagnose Delivery of the diagnosis Given more time by staff; taken seriously Mental health staff less knowledgeable; being kept

in the dark; staff hesitancy; being dismissed; might

present as clinically well; services geared towards

the 'most unwell' rather than people with BPD Illness causes More genetic; brain 'wiring' or 'chemical' problem More affected by the environment, especially early

life traumas; inconsistent parenting Illness management Medications efficacious; psychology has less of a role; established protocols; a more

passive process; staff better trained Primary psychological management but treatments

have limited effectiveness; never recover; needed

more self-awareness and self-management; become

one's own therapist; a difficult process to effect

personality change; symptoms mitigate against

recovery; staff 'anti-medication' even where it

worked Stigma and blame De-stigmatised by public exposure; received

sympathy; outside one's control; people

might fear you Reinforced by perceived staff attitudes and lack of

information; staff hopelessness; personal fatalism;

the name implies blame; responsible for being

unwell; lack of sympathy; receiving a diagnosis

could help remove some self-blame and provide

better self-understanding Relationships with others Supported by friends, family and colleagues;

can be concealed; infrequent nature would

make it less troublesome Insidious destruction and sabotage of relationships;

the need for a good therapeutic relationship;

sabotage professional care offered; seek out

conflict; ever-present and cannot be concealed

from relationships through thematic analysis using the software package NVIVO v.10 for Windows.

Results

Six main themes emerged: public information on the illnesses; delivery of the diagnosis; illness causes; illness management; stigma and blame; and relationships with others. Participants' comments are summarised in *Table 1*.

Public information on the illness

The largest theme to emerge was on 'public information': what these disorders 'looked like' and how one could find reliable information about them. All participants said they had more preceding knowledge of BPAD, primarily from mainstream media sources; most said they had never heard of BPD before being diagnosed and all thought the public at large would be quite ignorant of this diagnosis. With the hindsight of having been diagnosed with BPD, participants thought the two conditions were quite similar, with prominent problematic mood swings occurring more rapidly with a personality disorder. Several clinically delineating factors were suggested, fitting with the literature on the topic:⁷⁻¹⁰ 'self-loathing' was noted to be a core feature of BPD but not BPAD; a couple of participants opined that the rapidity of mood swings made BPD a more 'exhausting' illness, whereas four participants stated the 'highs' in BPD were not the pleasurable or euphoric type they imagined one might experience with BPAD:

'With borderline personality it all happens within sort of minutes, rather than a few months and elated mood for a period of time and then the depression, within the space of an hour you can be down again... which is pretty exhausting.'

Most participants had made attempts to find information prior to and after accessing healthcare, most commonly though the internet. All had found useful information on BPAD, though with the caveat that this is what they initially supposed themselves to have, but only one participant said she found a useful online resource on BPD after being diagnosed. However, this finding, which was the subjective view of the small number of participants interviewed, can be challenged and there are certainly numerous professional and peer websites providing information, support and advice. Putatively, the sense of there being 'less information' might be a better reflection of the celebrity culture that was cited by seven participants as informing their views specifically of BPAD, and no participants could think of parallel examples of hearing about BPD:

'[The public] haven't a clue, never heard of [BPD]. If you went out now and took a questionnaire, a very simple yes/no questionnaire: "Have you heard of?", I bet you would get 90% "no" as a response.'

Delivery of the diagnosis

An interesting finding to emerge was that not one of our sample 'wanted' to 'be bipolar', with all regarding this as a serious illness with no degree of 'social desirability'. The label of bipolar disorder had been self-affixed as a means of trying to understand the difficulties they faced, with a sense that it seemed a 'best fit'. Three of those already in mental health services said they had an awareness that (at least some) staff disagreed with their self-diagnosis, but that they were not offered any alternative. Most said that when the BPD diagnosis was first put to them they did not have enough time to ask questions about this or talk through what it meant, and several used the word 'abandoned' in this context. Several participants initially challenged the diagnosis of BPD, but only in the context of feeling they were being dismissed or pejoratively judged by staff. One recalled a staff member saying 'there's nothing we can do for you', whereas another said she was told, post-diagnosis 'oh well, yeah, that's a personality disorder, so we can't really help that'. Several thought this was because staff 'don't know as much' about BPD as they do about BPAD, and might 'cover their ignorance' through dismissive attitudes. Six participants acknowledged it might be more difficult for professionals to reach the diagnosis of BPD; that BPAD might 'look more obvious'; and that the labile nature of BPD meant their presentations might be erratic – including individuals presenting as clinically well – which might confuse staff. One participant had been seen intermittently for varying durations by mental health services over a period of 30 years before

a diagnosis of BPD was put to her. The discussion arose when she inadvertently saw the phrase on her psychiatrist's computer screen:

'It also makes me angry, not because I have got [BPD], but angry because I have been seen by mental health professionals over the years and no bugger has mentioned anything about this.'

All eight participants stated that when time and care were taken to explain what a personality disorder was, why it might occur, how it might manifest for different people, and how one might try to manage ensuing difficulties that the diagnosis of BPD 'made sense'. In fact, the majority of patients described a sense of relief at having had a long-term difficulty named and contextualised, allowing them to think of how they might prospectively deal with it. Two participants said that they felt sufficiently strongly that the appropriate discussion of diagnosis with patients was so critical a professional training need that they were happy to volunteer time to speak to staff groups about this:

'I felt absolutely over the moon because I had a real thing with a real name and I wasn't being told I was just hysterical and imagining it... so yes, to find out is a huge relief, and it is not that I am a complete bloody arsehole... it wasn't me being obnoxious or out of control as a person.'

There was unanimity in feeling that anyone diagnosed with BPAD would be given more time by staff to talk through the illness implications for them and their family, and that in such discussions professionals would be far less reticent and 'take it seriously'. However, not all help-seeking interactions with staff were reported in negative terms: one participant recalled a very supportive one-to-one session with her key worker, shortly after she had received her diagnosis:

'[He said] "it's something like having blue eyes, it's nothing you can help and it's nothing to be ashamed of, it is just the way you are and it's treatable", and he was very nice about it you know... it made me feel better'.

Illness causes

The literature supports an important role for environmental factors, particularly early life trauma, in both BPD¹¹ and BPAD,¹² although sexual abuse rates may be greater in those with BPD.^{13,14} Twin studies have shown a high degree of heritability for BPD,¹⁵ although this is still less than that of BPAD.¹⁶ Fitting with this there was reasonable unanimity among participants that BPAD was 'more nature' and BPD 'more nurture', with BPAD seen as variously a brain, neurological or chemical disorder that one was more likely to inherit and BPD a condition that developed in light of environmental stressors and traumas, with particular emphasis given by most (5) participants to the notion of inconsistent or unloving parenting:

'I have always thought that bipolar [disorder] was mainly a chemical imbalance of the brain and that to me it didn't seem that it was... environmentally affected. Borderline [personality disorder] seems to me as less of a chemical problem and more of a behaviour problem or reaction to environment and experiences.'

Illness management

Participants' comments on illness management were, in the main, in line with the principles encapsulated in national guidelines.^{17,18} Most considered that medication was the cornerstone of treatment for bipolar affective disorders. In this way treatment for those with a bipolar illness was seen as a more passive process, wherein one could 'just take the medication and get on with it':

'The way I look at it is, if someone is diagnosed with bipolar [disorder] and... you get to a stage where you work out what medication suits them, I am therefore assuming they would operate as a normal functioning human being. Now there isn't a pharmacological proposition for the likes of us, then we have to carry on in our own world and have to just get on with it, so we can't reach that level of normality, can we?'

Six participants expressed frustration that although they did not think medication was the primary treatment of BPD, staff had very negative views of issuing them any medication, certainly when compared with patients with BPAD:

‘I know you have this thing about why are people with [borderline personality disorder] given all this strong medication. From my experience I needed that to bring me down and keep my feet on the floor, because I was so impulsive and if I didn’t have that medication I probably wouldn’t be here as I would’ve jumped off a bridge or in front of a car.’

Participants thought that psychological engagement was more of a critical factor for BPD than BPAD, although interestingly five believed that the very nature of symptoms experienced in BPD mitigated against good outcomes: a labile mood could make it hard to predictably and consistently engage with therapy; and individuals might demonstrate impulsive sabotaging acts against those trying to help them that would ‘prove’ their worthlessness. One participant thought people with personality disorders could become ‘defensive and stubborn’ when offered advice, whereas another thought them ‘very sensitive’ to perceived criticisms compared with those with BPAD, and expressed her own general sense when speaking to staff that ‘I’ve tried everything and none of it works... it’s hard to imagine someone else can tell me how to deal with this’. Participants thought that individuals with BPAD were ‘more predictable’, whether having low or high mood, which would make it easier for the patient and clinician to engage and treat them.

Stigma and blame

All participants thought that significant stigma surrounded all mental illnesses: individuals with both BPD and BPAD were seen as likely to experience prejudice, with, in broad terms, neither disorder clearly ‘better’ or ‘worse’, although there is a body of literature to suggest that BPD carries a particularly strong sense of stigma.¹⁹ The commentary by Chan & Sireling⁶ noted the potential role of public exposure, celebrity discussions and TV programmes in portraying BPAD in a positive light and our work reflected this nuanced aspect, with most participants saying such public discussions had helped de-mystify BPAD:

‘It is quite uplifting, you look at someone like Stephen Fry, because if he has got it and he is still getting out and about and having a career, it’s not so bad for a person, I know... but borderline, I mean I don’t know.’

Although the point was not explicitly raised by any participant, and indeed denied by several, it remains possible that this ‘celebrity culture’ and media portrayal of BPAD might have imbued this condition with an implicit degree of social desirability and association with positive attributes such as artistic creativity, and therein account for the fewer negative comments accrued when compared with BPD. Staff attitudes were also seen to more negatively impinge on BPD, with the lack of discussion leading to a sense that ‘there’s something wrong with [borderline personality disorder]’. The very term borderline personality disorder was described by four participants as being demeaning, with one noting that it felt like a judgement on her life even though ‘there are aspects of my personality which are lovely, you know, I can be quite funny and humorous’. In 2003 the Treatment and Research Advancements National Association for Personality Disorders (TARA-APD) campaigned to change the name and designation of borderline personality disorder in DSM-5; more recently an internet survey of 646 individuals diagnosed with BPD noted that a considerable percentage thought this should be renamed in DSM-5, potentially to include the terms ‘emotion(al)’ and ‘(dys)regulation’.²⁰

A final delineating aspect with regard to stigma was a sense of attribution of blame: seven participants felt that they, staff and the public at large would regard someone with BPAD as a ‘victim’ of a serious mental illness, whereas those with BPD were more likely to be perceived as ‘perpetrators’ or creators of their problems, enhancing feelings of guilt, shame and self-loathing. Nevertheless, several participants noted that confirmation of the diagnosis of BPD had alleviated some of this self-blame, with a sense that they had ‘a real problem, like other people had’.

Relationships with others

In discussion of the relationships with friends and family as well as professional staff, all participants felt this was a more difficult issue for those with BPD than for those with BPAD. Interestingly, in both cases participants felt blame could at least in part be attributed to those with a BPD, as well as to prejudicial attitudes:

‘they would be more understanding [of BPAD]... with borderline it is just these personality traits that are very difficult to live with... it is just a lot of work and you have to understand and I don’t think people can be bothered to try and understand other people.’

‘I seem to have this dependence on the therapist or psychiatrist... sometimes I would get really angry and lose my temper with people who are caring for me, I understand why professionals would dread [individuals with BPD] more than [those with] bipolar [disorder].’

In general, BPADs were seen as something that might be more easily concealed from others, whereas a personality disorder was too pervasive for this:

‘Nobody at her work knew [my friend] had bipolar. It has never been discussed, never been an issue, why? Because there has not been any abnormality of behaviour. But [people who have a borderline personality disorder] are doing it all the time.’

Discussion

Both BPD and BPAD are common mental health conditions, affecting 4–12% (BPD)²¹ and 1–4% (BPAD)²² of the population, and of course they can occur comorbidly.²³ For professionals there are apparent similarities between them, and several recent systematic reviews have explored this topic.^{13,24,25} As well as an overlap in symptomatology there are interesting data indicating that both conditions demonstrate some similar neurobiological changes, especially to the limbic system and in frontolimbic connectivity – although with differences in amygdalar and hippocampal alteration – and to serotonergic and dopaminergic neurotransmitter systems. Nevertheless, most work supports the concept that these two disorders are fundamentally distinct conditions.^{7,13,26–28} Despite this broad literature, to the best of our knowledge no previous work has explored the opinions of those caught in the diagnostic dilemma on the similarities and differences between the two disorders.

Study limitations

Our study included only eight participants, all women and from a single London borough, and this may hinder the generalisability of our data. Furthermore, there might be a responder bias, and the opinions of the seven potentially eligible participants who declined to consider taking part might have been quite different. No clear differences in response were noted between those newly referred to mental health services and those already receiving care for some time, and the latter did not ‘know more’ about BPD. None of our participants were continuing to question their diagnosis of BPD, and all had had some time to contemplate it before the interview. There were more negative comments expressed about BPD, even if participants said they did not think this was a ‘worse’ condition. We did not identify, and are not aware of, any patients presenting with concerns that they have BPD only to be diagnosed with BPAD: this may be less likely due to the identified issue of public awareness. No viewpoints of those with BPAD on the difference between the disorders were obtained.

Implications

Our study suggests that people do not ‘want’ to be diagnosed with bipolar affective disorders; they are looking for information and clear communication with professionals. Whereas previous work has qualitatively explored the thoughts and feelings of those diagnosed with BPD (and BPAD), none has evaluated a diagnostic interface and prior knowledge of the disorder. One cannot receive appropriate treatment for something one is unaware of, and there must be many individuals suffering psychological distress and the symptoms of BPD without being aware of the nature of their illness and struggling to define their difficulties.

At the broadest level, there are interesting questions about the role of the mental health professions and professional bodies such as the Royal Colleges of Psychiatry and Nursing and the British Psychological Society in the UK, third-sector organisations and the media in the discussion of mental health disorders. Such organisations, and many others, continue to roll out worthy campaigns to target stigma and discrimination in mental health. Information on specific mental health difficulties, including BPD, is available, including a leaflet produced by the Royal College of Psychiatrists and designed to be read by non-professionals (<http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/personalitydisorder.aspx>). However, a critical question is how could one look for what one does not know exists? Most participants noted that their information about mental ill health came, at least initially, from general media and in particular from awareness of celebrities whose mental health difficulties had been well documented. Stephen Fry was held out as a particularly positive role model by most of our participants: his willingness to talk publicly and openly was cited as being both inspiring and informative, and had a marked impact on participants’ conceptualisations about their own problems, including influencing their thoughts on their diagnoses. A perhaps unanswerable question is how to achieve a similarly positive and educational context for BPD. Whether campaigns such as that by TARA-APD have significantly raised the profile of BPD remains uncertain.

Nevertheless, the challenge to mental health staff faced with patients in this diagnostic dilemma is clear. Our patients are asking us for information, for time to think about and question what we say, and for the respect of being treated honestly in such discussions. A recent review by Gask *et al*⁹ noted the critical importance of hope, optimism and an accessible ‘trusting relationship with an open, non-judgemental manner’ when managing personality disorders.

Diagnosis is part of healthcare, and while important debates about the validity of our existing models continue – and the British Psychological Society expressed concern in 2011 about the potential medicalisation of what might be considered normal variation in behaviour²⁹ – a diagnosis can help conceptualise difficulties and instigate appropriate and evidence-based care. Although professionals can be circumspect about making a diagnosis too rapidly (and many psychiatrists have been traditionally taught not to diagnose a personality disorder on first assessment), there is a very real danger that failure to do so can hinder care and mean that individuals receive no, or inappropriate, treatments that might not help, and indeed that might cause harm. If we are withholding or being unduly circumspect and hesitant about diagnosis, then we must ask ourselves why, and consider how our (in)actions might make a patient feel. Failure to openly discuss diagnostic thoughts risks perpetuating stigma and self-blame that can already be a common part of BPD. All our participants stated that having an accurate diagnosis was a hugely important step in self-reflection and understanding, and in considering their future, even if it came with other negative aspects.

In our sample several participants acknowledged that the diagnosis of a BPD might be hard to make; that the inherent lability could make it difficult to accurately assess the mental state and risk; and that the very nature of the symptoms suffered could make it challenging to consistently engage with a therapeutic programme and the staff providing care. There are real professional dangers of negative counter-transference in such situations and of projecting our frustrations or disappointments – current or historically accumulated – on those we treat, potentially furthering a sense of abandonment and rejection. Trust and the therapeutic alliance is a critical component of the relationship and process of our engagement with all patients, even if not addressed explicitly, and seldom more so that those with BPD,³⁰ many of whom have had a significant history of past abandonments. We must be careful in suppositions that people are ‘choosing’ or ‘want’ diagnoses to ‘escape’ or deny a personality disorder: our data would not support such a hypothesis.

We believe there are many positives for patients and staff to take from this work. The debates on diagnostic systems and the neuroscientific research will continue, but what is being asked for is freely available: open and honest discussion, respect and information. Disagreements are part of clinical life and outcomes are not always as optimal as one would like: however, these factors can only be worsened by not listening. Our attitudes and self-reflection are vital: it is an interesting fact that BPAD is often conceptualised as a ‘serious mental illness’, but BPD is not, when the evidence

suggests functioning and prognosis can be as bad in the latter.²⁴ Few staff working in mental health can be unaware of the frequency and often profound severity of BPD, but there is a critical issue of perception: of allowing those we try to help to see our concerns, and making them feel listened to in clear dialogue. Borderline personality disorder was initially named as it was felt to ‘border’ on a psychotic state, but perhaps bordering on a bipolar one would be more apposite.

We are grateful to those who gave their time to talk openly and thoughtfully about the difficulties they have faced. We hope they will derive some satisfaction from the fact that this may help the care of others.

1.8.31 Early Psychosis Intervention: A Culturally Adaptive Clinical Guide

Roger Ho¹

date

2015-2

Contents

- *Early Psychosis Intervention: A Culturally Adaptive Clinical Guide*

This book is written by multidisciplinary pioneers in early psychosis intervention in South-East Asia and is a product of two decades of development in this rapidly growing region, a cultural mosaic. In the foreword, Professor Patrick McGorry highlights that the essence of such intervention is to bring maximum recovery for young people with psychotic experiences.

The book is unique and attempts to connect early psychosis with transcultural psychiatry. The first part describes service structures of early psychosis programmes in Hong Kong, Singapore, Japan and Korea. The authors define early psychosis afresh by introducing the culturally adaptive translation in Chinese, *sijueshitiao*, meaning imbalance of thinking and perception. The second part discusses the cultural issues in management of early psychosis. The authors tactfully compare and contrast different Asian beliefs of mental illness including Islam (unbalanced lifestyle), Hindu (bad karma), Buddhism and Taoism (attacks by ghosts) and Christianity (demonic possession). The local cultural beliefs may increase duration of untreated illness because patients and families often consult their traditional healers instead of medical practitioners.

The authors present interesting data on public misconceptions about psychosis. They highlight salient points in early psychosis treatment such as recommended dose of each antipsychotic drug, topics to be covered in peer support groups, strategies for family work and medication adherence. I personally found the chapter illustrating the state-of-art information technology and database design very interesting.

I highly recommend this book to mental health professionals who are keen to establish early psychosis intervention services in other parts of Asia, Africa and South America. The authors carefully insert clinical vignettes throughout the book and enrich its clinical relevance. Mental health professionals working for well-established early psychosis

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intervention programmes may find the culturally adaptive strategies helpful in their clinical practice. In the near future, I hope Professor Eric Chen and his colleagues may consider writing a book on the neurobiology of early psychosis.

1.8.32 Alcohol dependence and driving: knowledge of DVLA regulations

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date

2015-2

Abstract

Aims and Methods The UK's Driver Vehicle Licensing Authority (DVLA) requires individuals to report if they have a medical condition such as alcohol dependence. General Medical Council guidance indicates that medical practitioners should ensure patients are aware of their impairment and requirement to notify the DVLA.

Results In a survey of 246 people with known alcohol dependence, none were aware of advice on driving given by medical practitioners and none had self-reported. In addition, 362 doctors, either attending a college symposium or visiting a college website, were asked about their knowledge of DVLA regulations regarding alcohol dependence: 73% of those attending the symposium and 63% of those visiting the website answered incorrectly. In Scotland, over 20 000 people have alcohol dependence (over 1 million people with alcohol abuse), yet only 2548 people with alcohol problems self-reported to the DVLA in 2011.

Clinical implications If the DVLA regulations were implemented, it could make an enormous difference to the behaviours of the driving public.

Contents

- *Alcohol dependence and driving: knowledge of DVLA regulations*
 - *Method*
 - * *Patients*
 - * *Doctors*
 - *Results*
 - *Discussion*
 - * *Situation in Scotland*
 - * *Limitations*

The dangers of driving while under the influence of alcohol are well known. Alcohol remains a significant public health risk and has been identified as the most important factor contributing to the occurrence of severe to fatal automobile crashes. ¹ Acute alcohol intoxication affects the behavioural and coordinating functions necessary for driving. ² Alcohol consumption at lower levels also interferes with performance on neurological and psychological tasks, ³ which include

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a wide variety of cognitive processes, ⁴ affects immediate memory span and short-term memory ⁵ as well as motor speed and coordination. ⁶

Driver licensing in Great Britain is governed by the third European Commission Directive on the Driving Licence. ⁷ Annex III of the directive provides the minimum medical standards for driving expected across all member states. It states: 'Driving licences shall not be issued to, or renewed for, applicants or drivers who are dependent on alcohol or unable to refrain from drinking and driving. After a proven period of abstinence and subject to authorised medical opinion and regular medical check-ups, driving licences may be issued to, or renewed for, applicant or drivers who have in the past been dependent on alcohol'. ⁷ The persistent misuse of drugs or alcohol, whether or not misuse amounts to dependency, is a relevant disability in the Motor Vehicles (Driving Licences) Regulations 1999.

Guidance from the Driver and Vehicle Licensing Agency (DVLA) states that persistent alcohol misuse requires licence revocation or refusal until a minimum 6-month period of controlled drinking or abstinence has been obtained, with normalisation of blood parameters. Alcohol dependency requires licence revocation or refusal until a 1-year period free from alcohol problems. ⁸ Abstinence will normally be required and medical reports from the driver's general practitioner (GP) are necessary, usually in conjunction with an independent medical report.

The aim of this study was to ascertain the knowledge of 'recovering alcoholics' of the DVLA regulations related to driving a car while still 'actively drinking' and whether they could recollect whether their health professional had given them appropriate advice. In addition, a total of 362 senior doctors, either attending a Royal College of Physicians (Edinburgh) symposium or visiting a Royal College of Physicians (Edinburgh)/Royal College of Psychiatrists (Scotland) website, were asked about their knowledge of DVLA regulations and alcohol dependence. The terms 'recovering alcoholics' and 'actively drinking' are recognised and regularly used by Alcoholics Anonymous. ⁹

Method

Patients

In total, 246 'recovering alcoholics' attending five different Alcoholics Anonymous (AA) meetings in Ayrshire, Scotland were surveyed during 2011. The individuals surveyed had all previously been heavy consumers of alcohol (> 100 units/week). They had attended AA meetings regularly for over 6 months and by self-report had been free of any alcoholic intake for at least this period. Membership of the Fellowship of AA is described in Tradition 3: 'The only requirement for A.A. membership is a desire to stop drinking'. ⁹ (Traditions and 'Steps' are the foundation of AA.) Of the sample, 194 (79%) were male and the ages ranged from 21 to 80 years, median 57 years. As anonymity is a very important aspect of AA, further demographic detail was not collected. All individuals questioned were in possession of a current driving licence and had the willingness and apparent capacity to provide consent for participation in the survey. They were asked to complete a brief, anonymous questionnaire (unsupervised) about their knowledge of DVLA regulations and about the information that they had been given by health professionals. Those involved in any drink driving offences were excluded. The survey was undertaken with the full knowledge of Fellowship of AA. However, as according to the AA Tradition 6: 'Our groups ought never endorse, finance or lend our name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose', ⁹ the work was conducted independently of the Fellowship. The questionnaires were distributed to members for completion before or immediately after AA meetings (*Table 1*).

Participant survey results

Question	Yes, <i>n</i> (%)
1 Are you a recovering alcoholic?	246 (100)
2 Do you have a driving licence?	246 (100)
3 Do you drive a car?	246 (100)
4 Did your problems with alcohol lead you to see your GP?	185 (71)
5 Do you recollect your GP giving you any advice about driving?	0
6 Have you ever been admitted to hospital due to your alcohol problems?	137 (56)
7 When you were in hospital do you recollect getting any advice about driving?	0
8 Do you recollect if your GP or a hospital doctor have ever asked you/told you to stop driving?	0
9 Have you ever informed the DVLA that you have/had a problem with alcohol?	0
10 Do you think that it would be sensible/reasonable to be told not to drive if you still had an active problem with drinking?	223 (91)
11 Have you ever driven a car knowing that you were under the influence of alcohol/were over the limit (including the morning after)?	246 (100)
12 Have you ever driven a car when you were withdrawing from alcohol?	194 (79)
13 Did you ever stop driving or think of not driving while still actively drinking?	103 (42)

GP, general practitioner.

Doctors

There were nine questions posed to doctors at the symposium and online: three were based on alcohol-related problems, three on cardiology, two on psychiatric issues and one on diabetes. Of the physicians who attended the Royal College of Physicians (Edinburgh) symposium, 292 took part in the survey and 70 doctors did so online.

The alcohol and driving question stated: 'If a patient is admitted to hospital with an alcohol dependence problem (requiring benzodiazepine treatment for withdrawal symptoms) the patient must be advised to inform the DVLA, who will revoke their licence for a year'. Respondents could answer that this was true, false or that they did not know the answer.

Results

The 246 'recovering alcoholics' answered all 13 questions (*Table 1*). All 246 had a driving licence and drove a car; 185 (71%) went to see their GP with an alcohol problem and 137 (56%) were admitted to hospital with alcohol problems. None recollected their GP or a hospital doctor asking them to stop driving. In addition, none had informed the DVLA that they had a problem with alcohol.

At the symposium, 73% physicians answered the question incorrectly and on the website 62% of physicians and psychiatrists gave an incorrect answer; 9% of those at the symposium indicated that they did not know the answer. With regard to questions on alcohol-related seizures and alcohol misuse, 64% and 62% respectively answered incorrectly. The other non-alcohol related questions demonstrated a higher level of knowledge among the symposium audience (13–42% incorrect).

Discussion

This study has shown that awareness of individual responsibility among recovering alcohol-dependent individuals is low and recollection of discussion with health professionals about driving is non-existent. The people we surveyed were regular attendees of AA meetings. This is likely to be a group who have developed a high level of understanding and insight into their alcohol problem and would be willing to engage in open discussion with doctors. A few specialist alcohol services in Scotland provide written information to newly referred patients alerting them to their responsibilities regarding the DVLA, but it is not known whether patients recall this (in the short or long term) and clearly very few act on the advice. It is also probable that a significant proportion of health professionals are not aware of the advice that they should be giving in relation to driving and alcohol dependency and alcohol misuse. These small but significant doctor surveys reflect that knowledge of alcohol-related DVLA issues is poor among hospital doctors. The Royal College of General Practitioners (Scotland) was invited to participate but declined this opportunity. General practitioners form a key professional group regarding health issues and driving. This lack of knowledge in 'recovering alcoholics' may reflect a number of elements, including lack of knowledge in health professionals, lack of willingness of health professionals to discuss the issue or lack of recollection from the individuals themselves. In addition, it is possible that health professionals who are aware of the appropriate advice are unwilling to discuss the topic in case it would adversely affect their relationship with the patient.^{10,11} In particular, there may be a reluctance to raise the issue of driving in case this becomes a disincentive for patients to be open about their drinking.

The DVLA guidelines⁸ give advice on a number of medical conditions that may affect driving, including diabetes mellitus, epilepsy, sleep apnoea, dementia, psychiatric disorders, as well as alcohol misuse and alcohol dependency. If a patient is admitted with a 'first' seizure, most doctors and health professionals would know to advise the patient that they may not drive for a year.¹² In addition, if a patient is started on insulin therapy, then most doctors and health professionals, particularly those associated with the management of diabetes,¹³ would know that they should advise their patient to inform the DVLA.

The definition of alcohol misuse used by the DVLA – 'A state which, because of consumption of alcohol, causes disturbance of behaviour, related disease or other consequences, likely to cause the patient, his/her family or society harm now, or in the future, and which may or may not be associated with dependency'⁸ – is helpful but can be difficult to interpret in the context of dealing with patients in an acute medical setting. The definition of alcohol dependence used by the DVLA – 'A cluster of behavioural, cognitive and physiological phenomena that develop after Table 2 Notifications to DVLA on UK licence holders with alcohol misuse or alcohol dependence from all sources, 2006–2011

Year	2006	2007	2008	2009	2010	2011
Self-reported	378	1268	1265	1176	1974	2548
Other (e.g. reported by doctor, family member)	41	26	52	24	83	168 ²

repeated alcohol use and which include a strong desire to take alcohol,

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DVLA, Driver & Vehicle Licensing Agency.

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difficulties in controlling its use, persistence in its use despite harmful consequences, with evidence of increased tolerance and sometimes a physical withdrawal state'⁸ – is much clearer and, particularly in relation to alcohol withdrawal, much easier to implement clinically. If more hospital doctors were aware of the DVLA repercussions of making the diagnosis of alcohol dependence or misuse, it may make the use of alcohol withdrawal regimens more problematic. For example, the Clinical Institute Withdrawal Assessment – Alcohol (CIWA–A) scale¹⁴ is commonly used in alcohol withdrawal situations in medical wards. Perfunctory attention to the history and frequent overreliance on unsubstantiated alcohol use can lead doctors to the inappropriate use of CIWA–A, which could have significant consequences on lifestyle and driving advice they give their patients.¹⁵

The responsibility for ensuring that the patient informs the DVLA lies with the licence holder. The guidelines for fitness to drive are available on the DVLA website (www.dvla.gov.uk) and are revised every few months. The website states that the General Medical Council (GMC) has issued clear guidelines to doctors with regard to their responsibility to the DVLA:¹⁶ 'the DVLA is legally responsible for deciding if a person is medically unfit to drive. They need to know when the driving licence holders have a condition, which may, now or in the future, affect their safety as a driver'. It also states that if a patient has such a condition, the doctor should 'make sure that the patients understand that the condition may impair their ability to drive' and 'explain to patients that they have a legal duty to inform the DVLA about their condition'. In addition, it states that doctors can 'suggest that the patient seek a second medical opinion, and make the appropriate arrangements for the patient to do so' if the patient is unwilling to accept the diagnosis (personal communication, DVLA freedom of information request responses 2010/2011). Patients who fail to notify the DVLA of a medical condition without reasonable excuse are guilty of an offence. Failure to notify the DVLA also invalidates their motor insurance cover. Current notification levels of alcohol misuse and alcohol dependency received by the DVLA are very low (*Table 2*). A small number are also reported through a third party (which may be family, friend, health professional, etc.).

Situation in Scotland

In the Scottish population, the estimated prevalence of alcohol dependence at 4.9% and of harmful and hazardous use at 27.9% indicates around 20 000 people with dependence and over a million with harmful or hazardous use.¹⁷ A high proportion of these are likely to be driving licence holders since approximately 86% of the UK adult population has a driving licence of some sort, with 73% being full UK licences.¹⁸ Most licence holders obtain their licence in young adulthood, before alcohol dependence develops. Therefore it is not unreasonable to estimate that there may be in excess of 150 000 licence holders with alcohol dependence in Scotland alone and a further 700 000 licence holders with harmful or hazardous use of alcohol. This represents an enormous cohort of people who should be reporting their alcohol problems to the DVLA. The Department for Transport report on the attitudes of health professionals giving advice on fitness to drive (including for people with alcohol and drug misuse and dependency) contains a series of recommendations for improving such advice.¹⁹ Key among these are recommendations on the inclusion of a question on fitness to drive in the exit examination for all relevant medical specialties, the creation of clear, well-signposted guidelines for use in general practice and the production of a clear flowchart for common medical conditions to which healthcare practitioners can refer.

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Limitations

There were some limitations to the study. The questionnaires had not been externally validated but the questions were simple, straightforward and easy to understand. We accept that the group of ‘recovering alcoholics’ questioned involved only a limited number of adults in Ayrshire. AA meetings provided a venue where motivated individuals who had recognised their problem with alcohol were present; it might be considered that their recall of advice would be greater than that of those who chose not to attend AA. Alternative methods for assessing recall of medical advice, such as surveying patients at addiction clinics, could have suffered from bias as the clinic staff became aware of the study. A presumption was made that none of the attendees experienced alcohol-related brain damage or other memory loss syndrome and could recall accurately the discussions that they had had with their medical advisers about their drinking. The study demonstrated non-existent knowledge of the DVLA regulations relating to alcohol dependence and misuse among a group of ‘recovering alcoholics’ plus a poor level of knowledge in a group of senior doctors. Very importantly, the figures obtained from the DVLA indicate very low levels of self-reporting. During the 2011/2012 period there were 38 737 alcohol-related hospital discharges in Scotland²⁰ and almost 97 830 alcohol brief interventions completed,²¹ which give numerous opportunities for alcohol advice. If the DVLA regulations were implemented, it could make an enormous difference to the understanding and behaviours of the driving public.

1.8.33 Personal experience: Suicide and psychiatric care – a lament

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date

2015-2

Abstract

A personal bereavement from suicide prompts a critique of current mental healthcare. Fragmentation, lack of long-term attachment to a tenured professional, the dearth of family therapy, and professional ambivalence are identified as weaknesses in current provision. Implicit is the case for change in UK psychiatric services, both structural (need for long-term therapies) and cultural (need for a mentalising rather than protocol-driven, ‘choice’-led ethos).

Contents

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Recently, a close relation of mine died, through suicide. An intelligent, beautiful, creative young woman, for nearly 20 years she had suffered from bipolar disorder, for which she had received intermittent psychiatric care. Although the scale of my grief is minuscule compared with that of her immediate family, the poignancy was magnified, because I am, or was, a psychiatrist.

Inevitably, as one vainly tries to elude the irreversibility of time and loss, I have replayed in my mind the story of her illness and last days. Inescapably, too, I have felt on her behalf and that of her family a degree of guilt, anger and regret. Surely things could have been done differently, I think to myself. I look back on the patients with bipolar disorder I have treated over the years – those who have survived, and those unforgettable few, who, like my relative, took their own lives. I think of lessons learned, and not learned.

Although many aspects of psychiatric services have undoubtedly changed for the better (e.g. patient empowerment, multidisciplinary teamwork), there are also ways in which current psychiatry lets down its patients, especially when suicidal. What follows is perhaps yet another ultimately futile, counterfactual ‘if only...’ narrative that typically haunts the bereaved. But for all that, it may contain some validity.

Death and psychiatry

There can be few psychiatrists who have not at some point been faced with the death by suicide of a patient under their care. ¹ Although psychological autopsy and critical incident review are unexceptionable, hospital authorities react very differently to death by suicide as compared with other deaths. Compared with the acceptance of the inevitable mortality associated with chronic physical illness, when a patient with a psychiatric illness takes their own life there is invariably an undercurrent of blame. ² Bipolar disorder, major depressive disorder and schizophrenia have a 20% mortality rate, ³ comparable with multiple sclerosis ⁴ or many forms of cancer, but the reactions they evoke are very different. This is reflected in the way that death by suicide is classified and recorded. Bipolar disorder, schizophrenia or borderline personality disorder are not in themselves ‘causes’ of death to be determined by a coroner. Suicide is grouped with the other stigmatised ‘-icides’, alongside homicide and infanticide.

Changing classification might well be desirable, but stigma-reducing biomedical attributions of ‘illness’ will still fail to capture the essence of the psychological pain with which the survivors are inundated. It is hard to accept that we can be so helpless in the face of unconscious forces over which we appear to have little control. The challenge to our sense of omnipotence and sense of freedom is overwhelming. There must, it seems, be an explanation, a narrative – someone or something to blame.

Changes in psychiatric care – and their consequences

Official enquiries into untoward deaths usually end up with bland banalities such as ‘poor communication’ and ‘failure of adequate risk assessment’. ⁵ But these gloss over the negative consequences of the many changes that have overtaken psychiatry in the past few decades.

The first is fragmentation of care. In the UK an ill patient is likely to be ‘looked after’ by at least three different groups in the course of her illness: the in-patient team, the assertive outreach team, and the continuing care team, each staffed by different people with differing philosophies, skills and limitations. Each team will be keen to get their job done and then pass the patient on, leading to eventual discharge. There is rarely one single individual who holds the patient in mind through all the phases of their illness, in sickness and in health. No ‘risk assessment’ protocol can substitute for this intimate knowledge, built up over time, of patients’ unique vagaries, strengths, weaknesses, vulnerabilities and inner workings.

This role could be, but so often is not, occupied by a senior tenured clinician – consultant psychiatrist, nurse-specialist, psychotherapist or clinical psychologist, supplemented by other members of the team. For this to happen there would need to be a move from short-termism and quick-fix problem-only therapies to long-term care for chronic illness. This

would entail recognition that, as in Germany, long-term therapy, despite its cost, is economically efficient and can be available as part of comprehensive universal healthcare. ⁶

Attachment theory: Refuge

Attachment theory provides a possible scientific underpinning for this perspective. The distressed – and what is suicide if not the ultimate manifestation of distress? – are psychobiologically driven to seek out a secure base in the hope of alleviating their mental pain. ⁷ In the absence of a secure base an abyss of despair and terror gapes, to which the illusory comfort of death may appear to provide a modicum of comfort.

Secure attachment is based on sensitive and responsive knowledge of the care-seeker, backed by ‘allo-parents’ ⁸ who augment and temporarily substitute, but can never fully replace, the primary attachment figure. The prevailing ‘customer-provider’ ethos, postmodern suspicion of inequalities in power relationships, and an underlying cost reduction imperative, are used to justify the current model. There is scant acknowledgement that the idea of ‘choice’ makes little sense in the context of severe mental illness. A commercial-type ‘contract’ anticipates, and tries to shape, the consumer’s needs, but is essentially non-‘mentalising’. ⁹ It does not take account of the uniqueness of attachment relationships or attend to the inner world of experience that drives external behaviours.

Understanding a person’s inner world is not a recipe for vague psychological theorising, but can be intensely practical. A mentalising parent is able to plan effectively, take account of her own states of mind, and make sensible guesses about what is going on in her child’s mind. Similarly, a primary ongoing psychiatric attachment figure offers not just support and therapy to her patient with bipolar disorder, but, based on a shared journey through the vicissitudes of illness, gauges the need for medication, and helps the patient regulate the basic parameters of life – sleeping, eating, working, relating. ¹⁰

Long-term care has benefits

Soon after my relation died I dreamt I was in charge of her care; ‘You are going to stay in the ward, sectioned if necessary, until you are really well, even if that means staying here for a year!’, I said in my dream narrative. In reality this could, and probably should, be no more than a dream. In-patient beds are vanishingly scarce; ward culture inimical to long-term care; sectioning a highly articulate and plausible patient increasingly problematic. The idea of a hospital as an asylum, of therapeutic communities in which people with mental illness live and learn together, seems little more than a nostalgic memory. But in a psychiatric world without walls, the need for long-term care based on enduring relationships becomes all the more important, not least because the developmental experiences of those who suffer from mental illness are typically characterised by disorganised and disrupted attachments. ¹¹ The current climate tends to reproduce and reinforce rather than mitigate these adverse developmental experiences.

The importance of family therapy

Finally – whatever happened to family therapy? From an attachment perspective family members – parents, spouses, siblings – however stressed, possess a unique sensitivity to the inner world of their loved ones. They have a lifelong baseline of normality against which to judge the subtle signs of relapse. They are an indispensable resource in which indefatigable altruism, based on the care-giving dynamic, can be taken for granted. Mental health professionals have often not yet fully thrown off their own adolescent rebellion, and too easily slip into excluding or even blaming the family, in part no doubt as a way of coping with the stresses of working in the beleaguered field of psychiatry. One consequence of ‘community care’, so called, is that families are relatively unsupported in their struggle to help their mentally ill relation, or cast as the ‘cause’ of the problem, and kept in the dark about professional formulation and planning.

Faced with the huge trauma of mental illness, the world typically becomes split into good and bad. When patients were detained for longer periods in psychiatric units, its staff at times became the necessary ‘bad object’, Rey’s ‘stone Mother’, ¹² a paradoxically safe container for all that was painful and destructive about mental illness. Hope and

recovery were associated with discharge and resuming the ongoing connections represented by friends and family. Today, without the secure base function of the hospital, the family itself is too easily scapegoated, while professionals take refuge behind ‘confidentiality’ as a rationale for excluding family members. Skilled family therapists are a rarity, despite robust evidence that family intervention prevents relapse in serious mental illness.¹³

Carrying on

Of course none of this call – for an attachment perspective, for more long-term therapy, for reviving therapeutic communities, for training family therapists – can reverse the horror of the loss one iota. When someone dies, from whatever cause, especially if young, a web of meanings, hopes and connections is severed. Restoration of meaning entails a painful recapturing and reworking of the past. The totality of the patient’s being – strengths, delights, loves, achievements, as well as suffering and pain – has to be sought and re-found. A similar task faces today’s psychiatric profession – to value the past, mourn what is irrevocably lost, reclaim what can be salvaged. In suicide, echoing Tennyson, a lifelong mourner,¹⁴ ‘much is taken’, but ‘much still abides’. This lament is a plea, when faced with suicide, for psychiatrists, alongside patients and their families, to ‘strive, to seek, to find, and not to yield’ – to fashion, finance or fatalism.

1.8.34 Anti-N-methyl-d-aspartate receptor encephalitis: review of clinical presentation, diagnosis and treatment

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Abstract

Anti-N-methyl-d-aspartate (NMDA) receptor encephalitis is a form of encephalitis occurring primarily in women and associated with antibodies against NR1 or NR2 subunits of the NMDA receptor. As a potentially treatable differential for symptoms and signs seen in neurology and psychiatric clinics, clinicians practising across the lifespan should be aware of this form of encephalitis. Common clinical features include auditory and visual hallucinations, delusions, behavioural change (frequently with agitation), impaired consciousness, motor disturbance (ranging from dyskinesia to catatonia), seizures, and autonomic dysfunction. We present a review of the literature on the disorder, including its clinical presentation, differential diagnosis, epidemiology, treatment and prognosis.

Contents

- *Anti-N-methyl-d-aspartate receptor encephalitis: review of clinical presentation, diagnosis and treatment*

1

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- *Epidemiology*
- *Pathophysiology*
- *Clinical presentation*
- *Diagnosis*
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Anti-*N*-methyl-d-aspartate (NMDA) receptor encephalitis was first described in 2007 by Dalmau and colleagues,¹ who identified 12 patients presenting with prominent neuropsychiatric symptoms. All were confirmed to have serum or cerebrospinal fluid (CSF) antibodies to the NMDA receptor.¹ In a subsequent case series of 100 patients, 77 initially presented to psychiatric services.² Although patients with anti-NMDA receptor encephalitis exhibit high rates of psychiatric disorder, psychiatrists may not be fully aware of the diverse presentation of this disorder. Given the high mortality rate (up to 25%), the likelihood of presentation across the age range and the potential for treatment, a high index of suspicion is warranted by clinicians.

Epidemiology

Epidemiological studies suggest that anti-NMDA receptor encephalitis may be the most common cause of autoimmune encephalitis after acute demyelinating encephalitis.³ While to date there are no estimates as to prevalence rates, more than 500 cases have been reported.⁴⁻⁶ Between September 2007 and February 2011, the California Encephalitis Project examined referrals of 761 patients presenting with encephalitis.⁷ Of the cases of identified aetiology, anti-NMDA receptor encephalitis was the leading entity (32 of 79 cases) within the cohort and was identified four times as frequently as herpes simplex – type 1, West Nile virus or varicella zoster virus.⁷ In another study, Steiner and colleagues examined 121 individuals with schizophrenia for diverse NMDA receptor antibodies. Approximately 10% ($n = 15$) were found to be positive for anti-NMDA receptor antibodies, two of whom had the specific immunoglobulin G (IgG) NR1a antibodies of anti-NMDA receptor encephalitis.⁸ Zandi *et al*⁹ observed NMDA receptor serum antibodies in approximately 6% (3 of 46) of patients with first-onset schizophrenia. The true rate of anti-NMDA receptor encephalitis in the population generally and among individuals with psychosis is thus not yet fully clarified.

Pathophysiology

Encephalitis and psychosis have a long association, with a viral aetiology of psychosis hypothesised as early as the 19th century. The influenza epidemic in the early 20th century led Karl Menninger to conclude that ‘dementia praecox is at least in most instances a somatopsychosis, the psychic manifestations of an Encephalitis’.¹⁰ While the dopaminergic model of schizophrenia has been the leading neurochemical hypothesis of psychosis for many decades, hypofunction of the NMDA-type glutamate receptors provides an alternative model to understanding the pathogenesis of schizophrenia. It is well described that antagonists of NMDA receptors (e.g. phencyclidine (PCP)) produce a clinical syndrome that closely resembles negative symptoms of schizophrenia and induce neuropsychological and sensory processing deficits that are very similar to those observed in schizophrenia.¹¹

The prominent psychotic symptoms, catatonia and indicators of dopaminergic involvement (orofacial dyskinesias) are all consistent with the effects of PCP,¹¹ which is well recognised to also replicate many aspects of the presentation of schizophrenia. NMDA receptor antagonists are believed to function by blocking the NMDA receptor in the presynaptic gamma-aminobutyric acid (GABA)-ergic neurons of the thalamus and frontal cortex, leading to a disinhibition of postsynaptic glutamatergic neurons and subsequent glutamatergic and dopaminergic dysregulation in the frontal cortex.

It has been observed that nitroprusside completely abolishes the behavioural effects of PCP in animal models.¹² Hal-lak and colleagues¹³ administered a sodium nitroprusside infusion to 20 patients with a diagnosis of schizophrenia, with a resultant rapid improvement in symptoms. They hypothesise that in addition to generating nitric oxide in the brain and increasing cAMP production, nitroprusside may also modulate NMDA receptor activity. In addition, reductions in plasma and brain glycine, D-serine and glutathione levels provide additional mechanisms underlying NMDA dysfunction.¹⁴

The neuropsychiatric presentation of these cases of anti-NMDA receptor encephalitis thus provides important support for the NMDA receptor hypofunction hypothesis for psychosis.^{15,16} Explanations for the proposed NMDA receptor hypofunction in schizophrenia are varied and may involve altered recycling of NMDA receptors.¹⁷ However, the possibility that autoantibodies to the NMDA receptor subunits may be causal in psychotic presentations is novel.

Acute psychosis in anti-NMDA receptor encephalitis is associated with serum and CSF IgG antibody titres against the NR1a subunit of the receptor. However, antibodies against different antigens (e.g. the NR2a and NR2b subunits) have been described in cases of limbic encephalitis and systematic lupus erythematosus,^{18,19} and psychiatric symptoms may not be exclusive to the NR1a subunit. Steiner *et al*⁸ examined the serum of 459 patients admitted with schizophrenia ($n = 121$), major depression ($n = 70$) and borderline personality disorder ($n = 38$) for a variety of antibody subtypes in order to determine whether antibody subtypes overlap with or are distinct from those in anti-NMDA receptor encephalitis. They identified NMDA antibodies in 9.9% of patients with schizophrenia. Diverse NMDA receptor antibodies, including those specifically found in anti-NMDA receptor encephalitis, were found primarily in those with an initial diagnosis of schizophrenia; two patients initially diagnosed with a disorganised or catatonic schizophrenia were subsequently diagnosed with, and treated for, anti-NMDA receptor encephalitis.⁸

Potential causes for the behaviour, learning and memory difficulties in anti-NMDA receptor encephalitis have been postulated by Iizuka and colleagues,²⁰ who noted reversible predominant frontotemporal atrophy, an area in which NMDA receptors are present in high density, therefore suggestive of an immunological cause to the atrophy.

Anti-NMDA receptor encephalitis is associated in some cases with ovarian pathology, in particular teratomas. It is considered that the antibodies to the NR1–NR2 subunits of the NMDA subtype of glutamate receptors develop in response to this abnormal tissue.

Clinical presentation

Presentations can be variable, thus posing a challenge to clinicians in neurology and psychiatry settings. With symptoms and signs ranging from psychosis to mania to catatonia, clinicians may be prompted to consider primary mental health aetiology. Dalmau *et al*⁶ have proposed a staged presentation. Maneta *et al*⁵ summarise these into early, middle and late symptoms, initially involving a prodrome, followed by more overt psychiatric manifestations and later physical symptoms.

Clinicians should be aware that the presentation of anti-NMDA receptor encephalitis includes several characteristic features.

A non-specific prodrome: in one series of 100 individuals with encephalitis, 86% had headache, low-grade fever or a viral-like illness (headaches, respiratory or gastrointestinal symptoms) in the weeks prior to acute presentation.² In our series of five cases, we identified a prodrome in four, with symptoms including poor concentration, anorexia, insomnia and slurred speech.⁶ Psychiatric symptoms are prominent: agitation, bizarre and disinhibited behaviour, delusions and auditory and visual hallucinations.² In our series, the psychotic phenomena observed were markedly fragmented in comparison with those typically found in functional psychoses, with delusions being poorly formed and non-systematised.⁶ Cognitive dysfunction: short-term memory loss can also be a presenting feature, as can concentration difficulties. Formal neuropsychological testing in the presence of psychosis and/or behavioural disturbance may present difficulties in clinical practice. Motor dysfunction: in addition to typical epileptic seizures, patients often develop dyskinetic movements, including orofacial dyskinesias (grimacing or lip smacking), which may be mistaken for seizures. These abnormal movements, especially orofacial dyskinesia, may present from an early stage and are often a clue to the diagnosis. Autonomic instability: autonomic instability and hypoventilation can also occur (41 of Dalmau's series² had one or both of these features), as can cardiac dysrhythmias often necessitating intensive care unit management.² Dissociative responses to stimuli during have been noted, including resistance to eye opening while

displaying no response to painful stimuli, a combination that may lead to diagnostic confusion.^{20,21} Association with known pathology: an association with ovarian pathology has also been identified. Dalmau and colleagues reported that in 59% of cases, the diagnosis was associated with ovarian tumours, primarily ovarian teratomas.² However, Irani and colleagues identified tumours in only 26% (9 of 34) of cases.²² Children under the age of 18 are unlikely to have an associated tumour.

Diagnosis

Confirmation of the clinical diagnosis of anti-NMDA receptor encephalitis requires a positive serum or CSF sample screening for antibodies to the NMDA receptor subunit. There is ongoing controversy as to whether serum or CSF is best tested. Dalmau recommends testing of both,⁶ whereas Irani & Vincent,²³ by contrast, report that serum levels of anti-NMDA receptor antibodies were similar or higher to those of CSF. The clinical symptoms of this disorder correlate well with antibody titre.² The test for anti-NMDA receptor encephalitis, although currently somewhat slow, is relatively cheap, and therefore should be considered in any patient presenting with an acute onset of psychiatric symptoms with atypical features or unusual movements.

CSF abnormalities have been described in approximately 80% of cases and include a mild lymphocytic pleocytosis, normally or mildly increased protein concentration, and CSF-specific oligoclonal bands.^{2,24}

Brain magnetic resonance imaging scans have been reported as normal in 70% of cases.⁴ In the remainder, hyperintensities in a variety of regions may be evident (implicated areas include the hippocampi, cerebellar and cerebral cortex, basal ganglia, brainstem, frontobasal and insular regions).²⁵

Typically, electroencephalograms (EEGs) may show non-specific slowing or slow continuous rhythmic activity during the catatonic phase of illness.²⁶ An EEG is very helpful if one is trying to distinguish between encephalitis and a primary psychiatric disorder, as the majority of patients (90%) with anti-NMDA receptor encephalitis have evidence of non-specific slowing at some stage during the illness.⁴

While not at present likely to support clinical practice, other investigations have been reviewed. Positron emission tomography has shown variable findings, with some evidence of cortical hypometabolism.²⁷ This contrasts with findings from other investigators, suggesting subcortical hypermetabolism.²⁸

Differential diagnosis

The condition may present in the domain of either the neurologist or the psychiatrist, depending on whether psychiatric symptoms precede the neurological features, as is often the case.

Neurological

Neurological differential diagnosis tends to include viral encephalitis, cerebral vasculitis or other forms of autoimmune encephalitis and encephalitis lethargica.²⁹ Dyskinetic movements may be mistaken for seizure activity or tardive dyskinesia. Patients can also have bizarre stereotypies. Repetitive stereotypies and orofacial dyskinesia can be mistaken for seizures.³⁰ The seizure-like dyskinetic movements may also be misdiagnosed as status epilepticus, a diagnosis that is reported in 6% of cases.³⁰ Dericioglu and colleagues³⁰ report two cases where status epilepticus was suspected but video EEG was indicative of encephalopathy, thus avoiding aggressive treatment with intravenous anaesthetics. Caution therefore is advised in interpreting these movements, unless clarified by video EEG, when status epilepticus is suspected.³⁰

Psychiatric

Psychiatric differential diagnoses are usually the primary differential in the initial phase of illness. New-onset psychosis is typically recorded in the literature as the most common initial diagnosis because of the presence of delusions, hallucinations and catatonic features. Recent studies explore the possibility that this disorder, or indeed other similar autoimmune conditions, may present with a more typical schizophrenia picture and be responsible for as much as 5–10% of first-onset psychosis.^{8,9} Zandi and colleagues⁹ screened a 46-patient cohort of first-episode psychosis patients in a prospective study for NMDA receptor antibodies and only 2 tested positive. The authors state that there were no clinical features to differentiate these individuals from other individuals with psychosis in the cohort.

Cases of ‘postnatal psychosis’ in association with ovarian pathology that bear remarkable similarity to anti-NMDA receptor encephalitis have also been described.³¹

The presence of rigidity and altered consciousness, which are common in anti-NMDA receptor encephalitis, may also lead to consideration of a diagnosis of neuroleptic malignant syndrome, particularly when antipsychotic medications are prescribed. This may present both a diagnostic dilemma and a management challenge in clinical practice, as these diagnoses are clearly not mutually exclusive.

Treatment options

It is important to note that treatment must target both the cause and the clinical consequences of the encephalitis (the behavioural and psychotic symptoms). With respect to the former, first-line treatment is immunotherapy, typically corticosteroids, intravenous immunoglobulins or plasma exchange, in addition to the removal of any identified teratomas. Titres are effectively reduced by immunomodulatory treatments, including high-dose steroids, intravenous gamma globulin and plasmaphoresis.

Behavioural disturbance can be a marked obstacle to initiation of treatment, often requiring patients to be sedated for administration of plasma exchange.

Second-line immunosuppression may be necessary using rituximab or cyclophosphamide.

These are often required in individuals who receive a delayed diagnosis or those without a tumour.²⁶ Liba *et al*³² report use of alemtuzumab in an 8-year-old child with a positive outcome.

Treatment is generally thought to be more effective in patients who have an underlying tumour removed. Cases of ovarian teratomas discovered years after initial onset of symptoms have been described, particularly in patients who experienced a slow recovery.²⁰ Peery and colleagues describe a case where oophorectomy was performed despite negative scan results and on postoperative biopsy an occult teratoma was revealed, with subsequent improvement in clinical symptoms.³³

With respect to the immediate management of behavioural and psychotic symptoms, both typical and atypical, antipsychotics have been utilised. It must be noted that use of antipsychotics can complicate the picture, particularly prior to definite antibody diagnosis. The development of autonomic instability and rigidity may be mistaken for neuroleptic malignant syndrome. In addition, use of corticosteroids may result in confusion with a steroid-induced psychosis. Clonidine, trazadone and benzodiazepines have been used successfully for reversal of sleep disturbance.³⁴

Catatonic symptoms are typically treated with benzodiazepine medication. Doses of up to 20–30 mg of lorazepam daily have been used to manage symptoms in catatonia, although little has been published on its efficacy in anti-NMDA receptor encephalitis.³⁵ Electroconvulsive therapy (ECT), though the gold standard for treatment of catatonia in the absence of a response to benzodiazepines, is little studied in the area of anti-NMDA receptor encephalitis. Case reports of catatonic symptom response in anti-NMDA receptor encephalitis have been described.³⁶ Interestingly, in animal models of ECT action, an elevation of messenger ribonucleic acid (mRNA) of the NMDA subunits NR2A and NR2B has been demonstrated, leading to an up-regulation of the NMDA receptor.³⁷

Prognosis

According to Dalmau's original case series, approximately 75% of patients with NMDA receptor antibodies recover or have mild sequelae; the other 25% have severe deficits or die.² Subsequent studies have identified a 12–24% risk of relapse.^{9,34,35} Mortality of 7% at 24 months has been noted.⁴ Other studies have noted that approximately 25% of patients at diagnosis give a history of one or more similar symptom episodes in the months preceding diagnosis, indicating a more relapsing and remitting course of illness than initially described.²⁶

Titulaer *et al*⁴ in a cohort study of 577 patients noted that first-line immunotherapy resulted in an improvement in 53% of patients in the first 4 weeks of treatment, 97% of whom showed a good outcome at 24 months. In the 47% of patients who did not respond to first-line treatment, those who received second-line immunotherapy (i.e. rituximab, cyclophosphamide or both) had better outcomes than those who continued first-line treatment or received no further immunotherapy.⁴

Several prognostic factors are implicated. With respect to duration of illness and treatment outcome, Finke and colleagues³⁸ demonstrated a better cognitive outcome in a small cohort of adult patients with anti-NMDA receptor encephalitis who were treated with immunomodulatory therapy within 3 months of disease's onset compared with those who were treated at a later stage or not at all. The authors proposed that a delay in treatment may lead to permanent hippocampal damage,³⁸ yet the optimal time frame from onset of symptoms to treatment has yet to be determined.

Other identified predictors of outcome include: lower severity of symptoms, not requiring ICU admission, prompt initiation of immunotherapy and tumour removal where present.^{4,39}

Summary and implications to clinical practice

Anti-NMDA receptor encephalitis is a relatively newly identified and potentially treatable cause of psychiatric symptoms in both adults and children. Several hundred cases have been reported since its identification in 2007; however, clinicians may be unaware of developments in this field. It is vital for psychiatrists working across the age spectrum to be aware of this condition and to engage in timely liaison with our neurology colleagues, thus facilitating early screening and diagnosis.

There are a wide range of presenting symptoms and signs. Patients may present with prodromal features, followed by psychiatric and perhaps later physical manifestations. As outlined, anti-NMDA receptor encephalitis is easily diagnosed using a blood or CSF test. This presents the opportunity for early treatment, and a low index of suspicion should be considered for any patient presenting with a constellation of symptoms.

To date, the recommendation for screening has advised testing of those patients, particularly females, with an atypical new-onset presentation of psychosis with motor features. However, recent studies have questioned how readily this disorder is distinguishable from those where patients receive a purely psychiatric psychotic diagnosis.

It is clear that early identification and treatment may have serious prognostic implications. Delay to treatment with immunosuppressive therapy probably results in worsened outcomes, with evidence for permanent hippocampal damage.³⁸ Management may prove clinically challenging, from the perspective of treating both the cause and the symptoms. Initiation of antipsychotic treatment is not without risk in these patients and behavioural management may prove challenging.

Anti-NMDA receptor encephalitis is a potentially treatable form of psychiatric illness that is illuminating our understanding of the neuropathophysiology involved in some individuals who present with symptoms of psychosis.

1.8.35 The cardiovascular safety of the empirical measurement of the seizure threshold in electroconvulsive therapy

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Abstract

Aims and method The Royal College of Psychiatrists' Committee on Electroconvulsive Therapy (ECT) and Related Treatments advises the measurement of initial seizure threshold in all patients undergoing ECT if possible. The subconvulsive electrical stimulation inherent in this process is thought to increase the risk of bradycardia and therefore asystole. Our aim was to establish the prevalence of asystole (no heart beat for 5 or more seconds) during empirical measurement of seizure threshold in patients who had not received anticholinergic drugs, as we were unable to find any published reports of bradycardia or asystole prevalence under these conditions. The electrocardiogram traces of 50 such consecutive patients were analysed later.

Results Asystole occurred in 5% of stimulations. Each episode of asystole resolved spontaneously with no adverse outcomes. Contrary to expectations, asystole was no more prevalent in subconvulsive stimulations than in convulsive stimulations.

Clinical implications There was no evidence that the empirical measurement of the seizure threshold added to the cardiovascular risk of ECT.

Contents

- *The cardiovascular safety of the empirical measurement of the seizure threshold in electroconvulsive therapy*
 - *Method*
 - *Results*
 - *Discussion*

The electrical stimulus of electroconvulsive therapy (ECT) may have effects other than the induction of cerebral seizure activity. It was recognised soon after the introduction of ECT that the stimulus could affect the heart, usually causing a bradycardia resulting from the electrical stimulation of the motor nucleus of the vagus nerve and nucleus ambiguus, within the medulla oblongata. ¹ This bradycardia can be severe and as long ago as 1978 the American Psychiatric Association (APA) stated that the bradycardia might even be prolonged enough to cause cardiac arrest. ² Although no references were given to support this concern, asystole and cardiac arrest have been reported since. ³ The APA recommended the routine intravenous administration of an anticholinergic drug to reduce the risk of severe bradycardia, but this never became routine anaesthetic practice in the UK. The Royal College of Psychiatrists recognises that 'severe bradycardia can usually but not invariably be prevented by pre-treatment with anticholinergic agents' and that such vagolytic drugs are sometimes used to attenuate bradycardia, but it does not specifically recommend the routine administration of an anticholinergic drug. ⁴

Evidence from case reports has been taken to mean that severe bradycardia is more likely after subconvulsive electrical stimulation; that is, stimulation that does not lead to generalised cerebral seizure activity. ^{1,2,4} This is because seizure activity has an opposite effect on the heart, leading to tachycardia, whereas in subconvulsive stimulation the vagal effect is unopposed. ¹ Subconvulsive stimulation was uncommon in traditional ECT practice because fixed, high doses of

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electrical charge were delivered. Contemporary ECT machines can deliver adjustable doses and it is now recommended that the dose is titrated for the individual patient, particularly for bilateral ECT.⁴ The convulsive dose depends on the seizure threshold for the individual patient. This is measured empirically by stimulation with repeated, increasing doses of electrical charge at the start of the course of ECT. In contemporary practice, the vast majority of patients receive at least one subconvulsive stimulation at their first treatment in a course of ECT. The APA now notes that not all anaesthetists routinely use anticholinergic drugs, but also states that the bradycardia after subconvulsive stimulation is of 'graver' concern, and that many anaesthetists routinely administer such agents at treatments in which the measurement of seizure threshold is planned.⁵ Some ECT practitioners simply do not undertake empirical measurement of the seizure threshold in patients with a known history of cardiac disease.⁶

We aimed to investigate the prevalence of asystole during empirical measurement of seizure threshold in the absence of anticholinergic drugs.

Method

We analysed the printed paper record of the electrocardiogram (ECG) taken during the first treatment of 53 consecutive patients referred for a new course of ECT at the Royal Edinburgh Hospital between 12 February 2008 and 5 March 2010. An individual patient was included only once. Three of these patients are not included in the present report because the anaesthetist administered an intravenous anticholinergic drug before ECT; in all cases this was because of previous excessive salivation during ECT. The present sample therefore consists of 50 from 53 consecutive referrals for ECT. The intravenous induction agent was etomidate in 38 patients and propofol in 12 patients. Muscle relaxation was always achieved by intravenous suxamethonium, after precurarisation with 5 mg atracurium. The vast majority of patients ($n = 47$) were treated with bilateral ECT; the remaining 3 received right unilateral ECT.

All treatments were administered using a Spectrum 5000M ECT machine, which has an inbuilt two-channel electroencephalogram (EEG) facility to measure cerebral seizure activity. The protocol for the empirical measurement of the seizure threshold at the first treatment was as follows: the first stimulation was with 4% (46 mC), and if cerebral seizure activity did not ensue, then a second stimulation was given with 7% (81 mC). In patients prescribed an anti-epileptic drug, the first stimulation was with 9% (104 mC) and if no cerebral seizure activity ensued, then a second stimulation was given with 18% (207 mC). For both groups of patients the protocol included doses for third and subsequent stimulations, when necessary. The flow chart presented in *Fig. 1* shows the number of patients receiving one or more stimulations.

Our clinic participates in the Scottish national audit of ECT practice, coordinated and reported by NHS National Services Scotland. This paper includes demographic, episodic and treatment data routinely recorded and reported. The only change made to our routine data collection was to print a paper record of the ECG. These paper records were given a coded number by the ECT consultant (A.S.) and then stored outside the ECT clinic until they were read by an independent rater (L.M.); clinical and treatment information was masked to the rater. We used ECG lead II and the paper record ran at 25 mm/s.

The point when bradycardia becomes asystole is arbitrary. The criterion that 5 s (125 mm on the paper record) without a QRS complex constitutes asystole is taken from a previous report.⁷ Its authors also conducted a secondary analysis of patients in whom the asystole lasted as long as 7 s and so we also considered a secondary analysis with this definition of asystole. The analysis of the paper records was standardised by discussion among the present authors before analysis. The electrical stimulation led to a characteristic type of artefact on the paper record (*Fig. 2*) and the time from the end of this artefact (that is, the end of electrical stimulation) to the time of the first QRS complex was measured. The morphology of this complex had to be the same morphology as complexes before electrical stimulation, which meant ectopic beats were disregarded. If the independent rater was uncertain about the measurement of this time, she consulted C.M. and the time was agreed between these raters; patient details remained masked to L.M., and C.M. was shown only the paper record and any other clinical or treatment information was masked. The results were analysed using Microsoft Office Excel 2007 and StatsDirect Version 2.7.9 for Windows. As the inter-subject variance (between different patients) was *Fig. 1* Numbers of patients in the sample receiving one or more ECT stimulations. *Fig. 2* ECG with electrical stimulus artefact followed by a period of asystole. likely to be higher than the intra-subject variance (multiple stimulations in one patient), each electrical stimulation was considered as an independent measure. Convulsive and subconvulsive stimulations were compared using Fisher's exact test and the 'exact' or 'Clobber-Pearson' method

was used to calculate 95% confidence intervals of proportions.⁸ The episodes of asystole in different stimulations were compared using paired *t*-tests.

It is the policy of NHS Scotland to withhold from publication data that may identify individual patients.⁹ This report respects this principle.

Results

As shown in *Table 1*, the sample consisted of 37 women and 13 men (mean age 57.4, range 22–87 years). The most prevalent primary psychiatric diagnosis was severe depression with ($n = 18$), or without ($n = 16$), psychosis; 6 patients had moderate depression and 7 were diagnosed with other types of depressive disorder. Six of the total group of patients with depression had bipolar affective disorder. Schizophrenia was the primary diagnosis in 2 patients.

The majority of patients ($n = 38$) were prescribed a combination of psychotropic drugs, including tricyclic antidepressants ($n = 6$) and lithium carbonate ($n = 7$); 8 patients were prescribed monotherapy, 6 with an antidepressant drug, 1 with lithium carbonate and 1 with diazepam; 4 patients were not prescribed any psychotropic drug treatment. Five patients were prescribed a beta-blocking drug for hypertension. Of the 8 patients who experienced asystole, 3 were anaesthetised with propofol and 5 with etomidate. None of these 8 patients were on anti-epileptic medication and so they received the standard electrical stimulation protocol (rather than the higher doses administered to patients on anti-epileptics).

Table 2 shows that the time to first R-wave ranged from 0.04 to 9.12 seconds. Because of the nature of the titration procedure, most patients ($n = 47$) did not have a convulsion after the first stimulation and so experienced more than one electrical stimulation.

The data were analysed with each stimulus measured as an independent variable and the total number of stimulations given in the study was 172. Most patients ($n = 49$, 98%) experienced cerebral seizure activity (CSA) in this study and the one patient who did not underwent 5 electrical stimulations with no seizure. This patient did not experience asystole. The mean number of stimulations before experiencing CSA was 2.5. Our primary analysis was with asystole defined as 5 s without a QRS complex. With this definition, asystole occurred in 4/124 (3%) subconvulsive stimulations (95% CI 0.89 to 8.05%) and 5/48 (10%) convulsive stimulations (95% CI 3.47 to 22.66%). The number of subconvulsive stimulations is considerably higher than that of convulsive stimulations because, from the second stimulation onwards, the patient has experienced previous subconvulsive stimulations, but for convulsive stimulations the patient has not experienced any previous convulsive stimulations. Of the asystolic events, 6 occurred after a second electrical stimulation and the other 3 occurred after a third stimulation. Only one patient, a 70-year-old female with severe depression, experienced multiple episodes (2) of asystole, which were after her second (non-convulsive) and third (convulsive) electrical stimulation. The average age of the 8 patients who experienced asystole was 69.9 years and only 1 of them was male. Six of these patients were prescribed a combination of psychotropic medications and one was not prescribed any psychotropic drugs. Six of these patients had no documented history of cardiovascular disease.

Secondary analysis carried out using a definition of asystole of 7 s without a QRS complex reduced the number of episodes of asystole to 2. One of these followed a convulsive stimulation in a 72-year-old female with severe depression and a history of hypertension and ischaemic heart disease with previous stent insertion. She was the only patient (of three) taking a beta-blocker (atenolol) to exhibit asystole. The other episode of asystole lasting longer than 7 s was in a 70-year-old female with severe depression without a history of cardiovascular disease. It followed a second non-convulsive stimulation, lasted 9.12 s and was therefore the longest period of asystole noted.

A two-tailed Fisher's exact test, comparing convulsive and subconvulsive stimulations, did not reach statistical significance ($P = 0.12$), but the odds ratio was 3.46 (95% CI 0.71 to 18.27) suggesting that a patient was more likely to have an episode of asystole after convulsive rather than subconvulsive stimulation. We compared the first and second stimulations in patients who had two or more subconvulsive stimulations, using a paired *t*-test, and found that the mean time to the first QRS complex was statistically longer after a second subconvulsive stimulus ($P = 0.04$, 95% CI -1.72 to -0.04). We then compared the first and second stimulations in all patients who had two or more stimulations, regardless of whether they experienced Table 1 Demographic of the study sample Asystole No asystole Whole sample Total n 8 42 50 Demographics , , , Male, n (%) 1 (12.5) 12 (28.6) 13 (26.0) , , , Female, n (%) 7 (87.5)

30 (71.4) 37 (74.0) , , , Age, mean (s.d. range): years 69.9 (54.0–85.7) 55.1 (38.8–71.3) 57.4 (40.5–74.3) *Diagnosis*
 Depression, *n* (%) , , , Unspecified 2 (25.0) 4 (9.5) 6 (12.0) , , , Mild 1 (12.5) 0 1 (2.0) , , , Moderate 0 6 (14.3) 6
 (12.0) , , , Severe without psychosis 1 (12.5) 11 (26.2) 12 (24.0) , , , Severe with psychosis 4 (50.0) 10 (23.8) 14
 (28.0) Bipolar affective disorder, *n* (%) , , , Moderate 0 1 (2.4) 1 (2.0) , , , Severe without psychosis 0 4 (9.5) 4 (8.0)
 , , , Severe with psychosis 0 2 (4.8) 2 (4.0) Schizophrenia 0 2 (4.8) 2 (4.0) Schizophrenia 0 2 (4.8) 2 (4.0)
 Schizophrenia + severe depression 0 1 (2.4) 1 (2.0) Severe depression with psychosis + Alzheimer's disease 0 1 (2.4)
 1 (2.0) Psychotropic drugs, *n* (%) , , , No 1 (12.5) 3 (7.1) 4 (8.0) , , , Single 1 (12.5) 7 (16.7) 8 (16.0) , , , Multiple 6
 (75.0) 32 (76.2) 38 (76.0) History of cardiovascular disease, *n* (%) 2 (25.0) 10 (23.8)^a 12 (24.0) Beta-blocker
 prescribed, *n* (%) 1 (12.5) 4 (9.5) 5 (10.0) Anaesthetic agent, *n* (%) , , , Propofol 3 (37.5) 9 (21.4) 12 (24.0)
 , , , Etomidate 5 (62.5) 33 (78.6) 38 (76.0) Type of ECT, *n* (%) , , , Bilateral 8 (100.0) 39 (92.9) 47 (94.0) , , , Right
 unilateral 0 3 (7.1) 3 (6.0)²³ Table 2 Asystole in convulsive and subconvulsive stimuli Cerebral seizure activity
 induced No cerebral seizure activity induced Stimulation Convulsive

stimulations

n Time to first

QRS, median

(range)^a Asystole

n Proportion

(95% CI) Subconvulsive

stimulations

n Time to first

QRS, median

(range)^a Asystole

n Proportion

(95% CI) 1st 3 2.36

(0.88–3.00) 0 0.00

(0–0.71) 46

(+1 off-page)^b 1.32

(0.04–4.84) 0 0.00

(0–0.08) 2nd 20 1.18

(0.04–7.08) 2 0.10

(0.01–0.32) 27 1.48

(0.04–9.12) 4 0.15

(0.04–0.34) 3rd 21

(+1 unreadable)^c 1.88

(0.04–6.96) 3 0.14

(0.03–0.36) 5 1.36

(0.56–3.84) 0 0.00

(0–0.52) 4th 4 1.52

(0.04–4.44) 0 0.00

(0–0.6) 1 0.56 0 0.01

(0–0.98) 5th 0 0 0 0.00 1 0.96 0 0.01

(0–0.98) **Total 48 0.10**

(0.03–0.23) 124 0.03

(0.01–0.08)⁴⁵⁶ seizure activity (again using a paired *t*-test), and again found that the mean time to first QRS

² ECT, electroconvulsive therapy.

³ Including pulmonary embolism + one decision based on medications suggestive of cardiovascular disease.

⁴ Time given in seconds.

⁵ Off-page: an ECG trace that went off the side of the page and could not be analysed.

⁶

Unreadable: an ECG trace so distorted it could not be analysed.

post-stimulation was significantly longer after a second stimulation ($P = 0.03$, 95% CI -1.09 to -0.05). We also compared the time to the first QRS complex after second and third stimulations in all patients who underwent three or more stimulations, using a paired t -test, but did not find a statistically significant difference ($P = 0.36$, 95% CI -0.66 to 0.96).

All episodes of asystole in this study resolved spontaneously without medical intervention.

Discussion

Asystole (5 s without a QRS complex) occurred in 9 of 172 stimulations in this study (5%; 95% CI 0.02 to 0.10). As each episode of asystole resolved without medical intervention, our findings suggest that the empirical measurement of seizure threshold does not add to the cardiovascular risk of ECT, nor is there a need to routinely administer an anticholinergic drug. Contrary to expectation, asystole was more prevalent after convulsive than non-convulsive stimulation. We have also shown that time to the first QRS complex post-stimulation was longer in patients who received two subconvulsive stimulations rather than one. As increasing doses of electricity are given on subsequent stimulations when titrating up to seizure threshold, this could suggest that time to the first QRS complex simply increases together with the dose of electricity. This is supported by the fact that none of the episodes of asystole occurred after a patient's first electrical stimulation and that the comparison of first and second stimulations, regardless of whether or not seizure activity ensued, showed a statistically significant difference between the times to first QRS complex ($P = 0.03$, 95% CI -1.09 to -0.05). On the other hand, there was no statistically significant difference between second and third stimulations ($P = 0.36$, 95% CI -0.66 to 0.96). This may be because the effect of increasing doses of electricity and/or absence of seizure activity is lost after a certain threshold, or because neither the electrical dose nor presence or absence of seizure activity are factors influencing the risk of asystole and the effect seen at previous stimulations may be due to small sample size. Further studies with a larger sample size would help to delineate this.

Our results support those of Burd & Kettl,⁷ who found that although asystole was common in elderly patients undergoing ECT (364/1146, 40.1%), routine use of atropine was unnecessary because brief asystole was not associated with adverse outcome. Burd & Kettl studied patients throughout ECT treatment courses, not just during stimulus titration, which may explain the difference in incidence of asystole observed in our study. They also refer to reports of asystole lasting up to 7 s and so we attempted to conduct a secondary analysis using a definition of 7 s without a QRS complex. However, in our sample there were only 2 episodes of asystole which exceeded 7 s (1 in a convulsive stimulation and 1 in which no convulsion was stimulated) and so no statistical analysis of these episodes could be performed. In 1996, McCall *et al*¹⁰ used an even more conservative definition of asystole (10 s of ECG electrical silence) in an attempt to capture only pathological asystolic events. Using this cut-off there were no patients in our study who experienced asystole, again supporting the idea that the periods of electrical silence in our study were not pathological. Furthermore, only one of the patients in our study suffered more than one episode of asystole, which suggests that, for a given individual, one episode of asystole does not generally predict further similar events. A limitation of our study was that it was not possible to statistically analyse the other factors that could prolong the time to the first QRS complex, because of the small number of patients. Larger prevalence studies will be needed to further investigate these factors.

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1.8.36 Voicing Caregiver Experiences: Wellbeing and Recovery Narratives for Caregivers

Debbie Mountain¹

date

2015-2

Contents

- *Voicing Caregiver Experiences: Wellbeing and Recovery Narratives for Caregivers*

In this easy-to-read book, ten authentic carer stories of different styles have been collected. Each has different themes, many of sadness and loss, and they describe the roller-coaster ride that most have had to endure until eventually finding stability and some acceptance of the situation in their own and their loved ones' lives. Tips between carers are shared, especially those of encouraging and steering others towards empowerment both in managing their own, often ignored, needs and to negotiate the fragmented, bewildering and inconsistent care delivery arrangements.

The most notable theme is that of hope. The stories demonstrate the process of finding hope, not a superficial denial of the challenges that lie ahead, but something worthy of respect. This hope is borne in adversity, is effortful and those who do find it have to overcome years of difficult associations to have future positive expectations.

Another theme is that of the care triangle between service users, carers and professionals. Many speak of how devastating some professional attitudes and practices can be, leaving wounds that take years to heal. Many also speak of positive relationships with professionals that have the capacity to become pillars of strength.

These stories are of heroes, and their own contribution to their relative's wellness is often under-recognised, overlooked and underestimated. In addition, their own care needs are often ignored as their caring role becomes engulfing. Many require active encouragement and permission to attend to their own wellness. When we as professionals see carers presenting as fraught or distressed, we should honestly ask ourselves 'What would we do?' After reading these stories, I am doubtful any of us, even experienced clinicians, would know what it takes to manage some of the situations described, let alone find the peace than many carers achieve.

1.8.37 Providing free heroin to addicts participating in research – ethical concerns and the question of voluntariness

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date

2015-2

Abstract

Providing heroin to people with heroin addiction taking part in medical trials assessing the effectiveness of the drug as a treatment alternative breaches ethical research standards, some ethicists maintain. Heroin addicts, they say, are unable to consent voluntarily to taking part in these trials. Other ethicists disagree. In our view, both sides of the debate have an inadequate understanding of 'voluntariness'. In this article we therefore offer a fuller definition of the concept, one which allows for a more flexible, case-to-case approach in which some heroin addicts are considered capable of consenting voluntarily, others not. An advantage of this approach, it is argued, is that it provides a safety net to minimise the risk of inflicting harm on trial participants.

Contents

- *Providing free heroin to addicts participating in research – ethical concerns and the question of voluntariness*
 - *Two concepts of 'voluntariness'*
 - *Why the circumstances of heroin addicts might undermine the voluntary nature of their consent*
 - *Voluntary consent and risk-minimising ethical analysis*
 - *Conclusion*

In the bioethics literature, there has been considerable debate as to whether giving heroin addicts legal access to free heroin in connection with research on the effectiveness of heroin prescription as a treatment alternative constitutes a breach of ethical research standards. The ethical issue here is that the researcher must obtain the informed consent of the study participants. For their consent to be valid, individuals must give it voluntarily. The question is whether consent can be said to have been given voluntarily if the person has heroin addiction (we are assuming, of course, that they are neither intoxicated nor experiencing withdrawal symptoms at the time of giving consent). Those who claim that it cannot argue that it is in the nature of heroin addiction for individuals to lose their ability to resist their desire for heroin. Since a loss of ability means heroin addicts cannot refuse offers of free heroin, neither can we presume that they can give voluntary consent to take part in research that involves giving them a choice of free heroin. ¹ According to those who maintain that consent given by heroin addicts can be valid, this argument is flawed. Several studies show that financial concerns, fear of arrest, values regarding parenthood and many other factors influencing decisions in general often persuade a person addicted to heroin to cease their drug-oriented behaviour. ² That heroin addicts frequently respond to such incentives means that they cannot have lost the ability to resist their desire for heroin. We can presume, therefore, that heroin addicts have the competence to give voluntary consent to take part in trials involving the drug.

We want to argue that both sides in this debate are mistaken. Although it is plausible that many – perhaps even most or all – heroin addicts have the ability to resist their desire to take heroin, the degree to which their consent is voluntarily given greatly depends on the wider social and psychological circumstances under which they choose whether to consent or not. Focusing on these circumstances rather than universal and hard-to-verify claims about abilities of resistance allows for a more flexible, case-to-case approach, one that does not rule out the possibility that while some heroin addicts might be competent to give voluntary consent, some might not. One advantage of this approach compared with the alternatives is that it provides a safety net to minimise the risk of inflicting harm on the individuals who participate

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in these kinds of studies.

Before presenting our argument, a note of caution is in order: we do not want to claim that the answer to the ethical question raised by research on heroin prescription as a treatment alternative is alone sufficient to determine whether or not such research should be carried out. Even if the issue of voluntary consent in heroin trials was problematic, it does not follow that prescribing heroin as a treatment alternative should necessarily be banned. If, for example, the risks to the participants were small or non-existent while the benefits outweighed such risks, strategies that circumvent the normal standards of consent should indeed be considered. One such strategy could be to appoint some surrogate authority who is not involved in the study (e.g. a family member) to ensure the best interests of the participant, or perhaps to relax competence-defining criteria.¹ Whether prescribing heroin therapeutically is an effective way of treating heroin users needs to be determined empirically and will not be discussed here.

Two concepts of ‘voluntariness’

What does it mean to say that a consent is voluntary? In the bioethics literature it is widely agreed that a person acts voluntarily if he or she wills the action (performs it intentionally) without being under the controlling influence of another person or condition.³ Controlling influences are divided into ‘external’ and ‘internal’ depending on whether they are caused by the intentional actions of other persons (such as different forms of coercion or manipulation) or lack of internal self-control, an incapacity typically associated with mental illness. Although this characterisation of voluntary action is both plausible and, no doubt, helpful in many situations in which clinicians have to assess a person’s capacity, we believe it is ill suited to explaining how certain social circumstances and the beliefs they inform might sometimes constrain choices. This is because the circumstances and beliefs might exert a controlling influence on the person, causing them to feel pressured into performing certain actions (like enrolling in clinical trials, for example), without necessarily removing their internal capacity for self-control. In fact, we believe research on the effectiveness of heroin prescription as a treatment alternative provides an illustration of this, as we try to show in this article. First, however, we need to introduce another concept of ‘voluntariness’ that comes from political and legal philosophy.⁴ This will allow us to explain how social circumstances and the beliefs they inform could deprive a person of their voluntariness without removing their internal capacity for self-control. We introduce it here with a view to suggesting an alternative – and, we believe, important – perspective on the effects addiction might be thought to have on the voluntariness of heroin addicts’ consent that has been largely ignored in the debate about this issue. It is worth noting that it relies on a consequentialist ethical theory, which some readers may have objections about. We cannot provide a full conceptual defence of this notion or its ethical foundations here. Consequentialism, however, is a widely used approach in much ethical analysis in the field of healthcare.

Very briefly, this alternative concept of voluntariness begins by distinguishing between three types of options in terms of ‘acceptability’, where the standard for the acceptability of options is an objective standard of well-being. First, there are options that one strongly dislikes, which one holds to be ‘unacceptable’ in the sense that they bring one’s well-being below a certain threshold. These are options that are thoroughly bad because they involve losses it would be unreasonable to expect anyone to bear. Second, there are options that are undesirable but not thoroughly bad, which one holds to be ‘acceptable’ in the sense that they bring one’s well-being above a certain threshold. These are options that have sufficient value to be choiceworthy. Finally, there are options that bring one’s well-being up to a high level and that one likes so much that one chooses them. Consider then the following plausible definition of voluntary choice: a choice is voluntary if it is not made because no other acceptable alternative options are available. This negative definition implies the existence of two types of situations in which a person makes a voluntary choice. First, there are situations in which she has at least two acceptable options and chooses one of them because, all things considered, she prefers one option to the other. Second, there are situations in which she has at least one option that she likes so much that she chooses it because of that, whether or not there are any acceptable alternative options. In neither of these cases is her reason for making her choice not having other acceptable alternative options. One implication of this concept of voluntariness is that whether a choice is voluntary or not depends not just on the person’s internal capacity for self-control, but crucially also on her *beliefs* about her options and hence actual motivation for making the choice. As we argue in the next section, we cannot rule out that the social circumstances typical of many chronic heroin addicts affect their beliefs about their options in a way that undermine the voluntariness of their consent even if they retain their capacity for self-control (for an extended version of this argument, see Henden, 2013).⁵

Why the circumstances of heroin addicts might undermine the voluntary nature of their consent

To determine whether heroin addicts are able to give voluntary consent, assuming the understanding of voluntariness just outlined, we need to know something about their beliefs about their options. Of course, one difficulty is that heroin addicts are not all alike. Their individual circumstances including social and personal resources are likely to differ, and their beliefs about their options are therefore likely to differ as well. That being said, there is widespread consensus that heroin treatment is suited to a minority of heroin users as a second-line treatment for those individuals who do not respond to methadone or buprenorphine treatment delivered under optimal conditions.⁶ Thus, heroin trials have essentially sought to determine the therapeutic value of prescribing heroin to high-risk heroin users for whom such benefits cannot be expected or achieved by existing treatment options.⁷ When discussing the competence of heroin addicts to consent to participation in heroin trials we should therefore focus primarily on chronic addicts with a history of repeated treatment failure. The prevalence of health and social problems in this group of addicts is widely acknowledged.⁷ Major psychopathological studies of heroin users report rates of comorbidity that far exceed those of general population estimates. In addition to having high rates of comorbidity, it is well known that many individuals with chronic heroin addiction lead marginalised, impoverished lives, often associated with criminal activity, anxiety and high levels of risk. Can it be ruled out that such circumstances might create situations of constrained choice? We believe that it cannot. To see how such a situation could arise, consider first the option of obtaining heroin from the street. Many individuals reach a point in their chronic heroin addiction history in which their current lifestyles do not seem to them to be sustainable any longer; evidence of this is that many eventually seek help for their addiction. Presumably the costs of maintaining this lifestyle begin to exceed the benefits. Put in the terminology introduced in the last section, we might say that they come to consider a life centred on the procurement of heroin to be ‘unacceptable’ in the sense of no longer bringing their well-being above a certain threshold. Consider next the option of abstaining from heroin. For an action to be an acceptable option, it is not sufficient to have the ability or power to perform it. One must also *believe* one has that ability or power. There are many studies showing that mood disorders such as depression and anxiety lower belief in the person’s capabilities or perceived self-efficacy.⁸ Since there is a strong correlation between mood disorders and chronic heroin addiction, it is reasonable to assume that many heroin addicts harbour a low sense of self-efficacy and lack confidence in their ability to abstain from heroin.⁹ Chronic heroin addiction is associated with hopelessness about the future and a sense of powerlessness to influence the direction one’s life is going – reinforced by a history of failed attempts to abstain. Now, a lack of belief in one’s own ability is clearly detrimental to one’s will. Thus, according to a standard philosophical view, intentions involve plans of action and such plans, in order to be rational, require the belief that one has an acceptable chance of changing the world in ways one believes are for the better.¹⁰ Given this view, it would not be rational to form intentions one believes one is not going to carry out. The implication is that individuals with heroin addiction who have little belief in their capacity to abstain are likely to find it extremely difficult to form the intention to abstain. That is, since they believe they are going to fail if they try, they are likely to lack the will to abstain. Consequently, their commitment to changing their way of life may be low. Since believing one has reasons not to make an effort to exercise an ability (since one thinks it is futile) is not equivalent to lacking the ability, the problem here is not a lack of ability. The problem rather is an impairment of rational will due to a lack of belief in self-efficacy. It cannot be ruled out that such impairments of the will may lead some chronic heroin addicts to falsely believe abstinence is a non-option.

If this is correct, everything depends on the option of taking part in research. Will a person with chronic heroin addiction consider this option to have a high value, not just as an acceptable way of avoiding the hassle on the street or to get free heroin from a legal source, but as a way of improving their well-being so much that they choose it *because* of that? In fact, there appears to be little reason to think so. Many heroin addicts actually refuse to take part in these studies. In heroin trials in Switzerland, only a third of participants decided to take part when given the choice.¹¹ One reason, presumably, is that they find the costs of keeping regular appointments with healthcare professionals too high. Chronic heroin addicts who do consent must judge these costs as less important than the benefits associated with obtaining free heroin. Presumably, they consider the value of obtaining free heroin to be sufficient to make participation in research acceptable, even if they do not consider the combined value of obtaining free heroin and taking part in research to be very high.

To sum up, it cannot be ruled out that many chronic heroin addicts for whom the problems of procuring the drug on the street are unacceptable, but for whom abstinence is not an option, believe they have only one option, which is to consent to research involving the medical provision of heroin. Since there is evidence to suggest that they might choose this option not because they like it very much, but because they have no acceptable alternative options, their consent

could be construed as non-voluntary. What constrains their choice is not their desire for heroin, but the wider social and psychological circumstances of their heroin addiction and the beliefs about the options these circumstances create.

Our reasoning here is, of course, hypothetical. We have no empirical evidence of the contents of the decision-making processes in individuals with heroin addiction (nor do we know whether any such evidence exists). However, if it is a plausible reconstruction of what these processes might look like given the situational constraints and our current state of knowledge, it suffices, we believe, for our current purpose, to provide a reason why we should not take the voluntariness of their consent for granted.

Voluntary consent and risk-minimising ethical analysis

As we have argued, given a certain plausible conception of voluntariness, we cannot rule out that the beliefs held by individuals with heroin addiction about their options and hence their motivation for action might undermine the voluntariness of their consent even if they have the ability to resist their desire for heroin. One important reason for this is that the wider social circumstances typical of many such individuals may shape their beliefs about their capacity to make choices (such as making abstinence seem impossible) and these beliefs (which may be false) could then impair their will to abstain from heroin use. This suggests that paying special attention to these circumstances should form an integral part of the assessment of whether or not the person's consent is voluntary. However, the argument may perhaps strike some as overly philosophical. On what basis can we decide between different conceptions of voluntariness? Let us end with some more general considerations in favour of the view we have presented.

According to the World Medical Association's declaration on ethical principles for medical research involving human subjects (the Helsinki Declaration), the participation of human subjects in research requires the voluntary consent of individuals who are considered competent to give their consent (www.wma.net/en/30publications/10policies/b3/). What makes it so ethically challenging to assess whether, in the case of heroin research, a person is competent to give their consent voluntarily is, of course, that we have no uncontroversial concept of voluntariness that applies to the specific circumstances of heroin addicts, and we have no direct access to the mental processes of the consenting individual to accurately appraise whatever conception we lean towards. This means that judgements about voluntary consent will always involve uncertainty. How can we best deal with this uncertainty? An ethical way of justifying why one approach is chosen over another might be to compare the potential harm these approaches may inflict on the research participants. Such an overall account of harm will have to reflect the inherent uncertainty of the assessment and also include considerations of harm potentially caused by a flawed assessment.

In this article we have identified three different approaches to consent in individuals with heroin addiction:

a person's desire for heroin rules out any ability to choose freely between receiving heroin or not, hence we should presume that no heroin addict can voluntarily consent to medically prescribed heroin; heroin addicts have the ability to choose freely between receiving heroin or not, hence we should presume that all heroin addicts can voluntarily consent to medically prescribed heroin; the social and psychological circumstances of some individuals with heroin addiction might be such that we cannot presume that they can voluntarily consent to medically prescribed heroin.

Which of these approaches would minimise the harm inflicted on the person if they were used to inform an assessment of their competence to give voluntary consent?

Consider (a). There may be circumstances in which it might be better for some individuals with heroin addiction to receive free heroin under medical supervision than getting it on the street. That is, the harm inflicted on these addicts by obtaining heroin on the street might greatly exceed the potential harm resulting from participation in heroin trials, because of mistaken assumptions about valid consent. Thus, these addicts might end up worse off than if (a) had not been used as the basis for an assessment of voluntary consent. Ironically, the protective safety net of the ethical standard of valid consent breaks down in this case, and in fact inflicts more harm than if the standard were ignored. Next, consider (b). The circumstances of many individuals addicted to heroin might suggest that they have some chance of succeeding in abstinence-based drug treatment programmes. However, this option of trying to achieve a life free of heroin is effectively ruled out if they receive heroin medication on a regular basis. Consequently, the harm these individuals may suffer could be considerable if their consent is accepted as valid without further questioning. Again, they could end up worse off than if we had not used (b) as the basis of the assessment of voluntary consent. Finally, consider (c). This approach differs from (a) and (b) by focusing on the particular person's social and psychological

circumstances (including motivating beliefs) as the basis of the assessment, rather than on universal and hard-to-verify claims about abilities of resistance of persons with heroin addiction. It therefore allows for a more flexible, case-to-case approach, one that neither rules out competence to consent voluntarily nor rules it in. This option would minimise the risk of inflicting more harm than if (c) had not been applied. Consequently, the potential of inflicting harm by assuming this approach is smaller compared with (a) and (b).

Conclusion

Philosophy and medicine are inherent to mental healthcare. Clinical assessments of mental non-observable categories rely on adequate philosophical conceptualisations. Since the adequacy of these conceptualisations cannot be settled *a priori* and uncertainty will always be involved whenever attempts are made to confirm or reject their appropriateness *a posteriori*, philosophy offers a means of identifying the most apt conceptualisation according to a risk-minimising ethical analysis. An assessment of capacity for voluntary consent in individuals with heroin addiction should be based on an approach that minimises the risk of harming them more than if the approach were not applied. According to our argument, focusing on addicts' social and psychological circumstances (including motivating beliefs) as the basis of an assessment rather than their abilities of resistance is the most apt approach in this regard. We therefore suggest that this approach to the assessment of participant consent should guide and inform an ethical practice of including and excluding heroin addicts in research on heroin provision.

1.8.38 Reforming the culture of healthcare: the case for intelligent kindness

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Abstract

There has been increasing interest in the culture of healthcare in the light of the two reports by Robert Francis into the care at Mid Staffordshire. This editorial encourages a comprehensive exploration of the conditions that promote a benign caring culture and make outbreaks of cruel neglect and abuse of patients less likely. Creating and sustaining such a culture is dependent on being honest and realistic about the forces that threaten to undermine it. The editorial argues that being able to confidently articulate the positive values that should define healthcare culture is particularly important at this time. The case is made for a conscious focus on the concept of intelligent kindness.

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- *The emotional task*
- *Problematic team-working*
- *Problematic organisations*
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- *Corrupting forces?*
- *Focusing on compassion and kindness*
- *‘Intelligent kindness’*
- *Conclusion*

Robert Francis’ two reports into the Mid Staffordshire scandal, ^{1,2} other inquiry reports such as Winterbourne View ³ and, most recently, Julia Neuberger’s inquiry into the Liverpool Care Pathway ⁴ face us with the reality that healthcare organisations and the healthcare workers within them are capable of neglectful and abusive behaviour that can justifiably be described as cruel. The outrage presses towards sackings and resignations, to a ‘never again’ attitude, or, in various quarters, towards further denigration of the National Health Service (NHS) as a public enterprise. The determination to do something directs us towards yet more regulation and hundreds of other initiatives. Many of these actions may make a difference, but there is a risk that they will become yet another ‘programme’ of activity, on top of an already toppling tower of initiatives, and vulnerable to becoming a mechanical activity rather than keeping their purpose (securing kindness and compassion) in mind.

There has been a general call to address the culture of the NHS. Again, there are signs that this will become another programme – split off from or, at best, sitting alongside, others like the drive for efficiency, promoting choice, etc., rather than a comprehensive consideration of the totality of the conditions in which the NHS works, a genuine exploration of how the NHS culture promotes kindness, or cruelty.

As part of this enterprise, this editorial makes the case for a more conscious and active focus on the concept of intelligent kindness in all parts of the healthcare system. It starts, however, by exploring the forces that create perverse dynamics that can pull in the opposite direction.

The emotional task

Why do seemingly caring staff behave unkindly? This question can be looked at from many perspectives, starting at the level of the individual. ⁵ While it is clearly important to think carefully about recruitment criteria and to encourage people to think clearly about their motivation to work in healthcare, studies suggest that the majority of healthcare students are motivated by the wish to make things better, but during their training become more distanced from patients and less empathic. ^{6,7}

Raymond Tallis, British philosopher and retired professor of geriatric medicine, comments on the enormity in the history of civilisation of the imaginative and moral step involved in engaging with the realities of illness. ⁸ He describes a challenging process of cognitive self-overcoming on the part of humanity and reminds us that humans found it easier to assume an objective attitude towards the stars than towards their own inner organs. This self-overcoming – surely one of humanity’s greatest achievements – has to be done on an individual level by thousands of NHS staff every day as they muster the will, the necessary balance of kindness and professional detachment, to perform the most intimate tasks imaginable. It is easy to forget the appalling nature of some of the jobs carried out by healthcare staff day in, day out – the damage, the pain, the mess they encounter, the sheer stench of diseased human flesh and its waste products.

Contact with emotional distress and disturbance can be equally, if not more, harrowing. Existential questions about identity, suffering, madness and death are raised and may put people in touch with extreme feelings of confusion, pain and loss. ⁹ The struggle with feelings of helplessness and hopelessness in the face of suffering cannot be avoided, and individuals, depending on their personality and past experience, protect themselves in different ways from the emotionally traumatic environment. ¹⁰ Psychological defence mechanisms are evoked frequently. Problems can arise if staff are exposed to frequent emotional trauma, without space to process their feelings. Defensive styles of coping

then become entrenched. ¹¹ As defensive walls build up, feelings of vulnerability and sadness become more deeply buried and the capacity for empathy recedes.

Problematic team-working

Attachment to a well-functioning group can help to contain disturbed feelings and facilitate a healthy focus on the emotional task, but groups can also be the scene of disturbed – often unconscious – dynamics. ¹² There is evidence that the quality of the team one is working within makes a lot of difference to staff experience, can buffer the effects of a wider dysfunctional organisation ¹ and enhances functioning generally. ¹³ Unfortunately, many hospital teams are not highly evolved in their functioning as teams. They tend to have unclear boundaries and conflicting objectives, with different professions approaching the task from different perspectives and tensions sometimes arising between professional and organisational hierarchies. In addition, many staff are on rapid training rotations or can be moved without consultation to cover shortages in other teams. The breakdown of close-knit medical ‘firms’ means patients often complain that they see a series of junior doctors and do not know the name of their consultant. Many staff, particularly senior staff, have a peripatetic role and belong in many different ‘teams’. Although most hospital staff say they belong to a team, Borrill *et al* ¹⁴ show that more than 60% are in what they call pseudo-teams, with no obvious cohesion or boundary. Responsibility-shifting, driven by fending off anxiety between team members or between teams in wider system, is a particularly prevalent dynamic in health and social care. ^{15,16}

Problematic organisations

Menzies Lyth’s famous study of nurses in the 1950s sought to understand why nurses resigned from their profession in such high numbers. ¹⁷ It showed that the stresses of nursing, and the intimate relationship it demanded with patients, made an impact on the organisation of care, leaving those closest to patients exposed to emotional pressures that most senior staff and managers were defended against. Menzies Lyth felt that the work of nursing – what she called the objective situation – because it involves physical and emotional contact with illness, pain, suffering and death, arouses feelings and associated thoughts linked to the deepest and most primitive levels of the mind. She proceeded to show how the organisation of the hospital can be seen as consciously and unconsciously structured around the evasion of this anxiety.

Menzies Lyth proposed that the success and viability of a social institution are intimately connected with the techniques it uses to contain anxiety. In the intervening years, these ideas have been developed, looking at the goodness of fit between organisation structures on the one hand, and the emotional demands of healthcare work on the other. There is little sign that the system as a whole has developed effective structures to support frontline staff process the emotional disturbance inherent in their interactions with sick patients; in fact, evidence from the annual staff surveys suggests the opposite (www.nhsstaffsurveys.com). Moreover, there is little understanding or attempt to contain the primitive anxieties that pervade the system and affect all involved, including decision makers at government level. If anything, there is more disconnection between the policy level of the organisation and the emotional reality of clinical encounters. ¹⁸

Whereas much of Menzies Lyth’s 1959 study could be describing the health service of today, there is one important difference. Menzies Lyth noted the resistance to change in the NHS of the 1950s and saw it as a significant part of the social defence system. I suggest here that it is the uncritical promotion of constant change and imposition of new ideologies that is the main social defence system in the modern health service, ¹⁹ overloading and fragmenting the system and distracting from the task of caring for the sick and dying. ²⁰⁻²³

Perverse dynamics

The health service sits within a broader society that shapes its rules, agreements and unconscious social pacts. The spirit of cooperation that was around in the immediate aftermath of the Second World War provided a fertile value base for implementing the NHS, but has been steadily encroached upon by individualism, consumerism and the hegemony of market forces. Susan Long describes and gives evidence for this in her book *The Perverse Organisation and Its Deadly Sins*.²⁴ A basic premise of her book is that there has been a move in society generally from a culture of narcissism to elements of a culture of perversion. Perversion flourishes where instrumental relations have dominance – in other words, where people are used as a means to an end, as tools and commodities rather than respected citizens. It is these relations that Long sees predominating increasingly. Her book considers large private corporations rather than the public sector. However, the fashion to idealise large private sector corporations and the subsequent corporatisation of the public sector means much of the thinking in her book is relevant to the modern health service.

It is important to realise that Long's emphasis is on perversity displayed by institutions rather than by their leaders or members. There is no suggestion that individual NHS workers, as people, are any more perverse than workers in any other organisation. Nevertheless, in reality, an organisation and its members are entwined: the decisions and actions of individuals are influenced by organisational culture and, in turn, reinforce it, for good or ill. The concept of perversion sheds light on frankly exploitative behaviour, helps explain how many people in positions of trust end up abusing those positions and how people may be collectively perverse despite individual attempts to be otherwise.

Corrupting forces?

There appear to be four closely intertwined processes at work. None of them is perverse in itself, but separately and together they can create perverse dynamics in the context of healthcare. The first is the active promotion of a competitive market economy, on the basis of a commodified view of need, skills and service. Such an economy works against the idea of an integrated service that prioritises the needs of vulnerable patients, and can insidiously affect the attitudes, feelings and relationships of staff.^{25,26} The second is the process of industrialising healthcare.^{27,28} This enterprise has the potential to undermine healthcare as work undertaken by skilled individuals in relationships with patients and to turn it into the mechanical delivery of processes and systems. The third is the framework and currency of specification, regulation and performance management. How services are specified, monitored and evaluated – and funded – has a profound effect on the day-to-day clinical work.^{29–31} The fourth is the inexorable rise of consumerism and the promotion of patient 'choice'. These four elements are of course interrelated and, some would say, reflect inevitable trends in society at large. But of particular concern is the way these processes have taken hold without proper debate and understanding of the unintended consequences for the system as a whole.

Focusing on compassion and kindness

In the light of the present crisis in the culture of our healthcare system, it is particularly important to be able to talk in terms of positive values, to have a clear vision of how we would like to see our organisations function, how we wish to encourage society – and the organisations that serve society – to relate to the sick and vulnerable. The NHS was founded at a particular point in history when there was a strong motivation to create a better future based on the idea of the common good – a concept that may be out of fashion but is still enshrined in the NHS constitution.³²

If our public organisations are to flourish, we need to be able to articulate our aspirations in ways that resonate with today's citizens. A number of writers and philosophers have attempted to address the worrying narrowing of the moral universe in organisational life: Paul Ricoeur refers to the loss of ethical intention in public life;³³ Onora O'Neil talks about the growing culture of suspicion linked to increasingly excessive accountability regimes and urges us to free professionals and their public services to serve the public;³⁴ Michael Sandel talks about the squeezing out of altruism and argues that we put limits on the current encroachment of market thinking into every sphere of life;³⁵ and Tony Judt made an appeal before he died that we rediscover a language around which we can be motivated collectively, whether on the issue of justice, inequality, cruelty or unethical behaviour – a language that will bind us together.^{36,37}

There has been a focus recently on compassion in healthcare.^{38,39} Although the popular press tends to see this as a nursing issue, there is wider acknowledgement that creating a more compassionate culture will need a systemic

approach. There has been a growing interest more generally in compassionate leadership and the ‘compassionate organisation’ (www.compassionateleadership.com; <http://instituteforcompassionateleadership.org>).⁴⁰

It is clear – and understandable from an evolutionary perspective – that if a person is feeling under threat, it is likely that the compassionate components of the mind are turned off and instead the mind has a pattern of motivation and ways of feeling that are about protecting oneself from danger. This is of obvious relevance to the NHS workforce and points to the creation of a culture that feels safe and affirming rather than unsettled and threatening.⁴¹

Clearly, there is a large overlap between the concept of compassion and the concept of kindness. Both words are defined in relation to other people: compassion literally meaning ‘suffering with’ whereas kindness is linked to the concept of kin and kinship. Kindness is a word very commonly used by patients. Many people’s stories about their experience of healthcare centre around the degree and quality of kindness they have (or have not) experienced. Often these accounts are complaints about the absence of kindness, the thoughtlessness, the lack of humane care. Sometimes they describe the power of small, but highly relevant, acts of kindness to transform an otherwise miserable experience of suffering (www.patientopinion.org.uk).^{42,43}

Kindness is a word with an interesting history. It is also a word that needs rescuing for it can evoke mixed feelings in the modern world and easily become a mere synonym for individual acts of generosity, sentiment and affection, for a general fuzzy ‘kindliness’. The warping and obscuring of what kindness is about have been extensively discussed by psychoanalyst Adam Philips and historian Barbara Taylor in their recent book, *On Kindness*.⁴⁴ They explore the way in which a philosophy and culture of competitive individualism and the pursuance of self-interest has challenged the value, and negatively influenced the meaning, of kindness. Kindness, they say, is not a temptation to sacrifice ourselves, but to include ourselves with others – kindness is being in solidarity with human need. They describe a process in which what had been a core moral value, with a subversive edge, at centre stage in the political battles of the Enlightenment, became something sentimentalised, marginalised and denigrated through the 19th and into the early 20th century.

‘Intelligent kindness’

Kindness has its roots in the Old English word *cynd* – meaning nature, family, lineage – kin. Kindness implies the recognition of being of the same nature as others, being of a kind, in kinship. It implies that people are motivated by that recognition to cooperate, to treat others as members of the family, to be generous and thoughtful. The word can be understood at an individual and at a collective level, and from an emotional, cognitive, even political point of view. Adding the adjective ‘intelligent’ signals, first that it is possible to think in a sophisticated way about the conditions for kindness, and second that clinical, managerial, leadership and organisational skills and systems can be brought to bear purposively to promote compassionate care. Intelligent kindness, then, is not a soft, sentimental feeling or action that is beside the point in the challenging, clever, technical business of managing and delivering healthcare. It is a binding, creative and problem-solving force that inspires and focuses the imagination and goodwill. It inspires and directs the attention and efforts of people and organisations towards building relationships with patients, recognising their needs and treating them well. Kindness is not a ‘nice’ side issue in the project of competitive progress. It is the ‘glue’ of cooperation required for such progress to be of most benefit to most people.

To illustrate how such behaviour is nurtured in the wider system a virtuous circle is envisaged, where there is not only a compassionate connection between the clinician and the patient, but the potential for something to happen in the wider system (*Fig. 1*).

There is a body of evidence that supports this virtuous circle, cited elsewhere.⁴⁵ Simply put, the more attentively kind staff are, the more their attunement to the patient increases; the more that increases, the more trust is generated; the more trust, the better the therapeutic alliance; the better the alliance, the better the outcomes. The result of all this is a reduction in anxiety, improved satisfaction (for staff and patient), less defensiveness and improved conditions for kindness. This system will flourish if individuals and the system as a whole are driven by a sense of kinship. This can be expressed as simply as seeing oneself in the patient – or as the King’s Fund put it, seeing the person in the patient and delivering the sort of care you would like for your family and friends.⁴⁶ This sense of kinship will promote the feeling and expression of kindness which then directs attention, and so on.

These dynamic processes can also contribute to productivity, a key challenge for all health services. A useful concept in the industrial model is that of ‘getting it right first time’ as a key driver for eliminating waste – of *Fig. 1* Intelligent

kindness: a virtuous circle. time and resources. All stages and the combined effect of this cycle contribute to such effective activity. The more work is founded on kinship, motivated by kindness and expressed through attentiveness and attunement to the patient's needs, the more it is likely to be timely and 'right first time'.

Conclusion

Kindness rooted in kinship is a powerful concept – ethically, politically, socially and clinically – in the project of improving healthcare. It increases patient satisfaction, staff morale, clinical effectiveness and efficiency. But virtuous circles are vulnerable and we know from history how quickly a benign culture can become malignant. The first part of this editorial described some of the difficulties inherent in the healthcare task that make a benign culture difficult to sustain if they are not properly understood and managed.

Menzies Lyth's work on social defence systems in healthcare was published over 50 years ago. In general, though, there has been a failure to create organisations that are fit for purpose and able to facilitate the emotional work that is such an important component of the healthcare task. There has been a failure to acknowledge and get to grips with the way overwhelming anxiety – largely unconscious – can unhelpfully drive and undermine the system. Moreover, it is suggested that some of the changes in society over this time period have had an impact on the health service in a way that has amplified the amount of anxiety in the system, pulling the culture in a direction where perverse behaviours become more likely. Many would say the system has already become a vicious circle where so-called 'solutions' involve overloading the system and creating ever more dangerous levels of anxiety. Virtuous circles unravel so easily; vicious circles, on the other hand, are extremely difficult to break.

It is more important than ever to have an explicit value base underpinning the work of both individual staff members and healthcare organisations, and to understand what that value base looks like 'in action'. The virtuous circle described here earlier could provide a basis for thinking about this, strengthening relationships between colleagues and with patients, and counteracting the pressures to adopt instrumental attitudes to the work that are all too prevalent at the present time. The possibility emerges of a kinder culture developing as all aspects of the NHS – evidence, skill, new technologies, where money is spent, how people are managed – are scrutinised in terms of how they support this virtuous circle.

At an anecdotal level, individuals report that the concept of intelligent kindness properly embedded in reflective practice has 'reconnected them to their altruism'; and teams from ward to board level have found the virtuous circle a helpful focus when thinking about culture change. There is scope for adapting the model for research and audit purposes, building on the evidence base for relational science to influence the organisation of healthcare delivery and outcome.

1.8.39 Our Encounters with Self-Harm

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- *Our Encounters with Self-Harm*

When I was working as a junior doctor in accident and emergency, one of my favourite jobs was suturing. A pleasant break from the constant decision-making, an opportunity to do something practical and almost artistic, and most of all a chance to just sit down and chat with the patient as I stitched. Despite this, one of my least favourite tasks was patching up those who had self-harmed. Something about the sight of the self-inflicted wounds upset me far more than the most horrendous accidental injuries; I tried to still be warm and not allow the distress and disgust I felt show, but I did not know what to say and we would often sit in silence as I worked. I had never been taught about non-suicidal self-harm, what it serves, how to approach it, anything. It was not until I began my psychiatric training that I began to understand it, and became retrospectively frustrated with how I had felt and responded to it earlier in my career. I now ensure I cover this subject in some depth with my medical students, to try to avoid them feeling about self-harm the way that I used to. Alternatively, I could just make them read this book.

Our Encounters with Self-Harm is made up of 37 pithy chapters by different authors. The majority are written by those who have, or still do, self-harm, and others are by family members and professionals (the last of which I found the least educational; an interesting reminder not to dismiss personal accounts in an era where quantitative research often feels the only thing that counts). Most take the form of a piece of prose about the writer's personal experience, followed by a short bullet-point list of thoughts that they would like the reader to take away from it.

These pieces are brave, articulate, occasionally harrowing, and frequently illuminating. Since it is an anthology, unsurprisingly there is a certain amount of repetition within the book. This is no complaint; it serves to reinforce the most common themes such as: accept that this is my coping mechanism, find out what it means to me, look beyond the act of self-harm to treat the person behind it with kindness. Meanwhile, the divergences remind us of other key points such as not making assumptions and remembering that 'everyone who self-harms is an individual, so everyone's self-harm has individual meaning'.

Buy this book and force every medical and nursing student you encounter to read a chapter from it. I suspect it would significantly improve in the future the care that patients presenting to accident and emergency with self-harm receive. While you are at it, share it with your psychiatric colleagues; a reminder of empathy and a deepening of our understanding of our patients can never go amiss. As one of the contributors writes, 'whatever you learn, get it out there, you never know who might benefit from your own experiences'.

1.8.40 Anti-NMDA-receptor encephalitis presenting with catatonia and neuroleptic malignant syndrome in patients with intellectual disability and autism

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Abstract

We report anti-*N*-methyl-d-aspartate (NMDA) receptor encephalitis in two patients with autism and intellectual disability presenting with neuropsychiatric symptoms of catatonia and neuroleptic malignant syndrome. Case reports such as these help raise awareness of this clinical issue. By paving the way for earlier diagnoses they ultimately maximise the potential for curative treatments and prevention of long-term complications.

Contents

- *Anti-NMDA-receptor encephalitis presenting with catatonia and neuroleptic malignant syndrome in patients with intellectual disability and autism*
 - *Case studies*
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 - * *Case study 2*
 - *Discussion*
 - * *Differential diagnoses*

Anti-*N*-methyl-d-aspartate (NMDA) receptor encephalitis is a recently recognised syndrome, which can be mistaken for psychiatric disorders. It is potentially reversible with appropriate treatment. It is usually idiopathic but can be associated with tumours, particularly ovarian teratomas in female patients. Surgical excision of the tumour (if present) and immunotherapy are currently considered optimum treatment for anti-NMDA-receptor encephalitis.

An increasing recognition has been given to the aetiological role of the immune system in the pathogenesis of various psychiatric disorders and early diagnostic tests have been recommended to rule out autoimmunity.¹⁻³ Anti-NMDA-receptor encephalitis is one of the recently described autoimmune encephalitides⁴ with a prominently psychiatric presentation.⁵ It is important to diagnose and treat anti-NMDA-receptor encephalitis. Untreated, it can lead to cognitive deficit and death.⁶ Definitive diagnosis relies on the detection of anti-NMDA-receptor antibodies, using a highly specific and sensitive assay, yielding no false positives as yet.⁷ The reduction in NMDA-receptor antibodies with clinical improvement supports the pathogenic role of antibodies in anti-NMDA-receptor encephalitis.⁸

A publication in the *British Journal of Psychiatry* describes four cases of anti-NMDA-receptor encephalitis initially presenting with signs and symptoms suggestive of a psychiatric disorder.⁹ We report two cases of anti-NMDA-receptor encephalitis presenting with catatonia and neuroleptic malignant syndrome (NMS) in individuals with autism and intellectual disability.

Case studies**Case study 1**

A 32-year-old single woman with a diagnosis of mild intellectual disability, autism and Larsen's syndrome presented with social withdrawal and a persistently low mood. Subsequently, her sleep and oral intake deteriorated. A preliminary diagnosis of depression was made and she was put on an antidepressant. Unfortunately, her skills deteriorated further and her parents had to attend to her basic needs. She then showed objective evidence of hallucinations when she would shout incoherently or burst into laughter for no apparent reason. She was therefore started on a low-dose antipsychotic medication but then developed incontinence, muteness and rigidity. She maintained a sedentary position

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and needed a wheelchair to be moved around. There were classic catatonic signs and symptoms such as negativism, echolalia and posturing. At this stage NMS was suspected as the patient had low urine output, low-grade fever, clammy skin and fluctuation of blood pressure. Her psychotropic medication was stopped and she was urgently admitted for further assessment. Investigations revealed a normal creatine kinase (CK) level and no evidence of infection or metabolic imbalance. With many presenting symptoms being of a psychiatric nature, an initial diagnosis of functional catatonia was thought most appropriate. Consequently, treatment with psychotropic medication was reinitiated targeting the psychotic and mood symptoms. Despite this, her condition continued to deteriorate. She then had at least two episodes of non-convulsive seizures (with inter-ictal electrocardiogram (EEG) not showing any evidence of epileptiform activities) and several episodes of what were initially thought to be breath-holding attacks. A referral to the respiratory department ruled out bronchomalacia reported in Larsen's syndrome. As her oxygen saturation and chest X-ray were normal, these episodes were first thought to be behavioural in nature. She later developed a rabbit-like movement of the lips, which lasted for 2 weeks. Magnetic resonance imaging (MRI) scans of the head and spine were normal.

Anti-NMDA-receptor encephalitis was suspected in view of her complex presentation and normal investigations. A serum sample later on in the course of illness was strongly positive for anti-NMDA-receptor antibodies. Following diagnosis, a thorough investigation was undertaken to rule out the presence of an underlying tumour, particularly an ovarian teratoma, which has been reported in a considerable number of cases of anti-NMDA-receptor encephalitis in females.^{10,11} Abdominal and pelvic ultrasound, brain MRI and chest, abdominal and pelvic computed tomography (CT) scans, blood tests for tumour markers and other autoimmune disorders revealed no abnormalities. By the time she received intravenous methylprednisolone, she had started to show improvement and this gradually continued with the second course.

During recovery she suffered mild amnesia. She would often be searching for something that she was actually holding in her hand, for instance a mobile telephone or spectacles. Owing to a prolonged period of immobility, she developed a flexion contraction in her upper and lower limbs, which improved partially with physiotherapy. Six months later, she had completely recovered with no evidence of psychosis or cognitive deficit and all her skills, apart from ability to walk, returned to a pre-morbid level. She is now awaiting orthopaedic intervention to facilitate her mobility.

Case study 2

A 42-year-old single man with moderate intellectual disability, autism and a history of affective psychosis in remission presented with urinary retention requiring catheterisation. This was attributed to anticholinergic side-effects of his psychotropic medications. These were therefore stopped. He later developed sepsis and needed to be treated with intravenous antibiotics. At this point, his estimated glomerular filtration rate had reduced dramatically (27 ml/min) and his urea and creatine increased (13.3 mmol/l and 240 umol/l respectively); as he also was on lithium, this had to be stopped to avoid toxicity. Following treatment, his kidney function tests came back to normal but his condition deteriorated and he displayed aggressive outbursts and insomnia. Given his recent history of urinary retention/renal failure, extreme aggression and a history of affective psychosis, he was subsequently treated with a new generation antipsychotic, aripiprazole, but this could not be continued because of allergic skin rashes. A few days following the cessation of aripiprazole he appeared vacant and confused, unable to communicate, and was rolling on the floor while kicking out in the air. Owing to extreme agitation, he needed benzodiazepine agents and intensive two-to-one support to ensure he did not sustain injury. The floor and walls of the room were covered with soft mattresses to prevent any skin breakdown due to friction on the floor. He had speech and language therapy input to prevent aspiration but soon stopped oral intake completely. With a working diagnosis of acute delirious state, he underwent extensive investigations including blood tests, lumbar puncture and brain scan, which all were reported as normal. His EEG at this stage reported generalised low-amplitude slow-wave activities in line with a mild diffuse cerebral dysfunction.

Since all investigations were within normal range, the clinical picture was attributed to a rapid withdrawal of his psychotropic medications and therefore a low dose of olanzapine (2.5 mg daily) was started. However, he deteriorated and his vital signs started to fluctuate. Blood investigations revealed extremely raised CK level (5369 iu/l). His white blood cell counts, kidney and liver function tests, however, were within normal range. Olanzapine was stopped and a working diagnosis of NMS was made. He received intravenous bromocriptine but even after CK level came back to normal, he did not show any improvement. During this time he presented as non-responsive, with decreased level of consciousness and some repetitive swinging movements of his arms and legs. All the investigations, including brain

MRI scan, lumbar puncture and numerous blood/urine tests came back as normal. Swallowing difficulties with a high risk of aspiration resulted in the requirement of a radiologically inserted gastrostomy. He subsequently developed pneumonia and was placed on positive airway pressure for a short time. Treatment with intravenous antibiotics resulted in recovery of pneumonia but he developed severe diarrhoea owing to *Clostridium difficile*.

At this stage it was felt that his condition could not be explained simply by a change in his medication or NMS and further investigations revealed positive anti-NMDA-receptor antibodies. Various investigations, including tests for other autoimmune encephalitides, tumour markers and chest, abdominal and pelvic CT scans were carried out to rule out an associated neoplasm, which has been reported to co-occur with anti-NMDA-receptor encephalitis in male patients,¹² but the results came back negative. He was treated with methylprednisolone, after which he started to improve cognitively; however, he continued to go through latter stages of the disease and developed seizures and orofacial dyskinesia. He had another course of methylprednisolone and gradually, over a period of a few months, started eating and walking.

Discussion

These two cases of anti-NMDA-receptor encephalitis, in individuals with intellectual disability and autism, presented with signs and symptoms of NMS and catatonia. In both patients the diagnosis was made with delay owing to the complexity of their presentation.

One of the characteristic features in Case study 1 was the presence of autonomic dysfunction which manifested with clammy skin, low-grade fever, persistent sinus tachycardia and fluctuation in blood pressure. These were unrelated to an underlying infection or dehydration. The patient also had short-lived episodes of central apnoea which confusingly presented itself similar to breath-holding attacks, which were first thought to be behavioural in nature. Autonomic instability in Case study 2 presented with episodes of urinary retention necessitating frequent catheterisations. Both patients developed frequent urinary and chest infections, muscle atrophy and contractures needing a multi-agency approach and intensive skin care to prevent pressure sores. During the first few months of their illness, both patients required two-to-one staffing support on a daily basis. In spite of intensive multi-agency support provided by the health and social care services, the experience was overwhelmingly traumatic and stressful for the families who had to cope with witnessing the patients going through a life-threatening and debilitating illness.

Differential diagnoses

Anti-NMDA-receptor encephalitis can be mistaken for psychosis¹³ or catatonia.^{14,15} Concerns have been raised that catatonia is underdiagnosed. One study¹⁶ found that in Scotland the prevalence of catatonia varied depending on the diagnostic criteria used, ranging from 1.3 to 32%. In that study the prevalence of psychiatric patients demonstrating any catatonic signs was at least 7.9–19.1%. The most common catatonic signs were marked underactivity, echolalia, palilalia, marked overactivity and *gegenhalten*. In those with catatonic signs, the most common diagnoses were schizophrenia, schizoaffective disorder, dementia and non-psychiatric disorders (1.5%).

Malignant (lethal) catatonia presents with clouding of consciousness, autonomic instability, mutism, refusal to eat and drink, rigidity, waxy flexibility and posturing, and can be mistaken for NMS. Raised creatine kinase-skeletal muscles isoenzyme and leukocytosis are present in both conditions. It has therefore been suggested that, on the basis of the similarity of signs, symptoms and response to treatment, malignant catatonia and NMS should be considered to be the same disorder; NMS may also be understood as an antipsychotic-induced form of lethal catatonia.¹⁷ Interestingly, both NMS and catatonia might be seen in a patient at the same time, with one evolving into another in the course of illness.^{18,19}

Catatonia resistant to benzodiazepine and electroconvulsive therapy has been treated with NMDA-antagonists (amantadine and memantine).²⁰ Theoretically, however, these may exacerbate anti-NMDA-receptor encephalitis. Care should be therefore taken to avoid diagnostic overshadowing in people with autism and intellectual disability who have communication difficulties, as early treatment prevents mortality and long-term cognitive complications.²¹ A recent case report of catatonia in a deaf patient²² highlights this important issue in a vulnerable population with communication difficulties.

It is also important to be aware of other differential diagnoses such as viral encephalitis,²³ a catatonic state induced by a psychiatric disorder or catatonia seen in people with autism spectrum disorder,²⁴ substance misuse, serotonergic syndrome, heat stroke,²⁵ other autoimmune encephalitides such as antiphospholipid syndrome,²⁶ and catatonia induced by pernicious anaemia.²⁷

This report highlights the complex presentation of anti-NMDA-receptor encephalitis in two patients with intellectual disability and autism. Whether or not people who have underlying brain pathology are more prone to develop this type of encephalitis or have a worse prognosis in comparison with the rest of the population needs further exploration through future case studies and multicentre research projects.

We are grateful to our patients and their families who kindly gave permission for the publication of this case report. We also thank our colleagues from allied healthcare professions for their invaluable input in the management and rehabilitation of our patients.

1.8.41 Preventing Mental Ill-Health: Informing Public Health Planning and Mental Health Practice

Benjamin Bouquet¹

date

2015-2

Contents

- *Preventing Mental Ill-Health: Informing Public Health Planning and Mental Health Practice*

This book covers an ambitious breadth of material concerning the definition, determinants and interventions for prevention of mental ill health. The sheer scale of material covered means that the reader should not expect an in-depth critique of all the evidence presented and this can pose questions around the methodology and conclusions of studies. The author notes that she is an agnostic entering the houses of such new religions as biological psychiatry and positive psychology. Their differing perspectives occasionally lead to a conflict in argument, which is not always resolved. Psychiatric labels are defended for their contribution to research, while later it is reported that improved understanding of schizophrenia has derived from breaking the diagnosis down into constituent symptoms.

My favourite statistic from the book is the reported finding that 2.4% of women from a Basque-speaking rural area screened positive for depression compared with 11% of women in a Spanish-speaking village in the Basque region. The degree of integration in each community is cited as an explanation, echoing the famous theories of Emile Durkheim around suicides and social cohesion.

Despite a thought-provoking chapter on ‘society, status and participation’, the focus of the book is very much on the individual’s place within society. There is a good discussion of negative consequences of housing policy and a look at unemployment and inequality, but in terms of social determinants of mental health, I was left wondering how to build societies with the kind of integration that seems so protective. For the individual, the take-home message is that what matters is to feel loved, safe, valued and in control.

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1.8.42 Heads in the sand may leave old age psychiatry looking foolish and vulnerable

: Commentary on ... A memory clinic v. traditional community mental health team service

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Abstract

Dementia has been recognised as a major challenge to health, social care and economies. Research by Rubinsztein and colleagues, in this issue, has compared the services provided by memory clinics with those of traditional community mental health team services. They conclude that memory clinics offer a more comprehensive and multidisciplinary service at no extra cost. Here I will question some of their findings and highlight the importance of better continuity of care between primary and secondary services.

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- *Heads in the sand may leave old age psychiatry looking foolish and vulnerable*
 - : *Commentary on ... A memory clinic v. traditional community mental health team service*
 - * *Rubinsztein et al's research*
 - * *Identifying weakness in existing services*
 - * *Conclusions*

These are heady times for the dementia lobby. London's G8 Conference on dementia was the latest in a series of national and international 'think-ins' that has seen the condition emerge from the shadows of denial and neglect to be recognised as the single most significant challenge to health and social care, economies and personal philosophy now and for the predictable future.¹

The Guardian's letters page and a thoughtful article from Richard Ashcroft laid bare the realities of our situation.^{2,3} Awareness of dementia has been improved, but are services being made available to help people affected by it and are the research initiatives producing better lives and reducing stress associated with the condition? Richard Ashcroft's mother-in-law received a diagnosis and was discharged after two contacts by 'old age psychiatry', leaving her, her family and general practitioner to feel left adrift in a sea made no-less frightening by having acquired a label.

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Rubinsztein *et al*'s research

Judy Rubinsztein and her colleagues⁴ provide an interesting and important description and analysis of what happens when someone with a memory problem is referred by primary care for specialist assessment and advice. They compare the experiences and costs associated with a memory clinic, the model that has become the Holy Grail of assessment through the National Dementia Strategy,⁵ and assessment with less formality by a community mental health team (CMHT). Referral rates were similar: 5 per 1000 of the over 64-year-old population per annum. The CMHT patients were older, they were less impaired and were seen more quickly after referral. The diagnostic spectra were similar. Neither service was bedevilled by a long waiting list such as is described by many floundering services.⁶ Stakeholders were happy with both systems but measures that equate quality with assessment by more than one profession, and make use of formalised paper protocols and checklists, prefer the memory clinic model: memory clinic patients were twice as likely to receive a copy of the letter summarising the findings and plans for their future care.

The increased 'quality' attributed to the memory clinic is said to be achieved at no greater, actually lesser, cost. Yet, we might wonder how useful all those paper scaled measures are and many will question the costings: digging deeper we find that half of patients referred to the CMHT service were seen only once, and by a consultant in their own homes. The paper judges this to be poor practice, yet this is not reflected in stakeholder views. It might alternatively be viewed as an elegant and efficient approach that reserves multidisciplinary assessments at the clinic, which are time-consuming, less convenient and more costly for patients and carers, for people with more complex presentations. The memory clinic model might be construed as: 'one-size-fits-all' with everyone attending the clinic, 22/33 having two to six contacts. This is the sort of consideration that makes people question the advantages of clinic-based services. The differential that deems the CMHT model more expensive relates exclusively to travel costs, where the high salary of consultants who are travelling and one outlier who was visited eleven times, load the CMHT pricing. This is a brave and important attempt to capture costs and relate these to activities and effectiveness. It leaves us to reflect how difficult a task this is.

The paper opens a fascinating window on what actually happens in this world of dementia care. A total of 35% per cent of people 'eligible' for cholinesterase inhibitors did not receive them. This is the reality and gives a degree of balance to criticism of the UK for its relatively low rate of prescribing these substances:⁷ even when assessed, not every patient will accept such treatment, others will encounter side-effects or become disabused. One wonders what is happening in those countries that report prescriptions to near 100% of the predicted prevalence of Alzheimer's disease.

Three CMHT patients (10%) were retained for further care, but only 1 of 33 in the memory clinic was directed to their CMHT. One patient (out of 66) received cognitive stimulation therapy and three saw a neuropsychologist. The memory clinic is applauded for 'signposting' more patients to other services: third sector, social services or benefits. Overall, Richard Ashcroft might be forgiven for feeling that not much of substance is evident after the initial flurry.

Identifying weakness in existing services

The arguments in favour of including specialist memory services within the spectrum offered by old age psychiatry and other disciplines are strong, cogent and widely accepted.⁸ With great respect, however, both models described here are failing. Their referral rates are such that they cannot close the gap that still exists between predicted prevalence and diagnosed prevalence.⁹ There is no increase in referrals associated with the memory clinic arrangement, nor are the patients seen by that clinic earlier in the course of their dementia (as measured using the Mini-Mental State Examination). Tellingly, neither makes a tangible contribution to the continuity of care that patients, families and colleagues in other agencies respect and expect.

Variations that simply replace doctors with cheaper nurses, rate per hour¹⁰ may not be more cost-effective. They are more likely to rely on standardised protocols with inclusion/exclusion criteria designed to be risk-avoidant and limit workload rather than respond to patient need.¹¹ Lessons from the 10/66 studies and initiatives encourage the use of low-tech, clinically competent approaches with training and support to local healthcare agents.^{12,13}

In countries with established large populations of older people, including the UK, the realisation is that we must bring specialist skills into primary care so that people with dementia can be assessed, treated and supported by a competent local team that knows them as whole people with multiple strengths and multiple weaknesses associated with a range of pathologies.¹⁴⁻¹⁶ Models that do this achieve referral rates more than twice those reported in East Anglia, sustain

patients, carers and primary care colleagues throughout the journey of dementia and other frailties before death, and reduce expenditure on secondary health care.¹⁷

Despite the rhetoric of ‘war on dementia’, and exposure of the myth of the dependency ratio,¹⁸ actual service support for older people, including those with dementia, has been reduced by 30% in this country.¹⁹ Populist politicians are given column space to stir up unjustifiable resentment against old people.²⁰

Psychiatrists and their colleagues need to remain clear-headed, open and honest as advocates and providers for people with dementia and their families. We are learning what works and is affordable and this is what matters.

Conclusions

Rubinsztein and her colleagues have done us good service in dissecting and comparing the innards of clinic-based and community-based memory services. They have answered some questions and opened others to be pursued, which is all to the good; but we must lift our heads from the sand of what we have been doing within the comfort and discomfort of secondary care to work across the false border that is assumed between primary care and secondary care. There is little to be gained from a well-made diagnosis unless it is part of a meaningful, continuing process of care for the patient and their caring family.

1.8.43 Cognitive-behavioural therapy by psychiatric trainees: can a little knowledge be a good thing?

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Abstract

Aims and method To establish the competency of psychiatric trainees in delivering cognitive-behavioural therapy (CBT) to selected cases, following introductory lectures and supervision. Supervisor reports of trainees rotating through a national psychiatric hospital over 8.5 years were reviewed along with revised Cognitive Therapy Scale (CTS-R) ratings where available. Independent *t*-test was used to compare variables.

Results Structured supervision reports were available for 52 of 55 (95%) trainees. The mean result (4.6, s.d. = 0.9) was at or above the accepted level for competency (3) for participating trainees. Available CTS-R ratings (*n* = 22) supported the supervisor report findings for those particular trainees.

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Clinical implications This study indicates that trainees under supervision can provide meaningful clinical interventions when delivering CBT to selected cases. The costs of supervision need to be judged against these clinical gains.

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- *Cognitive-behavioural therapy by psychiatric trainees: can a little knowledge be a good thing?*
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 - * *Supervisors' structured ratings of all trainees delivering CBT*
 - * *Trainees' ratings of supervisors*
 - *Discussion*

Developing competencies in psychotherapy is a requirement of basic psychiatry specialist training in both the UK and Ireland.^{1,2} Of the psychotherapies, cognitive-behavioural therapy (CBT) has gained increasing prominence both as a treatment alternative and adjunct to medication due to its proven efficacy in the treatment of mood,³ anxiety,⁴ psychotic⁵ and eating disorders.⁶ In England, the Improving Access to Psychological Therapies (IAPT; www.iapt.nhs.uk) outlines the government's commitment to use CBT in the future.⁷ This highlights a clear practical need for all psychiatric trainees to develop competencies in CBT.

In clinical practice, psychotherapy is often delivered by psychotherapy trainees under supervision, such as post-doctoral fellows or pre-doctoral interns in psychology or social work.⁸ Previous work by Brittlebank & Owens suggests that psychiatric trainees can deliver CBT effectively to patients.⁹ To date, much of the literature on psychiatric trainees delivering CBT has focused on comparing the recommendations of the Royal College of Psychiatrists with clinical practice^{9,10} and looking at strategies to improve its organisation.¹¹ Recommendations such as improving the availability of supervision,¹² protected time¹³ and suitable cases have been made.^{14,15} Although there has been literature published on the assessment of psychotherapy competencies for psychiatric trainees,^{16,17} to the best of our knowledge, there is little published on the competency of psychiatric trainees to actually deliver CBT based on structured feedback from supervisors and the use of structured tools such as those found on postgraduate psychotherapy courses.

Cognitive-behavioural therapy supervision sessions are based on an established format.¹² This incorporates agenda-setting, case discussion/review of session, didactic discussion of the CBT model for the presenting problem, questions for supervision, plan for next session with patient, homework task (e.g. recommended reading) and audio/videotape review if available. Trainees are expected to work with their patients for up to 12 sessions and are encouraged to record their sessions (audio or video) with the patient's consent. Trainees should attend regular supervision sessions with their allocated supervisor. Excerpts from the therapy session recordings are listened to and used as a tool to guide the trainee's supervision.

In addition to structured supervision reports, a further method of establishing trainee competence is the revised Cognitive Therapy Scale (CTS-R).^{18,19} The CTS-R is widely used in postgraduate CBT training courses as a way of grading course work and, although not without controversy, is considered the gold-standard measure of clinical competence.

We hypothesised that psychiatric trainees would perform effectively and competently as CBT therapists (based on structured supervision reports) if well supervised and if allocated suitable, uncomplicated cases.

Our aims were as follows:

to retrospectively review all available supervision reports for psychiatric trainees rotating through a national psychiatric hospital to investigate their competency at delivering CBT; to investigate whether CTS-R reports, where available, supported the findings of the supervisor's report; to investigate trainee satisfaction with receiving CBT supervision.

Method

The study was undertaken in St Patrick's University Hospital, a 300-bed facility in Dublin affiliated with the University of Dublin, Trinity College. It has a well-developed psychotherapy service. The hospital receives trainees from the Dublin University Psychiatric Regional Training Programme (DUPRTP) on 6-month rotations.

Since 2009, there has been a single, time-protected psychotherapy post on the DUPRTP located in this hospital, with supervision provided by a consultant psychiatrist with psychotherapy training. The time for this CBT delivery is protected by another trainee covering their work. Obtaining this post is a competitive process and trainees are expected to complete at least one case using CBT during their rotation.

All therapists working in the hospital have been accredited by the British Association of Behavioural and Cognitive Psychotherapies (BABCP) and are involved in training and examining on the cognitive psychotherapy course, University of Dublin, Trinity College, which uses the CTS-R extensively.

All trainees at the outset of their 6-month rotation in St Patrick's University Hospital were invited to provide psychotherapy with CBT under supervision. Initial consultant-led teaching is provided on basic psychotherapy and CBT skills. This comprises of three introductory 2-hour seminars for each 6-month intake of trainees at the hospital. The teaching sessions comprised: introduction to the CBT model; cognitive distortions; structuring a session; use of behavioural techniques; guided discovery and Socratic questioning; planning a course of therapy; and use of supervision.

The cases undertaken by the trainees were recruited from both out-patient and in-patient CBT waiting lists and assessed for suitability prior to allocation. Suitable training cases were individuals deemed to have a typical Axis 1 disorder²⁰ without active complications or comorbidities, who were easy to engage interpersonally. Trainees were encouraged to record their sessions using audiotape or videotape – with patient consent – for discussion at supervision. Supervision sessions occurred fortnightly.

Following the end of therapy, supervisors completed a structured report used by the hospital's psychotherapy service for rating trainees, using the common headings: Establishing a therapeutic relationship; Ability to apply CBT model; Understanding of model preparation; Use of supervision time; and Overall. They rated trainees using a simple Likert scale (0–6) that was incorporated from the CTS-R¹⁸ and work by Dreyfus.¹⁹ Ratings are: 0, negative impact; 1, no impact (neutral); 2, minimal impact; 3, some positive impact; 4, moderately successful impact; 5, successful impact; and 6, highly successful impact. A result of 3 or over for each item indicates competence.

All trainees under supervision were invited to submit an audio/videotape recording to be assessed using the CTS-R. The CTS-R¹⁸ is a revised version of the existing Cognitive Therapy Scale.²¹ The rater assesses trainee competence in 12 areas:

agenda setting and adherence
feedback
collaboration
pacing
efficient use of time
interpersonal effectiveness
eliciting appropriate emotional expression
eliciting key cognitions
eliciting behaviours
guided discovery
conceptual integration
application of cognitive change
homework setting.

Ratings are given using the same 7-point Likert scale as described above to establish the trainee's competency in each area. A result between 36 and 48 from a total of 72 establishes competency in that assessment.^{18,21} The CTS-R has demonstrated high internal consistency and interrater reliability.²²

Trainee satisfaction with the quality of supervision and free-text comments were also recorded using a specifically designed questionnaire (details available from the authors on request). Trainees were asked about: availability of supervision; atmosphere conducive to feedback; availability of suitable cases; supervisor's ability to communicate theory; and an overall rating.

Following approval by the hospital's ethics committee, we reviewed all available supervisor reports and CTS-R ratings made between July 2004 and December 2012.

Results

Over an 8.5-year period, 95 trainees expressed interest in participating in training to treat a patient using CBT (*Fig. 1*). Twenty-one trainees subsequently dropped out, citing lack of free time for psychotherapy and work pressures.

Seventy-four trainees attended introductory lectures and were allocated to a CBT supervisor. Of these, 37 attended supervision with nurse therapists and 37 attended supervision with the consultant. Nineteen trainees attended an initial supervision session but could not recruit a training case or a suitable training case was not available. Of the 95 trainees, 55 (58%) treated at least one patient using a CBT model.

Complete data were available for 52 of the 55 participants (95%). The remaining three supervisor reports were not completed or could not be located. Of the 55 participating trainees, 7 rotated through protected psychotherapy.

Characteristics of trainees

In total, 55 trainees treated a patient using CBT (55% male, mean age 31 years (range 25.1–42.8)). All were psychiatric trainees pre-membership (MRCPPsych) with no previous experience of delivering CBT. Trainees had spent a mean of 15 months (s.d. = 8.2) in psychiatric training.

Of the 55 trainees, 7 completed a protected training post. Characteristics of this subgroup were well matched to other trainees (43% male, mean age 31 (range 26.5–32.8)).

In total, 38 trainees took on 1 case, 14 trainees took on 2 cases, and 3 trainees took on 3 cases (total = 76 patients). Twenty-two trainees (40%) availed of the opportunity to have an assessment rated using the CTS-R. For those trainees who saw more than one case, we reviewed their CTS-R from their first case only.

Patient characteristics

Of the 76 patients seen, the initial working diagnoses included depression ($n = 21$), obsessive-compulsive disorder ($n = 12$), social anxiety ($n = 10$), panic disorder ($n = 7$), generalised anxiety ($n = 7$), health anxiety ($n = 3$), low self-esteem ($n = 2$) specific phobia ($n = 2$), eating disorder ($n = 2$), non-epileptic seizures ($n = 1$), behavioural activation ($n = 3$), anger management ($n = 3$), psychosis ($n = 2$) and borderline personality ($n = 1$).

Supervisors' structured ratings of all trainees delivering CBT

The average result for the complete data available for the 52 trainees was found to be at or above the accepted level for competency (3) across a range of areas. Results for each item were: Establishing a therapeutic relationship, mean = 4.6, s.d. = 0.7; Ability to apply model, mean = 4.4, s.d. = 0.9; Understanding of the model/reading preparation, mean = 4.5, s.d. = 0.9; Use of supervision time, mean = 4.7, s.d. = 0.9; and Overall, mean = 4.6, s.d. = 0.9. Trainees in the protected post ($n = 7$) scored higher in all areas of the supervisor's report compared with non-protected posts ($n = 45$). The greatest difference was seen in trainees' ability to apply the CBT model and the use of supervision time (*Table 1* and *Fig. 2*).

There was a significant difference ($P < 0.001$) in the supervisor scores obtained by those trainees ($n = 22$) who submitted an audio/videotape to be reviewed using the CTS-R (mean = 4.9, s.d. = 0.158) compared with the remaining ($n = 30$) trainees (mean = 4.28, s.d. = 0.13): $t(50) = 15$ (*Table 2*). Of the 22 trainees who submitted a tape, 7 were in the protected psychotherapy post. The remaining trainees ($n = 15$) were in a range of general adult psychiatry posts.

The average rating for all 22 trainees was 41.74 (s.d. = 5.16). Trainees were rated highest in interpersonal effectiveness (4.14) and eliciting key behaviours (3.89) and cognitions (3.63), and lowest at eliciting appropriate emotional expression (2.98). The results of the CTS-R findings are displayed in *Table 3*.

Trainees' ratings of supervisors

Of the 55 trainees, 49 (89%) rated their satisfaction with supervision over the training period. Six trainees did not return forms. The majority reported the supervision they received as either excellent, very good or good in separate areas: availability of supervision (48/49, 97%); atmosphere conducive to feedback (49/49, 100%); availability of cases (41/49, 84%); supervisor's ability to communicate theory (49/49, 100%); and overall satisfaction (49/49, 100%). Remaining trainees rated the availability of cases as adequate or unsatisfactory and 1 trainee rated the availability of supervision as unsatisfactory.

Free-text section feedback suggested that trainees wished for more opportunities to continue with psychotherapy training, more suitable training cases to apply the CBT model and more protected time. Those who agreed to have an audio/videotape reviewed using the CTS-R found it helpful for guidance as to what areas to focus on for future therapy sessions. Anecdotal feedback from supervisors suggested that the training experience was positive; however uncontracted 'goodwill' supervision of psychiatric trainees was felt to place an unsustainable extra demand on busy CBT practitioners. Arranging CBT supervision within the same multidisciplinary team was deemed ideal as the psychiatric trainee can take on cases that would have been allocated to the team's CBT practitioner.

Comparison of mean structured ratings for trainees in protected and non-protected and non-protected posts

Supervisor rating	Protected posts ($n = 7$) mean score	Non-protected posts ($n = 45$), mean score	Overall ($n = 52$) mean score
Establish therapeutic relationship	5.1	4.5	4.6
Ability to apply model	5.4	4.2	4.4
Understanding of model/reading preparation	5.4	4.3	4.5
Use of supervision time	5.7	4.5	4.7
Overall	5.5	4.4	4.6

Comparison of mean structured supervisor ratings for trainees who did (+) and did not (-) submit a recording to be rated using the revised Cognitive Therapy Scale (CTS-R)

Supervisor rating item	Mean supervisor rating CTS-R (+) ($n = 22$)	Mean supervisor rating CTS-R (-) ($n = 30$)	Overall mean ($n = 52$)
Establish therapeutic relationship	4.8	4.5	4.6
Ability to apply model	4.7	4.1	4.4
Understanding of model/reading preparation	4.8	4.2	4.5
Use of supervision time	5.1	4.3	4.7
Overall	5	4.3	4.6

Discussion

We conducted a retrospective review of supervisor assessments for psychiatric trainees who, under supervision, engaged in a programme of delivering CBT to patients. The completion rate in our study (58%) was broadly similar to that reported in other similar studies¹¹ evaluating a CBT training programme for psychiatric trainees. Our findings suggest that trainees can provide meaningful clinical interventions when delivering CBT under close supervision and with carefully selected cases. The mean rating for all trainees (i.e. 4.6, s.d. = 0.9) means that their CBT therapy had at least a moderately successful impact, which supports our primary hypothesis. Obstacles to participation cited by trainees included well-documented reasons of work pressures^{11,15} and lack of protected time.¹³ As the structured feedback shows, trainees who did participate found it a positive experience.

Trainees bring many strengths to the delivery of therapy as a result of their medical training, including knowledge of psychopathology and diagnostic systems and being used to working independently. Medicine as a profession has a strong academic base and doctors as professionals value characteristics such as ‘competence’.²³ A particular strength for the trainees in this study was their ability to establish a therapeutic relationship with clients. Indeed, this ability forms the foundation for delivering Table 3 Revised Cognitive Therapy Scale (CTS-R) ratings from 22 trainees who submitted a tape to be reviewed CTS-R item Mean rating

(*n* = 22) 1. Agenda setting and adherence 3.142. Feedback 3.203. Collaboration 3.324. Pacing efficient use of time 3.935. Interpersonal effectiveness 4.146. Eliciting appropriate emotional expression 2.987. Eliciting key cognitions 3.638. Eliciting behaviours 3.899. Guided discovery 3.3310. Conceptual integration 3.4011. Application of cognitive change 3.5812. Homework setting 3.20 Total (out of 72) 41.74 (s.d. = 5.16) therapy itself.^{24,25} It is likely to have contributed to trainee success.

Trainees who were in a dedicated psychotherapy post (*n* = 7) obtained higher supervision scores than those who were not (*n* = 45). They were time-protected during their delivery of therapy and were immersed in a team environment dedicated to delivering CBT. Furthermore, in obtaining their psychotherapy post, they were self-selected as having already an established interest in delivering psychotherapy. These factors are likely to have contributed to them obtaining higher scores than those who did not have protected time.

The competency ratings using the CTS-R are in line with the structured supervisor reports. For those who were assessed using the CTS-R, trainees were rated highest in interpersonal effectiveness and eliciting key behaviours and cognitions. They rated lowest at eliciting appropriate emotional expression. This is in keeping with our experience of supervising psychiatric trainees. Eliciting emotional expression is challenging because it requires the trainee to leave their established role as a doctor and enter the more experiential role of a therapist.

There was a significant difference in supervisor ratings in favour of those trainees who submitted an audio/videotape to be reviewed using the CTS-R (*n* = 22) compared with those who did not. We propose that these self-selected trainees were inherently more confident at delivering CBT to patients, as they agreed to an additional rating scale using the CTS-R. Trainees who did not submit a tape for CTS-R review were not surveyed as to reasons why, which retrospectively would have been helpful. Encouraging and engaging more apprehensive trainees in psychotherapy training and specifically video feedback may be a challenge. In many ways it is these trainees who might benefit most from structured/objective feedback. Meeting this challenge requires a judicious blend of mandatory training requirements and a supportive, non-judgemental training environment.

This study has several limitations. To reliably assess competencies on the higher diploma in cognitive psychotherapy offered by Trinity College, for example, one would need to examine one case report, one essay, three tapes and a class presentation. This study employed structured supervisor reports completed at the end of therapy and CTS-R assessments in some cases. The CTS-R was assessed at one time point during the course of therapy and ideally two time points should have been used.²² Furthermore, although all supervisors had been accredited by the BABCP, ideally an external supervisor should have also assessed the CBT delivered by trainees to remove any bias.¹¹ We do not have completed outcome measures from participating patients, which would have been useful.

With adequate planning, as in this study, trainees after a mean of 15 months’ training could treat selected cases with CBT, thus helping to address the demand for increased provision of ‘talking therapies’. Supervisors highlighted that

some supervision was delivered on a ‘goodwill’ basis and suggested that the cases chosen should come from the list of that particular team’s allotted therapist, thus helping to reduce their workload and enable them to provide supervision and protect their time. Trainees themselves can support their competencies by using structured outcome measures and session recordings when providing CBT. This can further help to demonstrate the therapeutic value of trainees’ CBT casework in resource-pressured clinical services.

Training in psychotherapy such as CBT affords the trainee the opportunity to enrich their role as a psychiatrist and gain valuable skills that can help them and the patients they treat throughout their career. In addition, it provides trainees with a valuable insight into a therapeutic intervention that they will be either delivering themselves or referring to another provider. As indicated in this study, trainees can provide meaningful clinical interventions when delivering CBT under close supervision and with carefully selected cases. The costs of training and supervision need to be judged against these clinical gains.

The authors would like to thank all the patients, trainees and supervisors who took part in this study.

1.8.44 Lorna Wing OBE, MD, FRCPsych Formerly psychiatrist and physician, Social Psychiatry Unit, Institute of Psychiatry, King’s College London, co-founder of the UK National Autistic Society

Christopher Gillberg

date

2015-2

Contents

- *Lorna Wing OBE, MD, FRCPsych Formerly psychiatrist and physician, Social Psychiatry Unit, Institute of Psychiatry, King’s College London, co-founder of the UK National Autistic Society*

Fig. 16: Lorna Wing. © Rex Features.

The psychiatrist and autism researcher Lorna Wing, OBE, has died at the age of 85. Lorna Wing was the figurehead of autism knowledge and the one person in the field of autism research who always had it right, right from the start. She has been a pioneering figure both clinically and scientifically. A whole world including colleagues, patients and relatives mourn her death. She contributed to a better quality of life for millions of people with autism.

Lorna Wing studied medicine at University College Hospital Medical School, London and specialised in general psychiatry shortly after qualification. After obtaining her specialist diploma she was appointed in the mid-1960s to a position in the Social Psychiatry Unit at the Institute of Psychiatry, where she worked until she retired. In the 1960s Lorna, with other parents, was deeply involved in the formation of the UK National Autistic Society, aiming to develop better services for children and older people with autism. The organisation established the first specialist schools for children with autism and later also adult services.

After retirement from university employment, Lorna continued to be professionally active. In 1991, together with Judith Gould, under the auspices of the National Autistic Society, she co-founded the Centre for Social and Communication Disorders for diagnosis, assessment and guidance for people of all ages. In 2008 this was re-named the Lorna Wing Centre for Autism. Lorna Wing specialised in general psychiatry after medical school and worked in the 1960s, 70s and 80s at the Institute of Psychiatry in London, where her landmark studies on social communication disorders changed the concept of autism. Her early epidemiological work together with her husband John and Victor Lotter, and later with Judith Gould resulted in a new delineation of the syndrome, a so-called triad of impairments in the areas of social interaction, social communication and social imagination, which later – in a modified form – became the definition of autism. The three problem areas are still referred to as ‘Wing’s triad’.

In the 1980s Lorna Wing launched the concept of an autism spectrum, and – together with our group in Gothenburg – she was among the first to realise that autism could be considered dimensionally, have very many different aetiologies and affect all age groups and people at all levels of intellectual abilities. When, together, we published reports in the 1990s stating that the likely prevalence of autism was about 1%, other groups considered this to be overstated, but time has supported the claim, and Lorna had it right, right from the start.

In 1981, Lorna Wing launched the term Asperger's syndrome in a scientific paper in *Psychological Medicine*. She described Hans Asperger's 'autistic personality disorder' and speculated about outcome and aetiology. Thanks to this publication, Hans Asperger's findings from the 1940s were also introduced to the English-speaking part of the world. Since then, Asperger's syndrome has become one of the most talked about diagnoses and concepts in clinical medicine.

Based on her vast experience of individuals within the autism spectrum, she outlined different trajectories for development into adulthood: the active-but-odd, passive, aloof and rigid groups. Together with our group she was involved in friendly debates about whether or not all people might actually be reasonably characterised as falling into one of these subgroups and it is only the addition of autism that makes each subgroup stand out much more clearly as a 'specific type'.

Together with Judith Gould, Lorna Wing developed the most comprehensive autism diagnostic interview in the field, the DISCO (Diagnostic Interview for Social and COMMunication disorders). This instrument is widely used both in clinical settings and research to help in the diagnosis of autism spectrum disorders and related conditions. The DISCO has been translated into several languages and is used all over the world.

Lorna and John Wing had a daughter, Susie, who had severe autism. When Susie died unexpectedly at the age of 49, I remember Lorna's devastation. She described how Susie had never been able to clearly express her emotions, but how, when Lorna or John came home after work, her face would light up. Lorna said that the feeling that filled her then was absolutely wonderful, unlike anything else.

Lorna Wing published several influential books and about 60 major scientific papers, the last one in 2013, at the age 85. She was the recipient of many honours including the Order of the British Empire.

Lorna Wing also contributed to the development of the recent 'autism pride' movement. She believed, and would let people know that she did, that to be really successful in science and arts you need to have some clear autism traits. She also believed that most of us have some such traits. One of her favourite sayings was that 'nature never draws a line without smudging it; you cannot separate into those "with" and "without" traits as they are so scattered'.

Lorna Wing was one of those rare individuals without a false note in her. She was one of the gentlest people, always generous with her time if she believed she could be of help, humble, but never meek. She had a fierce intellect, but she used it in such a way that some of her contemporaries did not understand what hit them until it was too late. She would not suffer pomposity. She had the greatest sense of humour, and hearing her special laugh (and she did laugh a lot) was always a treat and it would put everyone around her in a good mood.

To paraphrase Winston Churchill: 'Rarely has one person had such an enormous impact on the lives of so many people with autism'. Lorna Wing will live on in many of us who had the great privilege to count her as a true friend.

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1.8.45 A memory clinic v. traditional community mental health team service: comparison of costs and quality

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Abstract

Aims and method To compare the cost and quality of a memory-clinic-based service (MCS) with a traditional community mental health team (CMHT) service. Using a retrospective case-note review, we studied two groups, each with 33 participants. Consecutive referrals for diagnostic ‘memory’ assessments over 4 months were evaluated. Participants were evaluated for up to 6 months.

Results The MCS was less costly than the CMHT service but the difference was not statistically significant (mean cost for MCS was £742, mean cost for CMHT service was £807). The MCS offered more multidisciplinary and comprehensive care, including: pre- and post-diagnostic counselling, more systematic screening of blood for reversible causes of dementia, more use of structured assessment instruments in patients/carers, signposting to the third sector as well as more consistent copying of letters to patients/carers.

Clinical implications An MCS service offered more comprehensive and multidisciplinary service at no extra cost to secondary care.

Contents

- *A memory clinic v. traditional community mental health team service: comparison of costs and quality*
 - *Method*
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 - *Results*
 - * *Quality data*
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 - * *Costs of service*
 - *Discussion*

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In the UK, the national dementia strategy¹ strongly supports the concept of timely diagnosis and intervention in dementia. The cost-effectiveness of such services has been demonstrated.^{2–6} Studies show that memory services may improve quality of life for patients and carers.^{7–9} The recognition of dementia enables the provision of safer care by considering, for example, accommodation and care needs and encouraging advanced decision-making. Reaching a diagnosis can help patients and carers to tolerate their symptoms better and suitable treatments can be considered.

Advocates of dedicated ‘memory clinic services’ (MCSs) point to the benefits of a less stigmatising setting, with a focus on psychosocial interventions, education and the promotion of research and clinical governance.^{5,7,10–14} Opponents are concerned with resources being diverted from community mental health teams (CMHTs) and point to higher costs of MCS services.^{15,16}

In this study, Trust A has a dedicated memory clinic service (henceforth called MCS group) as well as a CMHT. In Trust B there is a ‘traditional’ CMHT-based service (henceforth called CMHT group) where referrals of all types are seen. We compared the costs with those of secondary care and the quality of the service offered to similar types of patients referred for a non-urgent diagnostic memory assessment in these two service models in neighbouring trusts. Patients were evaluated retrospectively using case-note review in terms of the cost and quality of care they received in secondary care for up to 6 months in similar rural/suburban areas.

Method

Study design

This study was a health service evaluation and used retrospective data collected routinely as part of the usual services provided in both trusts, so local research ethics committee permission was not needed.

Demographic matching

Two rural and suburban eastern areas of England were matched using data from the Eastern Region Public Health Observatory (ERPHO). The number of people over the age of 65 years, based on general practice (GP) records in these areas, was recorded: 20 289 people in the MCS group and 21 112 people in the CMHT group. Data from the British primary care Quality and Outcomes Framework (QOF),¹⁷ which requires the recording of dementia and other chronic conditions, showed that the prevalence of dementia and strokes, and the recording of cholesterol and blood pressure, were similar in both groups. The Indices of Multiple Deprivation (IMD)¹⁸ show that the GP practices in the CMHT service (Trust B) experienced less deprivation. The range of the IMD was 11.5–17.7 for the MCS and 5.7–8.96 for the CMHT service.

Patient identification

We examined all referrals received over the time frame of the study (4 months) from specific, predetermined GP practices in these two rural/suburban areas. All patients included in the study had to fulfil Department of Health memory clinic referral criteria.¹⁹ These criteria state that memory services will see all patients with subjective memory problems or change in everyday function, or a carer’s report of change in a patient over a period of more than 6 months. Patients referred should have no previous or definitive diagnosis of dementia. The Department of Health stipulates that memory services will not see patients where urgent treatment is needed, for example those with more complex behavioural and psychological problems, patients with suicidal ideation, psychotic behaviour or a crisis situation from the carer’s perspective. Patients with early-onset dementia (age under 64 years) were also excluded because the two areas have different referral pathways for such patients. The MCS service received two referrals of early-onset dementia, which were excluded from this study; there were no such referrals in the CMHT service. All referrals had to have been received between August and November 2011 in both services.

For the MCS group, a computerised search of all memory clinic patients referred by GP practices in the designated area of the trust was performed for the specified time period. Thirty-four consecutive patients were identified and all fulfilled

the Department of Health memory clinic criteria.¹⁹ One patient refused the diagnostic interview after pre-diagnostic counselling and that patient was excluded. Occasionally, patients may be passed on to the crisis team or CMHT, but none on our list had been dealt with in this way.

For the CMHT group, a member of the research team (M.J.V.R.) manually searched all consecutive referrals to the service from particular GP practices from a central written database. Thirty-three referrals were included in the CMHT group (by coincidence, the same number of patients as the MCS group). These 33 patients all fulfilled Department of Health memory clinic criteria¹⁹ and were identified by consecutively recruiting from the original list. Patients were excluded only if they did not fulfil memory clinic criteria.¹⁹ A second member of the research team (J.S.R.) ensured that all referrals met these criteria for inclusion or exclusion. There was uncertainty as to whether to include one patient and a senior nurse's opinion from the MCS team was sought to arbitrate.

Questionnaires

Quality of service

A data extraction sheet to assess the quality of the service was developed for this study. It was used for case-note analysis and captured information routinely collected by clinicians for assessment purposes (*Box 1*). The quality criteria were chosen based on the National Institute for Health and Care Excellence (NICE) guidance for dementia services,²⁰ the Memory Services National Accreditation Programme (MSNAP) criteria where they could be applied to both services,²¹ and literature evidence.^{10,11,22} We pragmatically assessed whether the data could be extracted retrospectively from the services. This information was obtained from computerised and handwritten notes from the initial contact with the patient and for the following 6 months of contact with the mental health service. The psychiatrists involved in the data collection conferred about any uncertainties with recording of data. M.J.V.R. and Z.A.-S. each initially screened at least four sets of case records together with J.S.R. to ensure interrater reliability in recording of data. All entries were scrutinised by J.S.R. to ensure data entry was consistent. Any missing information was noted. It is the view of clinicians in both trusts that GPs are best suited to conduct physical examinations and these are stated in the requirements for referral to the service by the MCS trust. However, individual psychiatrists often choose to conduct some aspects of the physical examination themselves and the extent to which clinicians were doing this was noted.

Cost of service

The Client Service Receipt Inventory (CSRI)²³ was adapted for this study (available from the authors on request). This includes all the mental health service costs for each individual patient from the initial point of contact and then all subsequent contacts with the mental health service over the following 6 months. Costing stopped at the point the patient was discharged back to the GP. However, patients found to need more extensive follow-up for more severe or complex behavioural and psychological symptoms of dementia (BPSD) were referred to the CMHT service in Trust A (one patient) and Trust B (three patients). Costs were excluded from that point. Costing was calculated from the perspective of National Health Service care²⁴ (secondary care only evaluated in this study) rather than from a wider medical or societal perspective. Costs for hourly contact with professionals were mainly derived from the unit costs for health and Social Services compendium and included 'on costs', for example for a consultant psychiatrist this includes salary, national insurance and superannuation, qualifications, overheads, ongoing training and capital overheads.²⁵ From this document,²⁵ the cost per hour for consultant time is £162 (including on costs such as administrative support and buildings) and the cost per hour for a non-medical clinician (e.g. CMHT nurse) is £44. The costs of drugs prescribed by secondary care were derived from the *British National Formulary*.²⁶ The costs of scans were derived on the basis of the Department of Health's Dementia Commissioning Pack.²⁷ Costs incurred as a result of time spent on discussion and meetings were based on the size of individual teams, allowing for an average of 6 min discussion per patient (team sizes and calculations available from the author). The average time taken for domiciliary Table 1 Demographic data and results of assessment in memory clinic service (MCS) group and community mental health team (CMHT) group MCS group ($n = 33$) a CMHT group ($n = 33$) a P Comments Mean age, years 80.84 0.03 Significantly older in Trust B Mean age when leaving school, years 15.15 / >0.05 Not recorded in 4 patients in MCS and in

20 patients in CMHT Female, n (%) 19 (58) 22 (67) >0.05 MMSE, median 23.52 50.2 $n = 32$ in both groups ACE-R, median (range) 67 (76) CMHT group not analysed as only 9 patients had ACE-R done, $n = 31$ in MCS group Accommodation – independent/sheltered, n (%) 32 (97) 30 (94) >0.05 Seen with relative/friend/carer, n (%) 33 (100) 24 (73) <0.001 Clinicians in CMHT group may have contacted relative by telephone after interview Mean days to be seen (s.e.), n (%) 25 (3) 20 (3) 0.23 Mean months since symptom onset 23 24.7 12 not known in CMHT group Received pre-diagnostic counselling, n (%) 32 (94) 2 (6) <0.0001 Dementia blood screen examined, n (%) 33 (100) 24 (73) 0.001 Physical exam done by GP/psychiatrist, n (%) 16 (48) 14 (42) n/s Functioning examined formally, n (%) 22 (67) 1 (3) <0.0001 e.g. Bristol Activities of Daily Living³⁰ Behaviour examined formally, n (%) 22 (67) 1 (3) <0.0001 e.g. Cambridge Behavioural Inventory³¹ Global assessment formal, n (%) 33 (100) 14 (42) <0.0001 e.g. HoNOS,³² EQ-5D-5L³³ Depression examined formally, n (%) 2 (6) 1 (3) >0.05 e.g. Geriatric Depression Scale³⁴ Risk assessment, n (%) 31 (94) 22 (67) 0.02 Patient/carer sent copy of GP letter, n (%) 29 (88) 14 (42) <0.0001 ²³ visit and/or administrative time costs were calculated on the basis of discussions with representatives from professional groups in each of the teams or on data recorded by team members (average times for appointment available from the author on request). The mileage travelled by clinicians was calculated using the Automobile Association Website (www.theaa.com). Travel and transport costs are part of general overheads in the unit costs of health and social care,²⁵ but as this was anticipated to be an area of difference between the two models, this was calculated separately for each patient seen at the rate of 54p/mile up to 3500 miles as suggested in this unit cost document.

Box 1 Measures extracted regarding the quality of the memory service

Background characteristics (age, gender, marital status, employment, school-leaving age, accommodation) Waiting time to be seen Symptom time prior to referral Presence of a carer, relative, friend Pre-diagnostic counselling Dementia blood screen: ordered, examined Informal assessment of functioning, behaviour, depression, global assessment Structured questionnaires to assess functioning, behaviour, global assessment Brain imaging Physical examination (record from GP/psychiatrist) MMSE, ACE-R or other cognitive tools utilised Record of a diagnosis Record of risk assessment Record of post-diagnostic advice to patient/carer Record of discussion about driving Copying of letters to patients/carers

ACE-R, Addenbrooke's Cognitive Examination-Revised; GP, general practitioner; MMSE, mini-Mental State Examination.

Analysis

Data were analysed using Excel 2007 and Stata Version 12.1 for Windows (², Fisher's exact tests if less than 5 in a cell, Wilcoxon rank sum test). Parametric and non-parametric tests were applied, as appropriate, to evaluate costs and quality of care provided. To be conservative and because non-parametric distributions were predicted, the cost data were analysed using the Wilcoxon rank sum test.

² ACE-R, Addenbrooke's Cognitive Examination-Revised; GP, general practitioner; HoNOS, Health of the Nation Outcome Scales; MMSE, mini-Mental State Examination; n/s, non-significant.

³ Unless otherwise stated.

Results

Quality data

A similar range of diagnoses were seen in both areas (Alzheimer's or mixed dementia: 17 in MCS group, 15 in CMHT group; vascular dementia: 9 in MCS and 8 in CMHT; Lewy body dementia: 0 in MCS group, 2 in CMHT group; mild cognitive impairment: 6 in both groups; depression: 0 in MCS and 1 in CMHT; other diagnoses: 1 chronic subdural in MCS group and 1 multiple sclerosis-related cognitive impairment in CMHT group). Demographic data and the analysis of data collected during patient assessments are shown in *Table 1*.

Diagnostic assessments included a clinical assessment of behaviour, functioning and a global assessment of severity in nearly all patients, with no significant differences between groups on these variables. Some structured questionnaires (e.g. EQ-5D,³³ Cambridge Behavioural Inventory³¹) were sent to patients and carers before the actual appointment in the MCS group. Others were administered by clinicians during the clinic appointment. However, structured assessments in patients and carers using symptom rating scales in these domains were not routinely done in the CMHT group. A Mini-Mental State Examination (MMSE)²⁸ was performed in all patients except one in each group. In the MCS group, the Addenbrooke's Cognitive Examination-Revised (ACE-R) test²⁹ was performed routinely, with a median score of 67, but it was not performed routinely in the CMHT group. Computed tomography head scans were ordered as part of the assessment to a similar extent in both groups (19 in MCS and 17 in CMHT), whereas scans that had been done previously and considered by the clinician to be recent enough to be helpful amounted to a further 6 in the MCS and 5 in the CMHT group. So, only 8 MCS (24%) and 11 CMHT (33%) patients did not have scans available for diagnostic purposes. Scanning is widely available in both trusts and it was patient preference and some clinician guidance that determined whether a patient had a scan or not. Diagnoses were recorded by clinicians in 100% of letters sent to GPs. A psychologist saw two patients in the MCS group (one for neuropsychological testing and one for cognitive stimulation therapy) and two patients in the CMHT group had further neuropsychological testing.

The post-diagnostic advice given by clinicians to patients and/or carers from the MCS v. CMHT group in percentage terms was signposting: to the third sector (70% v. 24%; $P = 0.0002$); for welfare benefits (55% v. 36%; $P > 0.05$); to Social Services (67% v. 48%; $P > 0.05$); advanced Table 2 Mean costs in memory clinic service (MCS) group and community mental health team (CMHT) group

Costs	MCS group £ (mean per person ±s.d.)	CMHT group £ (mean per person ±s.d.)
Total Costs	742 (250)	807 (375)
Direct costs	271 (82)	252 (124)
Office costs	182 (81)	224 (130)
Travel time	76 (59)	186 (106)
Mileage costs	28 (21)	32 (31)
Multidisciplinary team costs	44 (15)	30 (41)
Scan costs	74 (67)	69 (72)
Drug costs	67 (103)	12 (31)

planning discussions (55% v. 45%; $P > 0.05$). Interviewers were better at documenting whether patients were drivers in the MCS group (information not recorded in three patients in the MCS group and nine patients in the CMHT group). Anti-dementia drugs were prescribed in 65% of patients eligible for prescriptions (if patients had Alzheimer's disease, mixed dementias or Lewy body dementia and MMSE scores greater than 10). Payment methods differed between groups, with the CMHT passing on prescribing to GPs after 1–2 months compared with the MCS group, where clinicians continued to prescribe for 3–4 months.

⁴ Bold denotes significance.

⁵ Small differences in the total means can be accounted for by rounding off.

⁶

The only significant difference between the groups was in the travel time costs $P < 0.0001$; $z = -5.14$ (Wilcoxon rank sum test). The drug, scan and multidisciplinary team costs were not formally analysed as their distributions were not suitable for parametric testing and there were too many ties for the Wilcoxon rank sum test.

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Patient pathways

The major significant difference was that just under half of patients in the CMHT group ($n = 15$, 45%) were seen only by a doctor at their usual place of residence and then discharged, whereas in the MCS group 97% were seen by both a doctor and a non-medical clinician (once or twice). In the CMHT group, 55% of patients were seen by non-medical clinicians several times (range 2–11). Although some patients received no follow-up in the CMHT group, others received extensive follow-up within the 6-month period, incurring increased travel time, mileage and face-to-face costs. Most medical input was from the clinic base for the MCS group, but 85% of patients also received a domiciliary visit by a non-medical clinician either pre- or post-diagnosis (or both).

Costs of service

The total costs per person to secondary care between the MCS and the CMHT groups over 6 months were not significantly different in the non-adjusted analysis or the analysis adjusted for age and MMSE score. The mean total cost of care in the MCS group was £742 (median £722) and in the CMHT group it was £807 (median £833). Travel costs were significantly higher in the CMHT group where all patients were seen at their usual place of residence ($Z = -5.14$, $P < 0.0001$, effect size -0.63). Consultants travelling to see patients would often add a cost of £162/hour to each assessment in the CMHT group. This expense was not needed for clinic-based assessments by consultants in the MCS group. The costs for non-medical staff to travel to see patients more frequently than in the MCS group also added to this overall travel cost figure. Other costs between groups were not significantly different using non-parametric analysis (Table 2).

Discussion

This paper highlights the cost and quality differences between two service models for patients referred with concerns about their memory. The total costs to secondary care were less with the MCS-based service than the CMHT-based service (median cost of £722 v. £833 per patient), but this difference was not statistically significant. The MCS offered significantly more multidisciplinary care to a greater number of patients than the CMHT service. Both services offered a high-quality diagnostic service but we argue that the MCS service was able to offer more systematic and comprehensive care, including pre-diagnostic counselling, more systematic screening of blood tests for reversible causes of dementia/comorbidity, more extended cognitive examination and structured assessment tools, better evidence of signposting to the third sector as well as copying of letters to patients and carers. It has been demonstrated that there is greater satisfaction with multidisciplinary assessment^{35,36} where diagnostic and management options are explained to both patient and caregiver.

It is possible that patients in the CMHT group were not typical for an MCS or that a selection bias was introduced, with only 33 patients in the CMHT group. However, we feel this is unlikely as the Department of Health memory clinic criteria were applied to all referrals accepted into the study in a systematic way.

We acknowledge that the numbers included in the study were small and the findings can only be regarded as preliminary. However, we cannot exclude the possibility that a CMHT service may be more economical for all types of patients as it was beyond the scope of this study to examine the costs for all patients entering CMHT services in both areas. The study was also not a full economic evaluation where costs and outcome data (such as delays to institutional care) are combined to reach conclusions. The CSRI²³ as adapted for this study only examines costs to secondary mental healthcare and not primary care, social care or carer time costs. Using the CSRI, we detailed the patient's involvement with doctors and other clinicians as accurately and comprehensively as possible. In real life, clinicians do not return to base between patient visits so costs may have been inflated in both services for travel time. We were aware that there seemed to be differences between groups in the rate whereby prescribing was handed over to GPs.

This was a retrospective service evaluation and we encountered many of the pitfalls of examining data that were not specifically collected for research purposes. However, the pragmatic design of this study also means it is more reflective of actual practice and therefore less subject to a Hawthorne effect.

Stakeholder views had been sought in both trusts and satisfaction was high with both services in the year of the study, but this was not evaluated specifically in this research and satisfaction cannot be inferred from these data.

There will, of course, be differences among clinicians about what determines the quality of a memory service and we acknowledge our own subjectivity. However, we took a pragmatic view on which variables to include, based on the literature and the information we were likely to be able to obtain from retrospective data in these two services. Other quality indicators for a memory service may be helpful to consider in future studies, for example the rate of reversible causes found, the rate of 'no diagnosis' made, the range of diagnoses or the rate at which drugs were accepted by eligible patients. However, this sample was too small to find significant between-group differences on these indicators.

The IMD in the MCS group was lower than in the CMHT group. This could possibly influence referral patterns but we acknowledge that this is a complex issue, involving the attitudes of patients, families and their referring GPs. Ethnicity was not specifically matched for in this study and this is acknowledged as a study limitation. We acknowledge that both groups had higher than expected rates of patients not receiving anti-dementia drugs. Clinicians did not always offer the drug, because they were concerned patients would not comply with taking the medication. However, some patients refused the drugs because of possible side-effects or other factors.

Another emerging care model in the UK utilises the services of 'allied mental health professionals' in making diagnoses and offering interventions with medical input not provided face to face for most patients.^{5,37,38} It may be argued that some of the diagnostic quality provided by a 'medical' view on diagnosis may be compromised in such services and this needs further evaluation.

We thank all the clinicians who provided information for this project, and Christine Hill (CLAHRC administrator), Sam Norton (statistician for CLAHRC in Public Health Department), David Rubinsztein (statistical support) and Dr John Battersby (ERPHO) for providing help with demographic and QOF data. J.S.R. thanks her colleagues in psychiatry at the West Suffolk Hospital, who provided support for the project and backfill for sessions during the CLAHRC year of training. J.S.R. also thanks all those in the CLAHRC, Cambridge and Peterborough scheme for their generous support of her fellowship.

1.8.46 The planning, implementation and publication of a complex intervention trial for chronic fatigue syndrome: the PACE trial

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Abstract

The PACE trial was a four-arm trial of specialist medical care, compared with specialist medical care with a supplementary therapy: adaptive pacing therapy, cognitive-behavioural therapy or graded exercise therapy, for patients with chronic fatigue syndrome. The trial found that both cognitive-behavioural and graded exercise therapies were more effective than either of the other two

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treatments in reducing fatigue and improving physical disability. This paper describes the design, conduct and main results of the trial, along with a description of the challenges that had to be overcome in order to produce clear answers to the clinically important questions the trial posed.

Contents

- *The planning, implementation and publication of a complex intervention trial for chronic fatigue syndrome: the PACE trial*
 - *The PACE trial*
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 - *The main results*
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 - *Conclusion*

Chronic fatigue syndrome (CFS) refers to a constellation of symptoms, characterised by persistent and disabling fatigue that is typically made worse by exertion. Some believe that myalgic encephalomyelitis (ME) is another name for the same condition; others regard it as different. Whatever it is called, CFS or ME is an ‘orphan’ condition owned and cared for by no particular discipline. ME is classified within the *International Classification of Diseases (ICD-10)* as a neurological condition (G93.3),¹ yet the majority of UK neurologists do not regard it as such.² CFS may also be classified as neurasthenia (F48), a diagnosis found in the ICD-10 chapter on mental and behavioural disorders, or as a non-specific somatoform disorder.¹ However, psychiatrists rarely see the illness as a condition that they should treat and many do not regard it as a mental illness. Therefore, while there is a consensus that CFS exists as a discrete syndrome, there is little agreement about how it should be classified, who should treat patients suffering from it, or how it should be treated.

The PACE trial

The PACE (Pacing, graded Activity and Cognitive behaviour therapy: a randomised Evaluation) trial aimed to determine which of the non-drug treatments advocated for CFS worked best and was safe. The first research grant application to do a trial was submitted in 1998. At that time, two trials of cognitive-behavioural therapy (CBT) and two trials of graded exercise therapy (GET) had been published; these suggested that both were promising treatments, but neither treatment had been accepted by patient organisations. Therapeutic nihilism abounded and rest was often advocated as the only useful treatment.³

This original grant application was unsuccessful and it took a further 5 years before we obtained funding for a trial. In those 5 years, the trial design went through two more iterations. The first added a specialist medical care (SMC) arm to allow comparison of the two new therapies with the encouragement, education and support of a knowledgeable doctor. The second iteration was developed in collaboration with the patient organisation Action for ME, and added a therapy called pacing, which surveys of their members had suggested was the most helpful approach. The involvement of this patient charity, which included the involvement of the charity’s CEO as an active member of the trial management committee, was sought to ensure that the trial addressed the right questions in the right way, and to maximise the confidence of the patient community in its findings.

The concept of pacing had evolved from a strategy used in chronic pain. It is essentially an approach to management of the illness in which the patient is helped to better adapt to the symptoms by living within the limits they impose. The patient is encouraged to ‘listen to their body’ and to adopt the right balance between doing too much or too little. Pacing for CFS had never previously been tested in a trial, and the precepts behind it allowed a comparison of two different models of the illness: one adaptive (pacing), the other rehabilitative (CBT and GET). A standardised pacing therapy was

produced in collaboration with Action for ME and Professor Diane Cox of Cumbria University, who agreed to be the therapy lead, having had extensive experience in delivering an occupational therapy approach to CFS that incorporated pacing. We called it ‘adaptive pacing therapy’ (APT) so as to convey the main aim of the therapy – to enable the patient to optimally adapt to the illness.

The PACE trial was finally funded in 2003.⁴

Design issues

The PACE trial was designed to compare the efficacy and safety of SMC alone against SMC with additional APT, CBT or GET for patients with CFS recruited from six clinics in England and Scotland. We also sought to determine cost-effectiveness, mediators and moderators of outcome, as well as the patients’ long-term outcome. The trial raised a number of design issues.

Delivery of the therapies

A key design issue was how best to deliver the three therapies; should the same individuals deliver all three or should each be given by different people? We decided to have the most appropriate discipline deliver each therapy: CBT-trained therapists (clinical psychologists or nurse therapists) delivered CBT, physiotherapists (there was one exercise physiologist) delivered GET and occupational therapists delivered APT. This decision ensured optimal delivery of each therapy by the therapists most likely to deliver these therapies in clinical practice, but increased the risk that the relative effectiveness of the therapies could be compounded by differences in the effectiveness of the therapists themselves. Consequently, quality assurance of therapy delivery was vital. We did this in a number of ways: manuals for both therapists and patients were written and iteratively piloted, and extensive training and regular supervision of the therapists was provided.

Therapy quality was ensured by only allowing therapists to treat trial patients once their competency had been established with non-trial patients. Each therapy had a lead who delivered supervision: these were Mary Burgess, an authority on CBT for CFS; Jessica Bavinton and Lucy Clark for GET, a clinical specialist physiotherapist and a research sports physiologist, respectively; and Diane Cox for APT. All therapy sessions were audio-recorded to aid supervision and to allow ratings of therapy quality and fidelity.⁵ The treatment manuals we used in the trial are available for free download at www.pacetrials.org/trialinfo.

Eligibility criteria and outcomes

We decided that only patients who met the Oxford definition of CFS would be eligible to participate in the trial.⁶ This definition was widely used, broad and, unlike others, required fatigue to be the patients’ main complaint. This helped to differentiate CFS from other syndromes, such as fibromyalgia, in which fatigue is a common symptom. We were also interested in knowing whether the trial findings applied to the subgroups of patients who met alternative definitions of CFS and ME, so we stratified treatment allocation by the international criteria for CFS and also by the London criteria for ME.^{7,8}

The primary outcome was hard to decide on: should it be fatigue or disability? After much debate, we chose both as co-primary outcomes because we considered them equally important aspects of the illness and potentially different in their response to the different treatments.

In order to measure treatment safety, we chose to follow the stringent European Union Clinical Trials Directive for pharmaceutical interventions, a standard rarely applied to trials of therapies.⁹ The measures of safety included adverse events, serious adverse events and reactions, withdrawal from treatments, a global self-measure of worsening, and an *a priori* threshold for deterioration in physical disability.

We also measured a number of secondary outcomes as well as potential mediators and moderators. Outcomes were assessed at baseline, mid-therapy, the end of the main treatment phase and 1-year follow-up, as well as long-term follow-up 2.5 years after randomisation.

The analysis

Having two primary outcomes complicated the analysis, although the size of the trial gave sufficient power. Having three follow-up assessments allowed us to use a linear regression model that minimised any effects of the small amount of missing data, and also allowed us to adjust the model by factors such as baseline measures. We originally planned to use a composite outcome measure of the proportions of participants who met either a 50% reduction in the outcome score or a set threshold score for improvement. However, as we prepared our detailed statistical analysis plan, we quickly realised that a composite measure would be hard to interpret, and would not allow us to answer properly our primary questions of efficacy (i.e. comparing treatment effectiveness at reducing fatigue and disability). Before any examination of outcome data was started, and after approval by our independent steering and data monitoring committees, we decided to modify our method of analysis to one that simply compared scores between treatments at follow-up, adjusting the analysis by baseline scores. We also addressed the potential clustering effects resulting from different numbers of patients being treated by the different therapists.

The main results

Overall, we recruited 640 patients.¹⁰ Almost all participants (98%) provided some outcome data, and 95% provided outcome data at 12 months, with no significant differences between arms in missing data. These very high rates of follow-up were achieved as a result of the commitment of the participants and the assiduous work by the research staff. The strategies used by the latter included offering convenient interview times (including early evenings), mailing most questionnaires to allow sufficient time to answer them before interviews, paying travel expenses, following up non-attenders expeditiously by mail and telephone, offering to see the participants at their homes and, as a last resort, recording the primary outcomes over the telephone. However, if we were doing the trial again, we would seek ethical permission to also offer follow-up by email, Skype and FaceTime.

Only 8% of participants dropped out of treatment, again with no significant difference in dropouts between treatment arms. Between 82 and 88% of participants who received a therapy alongside SMC said that they were satisfied with it, whereas only 50% reported being satisfied with SMC alone.

Analysis of the primary outcomes revealed that both CBT and GET led to significantly greater improvements in both fatigue and physical disability than did either SMC or APT. The adjusted effect sizes ranged from 0.5 to 0.8. To our surprise, there were no significant differences between APT and SMC in either primary outcome.

The differences between treatments for the secondary outcomes were broadly similar to the primary outcome comparisons. There were no significant differences in any safety measures between treatment arms. There was also a similar pattern of results in the two subgroups that met the alternative criteria for CFS and ME.

The cost of one quality-adjusted life-year (QALY) gained was found to be £18 374 for CBT and £23 615 for GET.¹¹ Both CBT and GET were three times more likely to lead to recovery from the present episode of illness than SMC alone.¹²

We concluded that both CBT and GET were moderately effective, cost-effective and safe treatments for CFS. These results were important in confirming to patients, healthcare professionals and commissioners that the promise of CBT and GET found in the earlier and small trials was justified, and that these treatments were safe to receive, if delivered as designed by the appropriate therapists.

Implementation

The results of the trial supported the current National Institute for Health and Care Excellence (NICE) guidelines' recommendation that 'cognitive behavioural therapy and/or graded exercise therapy should be offered to people with mild or moderate CFS/ME [...] because currently these are the interventions for which there is the clearest research evidence of benefit.'¹³ The trial results also suggested that management by pacing, which was notably less effective than the other therapies, should not be recommended.

Now the trial has been completed and the main findings published, there is the challenging business of implementation within the National Health Service (NHS) at a time of reducing budgets. Despite the NICE guidelines suggesting that patients with long-standing CFS should be seen by specialists,¹³ many are now being sent to either Improving Access to Psychological Therapies (IAPT) services or mental health teams; these services are often neither confident nor competent in delivering CFS-specific CBT and GET. The evidence suggests that outcomes are better with specialist CFS services.^{14,15} Alternative ways of delivering therapies, such as through the internet and by telephone, which are easier to access and potentially more cost-effective, may provide ways to help patients in the future.^{16,17}

Challenges and solutions

Delivering treatment in a trial like this required the time and resources to recruit, employ, train and supervise numerous staff working across a wide geographical area. We also had to address staff turnover and the consequent extra training and supervision needed for new staff. Occasionally, it was necessary to train an existing therapist in a second therapy, which proved popular with those who did it. The morale of therapists giving a specific therapy was maintained by encouraging them to take ownership of their manualised therapy, by close supervision, and by peer support between centres.⁵

PACE was affected by several external influences. First, some patient organisations expressed opposition to the trial from the time that funding was announced.¹⁸ Our understanding is that this opposition reflected the fact that the trial did not focus on a biomedical approach to CFS. Meetings with those who objected did not alter their concerns and divergent views about the illness and its management continue to this day.¹⁹ Strategies against the trial have included a public petition to the prime minister and formal complaints to our funders and publishers.²⁰ None of these complaints have been upheld, but they did take considerable time to address. A large number of Freedom of Information Act requests seeking information on all aspects of the trial have been received since the main results were published in 2011. Both declined requests that were appealed all the way up to the Information Tribunal were rejected, one being considered 'vexatious'.²¹ There was even a debate on the trial in the House of Lords in 2013.²² Our deliberate policy, to help allay concerns about the trial, was to be as transparent as possible regarding what we did, while protecting medical confidentiality and our staff; this included publishing the protocol and the statistical analysis plan,^{4,23} and paying for open access to all publications. On a more positive note, some patient organisations, such as the Association for Young people with ME (AYME), have accepted the findings, and are advising their members accordingly.²⁴

Second was the challenge of delivering a complex trial in the NHS. One particular threat was the 'Agenda for Change' which had implications for the salary grades of therapists. As a result, some of the trial centres interpreted the fact that the trial therapists had to use a manual to mean that they were unskilled, and therefore should have their pay reduced. We were successful in making the case that the trial therapists were more rather than less skilled by taking on a research role. We also supported therapists in their career progression, providing guaranteed employment beyond the trial, when possible.

The third challenge was longevity. The trial was funded in 2003; the first patient recruited in March 2005; the last patient followed up by January 2010; the main paper published in February 2011. Eight years is a long time to keep a team together and motivated. The co-principal investigators (PIs) and treatment leaders had an important role in setting the standards for trial conduct and ensuring therapy and research team cohesion and direction. In turn, the external monitoring and support of the Medical Research Council, trial steering committee and data monitoring committees were essential in maintaining the morale of the PIs. All staff met annually for a team meeting, which incorporated fun as well as training and education, supplemented by regular newsletters updating staff about progress (www.pacetrail.org/trialinfo). It may be that the external criticisms of the trial enhanced the internal cohesion and determination shown by the 100 or so staff involved.

Conclusion

Delivering the PACE trial was an all-consuming, challenging, but ultimately rewarding task that lasted many years. We hope that it has provided useful information for patients, clinicians and commissioners about the efficacy, adverse effects and cost-effectiveness of rehabilitative interventions for CFS. We hope that we have also been able to show that it is possible to deliver a large trial of complex interventions in a challenging and sometimes hostile environment and to obtain clear results from it.

We thank the following for their involvement in the trial: the PACE Trial Management Group consisted of the authors of this paper plus (in alphabetical order): Brian Angus, Hannah Baber, Jess Bavinton, Mary Burgess, Lucy Clark, Diane Cox, Julia DeCesare, Eleanor Feldman, Kimberley Goldsmith, Tony Johnson, Paul McCrone, Gabrielle Murphy, Maurice Murphy, Hazel O’Dowd, Tim Peto, Laura Potts, Rebecca Walwyn, David Wilks. The Trial Steering Committee independent members included Janet Darbyshire (Chair), Jenny Butler, Patrick Doherty, Stella Law, Meirion Llewellyn and Tom Sensky. The independent members of the Data Monitoring and Ethics committees were Paul Dieppe (initial Chair), Astrid Fletcher (final Chair) and Charlotte Feinmann. The funders of the PACE trial were: the Medical Research Council, the Department of Health (England), the Department for Work and Pensions, and the Chief Scientist Office (NHS Scotland).

1.8.47 Illness perceptions in adolescents with a psychiatric diagnosis in Pakistan

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Abstract

Aims and method To assess adolescents’ perceptions of their psychiatric illness and the role of various demographic factors in a Pakistani setting. Adolescents with various psychiatric diagnoses were interviewed using a structured questionnaire including the Illness Perceptions Questionnaire–Revised (IPQ-R).

Results Fifty-two adolescents with various psychiatric illnesses were interviewed; their mean age was 12.7 years and the majority (67%) were female. Males had significantly higher scores on timeline and emotional representation ($P<0.05$), suggesting strongly held beliefs about chronicity of their illness and anger and worry about their condition. Adolescents’ own emotional state, stress, family problems and bad luck were endorsed by participants as some of the causal factors in their mental illness.

Clinical implications Despite the importance of early intervention in psychiatric problems, engaging youth in the treatment process in Pakistan remains difficult. Better understanding of how adolescents perceive their psychiatric difficulties may play a significant role in developing culturally sensitive interventions and better utilisation of services.

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Contents

- *Illness perceptions in adolescents with a psychiatric diagnosis in Pakistan*
 - *Method*
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The prevalence of child psychiatric disorders is reported to be high in Pakistan,¹ but engaging children and families in treatment remains challenging. Illness perceptions which are unique to different cultural groups have been found to be associated with families' engagement and help-seeking behaviours. Previous research has focused mainly on parental beliefs and identified various barriers which hinder help-seeking,^{2,3} but much remains to be known about how adolescents themselves perceive their illness. With changes evident in Pakistani society in the past few decades, adolescents' own views along with their families' perceptions are likely to influence their healthcare decisions. The current knowledge about Pakistani adolescents' perceptions of their illness, stigma and help-seeking behaviour is limited, despite assertions about adolescents' capability of 'making decisions and choices on the basis of their own representations of health threats and illness'.⁴ To address this knowledge gap, the current study focuses on the beliefs of adolescents regarding their psychiatric illness and treatment in the context of Pakistan's unique cultural, religious and social context and attempts to determine whether various demographic factors have any role in these perceptions. Insight into these factors may help in addressing the underutilisation of services by young people in Pakistan and to identify ways of engaging them in effective treatments.

Method

The study was approved by the Institutional Review Board of King Edward Medical University (KEMU). Participants were 11- to 18-year-old adolescents recruited from Child and Family Psychiatry Department of the KEMU/Mayo Hospital out-patient services. The adolescents included in the study had axis I psychiatric diagnoses (conversion disorder, major depression, schizophrenia, bipolar affective disorder, obsessive-compulsive disorder, generalised anxiety disorder and conduct disorder) and were taking psychotropic medications. Adolescents who were acutely ill or had intellectual disability, attention-deficit hyperactivity disorder (ADHD) and pervasive developmental disorders were excluded from the study because of the developmental nature of these disorders. Following informed consent from parents and assent from adolescents, a questionnaire was used to collect the demographic and relevant clinical information. The ICD-10 diagnostic criteria were used to assess the psychiatric diagnosis.⁵ The Illness Perceptions Questionnaire-Revised (IPQ-R) was used to glean the young people's perceptions of their illness.⁶ IPQ-R has various subscales reflecting different dimensions of illness perceptions: timeline (chronicity of illness), consequences (impact of illness on adolescent life), personal control (perception of their own control of their illness), treatment control (controllability of illness by treatment), illness coherence (adolescents' own understanding of their illness), timeline cyclical (cyclical nature of illness), emotional representations (feeling of emotions such as sadness, anger about their illness) and causes. Each statement is rated on a 5-point Likert scale ranging from 1, strongly disagree to 5, strongly agree, and addition of scores of various items yields subscale scores, except for causes in which individual items are scored as such. IPQ-R has been used in previous studies of adolescents with mental illness.⁷ The Cronbach alpha ranged from 0.79 for the timeline cyclical dimension to 0.89 for the timeline acute/chronic dimension. The questionnaire was administered to adolescents in an interview format to eliminate literacy concerns. Data were analysed using SPSS version 20. Descriptive statistics were used for socio-demographic information, and means and standard deviations of different subscales of IPQ-R were calculated. Independent samples *t*-test was used to compare the means of IPQ-R subscales across categories of binary variables such as gender, address etc.; $P < 0.05$ was considered as significant.

Results

Fifty-two youths were interviewed, with a mean age of 12.7 (s.d. 2.13) and the majority (67%, $n = 35$) being female. More than two-thirds of participants (71%, $n = 37$) lived in urban areas and almost half of the families had a nuclear family set-up (only parents and siblings) (52%) with monthly income of less than 15 000 Pakistani rupees. Family history of psychiatric illness was present in 21% ($n = 11$) and 15.4% ($n = 8$) had a history of psychiatric admission. Mean duration of illness was 14.4 months, ranging from less than 1 month to more than 30 months. Almost half of the participants had education up until the seventh grade.

Conversion disorder with comorbid emotional difficulties (depression and anxiety severe enough to warrant the use of psychotropic medication in addition to psychological treatment) was the diagnosis in 56% ($n = 29$) of patients. Other diagnoses were major depression (17.3%, $n = 9$), schizophrenia (5.8%, $n = 3$), bipolar affective disorder (3.8%, $n = 2$), obsessive-compulsive disorder (5.8%, $n = 3$), generalised anxiety disorder (1.9%, $n = 1$) and conduct disorder (1.9%, $n = 1$).

The mean scores of illness perceptions subscales along with standard deviation are presented in *Table 1*. Overall, the study sample perceived their illness' nature to be chronic and cyclical. The perception of significant negative consequences as a result of their mental health difficulties and a negative emotional response were also observed. There was a general perception of having some personal control of their illness as well as a positive belief in treatment role. Adolescents generally felt that they had a coherent model/understanding of their illness.

Participants' mean scores, standard deviation, median and range of subscales of IPQ-R

Cognitive processes	Items, n (maximum possible score)	Mean (s.d.)	Median (range)
Illness perceptions			
Timeline	6 (30)	16.4 (2.2)	16 (10)
Consequences	6 (30)	17.5 (2.4)	18 (12)
Timeline cyclical	4 (20)	11.0 (2.2)	11.5 (12)
Personal control	6 (30)	18.8 (2.2)	19 (10)
Treatment control	5 (25)	12.6 (3.2)	13 (16)
Illness coherence	5 (25)	14.8 (2.2)	15 (10)
Emotional representation	6 (30)	16.2 (3.5)	16 (10)

Table 2 shows the comparison of mean scores of IPQ-R subcategories across binary variables. Males had significantly higher scores on timeline and emotional representation, which suggests strongly held beliefs about chronicity of their illness and emotional representation (anger, worry) about the condition. Patients living in a nuclear family set-up had better beliefs about controllability of illness by treatment than those living in a joint/extended family system. The rest of the comparisons were not statistically significant.

Comparison of mean scores of subcategories of IPQ-R for binary variables

	Tim eline (acute/chronic)	Tim eline cyclical	Co nsequ ences	Per sonal co ntrol	Trea tment co ntrol	Il lness cohe rence	Emotional repr esent ation
Gender							
Male	17.5 (2.4) `* <#TFN 2>`__	11.0 (2.3)	17.6 (1.7)	18.9 (1.7)	12.5 (3.3)	14.8 (2.7)	17.8 (3.4) `* <#TFN 2>`__
Female	15.8 (1.9)	11.0 (2.2)	17.4 (2.7)	18.8 (2.5)	12.7 (3.1)	14.8 (1.9)	15.4 (3.4)
Family							
Nuclear	16.4 (2.5)	11.0 (1.8)	17.5 (1.8)	18.9 (2.2)	13.8 (3.0) `* <#TFN 2>`__	15.4 (2.2)	16.3 (3.7)
Joint	16.4 (1.9)	10.9 (2.8)	17.5 (3.0)	18.9 (2.4)	11.0 (2.6)	14.3 (2.0)	16.2 (3.5)
Address							
Urban	16.3 (2.2)	10.9 (2.4)	17.3 (2.3)	18.8 (2.0)	12.4 (3.2)	14.5 (2.2)	15.9 (3.8)
Rural	16.3 (2.4)	10.9 (2.1)	18.0 (2.8)	19.0 (3.0)	13.0 (3.3)	15.6 (2.0)	17.0 (2.9)
Family history							
Yes	16.9 (3.0)	11.4 (1.5)	17.6 (2.2)	18.0 (2.8)	13.7 (2.6)	15.0 (2.0)	17.1 (2.9)
No	16.2 (2.0)	10.8 (2.5)	17.4 (2.5)	19.0 (1.9)	12.7 (3.0)	14.8 (2.3)	16.1 (3.7)
Previous admission							
Yes	16.1 (1.8)	10.6 (2.2)	16.7 (1.7)	17.7 (2.3)	12.6 (2.5)	16.0 (1.6)	17.3 (3.4)
No	16.4 (2.3)	11.0 (2.3)	17.6 (2.5)	19.0 (2.2)	12.6 (3.3)	14.6 (2.2)	16.0 (3.5)

IPQ-R, Illness Perceptions Questionnaire-Revised.

$P < 0.05$ (calculated by applying t -test)

Table 3 shows the adolescents' understanding of various factors contributing towards their illness. Various psychological factors were clearly endorsed by the majority of respondents to be the cause of their emotional difficulties.

Participants' responses to illness attribution (causal) items of IPQ-R

IPQ-R causal items	Participants agreeing or somewhat agreeing to factor's contribution towards their illness <i>n</i> (%)
Psychological attributions	
Stress or worry	21 (40)
My mental attitude (e.g. thinking about life negatively)	15 (29)
Family problems or worries caused my illness	20 (39)
My emotional state (e.g. feeling down, lonely anxious, empty)	24 (46)
My personality	18 (35)
Risk factors	
Hereditary ('it runs in my family')	7 (13)
Diet or eating habits	10 (19)
Poor medical care in my past	21 (40)
My own behaviour	19 (37)
Aging	–
Smoking	–
Alcohol	–
Immunity	
A germ or virus	9 (17)
Pollution in the environment	10 (19)
Altered immunity	6 (12)
Accident or chance	
Chance or bad luck	20 (39)
Accident or injury	15 (29)

IPQ-R, Illness Perceptions Questionnaire-Revised.

Discussion

The present study provides insight into how adolescents in Pakistan understand their psychiatric illnesses. We observed poor mental health literacy among the adolescents in our study with regard to the nature, treatment and prognosis of their psychiatric illness. In comparison to a study of illness perceptions among Western adolescents with mood disorder,⁷ adolescents in our study believe their illness to be more chronic with serious adverse consequences. They also showed more emotional reactions (anger, sadness and worry) and appear less optimistic about the role of treatment in controlling their symptoms. Multiple factors such as cross-cultural differences, limited knowledge of available services, myths about possible causative factors and treatment for psychiatric illnesses, negative expectations of services by families, in addition to stigma, shame and reluctance to seek treatment may play a role in these beliefs as well as in underutilisation of services.⁸⁻¹⁰ Furthermore, children and adolescents with behavioural and emotional disorders either do not receive

treatment or do not take advantage of available services in high-income countries.^{2,3} Despite various psychoeducational measures even in high-income countries, literature suggests poor understanding among adolescents about the causes, nature and treatment of psychiatric health issues.

Depression in adolescents has been associated with most stigmatising attitudes.¹¹ In a study of 8- to 18-year-olds, 28% of respondents would prefer to 'wait for depression to go away' and 40% 'would try to think and act like normal'. Adolescents from higher socioeconomic status, of younger age at the start of treatment and with worries about public perception are associated with self-labelling and self-stigma.¹² These results are of concern as adolescents' own perceptions regarding their illness, stigma of treatment and concerns regarding confidentiality are considered to play an important role in professional help-seeking attitudes and behaviours.¹³ A significant proportion of children and adolescents with behavioural and emotional disorders in high-income countries either do not receive treatment or do not take advantage of available services.¹⁴

Our respondents' belief of treatment being not too helpful is likely to lead to reluctance to seek help or adhere to treatment. Misconceptions about psychiatric medications being addictive, need for medications to be taken for longer periods of time and slowness in learning because of medications may all contribute towards pessimistic views regarding psychiatric treatment.¹³ The majority of families perhaps prefer to seek help from informal sources such as the family, friends, religious scholars and faith healers, rather than mental health professionals, because of stigma. As a result, treatment needs of young people with a psychiatric illness remain largely unmet. There is a great need for evolving strategies to improve adolescents' perceptions about the effectiveness of treatment and to seek professional help for their emotional problems.

Gender differences were also observed in the study sample, with males being more concerned about chronicity of their illness. They also scored high on emotional representation, suggesting that they felt more shame, anger and became upset while thinking about their emotional and behavioural problems. This may be because of society's overall expectations for males to be stronger and able to manage their illness by themselves. It is important to highlight that the study sample is mainly composed of adolescents already in contact with mental health services and thus their perceptions might be different from perceptions of adolescents in the general population. The males' perception of showing 'emotions' as weakness in some studies¹⁵ may also explain stronger feelings of shame and anger among our sample who had to seek help because of the severity of their symptoms. Gender differences have been highlighted in previous research, with boys experiencing more stigma regarding mental illness, service use and treatment.¹⁶ Similarly, the positive perceptions of the role of treatment in helping their symptoms we observed in females is consistent with the results of previous studies.^{13,17}

The majority of adolescents in the study endorsed psychological and personal factors playing a role in their illness causation (i.e. my mental attitude, my emotional state, my personality, my own behaviour, poor medical care in my past) rather than genetic and immunological causes. Cultural differences have been observed in previous research on beliefs about causation of mental illness.¹⁸ In a few studies, however, adolescents did endorse genetics and biological factors, stress and personal responsibility as causes of mental illness in general.¹⁹⁻²¹ More negative causal attributions as compared with the general public, i.e. regarding illness as being caused by their own bad behaviour, is seen in adults and children with mental illness.²² These beliefs about causes of mental illness in turn influence public attitudes towards the patients, with studies reporting stigmatising attitudes, beliefs of lack of willpower and personal failure to overcome the illness.²³⁻²⁶ Children were blamed for their depression and ADHD by one in four peers in a study of stigma of mental illness among children.¹¹ Factors which are beyond patient control such as genetics and other biological causes are associated with less negative perceptions.^{26,27} Patients who attribute their illness to psychological factors have been shown to express more emotional reactions to their illness, as appears to be the case in the present study sample.⁶ Another interesting finding was an endorsement of bad luck by the study sample.

Pakistani culture has specific emphasis on religion and God's will, which can affect how adolescents perceive their mental illness. This is also seen in studies of Asian and Hispanic youth.²⁸ Anti-stigmatising strategies for adolescents in Pakistan need to take into account these cultural variations in beliefs about causation of these illnesses in order to address stigma as well as to develop effective, culturally sensitive psychological therapies to improve adolescents' sense of well-being.

Limitations

There were several limitations to this study. The sample size was small and was composed of people already utilising mental health services, thus results may not be generalisable to non-service-users in the general population. Furthermore, in-depth interviews in addition to a structured questionnaire are considered more helpful in understanding illness perceptions. It would also have been helpful to look at the attitudes towards professional help-seeking and determine if illness perceptions in our sample were associated with help-seeking behaviours. There was also no control group.

Despite the limitations, the study is important mainly because of its focus on adolescents' own understanding of their illness, its causation and the role of treatment. This significant area was largely ignored until now. It is difficult to develop psychoeducational programmes for the youth in Pakistan without understanding their own conceptualisation of the difficulties they are experiencing. Because of significant cultural, social and religious differences, multiple strategies need to be applied in improving mental health literacy among the youth. The stigma of psychiatric illness and treatment needs to be addressed to improve take-up of services. Counselling provision in schools and an awareness programme prepared and delivered in collaboration with paediatricians and family physicians may be more acceptable and helpful in engaging young people and families in services. Further research with a large sample, including representation from multiple sites, and in particular qualitative studies, are needed to understand and improve adolescent illness perceptions as well as attitudes towards seeking professional mental health services.

This study was presented as a poster at the 60th Annual Conference of the American Academy of Child and Adolescent Psychiatry in Orlando, USA, in 2013.

1.8.48 Impact of involuntary out-patient commitment on reducing hospital services: 2-year follow-up

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Abstract

Aims and method To evaluate whether involuntary out-patient commitment (OPC) in patients with severe mental disorder reduces their use of hospital services. This is a retrospective case-control study comparing a group of patients on OPC ($n = 75$) and a control group ($n = 75$) which was composed of patients whose sociodemographic variables and clinical characteristics were similar to those of

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the OPC group. Each control case is paired with an OPC case, so the control case must have an involuntary admission in the month that the index OPC case admission occurred. Emergency room visits, admissions and average length of hospital stay over a 2-year follow-up after the initiation of OPC were compared.

Results No statistically significant evidence was found in the use of mental healthcare services between the two groups. Different reasons for admission found between the groups limit similarity when comparing the two.

Clinical implications The findings cast doubt over the effectiveness of this legal measure to reduce emergency visits, the number of admissions and the length of stay in the hospital.

Contents

- *Impact of involuntary out-patient commitment on reducing hospital services: 2-year follow-up*
 - *OPC effectiveness data*
 - *Aims*
 - *Method*
 - *Results*
 - *Discussion*
 - * *Limitations of the study*

Involuntary out-patient treatment was introduced into North America and Australia in the early 1980s as a measure intended to benefit persons with severe mental disorder who need ongoing psychiatric care due to their poor adherence to treatment and lack of insight.¹ Several publications confirm that adherence to pharmacological treatment in disorders such as schizophrenia diminishes relapses and, consequently, hospitalisations (revolving-door syndrome) and the progressive deterioration that successive recurrences bring about.²⁻⁵ In recent decades, there has been a gradual introduction of various forms of out-patient commitment (OPC). Nowadays, it is a reality in many countries, among them Australia, Israel, England, New Zealand and the USA.⁶ In Spain, although there is currently no specific legislation on OPC, it is used in some cities (e.g. Valencia, Alicante, Barcelona and San Sebastian).

Application of OPC has caused a sharp debate at both the legal and medical levels. Its defenders believe that it is a less restrictive measure than hospitalisation,⁷⁻¹² ensures adherence to treatment facilitating clinical stability,¹³ and thus provides more freedom for patients. Opponents however believe that OPC does not respect human rights. It destroys the therapeutic relationship, discriminates against the psychiatric patient and increases their risk of stigmatisation.¹⁴ They base their argument on the lack of scientific evidence supporting the efficacy of OPC.

OPC effectiveness data

Non-randomised studies have reported conflicting results. Some have found a statistically significant association with a reduced rate of admission^{9,12,15-17} and a reduced length of hospital stay.^{9,12,15,16} Swartz *et al*⁹ evaluated the effectiveness of the OPC programme in New York and found that while under OPC there is a reduction in the number of admissions and length of hospital stay. They also evaluated the perceptions of stigma, coercion and satisfaction with treatment during the OPC and found no changes. Once the OPC was terminated, there was a sustained improvement (lower rates of hospitalisation and medication non-adherence) in those patients who received intensive treatment or whose treatment lasted for more than 6 months. Another noteworthy result is that patients who were subject to an OPC combined with assertive community treatment (ACT) had a lower risk of hospitalisation than did those who received ACT alone, but the first group had greater resources at their disposal.

Van Dorn *et al*¹⁰ showed that reduced admission rates were maintained for 6 months after the OPC had ended. Nakhost *et al*¹⁷ evaluated the effectiveness of OPC in Canada, discovering an association between patients under an OPC and

a reduction in the number of readmissions. In addition, they found evidence that this positive effect on the rate of hospitalisation remained after the OPC had ended. This was most notable in patients who had no admissions or who had only one admission prior to the implementation of the OPC. They found no association with the length of hospital stay. By contrast, other studies¹⁸⁻²⁰ have shown an association between an increase in the rate of admissions and length of hospital stay.

In a recent randomised controlled trial (RCT) in the UK with 12 months' follow-up, Burns *et al*²¹ found no significant difference in the rate of admission and length of hospital stay in individuals under OPC. These results are consistent with two RCTs from the USA in which no significant differences were found in the use of health services, social functioning or quality of life between the OPC and treatment as usual.^{22,23} These three RCTs are the only ones we found in the literature on community treatment orders. Despite being in different jurisdictions with different mental health systems and different laws, the consistency of performance is significant.

A recent systematic review by Maughan *et al*²⁴ which looked at effectiveness of OPC concluded that it has no significant effect on other outcomes of hospitalisation and use of community services. These results are consistent with previous reviews of international experience, for example by Churchill *et al*²⁵ and Kisely *et al*.⁶

Aims

Most previous studies have been performed in Anglo-Saxon countries so the aim of the present study is to provide information about the effectiveness of this legal measure to reduce the use of hospital services in other countries. Previous observational studies at Valencia (Spain) concluded that involuntary out-patient treatment might be useful for certain patients with severe mental disorder.²⁶ Because of the weakness of observational studies, our team previously conducted a retrospective study of cases and controls during 1 year follow-up, but the results indicated that OPC wasn't more effective than standard treatment.²⁷ We consider that the information offered by the present study can be of interest given the long period studied.

If one considers that OPC increases commitment to the achievement of clinical stability in patients with severe mental illness, then it is expected that the application of this legal measure will decrease both the number of emergency room visits and the number of hospital admissions, as well as shorten the length of hospital stay.

Method

This is a retrospective study of cases and controls where we compare a group of patients under an OPC with a control group.

The study population consisted of all patients in the city of Valencia who had been under an OPC for at least 2 years at the time of the study's initiation in August 2009. The admission which prompted the request for OPC was considered the index admission.

The control group consisted of a sample of patients admitted to the psychiatric unit of the Hospital Clínico de Valencia. Each control case was paired with an OPC case, so each had to have an involuntary admission in the same month as the index OPC case. Moreover, the control case must have had the same clinical diagnosis, the same sociodemographic variables (age, gender, place of residence) and the same clinical characteristics (the same number of admissions during the 2 years before the index admission) as the paired OPC case. Both groups received a standard treatment consisting of out-patient psychiatric follow-up medication monitoring, and community-based treatment, such as day centres. The only difference between the two groups was that the control group was not under OPCs.

The study compared the number of psychiatric emergency visits, the number of admissions and length of stay in the hospital for the OPC and control groups over a 2-year follow-up once the OPC had been initiated.

We recorded the following for each patient: age, gender, place of residence, psychiatric diagnosis according to the DSM-IV-TR,²⁶ number of psychiatric emergencies, number of hospital admissions, main reason for admission and average length of hospital stay for 2 years before and 2 years after the initiation of the OPC. Emergencies included psychiatric emergencies only. Admissions included all admissions, voluntary and involuntary, registered in the psychiatric services during the study period.

Results

The two groups comprised 75 patients - 50 males (66.7%) and 25 females (33.3%) - each. The average age was 41.4 years for the OPC group and 41.7 years for the control group.

Diagnoses on Axis 1 are shown in *Table 1*. In both groups schizophrenia was the most common diagnosis, affecting approximately 3 out of 4 patients with OPC (73%). Bipolar disorder was the second most frequent diagnosis (12%), followed by schizoaffective disorder and delusional disorder.

Diagnosis on Axis I (DSM-IV-TR)²³

	<i>n (%)</i>	
Schizophrenia	55 (73)	57 (75)
Bipolar disorder	9 (12)	8 (11)
Schizoaffective disorder	6 (8)	5 (7)
Delusional disorder	5 (7)	5 (7)
Total sample	75 (100)	75 (100)

OPC, out-patient commitment.

There are differences in the motives for index admission between the groups (*Table 2*). In the involuntary OPC group the main reasons were clinical decompensation because of non-adherence to treatment (78%) and aggressive behaviour (22%). In the control group, admission occurred mostly due to clinical decompensation without a clear non-adherence to treatment (47%), for example inconsistent use of medication, changes in the pharmacological pattern or substance misuse.

Main reason for index admission

	<i>n (%)</i>	
Aggressive behaviour	16 (22)	10 (16)
Abandonment of treatment	56 (78)	16 (26)
Suicide attempt	0	7 (11)
Clinical decompensation without clear treatment drop-out	0	29 (47)
Total	72 (100)	62 (100)

OPC, out-patient commitment.

The number of emergency visits, number of admissions and average length of hospital stay in the 2 years leading up to the start of the OPC index admission did not reach significant difference between the OPC group and the control group (*Table 3*). These results have led us to conclude that they were two 'similar' groups using healthcare services.

Use of hospital mental health services in the 2 years before and in the 2 years during out-patient commitment (OPC)

	2 years before OPC, mean		2 years of OPC, mean			
Admissions, <i>n</i>	2.16	2.4	0.6	1.69	1.34	0.4
Emergency visits, <i>n</i>	1.84	1.77	0.7	0.77	0.53	0.2
Hospital stay, days	21.94	21.33	0.7	16.41	19.55	0.3
Patients, <i>n</i> (%)	75 (100)	75 (100)		31 (41)	24 (32)	

Regarding the number of admissions in the 2 years before the index admission in both groups, more than half of the patients (52%) had one hospital admission ($n = 39$), 27% had two admissions ($n = 20$), and the rest (21%) had more than 2 admissions (between 3 and 6 in the previous 2 years).

At 2 years after the index admission, the same three variables were checked. A significant decrease in the number of emergency visits and admissions and a decrease in the average length of hospital stay were found in both the OPC and the control group when compared with the results for the previous 2 years. There were, however, no statistically significant differences found when comparing the OPC group with the control group (*Table 3*).

Overall, 41% of patients on an OPC and 32% of controls had a hospital admission during the 2 years after the index admission. Of the patients in the OPC group, 20% ($n = 5$) and of those in the control group 17% ($n = 13$) had only one admission, whereas the remainder (21% in the OPC group and 15% in the control group) had more than two admissions.

Discussion

In the present work, and in agreement with the medical literature, OPC is applied with greater frequency to persons with schizophrenia (73%). Like other authors,^{6,21,22,27-29} we found no significant differences between the control and OPC groups in the use of healthcare services: number of emergency visits, number of hospital admissions and average length of hospital stay.

The results of this work cast a shadow of doubt on the effectiveness of OPC as a measure of compulsory treatment in the community. No statistically significant differences were found between the number of emergency visits (mean 0.77), admissions (mean 1.69) and the length of hospital stay (mean 16.41 days) for the OPC group and for the control group (0.53, 1.34 and 19.55 respectively) (*Table 3*). If efficacy is defined by the reduced use of hospital services as examined in this study, our results indicate that this legislation is not more effective than standard treatment.

Limitations of the study

On the one hand, the differences found between the reasons for admission for the OPC group and for the control group undermine the similarity of the two study groups and, therefore, the suitability for comparison. On the other hand, there are the general limitations of retrospective case-control studies (such a study cannot rule out selection bias nor confounding bias given the impossibility of performing a random assignment of the participants).

It is striking that despite evidence in the literature that OPC has no significant effects on hospital service use outcomes, there is a remarkable consistency in the characteristics of patients who should undergo this intervention.^{22,26} The application of OPC should not be a generalised measure, but should be limited to those patients with severe mental disorders in whom a lack of therapeutic adherence will lead to a severe deterioration of the illness or the appearance of violent behaviour and, therefore, seriously compromise the patient's ability to live in the community.

One important question is whether OPC improves outcomes in services that are already offering a good quality of care. The answer at present appears to be no judging by the balance of evidence. Nevertheless, even if intensive follow-up programmes such as ACT are provided, it may be necessary in some cases to apply OPC.³⁰

The effectiveness of OPC can be estimated using other outcomes, for example patient satisfaction or adherence to treatment during or after the application of OPC. Further studies are required to provide more information about the effectiveness of this treatment strategy and to clarify the contradiction between negative scientific evidence and its use in clinical practice.

1.8.49 Stigma and self-esteem across societies: avoiding blanket psychological responses to gay men experiencing homophobia

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Abstract

Aims and method The relationship between homophobia (varying from actual and perceived to internalised) and measures of well-being is well documented. A study in Athens, Greece and London, UK attempted to examine this relationship in two cities with potentially different levels of homophobia. One-hundred and eighty-eight men who have sex with men (MSM) living in London and 173 MSM living in Athens completed a survey investigating their views on their sexuality, perceptions of local homophobia and their identity evaluation in terms of global self-esteem.

Results The results confirmed a negative association between homophobia and self-esteem within each city sample. However, Athens MSM, despite perceiving significantly higher levels of local homophobia than London MSM, did not differ on most indicators of internalised homophobia and

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scored higher on global self-esteem than London MSM. The city context had a significant impact on the relationship.

Clinical implications The findings are discussed in relation to the implications they pose for mental health professionals dealing with MSM from communities experiencing variable societal stigmatisation and its effect on a positive sense of self.

Contents

- *Stigma and self-esteem across societies: avoiding blanket psychological responses to gay men experiencing homophobia*
 - *Aims*
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Goffman¹ identified homosexuality as falling into a stigmatised category based on moral failing (i.e. being responsible and therefore being blamed for the condition) and rooted in patriarchal and heteronormative positions as well as the main, mostly monotheistic, religions. The most commonly used term to describe the stigmatisation of lesbian, gay and bisexual (LGB) people is ‘homophobia’ as the dislike or hatred towards homosexuals.² Homophobia is often experienced by gay people from their early years at school, within their families, within their immediate daily environment and in broader society including its institutions, such as the media, workplaces or legislative bodies. Homophobia takes many forms that have been described extensively in the literature in terms of discrimination, violence, prejudice and stereotypes and harassment.³⁻⁶ Importantly, homophobia appears to affect gay people’s own beliefs and attitudes towards themselves. This is known as ‘internalised homophobia’, the phenomenon where gay people are to a variable extent unhappy about their sexual orientation because of societal homophobia.⁷

In general, stigmatisation of an attribute may have a negative effect on a person’s positive sense of self. In the case of LGB people, there is evidence that homophobia, both perceived and internalised, affects them in terms of their overall well-being and often in terms of their self-esteem.⁸⁻¹¹ Self-esteem is an individual’s own evaluation of their personal worth and, according to Rosenberg,¹² it refers to the notion of a relatively stable sense of an overall or global, as it is often described, personal worth. There is a voluminous amount of work which has found a relationship between self-esteem and depression,¹³ anxiety,¹⁴ anger, hostility and aggressiveness¹⁵ and life satisfaction.¹⁶ Therefore, self-esteem is an important construct that mental health professionals need to take into account when dealing with mental health problems.

There are many recent surveys in the UK suggesting that homophobia is still widespread and experienced by gay men in their daily lives, affecting their psychological well-being. A number of studies have also shown the direct relationship between homophobia (or fear of being discriminated against) and mental health problems.^{4,6} Furthermore, recent epidemiological studies found that LGB groups have a significantly higher prevalence of mental health problems than the general population; in particular, conditions including common mental disorders and alcohol and substance misuse, and attempted suicide.^{17,18} In addition to a higher prevalence of mental health problems in gay men and LGB groups in general, further evidence suggests that there are disparities in access to mental healthcare. For example, LGB people report a mixed reception from mental health services.¹⁷ In particular, mental healthcare for LGB groups is very often associated with depreciation of their domestic circumstances, refusal to accept partners as next of kin,

professionals' excessive curiosity about LGB lives, concern about confidentiality, and fear that their sexuality will be regarded as the 'pathology' requiring attention.^{19,20} Along these lines, Kitzinger & Coyle²¹ argue that psychological research has always presented homosexuality as a form of pathology and, when dealing with gay or lesbian issues, it is concentrated in clinical and psychotherapeutic psychology.

Societal homophobia is not evident or perceived to be at the same level across all countries or societies. There are historical, cultural and institutional factors that affect its factual or perceived prevalence.^{8,21,22} For example, in institutional terms, there is a broad spectrum that includes countries where homosexual activity is punished to countries where same-sex marriage is recognised. Between these two ends, there are countries where homosexuality is neither illegal nor there are provisions for equal treatment of people irrespective of their sexuality. In relation to the context of this study, there is evidence that Greek society is more homophobic than the UK society^{23,24} and that Greek LGB people tend to face greater difficulties in disclosing their sexuality than Anglo-Americans.²⁵⁻²⁷ In Greece, sex between men was decriminalised in 1951 while there was never any mention of lesbians in Greek law. Today, the age of consent for gay men is set at 17, higher by 2 years than for heterosexuals. There is no official recognition of same-sex couples in any terms. In the UK, although 'homosexuality' was decriminalised later, in 1967, legislation today does not discriminate on the basis of sexuality. Currently, same-sex couples can marry and adopt children.

It needs to be noted that metropolitan and cosmopolitan cities such as London consist of people from a variety of countries and cultures. People who live in London or Athens are not exclusively of White English or Greek ethnic background, nor have they been born and lived in either city all their life. So, the term cross-cultural should be avoided in studies such as this one; instead, cross-city comparisons resemble more and should be referred to as cross-national comparisons. The term 'national' entails the space and the local rules of law, it does not necessarily refer to participants' nationalities in legal terms and in this case, it can include MSM from potentially any cultural communities that live within the national space, although the existence of a predominant cultural and ethnic majority should be acknowledged.

Aims

This study aimed to investigate the link between homophobia and self-esteem in Athens and London, two cities with potentially different levels of perceived homophobia. It investigated the following research questions: Is there a difference in perceived and internalised homophobia between MSM living in London and Athens? Does perceived homophobia relate positively to internalised homophobia and do they both relate negatively to self-esteem of London and Athens MSM? Is there a difference in self-esteem between London and Athens MSM? The study also attempted to investigate whether societal context is important in explaining the relationship between perceived and internalised homophobia and self-esteem.

Method

Participants

The sample included 188 MSM living in London and 173 MSM living in Athens, their mean age being 32 (range 16-64) and 27 (range 16-50) years respectively. The mean time of living in the city was longer for Athens than for London MSM. There was ethnic variation within both samples, but to a lesser degree in Athens than in London; the majority of both samples were White. In terms of sexuality, 89% of London MSM reported that they were sexually attracted to men only, with the remaining 11% being attracted to both men and women. The corresponding figures for Athens MSM were 71% and 29% respectively. In relation to educational level, about 7 in 10 London MSM and 8 in 10 Athens MSM reported to have at least a university degree. Finally, nearly half of the Athenians were recruited and completed the questionnaire online and the rest used a hard copy whereas a small majority of Londoners (56%) filled out the survey online. *Table 1* provides a summary of this demographic information.

Sample characteristics by city

	London (<i>n</i> = 188)	Athens (<i>n</i> = 173)
Age, years (mean)	32	27
Living in the city, mean	12 years 4 months	20 years 3 months
Ethnic group, %		
White	56.3	86.1
Other	43.7	13.9
Sexuality, ^a %		
Gay	89.1	71.4
Bisexual	10.9	28.6
Participation method, %		
Offline	44.1	52
Online	55.9	48

London *n* = 183, Athens *n* = 168

As there was some scepticism as to whether living in a city for only a few years would be considered sufficient for the participants to be 'typical' Londoners or Athenians and because such participants may not have had informed views about how their fellow citizens view gay men in their city, differences in the responses given on all variables of the questionnaire between participants living in London for less than 5 years or more than 5 years were investigated. No statistically significant differences were found. A similar analysis could not be conducted for the Athenian sample because only a handful of participants lived in the city for less than 5 years.

Procedure

A survey took place in the capital cities of Greece and the UK in Greek and English respectively. Participants were recruited using two methods: the distribution of questionnaires at gay venues (the questionnaires were then self-completed) and through an online questionnaire advertised in several popular gay-themed websites. The study was presented as one examining gay men's views about their social environment, being part of a broader research programme into how gay men see themselves and deal with everyday issues. Potential participants had to be residents of London or Athens for at least the past 12 months. They were assured that their responses and their participation in this research project would remain entirely anonymous and they were informed of their right of withdrawal. Data collection took place over a period of the same 3 months for both cities, although the majority of offline survey data were collected over 2-week periods in each city within those 3 months when the online survey link was live.

Materials

The study was conducted through a survey that, apart from questions on demographics, included four scales: ‘disclosure of one’s sexuality’, ‘perceived homophobia of the general public and of people close to the participants’, MSM’s ‘internalised homophobia’, and ‘global self-esteem’. The scales, based on existing English-language scales or developed first in English, were translated to Greek and back-translated until they matched each other so that similar items were asked to both English-speaking participants in London and Greek-speaking participants in Athens. Because of the cross-national element of the study, original scales were subjected to psychometric testing to standardise the scales between the two samples. In particular, all Likert-type scales were subjected to factor analyses for the English and Greek versions separately. Cross-language structurally identical scales were formed following the factor analyses solutions as well as conceptual interpretations, and the reliability of each emerging scale was measured in terms of Cronbach’s α in English and Greek separately. Details of the measurements used are given below.

Disclosure of one’s sexuality

Participants were asked to report the extent to which they were ‘out’ at work, to friends and family. For example, participants had to state whether they had discussed their sexuality with all, some or none of their friends.

Perceived homophobia of the general public and of people close to the participants

Participants’ perceptions of other people’s homophobic feelings and attitudes were assessed using 36 items based on the Modern Homophobia Scale developed by Raja & Stokes.²⁸ Eight items were preselected according to their original loadings in the factor analysis that Raja & Stokes ran. Preference was shown to items with higher loadings under each of the three factors of the authors’ factor analysis solution as well as items with relevance to this study and its cross-national context. For example, an item referring to gay men being allowed to join the military rather than the item that referred to openly gay celebrities advertising products was chosen despite the lower loading of the former; the reason was that both countries have armies but there are no openly gay celebrities in Greece. Furthermore, the selected items were modified to reflect representations of homophobia; instead of using the original statements written in the first person such as ‘I wouldn’t mind going to a party that included gay men’, the statements were modified to read ‘I think that most Londoners/Athenians wouldn’t mind going to a party that included gay men’. The same preselected eight items were repeated four times each to capture the perceptions of our participants on how homophobic they think that (a) the general public, (b) their family members, (c) their friends, and (d) their colleagues are. So, the expression ‘most Londoners’ or ‘most Athenians’ was replaced by ‘most members of my family’, ‘most of my friends’, and ‘most of my colleagues’ accordingly. Note that the wording of these representations assessed homophobia in terms of attitudes and behaviour towards gay men only rather than sexual minorities in general. All statements were scored on a 1 to 5 Likert-type scale with 1 meaning ‘strongly disagree’ and 5 meaning ‘strongly agree’. Reliability alphas for the scales made up of 8 items each and assessing perceived homophobia of the 4 different groups of people in both London and Athens were good and varied from 0.76 to 0.93.

Internalised homophobia

Mayfield’s²⁹ Internalized Homonegativity Inventory was used, including its three factors referring to ‘personal homonegativity’ (e.g. ‘I feel ashamed of my homosexuality’), ‘gay affirmation’ (e.g. ‘I believe being gay is an important part of me’) and ‘morality of homosexuality’ (e.g. ‘I believe it is morally wrong for men to be attracted to each other’). Factor analyses run for each sample confirmed the existence of these factors. One item was excluded from the ‘morality of homosexuality’ factor as it was reducing the α of the Greek scale below the 0.60 level; the same item had to be removed from the English version for equivalence. The alphas of the three factors were 0.69, 0.77, 0.90 and 0.63, 0.76, 0.88 for the English and Greek versions respectively.

Self-esteem scale

Finally, Rosenberg's¹² Global Self-Esteem Scale consisting of ten items was used in full to provide a measure of the participants' perception of self-worth. The items of the original scale were rated on a 4-point 'strongly disagree' to 'strongly agree' scale but we added a middle fifth option of 'neither disagree nor agree' to increase variance in the data. A single-factor solution was produced for both city samples with reliability 0.88 for London and 0.87 for Athens.

Results

In analysing the data, missing values met within any section of this survey were not treated in any way, and cases with missing values were excluded analysis by analysis. Because numbers of valid cases for each analysis conducted were adequate, treating of missing values with the potential to affect results was seen as erroneous.

Initially, in establishing potential differences in the views and attitudes of Athens and London participants themselves, an important observation was that there were statistically significant differences between the two city groups in relation to the disclosure of their sexuality to other people (*Fig. 1*). The scores obtained on this measure were subjected to a 3×2 chi-squared analysis. Differences between the samples were found to be highly significant when discussion with family members ($\chi^2 = 45.25$, d.f. = 2, $P < 0.001$) and friends ($\chi^2 = 39.15$, d.f. = 2, $P < 0.001$) was concerned and as far as hiding ($\chi^2 = 65.96$, d.f. = 2, $P < 0.001$) or revealing ($\chi^2 = 72.46$, d.f. = 2, $P < 0.001$) sexuality from colleagues at work or university was concerned.

A multivariate analysis of variance (MANOVA) was then conducted to investigate the differences seen in *Table 1* between London and Athens MSM in their views on how they think the general local public and people close to them see gay men (*Table 2*). Overall, Athens MSM perceived other people's homophobia, whether general public, friends, family members or colleagues, to be higher compared with London MSM perceptions. There was a significant overall difference between the two populations on the combined four dependent variables ($F_{(4, 298)} = 36.63$, $P < 0.001$; Wilks's $\lambda = 0.67$, partial $\eta^2 = 0.33$). In the separate analyses for each dependent variable, all differences between Londoners and Athenians were also found to be highly statistically significant (*Table 3*).

Descriptive statistics of the Likert-type variables of the study

5-point Likert-type variables (<i>n</i> items)	London <i>n</i> (mean) s.d.	Athens <i>n</i> (mean) s.d.
Perceived homophobia		
General public (8)	176 (2.38) 0.59	166 (3.14) 0.63
Friends (8)	176 (1.75) 0.63	156 (2.40) 0.68
Family (8)	175 (2.37) 0.96	156 (3.23) 0.83
Colleagues (8)	173 (1.98) 0.73	155 (2.67) 0.73
Gay men's personal homonegativity (11)	184 (1.87) 0.72	167 (1.95) 0.70
Gay men's negative views on morality of homosexuality (4)	185 (1.25) 0.46	167 (1.37) 0.51
Gay affirmation (7)	186 (3.72) 0.66	166 (3.60) 0.67
Self-esteem (10)	172 (3.92) 0.68	155 (4.10) 0.65

Between-subjects effects on the variables referring to perceived homophobia of others

Variables	<i>F</i> _a	<i>p</i> ²
Perceived homophobia of general public (8)	111.889	0.271
Perceived homophobia of friends (8)	85.349	0.221
Perceived homophobia of family (8)	75.872	0.201
Perceived homophobia of colleagues (8)	72.925	0.195

d.f. = 1, d.f. for error = 301, $P = 0.000$ for all variables.

In investigating the differences between the two samples in relation to 'internalised homophobia' as again seen in *Table 1*, a one-way between-groups MANOVA showed that there was a narrowly statistically significant difference between Londoners and Athenians on the combined dependent variables ($F_{(3, 340)} = 2.65, P < 0.05$; Wilks's $\lambda = 0.98$, partial $\eta^2 = 0.02$). When the results for the three dependent variables were considered separately, Athens MSM scored significantly higher only on the 'morality of homosexuality' variable ($F_{(1, 342)} = 6.545, P < 0.05$, partial $\eta^2 = 0.02$).

Third, an independent-samples *t*-test was conducted to compare the self-esteem scores (*Table 2*) for the London and Athens samples. There was a significant difference in scores between the two groups with Athenians reporting a higher self-esteem than Londoners ($t = 2.421$, d.f. = 325, $P < 0.05$, $r = 0.13$).

Correlational analysis showed, as expected, positive relationships between most perceived and internalised homophobia scales and negative relationships between homophobia and self-esteem scales. Online tables DS1 and DS2 show that these findings are relatively consistent across the two city samples. Further regression analyses were carried out to test the relationship of both internalised and perceived homophobia of others controlling for city. Correlations showed that factors for each scale were significantly associated with each other; this was expected given that they are subscales of the same construct. Therefore, and to avoid multi-collinearity, the composite scores of the scales were used. To test whether city explained the relationship between homophobia (internalised and perceived) and self-esteem, a stepwise hierarchical regression was conducted. The first step tested the relationship between homophobia and self-esteem and the second step tested whether the addition of city had a significant impact on the model. The inter-correlations between 'self-esteem' and 'perceived homophobia of others' as well as 'internalised homophobia' were significant ($r = 0.15, P < 0.05$ and $r = 0.27, P < 0.001$ respectively). The correlation between perceived and internalised homophobia was also significant ($r = 0.29, P < 0.001$). Model 1 is statistically significant (adjusted $R^2 = 0.070, P < 0.001$) but self-esteem is explained significantly only by internalised homophobia (*Table 4*). City, in model 2 has a significant impact on the relationship between internalised and perceived homophobia of others and self-esteem (adjusted $R^2 = 0.12, P < 0.001$). In particular, city explains an additional 5% of the model. Moreover, both homophobia scales in the model independently explain self-esteem significantly.

Explanation of self-esteem by homophobia scales (composite scores) and the role of city context

Independent variables	Standardised	<i>T</i>	<i>P</i>
<i>Step 1</i>			
Perception of homophobia in others	0.079	1.403	n.s.
Internalised homophobia	0.242	4.313	~0
$F_{(2, 321)} = 13.1, R = 0.275, R^2 = 0.076, \text{adjusted } R^2 = 0.070, P < 0.001$			
<i>Step 2</i>			
Perception of homophobia in others	0.228	3.479	0.001
Internalised homophobia	0.210	3.805	~0
City context	0.260	4.147	~0
$F_{(3, 320)} = 14.9, R = 0.351, R^2 = 0.123, \text{adjusted } R^2 = 0.12, P < 0.001.$			

Discussion

The first aim of this study was to explore potential differences between MSM living in Athens and London in relation to how they view their sexuality and on the ways in which others in their broader environment or those close to them see gay men. The findings suggested that there are indeed some significant differences between the samples of the two cities. Athens men were more 'closeted' than London men and reported higher levels of homophobia in terms of how the general public and people in their close environment see gay men. However, although Athenians again scored higher in the internalised homophobia scales, such a difference was found to be narrowly significant only when all factors measuring internalised homophobia were combined for the analysis. Finally, there was a difference between scores on the self-esteem scale with Londoners this time reporting lower levels of self-esteem than Athenians. Along these lines, society played a significant role in the relationship between homophobia and self-esteem; the relationship became stronger as a result of city of residence.

In general, Athenians appeared to perceive that they lived in a more homophobic city than Londoners and this could relate to the observation that they felt less comfortable to disclose their sexuality publicly. This finding comes into agreement with the difficulties reported by ethnically Greek gay people in Phellas's²⁶ and Fygetakis's²⁵ studies. One would expect, however, that Athenians' self-esteem might have been lower than Londoners' self-esteem, which in this study was not the case. This could be due to the likely possibility that sexuality was not considered to be the sole or even the most important and salient element of one's life. Our findings support Abrams & Hogg's³⁰ claim that global self-esteem evaluation may not reflect the particular group membership under investigation and also support other findings on the relationship between stigma and self-esteem not being inevitable.³¹ Similarly, Brady & Busse³² found no significant difference in terms of psychological well-being and adjustment among open or closeted respondents in the last three stages of Cass's coming out model. Such findings may relate to Alquijay's³³ argument that, in cultures where interdependence is valued, the meanings of self and self-esteem may be different; this point could be very relevant for our Athens participants. In general, progression through the stages proposed by Cass's model on 'sexual identity formation'³⁴⁻³⁶ may be influenced by expectations of the Greek society. Global self-esteem and its relationship to stigmatised identity may be negotiated in different ways by Greek sexually stigmatised groups compared with other nationalities or to other type of stigmatised groups, again because of specific societal norms that relate to sexuality.

It needs to be underlined that there was a clear negative correlation between self-esteem and personal homophobia in both samples; this supports findings such as Szymanski *et al's*,¹¹ among others, who linked internalised homophobia to the well-being of lesbians and gay men. There were also significant positive correlations between all measurements of perceived homophobia of family members and colleagues with internalised homophobia variables (the direction was negative for 'gay affirmation') and friends' homophobia was found to have the strongest relationship. Such findings demonstrate the potential consequences of societal homophobia on gay men and women. Therefore, it is society that needs to change; this can happen via the promotion of institutional social equity for gay people's self-acceptance and the building of a positive identity as Berg *et al's*⁸ argue.

Limitations

Although our results suggest some interesting relationships, there are limitations regarding the interpretation of findings. One of the main limitations is the correlational nature of the study that does not allow the data to show causal relationships regarding the extent of the contextual impact of homophobia on self-esteem. Additionally, the concepts' measures are related highly to each other and this may have an impact on the results and subsequent conclusions regarding the strength of associations. It would have been beneficial to have used additional outcomes variables that measure mental health and broader well-being. Although self-esteem is a good indicator of well-being, it does not capture its complexity. Therefore, the issue of homophobia and its relationship to well-being in conjunction with societal or cultural differences needs to be unpacked further.

It should also be acknowledged that one of the main limitations of this study is the inability to account for non-response due to the use of online data collection. This is a weakness of internet-based surveys because non-response can threaten the validity of data; participants may differ from non-participants on a number of characteristics. Still, as internet use and internet-based research are gradually becoming more and more common, at least within European contexts such as those in this study, issues of generalisability and validity are dealt with. As Hewson stated,³⁷ there is gradually less

sample bias as potential internet-based research participants are less and less the White, middle-class, technologically proficient people. Mathy *et al.*,³⁸ for example, compared the demographics of a small sample of lesbian and bisexual women with a larger sample collected by a large polling organisation and they found that their rigorous internet sampling designs were found to be more robust and equally representative of the US general population. The internet sample was more representative in terms of education and income and broader ethnic diversity and it was equally effective in representing the distribution of population in rural and urban areas. In addition, there is a point to be made on the online facilitation of self-disclosure and this is very relevant for this study as we recruited people who belong to a stigmatised group. The effectiveness of online or computer-based surveys or interviews for researching sensitive issues such as sexual behaviour is well established. There is ample evidence that computerised internet interface tends to facilitate self-disclosure and honesty among research participants and that participants report lower social anxiety and social desirability when they are using the internet than when they are using paper-based methods.³⁹⁻⁴⁵

In investigating cross-city differences, this study and the way it recruited participants could not have and does not claim to have done such investigations by employing homogeneous cultural groups within each city. Both cities, and especially London, include microcultures within any culture due to the diversity of their populations. This makes it impossible for this study to claim consistency of experiences among participants of each city. However, owing to the way data were collected, the study captures a relatively diverse sample of microcultures that constitute the populations of MSM within each city.

Relevance to mental health services

In conclusion, until societal changes in terms of homophobia happen, mental health professionals need to be aware of contextual differences in dealing with gay men and women who seek help. Although literature suggests that evidence-based interventions for the general population can also be beneficial for gay men,⁴⁶ studies (mainly qualitative in nature) have shown that LGB services are preferred over mainstream ones.²⁰ For example, research has shown that 'gay affirmative therapy' is preferred by LGB people as it views LGB lifestyles and sexual identities positively without pathologising them.⁴⁷ However, these findings come from qualitative studies with purposive samples. There needs to be a strong understanding of indigenous psychologies and the relationship between culture and psychology. Providing blanket responses to feelings of rejection, for example, which may encourage clients to disclose their sexuality as part of the process of self-acceptance and building a positive sense of self is not always the optimal strategy. Complete 'coming out' should not always be seen as the end goal because it may be that it has much graver consequences than incomplete 'coming out' within some societies. The existence of close societal ties between people may be more important for one's well-being. Jeopardising such ties as part of the 'coming out' process may be counterproductive for the gay individual. This may be particularly important in societies that do not have a developed gay community and gay movement that could provide alternative adequate support mechanisms.

1.8.50 Difficult to treat? A comparison of the effectiveness of treatment as usual in refugees and non-refugees

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Abstract

Aims and method To examine treatment response in traumatised refugees, we compared routine outcome monitoring data (Harvard Trauma Questionnaire) of two refugee populations with those of individuals experiencing profession-related trauma who were treated at a specialised psychotrauma institute.

Results Asylum seekers/temporary refugees ($n = 21$) and resettled refugees ($n = 169$) showed significantly lower post-traumatic stress disorder (PTSD) symptom reduction between intake and 1 year after intake than did a comparison group of non-refugees ($n = 37$), but the interaction effect was clinically small (partial $\eta^2 = 0.03$). Refugees who had more severe symptoms at intake showed significantly greater symptom reduction after 1 year.

Clinical implications Therapists and refugee patients should have realistic expectations about response to treatment as usual. Additional treatment focusing on improving quality of life may be needed for refugees whose PTSD symptom severity remains high. At the same time, novel approaches may be developed to boost treatment response in refugee patients with low responsiveness.

Contents

- *Difficult to treat? A comparison of the effectiveness of treatment as usual in refugees and non-refugees*
 - *Method*
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Among many clinicians, traumatised asylum seekers and refugees have a reputation of being difficult to treat. Low treatment response in refugees is often attributed to patient-related factors,¹ such as trauma history, current stressors and complex psychopathology. Many asylum seekers and refugees have been exposed to multiple, prolonged, interpersonal traumatic events such as war and human trafficking.² In addition, they have to handle the stress of forced migration, including involvement in legal procedures³ and loss of their home country, cultural resources, family and social status.⁴ Apart from post-traumatic stress disorder (PTSD),⁵ they may experience comorbid symptoms including depression, anxiety and psychosis,⁶ as well as symptoms sometimes referred to as complex PTSD.⁷ By contrast, some clinicians argue that it is the treatment offered to refugees, rather than their potential to benefit from treatment, that leads to low treatment response,⁸ and that refugees, like other adults with chronic PTSD,⁹ should be treated with trauma-focused interventions. One way to examine treatment response in refugees is by comparing the effectiveness of different kinds of treatment in refugee samples. In recent years, randomised trials have shown promising effects for trauma-focused treatment in refugees.¹⁰ Another way to examine treatment response is to compare the effectiveness of treatment in refugee samples and non-refugee samples. This has been done little, if at all. This study's aim is to compare traumatised

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asylum seekers' and refugees' response to treatment as usual with that of another multiply traumatised population: individuals affected by profession-related trauma (i.e. military veterans and police officers).

Method

Setting

Data were collected in Centrum '45, a Dutch mental health institute specialising in treatment of complex psychotrauma. Specific populations include asylum seekers and refugees, veterans of various peace missions, World War II resistance fighters as well as concentration camp survivors and their offspring, and police officers. Centrum '45 receives national referrals of patients who, owing to their psychosocial complexity, cannot be treated in general mental healthcare or who have shown insufficient response to treatment in general mental healthcare. Treatment for PTSD (individually or in groups) generally consists of a combination of supportive therapy, pharmacotherapy and trauma-focused therapy, particularly eye movement desensitisation and reprocessing (EMDR),¹¹ narrative exposure therapy (NET)¹² and brief eclectic psychotherapy for PTSD (BEPP).¹³ As these three trauma-focused treatments are evidence based, choice of treatment mainly depends on the therapist's training. Art therapy, psychomotor therapy and music therapy are also offered, especially to patients who follow a clinical or day-clinical programme.

Assessments

To evaluate the effectiveness of treatment as usual, Centrum '45 has routinely administered assessments at intake and at the end of treatment. Since 2007, a routine outcome monitoring (ROM) assessment 1 year after intake has been added for all patient populations. Since its introduction, ROM response has increased from around 40 to 55% in 2012. For several years, the Harvard Trauma Questionnaire (HTQ)¹⁴ was used as a ROM instrument with refugees and for a shorter period also with non-refugee populations. The HTQ has been specifically designed for use with refugee populations. It is a self-report instrument that consists of two parts: one focusing on traumatic events and one on symptoms of post-traumatic stress (specific to DSM-IV¹⁵ and additional symptoms reported by traumatised refugees). Symptoms are rated on a four-point scale ranging from 1 (not at all) to 4 (extremely). A mean score of 2.5 has been recommended as cut-off score for PTSD,¹⁶ although this recommendation has not been validated in a wide range of patient populations.

Sample

To answer our research question, we had at our disposal a ROM data-set that consisted of 577 patients who had completed assessments both at intake and 1 year after intake (with a range of 8 to 16 months). From this data-set, we excluded all partners and children of war-affected persons ($n = 218$; primarily children of parents traumatised in World War II) because their reasons for seeking help, generally speaking, do not include PTSD. We then excluded all patients who at intake had not been administered the HTQ ($n = 125$) but another instrument to assess PTSD (a Dutch self-rating inventory for PTSD).¹⁶ As the final dataset contained only a small number of patients traumatised during World War II ($n = 7$), we also excluded those patients. The final data-set consisted of 227 patients who had had their second assessment between March 2007 and April 2013. We divided the sample into three groups: asylum seekers/temporary refugees (i.e. those who are still awaiting the decision on their asylum application and those who have obtained temporary refugee status, which may not be extended after 5 years), resettled refugees (i.e. those who have obtained permanent refugee status or subsequent Dutch nationality), and patients with profession-related trauma (i.e. military veterans and police officers).

Statistical analysis

All analyses were performed using SPSS version 20.0 for Windows. Demographical and clinical characteristics were calculated, and chi-squared and *t*-tests were conducted to check for demographical and clinical differences between the groups. For the HTQ, mean PTSD severity at intake (T1) and one year after intake (T2) was computed as well as the difference between the two (PTSD symptom reduction). We checked HTQ variables for extreme outliers, but we found none. Missing data for the HTQ consisted of missing mean scores at T2 for 7 patients (2 asylum seekers/temporary refugees and 5 resettled refugees) and missing events scores at T1 for 42 patients (4 asylum seekers/temporary refugees, 34 resettled refugees and 4 professionals). We handled missing data by using pair-wise deletion.

We conducted pair-wise *t*-tests to determine treatment response within each group, and calculated by hand the effect sizes (η^2). Following Cohen, we interpreted $\eta^2 = 0.01$ to be a small effect, $\eta^2 = 0.06$ as moderate and $\eta^2 = 0.14$ as large.¹⁷ We set confidence intervals at 95%. To examine potential differences in treatment response between the three groups, we conducted repeated measures analysis of variance (ANOVA), using time as within-subjects factor and group as between-subjects factor. For the interaction effect, an effect-size (partial η^2) of 0.01 was interpreted to be small, 0.09 as medium and 0.25 as large.¹⁷ To examine variables associated with treatment response in asylum seekers and refugees, we performed a multiple regression analysis with PTSD symptom reduction (HTQ score at T1 minus HTQ score at T2) as the dependent variable and demographic variables (gender, age and refugee status (no/temporary/permanent)) and clinical variables (PTSD severity at T1, number of traumatic event types and time between assessments) as independent variables.

Results

Demographic characteristics

For demographic and clinical characteristics of the final sample, see *Table 1*.

Demographic and clinical characteristics of the groups

	Asylum seekers/ temporary refugees (<i>n</i> = 21)	Resettled refugees (<i>n</i> = 169)	Profession-related trauma (<i>n</i> = 37)	<i>F</i>	d.f.	<i>P</i>
Demographic characteristics						
Age, years: mean (s.d.)	36.1 (10.4)	43.8 (8.9)	44.5 (8.6)	7.32	2	0.001
Male, <i>n</i> (%)	12 (57.1)	123 (72.8)	34 (91.9)		2	0.009 ^a
Clinical characteristics						
HTQ score at intake, mean (s.d.)	3.14 (0.35)	3.08 (0.52)	2.80 (0.53)	6.72	2	0.002
Traumatic event types (HTQ), <i>b n</i> : mean (s.d.)	13.9 (4.0)	12.3 (5.4)	9.3 (4.6)	8.12	2	0.001
Time between assessments, months: mean (s.d.)	12.1 (1.7)	12.1 (1.4)	10.6 (1.5)	16.09	2	<0.001

HTQ, Harvard Trauma Questionnaire.

^a $\eta^2 = 9.47$.

Experienced or witnessed.

Because this study was observational, we found significant differences in demographic and clinical characteristics between the three groups for all variables. Asylum seekers/temporary refugees came predominantly from Afghanistan, Armenia, Iraq and Sierra Leone ($n = 3$, 14.3% for each country); resettled refugees came predominantly from the former Yugoslavia ($n = 59$, 34.9%), Iraq ($n = 28$, 16.6%) and Afghanistan ($n = 22$, 13.0%); and patients who had profession-related trauma came predominantly from The Netherlands ($n = 33$, 89.2%). The traumatic events that the asylum seekers/temporary refugees most frequently reported were physical torture ($n = 17$, 81.0%), threat of physical torture ($n = 17$, 81.0%) and other life-threatening situation ($n = 17$, 81.0%). Resettled refugees most frequently reported being close to death ($n = 135$, 79.9%), other life-threatening situation ($n = 125$, 74.0%) and forced isolation from family ($n = 123$, 72.8%). Professionals most frequently reported other life-threatening situation ($n = 34$, 91.9%), combat situation ($n = 34$, 91.9%), serious injury ($n = 31$, 83.8%) and being close to death ($n = 31$, 83.8%).

Treatment outcome

Figure 1 shows the results of the repeated measures ANOVA for the three groups.

Fig. 17: PTSD symptom severity at intake and after 1 year.

Mean PTSD symptom severity decreased from 3.13 (95% CI 2.91 to 3.35) to 2.92 (95% CI 2.65 to 3.20) for asylum seekers/temporary refugees; from 3.10 (95% CI 3.03 to 3.18) to 2.88 (95% CI 2.79 to 2.98) for resettled refugees; and from 2.80 (95% CI 2.64 to 2.96) to 2.31 (95% CI 2.11 to 2.51) for patients suffering from profession-related trauma. Paired-samples t -tests revealed a significant decrease in PTSD severity for resettled refugees (0.22, s.d. = 0.52, $t_{(163)} = 5.39$, $P < 0.001$) and for professionals (0.49, s.d. = 0.64, $t_{(36)} = 4.65$, $P < 0.001$), but not for the smallest group, asylum seekers/temporary refugees (0.21, s.d. = 0.59, $t_{(18)} = 1.53$, $P = 0.143$). Effect sizes for treatment response in asylum seekers/temporary refugees and resettled refugees were moderate ($\eta^2 = 0.12$ and $\eta^2 = 0.15$, respectively); effect size for patients with profession-related trauma was large ($\eta^2 = 0.38$).¹⁶ Repeated measures ANOVA showed a significant effect for time ($F = 32.27$, $P < 0.001$) with a medium effect size (partial $\eta^2 = 0.13$), and a significant group \times time interaction effect ($F = 3.65$, $P = 0.028$) with a small effect size (partial $\eta^2 = 0.03$).¹⁶

We then combined the two refugee groups and, using multiple regression analysis, we examined whether seven demographic and clinical variables were associated with PTSD symptom reduction (Table 2).

Factors associated with reduction in PTSD symptom severity in refugees after 1 year

	B	95% CI		P
Demographic variables				
Gender	0.11	0.07 to 0.29	0.09	0.238
Age	0.00	0.01 to 0.00	0.09	0.277
Refugee status				
None v. permanent	0.03	0.37 to 0.31	0.01	0.872
Temporary v. permanent	0.14	0.52 to 0.24	0.06	0.464
Clinical variables				
PTSD symptom severity at intake (HTQ)	0.48	0.32 to 0.64	0.45	<0.001
Traumatic event types (HTQ), n	0.01	0.03 to 0.00	0.11	0.157
Time between assessments, months	0.01	0.06 to 0.05	0.01	0.851

B, regression coefficient; , standardised regression coefficient; HTQ, Harvard Trauma Questionnaire; PTSD, post-traumatic stress disorder

As shown in Table 2, refugee patients with more severe PTSD symptoms at intake had significantly stronger reductions in PTSD symptom severity after 1 year. The other variables were not significantly associated with PTSD symptom reduction. The percentage of variance explained by the model (R^2) was 21.5%.

Discussion

This study shows that asylum seekers/temporary refugees and resettled refugees experienced significantly lower PTSD symptom reduction between intake and 1 year after intake than did a comparison group of multiply traumatised military veterans and police officers. However, greatest differences between groups were found in PTSD symptom severity at intake and 1 year after intake rather than in PTSD symptom reduction. Explorations of PTSD symptom reduction in refugees showed that those who had more severe symptoms at intake experienced significantly greater symptom reduction after 1 year; other variables (including variables related to refugee status and number of traumatic events) were not related to symptom reduction.

The results show that despite specialised treatment being offered to refugees, treatment response can be limited and PTSD severity frequently remains high. Possible explanations, and consequently clinical implications, might be three-fold: patient-related, therapist-related and treatment-related. As for patient-related factors, the multiple determinants of PTSD might influence refugees' ability to benefit from treatment. It is generally acknowledged that PTSD in refugees is influenced by both traumatic and current stressors, some (or many) of which may be beyond the patients' and therapists' control.¹⁸ Following this explanation, clinicians and patients should have realistic expectations about what treatment may achieve in such a heavily traumatised and burdened population. Interventions that focus on improving quality of life rather than on further symptom reduction, such as acceptance and commitment therapy,¹⁹ might be useful for those patients who despite prolonged treatment continue to suffer from clinically significant PTSD. Clinicians sometimes suspect asylum seekers to exaggerate symptoms to remain in medical care and thereby increase the chance of obtaining a refugee status. We found no substantiation for this hypothesis of 'secondary gain' - in our study, not having a permanent refugee status was not associated with a decreased treatment response.

As for therapist-related factors, therapeutic skills that might suffice in trauma-focused treatment of other multiply traumatised groups might fall short in the treatment of refugees. Therapists might need more extensive training and supervision regarding choosing and staying with a treatment focus, categorising and selecting of target memories, and understanding and restructuring of trauma-related cognitions in order not to lose their way in the multitude of symptoms, memories and transcultural challenges. At the same time, therapists need to maintain a sense of being 'good enough' to provide treatment to refugees with limited responsiveness.²⁰

Finally, regarding treatment-related factors, not all evidence-based treatments will work with all refugees. Therapists will need to explore non-response, and they may need to consult refugee patient populations themselves²¹ to examine which treatment aims and techniques speak to refugees who insufficiently benefit from treatment as usual. In addition, novel approaches may be developed to enhance treatment response. Centrum '45 is currently exploring the feasibility of refugee treatment that focuses primarily on prolonged grief rather than on PTSD, and of intranasal oxytocin as a novel strategy to boost treatment response in refugees.²²

Limitations

Although this study is valuable for comparing the effects of treatment as usual in refugee populations with those in a non-refugee population (which, to our knowledge, has not been done before), it also has several limitations. First, a division of the asylum seeker group into asylum seekers and temporary refugees, and of the profession-related trauma group into military veterans and police officers, would have been clinically meaningful but was not possible due to limited sample sizes for these groups. Second, some variables that might have shed light on differences in treatment response between the three groups (including comorbid disorders, the amount and content of treatment, change in refugee status and chronicity of PTSD) were not included in the data-set. Future studies should use a broader range of variables to more comprehensively assess predictors of refugees' treatment responses. Third, ROM assessments at our institute are completed by about 55% of patients, and findings might not generalise to our complete patient population, nor to traumatised refugees in general.

Nevertheless, our study contributes to the debate on refugees' treatment response by showing that it is indeed relatively lower than that of multiply traumatised non-refugees.

We thank Niels van der Aa for providing us with the data-set and methodological information.

1.8.51 Brain fog syndrome: a culture-bound syndrome that may be approaching extinction

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Abstract

Aims and method To explore the current salience of ‘brain fog’ as a nosological, diagnostic and clinical construct in modern West African psychiatry. A semi-structured questionnaire and vignette based on classical symptoms of brain fog syndrome were used to explore current knowledge, explanatory models and practice among Nigerian psychiatrists.

Results Of 102 psychiatrists who responded, 98% recognised the term ‘brain fog syndrome’ and most recognised the scenario presented. However, only 22% made a diagnosis of brain fog syndrome in their practice preferring diagnoses of anxiety, affective and somatic disorders.

Clinical implications A decreasing number of Nigerian psychiatrists are making a diagnosis of ‘brain fog syndrome’. We found strong evidence of nosological and diagnostic decline in the syndrome in its place of birth. This may signal the early extinction of this disorder or nosological metamorphosis from a ‘culture-bound’ syndrome in West African psychiatric practice.

Contents

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 - * *Aetiological explanations and attributions*

1

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- * *Recognition of brain fog syndrome*
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- * *Management*

In 1960 Raymond Prince,¹ a founding figure in the field of transcultural psychiatry, published a seminal paper describing unique cultural observations in Nigeria, a newly independent country in British West Africa. At the time, Prince (a Canadian psychiatrist) had been working in Yoruba-speaking south-western Nigeria. In the paper he described a cluster of symptoms he observed in Nigerian students, which were associated with study and manifesting a range of emotional and somatic complaints. Given the recurrent reference to mental exhaustion ('brain fog') Prince named this symptom cluster 'brain fog syndrome'.

Distinctive symptoms of the syndrome were: intellectual impairmentsensory impairment (chiefly visual)somatic complaints, most commonly of pain or burning in the head and neckother complaints affecting the student's ability to studyan unhappy, tense facial expressiona characteristic gesture of passing the hand over the surface of the scalp or rubbing the vertex of the skull. Citing Prince: "Most often the symptoms commenced during periods of intensive reading and study prior to examinations or sometimes just following periods of intensive study ... The patients generally attribute their illness to fatigue of the brain due to excessive "brain work".' (p. 561)¹" As Price elaborated, it is for this reason that the term brain fog syndrome has been used. The expression seems to be used by Nigerians generally to describe any psychiatric disturbance occurring in 'brain workers'. Exploring the unfamiliar nature of the presentation, brain fog was at the time ascribed to 'a clash between Western and African cultural values'.¹

This unfamiliar clinical presentation and manifestation of distress was initially felt to be a culture-bound syndrome localised to southern Nigeria. Subsequently, further reports were published from other African regions.^{2,3} These case reports and student population surveys highlighted psychological distress associated with study in some African students.^{2,3} Over the decades, there has been some debate by predominantly African psychiatrists as to whether this actually constitutes a unique nosological entity, cultural manifestation or unique amalgamation of more established mental disorders.⁴⁻⁶ An interesting review of brain fog syndrome literature by Ola *et al*⁵ details the different arguments.

While reference is made to brain fog syndrome in both the tenth edition of ICD-10⁷ and the 'Glossary of Culture Bound Syndromes' in the fourth edition (revised) of DSM-IV-TR,⁸ the current relevance to clinical practice is uncertain. The DSM IV-TR described brain fog syndrome as a culture-bound syndrome attributed to overwork and affecting West African students. Characterised by a loss of ability to concentrate, learn, remember or think and usually accompanied by sensations of pain, pressure or tightness around the head or neck and blurred vision, a condition which 'can resemble certain Anxiety, Depressive and Somatoform Disorders'.⁸ The newer DSM-5, however, is less detailed regarding brain fog and cites it as an example of a cultural anxiety syndrome.⁹

Nigerian psychiatric services, although based on Western models, are also familiar with the assessment and treatment of West African cultural presentations of affective, psychotic and anxiety disorders. Competition with traditional and faith healers abounds as do belief systems about emotional distress. The ICD-10 is primarily used for diagnostic classification, although DSM classification is also recognised. Medical instruction and scholarship is in English and the majority of practitioners are at least bilingual and speak one or more indigenous languages.

The limited diagnostic clarity about the validity of this culture-bound syndrome⁵ justifies an exploration of the existence of brain fog in modern West African psychiatry. A factor analysis and differentiation of somatic symptoms in Africans with depression¹⁰ and the validation of burning and crawling sensations in the Brain Fog Syndrome Scale are important empirical steps towards this.¹¹ If a prevalent disorder, the exponential growth in secondary and tertiary educational institutions (online Fig. DS1) would potentially have an impact on the mental well-being of millions of adolescents and young adults with health and resource implications. Conversely, if the diagnostic status is unclear, the pathologisation of young people may lead to inappropriate help-seeking or impair education.

When brain fog syndrome was originally described in Nigeria in 1960, Western models of psychiatric care were in their infancy, with only four indigenous, linguistically and culturally embedded psychiatrists in the country. International

psychiatrists from the UK, the USA, Canada (including Raymond Prince) and Germany made significant contributions to service development and the training of mental health professionals in the country. While the number of mental health professionals has shown sustained growth over the years, the number of psychiatrists remains grossly inadequate, with an estimated 0.15 psychiatrists per 100 000 Nigerians.¹⁰ Unfortunately, 25% migrate within 5 years of completing training.¹² Such specialist workforce changes may influence skill stability.

There have been no known surveys to date of West African mental health professionals on their opinions and practice relating to brain fog syndrome.

Aim

This study aimed to explore awareness of brain fog, its aetiology, diagnosis, explanatory models and management by psychiatrists in Nigeria, where this disorder was originally described.

We sought to explore the nosological salience of brain fog syndrome among contemporary West African psychiatrists in Nigeria and to ascertain whether it is still regarded as a distinct disorder or an idiomatic expression. We were also interested in exploring the historical course of the syndrome over time. Opportunities to explore the modern and cultural history of disorders do not arise often in anthropological medicine.

Method

A semi-structured, self-administered questionnaire that incorporated both coded and written text responses was designed as a survey of 'psychological distress' among students. It was mailed to psychiatrists in tertiary, secondary and private psychiatric facilities across Nigeria. Electronic copies were also disseminated. Further uptake was facilitated at the conference of the Association of Psychiatrists in Nigeria, the key professional body for psychiatrists. Questions were clustered into the following categories: clinical experience in psychiatry (number of years of practice, seniority) setting of clinical practice (e.g. teaching hospital, specialist psychiatric hospital, general hospital and private practice) geographical region of country clinical case-load and number of patients seen per month. Respondents were presented with a vignette (*Box 1*) describing classic brain fog features in a student. Though based on core diagnostic features of brain fog syndrome, the term 'brain fog' was withheld from respondents until the end of the questionnaire. Respondents were asked a few short questions (e.g. 'Are you familiar with this type of presentation in your practice?'), the frequency and approximate number of patients with this unnamed symptom cluster they had seen in the past 12 months. It is worth stressing that these questions referred to symptoms in the vignette and not a specific diagnosis of brain fog syndrome.

Box 1 Vignette presented to psychiatrists in the study

A 20-year-old student presents complaining of 'burning heat or pain in the head and neck'. The student also experiences difficulty concentrating, assimilating and recalling things studied, as if 'the brain ... is dead or not working'. Vision is sometimes blurred. Sleep has also been poor. The student wishes to pursue further studies and is concerned about the implications of this experience.

From the vignette, the psychiatrists were then asked to consider a diagnosis and differential diagnosis as they would in routine clinical practice such as anxiety disorder, depressive disorder, somatisation disorder, psychotic disorder, or another category. In addition, they were asked to proffer aetiological explanations for the presentation as well as the therapeutic options that they would offer the individual in the scenario. This was a free-text section so as to allow folk, social and other non-medical explanatory models. A content analysis of these responses was carried out to identify themes.

The concept of brain fog syndrome was introduced in the final part of the questionnaire to minimise contamination or bias to the earlier responses. This section explored whether the respondent had ever heard of brain fog syndrome and whether they made this diagnosis in routine clinical practice. The psychiatrists were encouraged to provide additional comments or alternative explanations, views and opinions on any aspect of the study.

Questionnaires were returned by prepaid envelope, hand delivery and electronically.

In addition, five decades of historical context into psychiatric services in Africa and the genesis of brain fog syndrome were obtained through personal communication with current and retired psychiatrists, as well as an anthropological field worker and interpreter used in the original work. Full qualitative details are outside the scope of this paper, but are being prepared for publication in another paper.

Results

Overall, 102 responses were received from all regions of the country. The national response rate of 36%, while relatively low, overcame logistical challenges and showed a good geographical, ethnic and clinical spread across Nigerian mental health services. Interestingly, this rate mirrored a mail survey of psychiatrists by the World Health Organization and the World Psychiatric Association (Nigeria 36%, USA 21%, UK 22%, South Africa 24%) across 44 countries¹³ and was also similar to other non-incentivised physician surveys.¹⁴

So as not to restrict opinions, more than one diagnostic response was permitted to some questions, therefore some totals were over 100%.

Psychiatrist characteristics

Forty-four percent of respondents were registrars, 33% senior registrars, 21% consultants and 2% psychiatric medical officers. The mean number of years of experience in psychiatry was 6.3 with a median of 4 years and a range of 1-37 years (*Fig. 1*). The doctors saw an average of 152 patients per month.

Location of practice

Sixty-nine (68%) of the psychiatrists were from the south of Nigeria and 33 (32%) were from the northern regions. This distribution closely reflects the regional density of psychiatric services in the country.

Awareness of symptoms in the brain fog questionnaire vignette

The majority of psychiatrists (95%) were familiar with the presentation in the vignette in their routine practice and 84.3% ($n = 86$) had seen patients with similar symptoms within the past year (*Fig. 2*). On average, each psychiatrist saw 14.2 patients presenting with vignette symptoms annually, approximately 0.78% of their annual clinical case-load or 1:128 patients.

Fig. 18: Number of patients with brain fog symptoms seen in past year

Nosology of symptoms and signs

The vignette symptoms were classified as an anxiety disorder by 49% of psychiatrists, while 37% considered brain fog syndrome; 36% felt the presentation was consistent with a depressive disorder and 30% associated it with somatisation disorder.

Aetiological explanations and attributions

Nigerian psychiatrists suggested a number of possible aetiological factors for the brain fog syndrome core criteria vignette symptoms (*Table 1*). Content analysis observed explanatory themes attributed to the following causes: mental disorders (9.23%), psychogenic (24.10%), educational difficulties (32.31%), sociocultural (9.23%), interpersonal (3.59%), biological (9.74%), substance misuse (4.61%) and demographic factors (1.02%) while 6.15% of the psychiatrists gave no aetiological explanation.

Causes of vignette symptoms suggested by respondents ($n = 195$)

Category	Subcategory	<i>n</i>
Mental disorder ($n = 18, 9.23\%$)	Somatisation	14
	Anxiety	2
	Depression	1
	Psychiatric history	1
Psychogenic ($n = 47, 24.10\%$)	Stress	29
	Psychological	12
	Poor coping mechanisms	3
	Behavioural	2
	Loss	1
Study and education ($n = 63, 32.31\%$)	Educational concerns	31
	Influence of foreign language	10
	Intensive study	9
	Desire to succeed	7
	Fear of failure	2
	Goal failure	1
	Motivational factors	1
	Low productivity	1
	Modernisation through study	1
Sociocultural ($n = 18, 9.23\%$)	Socioeconomic	11
	Cultural	3
	Environmental	3
	Witchcraft	1
Substance misuse ($n = 9, 4.61\%$)	Psychostimulants	
Interpersonal issues ($n = 7, 3.59\%$)	Personality	4
	Strained relationships	1
	Family disharmony	2
Organic/biological ($n = 19, 9.74\%$)	Genetic	13
	Biological	2
	Sympathetic activity	2
	Trauma	1
	Malaria	1
Demographic ($n = 2, 1.02\%$)	First born	1
	Male gender	1

Unknown ($n = 12$, 6.15%)

Management

Nearly half of the psychiatrists (46.47%) advocated the use of psychological therapies such as psychotherapy, counselling, cognitive-behavioural therapy and family therapy in the management of the symptoms. Psychotropic medications (e.g. antidepressant, anxiolytics) were suggested by 42.75%. Lifestyle changes such as changing study methods and sleep hygiene were recommended by 4.83% of the respondents (*Fig. 3*).

Fig. 19: Management of brain fog symptoms

Recognition of brain fog syndrome

Ninety-eight percent of the psychiatrists surveyed had heard of brain fog syndrome. However, only 22% of them actually made this diagnosis in their daily clinical practice.

There was a significant association between the duration of practice in mental health services and the diagnosis of brain fog syndrome ($P = 0.007$), with those practising for more than 5 years making the diagnosis more frequently than those practising for 5 years or less (59% *v.* 41%, $P = 0.003$), despite all but one being aware of the diagnostic features of brain fog. Similarly, seniority in clinical practice was associated with the diagnosis of brain fog ($P = 0.003$), with consultants diagnosing more than their junior colleagues. There was no difference in proportion of psychiatrists diagnosing brain fog when comparing respondents from different states and regions of Nigeria ($P > 0.05$). Also, the level of specialisation of institutions was not associated with a difference in likelihood of diagnosing (general hospital 23% *v.* teaching hospital 20%, $P > 0.05$). Using binary logistic regression analysis, the only independent predictor of diagnosing brain fog syndrome was the seniority of clinician ($P = 0.008$). Registrars were least likely to make a diagnosis compared with consultants (odds ratio 0.1, 95% CI 0.03-0.38, $P = 0.001$).

Discussion

These important findings suggest that the less experienced psychiatrists, who are more likely younger, made a diagnosis of brain fog syndrome least. It is unclear whether they found brain fog less attractive than their senior colleagues or if this may reflect differences in training (postcolonial *v.* contemporary) and diagnostic emphasis between the groups (A. Ayonrinde, personal communication, 2012) Should this trend persist, we foresee decline and possible extinction in the use of this diagnosis among Nigerian psychiatrists, critically within the society in which this culture-bound syndrome was originally described.

Symptom recognition and diagnostic instability

We observed diagnostic inconsistencies among Nigerian psychiatrists presented with the vignette with features of brain fog syndrome. Although familiar with the presentation (98%), and some consideration given to brain fog, the majority of psychiatrists preferred the more familiar ICD-10 diagnoses to a culture-bound syndrome. The phrase 'brain fog' was once a familiar idiom of distress during the earlier educational years of some senior clinicians, however, it is no longer common cultural parlance within Nigerian society. High rates of term recognition may also be a consequence of postgraduate psychiatric training where brain fog is taught as a disorder with a West African history. In fact, the authors (of Nigerian ancestry) with cultural and clinical experience of Nigerian mental health services have rarely heard use of the term brain fog outside academic circles.

The clinical and cultural consonance of the psychiatrists surveyed in this study enriches the findings as they span several decades of experience, clinical centres, ethnic and geographical regions. Their clinical and social awareness of emotional distress among students gives useful insight into the contemporary concept of brain fog.

Our finding of diagnostic fluidity and heterogeneity between anxiety, somatisation and depressive disorders is consistent with the DSM-IV-TR statement that brain fog syndrome can resemble anxiety, depressive and somatoform disorders.⁷

The diagnostic instability evident here calls into question whether brain fog syndrome is a homogenous or unique diagnostic entity, or actually a symptom co-variant of other somatisation, anxiety and affective disorders. The weight of cognitive and somatic complaints has been observed to differentiate from core features of depression in Nigeria and may well confirm unique culture-specific presentation¹⁰ as was proposed in the 1960s.¹⁵

Educational concerns, intensive or excessive study and the drive for success were the most common explanatory models for the vignette (32%). The emphasis on education and 'study' in the brain fog narrative may unwittingly bias clinicians towards cerebral and mental symptoms, thereby distracting from other somatic complaints. We hypothesise that brain fog was probably a historic idiomatic expression of impaired mental function with presentation of somatic complaints. Sleep impairment, poor attention and concentration and somatic complaints in an anxious or depressed individual would understandably impair educational activity – whereby symptoms worsen the potential to study rather than study triggering a mental disorder.

The brain fog explanatory models presented biological, psychological, social and stress models of illness. To date these aetiological links are lacking in robust empirical evidence. Further exploration of the somatic manifestations of common tropical diseases such as malaria would be insightful. Interestingly, one respondent cited 'witchcraft'. Beliefs in evil spirits, curses and malevolent forces are not uncommon in West African cultures. Psychoactive substance use and their effects such as impaired concentration and sleep difficulties and somatic effects may also easily mimic the brain fog symptoms.

Management

The preference for psychological therapies appears to reflect the aetiological attributions given to the symptoms such as stress, educational aspirations and interpersonal difficulties. To date there has been mainly anecdotal evidence or brief reports on treatments for brain fog.¹⁶ It is unclear from our findings what the response is to these therapeutic interventions and the degree of symptom relief. Given that the majority of psychiatrists were of the opinion that the symptom clusters were features of somatisation, anxiety and affective disorders, the additional choices of psychotropic medication are understandable.

Improving our understanding of the causes of brain fog symptoms has potential benefits in terms of identifying susceptible individuals and subsequently being able to manage them more appropriately. The fact that nearly a third of respondents pointed to educational concerns as a factor in the development of brain fog could have a significant influence on educational and public health interventions, policies as well as practice. Inaccurate information regarding causative factors and the care of mental distress in students carries a risk of prolonging mental distress. This confusion may result in individuals with depression or an anxiety disorder believing themselves to experience brain fog and abandoning education.

There is a need for improved understanding of mental disorders ascribed to study in this West African culture given the cultural salience of education as a key to success and social mobility. It remains unclear whether brain fog is a mental sequel of educational difficulties or the somatic, neurotic, cognitive and affective manifestation of distress in students. Significantly more research is required into cultural concepts of distress,⁹ an important consideration for the ICD-11.

Over half a century on from the original observations on brain fog it seems that our understanding of this culture-bound disorder has not advanced much. This study found that a large proportion of psychiatrists in Nigeria were familiar with and regularly manage students who present with anxiety, affective, cognitive and somatic symptoms. However, these African psychiatrists in the home of the brain fog syndrome infrequently consider this diagnosis in their routine clinical practice.

The semiotic salience of brain fog as a distinct, relevant and contemporary culture-bound syndrome is not supported by our findings in Nigeria. Idiomatic and syndromic use of the term brain fog became extinct in 19th- and 20th-century Britain, before its resurgence in Africa.^{17,18} Should the modern decline in brain fog persist, this culture-bound syndrome may well face diagnostic extinction.

1.8.52 What is culturally informed psychiatry? Cultural understanding and withdrawal in the clinical encounter

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Abstract

What is culturally informed psychiatry? What does it mean, and why is it important? These questions are discussed with a focus on the cultural aspects of the clinical encounter. The *DSM-5 Outline for Cultural Formulation* was developed as a method of assessing the cultural factors affecting the clinical encounter. It calls for the assessment of the cultural features of the relationship between the patient and the clinician; however, there is a lack of debate about what this means in practice. Clinicians run the risk of withdrawal rather than cultural understanding when facing patients with different cultural backgrounds. Using ethnographic material from anthropological fieldwork, I suggest that the encounter with cultural differences could be a useful point of departure for the clinician to develop cultural understanding. It is argued that recognising the experiences of differences is crucial in strengthening transcultural communication and preventing misdiagnosis in the clinician–patient encounter.

Contents

- *What is culturally informed psychiatry? Cultural understanding and withdrawal in the clinical encounter*
 - *DSM and the problem with culture*
 - *White person, where are you going?*
 - *The clinical encounter*
 - *Amazement: cultural understanding or withdrawal?*
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“‘Pathology’ is always a measure of difference.¹” Increased evidence points towards culture as one aspect influencing the prognosis, cause, manifestation and course of mental health problems. Mental health problems are more frequently misdiagnosed among patients from ethnic minority, immigrant and refugee groups than among native-born patients.² Misdiagnoses may involve failing to recognise the mental health condition or mistaking culturally normative behaviour for psychopathology.³ The cultural formulation in DSM-5 was developed as a standard method of applying cultural perspectives to the clinical evaluation.⁴ The *Outline for Cultural Formulation* (OCF) has been field-tested for diagnostic

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usefulness among clinicians.⁵ The cultural formulation has been praised as the most outstanding anthropological contribution to psychiatry, yet it has also been met by critiques by some medical anthropologists and psychiatrists. With the cultural formulation in the DSM-5 and its critique as the point of departure, this article questions what culturally informed psychiatry means. The argument is that the encounter between the patient and the clinician is a crucial, yet underappreciated, position from where the clinician might develop a cultural understanding.

DSM and the problem with culture

The contemporary model of the cultural formulation in the DSM-5 and DSM-IV dates from the criticism of the insensitivity to cultural issues in the DSM-III.⁶ The institutional culture of medicine was characterised as a 'culture of no culture', with limited interest in cultural issues.⁷ The OCF was first published in the DSM-IV in 1984, with a glossary of culture-bound syndromes, culturally relevant diagnostic categories and cultural considerations in the narratives introducing each chapter.⁸ The National Institute of Mental Health in the USA supported the creation of a culture and diagnosis group in 1991, whose main goal was to advise the DSM-IV task force on how to make culture more central to the manual.⁹ However, although the culture and diagnosis group succeeded in emphasising the relevance of cultural issues in psychiatry, there has been criticism of the cultural formulation from leading medical anthropologists over the years. This criticism can be summed up in the following four points. There is a lack of evidence that culturally informed therapeutic practices work.^{10,11} Kleinman & Benson suggest that the major claims about the value of cultural competence for professional caregiving are not supported by evaluation research showing that systematic attention to culture really improves clinical services.¹¹ This lack of evidence is a failure of outcome research to take culture seriously enough to assess the cost-effectiveness of culturally informed therapeutic practices.¹¹ Moreover, evidence-based practice should include a broader view of evidence that takes into account how different cultures recognise different ways of knowing.¹⁰ In striking contrast to its current use in anthropology, the concept of culture tends to be defined in medicine as something possessed by the patient and not the doctor. Culture is conceived as a confounding variable that White practitioners must deal with when they interact with people from ethnic minority groups.¹ The locus of normality is white. Taking whiteness for granted represents a specific view of culture that is shared by many White practitioners.¹³ The Black and minority ethnic patient is construed as the object of specialised knowledge, while the professional and their cultural context are left unquestioned.¹³ Historically, this view is reflected in the ways of linking psychiatric knowledge production and implementation to a strictly Western agency, while non-Westerners are often posited as passive receivers of this knowledge.¹⁴ Clinicians are criticised for lacking a cultural self-reflexive attitude towards their own professional practice.¹⁵ The cultural formulation of the DSM-5 aims to address these criticisms. The OCF is converted into the Cultural Formulation Interview (CFI), including 16 questions focusing on the patient's presenting concerns and definition of their problem and idiom of distress.^{16(p.749-760)} Culture is defined as the systems of knowledge, concepts, rules and practices that are learned and transmitted across generations, yet are open, dynamic and undergo continuous changes over time.

The formulation emphasises that cultural information must not be overgeneralised or stereotype groups of fixed cultural traits.^{16(p.749)} The OCF calls for a systematic assessment of the following four categories when conducting the CFI: cultural identity of the individual, cultural conceptualisation of distress, psychosocial stressors and cultural features of vulnerability and resilience, cultural features of the relationship between the individual and the clinician.^{16(p.750)}

A persistent challenge faced by clinicians in implementing the cultural formulation in the DSM-5 is how to translate insights from the social sciences in intelligible, practical and sustainable ways.¹⁷

I aim to delve deeper into the fourth category: the clinical relationship. I aim to translate insights from anthropological fieldwork into practical methods for clinicians. Cultural difference can affect the clinical encounter, and part of the role of culturally informed psychiatry is to address this difference. Using ethnographic material from my anthropological fieldwork in Tanzania, I explore the cultural experience evoked in the encounter. This knowledge is transferred into the context of medical practice.

White person, where are you going?

Dressed in training tights, a t-shirt and running shoes, I stood in an outside gathering hall in a squatter area of Dar es Salaam, Tanzania, in January 1989. I was preparing to exercise young Tanzanian women in aerobic. As a new teacher in physical education from Norway, I was engaged for 1 month in the Norwegian sports development project, Sports for All, with the aim of giving working class women the opportunity to exercise. Twenty women arrived; none of them was wearing training gear or running shoes, but they had colourful dresses or blouses and skirts and were barefoot. I started to count one, two, three, and then pressed the play button on the music player. The Tanzanian women questioned every move I made. They wondered if they would get paid for exercising. They wanted to touch my white, pale skin and glanced at my freckles. They laughed in a friendly way at jumping up and down, commenting that the moves were a bit childish. Every day, when I left the daily training, people glanced at me and called out: ‘White person, where are you going?’ This question persecuted me in the years to come during several field visits to Tanzania and filled me with uneasiness, curiosity and amazement.¹⁸

The amazement was first and foremost a ‘culture shock’ that caused me to question my whiteness, my way of practice and instruction. The Danish anthropologist Kirsten Hastrup used the term ‘amazement’ as a cultural pivotal point and a way of understanding that brings a person through emotional and embodied states.¹⁹ When our habitual practices are questioned we become amazed. When the Tanzanian women questioned the way I moved my arms up and down, they questioned body practices that were part of my professional education and that I had taken for granted. When they commented on my moves or skin colour, I was amazed, as I never thought about these in terms other than ‘normal ways’. The amazement is embodied and cultured.²⁰

It was in the encounter with the Tanzanian women that I became aware of my habitual practices and cultural ways. It was by being amazed that I became conscious that, like the Tanzanians, I too possessed systems of knowledge, concepts, rules and practices that are learned and transmitted across generations, yet are open, dynamic and undergo continuous changes over time.

Next, I will discuss how this experience can be relevant to a Western clinician by elaborating on some characteristics of the encounter between the doctor and patient, as discussed by Roland Littlewood, among others.²¹

The clinical encounter

The encounter between the psychiatrist and the patient involves two people who have their own expectations. If the doctor–patient situation is familiar to both, they will each probably make an effort to live up to the other’s expectations. For example, the expectation that the patient is seeking advice to solve a specific problem and that the doctor is an expert who will provide this advice. However, the psychiatrist and the patient face challenges if their cultural backgrounds differ considerably. The psychiatrist might have a less clear expectation of how the patient is likely to behave and what the limits of normality and abnormality are. In this sense, the encounter between the psychiatrist and the patient shares several similarities with the encounter between the researcher and informants from different cultural contexts. The psychiatrist’s attitude towards a patient from a minority ethnic background will be informed by the clinician’s own experiences, stereotypes and conscious and unconscious racial assumptions. For example, the clinician might have certain race-related assumptions and the patient might be assumed to have a core set of beliefs.²² Stereotypes of how other groups of people (such as Danish-Somalis, Native Americans and British Pakistanis) tend to behave influence the treatment options. Patients have their own expectations and the extent to which they see themselves as mentally ill varies with cultural background. What might be tolerated in Tanzania, such as spirit possession, witchcraft and healing ritual, are regarded as forms of abnormality (if not mental illness), in Britain.²³ Patients with a migrant background seeking help in psychiatric out-patient clinics in European countries might have experiences of mental illness that differ from the doctor’s experiences. For example, they might experience their illness as a physical disability or have felt lost in a fragmented health system.⁵ How the psychiatrist copes with their own amazement is therefore of importance.²⁴ I present two cases based on my own experience to demonstrate two ways clinicians might respond to amazement.

Amazement: cultural understanding or withdrawal?

Culturally informed psychiatry is required in domestic contexts familiar to the clinician. Clinicians' experiences of differences, such as language barriers, patients' expressions of distress and orientations of belief can trigger fear, anxiety and amazement. To be aware of one's own amazement might uncover issues taken for granted that the clinician assumes to be inevitable and universal. These often unnoticed assumptions may refer to all sorts of beliefs, habits, practices and values, from body comportment to being accustomed to urban infrastructure. I suggest two responses to this amazement: cultural understanding and withdrawal.

Example 1

At a Swedish conference on psychiatry and the cultural formulation in the DSM-5, the participants discussed diagnostic practices for asylum seekers. A psychiatrist said: 'It is very hard when you receive a refugee. The first thing you are supposed to do is to consider the person's mental health. I was really amazed when I discovered that my patient's strong sense of confusion was not necessarily due to his mental condition. Rather, it could be ascribed to his overwhelmed experience of seeing a Swedish city ... We should not be too quick to diagnose refugees with post-traumatic stress disorder [PTSD], before they have time to get used to the new cultural context.' The discussion that followed concerned various clinical experiences with 'cultural differences', such as the difficulty in understanding patients' expressions of distress and in making meaningful diagnostic evaluations.⁵ The psychiatrist was amazed at his own cultural attention to the patient. He took for granted, as a prerequisite for professional practice, that the patient was familiar with the material surroundings of the therapy practice: the buildings, roads, transport and so on. In the encounter with the patient, he had quickly diagnosed the patient's confusedness as PTSD. Although the refugee suffered in some ways because of his experience in a war-ridden country, the psychiatrist's amazement and reflection on it gave him alternative ways of interpreting the patient's suffering.

The psychiatrist was able to reflect critically upon his own cultural background and his taken-for-granted perspectives, which places him in a better position to understand and reconsider the mental state of the asylum seeker.

Example 2

A Norwegian family therapist was observing an 8-year-old Afghan boy to assess his mental health. The boy was not very talkative and was by himself. He had arrived in Norway with his family some years ago. His parents were reluctant towards family therapy as it appeared quite unfamiliar to them. The therapist, on the other hand, aimed at making a decision on the diagnosis of the boy. The parents came with the boy the day that the therapist informed them about the boy's problems. She explained to them that their son was diagnosed with autism spectrum disorder.^{16(p.50-55)} The therapist informed the parents about their welfare rights that followed their son's acknowledged diagnosis, information that was quite new to them. The therapist made a new appointment with the parents and their son. However, only the father attended the next appointment. He informed the therapist that they had received a letter from the director of the hospital claiming the director regretted that their son received the diagnosis and confirmed its withdrawal. Their son did not have autism. The father said there was no more to do, and politely left. Leaving behind the astonished therapist, the director of the hospital confirmed that the letter was never written. When the therapist called the father of the boy to tell him that there was never such a letter, the father replied that it must have been lost. The therapist was never in contact with the family again.

When giving this account, the therapist expressed great frustration that the family did not see the value of this diagnosis. She saw it as her duty to assess and diagnose the patient. She was amazed that the family did not accept the diagnosis and she thought of this as a cultural problem. Therefore, she did not try to explore how her own amazement could be interpreted as a cultural response to an unfamiliar situation (that the parents did not accept the diagnosis). In the encounter, the family therapist took it for granted that the patient and their relatives would accept the diagnosis given to them.

The amazed clinicians might not be able to develop an understanding in the encounter with the patient, but might withdraw instead. Clinicians may respond to their own experience of difference by using cultural categories on the

patients, setting themselves as the normative standard. Imposing identities on patients, such as ‘boy with autism’, ‘woman with bipolar disorder’, ‘man with suicidal tendencies’, helps clinicians feel more secure with their own identity and withdraw from an alternative identity experienced by the patient.²⁵

To be able to learn from one’s own amazement to develop understanding as a researcher requires a culturally reflexive research position. In anthropological fieldwork the researcher must take into account that they are always part of the situation being studied. Part of the criticism of the cultural formulation, as discussed earlier, is a lack of self-reflexivity among clinicians when it comes to their professional background. A clinician who understands something of their own cultural background and how it contributes to their values, perceptions and personal style is in a better position to learn from the clinical encounter with others.²⁶ Amazement that stems from the encounter with difference is, in this regard, a trigger point.

The two examples above demonstrate that it is not a straightforward matter for the clinician to use amazement as a tool to gain cultural understanding of the clinical situation.²⁷ Emotions can be as deceptive as statistics. That the clinician registers their own amazement does not mean the interpretation is accurate.

Conclusions

Multicultural societies with increasingly complex health problems make the practice of culturally informed psychiatry urgent. This article has demonstrated that the encounter between the patient and the clinician is a crucial, yet underappreciated, position from which the clinician might develop a cultural understanding. The cultural dimension of the clinician–patient relationship must be explored in actual situations through the clinician’s self-reflexive focus on amazement and questions such as, ‘How do I respond to situations where I become amazed?’, ‘Is it possible for me to develop understanding rather than withdrawal?’

The clinician is always formed by social and cultural contexts and is never culturally neutral. Moreover, the clinician has a clinical responsibility to make explicit his or her own assumptions, premises and categories in relation to patients to prevent misunderstandings and misdiagnoses. Culturally informed psychiatry cannot be defined once and for all; it is not a quick-fix technique or manual. It is rather the continuous development of a professional attitude, perceiving all human beings, including the clinician, as cultural bearers and cultural learners.²⁸ The clinician should take seriously their own amazement as a point of entry to this attitude. However, to develop amazement as a clinician to strengthen culturally informed psychiatry does not lead to an easy resolution of a client’s problem. A whole new series of questions arises, and we need culturally reflexive psychiatrists to deal with these questions.

1.8.53 ‘Spirituality’ and ‘cultural adaptation’ in a Latino mutual aid group for substance misuse and mental health

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Abstract

A previously unknown Spanish-language mutual aid resource for substance use and mental health concerns is available in Latino communities across the USA and much of Latin America. This kind of '4th and 5th step' group is a 'culturally adapted' version of the 12-step programme and provides empirical grounds on which to re-theorise the importance of spirituality and culture in mutual aid recovery groups. This article presents ethnographic data on this organisation.

Contents

- *'Spirituality' and 'cultural adaptation' in a Latino mutual aid group for substance misuse and mental health*
 - *Data collection and study aims*
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 - *Discussion*

Group Higher Power (a pseudonym, to protect confidentiality) is a mutual aid group in Northern California for Latinos with substance use problems and other mental health concerns. (By 'Latinos' we are referring to a very diverse population of persons from Latin America or their descendants. We do not mean in any way to present Latinos as a homogenous group.) It is a '4th and 5th step' group (grupo de Cuarto y Quinto Paso, henceforth 'CQ'), a variation of the 12-step recovery programme that was founded in Mexico in 1991.¹ New members join Group Higher Power by completing seven preparation meetings followed by a 2-day *experiencia espiritual* (spiritual experience) in a secluded mountain forest preserve a couple hours from where the group holds its nightly meetings. During the experience, the new members complete the 4th and 5th steps of the 12-step programme: step 4, 'We made a searching and fearless moral inventory of ourselves'; step 5, 'We admitted to God, to ourselves, and to another human being the exact nature of our wrongs'.² Afterwards, they are encouraged to attend the nightly meetings, which usually open with the meeting coordinator reading the bye laws of the group, including: 'Here is a 4th and 5th step group. We are a group of men and women that maintains itself by our own contributions'. In a traditional Alcoholics Anonymous (AA) group, the coordinator would next say: 'The only requirement for being here is that you wish to stop drinking'. But at Group Higher Power, the coordinator says: 'The only requirement for being here is that you wish to transcend the pain in your life, and to stop suffering'.

Unlike in AA, CQ members may identify as an *alcohólico* (alcoholic), a *drogadicto* (drug addict), an *enfermo emocional* (emotionally ill, used interchangeably with *neurótico* (neurotic)) or any combination of these. 'To be an *enfermo emocional*' is an idiom of distress³ that signifies a 'spiritual' ailment thought to be at the root of addiction, depression and other 'neuroses'. The idiom also indicates a correct form of treatment which members learn to engage in and provide to others in the spiritual experience – a dramatic, cathartic style of testimony.

This form of 'spiritual healing' can be found in CQ groups like Higher Power located throughout Mexico, the USA, Central America and in some parts of South America and Europe. Because there is no central organisation that unites all CQ groups, it is impossible to know exactly how many there are (see directory of US groups affiliated with the Amor y Servicio branch of CQ: www.amoryserviciosusa.org/directorio). That said, our preliminary ethnographic findings suggest that CQ is growing rapidly in Mexico and the USA, making it a community-based mental health resource for potentially thousands of Latinos across North America.

The apparently rapid growth of CQ is important from a public health perspective and interesting for theorising what makes psychotherapy 'culturally adapted'. Mutual aid groups for addiction are known to be cost-effective interventions.⁴

Latinos in the USA have a disproportionate burden of substance use,^{5,6} and yet they are underserved in the areas of substance use and mental health treatment.^{7,8} There is therefore a pronounced need for accessible, community-based and culturally adapted care for Latinos in the USA.^{9,10} Alcoholics Anonymous may meet this need for some, but whereas Latinos in the USA are thought to recommend AA equally as often as other ethnicities,¹¹ Project MATCH¹² suggests that AA has trouble attracting and retaining Latinos in the USA. Interestingly, Project MATCH also found that, relative to White Americans, Latinos who do attend AA display higher levels of involvement, including ‘God consciousness’,¹³ after out-patient alcohol treatment and several authors have suggested that the incorporation of spiritual and religious elements into culturally appropriate substance use treatment for Latinos merits further examination.^{7,12–14} However, the majority of Latinos in the Project MATCH study sample were south-western Hispanos and it is likely that their responses are not representative of other Latino groups in the USA, such as Puerto Ricans, Mexican–Americans and Mexicans.

Highly spiritual and religious behaviour can already be found in Spanish-speaking AA groups in the USA¹⁵ and especially in Mexico,² where AA has become over the past several decades the most prevalent source of substance use treatment in the country.^{16,17} But even members of these groups sometimes criticise CQ as being overly religious and refer to CQ derogatorily as a ‘religious sect’. So, if CQ is as popular among USA-based Latinos as our qualitative data suggest, we propose this may be due to how CQ incorporates a culturally appropriate form of spirituality into their recovery programme. In this article, we present ethnographic data on the therapeutic practices of Group Higher Power, which largely resemble those of other CQ groups we have observed in the USA and Mexico. In doing so we attempt to offer a qualitative understanding of ‘spirituality’ in CQ and more specifically, how the ‘spiritual experience’ is configured as a treatment for being *enfermo emocional*. Through this we enquire into how this form of mutual aid spirituality may mediate a successful cultural adaptation of the 12-step programme for underserved Latinos in the USA.

Data collection and study aims

The ethnographic data presented here come from an ongoing anthropological study of drug addiction, violence and treatment modalities for substance-using Latinos in Mexico and the USA. CQ has been a central focus of our ethnographic fieldwork since January 2013. We have observed and documented the therapeutic practices and living conditions of members of ten CQ groups (4 in Mexico) as well as several other 12-step groups that are specifically for Latinos.^{15,16} We have also conducted dozens of formal and informal interviews with 12-step group members, their family members and health professionals in both countries. Many of the 12-step members had participated in more than one kind of 12-step group over their lifetime (e.g. CQ and AA) and so we were able to gather information on CQ from interviewees who were not currently active CQ members. We have observed one spiritual experience hosted by Group Higher Power. In accordance with exploratory qualitative research methods,¹⁸ research sites and participants were selected by convenience, as dictated by the opportunities and challenges inherent in maintaining relationships with a dynamic and mobile population over several months. Iterative interpretive analysis of research materials (field notes, interview transcripts, photographs and videos) was conducted to better understand the emic categories of illness, health and healing. This study has been approved by the Institutional Review Board of Stanford University. A draft of this article in Spanish was presented to Group Higher Power, and it is being published with the group’s blessing.

Group Higher Power – characteristics

On its surface, Group Higher Power looks like other Spanish-language 12-step groups in the USA.^{15,19,20} Nightly meetings are held from 19.00 to 21.00 in a suburban storefront in a predominantly Latino neighbourhood. The membership consists of men and women ranging in age from their 20s to their 60s. They mostly hail from Mexico, but some are from Central America and many were born in the USA. Several members are undocumented immigrants. Many speak English, but meetings and informal conversations are conducted in Spanish.

The setting

The main room of the group has large posters with the 12 steps and 12 traditions of AA, which are in Spanish and hang on the far wall above the desk of the meeting *coordinador* (coordinator) and the podium where members stand and share their testimonials. Between the posters of the 12 steps and the 12 traditions hang framed portraits of Bill W and Dr Bob, the co-founders of AA. The other three walls of the room are adorned with one or two images of Jesus Christ and many more colourful framed certificates and plaques that Group Higher Power has received for giving *compartimientos* ('sharings' or testimonies) at the anniversary celebrations of other CQ groups in California, Nevada and Utah. By the dates on the certificates, most groups in this part of the country have only been in existence for 3 to 4 years; a few have been around for up to a decade.

There is a small room in the back where *ahijados* and *ahijadas* ('sponsees') can receive *apadrinamiento* (counsel) from their *padrinos* and *madrinas* (sponsors, also known as godfathers and godmothers) in private. And like in so many other Latino 12-step groups, on the wall near the main entrance hangs a black-and-white print of a man, shirtless, dishevelled and shackled, with the words *Reconozco mi derrota ante el alcohol* (I recognise my ruin from alcohol) (Fig. 1).

Group members

Unlike in Latino AA groups, members of Group Higher Power are explicitly seeking help for more than just their alcoholism; they say they want to cure their 'emotions'. To be an *enfermo emocional* is to have suffered traumatic and painful events in one's past, often as a child, and then to go through life with the memories of these events smouldering in the unconscious, causing the person to repeatedly hurt others and themselves. This pain is what CQ members say they used to try to avoid when they drank alcohol and used other drugs. The same pain led other members not to use substances, but instead to be 'neurotic' or unhappy and self-destructive. Like the 'dry drunk' in AA, the *enfermo emocional* displays the same harmful behaviours of an alcoholic who is abstinent but not in recovery, namely lying, being violent and generally suffering from 'ego'. The prescribed treatment is lifelong dedication to CQ's spiritual path, which starts with completing a spiritual experience.

This is why in the back of the Group Higher Power main meeting room there is another, medium-sized room where the seven preparation meetings are held for newcomers, called *escribientes* ('writers'), who will soon undergo their first *escritura* ('writing', meaning spiritual experience). There is no podium in this room, but there is a wooden desk behind which a coordinator sits, with two other members to his right and left, usually a man and a woman. Some days up to a dozen *escribientes* at a time are being prepared in this room, sitting in their brown, metal folding chairs facing the desk, above which also hang portraits of Bill W and Dr Bob. A couple of *escribientes* typically trickle in late, apologising for not being able to get off of work in time at the factory or cleaning houses. The usual attire is jeans, old tracksuit bottoms, well-worn tennis shoes, but there is also the occasional nice fleece or stylish watch. After everyone is offered coffee or water, the first prayer of the night, the Serenity Prayer, is recited and then the meeting begins.

The meeting

The members share their testimonies with the *escribientes*, weaving in the benefits they have received from being in the group, like gaining insight into their emotional problems. One man shared: 'When I came to the group, I had just smoked \$100 of crystal meth. I wanted to die ... It wasn't until the experience when I realised things were wrong; I had erased those memories. In the experience, I remembered these dark things. I remembered my dad dying, and when I was molested as a child.'

Testimonies also often include mention of a transformation or rebirth in the experience that has helped the person stay sober. It is common for CQ members to admit that they were actually drunk or high when they went for their first experience, but then after that day they no longer needed to drink, smoke or use.

Over the seven preparation meetings, the *escribientes* are gradually introduced to the cathartic style of testimony that is at the very core of CQ's 'emotional' therapy. When 'sharing' their testimony, members frequently cry, swear and shout, even to the point of sometimes becoming totally distraught. The *escribientes* do not practise giving testimony in the preparation meetings; they do not even speak for the duration of the 2-hour meetings. Instead, they are instructed to sit

and reflect on what is being shared with them. Once, after a meeting, an *escribiente* asked the meeting coordinator: ‘Do they always use so many bad words?’ She continued: ‘Because I was thinking about bringing my daughter here, but now I don’t know; I don’t want her to hear those things’. The coordinator smiled from behind the desk and counselled her with a phrase that is often said at the beginning of the preparatory meetings: ‘If you hear strong language, don’t focus on the words, focus on the feelings’. This is the heart of what the *escribientes* are being trained to do – to engage in a reflective, contemplative practice in which they identify with the testimonies of the group members to learn to identify these same emotions in themselves and then release them during the spiritual experience.

The spiritual experience

At Group Higher Power’s spiritual experience each *escribiente* underwent their 4th step by writing a ‘moral inventory’ for about 24-hours straight, with no sleep, little food and lots of coffee. They were instructed to be ‘100% honest’ while answering questions about their lives; these questions are standard across CQ groups and come from the 12-step literature. The 4th step culminated in a celebratory moment in which the *escribientes* and the members held hands in a circle formed around a large wooden cross, crying, reciting prayers and singing Christian hymns in Spanish backed up by a CD playing over a pickup truck’s stereo. The *escribientes* were encouraged to have visions of God while they looked up into the starry night sky.

A *padrino* in Mexico City with significant experience in CQ said that the point of the experience is to get the *escribiente* to go through a *colapso a fondo del ego* (‘when the ego hits bottom’) because that is when ‘your spirituality starts to flow’. Group Higher Power members joke that they ‘enter the fourth dimension’ during the experience, meaning that they go into a trance-like state. It is this state that lets them do the emotional healing that they say they cannot achieve with a psychologist, a doctor, not even a traditional AA group. Many cite the spiritual experience as their reason for why they stay in CQ, and why CQ has helped them make behavioural changes that they could not achieve otherwise.

After the experience, the members will attend nightly meetings and continue to rehearse and refine the dramatic testimonial style they learned in the experience. They will stand at the podium, look out of the corners of their eyes, and try to re-enter their painful or shameful memories, recounting them for the group, complete with details of the sights, sounds and smells of what it was like to be there. The meetings are brought to a close with the lights off and everyone standing in a *cadena de amor y servicio* (chain of love and service), holding hands in a large circle. As Christian worship songs are softly played in the background, members are instructed figuratively to leave in the room what they heard and felt that night by whispering it to God. They recite the Serenity Prayer, the AA Responsibility Declaration and the Our Father, and then the meeting is over.

Discussion

What exactly is it about CQ spirituality that makes this mutual aid organisation especially culturally adapted for Latinos? One observation that seems clear is that the kinds of dramatic public testimony, group prayer and healing and rebirth practices in CQ resemble those of the Pentecostal and Charismatic Catholic movements, which are currently quite popular in Mexico.^{21,22} While true, this does not explain with any real specificity why this would make CQ spirituality congruent with Latinos’ cultural frames and therefore a popular choice for those seeking psychological help.

Based on their meta-analysis of psychotherapy studies, Benish *et al*²³ propose that the key factor for enhancing the cultural adaptability of psychotherapy is the incorporation of an ethnic minority’s ‘illness myth’. This suggests that we should consider more closely the CQ idiom of distress, *enfermo emocional*, as a key to what makes CQ culturally adapted for Latinos. CQ emic understandings of being an *enfermo emocional* are sculpted out of a psychodynamic language of neurosis, the unconscious and childhood trauma. The fact that this aetiological discourse is flourishing within a spiritual healing movement might at first seem paradoxical, yet it arguably makes good sense given psychoanalysis’ historical ties with religion in Mexico. One of Mexico’s better known early champions of Freudian thought, the Catholic monk Gregorio Lemerrier, actually attempted in the 1960s to use psychoanalysis to revitalise monastic life,²⁴ whose traditions of intensive contemplative practices and spiritual retreats have strong parallels with much of what we see in CQ’s modifications and interpretations of the 12-step programme.

The highly 'spiritual' nature of being *enfermo emocional* has further implications for CQ's acceptance by Latinos that become even clearer when we consider how 12-step programmes are often criticised for disempowering their members by encouraging them to submit to a higher power and to identify as sick addicts who will forever be in recovery. In CQ, the *enfermo emocional* takes this a step further and is not only eternally in recovery, but they are also intermittently 'mad'. CQ members sometimes describe their spiritual experience as a form of *locura* (madness); and Mexican AA members and clinicians alike not only allege that CQ's cathartic practices are crude and ineffective, but some have even warned the public against participating in the CQ spiritual experience because of case reports of individuals who have developed psychosis or died by suicide shortly after their experience.

Nevertheless, perhaps it is by making its recovery programme even more 'spiritual' than AA that CQ is able to invert these concerns of clinical ineffectiveness and harm, turning the submission to a higher power into a much more positive experience. In Asad's critique of the secular notions of agency and pain,²⁵ he delineates how the modern narrative of agency makes clear that agency must be used to avoid suffering (p. 71). Moreover, one who gives into religious 'emotions' (glossed 'passions') is said to lack the prized agency of a rational subject. To counter these assumptions, Asad pushes us to consider a notion of sanity which, instead of turning on the ideal of self-control, 'presupposes knowing the world practically and being known practically by it' (p. 73). He asserts that this 'allows us to think of moral agency in terms of people's habitual engagement with the world in which they live, so that one kind of moral insanity occurs precisely when the pain they know in this world is suddenly no longer an object of practical knowledge' (p. 73). According to this alternative understanding of agency, sanity and pain, CQ members could submit to a higher power, enter a state of *locura* in the spiritual experience and dive into the passions of their 'sick emotions', and actually thereby maintain, or even regain, their *sano juicio* ('sanity'), as the 2nd step says can happen ('[We] Came to believe that a Power greater than ourselves could restore us to sanity'²). But for this to be a healthy process requires CQ groups to provide a practical purpose for members to relive their suffering night after night through the testimonies. And hence the prayer circle that ends every nightly meeting and spiritual experience, the *cadena de amor y servicio* (chain of love and service), points up the symbolic importance of service in CQ's practice of spiritual healing. Service, including sharing one's testimony and counselling one's sponsee, is the suture that stitches together CQ sociality and repairs the psychic wounds of the *enfermo emocional*. Given how important sponsorship is in AA in Mexico relative to the USA,²⁶ we propose that CQ capitalises on this Mexican proclivity for service to create a mutual aid environment where sectarian notions of agency and suffering can be more fully embodied, thereby allowing CQ members to more adequately respond to the spiritual 'illness myth' of the *enfermo emocional*.

Finally, we must stress that reports on the rapid uptake of CQ throughout North America are to this point based on qualitative data alone and they require triangulation with quantitative measures (our research team is currently preparing a survey of CQ groups in Northern California). Moreover, other elements beyond spirituality need to be considered to understand why CQ might be a highly 'culturally adapted' form of AA for Latinos. The role of family involvement in CQ should not be underestimated, especially since membership is not restricted to 'alcoholics', but can also include 'drug addicts' and 'neurotics' who do not use substances. Also, larger issues of political economy, state insecurity and violence should not be overshadowed by a narrow interest in 'cultural adaptability' when trying to understand why a grassroots treatment modality such as CQ is reported to be growing rapidly in underserved, displaced and marginalised communities. In the neighbourhoods where CQ seems to be growing the quickest, families must deal with poverty, a lack of access to healthcare and the general social fragmentation that Mexico's drug war-related violence has wrought on the country for the past decade. Detailed consideration of these factors is, however, beyond the scope of this article.

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1.8.54 Dementia in a Black and minority ethnic population: characteristics of presentation to an inner London memory service

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Abstract

Aims and method To examine data on referrals to an inner-city London memory service to explore any differences in referral rates, cognitive assessments and stages of dementia at presentation between ethnic groups.

Results African–Caribbean patients were well represented in the memory service. They were diagnosed with dementia on average 4.5 years younger than their White British counterparts and were more likely to be diagnosed with a vascular or mixed type dementia. However, scores on initial cognitive testing were significantly lower in the African–Caribbean group, possibly representing more advanced disease at presentation.

Clinical implications Initiatives to access Black and minority ethnic populations earlier in the course of their illness should be considered. Professionals need to consider the potential for cultural bias in memory testing and diagnosing dementia in these populations, and the importance of cultural competency in assessments.

Contents

- *Dementia in a Black and minority ethnic population: characteristics of presentation to an inner London memory service*
 - *Method*
 - *Results*
 - *Discussion*
 - * *International evidence*
 - * *Limitations*
 - * *Clinical implications*

The number and proportion of Black and minority ethnic (BME) people with dementia is set to increase sharply over the coming years.¹ As the ‘most ethnically diverse area’ across England and Wales,² memory assessment services in London must be able to meet this challenge and address the needs of people from BME backgrounds. Established in 2010, the Southwark and Lambeth Memory Service (SLMS) provides memory assessment services in two inner London

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boroughs, to people over the age of 18 with mild to moderate memory problems and without an existing diagnosis of dementia. Patients are offered a comprehensive assessment, with initial cognitive testing using the Standardised Mini-Mental State Examination (SMMSE) and Addenbrooke's Cognitive Examination III (ACE-III). Patients are also offered brain neuroimaging and, where indicated, additional neuropsychological testing. Diagnoses are considered within a multidisciplinary team and appropriate treatment and follow-up are agreed with patients and carers.

The National Dementia Strategy³ prioritises early diagnosis and intervention in people with dementia. Current research, however, suggests that people from BME backgrounds present to memory assessment services later in the course of their disease.⁴ This prevents them from benefiting from intervention and treatment as early as their White British counterparts.⁵ This study examines the stage at which the BME population presents to SLMS and their rates of dementia diagnosis, and considers subsequent areas for service development to better meet the needs of different ethnic groups.

Method

The study received approval from the shared research and development office of the Institute of Psychiatry and Maudsley Hospital. The analysis used anonymised data from a referrals database, maintained for the purposes of service monitoring, and includes patients referred during the first 2 years of the SLMS's operation. Information on patients' ethnicity, age at the time of referral, scores on initial cognitive testing and the diagnosis given by the service was collated. Data are drawn from the SLMS's use of earlier versions of the cognitive tests cited above (the Mini-Mental State Examination (MMSE)⁶ and Addenbrooke's Cognitive Examination Revised (ACE-R)⁷). In cases where patients' diagnostic classification changed during the course of their involvement with the service (e.g. from mild cognitive impairment to dementia), the initial diagnosis is used. To avoid bias, people unable to fully complete the two cognitive tests were excluded from the analysis.

We used the harmonised ethnic group categorisations from the 2001 UK census⁸ to allow for comparisons between the SLMS sample and data on the ethnic composition of the local population. For the purpose of data analysis, patients were divided into two groups: White British (WB) and Black and minority ethnic (BME). Definitions of BME are wide-reaching and may include anyone with a 'cultural heritage which is differentiated from that of the White majority of the UK'.⁹ Owing to the very small number of patients from some ethnic groups in the SLMS sample, only patients from Caribbean and African backgrounds were included in the BME group. Comment is made in the discussion section on the relevance of the findings to people from other BME backgrounds.

Differences in the stage of presentation to the memory service were analysed by comparing patients' ages at the time of referral and MMSE and ACE-R scores on initial cognitive assessment. The prevalence of dementia diagnoses within each of the two groups was compared using Pearson's chi-squared test. Scores on cognitive testing for patients receiving a diagnosis of dementia were also compared. Unless otherwise stated, all means were compared using Student's *t*-test, having first satisfied the criteria for Levene's test of equality of variances; $P=0.05$ were deemed to be significant.

Results

Overall, 460 patients referred between January 2011 and December 2012 completed the assessment process and received a diagnosis from the service. Of these, 384 were from White British, Black Caribbean and Black African ethnic groups (WB: $n = 239$, 68.7%; BME: $n = 109$, 31.3%). Then, 290 patients completed cognitive testing in full; proportions of patients from each group able and/or willing to complete full cognitive testing were similar (WB: $n = 199$, 83.3%; BME: $n = 91$, 83.5%).

The majority of SLMS patients were over 60 years of age. *Table 1* compares the most common ethnic groups within the SLMS sample and the local population of people over the statutory retirement age. These are notably different in distribution, with the SLMS sample comprising a smaller percentage of White British patients and larger proportions of the other featured ethnic groups.

Comparison of most common ethnic groups in the SLMS sample and local population

Ethnicity	Patients in SLMS sample (<i>n</i>)	Percentage of total SLMS sample ^a	Local population over 60 years of age (<i>n</i>) ¹⁰	Percentage of local population ^a
White: British	239	52.0%	36 100	63.4%
Black or Black British: Caribbean	86	18.7%	6300	11.1%
White: any other white background	47	10.2%	3500	6.2%
White: Irish	38	8.3%	3800	6.7%
Black or Black British: African	23	5.0%	2400	4.2%
Asian or Asian British: Indian	12	2.6%	1300	2.3%
All other BME groups	15	3.3%	3500	6.2%

SLMS, Southwark and Lambeth Memory Service.

Percentages may not add up to 100 owing to rounding.

At referral to the service, BME patients (mean age 77.19 years, $s = 7.094$) were significantly younger than WB patients (mean age 80.23 years, $s = 8.777$; $t(212.729) = 3.132$, $P = 0.002$). In this case, Levene's test could not conclude equality of variances ($P = 0.026$), therefore a t -test appropriate to samples with potential unequal variances was used. The age gap increases in patients subsequently diagnosed with dementia (mean age: BME patients 78.69 years, $s = 6.208$, WB patients 83.25 years, $s = 6.599$; $t_{(187)} = 4.685$, $P < 0.001$).

Patients in the BME group scored significantly lower on both the ACE-R and the MMSE: ACE-R total possible score 100; mean score: WB patients 66.2, $s = 16.652$, BME patients 54.5, $s = 14.482$; $t_{(288)} = 5.768$, $P < 0.001$, MMSE total possible score 30; mean score: WB patients 23.4, $s = 4.917$, BME patients 21.7, $s = 4.573$, $t_{(288)} = 2.759$, $P = 0.006$.

In patients subsequently diagnosed with dementia, there was a significant difference in scores on the ACE-R (WB mean score 57.4, $s = 13.464$; BME mean score 48.7, $s = 11.226$; $t_{(187)} = 4.431$, $P < 0.001$). BME patients with a new diagnosis of dementia also scored lower on the MMSE, but this difference was not found to be significant (WB mean score 21.0, $s = 4.613$; BME mean score 20.1, $s = 4.166$, $t_{(187)} = 1.294$, $P = 0.197$).

Three-quarters of the BME group (75.2%, $n = 82$) were diagnosed with dementia, compared with 65.7% of the WB group ($n = 157$). There was no significant relationship between ethnic group and the likelihood of receiving a diagnosis of dementia ($\chi^2_{(1, N = 348)} = 2.739$, $P = 0.098$). When dementia subtypes were considered, significantly more patients from the BME group were diagnosed with a dementia with a vascular component (either vascular dementia or mixed Alzheimer's disease and vascular dementia) ($\chi^2_{(1, N = 348)} = 4.531$, $P = 0.033$).

Discussion

Ethnic identity is multifaceted, subjective, can change over time¹¹ and may be based on collective identity, common ancestry, heritage, religion, culture, nationality, language and territory.⁸ Individual beliefs may be influenced by culture, and thus culture can shape the meaning which individuals ascribe to dementia.¹² Beliefs about dementia, such as it being part of normal ageing,¹³ may create barriers to help-seeking and influence when individuals present to memory services.¹⁴ Current research suggests that BME older people access services at a more severe stage of cognitive impairment than White British people,¹⁵ which may account for their lower cognitive scores in this study. In BME populations, the decision to seek formal help tends to be precipitated by a health or behavioural crisis¹³ or the emergence of neuropsychiatric symptoms and problems with basic activities of daily living.⁴ It may also be influenced by varying knowledge of Alzheimer's disease and dementia across ethnic groups (although all groups hold significant misperceptions).⁵ All ethnic groups attach stigma to dementia, although the extent and nature of this varies;^{5,16} family concerns about previous negative experiences of psychiatric services may, however, be particularly significant to BME groups.⁴

Cultural bias in cognitive testing may also explain the difference in scores. African–Caribbean patients have consistently been found to score lower than White British patients on the MMSE^{17–19} and the standard cut-off of 24 may have a high rate of false positive screening for dementia in BME groups.^{20,21} Adjusting for factors such as educational attainment did not always explain these differences;^{17,22} scores may also have been affected by unfamiliarity with the language and culture of the test setting, and higher levels of anxiety during testing.²³ The idea of cultural bias is particularly supported by one study which found that White British participants scored equally well on both the traditional version of the MMSE and a version validated for use with older African–Caribbean people,²⁴ while African–Caribbean participants scored significantly better on the culturally modified version.¹⁹

The ACE-R differs from the MMSE in its greater sensitivity to detect early dementia.²⁵ Modifying and validating it for other cultural contexts has required more than straightforward translation, including adaptations to cater for study participants with lower levels of education,²⁶ cut-off scores stratified by educational background²⁷ and modified cut-offs to account for variations in structure and difficulty between languages.²⁸ This demonstrates the difficulty of administering the test to a sample as culturally diverse as that found at the SLMS. Studies validating the ACE-R's diagnostic accuracy fail to mention ethnic diversity within their samples^{7,25,29,30} and tested a clinic-based population with a notably younger mean age than the SLMS sample, therefore their findings may not be transferable. A study carried out in another area of the UK required lower cut-offs to preserve diagnostic accuracy,³¹ although again the ethnic breakdown of participants is unknown.

Most studies carried out in the UK to date have also found a higher prevalence of dementia among African–Caribbean older people,^{17,19,32} although one found differences only between English and non-English-speaking members of BME groups.³³ The current study found no overall difference in dementia diagnosis rates, but revealed an increased prevalence of dementia with a vascular component in the African–Caribbean group. Although most of the studies cited did not explore dementia subtypes, one linked an increased incidence of conditions such as hypertension and diabetes to a higher prevalence of vascular dementia in their African–Caribbean sample.¹⁷ Another found an equal prevalence of hypertension in the African–Caribbean and British-born groups, but that awareness of it was reduced among African–Caribbean people, who were significantly more likely to have dementia if hypertension was not correctly treated.³⁴ Health education about risk factors for vascular dementia could therefore potentially benefit BME groups, especially given the earlier age of presentation to the SLMS.

Patients access the SLMS through their general practitioner (GP), therefore GPs influence the stage at which patients access specialist help. A suspicion of emerging dementia is often followed by 'watchful waiting' in primary care rather than immediate referral to a specialist.³⁵ People from BME backgrounds access primary care at a similar rate to White British people,^{4,36} however, there appears to be little research into factors which may influence this wait for specialist referral. Difficulties in cognitive screening in primary care may be further compounded when assessing older BME people, where culture and the language used to describe problems may influence presentation.²²

International evidence

This is a UK-based study at a local level, however, its findings are consistent with research carried out abroad. A survey of clinical dementia centres across Europe found varying levels of access by BME patients and that where these patients did access services, diagnostic evaluation was more challenging owing to language barriers and the availability only of cognitive assessment tools validated in Western cultures.³⁷ Older Chinese and Vietnamese patients in Australia were believed to present to memory services at a more advanced stage of cognitive impairment³⁸ and linguistic and cultural complexities may have contributed to longer waits for diagnosis in primary care.³⁹ BME populations were diagnosed with dementia at an earlier age in one Danish study,⁴⁰ and similar barriers to help-seeking for carers of BME patients with dementia were evident in research from both Australia^{38,39} and the USA.⁵ Given the international recognition of the growing need for culturally sensitive memory services (including throughout Europe,^{37,40} the USA¹² and Australia^{38,39}), the findings of this study are likely to be relevant to those working in such settings.

Limitations

This study is limited in its use of data collected in the course of routine clinical practice. Assessments were carried out by a variety of clinicians and although all were trained in the cognitive tools used, the question of interrater reliability remains. Standardised data on the educational background of participants are also unavailable. In addition, only patients who consented to and completed the assessment and diagnosis process were included in this study. There is no data on the ethnicity of the patients who refused assessment or who were unable to complete the process for other reasons, thus we cannot speculate on whether ethnicity may influence this. Some ethnic groups, such as South Asian people, were not represented in our analysis. The issues influencing presentation to memory services may be similar for these groups; for example, a study on Gujarati populations also found lower MMSE scores and a lower median age in the Gujarati group of a community screening programme.⁴¹ The small numbers of patients from other BME populations indicates the need for further research into the extent to which they are accessing the SLMS, and limits the ability of this study to draw wider conclusions about the experiences of BME people.

Clinical implications

Compared with local population figures, the SLMS sample includes a higher proportional representation of African–Caribbean-born people than might be expected. While this finding may seem positive, our results show a more marked degree of cognitive impairment in the BME group, despite the younger age at presentation. This indicates a need to work with local stakeholders to ensure a lower threshold for referring African–Caribbean patients to the service, and to investigate ease of access for patients from other BME groups.

Culturally sensitive assessment is also required. This includes reflection on the way cognitive impairment is assessed in a population with varied cultural and educational backgrounds⁴² and an avoidance of stereotypical beliefs.⁴³ Culturally sensitive cognitive tools should be used where they exist, and cognitive testing should not be the only means of determining diagnoses.²⁹ The SLMS should continue the approach of considering cognitive test scores in the context of patient and carer accounts, brain neuroimaging, screening for affective disorders and additional neuropsychological testing to ensure accurate diagnosis. GPs also need to be aware of potential differences in age at onset of dementia and vascular risk differentials, to ensure effective cardiovascular preventative measures and arrange appropriate and early onward referral to secondary care.

Further analysis of similar data from a range of local memory services would be useful in detecting whether the trends evident in this study are reflected in the local population and other BME groups. It would be useful to include non-mental health services diagnosing dementia (e.g. geriatricians' clinics and neurology) in this analysis. The analysis into severity of impairment at presentation could be expanded by combining cognitive scores with other rating scales assessing neuropsychiatric symptoms and activities of daily living. Differences in other aspects of service provision and quality of life, such as assessment refusal rates, treatment with cognitive enhancer medications and the role of support networks in encouraging or discouraging help-seeking could also be explored.

Caution must be applied to the interpretation of these results. Although the term BME may imply homogeneity, it encompasses a wide variety of unique individual and collective experiences⁹ and the diversity both within and between ethnic groups must not be overlooked. Ethnicity may play an important role in influencing presentation to memory services, but this is only one part of the picture, and consideration for individual difference must always remain paramount.

We thank Martin Scott for his assistance with statistical analysis.

1.8.55 Culturally adapted mental healthcare: evidence, problems and recommendations

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Abstract

Evidence suggests disparities in the prevalence of mental health problems and access to mental healthcare for a number of minority groups. The main response from mental health services falls into two related categories: (a) cultural adaptations of existing evidence-based interventions (EBIs) and/or (b) cultural competence of mental health professionals. This editorial looks at the evidence on culturally adapted EBIs and argues that although such interventions can be effective, they also carry the risk of alienating members of the groups they are aimed at. Recommendations focus on identifying issues that pertain to being from a racial minority and/or possessing other stigmatised identities that can have an impact on mental health problems, which may be overlooked by mental health services by assuming an overarching predominant cultural identity.

Contents

- *Culturally adapted mental healthcare: evidence, problems and recommendations*
 - *Cultural adaptations: do they work?*
 - *Culture v. subculture: does one size fit all?*
 - *Where next?*

Evidence suggests that disparities exist in the prevalence of mental health problems and access to mental healthcare for a number of high-risk groups.¹ Many of these groups share similar characteristics in terms of minority status (e.g. Black and minority ethnic (BME) groups) or belong in subgroups that exist within a larger racial/ethnic population (e.g. lesbian, gay, bisexual and transgender (LGBT) people, older people, refugees, asylum seekers). Findings from earlier and more recent reviews suggest that mental health services are unattractive to these diverse cultural and subcultural

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minority groups, who complain of stigmatisation, prejudice, unsuitable treatments and adverse experiences and as a consequence, seek care less frequently and drop out of contact more often than others.^{2,3} Anxiety about potential discrimination or inability of the services to understand the diversity of needs can cause reluctance to access healthcare, resulting in delayed treatment.

The main response from mental health services to deal with mental health problems in minority populations falls into two related categories: (a) cultural adaptations of existing evidence-based interventions (EBIs) to clients' cultures and backgrounds and/or (b) cultural competence of health professionals in terms of specialist knowledge relating to particular lifestyles and needs. It can be argued that cultural adaptations do not automatically translate into mental health professionals' cultural competence and similarly, cultural competence of health professionals does not translate to provision of suitable, culturally adapted EBIs. Although culturally adapted EBIs seem to be the right way forward, they can also be conceptually simplistic and narrow. On the other hand, cultural competence can solve many of the conceptual problems that cultural adaptations may pose but any subsequent interventions need to be evidence based.

Cultural adaptations: do they work?

Culture is a complex concept encompassing a number of elements, including shared knowledge, language, behaviours, cognitive constructs (e.g. thoughts, schemas, beliefs, norms). Health practices such as those around food and exercise, health beliefs about aetiology, course and outcome of illness as well as health behaviours are also heavily influenced by culture.⁴ Cultural adaptations of mental health EBIs incorporate some or all of these elements with the aim of narrowing inequalities in care and reducing the higher prevalence of mental health problems in disadvantaged groups.

Meta-analyses of such interventions have produced mixed, inconclusive or positive results.⁵⁻⁸ In particular and when compared with traditional EBIs, control groups and/or other care, effect sizes have ranged from small to moderate (0.21-0.46). Interventions analysed have included individual therapy or group therapy or a mixture of both. Clinical characteristics included at-risk groups, clinical populations already diagnosed with a mental illness, and community members without a psychiatric diagnosis. There was no reference to whether services were in-patient or out-patient. Results from the meta-analyses did not differ by type of intervention, clinical characteristics, gender and ethnicity. One of the meta-analyses has also produced effect sizes for a number of different elements of culturally adapted EBIs.⁷ For example, cultural, ethnic and racial matching of individuals from BME groups with service providers was more effective than when clients were not matched with the provider or therapist ($d = 0.58$ v. $d = 0.31$). Furthermore, non-English and/or ethnic-specific services were more effective than non-ethnic-specific services ($d = 0.49$ v. $d = 0.21$).

Culture v. subculture: does one size fit all?

It can be argued that overall the evidence for culturally adapted EBIs is encouraging. However, cultural adaptations may also carry the risk of alienating members of those groups they are aimed at. One of the risks is that mental health professionals and researchers often make the assumption that individuals from specific subgroups possess certain cultural characteristics^{9,10} and fail to take into account that within a larger group there are a number of subgroups with different characteristics, which may be overlooked by attaching an overarching cultural identity to them. These subgroups may also be those with the highest risk of developing mental health problems. We can refer to them as subcultural groups which exist within a larger racial population and share similar life experiences and a mutual sense of belonging.

For subcultural groups racial identity may be secondary and the primary identity may be either more in tandem with the mainstream culture where they reside or related to a different group membership. Such group membership may be related to another stigmatised identity such as ethnic minority, LGBT groups, refugees, asylum seekers, older people. Therefore, some minority groups may find themselves in membership of multiple stigmatised identities in addition to ethnicity and mental illness (e.g. sexuality, single motherhood, asylum seeker, offending, poverty). In these situations mental health professionals would need to question whether an existing culturally adapted intervention would be beneficial. Therefore, subcultural differentiation is important when both adapting EBIs and delivering a culturally competent mental healthcare, as it provides specific information that goes beyond the ethnic identity and can capture other characteristics and/or needs that are not ethnic specific.

A further risk of cultural adaptations is the cultural contexts where the original interventions were developed. In particular, the majority of EBIs have been developed with participants from majority groups (e.g. Western, White) and then have been culturally adapted and applied to minority groups residing in the context where these were developed originally. Since many cultural adaptations are developed from existing EBIs, they very often overlook the factors related to being a minority, such as racism, stigma, poverty, internalised oppression, and mainly focus on culture and mental health. For example, coping with a stigmatised identity has been found to be a crucial factor in recovering from mental illness in a number of studies. In particular, in a systematic review of published descriptions and models of personal recovery, Leamy *et al*¹¹ found that recovery for ethnic minority groups involved racial discrimination, stigma of mental illness and stigma of ethnic minority identity. Therefore, recovery was not as narrowly defined as recovering from mental illness.

A good example of incorporating these issues can be found in a culturally adapted mindfulness-based stress reduction (MBSR) intervention developed by Dutton *et al*.¹² The intervention was adapted for African American women from low socioeconomic background who were in abusive relationships and experienced post-traumatic stress disorder. Interviews and focus groups revealed that the main concerns were related to problems posed by living on a low income, lack of space to practise MBSR exercises (e.g. breathing, yoga, meditation), exposure to trauma, and also the structure of the intervention (e.g. time frames and length of sessions) in relation to childcare demands. Therefore, the adaptation involved, among other elements, shorter sessions and availability of childcare as well as a special focus on dealing with the everyday stressors of low-income existence and coping with trauma. The specificity of race did not appear to be a theme that needed to be included in the development of the intervention. However, the stigma of mental illness and the stigma of using mental health services, which has been found to be prevalent among African American populations,¹³ was also evident in the interviews and led to adaptations that involved elements to cope with the stigma of mental illness.

Where next?

Overall, it can be argued that mental health services are going in the right direction in terms of culturally adapting EBIs to reach at-risk groups and narrow the gap of mental health inequalities. However, cultural adaptations can be beneficial if applied by health professionals who are culturally competent and have the ability to explore differing values and needs with their clients instead of assuming cultural characteristics that may be either non-existent or not predominant. Therefore, training of staff which focuses on removing prejudice and promotes cultural competence and specialist knowledge pertaining to particular lifestyles needs to go hand in hand with cultural adaptations of EBIs. Cultural competence will help mental health professionals to make an assessment focusing on each client's experience before applying cultural adaptations. Such assessments need to happen on a case by case basis and mental health professionals need to identify a number of issues before making a decision. Such issues pertain to: (a) exploring the predominant identity of the client (e.g. cultural or other), (b) identifying issues that may be related to being a racial minority (e.g. internalised racism and discrimination) and/or having a mental illness (e.g. mental illness stigma in a particular culture) and (c) exploring the client's membership in other groups that may be stigmatised or have an impact on mental health (e.g. LGBT, low socioeconomic status).

In relation to exploring a client's predominant identity, Rucker Sobczak & West¹⁴ suggest that the initial assessment needs to involve an understanding of whether the client subscribes to a collectivistic (e.g. seeing the self as part of a cultural group or others with collective goals) or individualistic (e.g. seeing the self as a separate entity to others with individual goals) self-identity as this can have significant outcome implications. Such assessment can also add clarity about whether there is a dominant identity and whether this is the cultural one. Similarly, assessment measures that deal with issues related to being in a minority group such as stigma and perceived racism may reveal what type of interventions may be more beneficial for, or applicable to, which individuals.¹⁰

Finally, it is important to stress that cultural adaptations and cultural competence have to operate along other initiatives that aim to reduce discrimination and tackle social exclusion, which have an impact on further socioeconomic disadvantage and place someone at increased risk of mental illness, and to promote outreach effort to recruit underserved clients from high-risk groups and actively target communities with higher concentration of socially excluded groups (e.g. BME communities). Needless to say, culturally adapted EBIs and cultural competence training as well as initiatives to reduce discrimination and social exclusion must be evidence based and be subject to evaluations on

what works and for whom. Currently, most of the evaluation data on culturally adapted EBIs come from US studies, so future interventions and subsequent evaluations need to happen in a UK context.

1.8.56 Trauma exposure and refugee status as predictors of mental health outcomes in treatment-seeking refugees

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Abstract

Aims and method This study aimed to identify predictors of symptom severity for post-traumatic stress disorder (PTSD) and depression in asylum seekers and refugees referred to a specialised mental health centre. Trauma exposure (number and domain of event), refugee status and severity of PTSD and depression were assessed in 688 refugees.

Results Symptom severity of PTSD and depression was significantly associated with lack of refugee status and accumulation of traumatic events. Four domains of traumatic events (human rights abuse, lack of necessities, traumatic loss, and separation from others) were not uniquely associated with symptom severity. All factors taken together explained 11% of variance in PTSD and depression.

Clinical implications To account for multiple predictors of symptom severity including multiple traumatic events, treatment for traumatised refugees may need to be multimodal and enable the processing of multiple traumatic memories within a reasonable time-frame.

Contents

- *Trauma exposure and refugee status as predictors of mental health outcomes in treatment-seeking refugees*
 - *Method*
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 - *Results*
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1

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Refugees and asylum seekers have been shown to be at substantially higher risk of developing post-traumatic stress disorder (PTSD)¹ and comorbid mental health problems than the general population,² compatriots who have stayed in the refugees' home country,³ and economic migrants.⁴ Exposure to a high number of potentially traumatic events, involvement in asylum-seeking procedures and forced migration are stressors that set refugees apart from other populations and increase their psychological vulnerability. In Western psychiatric practice, insight in the determinants of PTSD and comorbid disorders in refugees may be helpful in guiding treatment interventions. Meta-analyses have shown that torture and cumulative traumatic events are the main predictors for development of PTSD in refugees.⁵ Additionally, researchers have begun to investigate whether different symptom profiles in refugees are related to different traumatic experiences. In a sample of Bosnian refugees, Momartin *et al*⁶ found that life threat and traumatic loss were related to PTSD and depression. In a sample of Mandeian refugees, Nickerson *et al*⁷ found that PTSD and prolonged grief disorder were predicted by traumatic loss, whereas PTSD only was predicted by difficulties related to loss of culture and support.

While these findings are highly relevant to treatment-seeking refugees, similar analyses have not yet been carried out in large, treatment-seeking refugee samples. In this study we examine whether symptom severity of PTSD and depression is predicted by refugee status as well as accumulation and specific domains of traumatic events in a sample of refugees seeking specialised mental healthcare.

Method

Participants

Participants were asylum seekers and refugees referred for treatment at Foundation Centrum '45, a specialised Dutch centre for diagnosis and treatment of complex psychological trauma. Refugees are individuals who have been granted temporary or permanent refugee status in The Netherlands whereas asylum seekers are those still awaiting a final decision. In 2001, Foundation Centrum '45 started to routinely monitor treatment outcomes by administering questionnaires to patients at intake and annually during treatment. For the present study, data collected at intake were used. Complete data with regard to refugee status, traumatic experiences and symptom severity of PTSD and depression were available for 688 asylum seekers and refugees. Characteristics for the total sample are presented in *Table 1*. Participants came from three main regions: 58% from the Middle East (e.g. Afghanistan, Iraq, Egypt, Libya), 17% from Sub-Saharan Africa (e.g. Burkina Faso, Eritrea, Congo) and 16% from Balkan Europe (Bosnia, former Yugoslavia, Croatia).

Demographic characteristics of the total sample and the main regions of origin

	Total sample (<i>n</i> = 688)	Middle East (<i>n</i> = 397)	Sub-Saharan Africa (<i>n</i> = 114)	Balkan Europe (<i>n</i> = 111)	Other regions (<i>n</i> = 66)
Male, <i>n</i> (%)	488 (71)	306 (77)	66 (58)	70 (63)	45 (68)
Age, mean (s.d.)	40.4 (10.4)	41.3 (9.9)	32.2 (8.5)	45.2 (9.1)	41.4 (11.2)
Permanent refugee status, <i>n</i> (%)	585 (85)	361 (91)	73 (64)	107 (96)	44 (67)

Measures

Traumatic experiences and PTSD symptom severity were assessed using the Harvard Trauma Questionnaire (HTQ).⁸ The HTQ consists of three parts, the first two of which were used in this study. In the first part participants were asked to indicate which of the 19 traumatic events they experienced, witnessed or heard of, and only self-experienced traumatic events were used in the study. For each participant a total number of different self-experienced traumatic events was calculated (range 0-19). In the second part of the HTQ the severity of DSM-IV PTSD symptoms was assessed by asking participants how much they were bothered by 16 PTSD symptoms during the past week, rated on a 4-point scale ranging from 1, not at all to 4, extremely. PTSD symptom severity was computed by averaging responses (range 1-4). The HTQ recommends a cut-off score of 2.5 to identify clinically significant PTSD. Internal consistency of the scale was high (Cronbach's 0.86).

Symptom severity for depression was assessed with the Hopkins Symptom Checklist (HSCL-25).⁹ Participants were asked to indicate how distressed they were by rating 10 symptoms of anxiety and 15 symptoms of depression during the past week on a 4-point scale ranging from 1, not at all to 4, extremely. Symptom severity of depression (range 1-4) was computed by averaging responses on the 15 depression items. The HSCL-25 recommends a cut-off score of 1.75 to indicate clinically significant depression. Internal consistency was high (Cronbach's 0.89).

The HTQ and HSCL-25 are self-report questionnaires that are widely used with refugees and are available in many different languages. Questionnaires were administered in the patient's native language if possible and interpreters were used when necessary. Both instruments have good psychometric properties.¹⁰

Statistical analyses

Statistical analyses were performed using SPSS version 20. To investigate whether specific domains of traumatic events could be identified, a principal component analysis with oblique rotation (direct oblmin) was conducted on the total set of self-experienced traumatic events. An initial analysis was run to obtain eigenvalues for each factor in the data and to evaluate the substantive contribution of each item to the extracted factors. Stevens¹¹ recommends interpreting factor loadings greater than 0.4 as substantive. The analysis was rerun without the items that did not contribute substantively to the extracted factors. For each participant a total score was computed on each of the extracted domains of traumatic events by counting the total number of self-experienced traumatic events within the domain.

Hierarchical regression analyses were used to test whether refugee status, total number of self-experienced traumatic events and the domains of traumatic events predicted symptom severity of PTSD and depression. These variables were independently added to the regression models, together with the gender and age covariates, as these have been found to predict PTSD in refugee samples.¹² Scores on the extracted domains of traumatic events were recoded into dummy variables before being added to the hierarchical regression models. To allow for multiple tests the alpha level of significance was set to 0.01.

Results

First, it was investigated whether specific domains of traumatic events could be identified by conducting a principal component analysis. In the initial analysis, four factors had eigenvalues greater than 1. Four traumatic events (combat situation, brainwashing, rape or sexual abuse, and being close to death) did not contribute substantively to any of the four extracted factors and the analysis was rerun without these items. Four factors were retained with eigenvalues greater than 1.0, which together accounted for 56.7% of the total variance. *Table 2* presents the factor loadings after rotation. The traumatic events that cluster on the same factor suggest that the first factor represents human rights abuses (31.1% of the total variation), the second factor traumatic loss (10.0% of the total variation), the third factor a lack of necessities (8.7% of the total variation), and the fourth factor separation from others (6.9% of the total variation).

Summary of principal component analysis for traumatic experiences^a

	Rotated factor loadings			
Threatened to be executed	0.78	0.13	0.13	0.09
Physical torture	0.77	0.10	0.03	0.12
Threatened to be physically tortured	0.77	0.03	0.10	0.08
Threatened to watch torturing	0.66	0.04	0.07	0.04
Serious injury	0.50	0.01	0.21	0.11
Lost or kidnapped	0.46	0.15	0.13	0.04
Imprisonment	0.46	0.04	0.16	0.28
Murder of family or friend	0.02	0.85	0.04	0.01
Unnatural death of family or friend	0.12	0.79	0.04	0.11
Murder of stranger or strangers	0.15	0.63	0.03	0.02
Lack of shelter	0.03	0.05	0.79	0.12
Lack of food or water	0.07	0.03	0.78	0.15
Ill health without access to medical care	0.13	0.03	0.68	0.07
Forced separation from family members	0.04	0.09	0.02	0.85
Forced isolation from others	0.14	0.03	0.06	0.75

Factor loadings over 0.40 appear in bold.

Mean symptom severity was 3.1 (s.d. 0.5) for PTSD and 2.9 (s.d. 0.6) for depression both within the clinical range. A clinical level of symptom severity for PTSD and depression was reported by, respectively, 84% and 95% of participants. Participants reported a mean of 11.2 different self-experienced traumatic events (s.d. 4.7). The most commonly reported events were being close to death (80%), forced separation from family members (74%), murder of family or friend (72%), threatened to be physically tortured (72%), and unnatural death of family or friend (66%). With regard to the trauma domains, human rights abuses were reported by 90% of participants, traumatic losses by 83%, lack of necessities by 77%, and separation from others by 81%.

Hierarchical regression analyses were used to test whether possession of refugee status, the total number of different self-experienced traumatic events, and different domains of self-experienced traumatic events predicted symptom severity of PTSD and depression. Results of the hierarchical regression models are shown in *Table 3*. First, symptom severity of PTSD and depression was adjusted for gender and age by adding them to the model in step 1. Refugee status was added to the model in step 2. Lack of refugee status was significantly associated with increased symptom severity for PTSD and depression. Refugee status accounted for 2% of the variation in symptom severity of those disorders. Total number of different self-experienced traumatic events was added to the model in step 3. Increased number of different self-experienced traumatic events was significantly associated with increased symptom severity for PTSD and depression. Total number of different self-experienced traumatic events accounted for 8% of the variation in PTSD symptom severity and for 7% of the variation in symptom severity for depression. To test the unique effect of different domains of self-experienced traumatic events to symptom severity of PTSD and depression, human rights abuses, traumatic loss, lack of necessities and separation from others were added to the model in step 4. None of

these domains were significantly associated with symptom severity. Adding the different domains of self-experienced traumatic events to the model accounted for an additional 1% of the variation in symptom severity.

Hierarchical regression models of predictors of symptom severity with regard to PTSD and depression *a*

	PTSD symptoms	Depressive symptoms						
Step 1				0.00				0.01
Constant	3.05	0.03			2.88	0.03		
Gender	0.04	0.05	0.03		0.11	0.05	0.08	
Age	0.02	0.02	0.03		0.03	0.02	0.05	
Step 2				0.02 `* <#TFN 4>`__				0.02 `* <#TFN 4>`__
Constant	3.02	0.03			2.84	0.03		
Gender	0.04	0.05	0.04		0.12	0.05	0.09	
Age	0.04	0.02	0.07		0.06	0.02	0.09	
Refugee status	0.21	0.06	0.14 `* <#TFN 4>`__		0.28	0.07	0.16 `* <#TFN 4>`__	
Step 3				0.08 `* <#TFN 4>`__				0.07 `* <#TFN 4>`__
Constant	3.00	0.03			2.82	0.03		
Gender	0.09	0.04	0.08		0.18	0.05	0.13 `* <#TFN 4>`__	
Age	0.04	0.02	0.07		0.06	0.02	0.09	
Refugee status	0.20	0.06	0.13 `* <#TFN 4>`__		0.26	0.07	0.15 `* <#TFN 4>`__	
Traumatic experiences, <i>n</i>	0.15	0.02	0.28 `* <#TFN 4>`__		0.17	0.02	0.28 `* <#TFN 4>`__	
Step 4				0.01				0.01
Constant	2.82	0.11			2.58	0.13		
Gender	0.09	0.04	0.08		0.17	0.05	0.12 `* <#TFN 4>`__	
1.8. 2015 Age	0.04	0.02	0.07		0.06	0.02	0.09	2583
Refugee status	0.20	0.06	0.13 `* <#TFN 4>`__		0.26	0.07	0.15 `* <#TFN 4>`__	

B, Unstandardised regression coefficient; Beta, standardised regression coefficient; PTSD, post-traumatic stress disorder.

Dependent variables: symptom severity with regard to PTSD and depression.

$P < 0.01$

R^2 , change in R^2 compared with previous step.

Clinical implications

In a large sample of asylum-seeking and refugee patients seeking treatment within a specialised Western mental health setting, PTSD symptom severity and depression was predicted by lack of refugee status and cumulative traumatic events, but not by specific domains of traumatic experience. Refugee status, total number of self-experienced traumatic events, domains of traumatic experiences, and gender and age together accounted for only 11% of variation in symptom severity of PTSD and depression. These results are in stark contrast with earlier findings among non-treatment-seeking refugee populations, which showed that torture and cumulative traumatic events accounted for 34.4% of variance in PTSD prevalence rates and for 33.4% of variance in depression prevalence rates.⁵

Clearly, PTSD symptom and depression severity among asylum seekers and refugees seeking specialised treatment is influenced by multiple factors, including some that were not measured in this study. To map predictors for PTSD and depression in refugee patients, assessment may need to focus on a broader range of both stressors and resources, including stressors and resources related to forced migration, such as safety of family in the home country and social support. Rather than traumatic stress, it may be the burden of current stress and lack of resources that leads to PTSD and depression, prompting refugees to seek mental healthcare. This finding implies that clinically, in this severely traumatised population, an exclusive focus on processing of traumatic experiences as prescribed in PTSD treatment guidelines may result in only limited symptom reduction. Consequently, for refugee patients with severe psychopathology treatment may need to be multimodal rather than trauma-focused only.

In addition, in contrast to other studies, which showed an association between life threat and traumatic loss on the one hand and PTSD and comorbid disorders on the other, in our treatment-seeking sample no such associations were found. In our sample, the number rather than domain of traumatic events was associated with symptom severity. This implies that trauma-focused treatments for refugees should be designed to enable the processing of a large number of traumatic events within a reasonable time-frame. Treatments such as narrative exposure therapy and trauma-focused cognitive therapy may enable that to a greater extent than *in vitro* exposure therapy or eye movement desensitisation and reprocessing therapy, which in refugees may require several sessions for the processing of a single memory.

Although our findings can be generalised to mental healthcare-seeking refugees and asylum seekers only and the range of questionnaires was limited, merits of this study lie in the satisfactory cultural validity of the questionnaires and the large sample size. Future studies using a broader range of instruments are needed to identify predictors for PTSD and depression in treatment-seeking refugees.

1.8.57 A guide to a new short course to promote interest and engagement in psychiatry in medical students

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date

2015-8

Abstract

This article describes a new course for preclinical medical undergraduates designed to promote interest and engagement in psychiatry. The course employed a range of innovative teaching techniques alongside ward visits to provide students with early clinical experience. Unusually, assessment for the course involved the production of creative works as well as reflective writing about students' experiences. We collected a variety of feedback from participants showing that they found the course enjoyable and educational. We conclude that, overall, the course had a positive effect on student perceptions of psychiatry.

Contents

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Psychiatry is one of several medical specialties undergoing a crisis in recruitment, with a 15% shortfall in core trainee (CT1) allocations year by year.¹ The Royal College of Psychiatrists is seeking to address this deficit by engaging with students before, during and after medical school,² with recommendations for interventions at each level. One such intervention is the provision of student selected components (SSCs) in psychiatry. In this paper, we discuss our experience of developing and delivering an innovative optional module for second-year medical students studying for the Bachelor of Medical Sciences (BMedSci) degree at the University of Nottingham and the impact this had on their attitudes towards psychiatry.

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Aims and objectives

The aims of the module were: to stimulate students to learn more about psychiatry before entering traditional 6-week clinical placements in year 4 to demystify and destigmatise the specialty and consider how psychiatric practice differs relative to the traditional medical models of medicine and surgery to improve students' critical reflection skills and to allow them to improve their medical practice by reflecting on personal experience.

When designing this course, we were guided by our aims and objectives and by literature available about other psychiatry SSCs (see below). We were, however, constrained by some practical considerations. The module had to fit into an existing undergraduate timetable that was already very busy. This meant that the SSC had to be completed in one semester and we managed to negotiate eight sessions of varying length for our teaching. The total duration of the course, including time for submitting the assessments, was approximately 3 months. We were also keen to avoid duplicating the teaching and experiences that students would receive during their clinical attachments to psychiatry in their fourth year.

A literature search was conducted to see whether other medical schools had undertaken similar SSCs and, if so, what their experiences were. A range of databases (AMED, Embase, HMIC, MEDLINE, PsycINFO, BNI, CINAHL, Health Business Elite) were searched using all combinations of the terms 'psychiatry', 'student selected component', 'special study module', 'SSC' and 'SSM'. This search yielded 21 results and, after removal of duplicates, review of the abstracts identified 4 articles of particular interest. Brown *et al's*³ survey of Scottish psychiatrists supported our view that engaging medical students early in their training was important for promoting positive attitudes towards psychiatry. We also found three published examples of SSCs/SSMs in psychiatry. One of these was a 3-week SSC at Hull York Medical School on mental health and the arts.⁴ The other two were both SSMs looking at the representation of mental illness in films.^{5,6}

Some parts of our design were influenced by these reports. For example, we included short examples from films and other popular media in our seminars (e.g. *Winnie the Pooh* cartoons). We also acknowledged the natural link between mental health and the arts in our innovative assessment scheme where students were asked to prepare and present creative pieces influenced by their experiences during the module. However, we felt that a design using only one approach (e.g. film or arts in general) would not allow us to meet all of our objectives. Hence, our course included a variety of teaching modalities and, very importantly, used early clinical experience in the form of structured ward visits.

The module structure comprises lectures, small-group teaching, student-led presentations, group work, self-directed learning and two field trips to psychiatric hospitals. The intention was not necessarily to recruit every member of this group to the specialty, but to sow the seeds of positive regard for psychiatry and its patients and to destigmatise mental illness.

The course consists of five 2-h seminars on the following topics: the history of psychiatry, psychosis, neurosis, the subspecialties and ethical dilemmas in psychiatry. Interspersed with these seminars are two clinical visits supervised by senior clinicians, each 3 h long. Twelve students are accommodated on the course. This early exposure to mental health in-patient care is to our knowledge rare in the UK. In the final 3-h seminar students present part of the course assessment in the form of a creative piece about psychiatry to an audience of their peers, consultants and an assessment panel.

Interesting and interactive sessions were devised which minimised didactic teaching, as far as possible, while still introducing the serious and sensitive nature of mental illness. It was also important not to duplicate any of the curriculum material the students would receive in their later fourth-year clinical psychiatry placements.

Course structure and materials

Seminar 1: History of psychiatry

An assumption was made that students' prior knowledge was comparable to a member of the public's and therefore likely to be influenced by popular media portrayals of mental illness⁷ or personal experience involving themselves, friends or relatives.

The session begins with students having to define the job descriptions of psychologists and psychiatrists in an interactive session with the facilitators for 20 min.

'Getting away with murder' is then played. This is an exercise designed to draw out student preconceptions and prejudices, which could then be challenged and revisited throughout the course. Students are divided into two groups and asked about the role mental illness plays in violence. A scenario is presented whereby students are asked to imagine they have committed a murder and have decided to feign symptoms of a mental illness to be found not culpable. Working in their groups facilitated by course tutors, the students then brief a patient simulator (who is experienced in portraying the symptoms of mental illness in medical assessment and training) on how to behave and what to say. Next, a specialist forensic psychiatry trainee interviews the simulators in front of both groups. Students are positively rewarded with chocolate for the simulator portrayal of a convincing symptom or syndrome of mental disorder.

This exercise successfully sparks the students' interest and leads to an open discussion, guided by feedback from the interviewing psychiatrist, about the symptoms the students describe and why they believe them to represent mental illness. The symptoms generated by the students were contrasted with symptoms that are typically seen in forensic psychiatry settings. The remainder of the session is spent presenting students with a broad history of psychiatry through the ages with a focus on attitudes towards mental illness in different societies and contrasting these with the students' own attitudes.

Seminar 2: Psychoses

The second seminar focuses on the nature of psychosis and the challenges it poses to patients, mental health services and society. The students are shown a video interview with a patient who experiences features of psychosis. To facilitate empathy, the patient selected for interview was also a student of a similar age. He talks through his experiences – the first time the students hear a description of a psychotic episode – and the impact the illness has had on his life. This challenges the students' previously expressed views as to the experience of mental illness and the information generated by students during the 'getting away with murder' game is revisited. A discussion is facilitated to establish the nature of the symptoms of psychosis.

To enable students to develop an experiential insight into schizophrenia, we attempted to simulate a psychotic symptom. There is an existing body of literature to support this approach.⁸ The experience of an auditory hallucination is simulated for the students by listening to an audio file played on their own mobile phones or other devices via headphones. The scripts were based on patients' descriptions of their auditory hallucinations and then anonymised. The hallucinations were voiced by members of the teaching team, recorded and mixed together. The audio file was distributed to students via the Moodle virtual learning environment (<https://moodle.org>) with instructions to bring it to the relevant session on a device with headphones attached, having not yet listened to it.

The pressure to perform well academically in medical students is well known, as is their competitive nature. A quick-to-administer intelligence test was identified and students take the test under normal conditions. Next, they complete a comparable test while listening to the simulated auditory hallucinations on their headphones. The tests are scored and students compare their two sets of individual results; group means are calculated and a paired *t*-test performed to demonstrate the effects of hallucinations on intelligence testing.

Seminar 3: Neuroses

This seminar aims to introduce depression and anxiety disorders by highlighting issues related to defining the boundaries between normal and pathological experiences. A small degree of anxiety is generated in students at the beginning of the session. On arrival they are told they are to sit an *ad hoc* examination under strict conditions. The teaching team act in an anxious manner themselves, talking about the need to standardise the course for external examiners, while students wait silently for everyone to arrive. When instructed to turn the exam paper over students discover a questionnaire asking about the acute symptoms of anxiety derived from the ICD-10 criteria for generalised anxiety disorder. Students then reflect on their feelings on being told they had an examination and how these match to those probed in the questionnaire. A number of anxiety symptoms are elicited. Having induced symptoms of anxiety, prior learning is then activated by a group discussion reminding the students of the biological basis of the physiological changes that occur in anxiety.

To further illustrate the concepts included in the broad area of neurosis, video clips of characters from *Winnie the Pooh*⁹ are then shown and discussed in the group. This illustrates how disorders can be identified (e.g. depressive disorder in Eeyore, anxiety disorder in Piglet) and the importance of having a structured means of drawing the line between the normal and the pathological.

It was considered important that issues of suicide and risk assessment are discussed. To facilitate this, examples of famous people who have died by suicide are called upon, allowing this emotive topic to be discussed in a sensitive way within the now-bonded group.

Seminar 4: Subspecialties

As psychiatry is a medical specialty with many subspecialties that most medical students do not get experience in, the students were introduced to the main subspecialties with brief talks from consultant psychiatrists in various fields (old age, child and adolescent, intellectual disability, forensic and psychotherapy). Exposure to the enthusiasm and expertise of specialist consultants is a valuable part of the module and speakers are briefed to talk to the topic 'I like my job, because ...' for 20 min and allow 5 min for questions. Following this seminar, students are asked to express individual preferences for their visit to a subspecialty unit.

Seminar 5: Ethical dilemmas in psychiatry

Psychiatrists face numerous clinical ethical dilemmas. It is important to introduce the students to these issues; they are taught ethical principles at an early stage in the medical curriculum and have a basic understanding of the area. Consultants from subspecialist areas within general adult psychiatry present to the students real clinical cases featuring ethical considerations. The consultants specialise in liaison psychiatry, perinatal psychiatry, eating disorders and gender identity issues. Feedback from students indicated that, before the presentations, they were unaware of some of these specialist areas of psychiatry.

Clinical visits

Within the module are two visits to in-patient psychiatric units. Students attend in pairs: visiting one of the six local acute general adult wards on the first visit and one of the available subspecialty in-patient units on the second visit (drug and alcohol, perinatal, forensic, intellectual disability, child and adolescent, old age). To prepare the students for the visit, information is given about ward etiquette (dress, ID, behaviour, safety), suitable questions are suggested for the meeting with a patient and opportunities are given to ask questions about the visits. Senior doctors, either consultants or higher specialist trainees, lead the visits. The visit format is prescribed as follows. First, students observe the psychiatrist interviewing a consenting patient (30 min) and then discuss the case. After a coffee break, students are introduced to a consenting patient to speak with them in a communal ward area for 30 min. Following this, students have the chance to reflect verbally on their experiences with the psychiatrist and ask questions about the patient they

have seen. By encouraging the students to focus on the impact of the mental illness and the care received, rather than take a formal psychiatric history, the importance of and need for high-quality psychiatric care is reinforced.

Assessment

As an optional module contributing towards an intercalated BMedSci degree, a summative assessment is mandated. As the aim of the module is to demystify and destigmatise psychiatry as well as developing empathy the assessment places emphasis on reflective processes. Students are required to produce two reflective essays, one entitled 'My impressions of psychiatry' (1500 words) and the other 'Meeting a psychiatric patient' (1000 words). They are also required to produce a piece of creative work that communicates their understanding of any aspect of psychiatry with an accompanying written explanation of the work. This was presented to the student group, the facilitators, consultants and psychiatric staff who facilitate the ward visits. A psychiatric occupational therapist helped to develop the marking criteria and was a member of the assessment panel. The creative work presented was emotionally poignant and exceeded expectations; students produced paintings, photography, poetry, interpretative contemporary dance, short films and sculptures. Their work has been exhibited at the medical school and is available for future groups to see online.

The student experience

The Attitudes to Psychiatry (ATP) questionnaire¹⁰ and a bespoke questionnaire to obtain qualitative and quantitative feedback on the creative assessment and the role of reflection in medical training were completed by students both before and after the course. There were no statistically significant differences in attitudes to psychiatry question items before and after the course. There were 11 students who completed the ATP before the module and 10 who completed it at the end of the module. When individual statements were examined using chi-squared results for the responses before and after the module compared with the mean response before the module for each question on the ATP, three questions initially seemed statistically significant (Question 3: 'Psychiatric hospitals are little more than prisons', Question 9: 'Psychiatric teaching increases our understanding of medical and surgical patients', Question 29: 'Psychiatric patients are often more interesting to work with than other patients'). However, once adjusted for multiple testing using a Bonferroni correction, the results were no longer statistically significant. The lack of statistically significant results in the ATP is probably due to the small sample size and the fact that students self-selected the course, which might have resulted in the group being biased positively towards those attracted to psychiatry at the outset.

The most positive effect of the course was apparent in the essays the students produced. Most chose to reflect on their personal journey through the course, with a common theme being the realisation that previously held stereotypic views of the psychiatrist and their patients were inaccurate. Our aim to give students a positive experience of psychiatry was achieved – one student wrote 'Considering that I chose this module having no intention of taking a career route in psychiatry, I must say that the module has certainly left positive impressions upon me, and right now, I definitely would not rule out such a possibility'.

An example of the impact of the module is voiced by a student who wrote: 'My impression of psychiatry has been very positive. [Psychiatry] is an exciting and ever-evolving profession'. Admittedly, students were aware of the 'hidden agenda' created by the recruitment crisis in psychiatry and perhaps they knew we would be delighted to read quotes such as, 'I have ended this course wanting to pursue a career in old age psychiatry'.

Another common essay theme was the belief that medical students should be taught about psychiatry earlier in their training. One student stated: 'My impressions of psychiatry have changed dramatically over the [past] year and I am of the opinion that all medical students would benefit from early exposure to this [specialty]'. Another student, having highlighted the stigma among medical students towards people with mental illness, said: 'I believe there should be a lot more emphasis on mental health in ... the preclinical phase of medical training, perhaps this can reduce the stigma associated with the subject'.

Clinical visits received excellent feedback from the students. One wrote: 'Probably the most important factor in sculpting my impressions, were my own experiences on the wards ... It felt like no other hospital ward that I'd been on before'. Another student wrote: 'Experiences such as meeting this patient, and the ward round, changed my views

and attitudes towards psychiatry entirely'. The effect of the contact with patients was clear, with one student writing: 'Thinking about psychiatry now, the patients are what I will take from this module'.

The aim to reduce stigma both towards psychiatric patients and their psychiatrists appears to have been achieved. One student stated 'I was greeted, not with a room of [Freuds], but kind, friendly, relaxed psychiatrists. People who seemed like the most passionate doctors of any [specialty] I'd encountered'. Another said: '[The course] has stripped away levels of stigma I barely knew I had, yet which society had conditioned me into having'. Several of the students commented on their desire to see stigma towards those experiencing mental illnesses to be reduced, typified by one student who wrote 'Mental illness is just as real as physical illness and deserves the same amount of respect'.

Discussion

It should be noted that the sample size of the first cohort was small, only 12, so it is difficult to draw anything more than impressions from the data collected. The course has been repeated but again with only 12 participants. Because funding streams are different for preclinical and clinical medical students at present there are practical limitations on the number of students who can undertake the module. However, with minor alterations, the module could be taught with larger numbers of students and in medical schools throughout the UK. A useful follow-up would be to conduct the ATP on second-year students who do not undertake this module and compare the results. In addition, following up this group of students to see whether the changes in attitude are sustained or short-lived might be of value. Comments made by the students during the module indicated that negative attitudes regarding mental health services are being propagated even in preclinical teaching sessions. As it has not been possible to do a long-term follow-up of these students yet, the effect of studying other areas of clinical medicine on their long-term career choice has not been established. This positive change in attitudes to psychiatry may or may not be sustained in the long term, but at least we have a tool that has demonstrated a positive impact on medical students that could be repeated in larger numbers.

Summary

In conclusion, by using innovative, interactive teaching techniques combined with early clinical visits to psychiatric units, the course achieved its aims of demystifying and destigmatising psychiatry. At the start of the course, none of the students had considered psychiatry as a career; by the end 25% stated they intended to become psychiatrists and a further 17% said they would consider a career in psychiatry. More than half of the students requested to do their BMedSci projects in areas related to psychiatry through the Institute of Mental Health, Nottingham. The remainder acknowledged a positive change in their attitudes towards psychiatry, viewing it as an interesting and important medical specialty. We are currently exploring the possibility of offering a similar bespoke course for local sixth-form pupils to encourage those interested in psychiatry to apply to medical school.

The assessment work demonstrated that all the students had increased their knowledge of psychiatry, with most having undertaken further personal study that was referenced in their submissions. The assessment process included a reflective piece enabling the students to develop reflective skills, with some being more able to demonstrate this in written form than others. As students are motivated by assessment, using an assessed reflective piece encouraged their focus on this skill that will benefit them in their future medical careers. Psychiatry in particular is an area where reflective practice is vital, so this assessment tool has face validity. We would encourage all psychiatrists in medical education to reflect on how we can make changes to improve recruitment of appropriately skilled doctors to psychiatry and present this module as one suggestion.

1.8.58 Nick Kitson MB, BS, FRCPsych

: Formerly consultant psychiatrist, Cornwall Partnership NHS Foundation Trust and Springfield University Hospital, honorary senior lecturer, St George's Hospital Medical School

Richard Laugharne

date

2015-8

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– : *Formerly consultant psychiatrist, Cornwall Partnership NHS Foundation Trust and Springfield University Hospital, honorary senior lecturer, St George's Hospital Medical School*

Nick Kitson, who died suddenly at the age of 64 while on holiday on 24 February 2014, was a pioneer and national expert in the psychiatric disorders of deaf people. He was the Founding Chair of the British Society for Mental Health and Deafness and the longest serving president of the European Society for Mental Health and Deafness (1990-1997), remaining honorary member and honorary vice president of each, respectively. He was clinical advisor to the Towards Equity and Access Implementation Panel (the Department of Health and National Institute for Mental Health England commissioning panel) in 2006/2007 and 'responsible owner' of a National Deaf Mental Health Commissioning Project. He remained a trustee of and medical advisor to the Sign health charity and awarded the title of Pioneer. He was joint editor of the standard introductory textbook *Mental Health and Deafness*. At the World Congress of Mental Health and Deafness held in 2014, a prize for the best poster was established in his name.

Nick completed his medical training at St Bartholomew's Hospital in 1975. He was appointed consultant psychiatrist at Springfield University Hospital and honorary senior lecturer at St George's Medical School in 1984. He was clinical director for the Specialist Mental Health Services for the Deaf Community at Springfield and medical director of Pathfinder NHS Trust from 1994 to 1998. When he became responsible for the psychiatric care of people with deafness, his health authority gave him 9 months to learn sign language. He visited psychiatric units for deaf people in America and realised the importance of employing deaf people fluent in sign language. At the time he wrote about sign language: 'It is a very sophisticated language capable of expressing everything you can say in English.' The service for deaf people that he led and developed for 18 years, with his wife Karen, covered the southern half and then a third of England. He became a Member of the Royal College of Psychiatrists in 1980 and was elected a Fellow in 1996.

While working as a consultant, he trained in short-term dynamic therapy in 1984 and group analytic psychotherapy in 1989. He became an associate member of the London Centre for Psychotherapy (British Psychotherapy Foundation) in 1989 and a Full Member in 1996, supervising short-term dynamic psychotherapy at the Tavistock and latterly at the London Centre for Psychotherapy. Psychotherapy was always an integral part of his clinical practice. He provided strong support for Jane Douglas, the first profoundly deaf person to train as a psychoanalytic psychotherapist.

Knowing the West Country well, Nick left London and moved to Cornwall in 2002. He initially worked as a community and in-patient psychiatrist covering the St Austell area but, wishing to reduce his workload owing to ill health, he became part-time consultant to the psychiatric intensive care unit (PICU). The service was awarded the National PICU of the Year in 2005. Formally retiring in 2009, he continued as his own locum for the PICU, regularly sailing and taking trips abroad with Karen and his family.

Nick was a hugely respected consultant psychiatrist. His colleagues frequently sought his advice in difficult circumstances, and the advice he gave was wise and supportive. He was down-to-earth and sensible; he never pretended he knew the answer when he did not, but his advice was even sounder in these circumstances. He continued to use his therapeutic skills after retirement and remained enthusiastic and determined to help the most challenging and difficult patients.

He will be sorely missed by his colleagues but his wise leadership will continue to be influential. He is survived by Karen, his two daughters and his grandchildren.

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1.8.59 Patient characteristics and predictors of completion in residential treatment for substance use disorders

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date

2015-10

Abstract

Aims and method To identify the patient characteristics and rates of retention in a residential rehabilitation drug and alcohol service (Springhill) based on an eclectic model of care. Patients were assessed using the Alcohol and Drug Outcome Measure (ADOM), a brief tool designed for the New Zealand setting. We looked at correlations between demographic, social and drug use parameters. Logistic regression assessed the relative impact of each variable on completion.

Results The 183 patients who completed the data collection did not differ from 47 non-completers by demographic data; 62.2% of patients completed the programme, with equal number of men and women. One in five participants was Maori, the indigenous minority. Alcohol (51.9%) was the commonest drug of misuse, with methamphetamine (16.4%) and cannabis (14.2%) also significant. Completers were more likely to be Maori, have conflict with family and housing problems, although the last became non-significant in logistic regression.

Clinical implications Retention rates are higher in Springhill than in comparable programmes. Ethnicity and family conflict predict completion, although the reasons for this are unclear. ADOM is an effective tool that can be used in a clinical setting to enable analysis of service provision.

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Substance use disorders (SUDs) are relapsing and remitting disorders that affect a significant proportion of the community. One-year prevalence rates of alcohol use disorders range from 3.5%¹ to 8.7%,² with lifetime rates for SUDs reaching 12.3%.³ The commonest age of onset for alcohol and drug problems is early adulthood,^{4,5} although the diagnosis may not be stable at this point.⁶ Not only are SUDs common, they cause significant social morbidity,¹ physical morbidity⁷ and mortality.⁸ The reasons for ongoing use in the face of such difficulties is unclear, however, this may be due to the compulsive nature of substance use.⁹ Despite this, recovery from alcohol use is an achievable goal,¹⁰ hastened by effective management strategies.

A wide range of treatment options are used clinically, adopting both harm reduction¹¹ and abstinence¹² models. The latter is often the preferred choice, yet the success of these treatments is well known to be poor.¹³ The most intensive intervention for addiction is residential rehabilitation,¹⁴ used in most countries and considered integral by almost half addictions clinicians.¹⁵ Drop-out remains a major difficulty for residential programmes^{16,17} and improved retention is related to improved outcomes.¹⁸ Patient factors such as family involvement and employment improve retention,¹⁹ as do interpersonal factors such as the therapeutic alliance.²⁰ A number of programme factors may also be important, including the ratio of counsellors to patients and a structured programme of therapy, as well as a balance between contributing to the community, specific addictions work and free time.²¹ Psychopathology has not been found to be correlated with outcome^{22,23} and this is interpreted as support for residential treatment for patients with drug use disorders and co-existing mental disorder.^{24,25}

Developing routine assessment of residential interventions enables both description of patients presenting to these services and analysis of outcome. Although previous research is a useful guide, it may not be generalisable. Country and culture are two factors that may have an impact on alcohol and drug use and its management.^{26,27} Similarly, the attitudes and beliefs of addictions clinicians are of significance in deciding who is referred for residential treatment.²⁸ Differences in culture,²⁹ policy,³⁰ funding and politics³¹ shape service provision and necessitate country-specific research. They also point to the need for country-specific, ideally easy to implement, research tools that have the capacity to translate into routine clinical practice. Only one New Zealand study has examined residential interventions,²³ despite the importance of understanding this costly intervention and for whom it is most appropriate. This study supported a 'non-discriminating approach' to referral but did not use New-Zealand-specific measures and assessed a long-term treatment setting. Replication and assessment in short-duration residential treatment settings is important to both compare outcomes and examine possible differences.

For these reasons, we investigated the outcomes in a short-duration (8-week), eclectic residential programme using a locally designed and validated tool and report on factors that were associated with programme completion.

Method

In total, 230 clients consecutively admitted to the Springhill residential rehabilitation programme were included in this study. These clients were admitted during 2011/2012. All completed standard clinical documentation on admission to Springhill and in addition were asked to complete an Alcohol and drug Outcome Measure (ADOM) on admission and discharge. The research was approved by the Southern Health and Disability Ethics Committee and the local district health board.

The programme

Springhill runs an 8-week residential rehabilitation programme for all substance use disorders. Up to 15 patients can be admitted at any one time. Patients undergo managed withdrawal with their referring teams before admission if this is considered necessary, particularly from high-dose alcohol. It is unique in New Zealand insofar as the clinical programme is delivered by clinicians from a district health board (a public health provider) but the facility is governed by a private trust. All clinicians are registered health practitioners with clinical expertise in addiction treatment. The programme has input from a substance misuse psychiatrist and general practitioner with a special interest in addictions providing medical oversight. The programme is abstinence based, including abstinence from tobacco, and draws on principles from the 12-step programme, cognitive-behavioural therapy, family systems theory and some elements of a therapeutic community. In this way it is similar to residential programmes elsewhere³² and would best be considered as eclectic. Each week is structured around facilitated large group sessions with all clients, supplemented by individual and family work. Exercise and involvement in the running of the facility are part of the programme. Each client has an individual therapist to work with alongside the group and all clients are reviewed medically and have access to psychiatric review if necessary. At the conclusion of the programme clients are referred back to their community addictions providers.

Client characteristics

Patients are accepted primarily from secondary addictions services in the community when this intervention has been ineffective as judged by their community clinician. There are few specific exclusion criteria and referrals are assessed on a case by case basis. Referrals are received from the lower North Island of New Zealand and include both rural and urban settings. Programme entry requires that there is a service to refer the client back to on completion. In the case of abrupt discharge each client has a person whom they have agreed to be contacted, with the referring service contacted the following day. If there are clinical concerns, a psychiatric crisis team is available to undertake assessment as deemed necessary. A clinical diagnosis of alcohol or drug dependence is a requisite for consideration for admission. Judicial direction is a specific exclusion criterion (i.e. clients cannot be legally directed into treatment at Springhill).

The ADOM tool

The ADOM is a brief tool to collect outcome data and measure improvements after intervention in substance dependence, specifically in a New Zealand setting. Part A of the tool is validated²⁴ and part B is similar to other tools used to collect information on social support and context, in line with other addictions rating instruments.³³ Part A focuses on drug use, particularly number of days' use in the past 4 weeks and total use of alcohol in units, this being the most prevalent drug of misuse in New Zealand. Tobacco use is measured as average number of cigarettes a day. Part B asks clients to rate the frequency of problems in multiple social domains as a result of drug dependence, again in the past 4 weeks. These include problems related to physical health, mental health, conflict in interpersonal relationships, difficulties with work or other structured activity, housing and criminal activity. These are self-reported on a 1–5 Likert scale. A score of 1 represents no difficulty in the social variable measured, whereas a score of 5 represents daily or almost daily problems. These variables were measured for the 4 weeks preceding admission during engagement with community alcohol and drug services. This allowed for a measure of current social problems and can allow for examination of changes on these scales over time. The advantage of a self-report measure is its acceptability to patients and the reporting of perceived difficulty as assessed by the client.

Data collection and analysis

At admission basic demographic information was collected from the patient and the ADOM tool was completed by the patient with their admitting therapist. At discharge, all patients completed discharge paperwork with their discharge therapist and the ADOM tool was again administered at this point. If clients were discharged outside of working hours they were contacted the following day to complete the ADOM if this was possible. All analysis was carried out in SPSS 19 for Windows and undertaken by one of the authors (J.S.).

The primary goal of this analysis was to identify what, if any, factors were associated with retention in the programme to 8 weeks or attrition over the 8 weeks. The purpose of this analysis is to provide services with information about clients who are at greater likelihood of succeeding to completion. All demographic and ADOM data used in this analysis are based on the measures collected at admission.

Descriptive statistics on sociodemographic and basic clinical characteristics (as collected at admission) are reported as means, standard deviations and proportions as appropriate. Logistic regression analysis was used to examine unadjusted relationships between each of the potential predictor variables and the outcome of completing the programme (defined as 8 weeks' participation in the residential programme). The predictor list set was developed *a priori*.

To consider the potential impact of confounding on the modelled estimates, subsequent logistic regression analysis looked at adjusted estimates for programme completion. Adjusted results are presented in four blocks. First, sociodemographic variables (age, gender and ethnicity) were entered into the model. Block two consisted of adding the primary drug of dependence as identified by the patients themselves (simplified to alcohol, cannabis, amphetamine and other drugs (e.g. opioids) and no drug specified). The third block included adding physical and psychological health variables and finally, social variables including work, paid employment, housing and crime. The model was developed to identify for whom completion was most likely as a proxy marker for positive long-term outcomes.

Results

Patient demographic data

During the study period 230 patients were admitted to Springhill, of whom 183 (80%) completed ADOM data on admission and discharge. The 47 patients for whom complete data were not available did not differ from the included patient data-set on basic demographic data. Overall, 143 patients (62% of all admitted patients) completed the 8-week programme (including 2 patients who stayed 9 weeks and 1 patient who stayed 10 weeks). For those included in the analysis the average age was 37 years with equal numbers of men and women. The majority of clients (74%) were White, 21% were Maori and the remainder identified with other ethnic backgrounds. At the time of admission 33% of clients had a partner, although 1 in 5 declined to answer this question. These variables are similar to those of clients not included in further analysis and similar to the demographic of the region (*Table 1*).

Demographic and drug use of the client group

Client status (at admission)	Analysed data (n = 183)	Missing data (n = 47)	Total (n = 230)	N valid by question
Age, years: mean (s.d.)	37.4 (11)	36.2 (11.5)	37.1 (11.1)	230 (100%)
Gender				
Male	96 (52.5%)	20 (58.8%)	116 (53.5%)	217 (94.3%)
Female	87 (47.5%)	14 (41.2%)	101 (46.5%)	
Ethnicity				
Maori	39 (21.3%)	3 (23.1%)	42 (21.4%)	196 (85.2%)
White	136 (74.3%)	9 (69.2%)	145 (74%)	
Other specified	8 (4.4%)	1 (7.7%)	9 (4.6%)	
Relationship status				
Partner	51 (32%)	8 (36%)	59 (33%)	181 (79%)
No partner	108 (68%)	14 (64%)	122 (67%)	
Main drug at admission				
Alcohol	95 (51.9%)	9 (33.3%)	104 (49.5%)	210 (91.3%)
Cannabis	26 (14.2%)	7 (25.9%)	33 (15.7%)	
Amphetamine, other	30 (16.4%)	5 (18.5%)	35 (16.7%)	
None selected	32 (17.5%)	6 (22.2%)	38 (18.1%)	
Substance use in past 4 weeks by main drug of dependence, days: mean (s.d.)				
Alcohol (n = 104)	13.2 (9.5)	11.1 (4.9)	13.1 (9.2)	95 (91.3%)
Cannabis (n = 33)	16.4 (11.8)	12.7 (12.8)	15.6 (11.9)	26 (78.8%)
Amphetamines (n = 27)	4.2 (7.6)	9.3 (12.7)	4.9 (8.4)	23 (85.2%)
Cigarettes (n = 230)	12.4 (12.8)	13.5 (11.7)	12.5 (12.6)	183 (79.6%)

A total of 8 clients reported using other substances outside the main categories.

Days' use represents the number of days' use of the substance identified as the primary drug of dependence by the client. The exception is mean number of days nicotine used; this is for the whole sample.

Amphetamine usage among those with amphetamine as main drug at admission.

Drug use variables

The commonest drug of dependence in the sample was alcohol with 51.9% of clients identifying this as their most problematic drug. Amphetamine, primarily methamphetamine (16.4%), and cannabis (14.2%) were the other significant primary drugs of misuse. Thirty-two patients could not identify a primary drug of misuse, having problems associated with multiple drug use. Eight patients identified sedatives, opioids or other drugs as their primary drug of dependence with no more than three in each group. Twelve patients used the intravenous route for drug administration in the 4 weeks before admission, with 3 patients sharing needles.

Patients with primary alcohol dependence drank on average 14 units a day in the month before admission, with alcohol consumed for 13 of the past 28 days. Those with cannabis dependence smoked on 16 of the past 28 days on average. The 27 patients with amphetamine dependence used on 4 of the 28 days before admission. All groups were engaged in community alcohol and drug out-patient programmes prior to their admission. Tobacco smoking was common in this group despite the admission criteria to Springhill identifying it as a smoke-free rehabilitation facility, with the expectation of discharge if smoking occurred during the admission.

Social variables

A quarter of clients stated their drug use led to daily physical health problems, with almost two-thirds identifying physical health problems occurring at least weekly and directly related to their drug use. Mental health problems occurred on a daily basis for one in seven patients, with three-quarters identifying mental health difficulties related to the use of drugs of dependence. Social difficulties were also common: 20% of patients recorded daily conflict with family or friends and almost two-thirds recognised conflict at least weekly. Recreational and work were similarly compromised, with 83% and 67% of clients respectively identifying problems at some point. Housing was a daily problem for three-quarters of clients. Despite the specific exclusion of referrals from the judicial systems, more than 90% of clients identified crime (other than the use of illicit substances) as related to their drug use, with more than half stating this was an almost daily problem.

Univariate predictors of programme completion

Sociodemographic, clinical and social variables were examined as univariate predictors of programme completion using logistic regression (*Table 2*). Identifying as Maori, conflict with family and problems with housing were associated with increased rate of retention. Only ethnicity had an odds ratio greater than 2. Drug of dependence was not associated with programme completion and no association was found between coexisting mental health problems and programme completion.

Unadjusted odds ratios for completion of the 8-week residential rehabilitation programme among respondents with complete data ($n = 183$)

Factor	Odds ratio (95% CI)	<i>P</i>
Age (analysed in 5-year blocks)	1.13 (0.98, 1.29)	0.10
Gender		
Male	0.97 (0.53, 1.77)	0.92
Female	1 (reference)	
Ethnicity		
Maori	2.31 (1.02, 5.23)	0.04
White/other	1 (reference)	
Primary drug of dependence		
Alcohol	1 (reference)	0.74
Cannabis	0.69 (0.29, 1.68)	
Amphetamine/other	0.66 (0.29, 1.54)	
None selected	0.85 (0.37, 1.95)	
Physical health problems _a	1.05 (0.87, 1.27)	0.64
Mental health difficulties _a	1.02 (0.83, 1.24)	0.97
Conflict with family _a	1.30 (1.04, 1.62)	0.01
Social role difficulties _a	1.17 (0.96, 1.42)	0.08
Employment problems _a	1.10 (0.92, 1.32)	0.24
Housing problems _a	1.47 (1.10, 1.96)	0.03
Crime _a	1.11 (0.87, 1.41)	0.40

Odds ratios are increase in odds of completion per one unit in change in the scale.

Regression modelling of programme completion

Logistic regression was carried out using a four-block, sequential adjustment method. Regression estimates (presented as odds ratios and 95% confidence intervals) are presented in *Table 3*. Model A included age, gender and ethnicity as predictors of treatment, model B added in the primary drug of dependence, while model C added scores measuring physical health, mental health and levels of conflict with family. The fully adjusted model (model D) added variables on social role, employment, housing and crime.

Logistic regression of factors associated with completion of residential treatment programme among clients with complete data (n = 183)

	Model A	Model B	Model C	Model D				
Age (per 5 years)	1.14 (0.99, 1.32)	0.07	1.12 (0.96, 1.31)	0.14	1.1 (0.94, 1.29)	0.231	1.08 (0.91, 1.27)	0.38
Gender								
Male	1.01 (0.55, 1.87)	0.97	1.03 (0.56, 1.92)	0.92	0.81 (0.41, 1.61)	0.55	0.80 (0.39, 1.63)	0.54
Female	reference)		reference)		reference)		reference)	
Ethnicity								
Maori	2.48 (1.08, 5.66)	0.03	2.57 (1.10, 5.98)	0.030	2.83 (1.18, 6.75)	0.02	2.82 (1.15, 6.92)	0.02
White/ other	reference)		reference)		reference)		reference)	
Primary drug of dependence								
Alcohol			reference)	0.93	reference)	0.92	reference)	0.95
Cannabis			0.72 (0.27, 1.89)	0.70 (0.26, 1.93)	0.74 (0.26, 2.08)			
Amphetamine/ other			0.88 (0.35, 2.17)		0.91 (0.36, 2.28)		0.94 (0.36, 2.47)	
None selected			0.93 (0.40, 2.19)		0.88 (0.36, 2.13)		0.88 (0.36, 2.15)	
Physical health problems <i>a</i>					1.09 (0.86, 1.39)	0.46	1.11 (0.86, 1.42)	0.434
Mental health difficulties <i>a</i>					0.86 (0.66, 1.12)	0.26	0.85 (0.64, 1.12)	0.248
Conflict with family <i>a</i>					1.47 (1.12, 1.93)	0.01	1.44 (1.03, 2.00)	0.031
Social role difficulties <i>a</i>							1.01 (0.74, 1.38)	0.96
Employment problems <i>a</i>							1.13 (0.92, 1.39)	0.25
Housing problems <i>a</i>							1.35 (0.97, 1.89)	0.078
Crime <i>a</i>							1.00 (0.73, 1.36)	1

Odds ratios are increase in odds of completion per one unit in change in the scale.

In the fully adjusted regression model (model D), only increasing conflict with family and ethnicity (being Maori) significantly predicted completion of the residential rehabilitation programme. Of all variables, being Maori more than doubled the odds of programme completion. Drug use was not predictive of completion. Notably, there was significant use in the 28 days prior to admission and no medical detoxification offered. This suggests clients did not leave rehabilitation because of withdrawal phenomena. Housing problems were not significantly associated with programme

completion in the full model, but the magnitude of the observed odds ratio and confidence interval (OR = 1.35, 95% CI 0.97, 1.89) suggest that such problems might also be associated with increased rates of programme completion. The modelling was reviewed using ordinal regression with weeks completed from 1 to 8 as the step-wise variable. This statistical model was largely the same as the linear regression, with the only alteration being the somewhat increased association between criminal activity and completion. Using ordinal modelling criminal activity significantly predicted greater length of stay (regression model available on request).

Discussion

The current research uses a specific tool, ADOM, to assess patient characteristics and potential indicators of programme completion within a residential rehabilitation setting in New Zealand. The ADOM tool was acceptable to patients with high completion rates, despite more than a third of patients leaving the service early. It was easily intercalated into routine clinical care and specific researchers were not used to collect this information, indicating its capacity for translation for routine use (see www.matuaraki.org.nz/supporting-workforce/adom). The potential for use throughout New Zealand would allow for in-depth understanding of addiction service use and potentially prediction of service matching.

Patients entering rehabilitation report high ongoing use of alcohol and other drugs, despite being engaged in community treatment programmes prior to entry. This implies difficulties for some patients with SUDs despite community intervention and the need to develop and deliver alternative interventions. Alcohol remains the most significant drug of dependence in those referred for residential support, although methamphetamine use is common. Low opioid use and low injecting rates may reflect the effectiveness of opioid substitution regimes.³⁴ The need for a drug-free environment is well recognised as a component in recovery for some patients and this is likely to remain the case. Completion rates of greater than 60% are high, with other programmes reporting rates as low as 16%,³⁵ and likely reflect a physical, social and therapeutic environment that is acceptable to patients. The lack of association between specific alcohol or drug use and completion demonstrates the ability to remain in a residential setting despite the varying biological impact of different drug classes and argues for a generic approach to treatment rather than one that is drug specific.

Significant morbidity is reported in physical, psychological and social domains by the patients in this study. These problems are directly related to drug use and small changes in use are likely to be associated with significant benefits to health, relationships and well-being. Previous economic analysis indicates major benefits associated with effective addictions intervention also.³⁶ The relative failure of community intervention for this cohort argues in favour of residential intervention, particularly if retention is high, and implies improved prognosis. This is the case for Springhill and may relate to positive longer-term outcomes.^{37,38} Follow-up studies will enable further examination of longer-term benefits and overcome the limitation of using completion as a proxy marker for improved prognosis.

Identifying who is likely to benefit most from residential treatment allows for a more targeted approach to management. Prior research has recommended a 'non-discriminatory approach to referral' and no clear indicators are apparent in the current literature base. Using regression analyses to consider the impact of several factors likely to alter treatment completion, we are able to show that Maori, the indigenous minority in New Zealand, and those with conflict in the home are more likely to complete the programme. The programme includes the capacity for patients to engage with a cultural assessment but does not include individual or group activities that are specifically culturally oriented. Previous research identifies greater social morbidity in Maori in an out-patient addictions setting³⁹ and greater satisfaction with a culturally specific service. Cultural factors have been a point of focus in policy debate about the provision of services,²⁹ with some advocating for a culturally appropriate approach research methodology frame, although support (and the application) of this is very limited. The current findings suggest Maori manage well in a generic eclectic setting. This does not indicate a generic service is likely to outperform a culturally specific service; rather, Maori are more likely than clients of other ethnicities to complete this programme. Ethnicity is not a proxy marker for social disadvantage as measured by social role difficulties, employment, housing problems and crime in this study as the linear regression of model D elucidates. Understanding the impact of homelessness in dependence is complex,⁴⁰ although the parsimonious explanation of having basic needs met does not preclude the potential for recovery and may be an important component of successful recovery.

The findings of this research are circumscribed by the limitations related to a naturalistic cohort design. Not all questions were completed by all patients and this leads to a weakening in the analysis, however, the advantage of developing the

data collection as part of routine care confirms its utility and capacity for translation from research to routine use. The benefits of using a country-specific tool may counterbalance the restrictions of its limited use. The outcome measure of programme completion is useful,^{37,41} however, long-term abstinence is a more powerful outcome. Follow-up studies are necessary to assess this.

This study highlights the acceptability for some of a residential setting to address their substance dependence. Significant pre-entry drug use, despite community care, does not prevent engagement and abstinence-based programme completion. Maori and homeless patients engage well and these factors predict retention. ADOM is a potentially valuable tool for monitoring outcome from a residential setting and has wider potential use in New Zealand.

1.8.60 The methamphetamine problem

: Commentary on ... Psychiatric morbidity and socio-occupational dysfunction in residents of a drug rehabilitation centre†

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Abstract

This paper introduces the reader to the characteristics of methamphetamine. Explored within are the drug's effects on those who consume it as well as the history and prevalence of its use. The highly addictive nature of methamphetamine is compounded by its affordability and the ease with which it is produced, with North America and East Asia having become established as heartlands for both consumption and manufacture. The paper discusses recent cultural depictions of the drug and also the role that mental health professionals may take in designing and delivering interventions to treat methamphetamine addiction.

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The nature of methamphetamine

Methamphetamine ('meth') is a stimulant which increases levels of monoamines (particularly dopamine, but also norepinephrine and serotonin) in the central nervous system. Its pharmacological effects occur via a number of neurochemical processes, including disruption of vesicular¹ and transporter² functioning, through the inhibition of monoamine oxidase³ and the facilitation of tyrosine hydroxylase.⁴ Like other stimulants, such as cocaine and amphetamine, it produces feelings of euphoria, alertness and increased energy. Unlike cocaine though, a single dose of methamphetamine sustains these effects for many hours. Methamphetamine can be smoked, snorted, injected or swallowed. The psychological effects of long-term use include hallucinations and delusions, depression, suicidality and aggression.⁵ Withdrawal may exacerbate these symptoms, while also leading to fatigue and intense craving.⁶ Long-term health effects are considerable, and include neural damage and associated cognitive impairment,⁷ cardiovascular damage,⁸ dental disease⁹ and stroke.¹⁰ The drug is also associated with risky sexual behaviour, resulting in a high prevalence of sexually transmitted disease.¹¹ Methamphetamine is also noted for its addictiveness. Evidence shows that addiction occurs more rapidly than with cocaine¹² and that unlike with amphetamine, methamphetamine-seeking behaviour may persist even when tolerance is reached.¹³ The trajectory of methamphetamine use over a 10-year period has been found to resemble that of heroin more so than that of cocaine.¹⁴ Methamphetamine is also associated with criminality¹⁵ and social decline.¹⁶ It therefore represents a major public health, social and political dilemma.

Who uses methamphetamine and where?

Across the world, methamphetamine use as a recreational drug has increased significantly since the 1990s, and it is reported as the second most widely misused substance, exceeded only by cannabis.¹⁷ In the USA during the 1960s and 1970s, methamphetamine was produced and trafficked mainly by motorcycle gangs, mostly in California.¹⁸ Patrons were typically White, male, blue-collar workers, but the drug has since become popular among white-collar workers, students, ethnic minorities and women,¹⁹ and manufacturing has spread to Midwestern states.²⁰ One of the principal factors in its rise is the ease with which it can be manufactured. The chemicals necessary for its production (e.g. methylamine, ephedrine or pseudoephedrine) are relatively easy to obtain, as is the equipment required for the 'cooking' process. This has led to a cottage industry in methamphetamine production, with home-based laboratories being commonly uncovered by law enforcement agencies in the USA²¹ and in other parts of the world, particularly in Asia.²² In addition to the home lab phenomenon, there exist industrial producers of methamphetamine, who manufacture and transport large quantities of the drug.²³ In North America, large-scale production occurs in both Mexico and Canada and the product is then brought across the border for sale within the USA. In the USA itself, 4.7% of respondents to a national survey admit to lifetime use of methamphetamine.²⁴

Data from Asia also indicate high levels of use. Japan has a long history of misuse, dating back to the 1940s,²³ when military stocks of methamphetamine flooded the market, giving rise to high incidence of misuse among young people. A second epidemic occurred in the 1970s, when use soared among blue-collar workers. This crisis has now stabilised and Japan's methamphetamine users now represent an aging population. Since the 1990s, the popularity of methamphetamine has spread to other East Asian countries. By 2007, 63% of worldwide methamphetamine seizures occurred within the Southeast Asian region, and it is estimated that half of the world's methamphetamine users are found there.²⁵ The Mekong region of Myanmar, close to the border of Thailand and China, is identified as Asia's most prolific production centre for methamphetamine. From there the drug is transported across the borders for sale in neighbouring countries.²⁵ In Myanmar, it is usually pressed into pill form, known colloquially as yaba ('crazy medicine'). Thailand has suffered its own epidemic, with methamphetamine treatment admissions rising dramatically in the late 1990s,²⁶ but evidence of increasing methamphetamine use is also found in Brunei, Laos, the Philippines²² and Cambodia.²⁷

In Europe, the meth epidemic has not yet arrived, perhaps because there is already a congested market for stimulant drugs, although the Czech Republic and to a lesser extent Slovakia have a history of high methamphetamine use.²⁸ In Australia, use has increased in recent years but not dramatically.²⁹ In South Africa, the past decade has seen a significant increase in treatment admissions for methamphetamine.³⁰ This increase in methamphetamine use is positively associated with risk-taking sexual behaviour,³¹ which if unchecked may in turn exacerbate an already urgent HIV epidemic.

Cultural depictions of methamphetamine

The emergence of methamphetamine as one of the most widely used recreational drugs is associated with its rise in the media. Methamphetamine has become a cultural phenomenon, in much the same way that heroin, MDMA (contracted from 3,4-methylenedioxy-methamphetamine; ecstasy) and cannabis had become popularised already. The most obvious cultural reference to methamphetamine is in the hugely successful American drama series *Breaking Bad*. This drama describes the exploits of a terminally ill chemistry teacher who chooses to become a manufacturer and then seller of methamphetamine, initially to guarantee financial security for his family after his death. The series focuses on the corruption of the main character and the erosion of his relationships with those close to him. What is notable about the series though is that the problem of devastating effects of methamphetamine on individuals and communities occupies only a minor part in the story. The series has done much to publicise the existence of methamphetamine to households across the world, but in not fully exploring its sinister effects (other than the moral degeneration of those who manufacture it), the series runs the risk of sanitising or normalising this destructive drug to the wider society.

At the other extreme, also in the USA, there has been a widely publicised campaign to highlight the unpleasant physical effects of methamphetamine addiction. The 'Faces of Meth' project³² exposes police custody photographs of users, showing images of the same individual at different points in time, so as to longitudinally chronicle the ravages of the drug on physical appearance. These before and after photos – which reveal apparently common features of long-term methamphetamine use: skin damage (caused by obsessive picking) and dental ill health (or 'meth mouth' as it is colloquially known)³³ – are designed to shock and appal observers. The effectiveness of the scheme is difficult to assess due to the absence of trials, however, the use of fear and shock is not always an effective deterrent in health campaigns and is generally regarded as inferior to positive reinforcement approaches.³⁴

The Faces of Meth-type approach has come under criticism from Naomi Murakawa,³⁵ who argues that its focus on the visual effects of methamphetamine, mostly in White methamphetamine users, represents a type of social panic. Murakawa argues that historically, drug panics in the USA have been constructed in line with racial prejudices (e.g. Chinese-focused opium scares, Mexican-focused cannabis scares and Black-focused crack scares). Methamphetamine addiction is often described along racial lines as a 'White trash' phenomenon. Murakawa claims that decayed or missing teeth mark prevailing fears over the decline in White social status, as traditional representations of American so-called 'White trash' typically depict poor dental health as a visual indicator of lower class.

Given the prevalence of methamphetamine use across the globe, considerable effort has been put into designing effective treatment programmes for its users. Broadly speaking, these interventions are pharmacological, psychosocial or community-based prevention approaches. The evidence in favour of pharmacological treatments is mixed, although some promising findings with modafinil, bupropion and naltrexone have been reported.³⁶ Psychosocial interventions have proved effective in the short term, but more evidence is needed to demonstrate long-term benefits.³⁷ Community-based prevention schemes have also shown evidence of benefit.³⁸ The promise shown by such interventions is encouraging, given the addictiveness of methamphetamine, the intensity and duration of cravings experienced by those who go through withdrawal⁶ and also the psychological comorbidity. Interestingly for mental health professionals, there is evidence that the cost-effectiveness of treatment³⁹ and prevention³⁸ approaches may compare favourably with alternatives, such as, for example, interventions by law enforcement to disrupt the supply of the precursor chemicals needed for methamphetamine production.⁴⁰ Furthermore, given the advance of this drug across Asia and North America and its potential for expansion across thus far untapped markets (e.g. Europe and Africa), the further development of robust treatment programmes for the future is urgently needed.

1.8.61 Exit examination: a survey of UK psychiatrists' views

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Abstract

Aims and method The Royal College of Psychiatrists is considering how best to introduce a post-MRCPsych-examination assessment ('exit examination') in anticipation of external pressures to ensure patient safety through the use of such assessments. The Psychiatric Trainees' Committee conducted an online survey to gather the views of psychiatrists regarding the possible format and content of this examination in the hope that this information can be used to design a satisfactory assessment.

Results Of the 2082 individuals who started the survey, 1735 completed all sections (83.3%). Participants included consultants and trainees from a range of subspecialties. There was general agreement that the content and structure of the exit examination should include assessment of clinical and communication skills.

Clinical implications UK psychiatrists believe that an exit assessment should focus on clinical and communication skills. It should assess both generic and subspecialty-specific competencies and incorporate a mixture of assessment techniques.

Contents

- *Exit examination: a survey of UK psychiatrists' views*
 - *Method*
 - * *Questionnaire development*
 - * *Recruitment of participants*
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- * *Preferred content of assessment*
- * *Examination content preferences by grade*
- * *Examination content preferences by subspecialty*
- * *Structure preferences*
- * *A question of awarding a diploma or certificate*
- *Discussion*
- * *Limitations*

The General Medical Council (GMC) is currently undertaking a review of the training and assessment of doctors in the UK, with a view to making a number of recommendations to improve the quality of training.¹ One of the main aims of the GMC in the area of training and education, as defined in their education strategy for 2011–2013, is that: “‘To ensure consistency and clarity, we will define clear outcomes which must be met by students and trainees on the completion of different stages of training.’”¹ Although higher specialist training examinations are not explicitly mentioned, the introduction of a clear means of ensuring that all doctors have been assessed as competent to practise independently before they are granted a Certificate of Completion of Training (CCT) is an important aspect of the GMC document. There is also inference that a final annual review of competence progression alone is not sufficiently rigorous and that some form of final, standardised assessment (an exit examination) is necessary. It has been acknowledged that an exit examination must be relevant and knowledge based, but its form and content has been left for individual medical Royal Colleges to decide.

Since 2008, psychiatric trainees have been required to sit three written papers and undertake one clinical examination (Clinical Assessment of Skills and Competencies, CASC) before gaining Membership of the Royal College of Psychiatrists (MRCPsych).² Before 2008, trainees would sit two written papers, an Objective Structured Clinical Examination (OSCE) and a long case examination. This increase in written papers was also accompanied by raising examination fees. These changes were viewed negatively by many trainees as it placed them under greater time and financial pressures.³ Further disquiet was caused among trainees in 2011, when it was revealed that the College had made a financial surplus from examination fees.⁴ In response to trainee concerns, the College has reduced the number of written papers to two and also cut exam fees.

In this historical context, there are fears that the introduction of an exit examination might be perceived unfavourably. With this in mind, the Psychiatric Trainees’ Committee (PTC), an elected group of psychiatric trainees from across the UK supported by the Royal College of Psychiatrists, established an Examinations Working Group in 2012, which set the following priorities: to ensure that the exit examination assesses what is really important for new consultants to ensure safe and effective care of patients to ensure the views of trainees have a major role in informing what the examination will look like and what it will assess.

Gaining the views of current trainees and consultants was seen as the necessary first step in working towards these priorities.

Method

Questionnaire development

A questionnaire was created by members of the PTC Examinations Working Group (see online supplement DS1). The first draft was piloted by an opportunistic sample of PTC members to determine where modifications were needed. Advice was obtained from senior officers within the Royal College of Psychiatrists and further modifications were made. In May 2013, the survey was uploaded to www.surveymonkey.com, an online survey hosting website.

A range of free-text responses were available. Owing to the unexpectedly large volume of such comments received, it was retrospectively agreed that they would be reported separately.

Recruitment of participants

An email was sent to all Members and Pre-Membership Psychiatric Trainees included in a mailing list held by the College (see online supplement DS2). In addition, PTC members were encouraged to pass on details of the survey to trainees and consultants locally. The survey commenced on 22 May 2013; responses were accepted up until 29 July 2013 (the initial deadline of 21 June was extended because the rate of responses remained high). All those who opted in to completing the survey were included in the final analysis.

Analysis

Data were separated with respect to participant seniority and by subspecialty. Subspecialty groups comprised both higher trainees and consultants. Given the categorical nature of the data collected, chi-squared tests were applied to identify differences between groups; calculations were performed on GraphPad, an online data analysis tool (<http://graphpad.com/quickcalcs>). It was anticipated that not all those who commenced the survey would complete all sections due to time constraints or distractions. It was agreed beforehand that all who had responded to any given question would be included in the analysis of that part of the survey.

For sample data to be accurate, they need to be representative of the population under consideration. Unfortunately, we were not able to ensure this because of governance difficulties. The mathematical theorems which justify standard statistical procedures apply only to random samples and so our statistical findings cannot be accepted as exact.

Results

Grade and specialty of survey respondents

Overall, 10 298 consultants and trainees were sent an email inviting them to take part in the survey. No email address was available for an additional 371 (3.6%) consultants and trainees in the College database. About a fifth of those contacted ($n = 2082$) started the survey and 1735 completed all sections (83.3%). These respondents included 487 core trainees (23.4%), 509 higher trainees (24.5%), 297 consultants with less than 5 years' experience (14.3%) and 788 consultants with more than 5 years' experience (37.9%).

Among higher trainees and consultants, there was a range of responses across the psychiatric specialties: 222 child and adolescent (10.7%), 146 forensic (7.0%), 810 general adult (38.9%), 117 intellectual disability (5.6%), 275 old age (13.2%) and 53 psychotherapy (2.5%) specialists.

Preferred content of assessment

In general, respondents considered clinical and communication skills to be the most important items to be assessed in an exit examination ($n = 1896$; *Fig. 1*); research methods, medico-legal issues, teaching and education and management were considered of lesser importance.

Examination content preferences by grade

There was little variability in the overall ranking of examination content when the data were separated with respect to seniority of survey participant. Clinical and communication skills were ranked first and second across all groups. Professionalism, team-working skills and leadership skills accounted for the next three components across all grades, although there were minor variations in their order, with senior consultants uniquely rating team-working skills above professionalism. In all groups, management skills, teaching skills and medico-legal issues were the next three components. Senior consultants considered teaching skills to be more important than the other two components, but consultants with less than 5 years' experience considered teaching skills less important, with a greater emphasis on management and

medico-legal skills. In all groups, research skills were considered to be the least important component of any proposed exit examination.

Consultants and trainees differed in their views regarding whether the exit examination should be specialty specific, general or a mixture of the two ($P < 0.001$; *Fig. 2*). The majority of trainees ($n = 472$; 52.3%), including 58.4% of higher trainees, thought that an exit examination should be unique to each psychiatric subspecialty, whereas consultants were predominantly of the opinion that it should comprise both subspecialty and general components (57.3% of all consultant participants).

Fig. 20: Preferences about subspecialty specificity by grade (%)

Examination content preferences by subspecialty

Despite the fact that the general pattern of rankings of examination content was similar to the overall ratings across subspecialties, there were some notable differences between specialty groups.

Clinical and communication skills were again ranked first and second in terms of importance for inclusion in an exit examination across all specialties. As was the case when the item rankings were separated by grade, professionalism, team-working and leadership were ranked in positions 3–5 across all specialties, although team-working skills were considered particularly important by those from the general adult, old age and medical psychotherapy Faculties.

Management and teaching skills were the items considered next by all groups except forensic psychiatrists. Forensic psychiatrists rated medico-legal skills higher than all other subspecialties at 6th v. 8th by all others. There was again a consistent view that research skills were the least important item to assess as part of an exit examination.

All subspecialties were consistent in favouring a mixture of subspecialty and general components to any proposed exit examination, with the exception of child and adolescent psychiatry, where 63.6% of respondents favoured a subspecialty-specific exit examination ($P < 0.001$).

Structure preferences

Across the whole sample ($n = 1818$) the majority of respondents ($n = 922$, 50.7%) were in favour of a mixture of practical, written and oral components; 361 (19.9%) favoured an oral examination alone, 285 (15.7%) opted for a practical examination and for 250 (13.8%) a written examination was the preferred option.

There were no significant differences between core and higher trainees in the overall distribution of responses given ($P = 0.65$). A mixture of practical, written and oral examination components was the preferred option across all groups regardless of grade, but significantly more popular with consultants (with a clear majority in favour) than trainees ($P < 0.0001$). On the other hand, a purely written examination was significantly more popular with trainees than with consultants ($P < 0.001$; *Fig. 3*).

A mixture of all three examination components was favoured by participants from all subspecialties. More than half of all participants preferred this option in all subspecialties except for intellectual disability psychiatry and there was a significant difference in the exam structure preferred by intellectual disability psychiatrists compared with the other subspecialties ($P = 0.003$). No significant differences were noted between the preferred exit examination structure of the other disciplines ($P = 0.25$).

Preferences for a written examination

We received 1818 responses about preferences regarding the format of the written component of any proposed exit examination. The most popular option overall was a reflective report about a clinical scenario and associated *viva* (37.2%). Short-answer questions and multiple choice questions (MCQs) were less popular, representing 23.3% and 23.2% of responses respectively. The least popular options were extended matching questions (EMQs; 10.1%) and essay writing (6.2%).

There was evidence of a clear difference in the preferred format of a written examination between trainees and consultants ($P < 0.0001$). Overall, trainees preferred MCQs (36.2%); however, core trainees were significantly more likely to favour MCQs than higher trainees ($P = 0.001$). The opposite was true with EMQs, with higher trainees being significantly more in favour of their use than core trainees ($P = 0.009$). Among consultants, only 11.5% favoured the use of MCQs; reflective report accompanied by a *viva* was the most popular option for the written component of the exit examination (44%). Essays were the least popular form of assessment by those of all grades, although consultants were nevertheless significantly more in favour of their use than trainees ($P = 0.007$).

There was a significant difference in views about how written examination components should be structured across the subspecialties ($P = 0.001$). Significantly more psychotherapists ($n = 31$, 70.5%) preferred the use of reflective writing and an associated *viva* than the other subspecialties ($P < 0.0001$). Excluding psychotherapy, there were no significant differences between subspecialties regarding their views about the use of MCQs ($P = 0.98$), EMQs ($P = 0.1$), brief assessment questions ($P = 0.12$) and essay writing ($P = 0.21$). There was evidence of a significant difference with regard to views about reflective practice ($P = 0.03$): this was popular among intellectual disability psychiatrists (48.1%) yet less favoured by forensic psychiatrists (30.1%).

Preferences for a practical examination

For two-thirds of respondents ($n = 1197$, 65.8%) assessments in the workplace (workplace-based assessments, WPBAs) were the preferred option for a practical examination; 621 (34.2%) were more in favour of the OSCE format. Higher and core trainees expressed a strong preference for the use of WPBAs over OSCEs, with a strong preference in both groups (80% of higher trainees ($n = 353$) and 80.4% of core trainees ($n = 336$)). Consultant psychiatrists favoured WPBAs over OSCEs and no significant difference between less experienced and more experienced consultants was found ($n = 147$, 58.1% v. $n = 361$, 51.1%; $P = 0.067$). On the other hand, there was greater support among trainee psychiatrists for WPBAs than among consultants ($n = 689$, 80.2% v. $n = 508$, 53.0%); this was a highly significant difference ($P < 0.0001$).

Preferences for an oral examination

Across all participants in the survey ($n = 1818$), 677 (37.2%) considered a structured *viva* to be the best option for an oral examination; 434 (23.9%) chose patient management problems (PMPs) and 707 (38.9%) opted for a combination of the two. There was no significant difference between the views of core and higher trainees ($P = 0.38$), who overall favoured the use of a structured *viva* alone (334 of 859 responses, 38.9%). Among consultants, the most popular type of oral examination was a combination of both structured *viva* and PMPs (427 of 959 responses, 44.5%), with no difference between consultants with more than 5 or less than 5 years' experience ($P = 0.79$). There was, however, a significant difference in the consultants' and trainees' preferences regarding any proposed oral examination components ($P < 0.0001$).

A mixture of PMPs and structured *viva* was the most popular oral examination structure for specialists in child and adolescent psychiatry (43.1%, $n = 197$), forensic psychiatry (45.9%, $n = 133$), general adult psychiatry (40.8%, $n = 701$) and intellectual disability psychiatry (42.6%, $n = 108$). Specialists in old age psychiatry and psychotherapy both preferred a structured *viva* alone (43.6%, $n = 243$ and 36.4%, $n = 44$). The differences between specialty groups did not reach statistical significance ($P = 0.39$).

A question of awarding a diploma or certificate

Across the whole sample, there was a small majority in favour of awarding a certificate or diploma for any proposed exit examination (50.2%, $n = 1818$); 10.3% were against and 39.5% were unsure or considered this matter unimportant. The numbers decreased with seniority, with 61% ($n = 418$) of core trainees, 56.5% ($n = 418$) of higher trainees, 45.5% ($n = 253$) of junior consultants and 41.5% ($n = 706$) of senior consultants considering a diploma to be necessary following successful completion of the proposed exit examination. The views of trainees and consultants were significantly different ($P < 0.0001$).

Discussion

The prospect of an exit examination to be taken by all psychiatric trainees before they are deemed eligible for a CCT is not new. Even before most current psychiatric trainees were born, Kendell⁵ wrote of his disapproval regarding the possible introduction of an exit examination at a time of major changes in the structure of postgraduate medical education in the UK. Kendell identified potential problems, including likely trainee dissatisfaction and the implications for recruitment into psychiatry. He expressed particular concern about the possible outcomes for those trainees who were unsuccessful in such exit examinations.

In the early 1990s, after the publication of the Calman report,⁶ both the then president of the Royal College of Psychiatrists⁷ and the Collegiate Trainees Committee⁸ (the predecessor to the PTC) spoke out strongly against the possibility of introduction of an exit examination.

Ten years ago, Tyrer & Oyebode⁹ discussed the need for changes to the College membership examinations. They acknowledged that political and other external factors would continue to have an influence on how doctors training to be psychiatrists would be assessed, predicting the likelihood of an exit examination being introduced at some point in the future. Around that time, major changes to the role and function of the GMC were proposed following the publication of the 5th report of the Shipman Inquiry¹⁰ and an associated growing public interest in the training and monitoring of doctors in the UK. In the intervening decade, there have been a number of reports highlighting concerns about patient safety and quality of care provided under the auspices of the National Health Service.^{11,12}

This paper presents one of the first psychiatry trainee- and consultant-wide surveys into exit examination of UK psychiatrists. The survey had a very large number of responses, giving insight into the views of about 2000 consultants and trainees from across the country. This no doubt reflects the understandable anxiety raised by the prospect of an exit examination. Owing to the number of responses we received, free-text comments were not included within this paper, nevertheless they are likely to provide an invaluable range of views that will further assist the College in ensuring that any future exit examination reflects the views of the College members and pre-membership trainees.

It is perhaps surprising that clinical and communication skills were considered the most important factors to be assessed, given that previous studies have demonstrated that these are the areas in which most new consultants feel relatively confident; resource management and supervision have been shown as areas in which new consultants feel underprepared by their training and might therefore be considered more important to assess towards the end of training.¹³ This may reflect the fact that trainees consider an 'examination' to be a concrete test of clinical or communication skill or knowledge and may not have considered other assessments, such as reflective writing, to be an 'examination'. An example of such an alternative assessment is the piloted Wessex advanced training professionalism programme.¹⁴

The degree to which an exit assessment should be generic for all trainees or should concentrate on testing subspecialty-specific knowledge varied significantly depending on the participant's status. Trainees were significantly more in favour of subspecialty-specific examinations, whereas consultants, particularly those with more experience, favoured a greater mixture of general and specialty-specific assessments. This may reflect the fact that on completion of the MRCPsych examinations, trainees feel confident with general psychiatry and that they consider a detailed knowledge of their subspecialty to be the primary goal of higher training. Those with more experience may value maintaining a broader skills base across the psychiatric disciplines. However, the recent publication of the *Shape of Training* review¹⁵ and its suggestion of broad-based training and post-Certificate of Specialty Training credentialing may complicate the issue of both when this assessment should take place in training and whether or not there is value in it being general across all psychiatric subspecialties.

Overall, the participants leaned towards a mixture of several different assessment styles for an exit examination. This finding could be explained by a perception that multi-modal assessment techniques increase the fairness, reliability and validity of an examination. Concerns have been expressed in the past by both trainees and consultants that changes made to psychiatric examinations (such as the introduction of CASC in 2008) did little to improve the validity and reliability of clinical examination.¹⁶

Exploration of views about the awarding of a diploma or similar certificate following successful completion of the exit examination revealed differences between trainees and consultants. A significant majority of trainees thought that such a reward should be provided, yet consultants differed markedly in their view. Given the potential difficulties in marketing the introduction of an exit examination to trainees, this difference in opinion might be something that the College should consider carefully.

Limitations

Despite the many strengths of this study, it is important to note that in pursuit of a wide range of responses, we were obliged to accept a number of methodological weaknesses that should be considered when interpreting the results. A study of this type is difficult to undertake in such a way as to encourage responses from a broad and representative audience; one of our principal goals was to gain the views from as many relevant individuals as possible. Given the subject investigated, it was essential to allow anonymous responses to the survey and this further limited our ability to control the recruitment of participants. Any sampling technique that would ensure a more demonstrably representative selection of views would have been associated with markedly fewer participants and might have led to the study being unfeasible, because of the difficulties in negotiating the relevant information governance arrangements of the Royal College of Psychiatrists. On balance, we agreed that the best way to obtain as representative a sample as possible in an acceptably efficient fashion would be to accept all responses from an open survey sent to all consultant psychiatrists and trainees known to the College. Consultants comprised 70% of those who were invited to participate, but only 52% of those who participated in the survey. It is perhaps unsurprising that this study would be of greater interest to those more likely to be directly affected by the introduction of an exit examination, but the possibility of bias should be borne in mind when considering results relating to the sample as a whole. We anticipated that the concerns about randomisation were likely to be magnified with regard to the data provided regarding the subspecialties. However, after comparing the survey data with a breakdown of the workforce as detailed in the most recently published census of the College membership,¹⁷ the distribution of survey respondents and the census data were broadly similar with respect to subspecialty, although the relatively small number of responses from psychotherapy and intellectual disability consultants might make their comments less representative.

In summary, this survey provides an interesting insight into the views of a wide range of trainee and consultant psychiatrists on the nature of any future exit examination. It suggests that overall trainee and consultant psychiatrists consider that if introduced, an exit examination should primarily focus on clinical and communication skills, should assess both generic and subspecialty-specific skills, and should be undertaken using a mixture of different assessment techniques.

1.8.62 New patient assessment in old age psychiatry: the importance of risk assessment

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date

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Abstract

Aims and method In recent years, the role of non-medical community mental health team (CMHT) clinicians has widened to include new patient assessments. It is unclear whether all professionals have the skills and confidence to undertake these to a high quality. This project investigated which professionals are doing new assessments, evaluated their quality and explored the assessors' unmet training needs. The study was based on the data extracted from electronic notes and a complete audit cycle in South Oxfordshire Older Adults CMHT; this was a cross-sectional study across Oxfordshire older adults services.

Results Most new assessments (72.4%) were done by non-medical clinicians; the majority were missing important information, especially relating to medications and risk assessment. Only 75% of assessors felt at least 'partially confident' to do assessments and found them stressful, with 86% keen to undertake further training.

Clinical implications Simple measures such as an assessment form, a programme of training seminars and adequate supervision, delivered to all CMHT clinicians, can ensure high-quality assessment in diverse clinical environments.

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The discipline of psychiatry has seen many changes in practice over recent years. One major change has been the shifting roles of the multidisciplinary team to include some clinical duties traditionally undertaken by psychiatrists.

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New patient assessments are one task now frequently delegated to the wider multidisciplinary team.¹ Non-medical clinicians often have capacity to see the increasing number of referrals arising from an aging population and are a more affordable option than psychiatrists.

Psychiatrists are taught assessment skills gradually throughout their training. Formal teaching in assessment occurs throughout medical school and the foundation programme; skills are then enhanced and specialised within psychiatry through weekly supervision, workplace-based assessments and postgraduate examinations. The same structure (focusing on assessment) is not necessarily in place for non-medical professionals. The revised General Medical Council (GMC) *Good Medical Practice* document provides guidance to doctors needing to delegate tasks to colleagues: ‘When delegating care you must be satisfied that the person to whom you delegate has the knowledge, skills and experience to provide the relevant care or treatment; or that the person will be adequately supervised’.² Typically, non-medical clinicians are provided with a weekly team meeting in which to discuss patients with psychiatrists as well as regular individual supervision. It has been assumed that this is providing appropriate support and supervision. However, there is limited evidence pertaining to the skills and confidence that non-medical staff have in assessing newly referred patients. A report by the Royal College of Nursing has highlighted a need for continuing postgraduate education to ensure high standards of community psychiatric nursing, including updating skills as an individual’s role within a team changes.³ Similarly, the recent Francis inquiry emphasised the importance of ensuring individuals’ skills are appropriately matched to their duties to ensure global high-quality care within the National Health Service (NHS).⁴ Being asked to perform skills beyond a clinician’s training can be stressful and reduce performance as well as leading to burn-out.⁵

We hypothesised that as non-medical clinicians have been asked to undertake new patient assessments, a skills gap has emerged. We designed a service evaluation to test this hypothesis. The aims were to identify which professionals are undertaking new assessments, investigate the quality of these assessments and explore the level of confidence individuals have in carrying out this work. The primary method of investigation was a complete audit cycle, complemented by a cross-sectional survey.

Method

This was a service evaluation undertaken in the three community mental health teams (CMHTs) of the South Locality Older Adults Service (Oxford Health NHS Foundation Trust). South Oxfordshire has a population of approximately 134 300, including 33 200 people over 60 years of age.⁶ The service evaluation was made up of three components occurring between June 2012 and July 2013 (*Fig. 1*). All of the components of the service evaluation were carried out in the same group of clinicians.

Fig. 21: Timeline of events

Audit cycle

The aim was to determine if existing practice meets agreed standards as to what information should be recorded during a routine new patient assessment. The initial audit covered the period 1 June to 31 July 2012, re-audited for 1 June to 31 July 2013. All consecutive new referrals were included. No international or nationally agreed guidelines as to how a new patient should be assessed could be located in either 2012 or 2013, so the proxy standard used within Oxford Health NHS Foundation Trust was chosen. This includes the completion of each section of the ‘core assessment’ and ‘risk assessment’ of our RiO electronic notes system (www.servelec-group.com/Healthcare/RiO.html). Medical records were reviewed (by R.M.) first in November 2012 and then in August/September 2013: an audit tool form was completed for each individual. For each part of the assessment, if any comment was present pertaining to that area it was marked ‘yes’. This included explanations as to why information was not available at that time. During October 2012–January 2013, a pilot set of 2-h training seminars and interactive workshops covering common psychiatric presentations were delivered weekly to multidisciplinary team clinicians. A new patient assessment form was introduced at the same time (available as online supplement DS1).

Cross-sectional survey of non-medical clinicians' training needs

We devised a 21-item questionnaire (online supplement DS2) covering confidence surrounding current assessment and education, plus unmet training need. This was distributed by email to 50 non-medical staff in 3 older-adult CMHTs. These included nursing staff, occupational therapists, social workers, mental health practitioners and psychologists. Healthcare assistants and support workers were excluded as they do not undertake new patient assessments. Participants returned an anonymous hard copy to their team manager.

Retrospective evaluation of professionals undertaking new patient assessments

All patient contacts (new and follow-ups) covering the period 1 March 2012 to 30 April 2013 were downloaded from the RiO electronic notes system. The profession of the assessing clinician was recorded as 'medical' (consultants and junior doctors) or 'non-medical' and proportions in each category calculated.

Upon the completion of the audit cycle and survey, and using feedback from the pilot training sessions, a programme of training in assessment skills was devised. This will be delivered by psychiatrists over 7 weeks on a yearly basis to all CMHT clinicians. Staff turnover and sickness will be closely monitored.

Statistical analysis

All results were entered into a Microsoft Excel spreadsheet for basic analysis. Audit data were analysed with SPSS v. 21 for Windows using unpaired chi-squared tests with $\alpha = 0.05$.

Results

Audit cycle

In the initial audit, 40 consecutive referrals were received; this increased to 62 in 2013. The demographic profile of the sample remained unchanged for both audit cycles (*Table 1*). The professionals conducting assessments were community psychiatric nurses (CPNs; 64%), psychiatrists (20%) and occupational therapists (16%). Of the psychiatrists, there were three consultants and three psychiatric trainees.

Results from audit cycle: sample characteristics

	2012	2013
Gender, male (%)	44.0	42.5
Age, mean (years)	79.5	80.0
Referral from primary care (%)	93.0	95.0
Time from assessment to documentation complete (days)	4.4	3.8

In 2012, the proportion of assessments clearly marked 'new assessment' and properly structured with subheadings was 45%; this increased to 75% in 2013 after the introduction of an assessment form ($P = 0.003$). In 2012, the information most frequently omitted from assessment was medication history, family history, use of substances and risk assessment

(Table 2). With non-psychiatrist clinicians, there was a tendency to list all living family members under family history rather than record the presence or absence of mental disorder. However, this was not the case in assessments done by psychiatrists (e.g. 2013: 83% v. 0%). By 2013 there had been a significant improvement in recording of psychiatric history, medications, substance use, mental state examination and risks (Fig. 2). However, out of 17 RiO subsections, only 7 had been completed in at least 75% of assessments. Psychiatrists were significantly more likely to record at least 90% of RiO sections than non-medical staff (81% v. 10% respectively; $P < 0.001$).

Results from audit cycle: assessments

	Assessments containing any information relating to the subject, %		
Reason for referral	82.5	90.9	
Comment on who was present at the interview	80	82	
History of presenting complaint	90	89.3	
Past medical history	52.5	59	
Past psychiatric history	52.5	72.7	0
Medications	40	76	0
Family history	42.5	44	
Personal history	50	48.5	
Social history	92.5	85	
Alcohol	22.5	45.5	0
Smoking	17.5	45.5	<
Substance use	15	45.5	0
Forensic history	20	28.7	
Pre-morbid personality	35	28.7	
Collateral history	80	71.2	
Mental state examination	50	66.7	0
Risk assessment	35	66.7	<
Diagnostic impression	80	77.2	
Management planning	95	89.3	

Chi-squared test. Non-significant P values not given.

Evaluation of cognition is an important part of assessment in older adults. In 2012, 70% of assessments included information on cognition and bedside cognitive tests; this fell to 58% in 2013 ($P = 0.04$). However, for patients referred with cognitive impairment, more than 95% had evidence of cognitive testing in both years.

Cross-sectional survey of assessment confidence and unmet training needs

This survey took place between the two audits but before the pilot intervention (*Table 3*). Overall, 36 questionnaires were returned (72%), representing CPNs (50%), social workers (17%) and occupational therapists (17%). Three-quarters (75%) of respondents felt at least 'partially confident' to assess a new patient, with 22% reporting 'no confidence'. Similarly, 75% reported feeling 'stressed or unsupported' while doing the assessment. Less than half of staff (44%) reported familiarity with the ICD-10 criteria for mental health disorders,⁸ and only 25% felt confident to use them to aid diagnosis. The majority of staff (80%) felt confident to 'cluster' patients according to type and severity of illness.

Cross-sectional survey results ($n = 36$ respondents in total)

$n = 36$	Respondents %
Profession of assessing clinician	
CPN	50
Social worker	17
Occupational therapist	17
Psychologist	9
Support worker/other	8
Level of confidence in assessing a new patient	
Confident	25
Less confidence	50
No confidence	22
No comment	2.8
Familiarity with ICD-10 criteria	
Yes	44
Partly	39
No	17
Confidence in using ICD-10 criteria to make a diagnosis	
Confident	25
Less confidence	33
No confidence	28
No comment	11
How often you feel stressed, unsupported when assessing a newly referred patient?	
Most of the time	64
Sometimes	11
Not at all	22
Would you like an opportunity to undertake training in the following? (yes/no) ^a	
Information on mental disorders	75
Assessment and diagnosis of mental disorders	86
Updates from recent research	94
Six disorders clinicians would most like training on (in preference order)	

continues on next page

Table 26 – continued from previous page

<i>n</i> = 36	Respondents %
Bipolar disorder	94
Depression	83
Anxiety disorders	80
Schizophrenia	72
Personality disorder	69
Dementia	58
Preferred method of teaching (in order)	
Teaching seminars (1–2 hours)	83
Short courses (1–2 days)	77
E-learning resources	47
Formal academic course and qualification	39
How important is it to you to gain an accreditation that is recognised by your employers and other organisations for the training that you undertake?	
Very important	39
Quite important	46
Not important	13
No comment made	2
What would be the most important reason to you to undertake further training?	
To improve my clinical practice	86
For personal development	8
To enhance my CV	0
To increase the likelihood of promotion	5
Other reason	0

CPN, community psychiatric nurse.

Only 'Yes' responses given.

In all, 86% were keen for training in assessment, diagnosis and management of mental disorder. The conditions for which training was most frequently requested were (in order) bipolar disorder, depression, anxiety disorders, schizophrenia, personality disorders and dementia. The most popular methods of delivering training were seminars (83%) and 1-day short courses (78%). Most staff (85%) felt it was essential to have accreditation recognised by employers for attending training.

Retrospective evaluation of professionals undertaking new patient assessments

Between March 2012 and April 2013, 485 new patient assessments were carried out within South Locality CMHT. In total, 41 individual clinicians were involved in the assessments, with 84% of assessments being conducted by one person. The breakdown of professionals involved was as follows: 60% CPNs, 20% psychiatrists, 16% occupational therapists, 4% social workers. The majority of new patient assessments were carried out by non-medical clinicians: 72.4% v. 27.6%. Similarly, 86.2% of follow-up contacts were carried out by non-medical staff. Of the new assessments by medical staff, 58% were done by consultants.

Staff turnover and sickness

During the period from June 2012 to June 2013 the turnover of non-medical clinicians within the CMHT was 50% (compared with 12% trust wide).⁸ The average within the trust at that time was 8%. At the time of the initial audit, 12% of staff were on long-term sick leave, including two band 7 nurses (1.8% trust wide).

Discussion

This service evaluation investigated which professionals are undertaking new patient assessments and investigated unmet training needs of the clinicians involved. We hypothesised that a skills gap has emerged as more non-medical clinicians have started to participate in assessments and that they find these new duties very stressful; our results corresponded with this hypothesis.

The Royal College of Psychiatrists recommends that CMHTs should ‘ensure the appropriate numbers of professionals with appropriate skills and competencies are in place to respond to local needs ... for assessment’.⁹ Our surveys and audit clearly show that the majority of new patient assessments are now being done by non-medical clinicians and that they frequently do not feel confident to undertake this role. Not only does this pose clinical risks, but also contributes to rising financial costs due to high rates of stress-related sickness and rapid staff turnover. Our local experience is that many staff on long-term sick leave are experiencing ‘stress, anxiety or depression’; this tallies with national data.^{5,8} The way that mental health services commissioning is now linked to diagnostic clustering means that poor knowledge of diagnostic categories and grading of severity of mental health disorders could have financial implications. These implications could be reduced by providing appropriate training. Adequate knowledge of the local area and its resources is also important and this is hard to achieve with high staff turnover.

Our initial audit highlighted the poor quality of risk assessments undertaken during new patient assessments. Recent publications have alerted us to the need for high-quality risk assessment in older adults, especially for suicide and self-harm.¹⁰ This was an area of great concern in the 2012 audit, but the 2013 re-audit demonstrated that very simple measures – an assessment form and some pilot teaching sessions – made a significant improvement in our teams’ skills and documentation. Similarly, Huh *et al*¹¹ report that a 1-day course in suicide risk assessment for healthcare professionals working with older adults was highly effective at increasing staff confidence and the quality of risk assessment. The Department of Health has previously emphasised the need to provide a range of flexible approaches to education and training,¹² and this is especially important as we increasingly recognise different styles of learning and diversify our working patterns. Key to this will be standardising access to training, for example making sure that all professionals have similar amounts of study leave provision.

We demonstrated that the majority of staff would like to undertake further training in the form of seminars or short courses, and would like accreditation for this. We have been unable to find any similar audit or research data with which to compare our results, but the Royal College of Nursing reports similar findings.³ Their survey of over 800 UK mental health nurses found that 89% would like further training in ‘acute mental health conditions’ and the favoured delivery methods were also teaching sessions or short courses. This work only included nurses, whereas our study includes all non-medical clinicians, but the demographics are otherwise similar. It could be argued that the ‘team’ nature of CMHTs (e.g. having staff supervision and a multidisciplinary team meeting at which new cases are presented to the consultant) allows for appropriate clinical guidance, but we have found it can be difficult to provide such guidance when faced with a lack of information gathered at an initial assessment.

Limitations

The main limitation of this service evaluation is the sample size and the fact that it covers only one geographic area. It might also be hard to generalise to outside older adult psychiatry. The response rate for the questionnaire was low, which may be partially explained by the work having occurred during the holiday season, but other ways of reaching staff need to be investigated. It should also be remembered that staff have highly variable experience in terms of the years of practice; we cannot expect newly qualified colleagues to be comparable to those with more years of service and we did not collect this information.

Assessment training

We propose to improve standards in new patient assessment and increase clinicians' skills and confidence in our area by providing a comprehensive training programme within normal working hours for all non-medical clinicians and junior doctors in the CMHT. This will be delivered as seven 2–3-h interactive seminars and will cover general assessment, risk assessment and management of common disorders presenting to old age psychiatry (see online supplement DS3). It will be provided at least yearly to include all incoming staff and, while led by consultants, will provide a platform for psychiatric trainees to enhance their teaching skills. Re-audits of new patient assessment structure and content will occur yearly.

Assessment is the foundation of high-quality management in psychiatry: we should work hard to ensure that all clinicians are appropriately skilled and supported to manage the vulnerable patients presenting to our services.¹³ Psychiatrists should take a leading role in delivering appropriate knowledge whereas mental health trusts should facilitate training and seek ways to encourage and reward aspiration.

We thank all staff of the South Locality team for assisting with data collection and providing support with the project. Special thanks go to Marion Evans who downloaded the RiO data to establish who had undertaken assessments between 2012 and 2013.

1.8.63 Lurasidone: a novel antipsychotic agent for the treatment of schizophrenia and bipolar depression

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2015-10

Abstract

Lurasidone is a novel antipsychotic agent approved for the treatment of schizophrenia in a number of countries including the UK, and is also approved in the USA and Canada for the treatment of major depressive episodes associated with bipolar I disorder as either a monotherapy or adjunctive therapy with lithium or valproate. In addition to full antagonist activity at dopamine D₂ ($K_{i(D2)} = 1$ nM) and serotonin 5-HT_{2A} ($K_{i(5-HT2A)} = 0.5$ nM) receptors, the pharmacodynamic profile of lurasidone is notable for its high affinity for serotonin 5-HT₇ receptors ($K_{i(5-HT7)} = 0.5$ nM) and its partial

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agonist activity at 5-HT_{1A} receptors ($K_{i(5-HT_{1A})} = 6.4$ nM). Long-term treatment of schizophrenia with lurasidone has been shown to reduce the risk of relapse. Lurasidone appears associated with minimal effects on body weight and low risk for clinically meaningful alterations in glucose, lipids or electrocardiogram parameters.

Contents

- *Lurasidone: a novel antipsychotic agent for the treatment of schizophrenia and bipolar depression*
 - *Pharmacodynamics and pharmacokinetics*
 - * *Metabolisation*
 - *Efficacy in schizophrenia*
 - * *Acute treatment*
 - * *Long-term treatment*
 - * *Tolerability and safety*
 - *Bipolar depression*
 - *Summary*

Lurasidone is a second-generation antipsychotic agent that initially received regulatory approval for the treatment of adults with schizophrenia in the USA in 2010.^{1,2} In March 2014, it received marketing authorisation for this indication by the European Medicines Agency and has also been approved for the treatment of schizophrenia in Switzerland, Canada and Australia. Additionally, lurasidone recently received US and Canadian regulatory approval for the treatment of adults with major depressive episodes associated with bipolar I disorder (bipolar depression), as either a monotherapy or adjunctive therapy with lithium or valproate. Detailed systematic reviews of the overall efficacy, tolerability, safety and place in therapy of lurasidone can be found elsewhere,^{3,4} including analyses of number needed to treat (NNT) and number needed to harm (NNH).^{5,6}

The published literature has used the US convention of describing the dose of lurasidone as the combined weight of the active drug moiety (lurasidone) plus the hydrochloride (HCl) salt, with tablet strength expressed in multiples of 20 mg. In the European Medicines Agency *Summary of Product Characteristics*,² tablet strength refers to the weight of active drug only, excluding the contribution from the HCl salt (*Table 1* shows the dose equivalence), and this dose convention will be used in the current review.

Lurasidone dose equivalents in the European Union (EU) and the USA

EU doses (mg, active moiety)	US doses (mg, HCl salt)
18.5	20
37	40
56a	60
74	80
111a	120
148a	160b

Tablet strength not available in the EU.

Tablet strength not available in the USA.

The purpose of this overview is to describe the pharmacodynamics and pharmacokinetics of lurasidone, and to summarise its efficacy and safety for the treatment of schizophrenia and bipolar depression based on results from both short-term and longer-term controlled clinical trials. Relevant information regarding switching and extension studies is reported, including functional and cognitive outcomes.

Pharmacodynamics and pharmacokinetics

Similar to most other second-generation antipsychotic agents, lurasidone is a full antagonist at dopamine D₂ and serotonin 5-HT_{2A} receptors, with binding affinities $K_i = 1$ nM and $K_i = 0.5$ nM, respectively.⁷ In addition, lurasidone is distinguished by its high affinity for serotonin 5-HT₇ receptors ($K_i = 0.5$ nM; comparable with dopamine D₂ and 5-HT_{2A} receptors) and by its partial agonist activity at 5-HT_{1A} receptors ($K_i = 6.4$ nM).⁷ The serotonin 5-HT₇ receptor is a target of interest that may be associated with the potential for both pro-cognitive and antidepressant effects,^{8,9} whereas the 5-HT_{1A} receptor may have a role in the treatment of major depressive disorder¹⁰ and schizophrenia.¹¹ Lurasidone lacks affinity for histamine H₁ and muscarinic M₁ receptors.

The pharmacokinetic profile of lurasidone is consistent with once-daily administration, with an elimination half-life of 20–40 h.² Mean C_{max} and area under the curve (AUC) for lurasidone were approximately threefold and twofold greater, respectively, in a comparison of administration with food *v.* fasting.¹² Based on these data, and results from clinical trials, it is recommended that lurasidone be taken once daily in the evening, with a meal or within 30 min after eating.^{1,2} Lurasidone absorption is independent of food fat content.¹²

Metabolisation

Lurasidone is metabolised primarily via CYP3A4 and, consequently, its use is contraindicated in the presence of strong inducers and inhibitors of CYP3A4. In the presence of moderate inhibitors of CYP3A4, the recommended starting dose of lurasidone is 18.5 mg/day instead of the usual recommended 37 mg/day, and the highest recommended dose is 74 mg/day instead of the regular maximum recommended dose of 148 mg/day. Lurasidone does not affect the pharmacokinetics of other drugs including lithium, valproate or agents that are metabolised by the CYP3A4 pathway.¹³

Examination of population subgroups based on gender, age and ethnic background did not reveal any clear evidence of differential response to lurasidone,^{1,2} however, Asian subjects had one-and-a-half-fold increased exposure to lurasidone compared with White subjects.² Clinical studies with lurasidone did not include sufficient numbers of patients aged 65 and older to establish whether dose adjustment is necessary on the basis of age alone. In patients with moderate or severe renal or hepatic impairment, the recommended starting dose is 18.5 mg/day; the maximum dose should not exceed 74 mg/day in moderate to severe renal impairment or moderate hepatic impairment and 37 mg/day in severe hepatic impairment.

Efficacy in schizophrenia

Acute treatment

Based on a robust registration programme that included five informative and similarly designed 6-week, fixed-dose, placebo-controlled studies,¹⁴⁻¹⁸ lurasidone is approved for the treatment of schizophrenia within a dose range of 37–148 mg/day. Reductions in the Brief Psychiatric Rating Scale¹⁹ or Positive and Negative Syndrome Scale (PANSS)²⁰ total scores were consistently greater for lurasidone compared with placebo across the approved dose range. A starting dose of 37 mg/day has demonstrated significant efficacy, thus no initial dose titration is necessary. Subsequent dose increases can be made based on clinician judgement, typically in increments of 37 mg at approximately weekly intervals. Patients with suboptimal symptom control at lower doses of lurasidone may benefit from higher doses. The NNT of lurasidone (v. placebo) for a 30% reduction in PANSS total score was 4 (95% CI 3–5) for lurasidone 148 mg/day compared with 6 (95% CI 5–10) at 37 mg/day.⁵

The short-term effectiveness of lurasidone has also been evaluated in a study in which clinically stable but symptomatic out-patients with schizophrenia or schizoaffective disorder were switched from their current antipsychotic medication to lurasidone in a 6-week study that examined the efficacy and tolerability of three different dosing strategies (starting at 37 mg/day for 2 weeks, v. starting at 74 mg/day for 2 weeks, v. starting at 37 mg/day for 1 week followed by 74 mg/day the second week).²¹ The primary outcome was time to treatment failure, defined as any occurrence of insufficient clinical response, exacerbation of underlying disease or discontinuation due to an adverse event. No clinically relevant differences were observed among the three groups in efficacy or tolerability outcomes; treatment failure rates were low for all three switch groups (~8%).

Long-term treatment

Longer-term data for lurasidone in patients with schizophrenia are available based on randomised, double-blind, 12-month trials that include comparisons with risperidone in a safety study,²² and quetiapine extended-release (XR) in a double-blind extension to one of the short-term pivotal trials.²³ In the risperidone comparator study, treatment with lurasidone was associated with comparable improvement in efficacy, with similar relapse rates at 12 months. In the quetiapine XR comparator study, lurasidone was non-inferior to quetiapine XR in risk for relapse. At 12 months, treatment with lurasidone (modal daily dose 111 mg) was associated with a significantly greater improvement in PANSS total score compared with quetiapine XR (modal daily dose 600 mg), numerically lower risk of relapse (23.7% v. 33.6%; $P = 0.280$; *Fig. 1a*), significantly lower risk of re-hospitalisation at 12 months (9.8% v. 23.1%; log-rank $P = 0.049$; *Fig. 1b*) and significantly higher rates of remission (61.9% v. 46.3%; $P = 0.043$; *Fig. 1c*). In the same study, a computerised cognitive battery (Cogstate; <http://cogstate.com>) was administered at the end of 6 weeks of acute double-blind treatment and after 6 months of double-blind extension treatment. At both time points, treatment with lurasidone was associated with significantly greater improvement in cognition compared with quetiapine XR, with a moderate effect size.²⁴

The long-term effectiveness of lurasidone in the treatment of schizophrenia has also been evaluated in two open-label extension studies. In the first, a 6-month extension of the switch study summarised above,²⁵ the mean PANSS total score continued to show improvement. Moreover, low rates were observed for both psychiatric emergency services utilisation (mean: 0.8% per month) and contact with the criminal justice system (mean: 1.8% per month).²⁵ In a second open-label extension study in which patients received 6 months of treatment with lurasidone, antipsychotic efficacy was maintained, with further reduction observed in mean PANSS total scores, in patients who had initially received lurasidone, olanzapine or placebo during the acute treatment phase.²⁶

Preliminary results of a double-blind, randomised withdrawal study examining the maintenance of efficacy of lurasidone treatment in patients with chronic schizophrenia have been presented.²⁷ Patients experiencing an acute exacerbation of schizophrenia received flexible doses of lurasidone (37 or 74 mg/day) during a 12- to 24-week open-label stabilisation phase. Those who maintained clinical stability for 12 weeks entered a 28-week, double-blind withdrawal phase and were randomised to receive either lurasidone (at the same dose they were receiving at completion of the stabilisation phase) or placebo. Lurasidone significantly delayed time to relapse compared with placebo (log-rank test $P = 0.039$) and was associated with a 34% reduction in risk of relapse (Cox proportional hazard model ratio 0.66 (95% CI 0.45–0.98); $P = 0.041$).

Tolerability and safety

Commonly observed adverse reactions in short-term trials in schizophrenia (incidence on lurasidone 5% and twofold greater than placebo) were somnolence (17% v. 7%; NNH = 10), akathisia (13% v. 3%; NNH = 10), nausea (10% v. 5%; NNH = 20) and extrapyramidal symptoms (excluding akathisia and restlessness) 14% v. 6% (NNH = 13).^{1,2} Akathisia and extrapyramidal symptoms appear dose related within the dose range of 18.5 to 111 mg/day.¹ The frequency of akathisia in patients with schizophrenia was 5.6% for 18.5 mg, 10.7% for 37 mg, 12.3% for 74 mg and 22.0% for 111 mg. In a study where lurasidone was administered in the evening,¹⁸ akathisia was reported by 7.4% of patients receiving lurasidone 148 mg/day. It is possible that evening dose administration is associated with more favourable tolerability overall relative to morning dosing. Adverse event frequencies (including movement disorders) reported in the bipolar depression programme, where lurasidone was dosed at night in all studies, were generally lower than observed in patients with schizophrenia.¹ The mean change in weight observed across 6-week trials in schizophrenia was +0.43 kg for lurasidone v. 0.02 kg for placebo.¹ In contrast, mean change in weight was +4.15 kg for olanzapine and +2.09 kg for quetiapine XR in 6-week trials where these agents served as active controls.^{1,17,18} In 6-week trials, the proportion of patients with a clinically meaningful (7%) endpoint increase in body weight was 4.8% for lurasidone v. 3.3% for placebo (NNH = 67; not significant).¹ In contrast, the proportion of patients with clinically significant weight gain during short-term treatment in one comparator study with olanzapine v. placebo was 34% v. 7% (NNH = 4);¹⁷ and the proportion of patients with clinically significant weight gain in a second comparator study with quetiapine XR v. placebo was 15% v. 3% (NNH = 8).¹⁸ The proportion of patients with clinically significant weight gain on lurasidone was similar to the rate for placebo in both comparator studies (NNH > 55).^{17,18}

Longer-term studies for lurasidone are consistent with short-term findings regarding changes in body weight; in a long-term study lurasidone was associated with a mean change in weight of +0.73 kg at month 12, compared with +1.23 kg on quetiapine XR.²

The short-term effect of lurasidone on metabolic variables appears minimal.¹ In pooled short-term (6-week) clinical trials, the mean last observation carried forward (LOCF)-endpoint change in total fasting cholesterol was 0.15 mmol/L for lurasidone and 0.16 mmol/L for placebo;²⁸ for fasting triglycerides it was 0.15 mmol/L for lurasidone and 0.17 mmol/L for placebo;²⁸ and for fasting glucose it was +0.07 mmol/L for lurasidone and +0.03 mmol/L for placebo.²⁸ Long-term data regarding metabolic outcomes extending out to 12 months are consistent with the short-term data.^{1,28} In long-term studies,²⁸ mean LOCF-endpoint change on lurasidone was 0.08 mmol/L for total fasting cholesterol, 0.08 mmol/L for fasting triglycerides and +0.11 mmol/L for fasting glucose.

A moderate dose-dependent increase in prolactin was observed in patients treated with lurasidone, with more pronounced effects in female than in male patients; however, the increase was lower than what is observed with risperidone and haloperidol. In a randomised, 12-month, double-blind safety study comparing lurasidone with risperidone, mean change from baseline to endpoint in serum prolactin levels in men was +2.51 ng/ml for lurasidone and +9.45 ng/ml for risperidone, and in women it was +5.16 ng/ml for lurasidone and +33.90 ng/ml for risperidone.²²

Serial electrocardiograms during short-term and long-term trials indicate that lurasidone, at doses as high as 558 mg/day, does not have a clinically meaningful impact on the QT interval.¹

Bipolar depression

There is an unmet need for efficacious and tolerable treatments for bipolar depression. Patients with bipolar disorder spend most of their symptomatic time in the depressed phase of their illness.²⁹ While multiple agents are approved for the treatment of bipolar mania, there is a paucity of approved medications for the treatment of bipolar depression.³⁰ The older interventions (quetiapine and olanzapine–fluoxetine combination) are as likely to provide therapeutic benefit as adverse effects.³⁰ Cross-study comparisons in populations with bipolar depression suggest that treatment with lurasidone is associated with less sedation than quetiapine and less weight gain than the olanzapine–fluoxetine combination.³⁰

Lurasidone, in the dose range of 18.5–111 mg/day, demonstrated superiority *v.* placebo in two 6-week, randomised, double-blind, placebo-controlled, flexibly-dosed acute studies in patients with major depressive episodes associated with bipolar I disorder, one using lurasidone monotherapy and the other using lurasidone adjunctive with lithium or valproate.^{31,32} As reported by Citrome and colleagues,⁶ monotherapy treatment with lurasidone (*v.* placebo) was associated with an NNT of 5 (95% CI 4–8) for treatment response, defined as 50% reduction from baseline on Montgomery-Åsberg Depression Rating Scale³³ (MADRS) total score; adjunctive therapy with lurasidone was associated with an NNT of 7 (95% CI 4–24). NNT for remission, defined as a final MADRS total score ≤ 12 , was 7 (95% CI 4–14) for lurasidone monotherapy and 7 (95% CI 4–23) for adjunctive lurasidone. These results are comparable with NNT values reported for quetiapine (6 for response, 6 for remission) and olanzapine-fluoxetine combination (4 for response, 5 for remission).

Lurasidone was not associated with clinically meaningful mean weight or metabolic changes compared with placebo in these bipolar depression studies. This is in contrast to olanzapine–fluoxetine combination where the NNH (*v.* placebo) was 6 for clinically meaningful weight gain (7% from baseline).⁶ The three most frequently occurring adverse events with the largest difference in incidence for lurasidone *v.* placebo were nausea (NNH = 17 for monotherapy, NNH = 16 for adjunctive therapy), akathisia (NNH = 15 for monotherapy, NNH = 30 for adjunctive therapy) and somnolence (NNH = 25 for monotherapy, NNH = 19 for adjunctive therapy).⁶ The high NNH of lurasidone for somnolence compares favourably with the NNH of 3 (95% CI 2.2–2.7) reported for quetiapine in studies of bipolar depression, regardless of formulation or dose.⁶

Overall, the results of double-blind trials indicate that lurasidone has a highly favourable benefit/risk ratio for the treatment of bipolar I depression, with ‘single-digit’ NNT (indicating significant efficacy) and ‘double-digit’ or higher NNH (indicating high tolerability).

Summary

Lurasidone represents a new addition to the pharmacological armamentarium available for the treatment of serious mental disorders. It has demonstrated efficacy in the treatment of schizophrenia, within the dose range of 37–148 mg/day, and bipolar depression, within the dose range of 18.5–111 mg/day. Across both indications, treatment with lurasidone appears associated with minimal effects on body weight and low risk for clinically meaningful alterations in glucose, lipids or ECG parameters. Lurasidone’s combination of efficacy in schizophrenia and bipolar depression with minimal metabolic disturbance and little effect on movement disorders and prolactin represents a potentially important clinical advance.³⁴

1.8.64 Experiences of ward rounds among in-patients on an acute mental health ward: a qualitative exploration†

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Abstract

Aims and method To address the gap in qualitative research examining patients' experiences of ward rounds. In-depth interviews were conducted with five in-patients on an acute mental health ward. Data were analysed using thematic analysis.

Results Data were organised into three first-order themes, positioned within an overarching theme relating to patients' perceptions of the use of power and control within ward rounds.

Clinical implications Systemic factors may make it difficult to facilitate ward rounds in a manner which leaves patients feeling fully empowered or in control, but there are practical measures to address these issues, drawn from participants' accounts.

Contents

- *Experiences of ward rounds among in-patients on an acute mental health ward: a qualitative exploration†*
 - *Method*
 - * *Participants*
 - * *Data collection*
 - * *Data analysis*
 - *Results*
 - * *First-level theme: not considering the patient's emotional state ('They could possibly take into account a little bit more how you are at that moment in time')*
 - * *First-level theme: 'behind closed doors' (wanting more involvement in the process)*
 - * *First-level theme: the importance of relationships ('He's the only one who has listened')*
 - * *Overarching theme: power and control ('they can keep renewing my section')*

1

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* *Suggestions for improvements*

– *Discussion*

* *Improving the patient experience*

Ward rounds are seen as a key component of care provision in in-patient psychiatric settings.¹ However, literature in this area has found that they evoke anxiety in a large proportion of patients,^{2,3} particularly when more people are present.⁴ Patients report not feeling listened to and feeling that information is withheld from them.³ Many patients also feel inadequately prepared for ward rounds by staff.⁵ Labib & Brownell³ highlight the scarcity of qualitative investigations in this area and suggest that addressing this may highlight additional unexplored factors affecting patient satisfaction with ward rounds. This study aims to address this need. It was carried out in an acute in-patient unit located in a district general hospital in the north west of England. The need for this project to take place was identified by the unit's psychiatry team, who wished to investigate how ward rounds could be adapted to facilitate patient satisfaction. It was also hoped the project might identify avenues of investigation for future researchers, as per Labib & Brownell's suggestions.³

Method

Participants

Participants were recruited from across three mixed-gender adult acute mental health in-patient wards attached to a general hospital. Each ward has a different consultant attached. Ward rounds within this unit are chaired by psychiatrists and bring together information from members of the multidisciplinary team (nursing, psychology, occupational therapy and psychiatry), followed by a direct review of the patient's progress and mental state, formulating risk and developing treatment plan changes accordingly.

Patients from the wards were eligible to participate if they had experienced two or more ward rounds. Although nine responded favourably and completed informed consent forms, four did not participate: two were unavailable on the days they were due to be interviewed, one declined to take part when approached by the interviewer, and one chose to terminate her interview citing her mental state as non-conducive to participation. Detailed characteristics of the five participants are presented in *Table 1*.

Participant characteristics

Patient	Gender	Age, years	Length of stay on ward, weeks	Ward rounds attended, <i>n</i>	Patient status
Patient A	Female	20	11	Too many to recall	Detained
Patient B	Male	41	4	4	Detained
Patient C	Male	36	5	4	Detained
Patient D	Male	49	2	2	Informal
Patient E	Male	27	1.5	Too many to recall	Detained

Data collection

Ethical approval was granted from a local research ethics committee and research and development department. Participants were recruited following an initial approach being made by an assistant psychologist. All participants were interviewed in the ward's 'quiet room' by R.C., using an interview topic guide (questions included 'Tell me how you've found the ward rounds here so far' and 'How do you feel when you're in the ward round?'). Interviews lasted between 30 and 45 min, were audio-recorded and were transcribed verbatim.

Data analysis

Data were analysed using thematic analysis, a flexible approach for organising large amounts of qualitative data.⁶ Data analysis followed the four conventions for thematic analysis suggested by Braun & Clarke.⁶

1. Familiarisation with the data, re-reading transcripts looking for patterns and meanings.
2. Generating initial codes: organising the data into groups according to content and meaning. Transcripts were then re-coded and initial codes were grouped into 'second-cycle' codes.⁷ For example, initial codes from patient C's transcript, such as 'feeling intimidated' and 'not being co-operative backfires' were subsumed under the second-cycle code 'serious consequences to not behaving in the right way'.
3. Searching for themes: second-cycle codes were grouped together into broader themes and subthemes. For example, codes such as 'staff as a supportive network' and 'approval means more within a good relationship' were grouped together in the development of a theme about the importance of relationships.
4. Reviewing themes: ensuring each theme was coherent and that themes capture the essence of the data. At this point the theme 'power and control' was identified as an overarching theme and remaining themes designated as first-order themes.

Coded transcripts and themes were reviewed by the research team to ensure analysis possessed sufficient quality and rigour.

Results

As the analysis of participants' accounts progressed, data were organised into an overarching theme running throughout the data, representing the data at the highest level of abstraction, and first-level themes representing participants' accounts in less abstract, more concrete ways. The terminology of 'overarching themes' and 'levels of themes' is derived from Braun & Clarke.⁶

First-level theme: not considering the patient's emotional state ('They could possibly take into account a little bit more how you are at that moment in time')

This theme concerns how the majority of participants felt that the ward round process does not take the patient's emotional state into account and actually increased their anxiety at times when it was already high. The theme's title is a quote from patient C, who reported unease at 'probing' questions in the ward round when he was also experiencing feelings of paranoia. Participants frequently admitted to anxiety about discussing personal issues with a group of people, some of whom were unknown to the participant: "'Well ... they can be scary at first ... 'cos there's all different people there, you've got support workers, staff nurse there, there's your consultant, there's a SHO [senior house officer,] there, you can have students there, I could be there, my parents could be there. So it's like a lot of people in the ward review and, er, it's like they're all talking about you' (patient E)."

Another point raised in relation to this theme was the timing of information-giving about the ward round. For example, patient B stated that when the ward round process was initially described to him: "'... they use all this, all this jargon, and you know, when your head's up your arse so to speak, you don't take much of it in, you're just looking at a load of professionals and you don't know what they do.'"

For patient B, information about the ward round which would have helped ameliorate anxiety was given at a time (and by a means) that did not take account of his mental state at that point.

First-level theme: 'behind closed doors' (wanting more involvement in the process)

Participants felt that staff held control over ward round processes and wished for more involvement. Participants described a lack of collaboration in the area of decision-making, where they felt their views were often not taken into account and that decisions were made away from them, without their involvement.

‘... it’s like most of the things they’re behind closed doors, and, and then they let you know, in your review they let you know “right we’re going to follow this, we’re gonna review this”.’ (patient E)

For patient A, the way in which events during ward rounds are documented was an area where control lay with staff and where she wished for more input and collaboration: “‘I think as well you should get like a copy of what they’ve wrote [sic] (...) ‘Cos you don’t know what they write down and stuff, I reckon they should tell you what they’ve wrote down so you could like read it for a bit and then next week feed back on what they’ve said and maybe like, like add things to it or develop what they’ve wrote.’” However, some participants devised ways of being able to have more input into the process, within the parameters they were confronted with. Patient C articulated this using a ‘game playing’ metaphor: ‘it’s gotten better now because I’ve just got some leave you see but I wasn’t entirely aware of how to play the game’. This was linked to the idea of having to adhere to unwritten rules of behaviour in the ward round: ‘there was a charge nurse in the last ward who was getting very frustrated with me because she was trying very clearly to show me the right way to behave and I was digging my heels in’. This resulted in what patient C described as a ‘meet you halfway situation, where if I cooperate with their goals they’ll offer me incentives’.

First-level theme: the importance of relationships ('He's the only one who has listened')

Participants stressed the importance of good relationships with staff and that such relationships had a positive impact on their ward round experiences. The theme is named after a quote from patient D, who said: “‘Like I say, he listened. That’s the main thing. And when you’re in. . . when you’re in the kind of situation I’m in at the moment, if people listen to you it’s half the battle, when you’ve got someone you can talk to, and I felt I could talk to that doctor and he listened.’”

Patient A described finding the ward rounds themselves daunting, but expressed a wish to use positive relationships she’d formed with staff to help her cope with them: “‘If you’re close to that member of staff and they’re sat at the side of you and if you were both speaking together . . . Like that would be good. ‘Cos you’d feel like somebody’s there for you, like, rather than being on your own.’” However, patient A also added that the parameters of these helpful relationships were controlled by staff, who may not always recognise the positive effects of staff relationships on ward round experiences. This could result in the ward round being set up in a way which does not take account of the importance of relationships for patients, for example when there are short-notice changes to which staff attend: ‘it’s nerve-wracking enough going into your ward review and then at last minute, “oh yeah by the way, such and such a person isn’t coming, this person’s coming in”.’

Overarching theme: power and control ('they can keep renewing my section')

The themes so far can be understood as part of an overarching theme relating to power and control. Issues of power and control were implicit within many issues that participants raised. The quote in this theme’s name originates from patient E’s interview, and relates to how some participants described their awareness during ward rounds that staff have the power to decide if they stay in hospital or leave.

Participants often talked about issues of power and control by describing staff in terms of police or other agents of the law. For example, while describing being assessed in ward rounds, patient C stated: ‘yeah, it’s kind of the feeling where, I don’t know if you’ve ever been stopped by the police but they do that kind of thing, you can feel them looking up and down at you . . .’. Such comparisons seemed to arise from participants’ awareness of the assessment function

of ward rounds and professionals' power to determine the outcomes of these assessments. Patient B described how this awareness led to anxiety about the outcome of ward rounds: '... at first, it's like having to tell these people here, if I tell them I'm having these mad thoughts, they're gonna lock me up forever'. As described in the first-level themes, participants felt that professionals hold power and control over how the ward round, and therefore the assessment process within it, is conducted. However, as indicated by the first-level theme 'the power of relationships', participants suggested these issues could be ameliorated by positive, collaborative relationships with staff.

Patient B also described how interpretations of the actions and intentions of those in the ward round may be influenced by previous encounters with those in authority: "'Cos my personal experience of walking into a room with loads of people is walking into a courtroom ... 'Cos they sent me to jail. So, I didn't have a very good experience of loads of people if you like.'" This account suggests that some ward round procedures may evoke patients' negative memories of encounters with powerful figures.

Suggestions for improvements

Participants seemed eager to share their ideas about practical improvements that could be made to ward rounds (*Box 1*). Indeed, in discussion with R.C. during recruitment, participants often cited the desire to share such ideas as their primary motivation for taking part.

Box 1 Participants' suggestions for improvements to ward rounds

- Allow patients access to ward round records and the power to negotiate additions to them
- Invite a smaller number of staff into patients' initial ward rounds and increase the number gradually
- Be open about when patients are being assessed on particular areas of their mental state and why
- Utilise patients' one-to-one time with named nurses so ward rounds can be prepared for
- Issue patients with a booklet about hospital procedures on admission, including information about ward rounds. This would serve as an aide memoire for patients to return to so they can remind themselves of ward round procedures

Discussion

Our participants' accounts lend support to past research indicating that patients may find ward rounds anxiety provoking.^{3,5} In support of previous findings linking ward round size to patient anxiety,^{4,8} participants in this study also spoke of the difficulties in talking to a room containing a large number of people unknown to them. Participants also reported that ward rounds are more distressing if they are already in an anxious or distressed state, an association which has not yet been studied in the quantitative literature. Findings from this study suggest that a lack of well-timed information about ward rounds could also contribute to anxiety.

As hoped, using qualitative methods led to a deeper understanding of participants' ward round experiences than has previously been possible using quantitative methods. It was hoped that more participants would be recruited but this proved difficult within the time available, owing to potential participants' apparent fluctuating mental state and their availability and motivation to take part. Although this is an exploratory study with a small sample, the findings highlight previously unexplored issues that may deserve further investigation. One such area is that of the potential importance to patients of their relationships with professionals and how sensitive use of positive relationships may positively affect the ward round experience. For example, future research might investigate whether anxiety in ward rounds is mitigated by the presence of patients' favoured members of staff, such as named nurses or key-workers.

Improving the patient experience

Study results and participants' suggestions for improvements to ward rounds were fed back to the research site's consultant psychiatrists. This generated discussion around how the practical measures suggested by participants (*Box 1*) may provide safeguards to minimise the issues of power and control that inevitably influence in-patient settings, and how members of other disciplines (e.g. nursing) can play a key role in ensuring that patients feel prepared for ward rounds, supporting them to manage their anxiety in the process. The study's findings contributed to a subsequent reorganisation of ward round procedures at the research site. During the feedback process, the psychiatry team emphasised that continuing cuts to National Health Service in-patient care may lead clinicians to change how they facilitate ward rounds and that keeping the patient experience in mind will be a challenging but essential task.

Using qualitative methods to investigate acute mental health in-patients' experiences of ward rounds led to a richer understanding than has previously been possible using quantitative methods. The findings suggest possible directions for future research into ward rounds and prompted clinical discussions that have informed changes to ward round practice at the research site.

We thank participants who gave their time; Charlene Rouski, James Dudley, Katie Usher and Dr Sarah Jones for their help with recruitment; and the psychiatry team on units K1, K2 and K3 at Royal Bolton Hospital for their support.

1.8.65 Update on the Improving Access to Psychological Therapies programme in England: author's reply†

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date

2015-10

Abstract

Fonagy & Clark confirm in their rebuttal that they have an ideological commitment to the failed technical model of understanding and intervening in mental health problems that dominates current service provision. They fail to acknowledge the limitations and problems associated with Improving Access to Psychological Therapies (IAPT) and Children's and Young People's IAPT (CYP-IAPT) and offer an unconvincing explanation for why they did not allow some of the vast tax payers' money that they had at their disposal to be used to implement evidence supported relational models.

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- *Update on the Improving Access to Psychological Therapies programme in England: author's reply†*

I will mainly comment on professors Fonagy and Clark's article¹ as they have attempted an evidence-supported rebuttal. Dr Law's letter² calls for more dialogue, which by itself will not change the implementation fundamentals, whereas Ms Swaile's letter³ points out the obvious – that if you spend more on psychological therapies, more of them will be available – whereas my editorial⁴ was critiquing how this extra available money was spent.

¹

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Fonagy & Clark's article reminded me why I initially got excited about Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT), with its desire to engage with the evidence and talk of improving access, collaborative working, focusing on outcomes, local learning and so on. My original enthusiasm was misplaced as there is a fatal flaw, which they seem unable to get past – their belief that the poor outcomes and inefficiencies of mainstream services happen because we are not rigorous enough in the way we enforce technical aspects of care. Their ideological intransigence on this matter has created a cartel-like monopoly where existing and successful alternative models have no opportunity to be tried.

Their critique of relational/contextual models (they refer to as 'common factors') is unconvincing. The most rigorous meta-analyses of evidence from randomised controlled trials (RCTs) note that of course papers can be found showing some model differences, but the overall evidence base finds that across presentations by far the biggest factors influencing outcomes have little to do with what we do – so called extra-therapeutic factors (the real-life contexts, beliefs and histories), whereas within therapy it is the therapeutic alliance.⁵ Therapeutic alliance is not a one-dimensional construct and includes, for example, the degree of 'engagement' – a two-way process including understanding what is meaningful to the patient. Thus, if a computer program provides a meaningful methodology for a patient, then that is where their 'alliance' may form.

The authors predictably avoid bigger issues with National Institute for Health and Care Excellence (NICE)-guideline-derived evidence-based-therapies (EBTs). In mental health (unlike the rest of medicine), NICE guidelines are eminence not evidence based, in other words they rely more on who was on the guideline group than what the evidence says.^{6,7} NICE guidelines focus on process adherence, but have little to say about outcomes. They derive from diagnostic constructs that have done little to advance scientific knowledge or clinical practice, and have no capacity to match treatments to aetiology, thus failing the basics required of a technical model.⁸ Mental health treatment RCTs use exclusion criteria, which often means the sort of multi-problem, diagnostic overlap patients typical of those who attend our clinics are not adequately represented. Like me, Fonagy & Clark want to do something about the dreadful record for outcomes that real-world mental health services have. Their solution is to 'beef up' existing diagnosis-based NICE-guideline EBTs that we have been using for years, but using more manualised process adherence. But the fantasy that expertise in technique is king is what got us into this mess in the first place. This ideological commitment seems to have by-passed simple logic. If the outcomes with a patient show improvement, does it matter what model you use to help achieve this? If an outcome is not improving, then it surely does matter and irrespective of what your manual says you may need a rethink what you are doing altogether.

As far as their concept of 'relational' is concerned, they describe a collaborative 'light' model. In the primacy of the technical model, 'collaborative' essentially amounts to convincing the patient that the expert knows what is wrong with them and what the right treatment is. Prioritising the relational means that therapy is potentially 'co-constructed' at every step. In a proper relational model we are constantly encountering 'experts by experience' whose insights, skills, choices, autonomy and resources should be harnessed to help shape therapy session by session.

Fonagy & Clark's article does little to dent the critique that CYP-IAPT has not, thus far, managed to develop patient-empowering, outcomes-focused, collaborative practice. Tellingly, after 4 years of implementation they were unable to reference any patient outcome data for CYP-IAPT. In the 3 years of our local Outcomes Orientated Child and Adolescent Mental Health Services (OO-CAMHS) project, we have amassed a database with over 4000 discharged cases with outcome ratings where a reliable clinical improvement and/or 'recovered' rate of 75% is being recorded. It is time for CYP-IAPT to stop being frightened of relational models and give them a seat at their table. If Fonagy & Clark wish to maximise the chances of having services that can improve the lives of many more people, then they should embrace the opportunity to include alternative models such as the Partners for Change Outcome Management System/OO-CAMHS that have a proven track record in real-world services, to keep open possibilities for discovering ways of designing services that are most effective and efficient. If they remain ideologically belligerent (as they have thus far), every word of my critique stands.

1.8.66 Update on the Improving Access to Psychological Therapies programme in England†

: Commentary on ... Children and Young People's Improving Access to Psychological Therapies

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date

2015-10

Abstract

Professor Sami Timimi recently expressed concerns about the Improving Access to Psychological Therapies (IAPT) programme. We argue that the concerns are largely unfounded and provide readers with an update on the programme.

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We are pleased to have the opportunity to respond to Professor Timimi's editorial in the April 2015 issue of *BJPsych Bulletin* and his comments on the Improving Access to Psychological Therapies (IAPT) programme in general and the Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) programme in particular. We hope to point out that many of his concerns about both programmes are unfounded, either because evidence we have collected should allay his concerns or because the issues he identifies represent misunderstandings of the literature and the initiatives.

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Adult IAPT

The IAPT programme for adults aims to make National Institute for Health and Care Excellence (NICE)-recommended psychological treatments for depression and anxiety disorders more widely available by training 6000 new psychological therapists and deploying them in specialised stepped-care services, along with experienced staff. The initiative has several distinctive features, which an editorial in the journal *Nature* described as ‘world-beating’.¹ For the first time, therapist training follows nationally agreed curricula that focus on the competencies required to deliver those treatments that have been shown by randomised controlled trials (RCTs) to be effective for particular conditions. An innovative session-by-session outcome monitoring system captures clinical outcomes on almost everyone (97%) who has finished a course of treatment (liberally defined as at least two sessions, although many people have more),² and clinical commissioning group (CCG)-level outcome data are published on a public website.³ This contrasts sharply with the picture before IAPT, when psychological therapy services obtained outcome data on less than 40% of patients and are likely to have overestimated their value, as people whose data are missing tend to have done less well.⁴

What does the more complete IAPT data tell us? Nationally, of patients who have finished a course of treatment in IAPT, 45% recover (based on a strict double criterion – dropping below the clinical threshold for both anxiety and depression) and a further 16% show reliable improvement that falls short of full recovery.^{2,5} However, there is considerable regional variability. About a third (70 of 211) of CCGs now report recovery over 50% and some are consistently over 60% (www.hscic.gov.uk). This shows what the IAPT model can achieve in services with a sufficiently large and appropriately trained workforce that benefits from excellent clinical leadership. The challenge for the next phase is to raise other CCGs to the same level.

Professor Timimi’s editorial⁶ asserts that there is little evidence for the premises on which adult IAPT is based, and that IAPT services are less effective and more expensive than pre-existing counselling services. Both assertions can be refuted.

IAPT outcomes

IAPT delivers therapies that have been shown to be effective for particular conditions in RCTs, on the assumption that this is the best way of ensuring good clinical outcomes. Timimi argues this is mistaken because ‘within treatment, the factor that has the biggest impact on outcomes is the therapeutic alliance (as rated by the patient) with matching treatment model to diagnosis having a small to insignificant impact’.⁶ Contrary to this statement, there is evidence in all anxiety disorders that some psychological treatments are more effective than others.⁵ In depression, the picture is less clear. Several psychological therapies have been shown to be better than placebo or no treatment, but there is little evidence of differential effectiveness between these therapies.⁵ However, there is no such thing as a therapeutic alliance therapy. Even if therapeutic alliance were the most important factor, one would still need to train therapists in procedures that allow the therapeutic alliance to emerge. Clearly, it makes sense to choose procedures from treatments that are known to work. It is also important to note that the use of weak research designs means that many studies of therapeutic alliance are likely to overestimate the importance of this factor. Alliance is often measured late in therapy when some patients have already improved. The correlation between alliance and outcome may therefore be a consequence, rather than a cause, of clinical improvement. Feeley’s studies⁷ showing that late alliance is related to outcome but early alliance is not are consistent with this point of view. Alliance studies rarely measure the competence with which a treatment is delivered, so we cannot rule out the possibility that positive alliance ratings reflect competent and sensitive delivery of a treatment, not just the establishment of a good therapist–patient relationship. The remarkable success of internet-delivered therapies strongly challenges the claim that a strong therapeutic alliance is essential.

The report⁸ that Professor Timimi cites as evidence that IAPT services are less effective and more costly than pre-IAPT counselling services is flawed. It was produced by a charity that funded some pre-IAPT counselling services and does not appear to have gone through a normal peer-review process. It fails to describe its methods and measures in the level of detail required for a journal article. However, from the details that are available, it is clear that the report is comparing chalk with cheese. IAPT recovery rates were based on all patients who had at least two sessions. Pre-IAPT services had high post-treatment missing data rates⁴ and recovery rates were based on those who contributed post-treatment data, which will inevitably inflate estimates.⁹ The IAPT recovery criterion was a strict double-measure criterion, whereas pre-IAPT recovery was based on a more lenient, single-measure criterion. Costs for IAPT and non-IAPT services were

also estimated differently, with the former including set-up, staff training and premises costs, while it seems unlikely these figured in the comparator costs.⁸

The characterisation of IAPT as a ‘fetishisation’ of cognitive-behavioural therapy (CBT) is also misplaced. As NICE only recommends CBT for anxiety disorders and depression, the initial focus of IAPT was on this modality. However, the programme now supports the training and employment of therapists who can deliver the four other therapies that NICE recommends for depression (counselling, couples therapy, interpersonal psychotherapy and brief psychodynamic therapy). Counselling is already strongly represented, by over a quarter of all IAPT high-intensity therapists. There is a need to build further capacity in the other three therapies and this is already underway. In the past 2 years IAPT has trained more therapists in non-CBT modalities than in CBT.

Children and Young People’s IAPT

Children and Young People’s IAPT (CYP-IAPT) is training many more systemic family practitioners, interpersonal psychotherapists and parenting therapists than CBT therapists, and our core curriculum has made use of client feedback to inform practice across modalities. Professor Timimi’s emphasis on therapeutic alliance is consistent with CYP-IAPT’s fundamental concern with collaborative practice and shared decision-making.

Professor Timimi’s first concern about CYP-IAPT is the risk of a top-down *v.* bottom-up approach to service transformation. He suggests that rather than using research evidence to guide selection and implementation of interventions, it would be cheaper and better for child and adolescent mental health services (CAMHS) simply to roll out usual care based on his own Partners for Change Outcome Management Systems (PCOMS) model for service transformation. He cites a selection of meta-analyses to suggest that interventions targeted at specific disorders have no effect, even when we know RCTs indicate large effect sizes. Comparisons of psychological therapies with usual care indeed tend to have small effects but this depends entirely on the services offered in usual care. For example, multisystemic therapy has very large effects because the usual care comparator is often part of youth justice provision.¹⁰ Comparisons with community-based active treatments yield far smaller effects. Many advocates of evidence-based therapies (EBTs) have pointed this out,¹¹ and there are indications that modular-based approaches integrating a range of EBT elements may well be the way forward.¹² On the whole, comparisons with usual care show the difficulty of designing new interventions that systematically outperform the old.¹³ But does this warrant complacency about usual care in CAMHS? Existing evidence for the effectiveness of ordinary CAMHS in the UK and elsewhere should worry both clinicians and policy makers. The observed effect sizes are small and sometimes even statistically insignificant. The majority of children receiving community-based usual care do not show clinical improvement.^{14,15}

Unfortunately, bringing about improvements appears quite challenging. In his editorial Professor Timimi cites the historical Stark County and Fort Bragg studies, which are relevant to this debate for two reasons. First, they highlighted the importance of the method of implementation in service improvements. When major service improvement initiatives are launched, evidence now has to be presented that implementation science principles are followed. For example, organising observation of clinical work as part of supervision is essential for rigorous training of therapists,¹⁶ as is the structuring of services to accommodate EBTs.¹² Second, the two studies led implementers and others to stress the likely importance of continuous, clinically meaningful feedback and progress monitoring. Implementation science considerations and meaningful use of session-by-session outcome measurement have informed CYP-IAPT’s work from the beginning.¹⁷ Rather than seeking to impose a single solution on all services, we have tried to disseminate a set of clinical principles (outcome focus, increased patient and parent participation, use of EBTs) and to implement these through local collaborations engaging a range of services, which jointly tried to find the best way forward.

CYP-IAPT: a model for child mental health services

There is no template for a CYP-IAPT service; there are services that use CYP-IAPT principles. PCOMS, or any other service model, could only be universally implemented as part of a top-down initiative. As Professor Timimi highlights, this was precisely what went wrong at Fort Bragg and Stark County, and we did not wish to repeat the error. As a national programme, CYP-IAPT required a modest governance structure, including focused work streams to develop curricula, outcomes measurement and service organisation, but it was delivered within CAMHS partnerships made up of commissioners and both statutory and non-statutory providers who wanted to deliver local change. Through a well-recognised (evidence-based) phasing of the change process (exploration, installation, initial implementation, innovation and sustainability), we engaged services covering 68% of the population in the 1–19 years age bracket within 4 years. Although we may not have succeeded everywhere, our explicit strategy was to mobilise the local leadership and workforce to engage children/young people and their parents in the process of service transformation, including – but reaching out beyond – the National Health Service (NHS), to achieve sustainable results.

A recent benchmarking survey found that 70% of CAMHS questioned said they were working to CYP-IAPT principles.¹⁸ According to the annual update of data submitted for CYP-IAPT, data completeness of matched cases at time 1 and time 2 cases was 63.2%.¹⁹ The Rapid Internal Audit²⁰ of 12 representative partnerships, over 350 clinicians and several focus groups of children and parents/carers found that: The percentage of cases closed by mutual agreement out of all closed cases has increased by 75% since the initiation of CYP-IAPT. The number of weeks between referral and first appointment has decreased from 16.6 in year 1 of CYP-IAPT to 6.6 in year 5. The proportion of self-referrals, although still relatively small, increased by 51%. 54% of clinicians agreed that the service was working towards the principle of increased self-referral; 61% agreed that access had improved for their local population over the past year. Well over half of clinicians questioned reported often or always using outcome data to review treatment progress or to inform therapy; a similar percentage reported often or always discussing outcomes data with children/young people and families. More than three-quarters of clinicians reported usually or always engaging in shared decision-making activities with parents/carers and children. Children in focus groups spoke spontaneously about how their involvement in service delivery gave them a personal sense of worth and empowerment. Children and young people also agreed that monitoring outcomes helped to keep things focused. Professor Timimi identified delivering EBTs as the sole objective of CYP-IAPT. In fact, we set ourselves six evidence-based objectives to improve services for children and young people (www.cypiapt.org/children-and-young-peoples-project.php). In addition to (1) delivering EBTs, we aimed to (2) improve access through self-referral, (3) work in partnership with the young person and their parent or carer throughout treatment, (4) deliver outcomes-focused treatments, (5) provide supervision to support delivery of evidence-based, user- and outcomes-informed practice, and (6) support whole-service transformation through leadership training. As we understand PCOMS' priorities, these have much in common with the CYP-IAPT curricula: the emphasis on consultation, involving optimal collaboration with other agencies; outcomes focus, using session-by-session patient-rated outcome data and changing treatment if outcomes are not improving; developing effective treatment alliances aided by the outcomes focus; developing team cultures that are recovery focused; and understanding how to use outcome data for clinical reflection, supervision and whole-team development.

CYP-IAPT insists on the use of treatment protocols based on manuals validated by one or more RCTs. Delivery of these protocols requires a clear set of competencies, which therapists must show they possess. Professor Timimi is committed to the common factors model of therapeutic change, and believes that generic therapeutic competencies are sufficient to deliver effective help regardless of the nature of the child's disorder. Although many therapies share important elements, such as a strong therapeutic relationship, researchers have found that not all therapies work equally well for all childhood disorders.²¹ Some therapies have actually been shown to be harmful.²² In the case of conduct problems, anxiety-related diagnoses (e.g. generalised anxiety disorder and obsessive-compulsive disorder), attention-deficit hyperactivity disorder and a number of other disorders, there is clear evidence supporting skilled manualised interventions, which could not be accounted for by common factors such as the therapeutic alliance.²¹ We also know from implementation science that attending training workshops is not sufficient to acquire competence in an intervention.¹⁶ The CYP-IAPT training includes intensive workshops and ongoing supervision/consultation, including practice sample review (e.g. audiotape review).

During the earliest exploration phase of the implementation process, the Department of Health and then NHS England sought to learn from local providers to build on existing best practice rather than implementing from above. We established collaboratives based around higher education institutions to lead the implementation locally, as individuals,

organisations and system units gained competence and confidence in the new ways of delivering therapy. In the current ‘innovation’ phase of CYP-IAPT, a national group, the Collaborative of Collaboratives, is presenting opportunities for CAMHS partnerships to refine and expand both the treatments and the implementation of the programme, and the group tasked with service transformation has drawn up a template for improved services (*Delivering With and Delivering Well*),²³ co-authored by the Child Outcomes Research Consortium (CORC), the Quality Network for Community CAMHS (QNCC), the Choice and Partnership Approach (CAPA) and Youth Access, young people and other voluntary organisations, against which the quality of services can be judged.

Our current focus is the sustainability phase, which requires a national system of quality assurance of training, performance and service characteristics so that CAMHS partnerships can be held to account for maintaining the system they have established. An Accreditation Council – working in partnership with the Royal College of Psychiatrists, the British Psychological Society, NHS England, Health Education England, the QNCC, and the professional groups representing family therapists, interpersonal psychotherapists and CBT therapists – has developed an individual accreditation system for CYP-IAPT. These measures help commissioners and providers ensure that children, young people and parents receive the appropriate, evidence-based, outcomes-focused care they deserve.

That these improvements have been possible against the background of the most significant challenges across child mental health since the establishment of child guidance clinics 60 years ago is a testament to the incredible commitment to innovation of the CAMHS partnerships, their clinicians, leaders, the children, young people and parents, as well as the higher education institutions supporting their development. The high profile of children and young people’s mental health has been boosted by the demonstration of effectiveness. We look forward to a brighter future for CAMHS, characterised by improved accessibility, more participation, an increased outcomes focus, greater transparency, and continued respect of NICE guidance and evidence-based practice.

1.8.67 Payment by results in forensic mental health

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Abstract

Forensic mental health services are low-volume, high-cost services. Payment by results (PbR) is the UK’s latest attempt to improve efficiency and controls pending behaviours within the secure services. This article discusses the utility of the PbR mechanic in forensic mental health. It explores PbR implementation in non-forensic mental health settings, similar funding processes internationally, and early PbR implementation work in the UK’s secure services. Finally, the article discusses the challenges faced when implementing PbR in forensic mental health services and puts forward possible next steps in determining the utility of PbR in forensic mental health.

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The majority of mental health services in England, including forensic mental health services, have previously been funded via block contracts, with annual budgets set and agreed between commissioners and service providers. Providers then distribute the finances, balancing governmental directives and strategies against local priorities. However, it has been reported that block contracting offers very little incentive to improve efficiency and control spending behaviours.¹ Payment by results (PbR), soon to be called pricing and currency, is 'the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs'² that attempts to address such issues. It is England's answer to a case-mix approach, in which funding involves the use of a predefined average care package, which is applied with a fixed price when certain diagnoses or factors are present. In 2003, this method of commissioning started to be rolled out in areas of physical healthcare and now the PbR mechanism is utilised in the bulk of elective in-patient/out-patient and emergency procedures. The government believes that it will provide more clarity on what to expect from services and achieve better, more efficient outcomes.³

PbR: key concepts

Within the scheme, when operating for physical health purposes, a currency represents a unit of healthcare for which a payment is made and a tariff represents the price paid for each currency. Consequently, varying patients are grouped into healthcare resource groups (HRGs), in accordance with similar consumption of National Health Service (NHS) resources. In mental health services, 'clusters' are used as the so-called currencies, which in turn define a relevant care pathway and ultimately the contract between commissioners and service providers.⁴ Similar to HRGs, clusters represent individuals with similar needs, requiring similar resources. Whether the PbR mechanism can be applied to a mental health domain is questionable. Owing to the complex nature of human condition and the often long-term nature of mental disorders, it would be naive to think that categorising mental health patients into discrete groups would be as simple as categorising patients with similar physical health problems.⁵ Consequently, any success of the PbR mechanism in the physical health domain does not necessarily mean that it is transferable to a mental health domain.

Are the positive effects of PbR smoke and mirrors? Evidence from non-psychiatric settings

Several countries operate mechanisms that attempt to match resources more directly to measured needs. This particular approach seems sensible for both commissioners and healthcare providers, as theoretically hospitals are prospectively reimbursed in accordance with diagnosis. Thus, any additional funding needed for a mismatch between diagnosis and service will result in financial loss for the hospital. Alternatively, any funds left unspent will result in profit for the service provider, offering incentive for careful management of funds.⁶ In addition, it has been reported that PbR may result in reductions in length of stay and shorter waiting lists for elective procedures.⁷ On the surface, PbR looks beneficial to commissioners, patients and possibly the service providers.

The seeming efficiency in terms of the management of finances, reduction in patient waiting times and shortened length of in-patient stay may not be all it seems. Reservations over taking such consequences at face value are held by the International Council of Nurses,⁸ who fear that such 'positive' effects may actually result in patients being discharged too soon ('quicker and sicker'), placing an extra burden on other support networks. It is possible that the PbR process in acute care does not offer monetary rewards for results as such, but rather it remunerates activity,¹ and activity that may not be necessary or in the patient's best interest.

'Gaming' in mental health services

Consistent and significant mismatches between clustering and ICD-10 diagnosis may be down to service providers 'cherry picking' cheaper cases and manipulating patient coding into higher tariffs.⁹ These fraudulent processes can be broken down further, illustrating how the system may be manipulated: 'cream skimming' or adverse election of lower-cost patients; 'skimping' or a reduction in quality of care; 'up-coding', which refers to the categorisation of patients into higher-income clusters than what is clinically necessary; and 'dumping', which is the selective, inappropriate referring of patients to other care settings.¹⁰ Such openness to fraudulent processes or 'gaming' is of interest to not only commissioners and service providers, but also auditors and researchers.

Informing funding through diagnosis: problems and international perspectives

The use of diagnosis to inform funding has been questioned in countries that have already rolled out similar schemes.¹¹ Mason & Goddard¹¹ reviewed the international literature on PbR in mental health along with an economic assessment of the approach in England. It is acknowledged that mental health treatment often extends far beyond the hospital sector and thus, by putting a limit on funding a care package, mental health patients' treatment may be cut short. There is evidence that individuals with mental health problems are more likely to experience physical ill health and are more likely to have greater non-clinical needs, such as educational, social and/or employment support.¹² The interface between in-patient and community care poses problems in predefining care pathways and currencies, as prognosis and course of treatment is highly variable, regardless of similar mental health diagnoses.

'Length of stay' has been found to be a major explanatory variable for cost variation between 'similar' patients, which would be particularly relevant for the NHS as a whole, if not for individual service providers, and a fair payment system must be able to compensate by being flexible enough to make appropriate adjustments for patients.¹¹ US health providers recognise such variation between mental health patients in both in-patient and outpatient settings and consequently operate a per diem system: there is recognition of the complexities of psychiatric problems coexisting in mental health patients and so funds are distributed on a day-to-day basis, taking into account average costs that are adjusted to account for diagnosis and comorbidity.

Alternatively, the Canadian methodology separates length of stay into three separate parts that are defined through resource intensity, allowing for an adjustment to payments for interrupted stays.¹ This is a vital consideration as, by comparison, the within-class homogeneity of the Australian and New Zealand mechanisms (the two systems that have the most resonance with the UK's) resulted in the systems never being rolled out to direct funding. However, they were never rolled out to direct funding, in the main because of within-class resource homogeneity. It is extremely difficult to classify resource consumption of different patients even though they may have similar diagnoses.

Both the American and Canadian methodologies account for outliers and facilitate flexibility around length of stay. The conversion of costs to price is not a simple exchange. The English methodology does acknowledge the need for review dates and results in some flexibility. Nevertheless, the date defines cluster episodes and costs, and so the malleability of care clusters may be somewhat limited when compared with its American and Canadian counterparts.

PbR in forensic mental health

The complexities of care for individuals who have mental health problems make PbR a difficult mechanism to employ with this population. It is noted that even though the rollout of PbR in mental health services has begun, it is still in its infancy. The acute hospital setting had a decade of development and refining. PbR in mental health services has yet to result in subsequent national tariffs and therefore block contracting still informs funding. Such complexities may be further extenuated when a forensic mental health population is considered.

Development of forensic clusters

The Mental Health Clustering Tool (MHCT)¹³ describes 21 clusters of mental health symptoms and treatment needs observed in general psychiatry. The tool is designed to assess and group individuals according to their clinical needs and resource consumption. It is a pivotal tool in PbR. It has been modified by a group of forensic practitioners to account for risk profiles and personality disorders, in an attempt to make it suitable for a forensic population.¹⁴ This modified version is called the forensic MHCT.

The modification of the MHCT leaves serious doubts about the suitability of the subsequent forensic MHCT. A multi-disciplinary team working in forensic services was convened and split into small groups. They then applied the MHCT to both fictitious and real patients in order to identify actual or possible issues when applying the MHCT to their forensic patients. To the best of our knowledge, there are no statistical underpinnings of the forensic clusters. Only the original clusters, devised through non-forensic samples, have any statistical underpinnings,¹⁵ and these do not allay concerns over the statistical foundations of the tool.

Forensic clusters and pathways: research so far

McCann & Green¹⁴ carried out pilot work to test the utility of the forensic MHCT and another ‘grouping’ instrument developed by forensic practitioners, the Five Forensic Pathways (5FP),¹⁴ which uses data from the HCR-20,¹⁶ HoNOS-Secure¹⁷ and patient’s offending history. Small sample size precluded sufficient statistical analysis, making it difficult to draw conclusions from the study.

Other considerations

Adaptability of PbR

It is not yet possible to see whether clustering routes lack specificity with regard to individual needs and resource consumption or whether such routes actually avoid creating complexities that could hinder the applicability of PbR to forensic mental health services. PbR guidelines recognise that patients’ needs change over time and that frequent re-assessment and clustering is needed to continually provide individuals with the appropriate care.¹⁸ The booklet states that ‘lessons are still being learnt’ about how well the PbR system reflects, and how well it accommodates, the dynamic needs of forensic mental health patients, highlighting the need for further research. If it is not known how the system adapts with changing patient needs then it cannot be used to define an individual’s care funding.

Patient outcomes and effects on funding requirements

Outcome measures are a further consideration in investigating the utility of PbR within forensic mental health. In England, the Department of Health is looking at outcome measures far more now than they did previously.¹⁹ In non-forensic settings, there is scope for outcome measurements in a set of quality indicators: clinician-related outcome measures (CROMs), patient-reported outcome measures and patient-reported experience measures.²⁰ How such outcome measurements transfer to a forensic setting has to be explored. Quality indicators in a forensic setting could include the percentage of patients with a forensic MHCT and 5FP score at admission and subsequent care pathway approach meetings. Similarly, CROMs could include HoNOS-Secure measurements.

However, such proxy measures undertaken when patients are contained cannot reliably inform on how a patient will behave or feel on release into society. Patients discharged from secure care are vulnerable to re-admission, re-offending and mortality,^{21,22} and therefore insight into how clusters and treatment pathways relate to patients' routes after discharge is imperative. A shorter length of stay, for instance, does not portray a positive outcome if the individual in question is subsequently re-admitted or re-convicted as a result of being discharged too soon. A patient's course after discharge should be considered as part of the clustering process, having a role in informing funding and not merely being used as an evaluative tool. Therefore, even though outcome measurements may be transferrable from non-forensic mental health to forensic settings, there are further considerations that should be undertaken due to the nature of the patient population.

Next steps

The utility of PbR within forensic mental health needs thorough examination. Currently, the only insight has been gained through small preliminary investigations conducted by proponents of PbR. The system has already been rolled out within acute hospital settings and the application of the process to non-forensic mental health is well underway. Even so, the Royal College of Psychiatrists released a statement at the beginning of 2014, expressing concerns over PbR.²³ More specifically, they highlight reservations over the statistical analyses underpinning the 21 clusters, the range (or lack) of complexity involved in the clustering process, whether the clusters allow for best evidence-based practice, the lack of outcome measures and consequent effect on costs of patient care and ultimately, concerns that the current system would risk severe destabilisation financially and organisationally.

The reservations over the implementation of the mechanism in general mental health generates concern as PbR in forensic mental health is in its comparative infancy. Indeed, the forensic MHCT clusters and the pathways in the 5FP have no statistical underpinnings.

To determine the utility of PbR in forensic mental health, the relationships between diagnoses, care needs assessments and outcomes post-discharge need to be explored. Economic assessments of the treatment costs throughout in-patient and post-discharge accommodation need to be undertaken. There needs to be a profile of economic outcomes for each care cluster if the PbR mechanism is to be rolled out within forensic mental health and ultimately define patient funding. There is a clear and urgent need for research focusing on how the forensic MHCT can be used (if at all) to best cluster patients and what complexities and difficulties exist in the clustering process.

1.8.68 Epidemiology on demand: population-based approaches to mental health service commissioning

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Abstract

One in three people will experience a mental health problem in their lifetime, but the causes and consequences of psychiatric morbidity are socially patterned. Epidemiological studies can provide aetiological clues about the causes of disorder, and when they can provide robust estimates about risk in different strata of the population these can also be used translationally, to provide commissioners and service planners with detailed information about local service need. This approach is illustrated using a newly developed population-level prediction tool for first-episode psychosis, PsyMaptic. Such public mental health prediction tools could be used to improve allocation of finite resources, by integrating evidence-based healthcare, public health and epidemiology together.

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- *Epidemiology on demand: population-based approaches to mental health service commissioning*
 - *Early intervention for psychosis*
 - *Towards integrated healthcare*
 - *Evidence-based EIP services*
 - *Population-level psychosis prediction*
 - *Conclusions*

One in three people will experience a psychiatric health disorder in their lifetime, according to recent estimates from a whole-population epidemiological study in Denmark.¹ Such burden is not shared ubiquitously across populations, but is highly patterned, be it by largely unknown, rare or non-specific genetic variants and abnormalities, observable phenotypes (age, gender, ethnicity) or environmental exposures (including, but not limited to, socioeconomic position, education, substance use, prenatal insults, childhood adversity, traumatic life events and neighbourhood social disadvantage). For example, the incidence of psychotic disorders is several times higher in some sociodemographic groups, such as certain migrant and ethnic minority groups,² most notably among Black Caribbean and African groups in England³ and Moroccan and Surinamese groups in The Netherlands,⁴ where excess rates are around 3–5 times greater than in the background population. Rates also vary in highly replicable ways by age and gender, with young men particularly at risk of psychotic disorder.⁵

While some of this patterning may be stochastic⁶ (genetic risk under non-assortative mating) or under biological control (risk by age or gender), the risk sets for, and consequences of, psychiatric disorders will also be shaped by socially patterned forces, which are disproportionately likely to affect poorer, more marginalised and vulnerable members of society, who are likely to shoulder the burden of our psychiatric morbidity. In terms of risk, this patterning may arise as a function of exposure to adverse environmental factors (independent or arising from gene-environment correlation),⁶ genetic risk due to assortative mating,⁷ epigenetic modifications⁸ or the role of cognitive impairment on risk of psychiatric disorder (which probably lies on the causal pathway between genes, environment and disorder).^{9,10} The consequences of psychiatric morbidity are also subject to strong social patterning, meaning some sections of society might be doubly disadvantaged.¹¹ For example, with respect to psychotic disorders, people may experience social decline or drift,¹² probably beginning premorbidly and usually sustained after the onset of first-episode psychosis (FEP), as a consequence of the onset of psychotic symptoms, especially negative symptoms,¹³ and cognitive impairment.¹⁴ This de-

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cline may continue or become exacerbated after onset of disorder as a result of additional issues, including side-effects from medication and stigma and discrimination experienced by people following psychosis onset. Social isolation,¹⁵ unemployment¹⁶ and drift into more disadvantaged communities¹⁷ are likely to be commonplace, in addition to the deleterious, and possibly synergistic,¹⁸ risk associated with these exposures.

Early intervention for psychosis

While we have yet to elucidate clear, specific aetiologies through which genetic and environmental factors operate to cause psychosis, epidemiological studies can provide reliable, accurate estimates about the risk of disorder in different communities, based on both incidence (risk) and prevalence (risk and consequences) of psychotic disorder.^{5,19} Such data should be a valuable resource for mental healthcare service commissioners, who must make difficult choices about the efficient and effective allocation of finite resources for mental and physical health disorders throughout the population. The visionary commissioning of early intervention in psychosis (EIP) services,²⁰ for example, was highly concomitant with a public mental-health-based approach for psychotic illness, based on available evidence. Thus, arising from evidence that a longer duration of untreated psychosis was associated with worsening functional, clinical and social outcomes,²¹⁻²³ EIP services sought to intervene early in the initial presentation of psychotic symptoms.^{24,25} This approach partly targeted improving the consequences of illness onset and was a universal public health measure, broadly aimed at the group for whom a first episode of psychosis was most common – people under 35 years old.⁵ Some EIP services also provided early detection of psychosis provision at the stage which precedes psychosis, termed clinical high risk state,²⁶ which focuses on preventing transition to a first episode of psychosis.^{27,28} This approach used both selective (young people with a family history of psychosis) and indicated (young people with early signs and symptoms of psychosis including a decline in functioning) prevention criteria to manage risk of disorder.

Accumulating evidence suggests that EIP services provide benefits across a plethora of individual, healthcare and societal outcomes.²⁹⁻³¹ They are seen favourably by young people experiencing psychotic symptoms,³² given the holistic service model that targets a range of domains, including mental and physical health, identity and well-being, family involvement and vocational support. They reduce the risk of compulsory treatment and suicide in young people with psychosis,^{33,34} and fewer people with psychosis in EIP services are unemployed than in standard mental health services,¹⁶ although this figure remains stubbornly high when compared with their population-based peers.³⁵ There is also a strong economic argument for EIP services. It is estimated that the NHS would save up to £44 million per year from fewer in-patient admissions if EIP were fully deployed,³⁶ and there is consistent evidence that EIP provides long-run, sustained economic incentives over standard care;³⁷⁻⁴⁰ there is evidence that every pound invested in EIP services results in £18 of downstream savings.³⁶ Psychotic disorders, more generally, also have pernicious effects on society. This can be measured acutely via lost economic productivity, with disorder onset typically coinciding with the age at which people have just completed their educational or vocational training and are about to enter the labour market.⁴¹ In the most severe cases, lost or reduced economic productivity may persist across the entire working age. The total societal cost of psychotic disorders in England has been estimated at £11.8 billion per year.³⁵ By keeping more people in employment and improving other social outcomes,²⁹ EIP services will provide long-term benefits to individuals, the economy and society over time.

Despite the strong rationale for such services, EIP have not been universally accepted or implemented.⁴² Services have faced a number of criticisms (see McGorry et al⁴³ for an introduction), some better supported than others, including a lack of sufficient evidence for individual benefit when care is not sustained,⁴⁴ cherry-picking of ‘easier’ cases,⁴⁵ inadequate flexibility of EIP service delivery in rural communities,⁴⁶ diversion of resources from standard mental healthcare services,⁴² case-loads being either below⁴⁷ or in excess of government targets,⁴⁸ and delays in treatment within mental health services in some regions threatening to jeopardise the very purpose of early intervention.^{34,49,50} This background of criticism has coincided with an increasingly difficult commissioning landscape⁵¹ where, despite ring-fenced NHS expenditure, real-term cuts to mental health services of 2% have been particularly keenly felt in EIP services, which have come to be viewed in some trusts as an unaffordable luxury.³⁴ A recent audit by the mental health charity Rethink found that 50% of EIP services have experienced healthcare cuts in the past year alone, with a parallel perception by staff that the quality of service has also been reduced.³⁴ Continued removal, reduction or restructuring of EIP services now threatens to undermine one of the National Health Service’s (NHS’s) exemplar models of integrated healthcare,⁵² at a time when other areas of healthcare delivery are moving towards such models.⁵³ Indeed, this perverse logic runs counter to National Institute for Health and Care Excellence (NICE) recommendations that EIP should be

provided for everyone in their first episode of psychosis, irrespective of age.⁵²

Towards integrated healthcare

Since the long-term clinical, social and economic benefits of EIP are most likely to be achieved when a full EIP package is implemented,⁵⁴ which includes providing physical health checks and supported employment opportunities, clinical commissioning groups (CCGs) should favour full-fidelity EIP models.^{52,55} This is undoubtedly challenging in stringent economic times, when commissioners must make difficult decisions about the allocation of a finite set of resources across the spectrum of healthcare services. While piecemeal implementation of EIP services may provide the illusion of integrated healthcare for young people with severe mental health problems, piecemeal solutions are only likely to deliver piecemeal results, leaving services as precariously positioned to deliver expected results as they currently find themselves.

The integrated healthcare model envisaged by the Department of Health has the potential to offer an alternative approach to difficult decisions about resource allocation across health and social services,⁵³ intractably founded on the fundamental principle of evidence-based decision-making. I suggest there are three aspects of the evidence base that need appraisal and integration to maximise the efficiency and effectiveness of resource allocation in an integrated healthcare model (*Fig. 1*). First, reliable and robust evidence about the epidemiological characteristics of any given disorder are required to understand whether and how risk varies between different members of the population, with a view to identifying those groups who are at greatest risk (empirical epidemiology). Second, services and treatments that have been shown to provide patient benefit in terms of prevention, reduced relapse or re-admission or improved quality of life and clinical and social prognosis must exist (evidence-based healthcare). Such care packages should also ideally have demonstrable cost-effectiveness over the medium- to long-term. Finally, a precise understanding of local population characteristics is required to understand how epidemiological risk translates into the public health impact of different disorders in different populations (evidence-based public health). An understanding of local needs is seen as central to the government's move towards integrated health,^{53,56} particularly as, with the exception of psychosis, less than a quarter of people experiencing mental health disorders are likely to be receiving any kind of treatment.⁵⁶⁻⁵⁸ This will only be achieved if the Department of Health, working alongside CCGs, can integrate these three strands of the evidence base to develop a detailed understanding of the multifaceted needs of local populations, and thereby allocate finite resources as efficiently as possible in response to dynamic local health issues.

Evidence-based EIP services

With respect to EIP services, an integrated evidence base has allowed us to develop, validate and refine an online planning tool for the prediction of FEP at the population level, based on local need. The prediction tool combines empirical estimates about the risk of developing psychotic illness by major sociodemographic and environmental factors,^{5,59} such as age, gender, ethnicity and population density, with information about the population structure of different local authorities in England and Wales. This gives rise to the expected number of new FEP cases that would occur in a given population each year, providing commissioners with guidance on likely resource needs for psychotic disorders. We have made predictions freely available for every local authority in England and Wales, broken down by age and gender, in an online repository known as PsyMaptic (Psychiatric Mapping Translated into Innovations for Care, www.psymaptic.org). The predictions from the tool have been validated in East Anglia⁶⁰ by comparing the predicted number of FEP cases with those empirically observed in a population at risk of nearly 1.4 million people over 2.5 years. We have recently published a revised version of this tool (version 1.1), which makes several important updates to improve its predictive accuracy (*Table 1*). Importantly, the new version simultaneously accounts for the effects of population density and socioeconomic deprivation,⁶¹ both of which are associated with the incidence of psychotic disorders, is validated over a longer period (3.5 years), and uses the latest population statistics for England and Wales, estimated from the 2011 census.

Model comparisons between PsyMaptic versions 0.5 and 1.1

	Version 0.5	Version 1.1
Models tested	7	36
Denominator source	2009 mid-year census estimates	2011 census
Observation period, years	2.5	3.5
Person-years at risk (16–35 years)	1397 305	2 021 663
Minimum level of geography	Local authority	Local authority
Best-fitting model covariates	Age group, gender, age* sex interaction, ethnicity, population density	Age group, gender, age* sex interaction, ethnicity, population density, extent of deprivation, quadratic for extent of deprivation
Observed FEP cases (ICD-10), <i>n</i>	522	676
Predicted FEP cases (ICD-10), <i>n</i> (95% CI)	508 (459, 559)	667 (610, 722)
Equivalentised RMSE (EIP level) ^a	19.0	16.3
Equivalentised RMSE (LAD level) ^a	7.8	6.4
EIP correct (<i>n</i> = 6) ^{b, n}	5	5
LAD correct (<i>n</i> = 21) ^{b, n}	19	19

FEP, first-episode psychosis; EIP, early intervention psychiatry; LAD, local authority district; RMSE, root mean squared error.

RMSE gives a measure of how closely each predicted value was to the observed value, either at LAD or EIP level. Lower scores indicate better model fit. Versions 0.5 and 1.1 used different denominators and direct comparisons between the original RMSE values for version 0.5 (published in Kirkbride *et al*⁶⁰) and version 1.1 were not possible, so equivalentised RMSE values for model 0.5 are presented based on the denominator used in model 1.1.

The number of times the observed value fell within the 95% CIs of the prediction at EIP level (out of 6) or LAD level (out of 21). Both models perform equivocally at LAD and EIP levels in terms of number correctly predicted. However, the lower overall RMSE scores for model 1.1 provide clear evidence of improved fit, favouring model 1.1.

Population-level psychosis prediction

Some of the aforementioned criticisms of EIP implementation (such as shortfalls or overestimates of expected case-loads) may have arisen as a direct result of the lack of tools to inform healthcare planners and commissioners about variation in need for services at the population level. Our tool overcomes part of this challenge by providing epidemiology ‘on demand’, centred on local population need and underpinned by a robust evidence base for FEP. It is important to recognise that PsyMaptic is only one of a suite of health informatics that commissioners will require to make effective decisions about the provision of local mental healthcare. For example, PsyMaptic predicts the expected incidence of ICD-10 clinically relevant FEP (F10–33), as confirmed by detailed OPCRIT review of case notes (<http://sgdp.iop.kcl.ac.uk/opcrit/>). It does not currently predict the additional resources required by EIP services to manage referrals who may present with underlying psychopathology, but require signposting to other, more appropriate services. Other data, such as the National Mental Health Minimum Dataset, which more accurately reveal all service use (not limited to those meeting clinical threshold for disorder), should be used in conjunction with such tools to inform commissioners about the probable additional burden of non-psychotic clinical psychopathology that EIP services may see, but were not originally provided for in the Policy Implementation Guide.²⁰ It should be apparent that this problem becomes greater the earlier one tries to intervene, since early prodromal symptoms may be transitory or have relatively low specificity to later psychotic disorder.⁶² The recent trend in some CCGs to re-organise services around a clinical staging approach, with EIP services superseded by generalised youth mental health services,⁶³ might be a service-side response to this phenomenon, but the non-specific (and perhaps non-clinical) nature of some early mental health symptoms will be a challenge for delivering effective, evidence-based youth mental healthcare, particularly where, for justifiable clinical and social reasons, services may delay formal diagnosis. We recommend that service commissioners use PsyMaptic as one part of a suite of evidence-based information available to them.

PsyMaptic provides proof-of-concept that empirical psychiatric epidemiology can be used to inform mental health service provision and public mental health. Predictions are prone to error, and we welcome observations from services where the tool performs well and where it does not, to enhance future versions. If similar forecasting could be applied to other mental or physical health disorders which have a robust empirical epidemiology, CCGs would have more complete information on which to make funding decisions across all health services in their locality, helping to drive the important demand for parity of esteem between physical and mental health.⁶⁴ Fortunately, a growing range of tools is becoming available for services, CCGs and the Department of Health to make evidence-based decisions. PsyMaptic is one of a number of health indicators being used by Public Health England. For example, community mental health profiles,⁶⁵ which detail the prevalence of various mental health disorders as well as risk factors and the wider determinants of health, are available for all local authorities in England. A further tool, by UCL Partners, is providing comprehensive mental health needs assessments,⁶⁶ drawing on a range of data sources and providing estimates of local economic savings from intervention, including those for FEP and clinical high-risk states.

Conclusions

Translational epidemiological tools have the potential to arm commissioners with evidence to allocate increasingly finite resources more efficiently across populations, centred on local need. The Health and Social Care Information Centre already publishes public mental health statistics which provide relatively comprehensive data for secondary mental healthcare. However, this information is not routinely combined with local estimates of variation in the incidence of different mental health disorders, using tools such as PsyMaptic (currently restricted to psychotic disorders). This synthesis would then allow for the potential size of the local unmet mental health need to be estimated, which can then be used to effectively inform local joint strategic needs assessments (JSNAs). This in turn informs commissioning and health and well-being board strategies. Therefore, routine inclusion of such information in JSNAs could have a very large role in reducing the size of mental health unmet need.

1.8.69 Psychiatric morbidity and socio-occupational dysfunction in residents of a drug rehabilitation centre: challenges of substance misuse management in a Bruneian context†

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date

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Abstract

Aims and method In 2011, a psychiatric clinic was started in Pusat Al-Islah, a drug rehabilitation centre. Our aim was to record self-reported socio-occupational dysfunction and patterns of drug misuse and to evaluate the usefulness of a psychiatric screening tool. A two-phased approach using the Self-Reporting Questionnaire (SRQ) and the Mini International Neuropsychiatric Interview (MINI) was used to examine the rates of psychiatric diagnoses.

Results Methamphetamine was the most commonly misused substance in 94.5% of residents. High levels of socio-occupational dysfunction were reported. In total, 5.5% met criteria for major depressive disorder, 4.8% for lifetime psychotic disorder and 11.5% for suicidal ideation. In addition, 13.3% reported previous untreated mental health problems.

Clinical implications A screening tool such as the SRQ can be used to identify those needing further psychiatric assessment. Interventions to address amphetamine misuse and associated socio-occupational dysfunction are required. Societal views and legislation influence the management of substance misuse problems in Brunei.

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Pusat Al-Islah is a residential drug rehabilitation centre run by the Narcotics Control Bureau (NCB) in Brunei, a small country in Southeast Asia. Residents are sent here after being convicted of drug use offences and testing positively for illegal substances. This is a prison diversion scheme that aims to rehabilitate drug misusers and reduce the rates of reoffending by offering a residential rehabilitation programme and post-release supervision. A small number are voluntary admissions. Treatment is based on a therapeutic community model and residents stay for up to 30 months. There is occupational training, Islamic religious lessons and counselling. A general practitioner and primary care nurse provide primary healthcare. In 2011, a psychiatric clinic was started. This was an opportunity to examine psychiatric morbidity among residents. The high prevalence of psychiatric morbidity in correctional and drug-misusing populations has been highlighted elsewhere, but there is no existing data for Brunei. This is a group who can be difficult to engage in treatment. Admission into the centre is an opportunity to screen for and treat any significant illness. Psychiatric morbidity is likely to have an impact on rehabilitation. Those individuals with mental disorders are more vulnerable to the adverse effects of imprisonment and are at higher risk of suicide.¹ They may have difficulty adhering to rehabilitation programmes.² We hypothesised that there would be a high level of psychiatric morbidity and socio-occupational dysfunction in this population. We also evaluated the usefulness of a psychiatric screening tool. Finally, we consider the challenges facing substance misuse management in the Bruneian context.

Method

This was a cross-sectional study. Ethical approval was obtained from the Research & Ethics Committee, Ministry of Health, Brunei Darussalam. Those who were residing in Pusat Al-Islah on 1 January 2012 or admitted by 31 March 2012 were approached to take part in phase 1 of the project after giving written informed consent. The interviews were conducted by three researchers, a consultant forensic psychiatrist (H.H.), a doctor training in psychiatry (A.M.A.), and a senior psychiatric nurse (R.O.).

Phase 1

All residents were interviewed using the Self-Reporting Questionnaire-24 (SRQ-24)³ between January and June 2012. This is a tool that has been shown to have good sensitivity and specificity for identifying psychiatric morbidity in primary healthcare settings.³ As Malay is the main language spoken in Brunei, we used a Malay language version that has been used to examine psychiatric morbidity in a Malay-speaking population.⁴ Questions 1–20 relate to neurotic symptoms and questions 21–24 to psychotic symptoms. Those who scored above a cut-off score of 6 and above for the first 20 questions and/or 1 and above for the last 4 questions, were entered into phase 2 of this study. This cut-off has been suggested to have the best ‘trade-off’ between sensitivity and specificity. Demographic details, educational and employment history, drug misuse history, psychiatric history, self-reported violence and offending history were also obtained. Data regarding socio-occupational function were obtained using an open questioning style. Any participant thought to require clinical assessment was referred to the psychiatric clinic.

Phase 2

Residents proceeding to phase 2 were interviewed using the Malay version of the Mini International Neuropsychiatric Interview (MINI, version 6.0).⁵ The MINI is a short semi-structured diagnostic interview for DSM-IV⁶ and ICD-10⁷ psychiatric disorders. It has been shown to have good validity and interrater reliability.⁵ The Malay version has been shown to have good reliability in diagnosing major depressive disorder and generalised anxiety disorder in a Malaysian community setting.⁸ The sections coding for the following groups of disorders were used: major depressive episode, suicidality, manic and hypomanic episodes, psychotic disorders and mood disorder with psychotic features, generalised anxiety disorder. The prevalence of these disorders was the main focus of the study as they are common treatable causes of psychiatric morbidity. All interview records were checked by the consultant forensic psychiatrist (H.H.) for accuracy.

Statistical analyses

Data were analysed using the Statistical Package for the Social Sciences, SPSS, version 16 for Windows.

Results

Demographics

In total, 195 residents were approached to take part and 165 residents (140 (84.8%) men and 25 (15.2%) women) consented and were interviewed for phase 1. Their mean age was 33.1 years (range 18–55, s.d. = 7.6). The mean length of stay before the interview was 14.8 months (range 1–33, s.d. = 9.7). A total of 155 (93.9%) were admitted under an order of the Courts or the Minister of Home Affairs; 10 (6.1%) were voluntary admissions. Of participants, 161 (97.6%) had been born in Brunei; 91 (55.2%) were married, 95 (57.6%) had children under the age of 18 years and 57 (34.5%) were unemployed at the time of admission. Well over half, 101 (61.2%) had not completed secondary school. All residents who declined consent were men.

Index offence

In total, 148 (89.7%) were admitted for a drug use offence alone, 16 (9.7%) were admitted for drug dealing in addition to a drug use offence. Data were missing for 1 (0.6%) resident.

Drug misuse history

The mean age of starting drug misuse was 19.8 years (range 9–46, s.d. = 7.1). The mean time period from starting drug use to the interview was 13.7 years (range 1–35, s.d. = 7.1). Methamphetamines were the most commonly misused substance. The drugs misused are described in *Table 1*. The majority of residents reported using drugs at least once a week and experienced some physical or psychological discomfort after a period of abstinence (*Table 2*).

Type of substance misuse ($n = 165$)

Substance misused	n (%)
Crystal methamphetamine	159 (96.4)
Main drug misused	152 (92.1)
Other amphetamine/stimulants	23 (13.9)
Cannabis	61 (37.0)
Cough medicine	52 (31.5)
Solvents	16 (9.7)
Opiates	8 (4.8)
'Pills'	64 (38.8)
Steroids	2 (1.2)
Intravenous drug misuse ^a	7 (4.2)
Alcohol problem ^b	102 (61.8)

All methamphetamines.

Residents who reported that they drank heavily or had an alcohol misuse problem.

Frequency of drug misuse, and symptoms after abstinence ($n = 165$)

	<i>n</i> (%)
Frequency of drug use	
Daily	72 (43.6)
At least twice a week	49 (29.7)
Once a week	16 (9.7)
1–3 times a month	24(14.5)
Less than once a month	3 (1.8)
Symptoms after abstinence	
Experienced physical (shaking, sweating, sleep disturbance) or psychological (irritability, craving, anxiety) discomfort	115 (69.7)

Psychiatric history

Of participants, 29 (17.6%) reported previous contact with psychiatric services, 9 (5.5%) residents were taking psychiatric medication (antidepressant, antipsychotic or mood stabiliser). In total, 13 (7.9%) had previous admissions for psychiatric treatment, 5 (3.0%) had received involuntary treatment under the Lunacy Act.⁹ Twenty-two participants (13.3%) reported experiencing mental health problems in the past, for which they had not sought treatment. There were 16 (9.7%) who reported experiencing previous suicidal ideation. In addition, 19 (11.5%) reported having a first- or second-degree relative with mental health problems. Psychiatric case-notes were found for 26 (15.8%) residents. When these were examined for recorded diagnoses, 13 (7.9%) had a psychotic illness (schizophrenia or acute psychotic episode), 9 (5.5%) had a depression, 1 (0.6%) had bipolar disorder, 2 (1.2%) had personality disorder and 1 (0.6%) had a child and adolescent mental disorder, unspecified. A total of 13 (7.9%) were recorded to have been non-adherent with treatment. Also, 9 (5.5%) participants had previous self-harm documented.

Forensic history

In total, 28 (17.0%) had previous admissions to Pusat Al-Islah; 61 (37.0%) had served at least one prison sentence; 20 (12.1%) had been convicted of an previous offence without a prison sentence, 39 (23.6%) had been remanded by the police but released without charge or conviction. Also, 41 (24.8%) reported performing previous physical violence such as assault.

Socio-occupational function

Of all the participants, 75 (45.5%) reported problems with their educational or work performance attributed to drug misuse. A total of 68 (41.2%) reported financial problems, 98 (59.4%) reported family relationship problems and 22 (23.2% of those with children <18 years old) reported having difficulty caring for their children adequately. Sixty participants (36.4%) reported offending behaviour related to their drug misuse. Also, 77 (46.7%) had a first-degree relative (parent, child or sibling) who misused drugs and 14 (8.5%) had a spouse or partner who misused drugs.

SRQ scores

The mean score for questions 1–20 was 3.6 (range 0–18, s.d. = 3.9) and for questions 21–24 was 0.25 (range 0–3, s.d. = 0.7). A total of 40 (24.2%) residents, 31 men and 9 women, met criteria for entry into phase 2. When means were compared using the independent *t*-test, no significant differences were found between the phase 1 and phase 2 groups for age (32.2 v. 33.4 years, $P = 0.386$), duration of drug misuse problem (13.75 v. 13.5 years, $P = 0.458$) and age of starting drug misuse (20.1 v. 18.9 years, $P = 0.357$).

Phase 2

Interviews occurred after phase 1 was completed, between August and October 2012. Of the 40 residents who were eligible for entry into phase 2, 10 residents had been discharged and were invited for interview, however, 7 discharged residents did not respond to the invitation for a second interview, 1 resident was not cooperative. Therefore, 32 participants (23 men (71.9%) and 9 women (28.1%)) were interviewed.

In total nine (5.5%) met criteria for major depressive disorder (two ‘current’, six ‘previous’ and one ‘current and previous’) of whom three (1.8%) met criteria for major depressive disorder with psychotic features (‘current’, ‘previous’ or ‘current and previous’). Three (1.8%) participants met criteria for previous manic episode, three (1.8%) met criteria for hypomanic episode (‘current’ or ‘previous’) and six (3.6%) met criteria for previous hypomanic symptoms. There were three (1.8%) participants who met criteria for bipolar I disorder (‘current’ or ‘previous’), three (1.8%) met criteria for bipolar II disorder (‘previous or current and previous’) and five (3.0%) met criteria for ‘uncategorised bipolar disorder’. Eight (4.8%) met criteria for lifetime psychotic disorder, of whom five (3.0%) met criteria for current psychotic disorder. There was one individual (0.6%) who met criteria for current generalised anxiety disorder. A total of 19 (11.5%) met criteria for suicidal ideation (15 at ‘low level’, 1 ‘medium level’ and 3 ‘high level’) (*Table 3*). Eight (4.8%) had more than one diagnosis.

Mini International Neuropsychiatric Interview (MINI) diagnosis	<i>n</i> (%)
Major depressive disorder	9 (5.5)
Major depressive disorder with psychotic features	3 (1.8)
Manic episode	3 (1.8)
Hypomanic episode	3 (1.8)
Hypomanic symptoms	6 (3.6)
Bipolar I disorder	3 (1.8)
Bipolar II disorder	3 (1.8)
Uncategorised bipolar disorder	5 (3.0)
Lifetime psychotic disorder	8 (4.8)
Current psychotic disorder	5 (3.0)
Current generalised anxiety disorder	1 (0.6)
Suicidal ideation	19 (11.5)
>1 diagnosis	8 (4.8)

Discussion

Screening and diagnostic tools

The SRQ is easy and quick to use. The interviewers found that questions 1–20, which asked about depressive and neurotic symptoms, were more easily understood than questions 21–24, which asked about psychotic symptoms. In particular, question 22 referring to grandiosity was often misunderstood. It was concluded that the first 20 questions would be a useful screening tool for depressive and neurotic disorders, whereas the psychosis questions should be amended. Of the 40 residents who entered phase 2, 24 (60%) were found to have a diagnosis and/or suicidal ideation when interviewed with the MINI. Thus, this method of identifying patients with psychiatric disturbance appeared to have produced a high 'yield'. The MINI, although straightforward to use as a diagnostic tool was time-consuming to

administer. We concluded that the SRQ could be used to screen residents on admission, and those scoring above the cut-off referred for further assessment.

Rates of mental disorders

Although the high prevalence of psychiatric morbidity in correctional populations has often been highlighted in Western countries,¹⁰⁻¹³ there is less data available in non-Western countries.¹⁴ High prevalence of mental disorders have been found in an Iranian prison population.¹⁵ Similarly, high rates of psychiatric morbidity were found in individuals who misused methamphetamine detained in Taiwan.¹⁶ This is the first investigation of psychiatric morbidity in a drug-misusing population in Brunei. Major depressive disorder was the most common diagnosis and was observed in 5.5% of the sample, similar to the Taiwanese finding. Lifetime psychotic disorder was found in 4.8% of residents, 3.0% of whom had a current psychotic disorder. Although we attempted to exclude psychotic symptoms directly associated with substance misuse, it is possible that some findings may have been methamphetamine psychosis rather than a primary psychotic disorder. Bipolar I disorder was observed in 1.8% of residents and bipolar II disorder was similarly observed in 1.8% of residents. The rates of psychotic¹⁷ and bipolar disorders¹⁸ appeared to be higher than in the general population, although no epidemiological data exist for the prevalence of mental disorders in Brunei.

Previous psychiatric disturbance and socio-occupational dysfunction

We found substantial rates of psychiatric morbidity. Our results also indicate substantial socio-occupational dysfunction, violence and offending behaviour. Given that these were self-reported, it is likely that they were underestimated. These findings emphasise the need for psychiatric, psychological, behavioural and socio-occupational interventions.

Pattern of drug misuse

Crystal methamphetamine is commonly available in Southeast Asia. It is locally known as 'syabu' and was the most common drug of misuse found in this sample. The first case of crystal methamphetamine misuse was reported to the NCB in 1993. Since then its use has spread across the country, affecting many lives and families. Drug supplies are manufactured abroad and transported across the border from neighbouring countries, often by land or water routes. Southeast Asia has a higher consumption of amphetamine-type substances compared with the global average. The neighbouring countries of Thailand, Malaysia, Cambodia and Indonesia have seized record high amounts of crystalline methamphetamine in the past few years. Annually, hundreds of illicit synthetic drug manufacturing facilities have been seized in the region over the same period.¹⁹ The availability of crystal methamphetamine is likely to contribute significantly to its popularity in Brunei. In contrast, the country has not had a widespread heroin misuse problem, avoiding the hazards associated with intravenous drug misuse. This pattern of drug misuse should inform national drug treatment and rehabilitation strategies. Substitute prescription such as methadone programmes used to treat heroin addiction more common elsewhere, cannot be usefully applied here.

We found that the rate of self-reported alcohol problems in this population was very high (61.8%). This may reflect the conservative Islamic view regarding alcohol use in Brunei, which may lower the threshold for viewing alcohol consumption as problematic and increase the likelihood of problems associated with its use.

Societal views of drug and alcohol use

Societal views regarding drug and alcohol use are generally very conservative. This is reflected in the heavy penalties imposed on those convicted of drug misuse, dealing and trafficking offences.²⁰ More than two-thirds of the population is Muslim and it is the official religion of the state. It is expected that alcohol should not be consumed at all by Muslims. The sale of alcohol is banned, and only non-Muslim adults are allowed to take controlled quantities into the country for personal use. Public drinking is not allowed. The phased introduction of the Syariah Penal Code,²¹ which began in April 2014, further increases the prospects of heavy punishment for those who contravene the strict laws relating to alcohol use. Under this new law, drinking alcohol is an offence for Muslims. Public drinking both in the country and abroad, providing alcohol to a Muslim and abetment of a Muslim to consume alcohol are listed as punishable offences for non-Muslims. Those convicted of alcohol offences may be fined, imprisoned and punished with whipping.

Treatment for alcohol and drug misuse

Many people are reluctant to admit their problems or seek help, although individuals can present themselves to psychiatric services. Pharmaceutical preparations such as disulfiram and naltrexone are available for the treatment of alcohol misuse. Structured community alcohol or drug misuse treatment programmes run either by medical services or the voluntary sector, are not available. There is limited open discussion about drug and alcohol misuse problems. The cause and impact of these problems locally and treatment and rehabilitation are areas that have received little research attention. Rehabilitation in Pusat Al-Islah, similar to other rehabilitation and training schemes in the country, places a strong emphasis on Islamic religious counselling. Psychological and behavioural treatment programmes require much development.

Our clinical experience working in psychiatric treatment facilities suggest that many individuals with substance misuse problems also have mental health problems requiring multidisciplinary care. The government provides largely hospital-based psychiatric services. Community, subspecialist and multidisciplinary services are limited although there have been some recent developments. New mental health legislation, in the form of the Mental Health Order 2014, has been approved. This legislation is designed to ensure the appropriate care of people with mental disorders and is scheduled to be implemented on 1 November 2014. The development of multisector partnerships is crucial to fully addressing the complex needs of this population.

Limitations

The two-phase design of this study may have reduced the accuracy of the results. Residents with a current diagnosis in phase 1 may have recovered before the phase 2 interview. However, the MINI allows for previous and lifetime diagnoses to be coded. The Malay translations of both tools may have limited validity in this population as the Malay dialect spoken in Brunei is slightly different to standard written Malay. The MINI interviewers were not masked to the diagnoses or treatment received by participants. This study depended on self-reporting of socio-occupational dysfunction as we were unable to obtain official reports. It is likely that the true prevalence of psychiatric disorders and socio-occupational dysfunction were higher given the limitations. The sample size in this study was small, with only 32 patients being finally assessed in phase 2. This may have affected the accuracy of our findings. We suggest that any future study should screen a larger sample of new residents on admission, with the diagnostic interview conducted as soon as individuals with mental disorders are identified. This would measure the incidence rates of mental disorders more accurately.

In conclusion, this is the first study to examine psychiatric morbidity, pattern of drug misuse and socio-occupational dysfunction in a Bruneian population of drug misusers. It highlights the treatment and intervention needs of this high-risk group and the challenges faced locally.

We thank the staff of Pusat Al-Islah and the NCB for their assistance. We thank David V. Sheehan and Christopher Gray of Medical Outcome Systems for their permission to use the MINI.

1.8.70 *Bulletin* comment: In praise of the psychiatric ward round†

date

2015-10

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- *Bulletin comment: In praise of the psychiatric ward round†*

Facing a room full of strangers when hallucinating, delusional or suicidal could clearly be seen as an ordeal. However, such a situation continues regularly during ward rounds in psychiatric hospitals the world over. Campaigners advocating for the rights of patients or service users have repeatedly called for the trial of the weekly review to be abolished. It causes anxiety and stress, with most attendees complaining of feeling as though they had not been listened to and that vital information had been withheld from them.

Considerations of the power and more subtle dynamics between patients and staff – specifically the more senior clinicians – during the ward round provide helpful insights as to how damaging such regular interactions might be. The only conclusion surely must be the immediate cessation of such an anachronistic institutionalised process. However, the psychiatric ward must have some positive or beneficial aspects not only for a multitude of multidisciplinary members who attend it but also for the distressed, sick patient who has to endure it. Ward rounds have been taking place for decades; had they been purely detrimental they surely would have been junked years ago.

The chance for medical students and trainee doctors to see a senior clinician interview a patient in a difficult and challenging environment is invaluable. Observing such an interaction may offer junior staff insights into both beneficial methods that work and harmful approaches that should never be repeated. The opportunity to see signs and symptoms of psychiatric disease is educational for all.

Eliciting such phenomena may be harmful to the patient and the degree to which the assessment results in a negative experience is as much to do with the skill of the interviewer as it is with the patient's pathology.

Seeing how an individual deals with and reacts to a challenging situation often provides valuable insights as to any underlying psychopathology. The ward round might lead the patient with more personality-based difficulties to exhibit a pathognomonic response that might not have been otherwise observed. The previously elated patient with bipolar disorder who is able to sit in the ward round without breaking into song or rhyme is obviously improving.

And finally, following in the footsteps of Foulkes it might be argued that the social interactions of the patient in the group setting are providing some therapeutic benefit, however small.

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1.8.71 Are psychiatrists only fools and horses to be open all hours?

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Abstract

The UK government's proposal for 24-hour healthcare means effectively asking doctors to work more unsociable hours for relatively little financial gain. In our opinion, psychiatry is particularly vulnerable to deterioration owing to negotiations of the terms of the current Consultant Contract that ensures fewer antisocial hours, whereas without parallel appropriate internal team and intra-agency working, provisions for which are not included in the government's proposals to extend care, patient care is vulnerable. Clarification and a narrower redefinition of what constitutes a psychiatric emergency is called for.

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- *Are psychiatrists only fools and horses to be open all hours?*

Psychiatry is no stranger to major shifts in the way it thinks or is delivered. The pre-pharmacological treatments of the 1950s shifted into the Brave New World of Largactil, and reacted with the therapy-rich and anti-establishment fad made famous by Laing and the railing against biological facets exemplified by Szasz. With its diversity of self-reflection, psychiatrists have a legacy to assist in changing practice.

Methods or modes of delivery of care have also been criticised. Deinstitutionalisation was followed by the crisis of care in the community, amid a spate of high-profile homicides. Risk management, best represented by the Confidential Enquiry into Suicides and Homicides¹ and at worst an ill-thought-out bureaucratic bungle, added to the administrative burden without clear evidence that the public and patients are now safer.

Recent assaults on the financial health of medical staff working in the National Health Service (NHS) have included 6 years of pay cuts and raids on future pensions. More general cuts in the organisation they work in have led to low morale and allegations that rather than this being viewed as a new paternalism, that somehow 'nanny [the State] knows best', it is a neglecting and neglectful state.² After several years of the 'Nicholson challenge',³ with further cuts in funding to mental health services, resources are at a dangerously low level⁴ and the Cinderella of the NHS faces unprecedented challenges, singled out for selective cuts with resources not following morbidity.

In this environment, the government is proposing a '24/7 service'. On the face of it, running a psychiatric service is a 24-h activity anyway. In-patients require constant access to appropriate medical and nursing help; relapses and remissions of community patients do not always coincide with their care coordinator's availability. So it seems self-evident that psychiatric services run 24 hours a day, 365 days a year. To many it seems that a disingenuous impression is being created that consultants do not provide a 24-h service when in fact they do so across specialties in the NHS.⁵

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The government appears to have used this sleight to demand that there be contractual changes to remove any obligation to pay consultants an appropriate premium for out-of-hours work.

However, if the government's drive is for the same level of service all the time, that is a separate matter. Examples of this would include routine out-patient clinics on a Sunday afternoon and late evening consultant-led ward rounds. Nearly all disciplines, especially psychiatry, deliver care in a team manner, so without expansion of numbers across professions, how are the same levels of interactivity to be maintained outside Monday to Friday, 9-to-5 opening hours? If Donne's metaphor is apt, psychiatry is not an island, so where will children and families' Social Services be, and the police, occupational therapy, clinical psychology and investigative services, when required? Although the government has acknowledged this problem,⁶ it is evident that an initiative from the Department of Health will not be prioritised in the same way by other departments.

The financial and human resource implications appear to be largely not considered. Although there is evidence of better outcomes for patients seen during the week in non-psychiatric specialties, there is no clear costing of the changes required to raise weekend services to the same level as those provided during the week. Many NHS staff have premium rates for unsocial hours: fewer staff will be spread more thinly across weekends and evenings, so without additional recruitment, daytime services will shrink and likely worsen outcomes Monday to Friday. Whereas there are theoretical savings in physical medicine with extended use of surgical theatres or radiological facilities, such potential is not so easy to find in mental health services. For those drawn to community work in particular, reducing family time, a reason many choose the specialty in the first place, will affect recruitment and retention. Surveys of consultants show that the average time spent on NHS activity is already well in excess of contractual requirements, at 5.8 hours extra unpaid labour a week,⁷ thereby further increasing the challenge of doing more with less.

We are aware that that several NHS trusts are attempting to alter Standard Operating Procedure to specify what consultants will do while on call, including mandating non-emergency tasks out-of-hours. Consultants, in particular, have the reasonable expectation that on-call work will be for tasks that require their level of experience and skill, rather than for bureaucratic reasons.

The 2003 Consultant Contract⁸ contains an important provision at Schedule 3, Paragraph 6: "Non-emergency work after 7 pm and before 7 am during weekdays or at weekends will only be scheduled by mutual agreement between the consultant and his or her clinical manager. Consultants will have the right to refuse non-emergency work at such times. Should they do so there will be no detriment in relation to pay progression or any other matter." To the government, this is a major impediment to an imposition of 24/7 working in the absence of agreement. To negotiators, it is an important safeguard against excessive and antisocial hours with the compromise of patient safety. For either side, its meaning could become totemic.

There may be much discussion over what an emergency is. We suggest a framework where the most important categories are akin to those used in time management:⁹ emergencyurgentimportantnot urgent not important.

Emergency is defined as 'a serious, unexpected, and often dangerous situation requiring immediate action'. So, a non-emergency is anything that is not an 'emergency'. An urgent problem may later become an emergency, but that is a separate issue.

The Cassandras among us may worry about litigation where an action is delayed. However, it is the commissioned service's responsibility to ensure that there are appropriate care arrangements in place, not the individual consultant's. Of course, the General Medical Council provides help on this matter when stating that: "If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy."^{10:para.25} Many will agree that acute suicidal ideation, an acute dystonic reaction and attempted self-harm are all emergencies. Likewise, while administrative procedures that allow leave while detained, or medication to be administered lawfully, are very important, they are not 'emergency' situations. Military training includes the mantra that 'A failure to plan on your part does not constitute an emergency on mine', something we would do well to remember.

So where do practitioners sit on the urgent category? There will be some that lie outside our comfort zone, for humanitarian or other reasons, such as advice to a trainee about medication for psychotic phenomena where few would not readily offer advice even when not deemed an emergency. However, where is the boundary with the Human Rights Act? Many NHS trusts have a seclusion review policy where after 24 h in seclusion a review in person by a consultant

must occur. Now this may be good practice according to the Mental Health Act Code of Practice, but an infringement of best practice is not an emergency.

It may well be that the solutions of other countries may help. Greenland, part of the Kingdom of Denmark, runs practically all of its psychiatric services over videoconferencing facilities.¹¹ In Los Angeles, time constraints and skills shortages have led to a parallel approach (R. Mendoza, personal communication, 2015). The British ‘special hospitals’ have used the same technology to reduce loss of clinical time to travel to disparate sites or courts.

The discussion about what is an emergency should rage, and it should rage hard. It is a point around which consensus would allow us to protect that which we cherish – a service delivered in a considered and coordinated manner, where there is a fair exchange of time and labour for salary and security. In a politically driven, evidence-poor initiative, psychiatrists should stand firm on whether the proposed changes hold merit. If they do, at what cost should we accept them?

1.8.72 Mindfulness for Health: A Practical Guide to Relieving Pain, Reducing Stress and Restoring Wellbeing

Thomas A. Ernst¹

date

2015-12

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- *Mindfulness for Health: A Practical Guide to Relieving Pain, Reducing Stress and Restoring Wellbeing*

This book leads the reader through a journey of how to deal with suffering from bodily symptoms-related illness and injury. It clearly describes the differences between primary suffering due to injury and secondary suffering largely created within the mind through learnt views, behaviours and fears the person has experienced in their life or through their illness. It then gently describes how, by engaging with the secondary suffering, much of the suffering can be relieved or brought down to the primary pain and suffering which is generally easier to manage within traditional medicine. The book also points out that traditional medical models of pain often miss secondary suffering, whereas traditional therapies often fail to address secondary suffering or can even make it worse. It is to the great credit of authors that they deal with this sensitive issue with compassion and empathy.

The book then turns into a step-by-step practical guide on how to approach secondary pain and suffering. The guide is complete with audio recordings of practices that the reader can easily follow and this will not require excessive time. Real-life experiences of people who were helped by following this guide are included.

The problem of dealing with pain and suffering is as old as humanity and the readers would have come across many hopes and promises made by medicine, alternative medicine and the spiritual sector among others. This book outlines not only anecdotal evidence in the form of testimonies from people engaging in mindfulness but also benefits from a wealth of research which it refers to.

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As a doctor having used mindfulness successfully to manage my own pain and suffering from illness, I found reading this book was somewhat challenging, as it would be to many other readers. However, I have not yet read a book on mindfulness so sensitive and gentle with the issue of pain and suffering as this one.

1.8.73 Should psychiatrists ‘Google’ their patients?

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Abstract

Since its beginnings in the 1980s the internet has come to shape our everyday lives, but doctors still seem rather afraid of it. This anxiety may be explained by the fact that researchers and regulatory bodies focus less on the way that the internet can be used to enhance clinical work and more on the potential and perceived risks that this technology poses in terms of boundary violations and accidental breaches of confidentiality. Some aspects of the internet’s impact on medicine have been better researched than others, for example, whether email communication, social media and teleconferencing psychotherapy could be used to improve the delivery of care. However, few authors have considered the specific issue of searching online for information about patients and much of the guidance published by regulatory organisations eludes this issue. In this article we provide clinical examples where the question ‘should I Google the patient?’ may arise and present questions for future research.

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 - *Uncovering dangerous lifestyle choices*
 - *Mistaken identity*
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Background

The internet is a part of everyday life and access to it is growing at a startling rate. According to the United Nations' specialised agency for information and communication technologies (the International Telecommunication Union), by the end of 2014, 3 billion people, approximately 43% of the world's population, will have access to the internet, compared with 60 million people in 2000. The number of mobile-broadband subscriptions will reach 2.3 billion globally by the end of 2014, almost five times as many as in 2008.¹ Social media has also weaved its way into people's lives over the past decade. There were 802 million daily active users and 1.28 billion monthly active users of the social media site Facebook in March 2014, and over 80% of the daily users of Facebook are based outside the USA and Canada.² According to the Office for National Statistics, the UK has one of the highest rates of social media use in Europe, with almost half of all adults (48%) using social networking sites such as Facebook and Twitter.³

Some aspects of the internet's impact on medicine have been better investigated than others. Various authors have looked at whether email could be used as an acceptable form of communication between doctor and patient.^{4,5} Psychiatrists have also looked into the possibility of using video conferencing for psychotherapy.⁶ The use (and misuse) of social media by doctors, in terms of professionalism and boundary violations, has been studied.^{7,8} This has led to a plethora of professional regulatory bodies and other medical organisations publishing guidelines to help doctors navigate the internet in general and social media in particular.⁹⁻¹³ The published guidance is reasonably thorough: guidelines concentrate on the advice given to professionals about their use of social media sites, and their profile on them. Professionals are advised against forming friendships with patients online. However, professional bodies are often behind the curve in doing this. For example, the UK's General Medical Council guidelines were first published on the 25 March 2013,⁹ a full 9 years after Facebook was founded.¹⁴

The issue of searching online for patient information has caught the imagination of doctors and ethicists writing in the blogosphere.¹⁵⁻¹⁷ Many raise concerns about the potential ethical 'slippery slope' of Googling your patient, but raise examples where it may be justifiable. However, there has been little discussion in formal medical ethics and law literature about this issue. There is also a paucity of official guidance to help doctors navigate their way through this particular online minefield. For example, the British Medical Association's guidance on social media does not refer to this issue at all and the Royal College of Psychiatrists in the UK has not yet issued any guidance in relation to this kind of online activity. Where professional guidance does touch upon the issue of 'online searching' it focuses on the problems that can arise when patients 'Google' their doctors rather than the other way around. We are not aware of any legal cases in this particular area either. In sum, there is an apparent regulatory lacuna in terms of whether and if so, how, doctors should use the internet to dig around in their patients' digital backyards.

The lack of research and guidance in this area is increasingly problematic because a great deal of information about patients is now available at the click of a search box button. Many of us are documenting our lives online far more than might have ever been expected 20 years ago and doctors and patients can now find out a huge amount about each other online with relatively little effort.¹⁸ In addition many patients post personal information online that could potentially harm them or have an impact on clinical assessments by their healthcare professionals and a growing number of doctors admit to using the internet to search for general clinical information.¹⁹

Clinton *et al* provide the only comprehensive review of the literature on the ethical difficulties surrounding searching online for information about patients, something they term 'patient-targeted Googling' (PTG).²⁰ They provide a list of questions for psychiatrists to consider before deciding whether to use PTG, shown in Box 1.²⁰ They argue that PTG can be an acceptable clinical tool but warn against 'unbridled PTG simply because online information is legally available in

the public domain'. They describe possible conflicts, such as using 'Google Earth' to look at photographs of a patient's large house, when the person has not paid for psychotherapy (the authors are based in the USA), and compare this with driving past the patient's house, which would be considered by many to be a boundary violation.²⁰ This raises questions about whether such media reconstitute the meaning of boundary violation: is looking at 'Google Earth' as intrusive as going to look at someone's house in person? The internet, whether we like it or not, has caused pre-existing boundaries to blur.

In this paper we will look at the potential benefits and harms related to internet searching being used as a clinical investigative tool and propose some questions for future research. In this article we use the word 'Google' as a verb intentionally, as it has become part of our everyday English language, meaning 'to use an internet search engine to find information'.

Checking conflicting and falsified information

Internet searching for information about patients may mean finding things you did not expect, that the patient had not shared or had even lied about. Should we use the internet to investigate factitious disorder or malingering?

Volpe *et al* discuss a case involving a 26-year-old patient who had requested a prophylactic bilateral mastectomy with reconstruction because of an extensive family history of cancer, where there was suspicion among the clinical team that some of the history was fabricated.²¹ In the paper Volpe, Blackall and Green argue that 'uninvited patient Googling' is bad practice for three reasons. First, it bypasses the personal relationship and makes it too easy to terminate a relationship with a patient, and to avoid discussion of personal topics. Second, it erodes provider-patient trust. Third, it represents an invasion of privacy. They also make the point that it is unclear why a healthcare professional would not just ask the individual in person if they had any concerns about them. In the same paper, George, Baker and Kaufmann argue for the opposite position.²¹ They note that it would be 'irresponsible not to exhaust all resources in learning about a patient with such troubling red flags'. They argue that the finding of a factitious disorder via the patient's two Facebook pages 'saved a team of professionals from aiding and abetting a fraudulent, deceptive and self-injurious scheme', stopping them from breaking their oath to first 'do no harm'.²¹

Clinton *et al* ask how the discovery of important information found online would then be broached with the patient and how this information should be documented in the medical notes.²⁰ Interestingly, no author we could find in a literature search had considered whether an online search could be performed with the patient's informed consent and, perhaps, in the patient's presence. In the Volpe *et al* case, for example, the surgical and genetics teams used an internet search in what they believed to be the patient's best interests, without telling her beforehand. What is also not explained is how the patient was told she would not be having surgery and what reasons the patient was given for this decision.

Uncovering dangerous lifestyle choices

Doctors could Google their patients in order to investigate concordance with advice about treatment and lifestyle changes, including advice about not driving or misusing various drugs. Psychiatrists, in particular, might be interested in discovering whether a patient with psychosis is drinking alcohol heavily or using other substances, which might cause or exacerbate psychotic symptoms.

Farnan *et al*'s main concern is that 'digitally tracking the personal behaviours of patients, such as determining whether they have indeed quit smoking or are maintaining a healthy diet, may threaten the trust needed for a strong patient-physician relationship'.²² The violation of trust might occur because patients assume that doctors do not perform such searches (i.e. the violation relates to a real, or perceived, deceit) or because they feel that such activity violates important boundaries. Gabbard *et al* note that the boundary violation may be the nub of the problem.²³ It is hard to imagine how the doctors in the Volpe *et al* case, described above, approached their patient with the information found on her Facebook accounts. If the information was related to her – as it presumably was – it is hard to see how this could have led to a positive, therapeutic, outcome. Indeed, the patient may well have felt betrayed by the team caring for her.

Of course, if a doctor can find out about such things as alcohol and drug misuse by searching in the 'online public domain', the same holds true for other people. Accessing information on an internet search engine or social media site would be much easier for a patient's future employer than accessing a person's medical records without their

consent. In an era of recovery-oriented medicine, including supporting people to return to work, perhaps we should be proactively and openly discussing online presence, for example as part of the employment support provided by a community psychiatry team?

Mistaken identity

Another problem may arise from the fact that many people have the same names. How do we know information found on Google about a patient is actually about them? If you Google one of our names (G.A.L.), an online namesake is a character from the film ‘The Devil’s Advocate’, in fact ‘Alice Lomax’ in the film is Satan’s child’s mother. We doubt anyone is actually confused by this, but clearly less obvious confusions might happen, and the simple answer is that identities online cannot be absolutely confirmed. Furthermore an individual may use pseudonyms, or internet information might obviously be wrong, as anyone can post anything.

If, however, we had asked for informed consent from the patient to do the search in the first place, especially if they were present during the search, the potential for confusion could be reduced because they could identify any obvious errors with ease. The patient could also more openly discuss with their doctor any negative – and potentially defamatory – comments posted about them online by other people and it would also help doctors identify situations where the patient was the victim of ‘cyber-bullying’.

Delusions of grandeur or reality?

An internet search can act as a form of collateral history. For example consider a man who presents with an exuberant, energetic persona, speaks rather quickly and loudly, and then tells his doctor he knows some Royals and has written a famous book or been in a film. Googling his name might immediately clarify whether these were grandiose delusions and this information might also make a difference in determining whether or not the patient is diagnosed with mania in the context of bipolar disorder.

Clearly the difficulty with this is that something being online does not mean it is true. It is possible to ‘be who you want to be’ online; to invent an ideal persona or avatar is almost as simple as revealing information about yourself that ‘you did not want to be made public’. However, we suspect that many clinical psychiatrists have used Google for this purpose before, as often multiple references, or references on trusted sites, can give reassurance that what someone is saying is true. There is a clear negative side to this however. Patients in psychiatry may be particularly vulnerable to not being ‘believed’ and routine Googling to check what the person has said might reinforce this tendency and stigma.

Mental health monitoring using social media

Consider a long-term patient with severe depression, who has regular appointments with a community psychiatry team. Could someone from the mental health team monitor the patient’s mental state via their social media feed or blog, with their consent? Assuming people write honestly and use the same websites regularly, social media can give a unique, time-relevant insight into a person’s mental state. For example a Facebook ‘status’ or a ‘tweet’ on Twitter might often include information about how a person is feeling. The posting of certain pictures and videos or even ‘emoticons’ (cartoon faces depicting different emotions) might also reveal important insights into the patient’s current frame of mind.

Clearly, if psychiatrists were to monitor mental state in this way, it would fundamentally change how mental health systems work, but it is not as far fetched as it sounds. It would not necessarily involve a person constantly watching the millions of messages streaming via a forum, Facebook or Twitter feed, which would clearly be impossible. The technology to automatically flag the use of certain phrases in emails or on social media already exists, and a team at Dartmouth University in the USA, involving computer scientists and psychiatrists are developing this technology to help prevent suicide, as part of *The Durkheim Project*.²⁴

Familiarity with the internet does depend on age. Marc Prensky describes ‘digital natives’ as compared with ‘digital immigrants’, born before the ‘rapid dissemination of digital technology in the last decades of the 20th Century’.²⁵ He, fairly terrifyingly asserts that today’s average university graduate has ‘spent less than 5,000 hours of their lives reading,

but over 10,000 hours playing video games [and] 20,000 hours watching TV' and that 'as a result of this ubiquitous environment and the sheer volume of their interaction with it ... think and process information fundamentally differently from their predecessors'. There is evidence that young people who self-harm find it easier to express their feelings honestly and openly in an online forum than during a face-to-face consultation and would prefer this.²⁶

This suggests to us that we should be open to different methods of communication with different age groups, as not doing so means we may miss vital information. In the mastectomy case described above, George, in the paper with Volpe and colleagues, goes further, and suggests we should use all the resources we have where there are 'red flags', and that not using an internet search would be negligent in some cases.²¹ This tracking would, potentially, allow interventions to be made, for example to intervene urgently if a patient was suicidal. Clearly the difficulty with this is that doctors cannot check the online 'statuses' of all their patients all the time, and it would be difficult to gauge where responsibilities would stop and what the standard duty of care amount to in such cases. In addition, tracking a patient's blog, or social media feed might actually, quite rightly, increase a sense of paranoia.

Safeguarding vulnerable adults online

Given that anyone and everyone can read what is openly online, an online search can sometimes protect vulnerable adults from abuse from others. Cyber-bullying, for example, involves threatening or derogatory messages posted on social media sites or online chat forums. It might also include things like encouragement to lose weight in anorexia nervosa or messages inciting self-harm or violence. Discussing this issue openly with patients and carers, in the same way that psychiatrists would openly discuss other risk issues, seems sensible. Also imagine a young man with paranoid schizophrenia who is in hospital, very unwell with psychosis, and finds it frustrating that no one 'believes' what he is experiencing. He tells his psychiatrist to look at his blog online, in order to fully understand what he means. The team agree that with informed consent it is acceptable to do this search and they proceed with the online search. In the process they find that the blog, which has almost daily entries, gives good information about when the patient started to become unwell since there is marked evidence that his thought disorder and delusional beliefs increased in severity over the course of the past few weeks. However, the team also see that in one blog post, the patient has included sensitive personal information about himself, including his home address. They discuss this with him, and how vulnerable this might potentially make him, and arrangements are made for the blog post to be taken down.

In this situation the patient has given permission for the online search and has, in fact, asked the team to specifically read his online blog. In such cases searching online for information seems reasonable. However, this kind of scenario raises deeper ethical questions about whether mental health professionals should be proactively discussing online presence with patients, not just to find out information about deteriorating mental state, or to help holistically with recovery, but also to safeguard vulnerable individuals and potentially assess risk to others, for example by discovering threats made online in the context of illness.

Only Googling when there is no other option

Searching for information about a patient online should also clearly be done on a 'need to know' basis and not purely out of curiosity or voyeurism. Imagine a core trainee being called to a forensic psychiatry in-patient unit on-call, which they do not usually work on, to examine a patient who might have a chest infection. We would not expect this doctor to search online to find out what crime was committed by the patient because this information has no bearing on the patient's physical problem and will not help the doctor to provide whatever treatment the patient may need. In fact, the internet search might even have an impact on the ability of the doctor to treat the patient in an impartial and non-judgemental manner, especially if the crime was especially heinous.

Of course, doctors have the right to protect themselves from harm and the need to perform a risk assessment may mean that the doctor would need to know about any danger posed by the patient. However, there would be no indication for an internet search in this case as other members of the team would know the patient's history well and would be able to inform the doctor if the patient was dangerous. The doctor could also, of course, consult the patient's notes if no other team members were available to consult.

To consent or not to consent?

Would it be better practice to routinely ask consent and is informed consent possible for a Google search in psychiatry? The key elements of consent for an intervention in medicine usually include patient competence, the health professional giving clear information about potential benefits and risks and voluntariness. Many psychiatric patients fulfil all of these requirements and could, thus, consent to an online search. However, some of the patients in whom an online search may be a useful ‘investigation’ may not have the mental capacity to consent.

Likewise, patients on a psychiatry ward or in clinic may feel coerced into allowing an internet search, feeling that a ‘no’ will mean doctors will get suspicious or carry out a more ‘invasive’ online search without their consent. It is also worth pointing out that some patients might want to delete a few posts and images before the search is carried out because they deem some information to be ‘embarrassing’ (for example a photograph of them when they were an ‘awkward’ teenager). This does not seem unreasonable but it might be difficult if the doctor wants to conduct the search immediately. We are also concerned about the discussion about risks and benefits: if we do not know exactly what we will look for or find, is discussing the relative merits of a search possible? It is unusual for a doctor to discuss every possible finding of a magnetic resonance imaging scan or blood test with a patient before carrying it out, but of course the standard expected would be that relevant information is shared.

Informing patients would neuter the problem associated with deceit, however, it would not deal with the problem of potential boundary violations and it would not solve the potential for coercion either. The only way around these problems would be to seek consent from every single patient and make it clear that any refusal would be honoured. In other words, perhaps we should seek consent to search online for information about patients just like we ask for consent to speak to a relative or friend to discuss a patient’s condition? If we were to do this openly, perhaps the risk that patients might become upset or angry about the process might be reduced and, as Chretien & Kind note, this would help to limit foreseen harms.²⁷ There may be situations where risk to the patient, or to others, means that a Google search is appropriate without the patient’s consent.

Mental health specific concerns

Some of the ethical issues raised may be more pertinent to psychiatry than to other branches of medicine. Many patients will have experienced the validity of what they are saying being doubted by their doctors. If psychiatrists embrace PTG it could be seen as another paternalistic intervention. The capacity of patients in psychiatry will by the nature of their conditions be more likely to be impaired than in other branches of medicine. They may well lack capacity to understand the consequences of what they post on Facebook if, for example, manic and may cause damage to work and social relationships as a result. This raises difficult questions for concerned family and professionals about looking at posts on the internet, and even trying to get posted information removed.

Conclusions and proposals for future research

Many questions remain unanswered about the acceptability of Googling patients, especially those with mental ill-health, from an ethical and legal point of view. There is clearly an urgent need for this topic to be addressed in the ethics and medical law literature.

Should psychiatrists Google patients at all? Should they do it routinely, for all their patients? Should they ask for consent each and every time? Should they share the information with the patient? These kinds of questions urgently need to be addressed by ethicists and psychiatrists alike. We feel that when making a decision to Google a patient, it would be appropriate to work through a list of questions and reflect on how one would respond, the most important question being ‘why am I doing this internet search, and is it likely to help my patient?’

Further analysis of the legality of conducting Google searches is also needed. Given that the kind of online searches we are talking about here would only involve looking for information that is already in the public domain it is not clear that this activity could be considered unlawful. However, the lack of case law in this area makes the legality of the activity harder to judge.

We feel that clear guidelines are needed from the bodies that regulate health professionals on the use of internet searching, and where these newly emerging doctor-patient boundaries lie, especially within psychiatry. We propose that more empirical research is needed on this topic. For example, we would like to know how widespread the practice of PTG is among health professionals, and whether this varies depending on age, experience or professional group. Much more qualitative information is needed about the views of patients, their friends and families, and healthcare professionals about this kind of activity: the problems it might cause and potential benefits.

Failing to make use of modern technology when this technology can improve patient care is not an option. Failing to discuss the merits and demerits of using online searchers in an open and honest fashion is not really an option either. The reality is that the internet has become an integral part of our daily lives and medicine as a whole, and psychiatry in particular, need to get to grips with what this means for modern medical practice.

1.8.74 Bipolar Disorder

Lena Jawad¹

date

2015-12

Contents

- *Bipolar Disorder*

Bipolar Disorder is a pocket-sized book whose target audience is any member of the multidisciplinary team involved in looking after a patient with bipolar disorder.

It begins with an interesting glimpse into the history of bipolar disorder and how the illness was documented in biblical texts as early as 1000 bc. Its key themes include the diagnosis of bipolar disorder, epidemiology, comorbidities, neurophysiology, genetics, psychopharmacological and non-psychopharmacological management, and managing 'special' populations with bipolar disorder (e.g. children, pregnant women).

The text is easy to read and key points are excellently summarised in boxes throughout. The book fulfils its aims (stated in the blurb) to a very high standard, covering all important areas of bipolar disorder in a way that is succinct and aids retention of knowledge. Although not fully comprehensive, it helpfully lists references after each chapter to guide the reader to further reading around the topic.

One of the main strengths of the book is its effective presentation of information, using a combination of prose, bullet points and diagrams to cater to the needs of a variety of learners. The chapter entitled 'A programmatic approach to treatment' takes readers through a thorough management plan, making the whole process more holistic – this is something I will most certainly take from the book and apply to the management of all my patients, regardless of their illness.

The only limitation is, perhaps inevitably, its emphasis on US Food and Drug Administration-approved medications in its pharmacological management chapter, which may not be as relevant to psychiatrists practising in countries other

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than the USA. The book, however, does its best to incorporate global knowledge of bipolar illness, with references to a variety of countries.

I would wholeheartedly recommend this guide to anyone interested in learning more about bipolar disorder or who simply requires a revision of the key topics surrounding the illness.

1.8.75 The application of mental health legislation in younger children

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Abstract

We review a case history of a young child who was admitted to an in-patient mental health unit due to extremely challenging behaviour and review the legal issues that had to be considered in ensuring that there was appropriate legal authority for the child's admission and treatment. In this particular case, the patient was detained for assessment under section 2 of the Mental Health Act 1983. This case demonstrates that all clinicians working in this area require a good understanding of the law in relation to treatment of children with mental disorder, which is extremely complex.

Contents

- *The application of mental health legislation in younger children*
 - *Competence, parental responsibility and zone of parental control*
 - * *The zone of parental control and deprivation of liberty*
 - *Case study*
 - *Discussion*

Competence, parental responsibility and zone of parental control

Much of the debate around consent to treatment by young children has focused on competence. 'A child who has attained sufficient understanding and intelligence to be able to understand fully what is involved in the proposed intervention will be regarded as competent to consent'.¹ This concept is known as Gillick competence.²

However, especially for younger children, persons with parental responsibility are, in general, responsible for treatment decisions. Parental responsibility is defined by the Children Act 1989 as 'all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property'. The Code of Practice for the Mental Health Act:^{sup: [2]_`} advises that the person responsible for the care and treatment of the patient must determine whether a person with parental responsibility has the capacity, within the meaning of the Mental Capacity Act 2005, to make a decision about the child or young person's treatment and whether the decision is within the 'zone of parental control'.³ The 'zone of parental control' is a concept derived largely from European Court of Human Rights case law and has become central to parent-related decision-making.^{3,4}

¹ Victoria Thomas is a specialty doctor, Barry Chipchase, Lisa Rippon and Paul McArdle are consultant psychiatrists, all at Northumberland, Tyne and Wear NHS Foundation Trust, Ferndene, Prudhoe, Northumberland, UK.

Although not a clearly defined concept,⁵ there are guidelines in the Code about whether a particular decision falls within the zone of parental control. There are two key questions.³ First, ‘is the decision one that a parent would be expected to make, having regard both to what is considered to be normal practice in our society and to any relevant human rights decisions made by the courts’? Second, ‘are there no indications that the parent might not act in the best interests of the child or young person’? The less confident a professional is that they can answer ‘yes’ to both questions, the more likely it will be that the decision falls outside the zone.

The zone of parental control and deprivation of liberty

The Code acknowledges that the parameters of the zone will vary from one case to the next, but the following factors should be considered: the nature and invasiveness of what is to be done to the patient (including the extent to which their liberty will be curtailed); whether the patient is resisting; the general social standards in force at the time concerning the sort of decisions it is acceptable for parents to make; the age, maturity and understanding of the child or young person; and the extent to which a parent’s interests may conflict with those of the child or young person. Certain treatments that could be considered particularly invasive or controversial, for example electroconvulsive therapy (ECT), are likely to be considered to fall outside the zone of parental control.³

Decisions that would result in a deprivation of liberty will be outside the zone, as detention engages the article 5 rights of the child (Convention for the Protection of Human Rights and Fundamental Freedoms right to liberty and security) and a parent may not lawfully detain or authorise the detention of a child.⁶ There is no specific definition of deprivation of liberty, but various factors have been identified that are likely to be relevant; for example, the use of restraint (including sedation) to admit a person to an institution where that person is resisting admission; staff exercising complete and effective control over the care and movement of a person for a significant period; and the person being unable to maintain social contacts because of restrictions placed on their access to other people. A recent judgment from the Supreme Court,⁷ commonly referred to as the Cheshire West case, has provided a clear ‘acid test’ on the meaning of deprivation of liberty. The Supreme Court has made it clear that, for a person to be deprived of their liberty, they must be subject both to continuous supervision and control and not be free to leave. The Supreme Court also held that, in all cases, the following are not relevant to the application of the test: (1) the person’s compliance or lack of objection; (2) the relative normality of the placement (whatever the comparison made); and (3) the reason or purpose behind a particular placement.

One of the matters the Court considered in the Cheshire West case was whether children could be deprived of their liberty in the family home. It was noted that all children are (or could be) subject to some level of restraint. The necessity for this adjusted with their maturation and change in circumstances. The Court expressed the view that ‘very young children . . . because of their youth and dependence on others, have – an objectively ascertainable – curtailment of their liberty but this is a condition common to all children of tender age. There is no question, therefore, of suggesting that infant children are deprived of their liberty in the normal family setting.’ In the case of children living at home with either birth or adoptive parents, Lord Neuberger said that: ‘what might otherwise be a deprivation of liberty would normally not give rise to an infringement of article 5 [of the Convention] because it will have been imposed not by the state, but by virtue of what the Strasbourg court has called “the rights of the holder of parental authority”.’ Foster placements were viewed differently because children would generally have been placed in this environment by local authorities and therefore if there was a deprivation of liberty it would be ‘imputable’ to the state.

Prior to the Cheshire West case, many clinicians viewed the level of supervision in place in a hospital environment as amounting to a restriction, rather than a deprivation, of liberty. Since the case, there have not been any reported cases specifically considering the position of children and young people in hospital. It is inevitable however that, in the wake of the judgment, a number of children and young people who lack competence or capacity to consent to their admission to hospital and who are being treated on an informal basis will need to be assessed to evaluate whether they are being deprived of their liberty.

Hence, there will be situations where neither the consent of the patient nor parental consent may be relied on and an alternative legal authority for treatment will be necessary. The following case example demonstrates how clinicians working with children and young people are now required to manage difficult clinical scenarios within a complicated legal framework. Here we describe the reasoning behind the use of the Mental Health Act 1983 in an unusually young patient. We have been unable to find a published example of use of the Act in such a young child.

Case study

B was an eight-year-old boy admitted to a child and adolescent mental health in-patient unit as an emergency, because of extremely challenging behaviour. He had been referred to his local community child and adolescent mental health service several months previously and was diagnosed with autism spectrum disorder. He also exhibited features of hyperkinetic conduct disorder. He was subject to a child protection plan and accommodated by the local authority on a voluntary basis at the time of admission. Because of episodes of extreme unprovoked aggression and sexualised behaviour B had been excluded from a special school and two foster placements had broken down.

On admission, B received a comprehensive package of care, which included assessments and interventions by nursing and medical staff, psychologists and other therapists. He received a carefully structured intervention involving nurses experienced with younger children, play therapy, education appropriate to his developmental level and medication (methylphenidate). B was nursed away from the older adolescents within a self-contained children's area of the in-patient ward. He had two members of nursing staff with him at all times because of his challenging behaviours, including highly sexualised behaviour, physical aggression and destruction of property. He required regular, difficult restraints involving up to four members of staff at a time, and occasional use of seclusion to maintain his own safety and the safety of others. The Code of Practice for the Mental Health Act advises that seclusion of an informal patient should be taken as an indication of the need to consider formal detention.³

With legal advice from trust and local authority solicitors, it was agreed that as long as B met criteria for detention under the Mental Health Act 1983, this was the preferred route. The 'least restriction' principle of the Act suggests that detention under the Act should be the last resort. However, it is undoubtedly necessary in cases where the option for informal admission is not appropriate or the risks in managing the child informally are too great. A patient may be detained under section 2 of the Mental Health Act 1983 for a period of assessment of up to 28 days. The application is based on the recommendations of two medical doctors, and an approved mental health practitioner is the applicant. The professionals must be satisfied that the following grounds are met: the person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by treatment) for at least a limited period; and the person ought to be so detained in the interests of their own health or safety or with a view to the protection of others (para. 4.2).³ In this case, B both had mental disorder (autism spectrum disorder and hyperkinetic conduct disorder) and was presenting in a way that put his own safety, and that of others, at risk.

Following a Mental Health Act assessment and close consultation with local authority and trust legal services, B was detained under section 2. B appealed to the mental health tribunal with the assistance of his independent mental health advocate and solicitor. His detention was upheld. During the period of detention, the local authority obtained an interim care order and acquired parental responsibility. The local authority questioned whether it would be able to agree to B being in hospital informally, however, the clinical team felt that the treatment decisions about restraint and seclusion required fell outside of the zone of parental control, regardless of who had parental responsibility. B's behaviours did begin to settle and he gradually ceased to require the restraint and seclusion that he had earlier in his admission. He was therefore discharged from section 2 shortly before the end of the 28-day period and remained on the ward as an informal patient while an appropriate community placement could be identified. Following several months' intervention it was possible to discharge B safely to a children's home, where he has not required restraint.

Discussion

Detention of such a young child using the Mental Health Act 1983 is unusual and we could find no published case that would discuss this, although, anecdotally, others have faced similar decisions.

In this case, the team was confident that B's age and immaturity prevented him from being regarded as Gillick competent and therefore he could not provide authority for his own admission and treatment. Both of B's parents had parental responsibility and were supportive of his admission to hospital. Initially, the clinical team had relied on their agreement. However, in the light of B's deprivation of liberty parental consent to treat him could not be relied upon. In addition, the child protection plan raised concerns about the parents' ability to act in the best interests of the child. The team therefore decided that the decisions that now needed to be made about B fell outside of the zone of parental control.

In emergency situations, a doctor can lawfully treat a child even if there is no time to obtain valid consent. This is known as the doctrine of necessity. The Code of Practice for the Mental Health Act advises that: 'In such cases, the courts

have stated that doubt should be resolved in favour of the preservation of life, and it will be acceptable to undertake treatment to preserve life or prevent irreversible serious deterioration of the patient's condition' (para. 36.51).³ In B's case, incidents of extremely challenging behaviour required urgent intervention, but these were frequent and repetitive and therefore the clinical team was unable to rely on the doctrine of necessity.

If a child is subject to a care order or emergency protection order under the Children Act 1989, the local authority acquires parental responsibility (Children Act 1989 s 33(3)(a) and s 44(4)(c), respectively). Section 25 of the Children Act 1989 can be used to detain a person with mental disorder under a secure accommodation order, but only if the primary purpose of detention is not to provide treatment for mental disorder, for example, if detention is required to maintain the safety of someone who exhibits severe behavioural disturbance. A child subject to a section 25 order does not have to be subject to an interim care order. The Children Act 1989 does not, however, specifically address mental disorder, does not provide specific powers to enforce treatment, and does not provide specific safeguards for the rights of the detained patient.⁸ B needed to be in hospital for further treatment of his mental disorder and therefore a secure accommodation order was not judged appropriate at that time.

In some situations, particularly if there are disputes between the family and the treating clinician or between family members, or if other authorities for treatment are not appropriate, there should be recourse to the courts. The High Court can use its inherent jurisdiction to make decisions that it considers to be in the child's best interests. Some issues may be resolved by section 8 orders made under the Children Act 1989. B met the criteria for detention under section 2 of the Mental Health Act and therefore the legal authority for B's assessment and treatment was provided without a court application needing to be made.

Detention under the Mental Health Act 1983 provides the child with a number of important safeguards, such as the right to appeal against detention. The 2007 amendments to the Act have resulted in greater protections for the rights of children and young people, for example the duty to ensure an age-appropriate environment (s 131A) and further safeguards for ECT (s 58A).

It is important that clinicians working with children with mental disorders equip themselves with a good understanding of the law and its application, in order that the appropriate legal authority for admission and treatment is used, taking into account all of the needs of the patient and the relevant factors of each case. The Mental Health Act 1983 can be appropriately applied to children, as this case illustrates.

We are grateful to B's parents for giving their consent for this paper, to the Redburn nursing staff, and to Camilla Parker and Anthony Harbour for their comments on an early draft of this paper.

1.8.76 Debate: Can and should psychiatrists use online information?

Elly O'Brien Christopher Pell

date

2015-12

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 - *Yes*
 - *No*

Yes

When considering professional use of the internet, the focus tends to be on access to information. Yet the development of Web 2.0 and the growth of social media have transformed the internet from a largely read-only medium to one that facilitates interaction and user-created content. I will discuss some of the positive effects that online resources can have on professional practice, looking not just at access to information, but what we do with that information and how we interact online with fellow professionals and the public.

Doctors can access the best evidence online during consultations: using Google Scholar to identify relevant journal articles, consulting guidance using the NICE app¹ or checking doses and contraindications on the BNF mobile app (even when you have no mobile signal). Sites that aggregate high-quality content from elsewhere, such as NICE Evidence Search (www.evidence.nhs.uk) and Trip (www.tripdatabase.com), make searching for information and staying up to date quicker and easier. Trip's 'rapid review'² even allows you to search for primary studies for an intervention in a particular population, then compares the results to provide an overall score (although not designed to replace a full systematic review, it provides a useful and rapid overview of the evidence in an area).

The potential for variation in the quality of online information is often cited as a criticism of it. Using high-quality resources helps to reduce this risk, but the principles of critical appraisal apply to any information, regardless of the medium. Wikipedia has been shown to be as reliable as traditional textbooks in psychiatry,³ and 'comes close to' *Encyclopaedia Britannica* in accuracy.⁴ Wikipedia should not be written off as a resource in research, but its contents must be subject to scrutiny and facts always cross-checked.

Online patient information is useful for patients, who can read it in their own time and refer back to it if they have queries. NHS Choices⁵ offers a wealth of information for patients, and NHS England's Information Standard⁶ helps psychiatrists to identify high-quality patient information from a variety of sources (including the Royal College of Psychiatrists),⁷ reducing the need to produce leaflets in-house. Material with the Information Standard is also included in NICE Evidence Search – so doctors can retrieve high-quality patient information alongside clinical evidence.

Blogs can be used by patients much like a traditional diary, to express themselves and track the course of their illness. Psychiatrists can also direct patients to blogs that they may find useful to read. However, there is huge variation in blogs, and are prone to a type of response bias whereby only those with the most extreme experiences (whether positive or negative) will blog about them; therefore, blogs should be carefully vetted before being recommended to patients.

Educational and informative materials can also be shared and viewed online as videos via YouTube (see the Royal College of Psychiatrists' YouTube channel⁸) or presentations on SlideShare (www.slideshare.net). Following the 'do once and share' principle, this gives material greater reach as well as encouraging discussion and collaboration between professionals.

Twitter offers a forum for current awareness through discovering and sharing new evidence and useful resources. It also provides a medium for interactions between professionals, where they can discuss issues and, potentially, crowdsource solutions. The Department of Psychiatry at the University of Toronto runs the International Psychiatry Twitter Journal Club,⁹ allowing a large number of professionals from around the world to discuss a paper. Those who cannot attend can catch up or continue the conversation using the hashtag #psychjc. Conferences also increasingly promote tweeting, allowing those unable to attend in person to keep up with proceedings by monitoring the relevant hashtag. Storify is a free tool that can be used to draw together various media such as photos, videos and tweets from conferences (or anything with a hashtag) to produce a record of the conference.¹⁰

Twitter also allows interaction beyond fellow professionals; for example, the successful Twitter campaign last year that forced major supermarkets to stop selling 'mental health patient' Halloween costumes.¹¹ The campaign involved thousands of messages from members of the public, professionals, politicians and charities. Twitter also provides a valuable medium for promoting events such as World Mental Health Day, aimed at breaking down stigma, addressing misconceptions, advocating for patients' rights and giving patients a voice.

There is a lot of scaremongering about social media for doctors. However, arguably this is simply a new medium in which age-old problems can arise. Indeed, the General Medical Council (GMC) guidance states that: 'The standards expected of doctors do not change because they are communicating through social media rather than face to face or through other traditional media'.¹² So principles of patient confidentiality, respect for colleagues and maintaining appropriate boundaries with patients apply equally online and face to face. Accepting 'friend requests' and 'follows'

from patients or caregivers requires careful consideration, especially with vulnerable patients. But how different is this to psychiatrists having to decide how to deal with bumping into a patient at the supermarket? Social media can blur the distinction between the professional and the personal, but there are solutions, such as separating these personas into different accounts and increasing privacy settings (for example, having a protected account on Twitter). What should not be overlooked is the potential of social media for enabling interaction with patients and their caregivers, for new dialogues that challenge professionals' perceptions of service users' experiences and that create a more collaborative care model.

Psychiatrists must always question the information in front of them and the source from which it originates, regardless of the medium. Online resources enable psychiatrists to keep up to date with the latest research and to engage with it in a more interactive way. Psychiatrists now also have the opportunity to create and share their own high-quality media to raise the profile of the profession, and to combat misinformation and stigma. The use of online resources should not only be encouraged but be considered essential in contemporary psychiatry.

No

Social media and Web 2.0 are driving major social changes – one seventh of humanity has signed up for a Facebook account since its inception just a decade ago – and it would be naive to think that psychiatry would ignore the many advantages these changes bring.¹³ More than ever before we have access to the best-quality information, opportunities for professional and public collaboration and engagement, and multiple forums in which to raise awareness and standards in psychiatry. Or so it would seem.

In reality, our ability to use these technologies in professional practice has become fraught with difficulty as psychiatrists try to adapt to this shifting landscape. Indeed, new avenues for problems seem to crop up with alarming regularity, whether it be emerging legal trends, fresh ways to be censured by the GMC, or even novel clinical presentations such as addictive behaviour towards new technology.¹⁴ Such was the concern about professional use of the internet that the GMC update to *Good Medical Practice* now clearly defines the expected standards of practice that UK doctors use when going online.¹²

Whether we can access professional information online is often dependent on what is being searched for, and the location of the clinician. Many of the internet resources we take for granted at home are blocked or limited by internet filters. Websense and similar filters err on the side of caution to protect National Health Service networks from malware at the expense of many sharing and networking sites, rendering useful resources such as Dropbox, Slide-Share, Twitter and YouTube all but inaccessible from the hospital. Often, lack of hardware or mobile data access within the hospital can make accessing information online a frustrating exercise. Much more needs to be done to provide clinicians with smart devices and to open up wireless internet access within healthcare settings before we are truly able to take advantage of online information.

Even assuming this is achievable, there is an emerging opinion that doctors spend too much time staring at a computer screen and typing, rather than engaging with, actively listening to and carefully thinking about their patients. Furthermore, the illusion that such technologies improve our workflows by allowing us to multitask (for example, by searching for pertinent information during interviews or meetings) is severely challenged by the finding that our cognitive abilities and working memory are limited. The simple fact is that multitasking makes us more distraction prone – so we perform multiple tasks with an increasing lack of attention and efficiency.^{16,17}

Let us assume, though, that you have relatively unfettered access to the internet and have easy access to a computer in a distraction-free environment: should you use the internet to find professional information?

An initial problem is quality control. In the 'information age' critical appraisal is more than ever a vital skill, particularly with the proliferation of open access online journals with seemingly less-than-robust peer-review structures to safeguard article accuracy.¹⁸ This takes up time that you may not have, yet fails to provide the same level of coverage as a systematic literature search.¹⁹ Although we like to think that we can sift out the incorrect information, we are all prone to inherent biases when analysing multiple sources of data. Interrogating Google or other search engines for clinical information may compound this by selectively presenting data according to the search engine's own algorithms, rather than by the robustness of studies themselves.

The issue of quality of information costs us more time, as those attending our clinics and hospitals may now come armed with information they have uncovered online regarding their symptoms and treatments. In each case the validity and relevance of the information must be examined, before explaining to the individual why the ‘facts’ they have found may not be quite as they seem. This also extends to information that a patient may have learned online about their doctor, either through rating sites or informally via a Google search. Social media has considerably blurred the boundaries between our professional and private personas. While some professionals strive to separate these two aspects of their lives online, this is hard to achieve fully in practice. Psychiatry is no stranger to boundary issues, however. As our patients and their carers enter cyberspace, online interactions require care and attention in order to avoid difficulties in subsequent clinical interactions.

Although doctors are generally becoming more experienced at safely managing their digital identities, many still do not fully understand or adjust privacy settings on social media sites. Still other doctors fall foul of expected professional standards in terms of what information they make available online.^{20,21} With the increasing integration of location-sharing functions to such sites, this opens up new avenues for access and contact not previously available and may lead to unwanted communication or harassment. Some go as far as to suggest that professionals may wish to limit their use of social media so as to reduce the risk of stalking.²² All of this places considerable onus on psychiatrists to be at least aware of their digital footprint; better still, to actively curate their web presence and privacy settings so that oversharing and misinformation are swiftly identified and tackled. This same challenge extends to the specialty as a whole, as any search of Google or YouTube for terms such as ‘ECT’ or ‘psychiatry’ can yield reams of misinformation.

And what of reciprocity? Can patients expect to have their online identities scrutinised by healthcare staff prior to attending clinics, or should this information (however publicly available) require their explicit consent before being used in clinical decision-making?

It is questions such as this that highlight the rapidity with which these technologies have changed the landscape of interpersonal interactions within our society. With a mere decade of experience and with new social media trends and websites constantly emerging, no-one yet has a clear idea where the ethical, legal and professional sensibilities will eventually settle. What is clear is that using online information will necessarily change our practice, both by requiring greater attention to and scrutiny of the information yielded, and by changing the parameters of the doctor-patient relationship.

With our seeming acceptance of the erosion of personal privacy and our constant searching, editing and sharing of information, we may unwittingly be setting up as yet unknown difficulties and challenges for professional practice in the future. Whether we can skillfully navigate the minefields of professional information in the online world remains to be seen.

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1.8.77 Mobile telephone apps in mental health practice: uses, opportunities and challenges

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Abstract

Smartphones are used by patients and clinicians alike. Vast numbers of software applications (apps) run on smartphones and carry out useful functions. Clinician- and patient-oriented mental health apps have been developed. In this article, we provide an overview of apps that are relevant for mental health. We look at clinician-oriented apps that support assessment, diagnosis and treatment as well as patient-oriented apps that support education and self-management. We conclude by looking at the challenges that apps pose with a discussion of possible solutions.

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- *Mobile telephone apps in mental health practice: uses, opportunities and challenges*
 - *Clinician-oriented apps*
 - * *Assessment and diagnosis*
 - * *Treatment*
 - * *Medical apps*
 - * *Apps to assist in psychosocial interventions*
 - *Patient-oriented apps: education and self-management*
 - *Challenges*
 - *Conclusions*

Mobile telephones are ubiquitous and have more recently evolved into the smartphone, a combination of a handheld computer and mobile telephone. Smartphones support software applications (apps) with specialised functions. Some apps may be pre-installed on the telephone but many apps are downloaded. Downloading apps (either free or for a nominal fee) is straightforward. Apps are available for a large number of mental health conditions and are also known as mHealth apps. Many of these apps have already been investigated by researchers and include apps for psychosis,¹ depression,² anxiety,³ alcohol use disorders,⁴ smoking cessation,⁵ sleep disturbance⁶ and weight loss.⁷ In this article we will avoid the more generic productivity apps (e.g. email apps) and will instead focus on general clinical and mHealth apps as well as regulated apps where possible.

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Clinician-oriented apps

Assessment and diagnosis

Smartphone apps can aid in diagnosis in two main ways: by supplying clinicians with diagnosis-related information and less commonly through data acquisition. Apps can be used in clinical encounters or remotely, although the latter overlaps with self-monitoring. Apps have proven useful in assessment and diagnosis in clinical practice. In one study, 50% of doctors reported that apps facilitated diagnosis during on-call work whereas 43% reported apps helped them interpret laboratory values.⁸

As an example, Lab Tests Online UK (www.labtestsonline.org.uk) is a peer-reviewed online resource for clinical laboratory tests with corresponding apps for the iPhone and Android (*Fig. 1*). The app enables the clinician to look up explanations of test results through a search facility or an index. The explanations are intended for the general public but there is enough information there to be useful for clinicians. Other useful features include news updates, information on screening for populations and an index of conditions.

Fig. 22: Screenshot from the desktop version of Lab Tests Online-UK

There are a large number of apps relating to the diagnosis. Many of these are American apps that supply ICD-10 coding information for billing purposes. There are a number of variations including apps that convert between ICD-9 and ICD-10. The American Psychiatric Association has produced a DSM-5 app that contains detailed information on the DSM-5 diagnostic categories as well as ICD-10 coding equivalents. The app includes a series of instructive videos on many of the diagnostic categories.

Less commonly, apps can also be used in conjunction with hardware devices that connect to the smartphone. These apps may acquire and process data from external appliances such as digital stethoscopes, ophthalmoscopes and electrocardiogram (ECG) monitors. A similar principle can be seen with the self-monitoring apps that can provide clinicians with patient-collected data. Storing patient data on mobile apps brings additional complications relating to the Data Protection Act 1998 as well as principles of patient confidentiality that need to be worked through appropriately.

Treatment

Treatment-related mHealth apps can be broadly divided into medical and psychosocial and may be professional or patient-focused.

Medical apps

In terms of UK practice, the National Institute for Health and Care Excellence (NICE) produces both the *British National Formulary* (BNF) app and an app for NICE guidance (www.nice.org.uk/about/what-we-do/nice-apps-for-smartphones-and-tablets). The NICE BNF app offers a search facility to rapidly locate drug information and contains the contents of the paper version of the BNF. The app ensures that clinicians are able to access an up-to-date BNF even in the busiest clinical environments. This is contingent on the accessibility of the smartphone as well as regular updating of the app. The NICE guidance app features indexed evidence-based guidance from NICE on the management of a range of conditions. This app effectively utilises the large storage capacity of current smartphones.

Apps to assist in psychosocial interventions

There are many psychology-related apps, including those listed on the NHS Choices apps site (<http://apps.nhs.uk>) such as Phobia Free. Phobia Free supports the use of exposure therapy for the treatment of phobias in the form of games and augmented reality. Rizvi *et al* described an app called DBT Field Coach that provided instructions, exercises and reminders to help patients with borderline personality disorder manage emotional crises.⁹ The researchers found that the app helped patients to self-monitor and complete homework assignments.

Another group of apps support patient education. One example is the Brain Tutor 3-D/HD (online Fig. DS1) which features a 3-D magnetic resonance imaging (MRI) reconstruction of a brain (www.brainvoyager.com/Mobile/BrainTutorHD_iOS.html). The clinician is able to select views of a virtual brain or an MRI reconstruction of the head including the brain. All views support 3-D manipulation of the images. For instance, the clinician may explain the MRI findings to a patient and then proceed to demonstrate these on the 3-D models on their smartphone.

Patient-oriented apps: education and self-management

A large proportion of mental health apps are directed towards the public. One example of this is Moodscope from NHS Choices (<http://apps.nhs.uk/>), which enables a person to track their mood. The scores can be stored and a patient may allow the clinician to access their records to facilitate assessment. SAM (Self-Help Anxiety Management) supports patients in managing panic attacks. These apps support self-management of conditions including chronic illnesses through diary functions and education. Such apps may be particularly useful after discharge from specialist services or in-between appointments.

Self-monitoring apps create personal health records which are fundamentally different from clinical patient records in their function and composition. Patients will be more empowered by holding their own records and managing access rights to professionals. However, this is accompanied by a variability in the quality of information held in the records,¹⁰ an expanding number of record systems and the potential for further use of these records by third parties. The divergence of app-based personal health records and clinical records will generate complex interactions between these two systems.

Challenges

Smartphone apps present many challenges (*Box 1*). One of the primary difficulties is the regulation of mental health apps due to their abundance. A number of studies have highlighted evidence of unsafe medical apps¹⁰ and the US Food and Drug Administration (FDA), the UK Medicines and Healthcare Products Regulatory Agency (MHRA) and NHS England have started to regulate apps. The NHS Choices website identifies regulated clinical apps and lists a number of other medication-related apps intended for professionals and patients. The relevant regulator depends on the function of the app. For instance, the MHRA would regulate apps classed as medical devices.

Self-certification has been suggested as one solution for the regulatory challenges.¹¹ Lewis & Wyatt suggest a regulatory framework which addresses challenges intrinsic and external (e.g. hardware) to the app.¹⁰ Charani and colleagues go one step further, arguing that there needs to be a governance and legal framework in place for the use of apps in clinical practice.¹² If clinicians or subject matter experts have not been involved in app development this may influence its quality and effectiveness. An absent evidence base for an app may limit clinical uptake. Privacy and security are other challenges for the app market.

The effectiveness of apps may also depend on the characteristics of the patient population. In one study looking at smartphone apps for weight loss, young adults considered simple weight measurement alone too narrow in focus and advocated behavioural software features.¹³ Access to a smartphone was negatively correlated with age in one study looking at consecutive patients in a neuropsychiatry and memory clinic.¹⁴

Box 1 Challenges of mental health apps

Extrinsic to the app: hardware constraints that limit the apps.¹⁵

Intrinsic to the app

Relating to the patient or app user: concerns about how the data will be used by the app service.

Relating to the clinician: accuracy of clinically related processes¹⁶lack of medical involvement in app development¹⁷insufficient information to keep doctors or medical students interested.¹⁸

Relating to the healthcare service: deviation from or lack of evidence based practice recommendations³patient confidentiality issuesclinical risk emerging from use of apps.¹⁹

Conclusions

Mental health apps have expanded rapidly in number and regulation is playing catch-up. There are many useful apps that can support clinicians in the assessment and management of patients. There is also a burgeoning market of personal health apps that are reshaping the health economy. A sustained and multifaceted response from individual clinicians, health services and policy drivers is needed to adapt to this new health economy.

We thank Lab Tests Online-UK for their permission to include app screenshots in our article, Professor Rainer Goebel for permission to use the Brain Tutor HD screenshot and Dr Omer Moghraby for helpful discussions around the subject matter.

1.8.78 Commissioning neuropsychiatry services: barriers and lessons

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Abstract

Aims and method

Previous studies have shown variations in commissioning of neuropsychiatry services and this makes access to neuropsychiatric services a post-code lottery. In this survey, we approached all mental health and neuropsychiatric service commissioners within London to map current funding and commissioning arrangements, and explored perceived barriers to neuropsychiatric service commissioning.

Results

83% of commissioners within London responded. There was significant variability between neuropsychiatric services commissioned through the mental health stream. Contracting arrangements were variable. Lack of earmarked fund for neuropsychiatry and disjointed funding stream for such

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services were identified by commissioners as a barrier, as was the critical mass of neuropsychiatric cases.

Clinical implications

Neuropsychiatric service development continues to be hindered by lack of clear commissioning process. Strategic drive is needed to promote more equitable neuropsychiatric services. National or regional commissioning covering a large population will provide a better model for neuropsychiatric services to be commissioned.

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Neuropsychiatry lies at the interface between neurology and psychiatry.¹ It is often debated that the narrow focus of neurology and psychiatry services fails to meet the need of patients from a broader neuropsychiatric perspective.² The Cartesian belief of the dualism of mind and body has had repercussions for neuropsychiatric training as well as service provision including commissioning.³ Being at the interface of neurosciences, neuropsychiatry services are commissioned through both physical health funding stream and mental health commissioning, though there is lack of clarity around this. This leaves this complex discipline vulnerable to falling between different funding streams.

In the UK, mental health services underwent significant growth under the *National Service Framework* (NSF) initiative for mental health, where the predominant focus was around community services.⁴ Although community models were recommended, neuropsychiatry services remained largely based within academic institutions.⁵ At the height of the NHS expansion, a national survey of neuropsychiatry services revealed them to be ‘patchy’ and ‘grossly inadequate’, and discovered that most of the neuropsychiatry services existed from pre-NSF days.⁶ Historically, neuropsychiatry services developed at certain national or regional centres, such as a national hospital, significantly before NSF or current commissioning arrangements. They continued to serve or were developed at certain regional centres in an *ad hoc* way dependent on local clinical enthusiasm or leadership. At times, such developments were not accompanied by specific commissioning initiatives. There were no systemic drivers or a comprehensive plan to meet the population need. Consequently, patients were often referred ‘out of area’ and services often struggled to meet demand, resulting in long waiting times. The reasons for lack of neuropsychiatry service development in recent years has not been examined, despite increasing recognition of need and demand for neuropsychiatry services and its impact on patients’ quality of life. Commissioning arrangements and awareness of neuropsychiatry among commissioners and managers could be one of the reasons behind this.³

The aim of this study was to explore commissioning arrangements for neuropsychiatry and perceived barriers for neuropsychiatry commissioning from the perspective of managers responsible for commissioning neuropsychiatry services. We based this study in London as the city is unique in having a significant concentration of neuropsychiatric services along with recognised variability in service provision.^{5,7} At the time of carrying out the study, the Greater London area came under the regional commissioning unit or strategic health authority (SHA), which also made London a regional unit. Therefore, London provided a unit of regional commissioning that could be studied and compared with previous literature. Primary care trusts (PCTs) are local units within the SHA that cover well-defined geographical areas, usually

within an administrative unit called a borough. In London there were 31 boroughs and 30 PCTs during our survey. Two boroughs collaborated and acted as one unit.

Apart from mapping current practice, the survey explored perceived barriers for neuropsychiatry service provision from commissioners and providers.

Method

Two surveys were carried out. One approached all mental health commissioners based at the 30 PCTs in London and the other was a separate survey of neuropsychiatry service providers. See the accompanying paper for details.¹⁰

All local mental health commissioners (within the PCTs) were contacted electronically with the survey questionnaire and this was followed up by a telephone call. The commissioners were asked whether they were aware of a different route of commissioning neuropsychiatry in their PCT. We were directed to the specialist commissioning unit for neurorehabilitation for the London area and they were contacted for the survey. The specialist neurorehabilitation commissioning forms a non-mental health commissioning route. We were not directed to any other funding or commissioning stream for neuropsychiatry.

The survey mapped commissioning arrangements for neuropsychiatry and provision of services. It was factor-analysed for emerging themes from providers' and commissioner' responses for 'perception of neuropsychiatry' and 'perceived barriers to neuropsychiatry service commissioning'.

Results

Overall, 30 mental health commissioners from 25 PCTs responded. There was no information from 5 PCTs; response rate for commissioners was therefore 83%. The specialist mental health commissioner for neurorehabilitation for London also responded. There was response from all 9 mental health trusts (specialist mental health providers), although 1 returned an incomplete response; thus, response rate for providers was 100%. Data were also gathered from a tertiary neuropsychiatry centre embedded within an acute hospital trust and one in the voluntary sector catering to patients from London but based outside London. Two independent-sector specialist neurorehabilitation centres were identified and contacted with provider questionnaire, and one of them responded.

The commonest mode of commissioning of neuropsychiatry services was to tertiary services followed by local services. This was followed by 'national' services which are essentially tertiary services which are open to referrals from across the country. Funding streams for certain conditions were identified to be other than mental health. Although neuropsychiatry services were tertiary services, they were often also open to direct referral from primary care. Brain injury or neurorehabilitation was commissioned through pan-London specialist commissioning group, i.e. from a 'specialist' commissioner across a larger geographical area and services provided by specialist tertiary providers. Commissioning for young-onset dementia and cognitive difficulties was often aligned with other health services for 'older adults'.

Figure 1 describes different modes of purchasing neuropsychiatry services. Block contract was the most popular method, closely followed by commissioning per patient but needing approval for all the patients. In only a small minority of cases referrals did not require commissioners' approval. Interestingly, the mode of commissioning was unclear in 4 cases. Some of the commissioners were using more than one method of purchasing neuropsychiatry services.

Fig. 23: Modes of purchase of neuropsychiatry services.

A whole range of neuropsychiatry services were commissioned and provided (*Fig. 2*). There appears to be a significant disparity in the range of provision and commissioning. This may indicate that some neuropsychiatry services were commissioned as part of a larger service without specific earmarked funding. There was a lack of clarity of commissioning processes in such cases.

Overall, commissioning interest and service provision for specific neuropsychiatric services did not mirror each other. The nine mental health trusts in London were asked about whether they provided neuropsychiatry services. Among

them, five identified themselves as providing some form of neuropsychiatry service while four reported not providing any neuropsychiatry service. One of the trusts that no longer provided neuropsychiatry service had a brain injury rehabilitation unit that was closed the year before the survey. There was significant interest in commissioning neurodevelopmental disorders such as autism spectrum and adult attention-deficit hyperactivity disorder (ADHD) (80% and 68% of responding commissioners, respectively), but only 33% of mental health trusts had provision for autism spectrum disorder and 22% provided service for adult ADHD. One of the commissioners reported they commissioned services for sleep disorder but none of the providers had service provision for sleep disorder. Similarly, one of the providers had service provision for stroke-related neuropsychiatry, though none of the commissioners we were able to contact were commissioning such a service.

Both service providers and commissioners identified lack of funds in general and lack of funds specifically earmarked for neuropsychiatry as a barrier to neuropsychiatric service development. Both identified the disjointed nature of commissioning funding streams for neuropsychiatry and lack of national strategic drive for neuropsychiatry as further barriers to commissioning such services. But there were variations in perceptions of commissioners *v.* providers. Of the 30 commissioners who responded, 23 perceived there was a barrier to commissioning neuropsychiatry services (77%). Commissioners were more concerned about lack of critical mass ($n=8$; 35%) of individual neuropsychiatric disorders in their commissioning units or areas (*Fig. 3, Box 1*).

Providers often perceived a 'lack of interest' in commissioning neuropsychiatric services as a barrier to setting up or providing neuropsychiatry services (*Fig. 4*).

Commissioners were asked if they were aware of new neuropsychiatry services that were commissioned (expansion) in the past 10 years. There were only 8 responses, suggesting some of the local mental health commissioners were unaware of how services had evolved in the past 10 years locally. We also explored whether there were plans for expansion for neuropsychiatry services locally in the future. From the responses we received, there were services being considered for certain conditions: adult autism spectrum disorder (6; 27%), adult ADHD (4; 18%), young-onset dementia (4; 18%), memory clinic/dementia services (2; 9%), other specific conditions in individual areas (3; 14%); 4 commissioners reported there were no plans to develop new services (18%)

Box 1 Some comments on neuropsychiatry services from commissioners:

- 'The numbers of patients requiring these types of services are small in comparison to other psychiatric services and the challenge is therefore being able to provide affordably and locally for this group.'
- 'Economies of scale for larger areas (e.g. across west London) are needed given that the service may not be sustainable at a borough level'
- 'The low volume affects local commissioning.'
- 'Neuropsychiatry is a relatively small field and not high up on the national agenda'.

Two of the nine mental health trusts reported expansion of generic neuropsychiatry services over the past 10 years; two trusts reported no expansion and two other trusts did not know whether there was any expansion. One trust reported there was some patchy development of adult ADHD and young-onset dementia services without commissioning support, largely led by the 'individual' interest of clinicians. Another trust also reported patchy (not across all boroughs) development of young-onset dementia, adult autism spectrum disorder and ADHD services. One of the trusts closed down a brain injury rehabilitation service. One of the specialist providers reported developing an adolescent brain injury rehabilitation unit while another reported expansion in the services for medically unexplained neurological symptoms, including in-patient facilities and services for Tourette syndrome.

Commissioners were also asked about future planning in the field of neuropsychiatry services. A third responded that there were no plans for expansion (11/30; 37%). Medically unexplained neurological conditions (along with generic medically unexplained symptoms) were being considered for commissioning in two PCTs while three more PCTs would 'review' their current commissioning in this field. Adult ADHD services were being considered in three PCTs while one borough was reviewing their commissioning in the field. Adult autism spectrum disorder service commissioning was being considered by one borough.

Three trusts (one with existing neuropsychiatry services, two without) were unsure whether there would be further expansion of neuropsychiatry services. Two of the mental health trusts had plans of developing generic neuropsychiatry

services. One trust reported plans to enhance psychological therapy (cognitive-behavioural therapy) services within the existing neuropsychiatry services. One of the trusts reported plans to develop services for adult ADHD. Two mental health trusts and one of the specialist providers had no further plans to develop neuropsychiatry services in the near future.

Discussion

This is the first detailed study of commissioners' and providers' views on neuropsychiatry services commissioning. Data were gathered from all the providers and 83% of commissioners, making a robust data-set.

This study shows significant variations and inconsistencies in commissioning of neuropsychiatry services. There is evidence of a disjointed approach towards commissioning neuropsychiatry, despite London being a relatively small geographical area. Certain themes emerged as major barriers which may have contributed to the current state of affairs.

Critical mass for commissioning neuropsychiatry services

Commissioners identified a lack of 'critical mass' as a common barrier to neuropsychiatry service commissioning. Providers also reported this to be a big barrier. In the UK, commissioning is changing radically. As the current structure of purchasing healthcare is reorganised, it can be replaced by a more localised and potentially fragmented system, mirroring the current system. This would be detrimental for neuropsychiatry commissioning as it may mean lower numbers of neuropsychiatry patients per neuropsychiatric condition per commissioning unit and further aggravate the problem of the lack of 'critical mass'. The barrier of critical mass can be addressed by commissioning neuropsychiatry services for a larger population. We believe a regional or national specialist commissioning panel would best achieve this purpose. This already exists for services such as neurorehabilitation. The specialist commissioning panel mentioned previously reduced variability in neurorehabilitation when compared with borough-based commissioning of neuropsychiatry services.⁸ With the current restructuring of health services in the UK, PCTs and regional commissioning units (SHAs) have been abolished and from 2013 neuropsychiatry is being commissioned by NHS England, although this is going to be reviewed in a few years' time. This might provide commissioners the critical mass to commission neuropsychiatry services more effectively, reduce variability and address unmet needs.

Knowledge and expertise of commissioners and integrated commissioning

Historically, neuropsychiatry has fallen between neurosciences and mental health commissioning.⁹ The vast majority of providers reported a perceived lack of knowledge and expertise among commissioners, disjointed or unclear commissioning processes, and lack of earmarked funds for neuropsychiatry as challenges to setting up neuropsychiatry services. Commissioners also found a lack of earmarked funds and negotiating multiple funding streams confusing.

Disjointed commissioning and fragmented funding streams without any clear resources earmarked for neuropsychiatry leaves neuropsychiatry at the periphery of multiple streams of funding, for example mental health, older adults' health, neurosciences, specialist neurorehabilitation. It has been hypothesised that there is a lack of adequate understanding of neuropsychiatry among commissioners and service managers, be it of mental health or physical health.³ To expect a high level of specialised expertise at every local commissioning unit for a range of neuropsychiatric disorders, each of which have a small local population, is unrealistic. Current restructuring also provides the opportunity for neuropsychiatry services to be commissioned through 'specialist commissioners' with earmarked funding. Specialist commissioning covering a substantial geographical area will address concerns of lack of understanding through specialist knowledge as well as ensure there are sufficient patient numbers (critical mass).

From our survey we gathered that very few mental health providers, apart from a few large neuropsychiatry centres, provided care for the vast range of neuropsychiatric conditions. We hypothesise that conditions such as sleep disorder or neuropsychiatric input into neurodegenerative conditions and epilepsy may be closely aligned with acute healthcare, which was possibly not wholly captured in this survey, as they are both far removed from mental health commissioning or mental health trusts and do not have earmarked funding stream that can be reliably traced. There was indirect

evidence that the commissioning of these services was possibly linked with generic acute hospitals and funded through physical health funds or a specialist neurosciences funding panel (*Fig. 2*).

Commissioning in neuropsychiatry needs to be integrated and streamlined. Funding and resources for neuropsychiatry need to be transparent and ring-fenced to allow services to be equitable across the country.

Need for strategic drive in neuropsychiatry

Commissioners and providers identified a lack of strategic drive as a barrier for neuropsychiatry commissioning. The study shows that where strategic drive exists, even if the condition is rare, it improved standardisation and access to services. The two conditions where this survey found a good degree of shared understanding from provider and commissioning perspectives were brain injury neurorehabilitation and young-onset dementia. Both were supported by the presence of strategic drive, for example the NSF for long-term conditions,¹⁰ a House of Lords report,¹¹ the Department of Health's dementia strategy,¹² or the National Institute for Health and Care Excellence (NICE) guidelines on dementia.¹³ Services for medically unexplained neurological conditions in London were possibly helped by the recognition of medically unexplained conditions as one of the four streams for which Healthcare for London started working on care pathways in 2008, which later evolved into the Darzi care pathways (the work has been summarised by the report from the Commissioning Support London).¹⁴ Unlike the NSF for mental health, the NSF for long-term conditions provided an opportunity to foster neuropsychiatric service development.¹⁰ It was recognised by neuropsychiatrists as a potential strategic driver,¹⁵ but so far its impact has been arguably limited. Adult ADHD and autism spectrum disorder services were boosted by their respective national clinical guidelines.^{16,17}

We believe there is an imminent need for a strategic drive for generic neuropsychiatry, both nationally and internationally. The Royal College of Psychiatrists' working group consensus paper provides an ideal platform to develop strategic drivers to foster neuropsychiatry services' development to meet population needs.⁹

Developing a shared understanding of what is neuropsychiatry

Different definitions and interpretations of the core neuropsychiatric territory are damaging to the development of neuropsychiatric services globally.³ This confusion is not new. In 2005, the International Neuropsychiatric Association identified 'defining of neuropsychiatry' as one of the key priorities and 'first and the most difficult challenge' to help identifying 'the legitimate territory of neuropsychiatrist'.¹⁸ This confusion around the remits of the discipline spills over to neuropsychiatry service provision. There was a significant variation in the familiarity of the different conditions and their commissioning and service provision (*Fig. 2*).

The perception of what constitutes neuropsychiatry varied significantly among both commissioners and providers. Assessment of local need for commissioning is affected by this uncertainty around prevalence of 'neuropsychiatric cases'. Through our survey we obtained direct and indirect evidence that neuropsychiatry services were highly non-uniform in what they provided.

It is important to look at neuropsychiatry as a discipline with more clear boundaries and foster development of specific drivers that promote uniform service provision that is both adequate and equitable. Neurodevelopmental disorders (such as autism spectrum disorder and adult ADHD), young-onset dementia and psychiatry of intellectual disability often require skill-sets similar to neuropsychiatry, but traditionally have not been considered its core business. In fact, they do not form part of the core Specialised Services National Definitions Set definition of neuropsychiatry.¹⁹

We believe the nature of the difficulties seen by neuropsychiatry services is by definition complex and beyond the service provision that could be delivered by either neurology services or mental health services alone. We suggest a basic model with four categories to define the core boundaries of neuropsychiatric disorders (*Box 2*).

Limitations

The study was carried out within the Greater London SHA. One can therefore argue that the results might not be generalisable to other areas. However, London was chosen as it had a high concentration of neuropsychiatry centres within a well-circumscribed geographical area located within an SHA where previous service mapping had been carried out.^{5,7} We believe that the problems identified in London can only be an underestimate of commissioning barriers across the country. This can be taken as a pilot study, as information and literature in this field nationally or internationally is very limited.

Box 2 Core neuropsychiatric disorders

Broadly speaking, neuropsychiatry services provide assessment, investigation and treatment for patients with: a neuropsychiatric disorder (cognitive, behavioural or psychiatric symptoms) associated with a recognised neurological condition or organic brain lesion such as Parkinson's disease, epilepsy, acquired brain injury a neuropsychiatric disorder or mental illness with a yet unrecognised neurological condition or probable organic aetiology (e.g. psychosis related to as yet undiagnosed epilepsy or encephalitis) functional neurological disorders (e.g. dissociative seizures, dissociative memory disorder or conversion disorder) excluding primary presentation with general somatoform disorders without prominent neurological symptoms, chronic fatigue and chronic pain disorders other neuropsychiatric conditions may include specific conditions such as neuropsychiatric sleep disorders, complex neurobehavioural disorders or neuropsychiatric manifestations of extracranial physical conditions.

The study looked into commissioning from the mental health commissioners' perspective and incorporated neurorehabilitation specialist commissioning. However, neuropsychiatry services are located at the interface of neurology and psychiatry and therefore the study may have failed to capture any neuropsychiatry services that are commissioned through and embedded within acute or psychical healthcare setting.

The study surveyed service providers and commissioners and can only comment on the responders' understanding, knowledge and perception of how services were aligned. For the purpose of this study these responses were taken to be proxy measures of the reality of service provision on the ground and the process of their commissioning. The data collected may have been contaminated due to confusion over 'caseness' of neuropsychiatry patients.

Neuropsychiatry commissioning remains disjointed and variable. This study identifies barriers for neuropsychiatry commissioning and service development. This makes a case for neuropsychiatry to be commissioned in its entirety through a national specialised commissioning group in the future. This should help to reduce inconsistent provision nationally and help respond to unmet need. There is urgent need for increasing collaborative working between national commissioners and national bodies of neuropsychiatric expertise such as the Royal College of Psychiatrists' Faculty of Neuropsychiatry in the UK. Such a joined-up approach is necessary to develop universally acceptable strategic drives that can foster real improvements in services and benefit patients with neuropsychiatric conditions. We must learn the lessons of the past to break the barriers we continue to encounter.

1.8.79 The changing face(book) of psychiatry: can we justify 'following' patients' social media activity?

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Abstract

Individuals with mental health issues may post information on social networking sites that can provide an insight into their mental health status. It could be argued that doctors (and specifically psychiatrists) should understand the way in which social media is used by their patients to gain a better insight into their illnesses. However, choosing to actively monitor a patient's social media activity raises important questions about the way in which medical students, qualified clinicians and other healthcare professionals obtain information about patients. While this may be framed as a mere form of 'collateral history-taking', there are obvious practical and ethical problems with doing so. Here, a case is made against monitoring the social media activity of patients involved with psychiatric services.

Contents

- *The changing face(book) of psychiatry: can we justify 'following' patients' social media activity?*

In 2013, nearly one in four people worldwide actively used social networking sites, a statistic predicted to increase rapidly throughout this decade.¹ Given that so many people are using social networking sites, it may be no surprise to find that many people with mental health issues have a social media presence too. For example, there are a plethora of 'pro-ana' (pro-anorexia) websites, blogs and Facebook groups in existence for individuals with eating disorders. These have proven to have both therapeutic and potentially dangerous effects on illness behaviour.^{2,3}

People with mental illness may post information online that provides an insight into their current mental health. If this is the case, then doctors (and specifically psychiatrists) should understand the way in which social media is used by patients as it may allow them to gain a better insight and, subsequently, provide better care.

To explore these premises, I consider the act of looking at a patient's Facebook page, Twitter activity or personal blog as merely another form of 'collateral history-taking'. Focusing specifically on the Facebook 'status update' – a way in which individuals may post their current thoughts and feelings (with a time and date stamp) – I ask whether this is a way to access a patient's mental state in real time. Given that the majority of Facebook profiles are public (meaning that the profile owners have chosen not to opt into privacy settings), any updates posted are available to not only Facebook 'friends' but also others within the person's associated 'networks' and those outside, for instance healthcare professionals.

A study carried out in the USA aimed to assess the prevalence of college students' disclosures of depression symptoms on Facebook.⁴ Despite the potential for stigma surrounding mental health symptoms or diagnoses, a quarter of profiles observed publicly displayed depression references. However, should we take this statistic seriously? We may, wrongly, be talking about an overrepresented population. It might be that patients with particular mental health conditions or certain personality types are more likely than others to frequent the likes of Facebook, Twitter and other forms of social media more often. It has been suggested that there may even be a correlation between excessive internet use and social anxiety, depression and introversion.⁵ Furthermore, we cannot be sure that the information posted in an update is accurate. Creating a social media profile allows profile owners to be selective about the aspects of their identity they wish to display and those they wish to avoid putting into focus. The 'online disinhibition effect'⁶ states that when people are online, they tend to disclose more about themselves or act out more intensely or frequently than they would in person. This suggests that we should exercise a degree of caution when considering information posted online.

Nonetheless, even if the information posted online by individuals with mental health issues is accurate, there appears to be a 'fine line' between monitoring and being meddlesome. Once a doctor has demonstrated that their actions would be of benefit to the patient, the most pressing question to consider next is whether they should ask the patient for their consent. The Human Rights Act 1998 states that everyone 'has a right to respect for his private and family life, his

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home and his correspondence'. This applies even if seeking a patient's consent will have an effect on their future activity online. The obvious response to this is that the information has already been made public, and so patients have waived any rights that they had to privacy. Yet, a survey of 492 bloggers demonstrated that people often disclose information online with a particular audience and time period in mind, even though the information may then become broadly available for an indefinite period.⁷ Medical students and qualified clinicians should be aware that accessing a patient's social networking profile through covert and unauthorised means may form a basis, at least in the patient's opinion, for the argument that they have infringed upon their patient's private life.

Finally, if we proceed without consent and the patient finds out, there may be serious effects on the psychotherapeutic relationship: a relationship based on the active engagement of the patient which can no longer happen if the patient does not trust the healthcare professional. This is likely to have implications for the patient's health. There is an implicit understanding that a patient's trust in their doctor is unconditional. In response to the new dilemmas that may arise in clinical practice due to the rise of social media use by both patients and clinicians alike, the General Medical Council has reiterated the importance of trust not only in a doctor's clinical practice but also in their online behaviour.⁸

If a psychiatrist takes it upon themselves to do further research on their patient online and finds conflicting information, it is difficult to see how this could be used without challenging the patient's narrative. This is further complicated by the question of what to do with any new discoveries about the patient that may surface. Options for the psychiatrist may include: documenting new information in the patient's notes, conferring with colleagues, telling the other members of the multidisciplinary team involved in the patient's care, or disregarding what they have seen for fear of future repercussions. It is, however, important to consider whether the psychiatrist has a duty of care to act on information of which they would have otherwise been unaware.

While not specifically social media, the internet has been used as part of risk assessment in accident and emergency settings before. The information obtained from a Google search proved to be crucial in a doctor's decision to classify a patient as high- rather than low-risk for future suicidal intention.⁹ However, it would be a slippery slope to suggest that one success justifies following the social media activity of all of our patients. Whereas in theory actively looking at a patient's social media profile might be advantageous, in reality it is unethical (particularly without consent). If doctors plan to use any information found for treatment, then they will have to disclose their intentions to patients before they do so.

I would like to thank Dr Angelika Luerhs for her support while researching this topic.

1.8.80 Mental health problems associated with female genital mutilation

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date

2015-12

Abstract**Aims and method**

To study the mental health status of 66 genitally mutilated immigrant women originating from Africa (i.e. Somalia, Sudan, Eritrea and Sierra Leone). Scores on standardised questionnaires (Harvard Trauma Questionnaire-30, Hopkins Symptom Checklist-25, COPE-Easy, Lowlands Acculturation Scale) and demographic and psychosocial correlates were analysed.

Results

A third of the respondents reported scores above the cut-off for affective or anxiety disorders; scores indicative for post-traumatic stress disorder were presented by 17.5% of women. Type of circumcision (infibulation), recollection of the event (a vivid memory), coping style (avoidance, in particular substance misuse) and employment status (lack of income) were significantly associated with psychopathology.

Clinical implications

A considerable minority group, characterised by infibulated women who have a vivid memory of the circumcision and cope with their symptoms in an avoidant way, reports to experience severe consequences of genital circumcision. In terms of public healthcare, interventions should target these groups as a priority.

Contents

- *Mental health problems associated with female genital mutilation*
 - *Method*
 - * *Design*
 - * *Procedure*
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 - * *Instruments*
 - * *Statistical analysis*
 - *Results*
 - *Discussion*

Female genital mutilation (FGM) ‘comprises all procedures involving the partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons’.¹ The procedure is performed within a wide range of mainly African ethnic groups. Appropriate estimations are that between 100 and 140 million women and girls have undergone the practice.² FGM is defined as a violation of human rights, and in many countries it has been outlawed. Nonetheless, FGM is still performed in a large part of Africa, particularly in Eastern regions. Currently, FGM is also performed in small migrant girls resident in European countries.³ The impact of FGM on social and psychological health is underresearched⁴⁻⁹ and knowledge of the psychosocial consequences in a migration context is even scarcer.¹⁰⁻¹² Moreover, reports vary from high prevalence of trauma-related and other psychiatric symptoms such as anxiety and depression,^{4,13} to no mental health problems at all¹⁴ or even positive feelings.^{15,16}

The aims of this study were to explore the relationship between FGM and psychopathology in circumcised women originating from an African country who have migrated to The Netherlands. Research questions were: What kind of mental health problems are reported by circumcised immigrant women? Which factors are associated with the presented psychopathology? Based on the literature,⁴⁻¹² we hypothesised potential predictors of psychopathology which could be

distinguished between demographic factors (e.g. country of birth, years of residence in The Netherlands, educational level), circumcision-related factors (type of circumcision, age at the time of circumcision, vividness of recollection of the circumcision), coping mechanisms and acculturation demands.

Method

Design

In a cross-sectional research design, a survey among a sample of circumcised immigrant women in The Netherlands was conducted. Topics were measured in a quantitative way by means of culturally sensitive standardised questionnaires (the complete study design is described in Vloeberghs *et al*¹⁷).

Procedure

The estimated size of the target population (women who have undergone FGM living in The Netherlands) is about 26 000 women.³ We involved representatives of this population actively in the research process, at the level of both data acquisition and data interpretation. Participants were recruited by means of snowball sampling, a sampling method that is being used to study hard-to-reach populations (see, for example, de Jong & van Ommeren¹⁸).

The first stage of snowball sampling involves selecting individuals using referrals by insiders within the target population. These individuals were asked to list others with identical characteristics. From this list at least one person was randomly selected and approached for an interview. The interviewee was then asked to list others and the same procedure was repeated several times. Attempts were made to maximise sociodemographic diversity. Approximately half to a third of the solicited women (depending on the interviewer and her network) agreed to participate. It was not possible to compare those who chose to participate in the interview with those who declined.

The interviews were conducted by seven interviewers (all females coming from the participants' countries of origin). We consulted various key persons in the different communities during the development of the measures and the interpretation of the results (e.g. during 'experts meetings'). Interrater reliability across the interviews was enhanced by means of a protocol that guided the interview process and a training concerning the way in which the interviews should be conducted, how to handle possible risks of (re-) traumatisation and ethical aspects concerning the process of personal data collection.

The respondents were informed about the aim of the study by means of an information sheet. The interviewers – who were awarded financial compensation – were instructed to read the information sheet to illiterate respondents. It was emphasised that they had to guarantee anonymity and that participation of the respondents was voluntary. Participants were reassured about confidentiality and told that they were not obliged to answer questions that they did not wish to answer. They were given the telephone number of a family doctor attached to the project (M. van den M.) whom they could contact in case of problems or questions concerning their well-being.

The interviews mainly took place at the respondents' homes. In some cases they were conducted at community centres or in public places, depending on the preference of the participant. The interviews were completed within an 18-month period in 2008/2009. The duration of the interviews varied from 40 to 180 min (mean duration about 90 min). The answers were recorded verbatim and later transcribed by the researchers (J.K. and E.V.).

Sample characteristics

A group of 66 women participated in the study (*Table 1*). The participants' ages ranged from 18 to 69 years, averaging 35.5 years (s.d. = 10.5); 43% were married, 79% had children (mean 1.78, s.d. = 1.6). The group included 36 (54%) heavily circumcised (infibulated) women, mainly from Sudan and Somalia. The other women had undergone less invasive forms of circumcision: 9 women got an excision (type 2), whereas 21 had undergone type 1 circumcision.¹⁹ The age at which the participants were circumcised ranged from 8 months to 16 years (mean 6.4, s.d. = 4.1).

Descriptive statistics of demographic variables of the FGM sample ($n = 66$)

Variable	
Age, years: mean (s.d.) range	35.5 (10.5) 18–69
Age at circumcision, years: mean (s.d.) range	6.4 (4.1) 0.8–16
Years in The Netherlands, mean (s.d.) range	10.9 (6.3) 2–29
Number of children, mean (s.d.) range	1.78 (1.6) 0–8
Country of birth, n (%)	
Somalia	18 (27)
Sierra Leone	12 (18)
Sudan	18 (27)
Eritrea	12 (18)
Ethiopia	6 (9)
Type of mutilation, ^a n (%)	
Type I clitoridectomy	21 (32)
Type II excision	9 (14)
Type III infibulation	35 (54)
Marital status, n (%)	
Alone (single, widow, divorced)	33 (57)
Married with family	25 (43)
Education, n (%)	
Low (6 years)	9 (16)
Middle (6–12 years)	24 (43)
High (12 years)	23 (41)
Source of income, n (%)	
Job, education fee or social benefit	37 (66)
No income	19 (34)

FGM, female genital mutilation.

According to World Health Organization classification.¹⁹

Instruments

The survey consisted of four questionnaires including the Harvard Trauma Questionnaire (HTQ-30),²⁰ a 30-item transculturally validated screening instrument for post-traumatic stress disorder (PTSD) symptomatology (Cronbach's $\alpha = 0.96$ in the current sample); the Hopkins Symptom Checklist (HSCL-25),²¹ which measures anxiety (10 items) and depression symptoms (15 items) and has proven to be useful as a screening instrument in several cross-cultural studies and patient studies²²⁻²⁵ (Cronbach's $\alpha = 0.96$); the COPE-Easy,²⁶ which measures different coping styles by means of 32 items grouped under three theoretical head dimensions: (a) actively problem-directed coping, (b) support-seeking coping and (c) avoidance behaviour; the internal consistency of the subscales of COPE-Easy in this sample was satisfactory (Cronbach's α varying between 0.67 for avoidance behaviour and 0.91 for active problem-directed coping); and the Lowlands Acculturation Scale (LAS),²⁷ which assesses the level of cultural adaptation with 20 items and distinguishes between a global orientation towards the past (and land of origin) as opposed to the orientation towards the future (and country of current residence) in terms of integration skills and culture-bound traditions (Cronbach's $\alpha = 0.63$). All instruments were translated into languages spoken by the participants, applying a back-translation procedure. A preliminary version of the questionnaires was pilot-tested with ten women and both content and format were revised on the basis of results.

Statistical analysis

Hierarchical regression analyses were used to test whether demographic factors (country of birth, age, years of residence in The Netherlands, marital status, educational level, source of income and number of children), circumcision-related factors (type of circumcision, age at the time of circumcision, vividness of recollection of the circumcision), coping strategies (COPE-Easy subscales) and acculturation demands (LAS subscales) predicted symptom severity of PTSD (HTQ-30 total score), anxiety and depression (HSCL-25 total score).

Results

More than a third of the participants ($n = 24$, 36%) scored above the cut-off level for indicators of psychopathology: a fifth of the total sample ($n = 13$, 20%) met the criteria for PTSD (mean HTQ-30 score >2.5), a third met the criteria for depression ($n = 22$, 33%), nearly a third met the criteria for an anxiety disorder ($n = 20$, 30%; mean HSCL-25 score >1.75) and a sixth ($n = 11$, 18%) scored above the cut-off level for all three psychopathology indicators. Almost two-thirds of all participants ($n = 42$, 64%) did not report scores above the cut-off on indicators for PTSD, anxiety or depression.

Type of circumcision, country of origin, source of income, vividness of recollection and coping style were significant factors in a multivariate context concerning mental health symptoms. Infibulation, a 'vivid recollection' and a substance-misuse coping style were associated with enhanced PTSD scores, whereas originating from Somalia was associated with decreased post-traumatic symptoms ($R^2 = 0.67$, $F_{(4,38)} = 22.04$, $P < 0.0001$; Table 2). Associated with higher anxiety and depression scores were infibulation, substance misuse, avoidance coping and lack of income; however, women originating from Somalia reported less anxiety and depression ($R^2 = 0.59$, $F_{(5,39)} = 13.68$, $P < 0.0001$; Table 3).

Summary of hierarchical multiple regression analysis on HTQ-30 total score ($n = 66$)

Variable	Beta	95% CI low	95% CI high
1 Memory	0.648***	0.644	0.296
2 Memory	0.522***	0.536	0.222
Coping substance mis- use	0.421***	0.062	0.194
3 Memory	0.545***	0.542	0.248
Coping substance mis- use	0.422***	0.067	0.190
Somalia	0.255 **	0.739	0.101
4 Memory	0.478***	0.489	0.204
Coping substance mis- use	0.335***	0.041	0.163
Somalia	0.358***	0.915	0.263
Infibulation	0.285 **	0.076	0.625

HTQ, Harvard Trauma Questionnaire.

$P < 0.05$

$P < 0.01$

$P < 0.001$.

Summary of hierarchical multiple regression analysis on HSCL total score ($n = 66$)

Variable	Beta	95% CI low	95% CI high
1 Coping substance misuse	0.656***	0.140	0.293
2 Coping substance misuse	0.551***	0.101	0.263
Coping avoidance	0.254*	0.002	0.094
3 Coping substance misuse	0.546***	0.102	0.258
Coping avoidance	0.289*	0.009	0.099
Somalia	0.219*	0.781	0.000
4 Coping substance misuse	0.467***	0.078	0.230
Coping avoidance	0.207	0.005	0.083
Somalia	0.322**	0.970	0.183
Infibulation	0.316*	0.090	0.737
5 Coping substance misuse	0.454***	0.076	0.223
Coping avoidance	0.224*	0.000	0.084
Somalia	0.330**	0.969	0.210
Infibulation	0.284*	0.059	0.687
No income	0.199*	0.001	0.547

HSCL, Hopkins Symptom Checklist.

$P < 0.05$

$P < 0.01$

$P < 0.001$.

Discussion

FGM is associated with a wide range of long-term health and psychological problems (e.g. Andro *et al*²⁸). Circumcised immigrant women in this study are likely to report emotional disturbances that relate to FGM, with about a sixth reporting scores above the threshold for PTSD and a third reporting severe levels of depression or anxiety. Specific factors, associated partly with FGM and partly with current life stressors, influence the severity of psychopathology. In particular, infibulated immigrant women who have a vivid recollection of the circumcision, who do not have a paid job, and who cope with their problems mainly in an avoidant way (substance misuse), may form a group at risk of severe psychological problems.

The majority of the sample reported mental health problems but did not meet criteria indicative of psychopathology. These relatively low percentages could be due to the common fact that the majority of the survivors of traumatic events are able to recover without developing mental health problems. The underreporting of symptoms could also be owing to different perceptions (not the circumcision but other stressors would be responsible for the current complaints/symptoms) or taboo (being ashamed to talk about the problems, feeling a sense of stigma). In addition, the reluctance to speak out can be related to the fact that thinking or talking about the mutilation may cause the pain experienced at the time of the ritual to reappear; chronic pain and traumatisation can have a mutually reinforcing effect.²⁹ Nonetheless, it may also be true that the majority of the women experience no substantial traumatic symptoms as a consequence of FGM (see Lockhat,¹² who showed that women who were circumcised according to the mild sunna variant (type 4) did not report PTSD-related problems).

The finding that infibulation and a vivid recollection may enhance symptomatology may not come as a surprise. Still, some findings do puzzle us, such as the finding that Somali background appears to have a protective effect.

Speaking openly about the trauma may only be beneficial when this is appropriate within a culture of recognition of the trauma and its psychological consequences. Somali respondents may have more problems communicating about FGM in their culture. Another explanation may be that Somali women assess the event less negatively than women from other countries. According to the Lockhat model,¹² a negative judgement is predictive of PTSD development. In fact, some Somali women refer to the Islamic teachings saying that sunna is not prohibited. To them sunna has a normative and positive connotation within Islam, whereas, for instance, Sudanese respondents reject the Somali reinterpretation (Idjihad) of what is being said in the Holy Writings.¹¹

Another finding concerns the relationship between symptoms, avoidant coping and substance misuse. Avoidance plays a pivotal role in PTSD symptom maintenance.³⁰ Accordingly, it is not surprising that avoidant coping is associated with PTSD symptom severity. Participants may develop substance misuse problems in an attempt to manage distress associated with the effects of FGM and related stress symptoms, or to numb themselves from the remembrance or experience of intense emotions. In our sample this coping style seems to exacerbate the problems in those experiencing anxiety and depression.

Our study has a unique character. The active participation of the target population and the way we obtained data provide sufficient ground for answering the research questions validly. For HTQ and HSCL excellent cross-cultural psychometric results have been reported. Some caution, however, is warranted in interpreting the results. Using a cross-sectional design, we can only employ a relatively passive approach to making causal inferences based on the findings – we may only speak about potential predictors. Moreover, the small group size, which is an inherent consequence of studying such a precarious topic, presents an important limitation as do the composition characteristics of the group (i.e. the high level of education and low marital state).

Incorporated in the clinical treatment of circumcised immigrant women should be providing them with coping mechanisms to help them come to terms with their experiences. Using therapy to equip women with instrumental skills to help them cope in day-to-day life and promote social integration to avoid social isolation (e.g. by enrolling the women

in education/training) is also a good starting point for improving mental health (see also Summerfield³¹). In addition, when treating women who experienced FGM one must be able to discern the various types of FGM, be knowledgeable about the related symptoms and the effects these may have on the woman, and have awareness regarding the taboo surrounding the practice. Finally, mental healthcare providers should be attentive to the fact that FGM is but one of a range of possible traumatising experiences the patient may have been subjected to. They should not only focus on FGM but check whether there are other factors, such as social or financial circumstances, that may be causing the symptoms presented by the patient.

On the basis of the empirical findings presented, our study shows that FGM is associated with psychological health problems for a substantial group of immigrant women. However, a considerable number of women are capable of coping with most impediments and may regard the ritual as 'normal' and therefore not sickening. Our data thus underline the diversity in interpreting the events and the level of remembrance as crucial for experiencing psychopathology. For future studies, it is important to elucidate the contextual factors that influence decisions about service utilisation. Prevention and clinical efforts should focus on the individual within its context and should be aware of potential hesitation among some women to seek psychological help. Clinicians are encouraged not to pathologise the consequences of FGM but to focus on the urgent psychological, social and psychosexual needs identified among a significant number of circumcised women.

1.8.81 YouTube and 'psychiatry'

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Abstract

YouTube is a video-sharing website that is increasingly used to share and disseminate health-related information, particularly among younger people. There are reports that social media sites, such as YouTube, are being used to communicate an anti-psychiatry message but this has never been confirmed in any published analysis of YouTube clip content. This descriptive study revealed that the representation of 'psychiatry' during summer 2012 was predominantly negative. A subsequent smaller re-analysis suggests that the negative portrayal of 'psychiatry' on YouTube is a stable phenomenon. The significance of this and how it could be addressed are discussed.

Contents

- *YouTube and 'psychiatry'*
 - *Study*
 - *Study results*

1

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– Discussion

* *Psychiatry fighting back*

YouTube (www.youtube.com) is a video-sharing website created in 2005, which now provides a platform for 2 billion clip viewings every day.¹ The website's viewership statistics are eye opening. More than 1 billion unique users visit YouTube each month. Over 6 billion hours of video content are watched each month and 100 hours of video are uploaded to YouTube every minute. It is available in 61 countries and across 61 languages, and according to Nielsen, YouTube reaches more US adults aged 18-34 than any cable network.²

Clip content is varied, uncontrolled and often anonymous. Whereas clips are uploaded and accessed by diverse individuals, groups and political bodies across the globe, universal access is restricted in some countries. In China, for example, YouTube access was blocked by the government in 2009 as a response to Tibetan content.³ YouTube website administrators also reserve the right to remove uploaded content should users violate specified terms and conditions. Video files that ignite social political unrest, violate copyright and intellectual property protection laws, or breach national security legislation are likely to be removed. According to the YouTube terms of service, material which is obscene, defamatory or unlawful must not be submitted.⁴ Despite these restrictions, the YouTube platform is largely an unregulated medium which is being used to circulate extraordinarily varied material. This includes sharing and disseminating health-related information, particularly among younger people.^{5,6} Against this backdrop, there is growing concern that internet social media are being increasingly used to communicate an anti-psychiatry message.⁷ However, to our knowledge, this has never been confirmed in any published systematic analysis of YouTube content. This descriptive study aimed to determine whether YouTube portrayed 'psychiatry' in a positive, neutral or negative light. In view of the enormity of the viewership statistics, we consider the implications of this.

Study

On 12 July 2012 we examined YouTube on default search settings using the solitary search term 'psychiatry'. We believed this to be the most appropriate description of the discipline as a whole and the most likely reductionist YouTube search term for the specialty. Other possible search terms such as 'mental health' were discounted owing to the conceptual overlap with psychopathology and other constructs and the likelihood of generating broad and irrelevant search results. YouTube ranks search results according to relevance gained from the title of the clip, descriptive language within 'relevant keywords' and 'video tags', and the video description itself. Furthermore, the higher the number of 'comments' a video possesses, the higher the 'authority signal' becomes (i.e. the inherent video popularity, which also promotes a higher ranking).⁸

The first 100 clips of more than 1000 ranked results were viewed independently by two researchers (R.G. and J.M.) and categorised as positive, negative or neutral in their representation of psychiatry. No explicit criteria were used in categorising clips, which were assigned to each category according to the global impression of reviewer regarding the overall theme of each clip. Clips were assigned 'neutral' as a default if no overall negative or positive theme was identified. Disagreements in clip category were arbitrated by a third reviewer (N.C.). The number of views and clip length were also recorded. Non-functioning, deleted or repeated clips were excluded from analysis. Browser software at the time of examination was up to date and there was no disagreement between non-functioning clips observed on different computers.

Study results

The kappa agreement between observers was 76%. The observers excluded 20 clips from analysis. The majority of eligible clips portrayed psychiatry negatively (51%) compared with neutrally (29%) and positively (20%) (*Table 1*). Negative clips were viewed more frequently and were longer than both positive and neutral clips. A subsequent smaller re-analysis of the first ten ranked clips on 14 July 2013 (five negative, two positive, three neutral) and 13 August 2014 (six negative, one positive, three neutral) revealed similar findings. A selection of analysed clips is provided in *Box 1*.

Characteristics of negative, positive and neutral clips on 12 July 2012

Clip type	Eligible clips, <i>n</i> (%)	Average number of clips views	Average clip length
Negative	41 (51)	77 035	14m 49s
Positive	16 (20)	54 234	9m 34s
Neutral	23 (29)	7244	7m 20s

Common themes of negative clips related to the process of diagnosis and treatment. In particular, psychiatric diagnoses were criticised for being invalid, unreliable and a non-scientific mechanism of social control. Other concerns included stigma and the ‘labelling’ of individuals with diagnoses, administering toxic psychotropic medication to children and the potential harm of psychiatric treatment. Themes of positive clips included the benefits of psychiatric research, improvements in treatment and an anti-stigma video (‘Beards and Bowties’ by Dr Kamran Ahmed: <http://www.youtube.com/watch?v=70loMcIqd9Q>). Neutrally themed clips were largely educational in nature, including a cartoon portrayal of the proposed neurotransmitter mechanism of bipolar affective disorder.

Discussion

This study reveals that the representation of ‘psychiatry’ on YouTube in July 2012 was predominantly negative. Subsequent clip analyses in 2013 and 2014 suggest that this is a stable phenomenon. The source of negative YouTube clips was unclear owing to blind authorship. However, there were three ‘regularly negative’ authors of clips promoting a seemingly ‘anti-psychiatry’ campaign.

What does a search term of ‘psychiatry’ mean? Content analysis of clips suggested the discipline of psychiatry itself was the implied meaning of ‘psychiatry’ in the majority of clips. Although other medical specialties also suffer from negative portrayals on YouTube, this is usually topic-specific such as paediatric immunisation or objections to tanning by dermatologists.⁹⁻¹¹ ‘Psychiatry’ as a medical discipline appears uniquely targeted on YouTube for negative representation.

Why is portrayal of psychiatry on YouTube negative? The YouTube medium itself is vulnerable to extreme content owing to blind authorship, presentation of opinion as fact and the distinct lack of any peer review or editorial process.³ The online anti-psychiatry campaign has been linked to Scientology, disgruntled patients and psychiatrists, critical social scientists, humanistic psychologists and journalists sceptical towards psychiatry.⁷ It has also been suggested that an anti-psychiatry group now exists as a patient-based consumer movement.⁷ This online antipsychiatry message may be increasing,⁷ with the release of DSM-5 being a particular nidus of further criticism.¹² The negative online representation of ‘psychiatry’ may also be an extension of long-standing societal scepticism of ‘psychiatry’ into a contemporary medium. It could also be symptomatic of the overall failure of psychiatry to promote itself more positively.

It is unclear whether information disseminated through social media platforms influences health-related attitudes and behaviours.⁶ More educated viewers appear relatively resistant to inaccurate information on YouTube, even when the message is framed as scientific reasoning.⁶ However, it does appear that social media websites are becoming an increasingly popular source of health information.¹³ The spiralling volume of uncensored information being uploaded to social video platforms such as YouTube makes it difficult for health consumers to discern reliable health information from misleading content. Certain patient groups, such as younger adults and people with anorexia, may be more

vulnerable to extreme content.¹³ It is also unclear how the negative online representation of psychiatry interacts with real-world stigma surrounding psychiatric illness and its treatment.

Box 1 A selection of clips from the original 2012 analysis

Negative:

http://www.youtube.com/watch?v=y_AC-JhPOI (The psychiatric drugging of children & elderly)

<http://www.youtube.com/watch?v=hy79C0v8eIE> (Psychiatry)

<http://www.youtube.com/watch?v=PcuhhJ1BaMk> (The DSM: psychiatry's deadliest scam)

Positive:

<http://www.youtube.com/watch?v=dFs9WO2B8uI> (RSA animate – the divided brain)

<http://www.youtube.com/watch?v=tTCwihayOv0> (Peggy Rodriguez, MD for UNM Department of Psychiatry Residency Program)

<http://www.youtube.com/watch?v=89-LDCnP8qw> (Anthony Rothschild, MD: Brudnick Chair & professor of psychiatry)

Neutral:

<http://www.youtube.com/watch?v=5N8LJjGjsfI> (Ask the doctor: cardiology, psychiatry, geriatric medicine)

<https://www.youtube.com/watch?v=qVkYHioCHPk> (Psychiatry, Ain Shams University, basic interviewing skills 1.wmv)

<https://www.youtube.com/watch?v=jq5F2XRt6QM> (Psychiatrist vs psychologist (mental health guru))

Despite negative representation, viewing rates of YouTube 'psychiatry clips' are low compared with other content. The most popular 'psychiatry' clip, a music video by The Avalanches entitled 'Frontier psychiatrist', including a parody of the psychotherapist and patient encounter, attracted 2.3 million views. To give some perspective, 'Gangnam Style', a music video by the South Korean musician Psy, attracted 1.5 billion views, 'Charlie bit my finger again' 520 million and the Taiwanese 'Nyan cat' animation 101 million views.

Although the effects of negative representations of psychiatry on social media remain questionable, it is clear that YouTube content is capable of exerting global impact. Sceptics of this need only heed the story of Sonya the slow loris. In 2009, Dmitry Sergeyev uploaded a video of her being tickled. Although illegal to have a captive slow loris as a pet outside of Russia, this single viral video has increased the illegal pet trade of these animals and has now led to the near extinction of the species.¹⁴

Psychiatry fighting back

Accepting that negative representation of psychiatry on YouTube is a concern, how can it be addressed? Psychiatrists, their professional bodies and healthcare providers could start by recognising the influence of social media and its potential for disseminating health information, particularly in younger health consumers.⁵ Promisingly, the Royal College of Psychiatrists has launched its own YouTube channel (www.youtube.com/user/RCofPsychiatrists). This currently has low impact, with its introductory clip displaying a modest (2000) number of views, but it could eventually be a platform to provide unbiased and accurate information and to convey a positive message about psychiatry more generally. It may be as important to raise awareness among younger people and vulnerable patient groups about the trustworthiness of online information more generally.¹³ Others have suggested political leverage on YouTube to communicate more objective information⁶ or to carry explicit disclaimers when an extreme view is represented (in the same manner as television). Further options include the development of algorithms to automatically detect and filter extreme videos before they become popular.¹³ However, these proposals are somewhat at odds with the overarching YouTube ethos of free 'self-broadcast'.

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1.8.82 ECT practices in Iraq: a national audit

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Abstract

Aims and method

This national audit examined practice of electroconvulsive therapy (ECT) in Iraq against local standards. Data were collected by a questionnaire sent to heads of departments or medical directors in the 10 Iraqi hospitals which provide ECT and by examining case notes of all patients who had ECT in the first 6 months of 2013.

Results

Of the 26 psychiatric hospitals in Iraq, 10 provide ECT. There were some resource shortcomings in the ECT clinics (e.g. only 2 had a minimum of 2 rooms and all had no EEG monitoring). During the audit period, 251 patients had ECT. The mean age was 36.2 years and 51.8% were males. Bilateral ECT was used in all cases, general anaesthesia in 77.15%. The main indication for ECT was schizophrenia, followed by severe depression, resistant mania, catatonia and others.

Clinical implications

More work is needed to ensure all patients receive modified ECT. ECT is still used widely for schizophrenia. This needs further exploration and training.

Contents

- *ECT practices in Iraq: a national audit*
 - *Method*
 - *Results*
 - *Discussion*
 - * *Limitations*

Electroconvulsive therapy (ECT) is an effective treatment for a small number of patients who have severe mental disorders.^{1,2} Its use has declined in Western countries over the years³ and it has been associated with stigma.^{4,5} Unmodified ECT and its portrayal in the media might have contributed to that stigma.⁶

1

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ECT practice varies across countries.^{3,7} In Asia, a survey of 257 institutions in 23 countries suggested that the practice may be seen as suboptimal, schizophrenia was the main indication, unmodified ECT is commonly used, electroencephalography (EEG) is not common and no formal training was given.⁸

International guidelines have been developed to ensure good practice in delivering ECT.^{1,2} In Iraq, the ECT Policy 2009 was produced by the Ministry of Health as part of a quality and standards project aimed at developing standards for care in psychiatric services. The project was carried out as a collaboration between the Royal College of Psychiatrists' Iraq Sub Committee and the Ministry of Health in Iraq using consensus conferences methodology.⁹ The aim of this audit was to assess the practice of ECT in psychiatric hospitals in Iraq by measuring the degree of compliance with the standards of the Iraqi ECT Policy 2009.

Method

Psychiatric services in Iraq are provided in 26 hospitals. Three of these are psychiatric hospitals and the rest are psychiatry wards or units within general hospitals.⁹ We contacted medical directors or heads of psychiatry departments by email or telephone to find out how many hospitals have ECT facilities: it transpired that only 10 provide ECT treatment.

The audit was designed to investigate compliance with the Iraqi ECT Policy 2009. The policy is written in Arabic and English. We divided the standards of this policy into two groups: the first group included standards related to the requirements of ECT clinics in terms of number of rooms, equipment, medicines, processes and staff. The second group covered the standards related to individual ECT treatments. The full policy is available from authors on request.

A self-completed questionnaire covering the first group of standards and a data collection form covering the second group were developed by the authors. The questionnaire was sent by email to medical directors or heads of departments in the 10 hospitals. The data collection form was completed by psychiatry trainees (students of the Iraqi Board of Psychiatry) in these hospitals providing data from case notes of all patients who had ECT in the first 6 months of 2013. The patients were identified from the ECT clinics' records. This audit was approved by the Iraqi Board of Psychiatry.

Data were analysed with SPSS version 19.

Results

All 10 hospitals returned the questionnaire regarding the first group of standards. For individual ECT treatments, data were available from 8 hospitals only. One hospital did not provide data and in the other no ECT treatment was given during the audit period.

Results showed that only 2 hospitals (20%) have a minimum of 2 rooms in their ECT clinics. Only 3 hospitals (30%) have an ECT machine which is less than 5 years old. No hospital has a machine which has EEG monitoring. Apart from one hospital, all machines used brief-pulse wave electrical current. Only in 4 hospitals (40%) was there an anaesthesia specialist attached to the department. There was a nurse responsible for the department in 7 out of the 10 clinics (70%). A nominated psychiatrist responsible for the department was available in 6 clinics (60%); all clinics (100%) train their ECT team and 4 (40%) conduct an annual audit of the work of the department (*Table 1*).

Responses to the questionnaire in relation to 10 ECT clinics requirements

	<i>n</i>		
Anaesthesia drugs are used according to Iraqi standards	5	0	5
Is there anaesthesia specialist in the ECT department?	4	1	5
Is there is a nurse responsible for the ECT department?	7	3	0
Has a minimum of two rooms	2	8	0
ECT device has EEG	0	10	0
ECT device has different doses	8	2	0
ECT device is less than 5 years old	3	7	0
A nominated psychiatrist is responsible for the ECT department	6	4	0
If yes, was the ECT team trained by the psychiatrist?	6	0	0
If yes, did the psychiatrist conduct annual audit?	4	2	0

ECT, electroconvulsive therapy; EEG, electroencephalography.

During the audit period, 251 patients had ECT: 130 male and 121 female. The average number of patients per hospital was 26.1 (range 0-47). The mean age was 36.2 years (range 17-67 years). The majority of patients ($n = 181$, 72.1%) were 18 to 44 years old, followed by the age group 45 to 64 years ($n = 67$, 26.7%). There was only 1 adolescent patient (<18 years old) and only 2 elderly patients (>65 years old).

The gender distribution was roughly equal with 51.8% of the patients male and 48.2% female. Only about a third (28.3%) were in-patients. Written consent by the patients or their relatives was obtained in all cases. ECT was given through bilateral electrodes placement in all patients. General anaesthesia was used in 77.15% of the cases. Unmodified ECT was given in three hospitals. Further correspondence with these hospitals revealed that the reason for using unmodified ECT was the unavailability of anaesthetists.

The main indication for ECT was schizophrenia (51%), followed by severe depression (31.5%), resistant mania (10.4%) catatonia (2.4%) and others (4.4%). In those diagnosed as having schizophrenia, only 5.5% had a second opinion before ECT was prescribed and in 40% the reason was poor response to other treatments (Table 2).

Demographic and clinical characteristics of the sample ($n = 251$)

	<i>n</i> (%)
Gender	
Male	130 (51.8)
Female	121 (48.2)
Service setting	
In-patient	180 (71.7)

continues on next page

Table 28 – continued from previous page

	<i>n</i> (%)
Out-patient	71 (28.3)
ECT prescriber: psychiatric specialist	251 (100)
Diagnosis	
Severe depression	79 (31.5)
Resistant mania	26 (10.4)
Catatonia	6 (2.4)
Puerperal psychosis	1 (0.4)
Schizophrenia	128 (51)
Other	11 (4.4)
In schizophrenia, reason for ECT	
Previous good response to ECT	3 (1.2)
Poor response to other treatments	102 (40.6)
Risk to self or others	20 (8.0)
Other	3 (1.2)
In schizophrenia, second opinion was obtained: Yes	7 (5.5)
Written consent by patient or relatives: Yes	251 (100)
ECT was done under general anaesthesia: Yes	176 (70.1)
Patient was informed to fast 10 h before treatment: Yes	251 (100)
ECT dose given according to Iraqi standards: Yes	251 (100)
There was a prolonged seizure: Yes	0 (0)
Bilateral ECT: Yes	251 (100)
Patient had ECT previously: Yes	102 (40.6)
Patient notes had documentation about response to previous ECT: Yes	62 (24.7)

ECT, electroconvulsive therapy.

All of the 251 patients (100%) received a physical health examination. However, investigations were done more often in the patients who had modified ECT than those who had unmodified ECT (*Table 3*).

Investigations

	Unmodified ECT (<i>n</i> = 75) <i>n</i> (%)	Modified ECT (<i>n</i> = 176) <i>n</i> (%)	<i>P</i>
Complete blood count	21 (28.0)	171 (97.2)	***
Fasting blood sugar	17 (22.7)	168 (95.5)	***
Urea and creatinine	8 (10.7)	170 (97.1)	***
Liver function test	8 (10.7)	171 (97.2)	***
Chest X-ray	11 (14.7)	176 (100)	***
Electrocardiogram	12 (16.0)	176 (100)	***

$P < 0.001$, chi-squared test.

There were no statistically significant differences between males and females across clinical and demographic variables.

Discussion

As far as we know, this is the first national audit of ECT practice in Iraq against clear and explicit standards. We collected data through two routes, a health professional questionnaire and a review of patient case notes. The audit highlighted areas of good practice and areas which need further improvement.

The majority of our patients were young (72.1% were 18 to 44 years old), which is very similar to Asian patients having ECT⁸ but different from trends in Western countries, where patients are usually elderly.¹⁰ Chanpattana et al¹⁰ suggested that this difference in age group trends could be caused by Asian population demographics and the fact that schizophrenia (with higher prevalence in younger patients) is the main indication for ECT in Asian patients. These explanations could also be valid for our Iraqi sample.

The gender distribution of our sample was roughly equal. This is slightly different from what is known in Asian countries, where more males receive ECT,⁸ and from Western countries, where more females do.¹¹⁻¹⁴ A possible reason for this near-equal gender distribution is that, in Iraq, there was found to be no gender difference in depression;¹⁵ however, it is also possible that our finding was accidental.

Another finding which was very similar to Chanpattana et al's⁸ was that schizophrenia was the major indication for ECT (51% v. 41.8% in their sample). This finding is slightly different from what Iraqi psychiatrists report about the indications for ECT. In a recent survey which included 73 Iraqi psychiatrists, the first indication mentioned was depression, followed by schizophrenia.¹⁶ The use of ECT in schizophrenia could raise a number of questions about the appropriateness and reasons for its use. International guidelines do not recommend ECT in general cases of schizophrenia, but as an option where clozapine has already proved ineffective or intolerable.² A review concluded that ETC might be an option in patients who show poor response to medication¹⁶ and this was also cited as the main reason for ECT in our sample. The lack or unavailability of clozapine and the difficulties associated with blood monitoring in Iraq might be one reason for poor treatment response. The practice of having a second opinion for the use of ECT in schizophrenia is still very rare in Iraq (5.5%) and needs to be encouraged.

It is encouraging that the majority (70.1%) of ECT in our study was modified ECT. This figure indicates a significant improvement in this area: although we do not have exact figures, we are aware that prior to 2003 ECT was mostly given in an unmodified way. This also seems better than the practice of ECT in Asian countries in general, where 55.7%

of patients still receive unmodified ECT,⁸ but is below the 100% standard stipulated by the Iraqi ECT Policy and the practice in high-income countries.^{1,2} Unmodified ECT was applied only in three hospitals and the unavailability of anaesthetists was the only reason. Measures to address this resource issue need to be taken by the Ministry of Health. Closure of ECT clinics where general anaesthesia is not available might be one, albeit the last resort, option. In this context, we are aware that the biggest psychiatry hospital in Iraq (which has 1200 beds) has stopped ECT treatment because of the unavailability of anaesthetists and patients who need ECT are transferred to an acute hospital where a modified ECT is given. This has led to a significant reduction in the number of ECTs (Tamimy J, 2011, personal communication).

In addition to human resources, this audit identified other shortcomings such as the number of rooms, the age of the ECT machine and the lack of EEG monitoring facilities. Improving these areas could lead to an improvement in the quality of care patients receive. For example, EEG monitoring, which was absent in all clinics, could mean lower doses being given and subsequently, fewer cognitive side-effects.¹⁸ One way of improving these areas could be by nominating a consultant psychiatrist (in our sample, this happened in only 60% of the ECT clinics) and a nurse who are responsible for ECT delivery, oversee its practice and audit it.

Bilateral ECT was performed on all patients in compliance with the Iraqi ECT Policy, which stipulates that bilateral ECT should be used except in patients under the age of 18 (only one patient in our sample) or in elderly patients with cognitive impairment. Bilateral use of ECT seems to be the norm in many countries.^{8,10,19,20}

Limitations

One limitation of our study is that we did not collect data about the number of ECT sessions given to each patient. This information could inform us about Iraqi practice in that area, but not necessarily in measuring compliance with the policy, which does not include a standard about the number of ECT sessions. Another limitation is that we did not record how many of the consent forms were signed by patients as opposed to relatives. This could have shed light on transcultural differences in that area. In Iraq, giving consent by the family on behalf of the patient is seen as acceptable. This is something which needs to be explored further in the absence of an active mental health act. This audit has not covered ECT practice in private clinics. We know from personal contact that this is not uncommon but it is not governed by any policy. Regulations might need to be enforced to ensure good practice. We did not collect data about who administered the ECT treatments; however, we know that in Iraq ECT is administered by a psychiatry specialist or a trainee.

The recent history of Iraq has been very traumatic, with three wars, years of economic sanctions and more than 11 years of civil unrest. These major events have affected the health services', including mental health services', infrastructure. Since 2003, there have been attempts to improve and modernise mental health services in collaboration with international bodies such as the Royal College of Psychiatrists through its Iraq Sub Committee. This subcommittee has contributed to many projects,⁹ for example drafting the ECT standards. This audit has examined the practice of ECT in Iraq against these standards and identified areas for further improvement. There are resource issues that need to be addressed by the Ministry of Health and areas which could be improved by training or research. In particular, the use of ECT in schizophrenia needs further exploration.

We thank the medical directors and heads of departments who answered the questionnaire. We also thank the trainee psychiatrists in the Iraqi Board of Psychiatry who helped in the data collection: Dr Ghada Adeeb, Dr Tharaa Wadaah, Dr Lava Dara, Dr Haeffa Ahmed, Dr Akeel Ibraheem, Dr Sadoon Abid, Dr Yassir Saad, Dr Ashwan A. Shwan, Dr Arafat Aldujaili.

1.8.83 Chemotherapy for Hodgkin's lymphoma in a patient receiving clozapine for treatment-resistant schizophrenia: use of the Mental Capacity Act 2005

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Abstract

Treatment resistance occurs in approximately 30% of individuals with schizophrenia and is commonly treated with clozapine. Nodular sclerosing Hodgkin's lymphoma is a subtype of Hodgkin's lymphoma predominantly affecting those under 50 years of age. In this case report, an individual with treatment-resistant schizophrenia developed nodular sclerosing Hodgkin's lymphoma and is treated with concurrent clozapine and systemic chemotherapy. The aim of this case report is to act as guidance for clinicians and to outline the difficulties of treating individuals with psychiatric illness under the Mental Capacity Act 2005 when the proposed treatment could lead to high levels of morbidity and mortality.

Contents

- *Chemotherapy for Hodgkin's lymphoma in a patient receiving clozapine for treatment-resistant schizophrenia: use of the Mental Capacity Act 2005*
 - *Case presentation*
 - *Discussion*
 - *Conclusion*

Nodular sclerosing Hodgkin's lymphoma is the commonest subtype of Hodgkin's lymphoma.¹ It is characterised by proliferation of malignant lymphocytes in the reticuloendothelial system and presenting with lymphadenopathy or systemic 'B' symptoms.² It affects men and women equally and predominantly those under 50 years.¹ There are 3 cases of Hodgkin's lymphoma per 100 000 people in England,³ and without treatment 5-year survival ranges from 40 to 95%.^{2,4} Treatment includes radiotherapy, systemic chemotherapy or both² and is curative in 90% of cases.¹ Risks from systemic chemotherapy treatment include myelosuppression, febrile neutropaenia and thrombocytopenia.² The mortality rate from febrile neutropaenia is 9.5%.⁵

The Mental Capacity Act 2005 is a legal framework in England and Wales for making decisions on behalf of adults who lack capacity to make particular decisions for themselves. All adults are presumed to have capacity for a particular decision unless it can be proven otherwise. Patients who lack capacity require their nearest relative or an independent mental capacity advocate (IMCA) to make a decision on their behalf. Under certain circumstances, decisions are made

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by the Court of Protection. Treatment under the Mental Health Act 1983 does not include the treatment of physical illness except in cases where the mental illness is a consequence of a physical illness.

Treatment resistance is found in approximately 30% of patients with schizophrenia.⁶ Clozapine is currently the most effective management option in schizophrenia, but because of its side-effect profile it is reserved for use only as a third-line agent.⁶⁻⁹ This includes a 0.3-2% risk of potentially fatal agranulocytosis,⁸⁻¹⁰ which is higher among the Asian population^{8,11} and carries a mortality rate of 5-10%.¹² Despite this, a delay in starting clozapine in those with treatment-resistant schizophrenia has been shown to lead to poor outcomes.^{9,13}

To reduce the risks associated with the development of agranulocytosis, blood parameters should be monitored closely¹⁴ and clozapine should be discontinued permanently if leukocyte counts drop significantly.¹⁰ During clozapine treatment clinicians should avoid prescribing drugs that depress leucopoiesis.¹⁰ Here we describe an unusual case where a patient was successfully treated for nodular sclerosing Hodgkin's lymphoma using the Mental Capacity Act 2005 while concurrently treated with clozapine under Section 3 of the Mental Health Act.

Case presentation

A Bangladeshi patient with a 20-year history of treatment-resistant schizophrenia was treated with clozapine. Since diagnosis, the patient has had frequent admissions to acute psychiatric hospitals due to non-adherence, leading to rapid relapse of psychotic symptoms within days of cessation. However, when adherent to clozapine, the patient remains relatively independent with only mild residual delusional ideas persisting in the background.

An abnormal swelling developed in the patient's neck, but believing this to be a side-effect of clozapine, the patient refused to comply with further treatment. While admitted as an in-patient under Section 3 of the Mental Health Act 1983, the patient was diagnosed with stage IIA nodular sclerosing Hodgkin's lymphoma and managed expectantly. However, the patient developed severe leg oedema secondary to inferior vena cava syndrome. Meanwhile, the lymphoma progressed to stage IIIB, with a very poor prognosis if untreated.

The patient refuted the diagnosis of Hodgkin's lymphoma and accounted for symptoms using a multitude of delusional ideas. These included being 'incriminated by someone – who tried to get into my blood and body' and saying that their neck was 'just bloated'. It was deemed that the patient did not have the capacity to consent to or refuse treatment for Hodgkin's lymphoma at that time. The patient was unable to make use of the information that without treatment, a likely outcome would be death, but with treatment the prognosis was excellent. They were not able to understand the gravity of their illness, or why treatment was being offered, as well as continuing to deny the diagnosis. The patient could not weigh up the information provided but was, however, adamant that they did not want their life to end.

The risk to the patient and to others from a prolonged schizophrenia relapse if clozapine was withheld during chemotherapy treatment was weighed against risk of death from myelodepletion. Switching to an alternative antipsychotic agent was considered but not possible due to failure of multiple first- and second-line agents in the past. A literature search failed to provide any evidence of agranulocytosis from treating patients with clozapine and systemic chemotherapy previously.¹⁵ It was therefore deemed in the patient's best interests to give systemic chemotherapy and clozapine concurrently.

The urgency of treating the Hodgkin's lymphoma took precedence over waiting to see whether capacity could be regained with sustained clozapine adherence. In the absence of a nearest relative to consult, an IMCA was appointed, who agreed that systemic chemotherapy treatment should progress immediately against the patient's wishes in their best interests. Application was successfully made to treat the patient with clozapine off-licence.

Before commencing systemic chemotherapy, haematological parameters and clozapine level were within normal range. The patient was treated with six cycles of systemic chemotherapy. Each cycle consisted of doxorubicin 25 mg/m², bleomycin 10 000 iu/m², vinblastine 6 mg/m² and dacarbazine 375 mg/m² on day 1 and day 15 with a 28-day break between cycles. During the first cycle of systemic chemotherapy the patient became agitated and required sedation. It was decided that continuing with further treatment should be decided by the Court of Protection, which granted permission.

The patient completed treatment successfully and obtained complete remission from Hodgkin's lymphoma 6 months after treatment completion.

Discussion

This case illustrates some of the practical difficulties in treating patients under the Mental Capacity Act 2005. Although the probable outcome of not treating this patient's lymphoma was death, the proposed treatment also carried a high risk of morbidity and mortality and the administration of cytotoxic agents requires total compliance on behalf of the patient to avoid causing unnecessary harm to the patient and staff administering the treatment.

Any proposed intervention should be the least restrictive of the patient's basic rights and freedoms and the patient must be given all appropriate help to restore capacity to make such a decision. In this case, there was no time to spare to see whether reinitiating clozapine would restore the patient's capacity to consent to treatment and avoid application to the Court of Protection to treat without the patient's consent.

Since a third of the general population will be diagnosed with cancer in their lifetime¹⁶ and the population prevalence of schizophrenia is 0.30-0.66%,¹⁷ the concurrent use of clozapine and systemic chemotherapy in Hodgkin's lymphoma and other malignancies needs formal investigation. Our current knowledge base is from a handful of case reports which are not necessarily relevant to the malignancy in question.^{15,18} There is, however, a growing body of evidence from case reports that it may be safe to reintroduce clozapine treatment to control psychotic symptoms once the patient is established on systemic chemotherapy treatment.¹⁹⁻²¹ One case report exists where clozapine was reinstated in a case of Hodgkin's lymphoma when other antipsychotic agents failed to maintain psychotic symptom remission.²² But there is a lack of clear national and local guidelines as to the safe monitoring of these two potentially lethal treatments when prescribed concurrently. In the case of the patient we have described, blood parameters and clozapine levels were measured twice weekly and physical observations conducted 4-hourly throughout treatment.

It is widely established that patients are at greatest risk of agranulocytosis in the first 6 months of treatment with clozapine. A few cases of delayed-onset agranulocytosis have been described.^{23,24} The mechanism remains unknown, and thus physicians and psychiatrists are reluctant to prescribe concurrent myelosuppressing medication.²¹ Whether those well established on clozapine therapy are less likely to develop agranulocytosis while receiving systemic chemotherapy than those within 6 months of treatment needs also to be investigated.

Lithium has been used to increase neutrophil counts in those with neutropaenia during systemic chemotherapy and also in those with neutropaenia from clozapine therapy.^{8,9,25} The mechanism is poorly understood and may lead to an increased risk of lithium toxicity despite levels being within the therapeutic range.⁸ There is also some evidence that granulocyte-colony stimulating factor (G-CSF) can be used to treat agranulocytosis associated with chemotherapy and clozapine.⁸ However, whether lithium and G-CSF can be used prophylactically in cases where systemic chemotherapy and clozapine are concurrently prescribed has not been examined.

Conclusion

Despite the fact that none of the haematological parameters fell below critical levels in our patient, further research is needed before full conclusions with regard to safety during concurrent clozapine and systemic chemotherapy treatment. This case demonstrates the importance of regular immune and haematological parameters monitoring when such treatments are proposed.

1.8.84 Newspaper reporting of homicide-suicide and mental illness

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2015-12

Abstract**Aims and method**

To explore the portrayal of homicide-suicide in newspaper articles, particularly how mental illness was reported. We carried out a qualitative study in England and Wales (2006-2008). Data from newspaper articles obtained via the LexisNexis database were used to examine a consecutive series of 60 cases.

Results

A fascination with extreme violence, vulnerable victims and having someone to blame made homicide-suicides newsworthy. Some offenders were portrayed in a stereotypical manner and pejorative language was used to describe mental illness. The findings showed evidence of inaccurate and speculative reference to mental disorder in newspaper reports.

Clinical implications

The media should avoid speculation on people's mental state. Accurate reporting is essential to reduce stigma of mental illness, which may in turn encourage people to seek help if they experience similar emotional distress.

Contents

- *Newspaper reporting of homicide-suicide and mental illness*
 - *Method*
 - * *Study design*
 - * *Data collection and sample*
 - * *Missing data*
 - * *Quantitative analysis*
 - * *Qualitative analysis*
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 - * *Description of the sample*
 - * *What makes homicide-suicide newsworthy?*
 - * *How are the homicide-suicides reported?*
 - * *Accuracy of newspaper reports of mental illness*

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– *Discussion*

- * *Newspaper interest in homicide-suicide*
- * *Reporting mental illness responsibly*
- * *Speculating on offender's mental state*
- * *Limitations*

Homicide-suicide refers to an individual who commits homicide and subsequently takes their own life. There is no standardised definition regarding the time between the two incidents. A 3-day period has previously been taken as a cut-off point, the rationale being that a 24-hour cut-off is too restrictive. Mental state is likely to remain the same over a period of days and the two events are therefore connected, but reasons for the suicide may begin to change in excess of 3 days.^{1,2} These incidents attract widespread coverage in local and national newspapers. Consequently, the way they are reported informs both the general public's understanding of these incidents and their attitude towards offender and victim.³⁻⁵ Therefore, it is important that the circumstances are reported accurately, particularly when incidents involve people with mental illness. For instance, there is an association between certain methods of reporting suicide and increased suicide risk in young people and vulnerable adults (i.e. contagion).⁶⁻⁸ In addition, it has been uncovered that 14% of articles in the print media in 2011 referred to people with mental illness as a 'danger to others',⁹ reinforcing the stereotype that people with mental illness are violent. Speculating on a person's mental state without evidence is as stigmatising as the use of derogatory language. The UK 'Time to Change' campaign, led by the charities Mind and Rethink Mental Illness, aims to encourage the media to promote positive attitudes towards mental illness.¹⁰ If successful, this may encourage people to seek help.

This is the first study to examine newspaper reporting of mental illness in homicide-suicide. We aimed to explore how UK newspapers reported incidents of homicide-suicide and how mental illness was reported in relation to these cases.

Method

Study design

The findings presented are from a larger, mixed-method study of homicide-suicide undertaken by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) (details available from the authors on request). In brief, 60 cases of homicide-suicide were reported to NCISH by the Home Office Statistics Unit of Home Office Science and by individual police services. The offences occurred between 1 January 2006 and 31 December 2008 in England and Wales. The inclusion criteria for these incidents were that the suicide occurred within 3 days of the homicide and that a coroner returned a verdict of unlawful killing for the victim and suicide/open verdict for the offender. Additional information on each case was sought from coroner's files, police records, newspapers, general practitioner medical records and mental health service records. A diagnosis of mental disorder was determined from the offender's medical records.

Data collection and sample

A search was undertaken for newspaper articles pertaining to the 60 cases of homicide-suicide. The LexisNexis database (www.lexisnexis.com) was consulted to locate articles published between January 2006 (the date of the first offence) and September 2012 (the date when analysis commenced), allowing time for the legal process to be concluded and reported in the media.

Searches of all local and national UK newspapers were undertaken, including tabloid and broadsheet publications, which ensured the data were representative and encapsulated a range of journalistic styles and biases. The victims' and offenders' names were used as search terms rather than the generic phrase 'homicide-suicide'. In instances where individual searches yielded thousands of returns owing to common names, the term 'suicide' or 'homicide' was added to the search. In instances where there were no returns or the count was low, alternative spellings, name variants or

known aliases were used. In six incidents where no articles were returned on LexisNexis, an additional search of online news media was undertaken.

Missing data

After an extensive search, newspaper reports were obtained on 54 incidents (90%); no articles were found on 6 incidents (10%). It is possible that these events were not reported in the media; a previous study found only 62% of homicide-suicides were reported in national newspapers.¹¹ Consequently, we felt that 10% missing data was within an acceptable range that would not bias the findings and would retain the generalisability of the results.

Quantitative analysis

Descriptive statistics were generated to provide context for these homicide-suicide incidents and limited information has been presented. The results were reported using 95% confidence intervals. The analysis was undertaken using Stata version 12. If an item of information was not known for a case, the case was removed from the analysis of that item; the denominator in all estimates was the number of valid cases for each item and it indicates the number of missing cases per item.

Qualitative analysis

The analysis of documents was undertaken in accordance with the principles set out by Hodder (2003).¹² A systematic and comprehensive approach was adopted by applying framework analysis which involves five key stages: familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation.¹³ Each article was read and an iterative coding process was undertaken until saturation was reached. The themes were subsequently refined into three domains. The coding was carried out by S.F. and themes were discussed with L.G. and J.S.. Data were analysed using MAXQDA version 10 (www.maxqda.com). The approach differs from other qualitative analysis methods in stages four and five as it enables the data to be managed into a series of matrices whereby the data can be explored by theme and by case.¹⁴ This systematic, yet flexible, approach was preferred to other methods owing to the volume of data collected. Alternative methods to analyse media coverage used in previous research, such as content analysis with predetermined 'deductive' coding structures,¹⁵ latent class analysis¹⁶ or multivariate analysis,¹⁷ were not considered appropriate for this data.

Confidentiality and anonymity

The main data source were newspaper articles. Details of these incidents are therefore in the public domain.

Ethical approval

The study received the Medical Research and Ethics Committee (MREC) approval on 9 April 2008 and is registered under the Data Protection Act. The study was granted exemption under section 251 of the National Health Service Act 2006 (formerly Section 60 of the Health and Social Care Act 2001), enabling access to confidential and identifiable information without informed consent in the interest of improving patient care (approved 23 October 2008).

Results

Description of the sample

Over a 3-year period (2006-2008), 60 incidents of homicide-suicide were identified in England and Wales. Newspaper articles were obtained on 54 (90%) of these cases. Overall, 16 323 articles were found on these incidents. Duplicate articles (repeated in later editions) were excluded and the content was filtered for relevance. A total of 1163 articles were used in the analysis, an average of 22 per incident (range 0-115). The characteristics of offenders and victims are presented in *Table 1*. Most offenders were male, with a median age of 44, and over a quarter were from a Black and minority ethnic group. The victims were most commonly the offenders' spouse/partner or ex-spouse/partner, or their child. Nearly two-thirds of the offenders had a history of mental disorder.

Characteristics of offenders and victims

	<i>n</i> (%)	95% CI
Offender (<i>n</i> = 60)		
Median age, years (range): 44 (18–85)		
Gender: male	53 (88%)	80–97
Black and minority ethnic group	17 (29%)	17–41
History of mental illness from medical records	33 (62%)	49–76
Victim (<i>n</i> = 70)		
Median age, years (range): 38 (1–85)		
Gender: female	54 (77%)	67–87
Black and minority ethnic group	14(18%)	10–30
Relationship to the offender:		
Spouse/partner or ex-spouse/partner	45 (64%)	53–76
Child	20 (29%)	18–39

Three themes emerged from the qualitative analysis: characteristics that made these incidents newsworthy: how homicide-suicides were reported and the accuracy of newspaper reports of mental illness compared with the information contained in the deceased's medical records (*Table 2*).

Themes emerging from newspaper analysis

	Sub-theme
Theme 1: What makes homicide-suicide newsworthy?	Fascination with extreme violence and personal tragedy Characteristics of victims and offenders Having someone to blame
Theme 2: How are homicide-suicides reported?	Offender stereotypes The offender's personality Mental illness
Theme 3: Accuracy of newspaper reports of mental illness	Speculation that the incident was motivated by mental illness

What makes homicide-suicide newsworthy?

Fascination with extreme violence and personal tragedy

Tabloid newspapers exhibited a fascination with the level of violence involved in the incident. More often this referred to the violence against the victim in the homicide rather than the suicide. Graphic descriptions were used in the headlines, presumably in an attempt to attract readers. An example of a headline that illustrates the sensationalist nature of the reporting is: ‘CRAZED; EXCLUSIVE: Dad hacks toddler son to death and then kills himself’ (*The Mirror*, 2 September 2006).

Characteristics of victims

The newsworthiness of these incidents was also associated with the characteristics of the victim. The deaths of vulnerable or innocent victims added a further tragic element to the story. In addition to labelling the victims and offenders as good or evil, the status of the victim was elevated due to their profession. When reporting on the deaths of two police officers, one in the line of duty while responding to a serious incident, the language used emphasised the bravery of the victim while simultaneously showing disdain for the offender: “HERO cop [victim] was shot dead yesterday when a gunman went berserk during a furious row with his girlfriend. [The victim] was part of a police armed response unit called out to a domestic dispute after crazed [offender] armed himself with a hunting rifle (*The Sun*, 4 October 2007).”

Apportioning blame

There was increased newspaper coverage when the details of the homicide-suicide were used to highlight failure by services. In one article, the offender’s personal responsibility was marginalised and the focus turned towards perceived institutional failings, for which the newspaper blamed the prime minister: “Perhaps our PM and members of his government might like to imagine some inept social services bod bursting into THEIR home uninvited and removing their partner by force, saying: “It’ll be better for everyone.” What’s better for old people is that they feel safe and secure, and how the hell can they feel that when social-services Nazis tear them away from the one person left in the world who loves and understands them? The only person who remembers them as they were – strong and vibrant – not dependent on a state that doesn’t give a stuff about them?” (*News of the World*, 18 May 2008)”

How are the homicide-suicides reported?

We found markedly different styles of reporting between broadsheet and tabloid newspapers. A considerable number of articles reported short, factual accounts of the incident. By contrast, where the reports were opinion-based, these articles provided valuable insight as to how the offenders were perceived and portrayed to the general public.

Offender stereotypes

The portrayal of homicide-suicide in the media seemed to reinforce stereotypes and oversimplify the context of these events. For example, it was common for elderly couples with declining health to be described as being ‘devoted to each other’. Journalists assumed an empathic attitude toward the offender and the couple’s situation in general. Commonly referred to as ‘mercy killings’, a similar sympathetic tone was observed in cases of filicide by mothers where a child was killed for perceived altruistic reasons. However, fathers who killed their children did not receive the same level of sympathy, even when they experienced similar emotional distress before the homicide. In one article, the newspaper reported a mother’s defence of her son’s actions, in which two of her grandchildren died. This sentiment was subsequently criticised in the article, presumably to reinforce the message to the reader that there was no excuse for the offender’s actions and he did not deserve any sympathy.

The offender's personality

Direct quotations from family and friends were commonly used to generate a profile of the offender. These descriptions provided insight into how the person was perceived, and consequently, the image created of the offender in the media. Each case of homicide-suicide generated numerous articles in a range of publications. The witness descriptions of the perpetrator differed depending on the newspaper and the informant quoted. The contrast in the portrayal of the same offender is demonstrated: “‘Everyone is stunned and no one can believe it. He was such a nice bloke, he’d do anything for anyone and was very helpful and he absolutely loved his children.’ (*Daily Telegraph*, 23 September 2008) ‘There was something weird about him. I knew [he] wasn’t right in the head. He was an attention-seeking control freak who had a thing about teenage girls.’ (*News of the World*, 28 September 2008)”

Mental illness

Comments regarding the offender's perceived mental state were prominent in several newspaper headlines. Whereas most descriptions were written with sensitivity, there were some exceptions to this, notably from the tabloid press: ‘Nut free to kill for 3rd time’ (*The Sun*, 18 March 2006), ‘PSYCHO DADDY; Father strangled mum of his 4 kids then hung himself at home’ (*The Mirror*, 12 March 2009).

Accuracy of newspaper reports of mental illness

Speculation that the incident was motivated by mental illness

Newspapers are produced for commercial reasons and articles are written for specific audiences. We found the majority of the homicide-suicide incidents involving people with a history of mental illness were reported responsibly and newspapers did not stigmatise the offender. However, it was observed that some newspapers published speculative comments concerning the offender's mental state, without being able to substantiate these claims: “‘She must have had a very troubled mind to do what she did. We can’t imagine why she said to people she had cancer; she may have been suffering from some sort of mental illness. We are not aware of any mental health issues but that is something we shall be looking into.’ (*Birmingham Evening Mail*, 12 December 2007) ‘I would describe him as a psychopath. I saw him attack his brother with a hammer then run after him with a knife in the street.’ (*Yorkshire Post*, 9 March 2009)” In addition to the speculation regarding diagnoses, reporters often seemed to select quotations from witnesses that provided a default assumption of mental illness when there was seemingly no other plausible explanation. For example, they referred to the offender having ‘cracked’, ‘snapped’, ‘flipped’ or ‘gone berserk’. Although these terms appear in direct quotations from witnesses who knew the offender, the words imply the offender had experienced a mental health crisis at the time of the offence, yet no supporting evidence was provided to substantiate this.

Discussion

Newspaper interest in homicide-suicide

We found that homicide-suicides were highly newsworthy, with 90% reported in national and local newspapers, an average of 22 articles per incident. There are aspects of these offences which made them of public interest, notably they involved multiple victims, the majority of whom were intimate family members, consistent with previous research.¹⁸ Our data showed that extreme violence towards the victim, characteristics of the victim and the perceived failure of services to intervene in certain circumstances added to their media appeal. Emotive language, particularly in headlines, was used to attract the attention of the reader, which was consistent with findings from previous studies.^{17,19}

Reporting mental illness responsibly

In this study, we found the complexity of the events was often lost in the reporting. People who committed these acts were often assigned labels and portrayed in a stereotypical manner. We found evidence of derogatory language used to describe mental illness, such as ‘nut’ or ‘psycho’, although the majority of articles referred to people with mental illness more sensitively. This finding is consistent with a recent study undertaken by researchers at the Institute of Psychiatry in the UK which showed a decrease in the number of articles using pejorative language and referring to people with mental illness as being dangerous. The data also showed a simultaneous increase in anti-stigmatising newspaper articles and positive mental health promotion. However, the research reported no overall change in the proportion of stigmatising articles between 2008 and 2011.¹⁵

Speculating on offender’s mental state

Evidence of newspaper speculation on an individual’s mental state without any corroborating medical evidence was an important finding of this study. Labelling offenders as ‘psychopaths’ not only stigmatises the deceased, it also causes distress to the surviving family members. Previous research has shown how relatives of people who carried out a homicide or suicide experienced additional anguish due to the person’s portrayal in the media.^{20,21} Even where the evidence is lacking, reporters chose to reinforce the perception that mental illness is the only credible explanation for the offender’s actions. This conjecture promotes a widespread belief that ‘all’ people who commit homicide-suicide must have been mentally ill, when in many cases mental illness was not a feature. Data from the larger study of homicide-suicide have shown that 38% of offenders had no history of mental illness, consistent with a similar study in the USA.²² Guidance published by the American Foundation for Suicide Prevention and partners suggests that careful newspaper coverage could help to change these misconceptions.²³ Similarly, guidance for the media by Time to Change¹⁰ suggests to journalists: ‘Don’t speculate about someone’s mental health being a factor in the story unless you know it to be 100% true’. A further ‘reporting tip’ asks journalist to consider: ‘Who are your sources? Can you rely on eyewitnesses or neighbours to provide facts or has an assumption been made about someone’s mental health status?’ Examples of language that should or should not be used to avoid the perception of dangerousness are also detailed.

Limitations

Newspaper databases such as LexisNexis have been criticised for not being comprehensive and have been described as inconsistent and incomplete.²⁴ Previous research has shown that content (i.e. news wire stories) could have been removed before archiving; consequently, the original news content could be different from the archived version, which can introduce error.²⁴ Restrictive search terms could also lead to articles being missed. However, in this study the use of the individuals’ names in the search in conjunction with terms such as homicide or suicide made missing data less likely.

It is possible that mental illness was underreported, either through the reporter’s lack of interest in the offender’s mental health history or because they were unable to access medical information. Websdale & Alvarez²⁵ suggested that at the time of the incident the pivotal features of an article for journalists are ‘the crime-scene, the victims, and the aftermath of these killings’.

Homicide-suicide attracts a disproportionate amount of media attention. Although the number of incidents per year may be relatively small, the excessive and prominent newspaper reporting will inevitably influence our perception of these incidents and inform our understanding of the motivation for these acts. Previous research has shown an association between mental illness and homicide-suicide and this remains an important risk factor.¹⁸ Consequently, we would encourage the accurate reporting of mental illness in the media and advocating help-seeking behaviour in people who may be experiencing similar emotional distress. This is particularly important for men following the breakdown of a long-standing intimate relationship.²⁶

The study was carried out as part of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. We acknowledge the help of HM Coroners, Police Services, particularly Greater Manchester Police, and primary care trusts for providing access to data.

1.8.85 Provision of neuropsychiatry services: variability and unmet need

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Abstract

Aims and method

Neuropsychiatry services remain underdeveloped and underprovided. Previous studies have shown variability in service provision in the UK. In this survey we approached all mental health and neuropsychiatric service providers within London to map current neuropsychiatric service provision and explore perceived barriers.

Results

All the specialist mental health service providers responded. There was huge variability in neuropsychiatric service provision within different parts of London. There was evidence of significant unmet need and variability in service pathways. Lack of earmarked funds for neuropsychiatry and disjointed funding stream for such services were identified by providers as a barrier.

Clinical implications

This study provides further evidence of an ongoing lack of adequate neuropsychiatric service provision. Reasons for variability and unmet need are discussed. Adoption of a previously proposed hub-and-spoke model of service provision and the removal of commissioning barriers through uniform national commissioning may help deal with this problem.

Contents

- *Provision of neuropsychiatry services: variability and unmet need*
 - *Method*
 - *Results*
 - *Discussion*
 - * *Variability in service pathways*
 - * *Continued unmet need in neuropsychiatry*

1

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- * *Continued lack of equitable care*
- * *Reasons for variability and inadequate provision*
- * *Limitations*

Neuropsychiatric conditions are frequently encountered in neuroscience settings and are not uncommon in mental health services. However, the provision and development of neuropsychiatric services has lagged behind in the UK and globally.^{1,2} Attempts at establishing the neuropsychiatric needs of the general population have taken two different routes. Researchers have either assessed ‘mental health needs’ in neurology patients or have searched for ‘organic’ problems in general psychiatric patients. A number of studies from Europe have estimated psychiatric morbidity in neurology patients at 40-55%.³ A study from London looking at neuroscience in-patients found a prevalence of neuropsychiatric conditions of 55%.³ Similar figures were reported from Scotland (47%) and additionally, a 30% prevalence of conditions ‘not explained by organic cause’ in neurology out-patients was described.⁴ A study from Scandinavia reported the prevalence of psychiatric conditions in neurology patients as 55.1%.⁵ However, referral rates to mental health services in this study were only 4.6%. Therefore, one should not assume that these relatively high needs are always addressed. Data on assessment of neurological or organic conditions in mental health patients are poor, but these are estimated to be around 10%.⁶

Estimates of the prevalence of neuropsychiatric presentations in specific neurological conditions range from 20 to 75%, depending on the nature and severity of the condition, method of assessment and the population studied.⁷⁻⁹ Rates of neuropsychiatric problems are generally higher in the specialist or tertiary centre settings.

What constitutes a neuropsychiatric condition and which of those conditions require specialist neuropsychiatric service input has also been open to interpretation. We have defined neuropsychiatric conditions under four broad categories in the accompanying paper.¹⁰ Not all patients in those categories would require specialist neuropsychiatric input. Neuropsychiatry services would see patients that are complex and beyond the service provision capacity of either neurology services or mental health services alone. Patients accessing neuropsychiatry services should have problems that fall within one of the four categories that define neuropsychiatric conditions¹⁰ and should meet at least one of the criteria described in *Box 1*.

Information on neuropsychiatry need and demand at a clinical services level is available from two large-scale audits carried out in south England, led by two of the most established providers of neuropsychiatric services in the UK.^{11,12} The authors concluded that geographical distance from a specialist service was the most significant barrier to access to care. They also suspected there was a lack of localised service provision for neuropsychiatry, both of which contributed to unmet need. Both studies found unmet neuropsychiatric need, particularly in areas geographically distant from neuropsychiatry centres. It was concluded that there was emerging consensus that a referral rate of less than 20 per 100 000 population per year possibly signified unmet need in terms of service provision.⁶

Box 1 Criteria for referring a neuropsychiatric condition to a specialist neuropsychiatry service.

- Complex
- Requires specialist investigations
- Requires specialist assessment
- Requires specialist treatment
- Requires neuropsychiatric clinical expertise, which lies outside of that which may be expected in either mental health or neurology services.

Neuropsychiatric care pathways and commissioning are not standardised and are highly variable across the UK. We suspect that neuropsychiatry service provision and access to care for patients are likely to be influenced by other complex factors over and above the well-established ‘geographical distance’ from a centre of neuropsychiatry. In this study we aimed to explore whether there is still geographical variation in neuropsychiatry service usage. Rather than exploring this from a purely service provider perspective, we invited both service providers and service commissioners to share their views. Through this process we aimed to minimise potential bias of data on variability obtained in previous studies solely from tertiary referral centres. The ‘top-down’ approach of assessing variability purely from one specialist service

provider perspective may be prone to bias as more than one provider may be catering to the needs of the population in an area and indeed some services may be provided locally outside large tertiary centres.

Method

Two separate regional cross-sectional surveys were carried out. R.B. and N.A. devised two standardised questionnaires: one for commissioners and the other for service providers. The questionnaires were developed through iteration and in consultation with the national questionnaire survey into neuropsychiatry services.¹⁴ Questions were very broad and open ended to establish the current state of affairs rather than to prove or disprove an *a priori* hypothesis. Mapping of existing neuropsychiatry services in London was completed. Mapping of services was carried out by an electronic search for neuropsychiatric services by inputting words 'neuropsychiatry' and 'London' into a generic search engine. In addition, information on existing neuropsychiatry services was obtained through the Faculty of Neuropsychiatry at the Royal College of Psychiatrists and by calling all the major mental health trusts in the London area. All specialist mental health providers were identified within the target geographical area. National or tertiary level referral centres providing neuropsychiatry services and neurorehabilitation to the population of London, including public and private or independent providers, were also identified. Senior management for each provider were contacted electronically with the questionnaire and this was followed up by a telephone call.

All local mental health commissioners from primary care trusts (PCTs) were contacted using a similar method. The survey attempted to assess existing provision and service usage for neuropsychiatry to capture variation within the well-defined geographical units (boroughs covered by PCTs). We discovered there was a centralised regional (strategic health authority (SHA) level) specialist commissioning panel for neurorehabilitation in London that commissioned services related to acquired brain injury across the city. We approached it with the commissioning questionnaire for our survey. We also explored the commissioners' and providers' perceptions of neuropsychiatry and perceived barriers to neuropsychiatry service and commissioning. Data were verified and cross-checked between providers and commissioners, although it was recognised that commissioners often went to more than one provider for different elements of neuropsychiatry services. Data captured were subjected to descriptive analysis and no inferential statistics were used.

Results

Data were collected from the local PCT commissioners and from the London-wide specialist commissioning group referred to above. Most local commissioners reported on commissioning that took place through generic mental health streams, as opposed to the specialist stream referred to by the specialist commissioning group. Mental health commissioners were requested to report actual figures, however, if these were not available they were asked to offer estimated figures based on the available data. There were 31 boroughs and 30 PCTs in London, which covered a population of 185 000 to 399 000 each (average 284 000). Response rate from the PCTs was very good (83%) and 100% responses were received from the providers of neuropsychiatric services in the area. We were not made aware of any patients going out of area from London for neuropsychiatric need, on the contrary, providers in London see a number of patients from outside the local area.

The number of patients for the specialist commissioning group ranged from 3 to 76 per year (*Fig. 1*). Therefore, there was a 25-fold variation in incidence among the 30 referring geographical units within London. About half the PCTs ($n = 15$) were able to provide an estimate of the number of neuropsychiatry patients they funded: from 4 to 472 per year. The variation of incident referrals at the unit PCT mental health commissioning level was a staggering 118-fold. The variation in population between the 31 boroughs and the PCT catchment areas was approximately two-fold. In *Fig. 1*, bars 6 and 19 represent patients commissioned through specialist panels from two PCTs. For commissioning of neuropsychiatry through local commissioning they functioned as one unit and are represented as bar 7.

Fig. 24: Breakup of neuropsychiatry cases funded.

The commonest mode of commissioning of neuropsychiatry services was to tertiary services followed by local services. Funding streams for certain conditions were identified to be other than mental health, for example through acute care, physical health, neurosciences or older adults, or even Improving Access to Psychological Therapies (IAPT).

Brain injury rehabilitation was commissioned through the pan-London specialist commissioning group referred to earlier. Certain services, which were not specifically commissioned, were provided by mental health trusts (therefore commissioning of these services remains unclear).

Discussion

Variability in service pathways

Neuropsychiatry is a complex discipline which requires a highly skilled workforce dealing with a range of conditions. Different service models have been proposed to meet neuropsychiatric needs. In one of the models, neuropsychiatry services are based at a 'tertiary level', accepting referrals from psychiatry, neurology, geriatrics and general medicine.¹⁵ In London, though most neuropsychiatric service provision was at a tertiary level (*Fig. 2*), no clear service models or pathways of neuropsychiatry services emerge from the data. The lack of consistency of neuropsychiatry service provision in a relatively small geographical area is quite striking.

Internationally, different models for neuropsychiatry service provision have been reported. In Ireland, an in-patient neuropsychiatric service is closely aligned to neuroscience services and receives referrals from neurology and neurosurgery.¹⁶ Although neuropsychiatric services are commonly aligned to large neuroscience centres, successful neuropsychiatric services have been set up aligned to district or local general hospitals. There is a published report of such a service from the UK.¹⁷ Although there has been mention of community outreach model in line with stroke-related rehabilitation,¹⁸ there is little evidence that neuropsychiatry has adapted to such a service model. Most neuropsychiatry service models from outside the UK refer to a liaison consultation model.^{10,19} In the UK, the College's Faculty of Neuropsychiatry working group proposed a hub-and-spoke model, with the hub closely allied to the neurosciences centre but the spokes working closely with services in the community.⁶ Currently, there is no evidence that this model has yet been adopted consistently in London. There is an urgent need to create clear neuropsychiatry service pathways and a hub-and-spoke model is likely to be the best option.

Continued unmet need in neuropsychiatry

This study found huge variability in annual rates of funded neuropsychiatry cases in the London area. This may to some degree represent poor data collection, or it may reflect real variability in the provision of neuropsychiatry services. The rate of referral in some areas was as low as 2 per 100 000 population, and estimates of referral below 20 per 100 000 have been proposed to represent an unmet local need for neuropsychiatry services.⁶ This study once again found evidence that there continues to be very significant unmet need in neuropsychiatry within London, despite the presence of a number of well-recognised neuropsychiatry services. There appears to be very little progress in meeting neuropsychiatric need in recent years.^{11,12} Barriers to commissioning, which may be responsible for the current state of affairs and are proving to be persistent, need to be explored.¹⁰

Continued lack of equitable care

This survey continued to find significant variation in the number of patients accessing neuropsychiatry services in the different London areas served by different PCTs. Earlier audits by tertiary referral centres for neuropsychiatry had identified a significant variation in service usage from different areas. A south London study showed up to 34 times' variation in neuropsychiatry cases per 100 000 population, ranging from 0.910 to 30.8.¹² A north London audit also discovered variation, although on a slightly smaller scale ranging from 1.7 to 25, which amounted to almost 15 times' variation between the highest and lowest referring boroughs or counties.¹¹

Whereas these previous studies took a provider-facing approach, our study examined variation in service usage from both secondary and tertiary provider perspectives as well as local and specialist commissioner perspectives. It revealed a more acute variation in neuropsychiatry provision in London. There was approximately 25-fold variation across boroughs for head-injury-related admission for neuropsychiatric rehabilitation. This is similar to the variations noted above. This is in spite of the relatively homogeneous 'caseness' for acquired head injury, a relatively well-established

service provision across London and the specialist commissioning panel dedicated to brain injury rehabilitation. Variability for out-patient neuropsychiatry provision was much more marked. The level of variability of provision in different areas of London cannot be explained by differences in demographics, which at best can explain a small degree of variation in a relatively small geographical area. This study shows that there is lack of equitable access to neuropsychiatry care in different parts of London that requires careful exploration and explanation.

Reasons for variability and inadequate provision

This study concurs with the findings from the other two London studies that geographical distance from neuropsychiatry centres does adversely affect service usage. However, it indicates that there are other factors that contribute to this variability, given that the geographical distance from a centre of neuropsychiatric provision in London is not excessive.

We hypothesise that factors that present as barriers to care in neuropsychiatry include contractual arrangements, funding streams, awareness of neuropsychiatry among commissioners and providers, and national strategic drivers which have an impact on service provision. Areas local to tertiary or national neuropsychiatric services may have better communication with commissioners to overcome these barriers and more favourable contractual arrangements to minimise barriers to funding approval, compared with services located at a distance. Local mental health commissioners were more aware of neuropsychiatry as a discipline, its boundaries, funding streams and local needs when they were working in areas in close proximity to tertiary or national service provider. We also found that, in areas located in close proximity to neuropsychiatry centres, 'secondary' mental healthcare was sometimes provided by the same provider as the neuropsychiatry service, which may have minimised funding and pathway barriers.

Limitations

The study was carried out within the area of Greater London, which may raise concerns about generalisability of the data to the rest of the UK. London traditionally has a better level of neuropsychiatry service provision and has well-known services that received referrals from outside London. Data from previous studies^{11,12} show that the provision of neuropsychiatry services outside London is not as good and the variability and unmet need is likely to be even more acute. Hence, the data from this study are pertinent to the whole of the UK and any solutions to deal with unmet need and variability should be applicable country wide. Indeed, given that a similar state of affairs has been reported anecdotally elsewhere in Europe,⁵ we believe the lessons learnt from this work are global.

The study looked into commissioning and provision from the mental health perspective and incorporated neurorehabilitation specialist commissioning. However, neuropsychiatry services are located at the interface of neurology and psychiatry and therefore the study may have failed to capture any neuropsychiatry service provisions that were embedded within acute healthcare setting. However, evidence of huge variability, unmet need and the fact that some boroughs had no local neuropsychiatric commissioning arrangements reasonably close to areas of neuropsychiatric service provision strongly suggests that provision for neuropsychiatry in London remains inequitable and inadequate.

The study surveyed service providers and commissioners and can only comment on the responders' understanding, knowledge and perception of how services were aligned, and provides proxy measures as opposed to real ones. The participants' responses might be affected owing to a lack of coherent understanding around caseness in neuropsychiatry. We have proposed a clearer definition of what constitutes a neuropsychiatric condition in Box 2 in the accompanying paper,¹⁰ and have defined the threshold criteria for when a referral should be made to a neuropsychiatric service for such conditions in Box 1 in this paper. In our opinion, a combination of a clear definition of neuropsychiatric condition and the threshold criteria will help resolve the issue of caseness.

This study provides further evidence of a continuing unmet need, significant variability of provision and lack of consistent service models and pathways in neuropsychiatry in the Greater London area. We believe this is representative of the situation in the rest of the UK, where the problem may be even worse given that London has a higher level of neuropsychiatric service provision with a few regional and national centres. The reasons for such variability need to be explored and minimised. Barriers to commissioning and provision¹⁰ need to be explored and removed. A hub-and-spoke model of neuropsychiatry provision closely allied with neurosciences centres⁶ should be adopted widely to bring

consistency of pathways. National commissioning with a mandate for abolishing undesirable variability and unmet need is the real solution, but one that is not without significant challenges.

1.8.86 *BJPsych International*: new name, new strategic focus

date

2015-2-01

Contents

- *BJPsych International: new name, new strategic focus*

With this issue of our journal we are beginning a new chapter in facilitating communication between psychiatrists throughout the world. *International Psychiatry* was established in 2003, as the *Bulletin of the Board of International Affairs* of the Royal College of Psychiatrists. It continues to be provided free of charge, both in paper and online, thanks to the generosity of the members of the Royal College of Psychiatrists. Our potential readership is enormous: over 15 000 members of the College receive the print edition regularly, and all issues can be downloaded from the College website. We need to address both the clinical interests and the needs of this diverse readership, and in so doing we will be redirecting the focus of the journal over the next few months and years. Publication of articles in the journal will remain cost free to contributors and rigorous refereeing will be sustained.

The time has come to review our strategic aims. Over the past decade, there has been a gradual evolution in content. We have focused increasingly on issues that have practical application in countries that do not have the resources to be adequately supporting psychiatric services.

First, we published accounts of the infrastructure of psychiatry provided worldwide in ‘Country Profiles’, a series that began with our first issue and emphasised diversity in mental health policies. We will continue with this policy and we have added an important section on international aspects of ‘Mental Health Law’, which is curated by George Ikkos, Deputy Editor.

Second, since the very first issue, we have reviewed diverse ‘Themes’, with a brief editorial and three papers that address the same topic from different perspectives. We intend to continue to address themes that have real practical relevance to supporting patients, with a particular, but not exclusive, focus on the needs of low- and middle-income countries as well as the mental health needs of the poor and socially excluded in high-income countries. Contributors who can provide examples of innovative practice, which could be emulated elsewhere at minimal cost, are especially welcome, as are papers on public mental health. Most articles in this thematic section are commissioned.

We receive a regular stream of uncommissioned articles, including some that concern original research findings. In future, we will not be publishing research articles of this type. The journal’s identity will be focused on practical issues, rather than theory or scientific studies that have no immediate relevance to the delivery of clinical services. We will pass such submissions on to the *British Journal of Psychiatry*’s new online sister journal, *BJPsych Open*, for consideration for publication there. We will continue to accept uncommissioned ‘Special Papers’, on subject matter that does not necessarily fit within a theme, but which is consonant with our aims.

There was a pressing need to address our limited online presence, and we have done so principally in the form of a blog. As we will no longer be publishing a Correspondence column, we will arrange for submitted comments about published articles, and also other relevant material, to be placed in the blogosphere, at <http://www.BJPsychInternationalblog.org>. A new member of the Editorial Board, David Jimenez, will be managing it, along with a social media presence with the journal’s new Facebook page (<https://www.facebook.com/BJPsychInternational>) as well as a Twitter account ([@BJPsychInt](https://twitter.com/BJPsychInt)). We will also be changing the face of ‘News and Notes’. In a journal that is published quarterly, it was inevitable that most news was out of date by the time it appeared in print. Accordingly, a change of focus was needed. Eleni Palazidou will be managing the new commentary section of the journal, ‘Pandora’s Box’, which will take as its theme important developments in psychiatric practice over the previous few months that have direct clinical relevance to the non-specialist.

Finally, we have reviewed membership of the Editorial Board. We are keen for Editors to be active ambassadors for the journal, and we have consulted with members over the past few months about their roles. We have assigned specific tasks to many members of the revised Board, who will, we hope and anticipate, be actively eliciting contributions to the journal from colleagues in their region of the world. An important innovation is the appointment of new regional Associate Editors, who will help ensure the increasing local importance of the journal to psychiatrists worldwide. We have a new Associate Editor, Daniel Maughan, with responsibility for 'Psychiatry and Sustainability', a subject that is of increasing importance to all psychiatrists.

We trust the changes we have introduced, in the relaunched and renamed *BJPsych International*, will be welcomed by our readership. We look forward to hearing your comments.

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